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SENATE—*Friday, June 20, 2003*

The Senate met at 9 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today the prayer will be offered by our guest Chaplain, Rev. Mark Batterson, National Community Church, Washington, DC.

PRAYER

The guest Chaplain offered the following prayer:

Heavenly Father, we recognize that every good and perfect gift comes from You. It is in You that we live and move and have our being. It is Your Spirit who empowers us when we are weak and enlightens us when we are confused.

I pray that You would give the men and women who serve in this Senate a spirit of wisdom and revelation. Help them discern between what is good and what is best. Help them to discern between what is temporal and what is eternal.

Give them the wisdom to discern Your good, pleasing, and perfect will and the courage to do it. In Jesus' name. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, in a moment the Senate will have a short period for debate and closing remarks in relation to S. 504, the American history and civics education bill. The vote on passage of the bill will begin promptly at 9:15 this morning.

Following that vote, the Senate will resume the prescription drug bill and proceed to a vote in relation to the pending Dorgan amendment on drug reimportation.

Following those votes, Members are encouraged to remain and offer their amendments. The chairman and ranking member will be here throughout the day to process as many of the amendments as possible. Later today, I will have more to say on the schedule for next week. I might add that we will be voting late Monday afternoon, but we will have more on that a little bit later this morning.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER (Mr. CHAMBLISS). Under the previous order, the leadership time is reserved.

AMERICAN HISTORY AND CIVICS EDUCATION ACT OF 2003

The PRESIDING OFFICER. Under the previous order, the hour of 9 a.m. having arrived, the Senate will resume the consideration of S. 504, which the clerk will report.

The legislative clerk read as follows:

> A bill (S. 504) to establish academies for teachers and students of American history and civics and a national alliance of teachers of American history and civics, and for other purposes.

The PRESIDING OFFICER. The Senator from Tennessee.

AMENDMENT NO. 951

Mr. ALEXANDER. Mr. President, I ask unanimous consent the substitute amendment to S. 504, which is at the desk, be agreed to, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 951) was agreed to.

(The amendment is printed in today's RECORD under "Text of Amendments.")

Mr. ALEXANDER. Mr. President, on March 4, I made the maiden speech the majority leader has encouraged each of us new Senators to make. I chose two urgent issues I care most about: The education of our children, No. 1; and the principles that unite us as Americans, No. 2. I then introduced S. 504, the American History and Civics Education Act of 2003.

In a few minutes, we will vote on that bill. Its purpose is to help put the teaching of American history and civics in its rightful place in our schools so our children can grow up learning what it means to be an American. Its purpose is to inspire better teaching and more learning of the key events, key documents, key persons, and key ideas that shaped the institutions and democratic heritage of the United States of America.

This legislation would do that by creating summer academies for students and teachers of American history and civics. There will be up to 12 Presidential Academies for teachers. These might last 2 weeks and be sponsored by an educational institution or a nonprofit organization. And there will be up to 12 4-week Congressional Academies for students.

It also creates a State-by-State national alliance of history and civics teachers, and authorizes $25 million for these purposes.

We need this legislation because our children are not learning what it means to be an American. In his testimony before our committee, author David McCullough spoke of Ivy League college students who think Abraham Lincoln was President before the Civil War and that Germany and Italy were our Allies during World War II. One-third of fourth, eighth, and twelfth graders do not even have basic knowledge about American history and civics, making them what one might call civic illiterates. They are not learning it because, in too many instances, it is not being taught.

Civics too often is dropped from school curricula. More than half the States have no requirements for a course in American government and American history. When it is taught, it is too often watered down. The textbooks are too dull, the pages too often feature victims and diminish heroes. Because of politically correct attitudes from the right and from the left, teachers are afraid to teach the great controversies, the great conflicts, the

● This "bullet" symbol identifies statements or insertions which are not spoken by a member of the Senate on the floor.

great struggles, the great stories that are the heritage, the essence of American history.

This effort has overwhelming support in the Congress—36 U.S. Senators of both parties. An identical bill has been introduced in the House of Representatives by ROGER WICKER of Mississippi, and 160 Members of the House, of both parties, support it.

I want especially to reiterate my thanks to the majority leader who, during a busy time, has found time for this small but important piece of legislation, and to the Democratic whip, Mr. REID, who has also made it possible for there to be time for this in the midst of this debate and who is the prime cosponsor of this legislation. I thank Chairman GREGG of our committee for reporting it promptly and for cosponsoring it, and Senator KENNEDY, the ranking member, who did not just cosponsor it but was busy gathering other cosponsors.

I want to acknowledge, too, the support of CONRAD BURNS, the Senator from Montana, a historian who is chairman of the relevant appropriations subcommittee, and especially Senator BYRD of West Virginia, who has been a leader in other legislation that has passed this body on American history, and who took the time to come to the hearing on this legislation, in person, and to testify.

I yield the floor and reserve whatever time remains.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I ask unanimous consent Senator LAUTENBERG be added as a cosponsor to S. 504.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Senator ALEXANDER said, "It's time to put the teaching of history and civics back in its rightful place in our schools so our children grow up learning what it means to be an American."

That is really what this is all about. It is about having history and civics as a part of what our schools are about and should be about. I acknowledge, as I did last night on the Senate floor, the leadership of the Senator from Tennessee, the former Secretary of Education, in pushing this legislation to the point where it is.

I hope this is the first of many such measures that we work on here. I believe in local control of schools. But I also believe the Federal Government must recognize national problems in education and address those problems and help local school districts meet what I believe are national imperatives. Certainly, this is one.

It is so easy to shortchange these courses. As I look back at some of the great teachers I had, they taught history and government on the high school level. A man by the name of Michael Callahan taught basic history and government in high school in Henderson, NV, where I went to school. But for him I am not sure I would have the interest in government and history that I have today. He allowed us to participate in government. He allowed us to understand history. He was a dynamic teacher.

I believe that is what we are trying to do here—give teachers the tools they need to become better teachers. Obviously, teachers have chosen their profession in the effort to improve the lives of children they teach. This legislation deals with courses K through 12. But even though these teachers have chosen teaching as their profession, it doesn't mean they don't need help. That is what this is all about—to help them through this academy and become better teachers who are better equipped to do the things they need to do to teach.

This legislation is not going to be based just in the South or the Northeast or just in the Midwest. The legislation calls for 12 regional academies to be determined by the Chairman of the National Endowment for the Humanities. He will choose the academies on a regional basis. This program will be effective all over the United States. I am confident that the Presidential Academies for teaching American history and civics will be important. There will be 12 of them. There will be up to 12 Congressional Academies for students of American history and civics.

I am convinced that if we show we are concerned about education here in Washington, the schools at home will become better schools and teachers will become better teachers. I hope this will receive unanimous support.

This is only the first step. It is easy for us here in Washington to pass legislation where we authorize things to happen, but the next step is appropriating the money to make sure that the authorization we have made is effective. The distinguished Senator from Tennessee and I have had the assurance of members of the Appropriations Committee that they will allow us to go this next step and have money appropriated.

As I indicated last night, Senator BYRD having participated in the public hearing is a step in the right direction. Senator CONRAD BURNS has indicated he will be helpful. I look forward to working in the appropriations process to make sure we carry forward on the promise of Senator LAMAR ALEXANDER, a Senator who authored this legislation, indicating it is important to put the teaching of American history and civics in its right place in our schools so children can grow and learn what it means to be an American.

Mr. KENNEDY. Mr. President, I am pleased to support the American History and Civics Education Act to create academies for teachers and high school students of American history. The bill will expand the programs of the National Endowment for the Humanities to improve the educational experience of young Americans and broaden their understanding of our unique heritage.

The American national experience is a comparatively short one, but its early struggles, revolutionary roots, and democratic ideals have shaped our national character. Early American history includes eras of prosperity and progress, dark years of war, and racial struggles. Each of these defining moments has called forth great leaders and national heroes, in all walks of life, who unhesitatingly offered their resources, their efforts and, sometimes, their lives on behalf of their belief in the principles of tolerance, religious freedom, and equality. Each generation of Americans has defended those principles and, in the process, strengthened our national purpose and resolve.

To prepare the next generation of American leaders, we must ensure that they understand not only these historic challenges and achievements but also the key documents that are our enduring guideposts, especially the Constitution and Bill of Rights.

This legislation, introduced by my colleague from Tennessee, will authorize a competitive grant program for institutions of higher education and nonprofit educational research centers to conduct summer seminars for history teachers to strengthen their skills in their subject area. These seminars will enable teachers to develop a broader understanding of history and also new skills and enthusiasm to present this material to their students.

The legislation also authorizes a competitive grant program for academies for outstanding high school juniors and seniors who have excelled in their study of history. These academies will enable these promising young students to learn from especially talented teachers and provide a special opportunity for them to advance their understanding of the great achievements of our proud Nation.

The HELP Committee conducted an impressive hearing on this legislation earlier this year. Among the several distinguished witnesses who appeared before the committee was the Pulitzer Prize-winning historian, David McCullough. He spoke eloquently of the urgent need to improve the educational experience of history students.

He reminded us that passion for learning is "caught not taught," and that the better prepared our teachers are, the more likely we are to stimulate a new generation of historians, history lovers, and national leaders.

Mr. McCullough also suggested that those institutions that ultimately conduct these academies should reach out to their local Park Service historic sites, which offer incredible resources and a birds-eye view of history to enthusiastic visitors. He has been an ongoing presence at both the Longfellow House and the Adams Historic Park sites in Massachusetts during his research on his impressive biography of John Adams. Those same artifacts are accessible to all aspiring history lovers and can ignite a passion for visitors to these sites as they visualize John Adams at his desk writing his friend, Thomas Jefferson, debating the goals and dreams of a young Nation.

John Adams wrote, "I must study politics and war that my sons may have the liberty to study mathematics and philosophy . . . in order to give their children the right to study painting, poetry and music." Our second President was a great leader in his time and his words inspire all Americans to learn more about our past in order to better prepare for the future. If we neglect study in the arts and humanities, we will know considerably less about ourselves, our Nation, our allies and our adversaries—and we will be considerably less prepared for the challenges which loom on the horizon.

The new academies will be under the jurisdiction of the National Endowment for the Humanities whose Chairman, Bruce Cole, is doing an impressive job at the Endowment. As an historian himself, he knows the importance of our goal.

The bill is a timely and important initiative which will make American history come alive for students, and serve our communities and our country well in the years ahead. I commend Senator ALEXANDER for his leadership in developing this bipartisan legislation that is based on the model which he implemented earlier as Governor of Tennessee. I am confident that these summer academies will enrich the learning experience of thousands of young students who want to know more about their heritage as Americans.

It is a visionary effort and I hope that my colleagues will join me in supporting it today.

Mr. ALEXANDER. Mr. President, I thank the Senator from Nevada, the distinguished assistant Democratic leader, for his comments late last evening when we discussed this bill and for his support. I look forward to working with him on other education legislation in a bipartisan way. I am glad he talked about appropriations. Senator STEVENS also is a cosponsor of the bill, for which we are pleased.

People from potential sponsoring institutions have asked me how this might work.

First, the legislation has to be passed. But given the strong bipartisan support it has in both Houses, if it were to be passed and the money were to be appropriated in a reasonable period of time, the first of these academies might open in the summer of 2004. For that to happen, the National Endowment for the Humanities would need to receive applications beginning this fall. I hope the universities, the nonprofit organizations, and the State educational institutions will begin to prepare for that. They might look at the Governors' Schools across this country in many States as models.

At a time when the United States of America is under attack because of who we are, it is crucial that our children learn the values and principles that make this the United States of America. When you move to France or Japan, you don't become French or Japanese. When you move to the United States and seek to become an American citizen, you become an American, because of what we believe in, a few principles—liberty, equal opportunity, individualism, laissez-faire, the rule of law, federalism, e pluribus unum, the free exercise of religion, the separation of church and state, and a belief in progress. We almost all agree on those principles. Our politics is about applying them. That is what we debate every day here. We need to be teaching our children, as the Senator from Nevada said, these principles so they will grow up knowing what it means to be an American.

I urge all Senators to support this legislation.

Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

The PRESIDING OFFICER. The question is on passage of the bill, as amended. The clerk will call the roll.

The legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Utah (Mr. BENNETT), the Senator from Colorado (Mr. CAMPBELL), the Senator from Nebraska (Mr. HAGEL), the Senator from Indiana (Mr. LUGAR), and the Senator from Ohio (Mr. VOINOVICH) are necessarily absent.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from North Carolina (Mr. EDWARDS), the Senator from Hawaii (Mr. INOUYE), the Senator from Massachusetts (Mr. KERRY), and the Senator from Vermont (Mr. LEAHY) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY), and the Senator from Vermont (Mr. LEAHY) would each vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 90, nays 0, as follows:

[Rollcall Vote No. 231 Leg.]

YEAS—90

Akaka
Alexander
Allard
Allen
Baucus
Bayh
Bingaman
Bond
Boxer
Breaux
Brownback
Bunning
Burns
Byrd
Cantwell
Carper
Chafee
Chambliss
Clinton
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Crapo
Daschle
Dayton
DeWine
Dodd
Dole
Domenici
Dorgan
Durbin
Ensign
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham (FL)
Graham (SC)
Grassley
Gregg
Harkin
Hatch
Hollings
Hutchison
Inhofe
Jeffords
Johnson
Kennedy
Kohl
Kyl
Landrieu
Lautenberg
Levin
Lieberman
Lincoln
Lott
McCain
McConnell
Mikulski
Miller
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Nickles
Pryor
Reed
Reid
Roberts
Rockefeller
Santorum
Sarbanes
Schumer
Sessions
Shelby
Smith
Snowe
Specter
Stabenow
Stevens
Sununu
Talent
Thomas
Warner
Wyden

NOT VOTING—10

Bennett
Biden
Campbell
Edwards
Hagel
Inouye
Kerry
Leahy
Lugar
Voinovich

The bill (S. 504), as amended, was passed as follows:

S. 504

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "American History and Civics Education Act of 2003".

SEC. 2. DEFINITIONS.

In this Act:

(1) AMERICAN HISTORY AND CIVICS.—The term "American history and civics" means the key events, key persons, key ideas, and key documents that shaped the institutions and democratic heritage of the United States of America.

(2) CHAIRMAN.—The term "Chairman" means the Chairman of the National Endowment for the Humanities.

(3) EDUCATIONAL INSTITUTION.—The term "educational institution"—

(A) means—

(i) an institution of higher education;

(ii) an educational institution created by a legislative act of a State for the express purpose of teaching American history and civics to elementary school and secondary school students; or

(iii) a nonprofit educational institution, library, or research center; and

(B) includes a consortium of entities described in subparagraph (A).

(4) INSTITUTION OF HIGHER EDUCATION.—The term "institution of higher education" has the meaning given the term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

(5) KEY DOCUMENTS.—The term "key documents" means the documents that established or explained the foundational principles of democracy in the United States, including the United States Constitution and the amendments to the Constitution (particularly the Bill of Rights), the Declaration of Independence, the Federalist Papers, and the Emancipation Proclamation.

(6) KEY EVENTS.—The term "key events" means the critical turning points in the history of the United States (including the encounter of Native Americans with European settlers, the American Revolution, the Civil War, the world wars of the twentieth century, the civil rights movement, and the major court decisions, legislation, literature, and the arts) that established democracy and extended its promise in American life.

(7) KEY IDEAS.—The term "key ideas" means the ideas that shaped the democratic institutions and heritage of the United States, including the notions of liberty, equal opportunity, individualism, laissez faire, the rule of law, federalism and e pluribus unum, the free exercise of religion, the separation of church and state, and a belief in progress.

(8) KEY PERSONS.—The term "key persons" means the men and women who led the United States as Founding Fathers, Native American leaders, elected officials, scientists, inventors, pioneers, advocates of equal rights, entrepreneurs, and artists.

(9) STATE.—The term "State" means each of the 50 States and the District of Columbia.

(10) TEACHERS OF AMERICAN HISTORY AND CIVICS.—The term "teachers of American history and civics" means kindergarten through grade 12 teachers who teach American history, government, or civics, or who incorporate such subjects into their teaching.

SEC. 3. PRESIDENTIAL ACADEMIES FOR TEACHING OF AMERICAN HISTORY AND CIVICS.

(a) ESTABLISHMENT.—From amounts appropriated under subsection (j), the National Endowment for the Humanities shall award grants, on a competitive basis, to educational institutions to establish Presidential Academies for Teaching of American History and Civics (in this section referred to as "Academies") that shall offer workshops for teachers of American history and civics—

(1) to strengthen such teachers' knowledge of the subjects of American history and civics; and

(2) to learn how better to teach such subjects.

(b) APPLICATION.—

(1) IN GENERAL.—An educational institution that desires to receive a grant under this section shall submit an application to the National Endowment for the Humanities at such time, in such manner, and containing such information as the National Endowment for the Humanities may require.

(2) CONTENTS.—An application submitted under paragraph (1) shall—

(A) include the criteria that will be used to determine which teachers will be selected to attend workshops offered by the Academy;

(B) identify the individual the educational institution intends to appoint to be the primary scholar at the Academy;

(C) include a description of the curriculum to be used at workshops offered by the Academy; and

(D) provide an assurance that the recruitment plan for which teachers will be selected to attend workshops offered by the Academy will include teachers from schools receiving assistance under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.), particularly those schools with high concentrations of students described in section 1124(c) of such Act.

(c) NUMBER OF GRANTS.—The National Endowment for the Humanities shall award not more than 12 grants to different educational institutions under this section.

(d) DISTRIBUTION.—The Chairman shall encourage equitable distribution of grants under this section among the geographical regions of the United States.

(e) GRANT TERMS.—Grants awarded under this section shall be for a term of 2 years.

(f) USE OF FUNDS.—

(1) WORKSHOPS.—

(A) IN GENERAL.—An educational institution that receives a grant under this section shall establish an Academy that shall offer a workshop during the summer, or during another appropriate time, for teachers of American history and civics—

(i) to strengthen such teachers' knowledge of the subjects of American history and civics; and

(ii) to learn how better to teach such subjects.

(B) DURATION OF WORKSHOP.—A workshop offered pursuant to this section shall be approximately 2 weeks in duration.

(2) ACADEMY STAFF.—

(A) PRIMARY SCHOLAR.—Each Academy shall be headed by a primary scholar identified in the application submitted under subsection (b) who shall—

(i) be accomplished in the field of American history and civics; and

(ii) design the curriculum for and lead the workshop.

(B) CORE TEACHERS.—Each primary scholar shall appoint an appropriate number of core teachers. At the direction of the primary scholar, the core teachers shall teach and train the workshop attendees.

(3) SELECTION OF TEACHERS.—

(A) IN GENERAL.—

(i) NUMBER OF TEACHERS.—Each year, each Academy shall select kindergarten through grade 12 teachers of American history and civics to attend the workshop offered by the Academy.

(ii) FLEXIBILITY IN NUMBER OF TEACHERS.—Each Academy shall select not more than 300 and not less than 50 teachers under clause (i).

(B) TEACHERS FROM PUBLIC AND PRIVATE SCHOOLS.—An Academy may select teachers from public schools and private schools to attend the workshop offered by the Academy.

(g) COSTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a teacher who attends a workshop offered pursuant to this section shall not incur costs associated with attending the workshop, including costs for meals, lodging, and materials while attending the workshop, and may receive a stipend to cover such costs.

(2) TRAVEL COSTS.—A teacher who attends a workshop offered pursuant to this section shall use non-Federal funds to pay for such teacher's costs of transit to and from the Academy.

(h) EVALUATION.—

(1) IN GENERAL.—At the completion of all of the workshops assisted in the third year grants are awarded under this section, the National Endowment for the Humanities shall conduct an evaluation and submit a report on its findings to the relevant committees of Congress.

(2) CONTENT OF EVALUATION.—The evaluation conducted pursuant to paragraph (1) shall—

(A) determine the overall success of the grant program authorized under this section; and

(B) highlight the best grantees' practices in order to become models for future grantees.

(i) NON-FEDERAL FUNDS.—An educational institution receiving Federal assistance under this section may contribute non-Federal funds toward the costs of operating the Academy.

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $7,000,000 for each of fiscal years 2004 through 2007.

SEC. 4. CONGRESSIONAL ACADEMIES FOR STUDENTS OF AMERICAN HISTORY AND CIVICS.

(a) ESTABLISHMENT.—From amounts appropriated under subsection (j), the National Endowment for the Humanities shall award grants, on a competitive basis, to educational institutions to establish Congressional Academies for Students of American History and Civics (in this section referred to as "Academies") that shall offer workshops for outstanding students of American history and civics to broaden and deepen such students' understanding of American history and civics.

(b) APPLICATION.—

(1) IN GENERAL.—An educational institution that desires to receive a grant under this section shall submit an application to the National Endowment for the Humanities at such time, in such manner, and containing such information as the National Endowment for the Humanities may require.

(2) CONTENTS.—An application submitted under paragraph (1) shall—

(A) include the criteria that will be used to determine which students will be selected to attend workshops offered by the Academy;

(B) identify the individual the educational institution intends to appoint to be the primary scholar at the Academy;

(C) include a description of the curriculum to be used at workshops offered by the Academy; and

(D) include a description of how the educational institution will—

(i) inform students from schools receiving assistance under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.), particularly those schools with high concentrations of students described in section 1124(c) of such Act, of the Academy; and

(ii) provide such students with information on how to apply to attend workshops offered by the Academy so that such students may attend the workshops.

(c) NUMBER OF GRANTS.—The National Endowment for the Humanities shall award not more than 12 grants to different educational institutions under this section.

(d) DISTRIBUTION.—The Chairman shall encourage equitable distribution of grants under this section among the geographical regions of the United States.

(e) GRANT TERMS.—Grants awarded under this section shall be for a term of 2 years.

(f) USE OF FUNDS.—

(1) WORKSHOPS.—

(A) IN GENERAL.—An educational institution that receives a grant under this section shall establish an Academy that shall offer a workshop during the summer, or during another appropriate time, for outstanding students of American history, government, and civics to broaden and deepen such students' understanding of American history and civics.

(B) DURATION OF WORKSHOP.—A workshop offered pursuant to this section shall be approximately 4 weeks in duration.

(2) ACADEMY STAFF.—

(A) PRIMARY SCHOLAR.—Each Academy shall be headed by a primary scholar identified in the application submitted under subsection (b) who shall—

(i) be accomplished in the field of American history and civics; and

(ii) design the curriculum for and lead the workshop.

(B) CORE TEACHERS.—Each primary scholar shall appoint an appropriate number of core teachers. At the direction of the primary scholar, the core teachers shall teach the workshop attendees.

(3) SELECTION OF STUDENTS.—

(A) NUMBER OF STUDENTS.—Each year, each Academy shall select between 100 and 300 eligible students to attend the workshop offered by the Academy.

(B) ELIGIBLE STUDENTS.—A student shall be eligible to attend a workshop offered by an Academy if the student—

(i) is recommended by the student's secondary school principal (or other head of such student's academic program) to attend the workshop; and

(ii) will be a junior or senior in the academic year following attendance at the workshop.

(g) COSTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a student who attends a workshop offered pursuant to this section shall not incur costs associated with attending the workshop, including costs for meals, lodging, and materials while attending the workshop.

(2) TRAVEL COSTS.—A student who attends a workshop offered pursuant to this section shall use non-Federal funds to pay for such student's costs of transit to and from the Academy.

(h) EVALUATION.—

(1) IN GENERAL.—At the completion of all of the workshops assisted in the third year grants are awarded under this section, the National Endowment for the Humanities shall conduct an evaluation and submit a report on its findings to the relevant committees of Congress.

(2) CONTENT OF EVALUATION.—The evaluation conducted pursuant to paragraph (1) shall—

(A) determine the overall success of the grant program authorized under this section; and

(B) highlight the best grantees' practices in order to become models for future grantees.

(i) NON-FEDERAL FUNDS.—An educational institution receiving Federal assistance under this section may contribute non-Federal funds toward the costs of operating the Academy.

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $14,000,000 for each of fiscal years 2004 through 2007.

SEC. 5. NATIONAL ALLIANCE OF TEACHERS OF AMERICAN HISTORY AND CIVICS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—From amounts appropriated under subsection (e), the National Endowment for the Humanities shall award 1 or more grants to organizations for the creation of a national alliance of elementary school and secondary school teachers of American history and civics.

(2) PURPOSE.—The purpose of the national alliance is—

(A) to facilitate the sharing of ideas among teachers of American history and civics; and

(B) to encourage best practices in the teaching of American history and civics.

(b) APPLICATION.—An organization that desires to receive a grant under this section shall submit an application to the National Endowment for the Humanities at such time, in such manner, and containing such information as the National Endowment for the Humanities may require.

(c) GRANT TERM.—A grant awarded under this section shall be for a term of 2 years and may be reapplied after the initial term expires.

(d) USE OF FUNDS.—An organization that receives a grant under this section may use the grant funds for any of the following:

(1) Creation of a website on the Internet to facilitate discussion of new ideas on improving American history and civics education.

(2) Creation of in-State chapters of the national alliance, to which individual teachers of American history and civics may belong, that sponsors American history and civics activities for such teachers in the State.

(3) Seminars, lectures, or other events focused on American history and civics, which may be sponsored in cooperation with, or through grants awarded to, libraries, States' humanities councils, or other appropriate entities.

(4) Coordinate activities with other nonprofit educational alliances that promote the teaching or study of subjects related to American history and civics.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, and for any administrative costs associated with carrying out sections 3 and 4, $4,000,000 for each of fiscal years 2004 through 2007.

Mr. BAUCUS. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

The PRESIDING OFFICER. The clerk will report the pending business.

The legislative clerk read as follows:

A bill (S. 1) to amend Title XVIII of the Social Security Act to make improvements in the Medicare Program, to provide prescription drug coverage under the Medicare Program, and for other purposes.

Pending:

Bingaman Amendment No. 933, to eliminate the application of an asset test for purposes of eligibility for premium and cost-sharing subsidies for low-income beneficiaries.

Dorgan Amendment No. 946, as amended, to provide greater access to affordable pharmaceuticals.

AMENDMENT NO. 946, AS AMENDED

The PRESIDING OFFICER. There are 4 minutes of debate equally divided on the Dorgan amendment.

Who yields time?

Mr. BAUCUS. Mr. President, who controls time?

The PRESIDING OFFICER. The Senator from North Dakota controls 2 minutes. The manager will control 2 minutes in opposition.

Mr. DORGAN. Mr. President, this amendment deals with reimportation of prescription drugs. It is designed to try to put downward pressure on prescription drug prices in this country. It is not my intention or desire that Americans go elsewhere to acquire prescription drugs. But the fact is that U.S. consumers pay the highest prices in the world for prescription drugs. In North Dakota, for example, there is a pharmacy in the town of Pembina, and if you buy a prescription drug in that one-room pharmacy—

Mr. BAUCUS. Mr. President, the Senate is not in order.

The PRESIDING OFFICER. The Senate will be in order.

Mr. DORGAN. Mr. President, 5 miles north of that North Dakota one-room drugstore, in Emerson, Canada, you will find, if you have breast cancer and have to buy Tamoxifen, that the drug that you pay $10 for in the U.S. can be purchased for $1 5 miles north.

The question is, why should that happen? It should not happen. Let the market system deal with this. These are FDA-approved drugs. It is the same pill put in the same bottle by the same company. We ought to have fair pricing for Americans, and if not fair pricing here, then allow them to access those prescription drugs from a chain of custody in Canada that is safe. We are only talking about licensed pharmacists and distributors being able to access that FDA-approved drug from a licensed pharmacist or distributor in Canada. We have accepted the Cochran language. We don't think that injures this because, in the circumstance, we have changed the reimportation amendment to deal only with Canada, which has nearly an identical chain of supply and would therefore represent a safe drug supply for our pharmacists and distributors to access and to be able to pass the savings along to the American consumer. That is the purpose of this amendment.

I reserve the remainder of my time.

Mr. JOHNSON. Mr. President, I rise today in strong support of addressing a major oversight in S. 1, the Prescription Drug and Medicare Improvement Act of 2003. The bill has absolutely no provisions to control the skyrocketing costs of prescription drugs, and, as currently written, is really just a blank check for big drug companies.

If one looks at the costs of prescription drugs, the numbers are just astounding. Seniors in the U.S. who lack drug coverage must pay twice as much for the five most popular drugs as purchasers in many foreign countries. All Americans who need prescription drugs could benefit from improved access to lower-priced drugs from Canada. Brand-name drugs cost an average of 38 percent less in Canada than in the United States. This could mean literally hundreds of dollars less a year for U.S. purchasers.

For several years now, many of my colleagues have been fighting to provide access to lower prescription drug prices for seniors and all Americans by sponsoring a reimportation plan that is safe, effective and keeps savings in the pockets of seniors. I am happy to join several of my colleagues here today to cosponsor and support this amendment to the prescription drug bill. I want to especially thank Senator DORGAN for his leadership on this issue. He has worked hard to try to bring a solution to the skyrocketing prices seniors and all Americans must now pay for their prescription drugs.

As costs continue to rise for consumers, and pharmacies' profit margins continue to shrink, a quick look at net profits of drug firms paint the real story. While Fortune 500 companies have experienced close to only a 1-percent increase in net profits over the last 30 years, and pharmacies have experienced a net loss of about that amount, drug firms have experienced an over 1-percent increase in such profits. But still, we seem to ignore the manufacturers exorbitant U.S. prices over and over.

The Dorgan amendment would improve access to lower priced drugs by allowing wholesalers and pharmacists to import prescription drugs from Canada, which has a similar drug approval and distribution system as the United States. The amendment also would enable individuals to import prescription drugs from Canada as long as the drugs are for their personal use and they do not exceed a 90-day supply.

This amendment finally says to the drug companies, enough is enough. I think if we work together we get a handle on the unrestrained costs of drugs in this country. Efforts such as those in the Dorgan amendment and those just embraced by many of my colleagues who joined me in cosponsoring and supporting the generics amendment yesterday will make such an important difference in the true value of what a drug benefit can really do to help seniors. I sincerely hope that all of my colleagues, on both sides of the aisle, will commit to adopting the provisions in the reimportation amendment in order to enhance the value of this legislation.

Mr. HATCH. Mr. President, I rise to oppose the Dorgan amendment on drug importation.

Frankly, given the history of this amendment, I feel a little like we are in the movie, Groundhog Day. We have been there and done that. And like the Bill Murray movie, we appeared to have gone there and done that again last night. When I woke this morning, I had the feeling of deja vu all over again.

Each time the same thing happens. First we consider a flawed drug reimportation amendment. Then we adopt a second degree amendment that virtually guarantees the amendment can never be implemented. We did it in the 106th Congress, and Secretary Shalala—the Clinton administration's Secretary of Health and Human Services—could not certify the safety of reimported drugs. We did it in the 107th Congress again last year when the Senate adopted a reimportation amendment during the debate on the ill-fated vehicle, S. 812. And now last night we did it in the 108th Congress. The same dynamic played out yet again with the Dorgan amendment and the second degree amendment thereto.

Let me remind my colleagues. Here is what the Bush Administration's Secretary of Health and Human Services, Tommy Thompson, said about this idea last year: "Opening our borders to reimported drugs potentially could increase the flow of counterfeit drugs, cheap foreign copies of FDA-approved drugs, expired and contaminated drugs, and drugs stored under inappropriate and unsafe conditions. In light of the anthrax attacks of last fall, that's a risk we simply cannot take."

I agree with Secretary Thompson that reimportation was not ever a good idea. But, it could be even more deadly after September 11th. Although I am not a betting man, I can guess what Secretary Thompson will say if this unfortunate amendment survives the conference committee.

This year's version of the Dorgan amendment contains a new section relating to the effective date of the amendment. This modification attempts to make the proposal effective prior to the Secretary determining that the benefits of this law outweigh the risk.

Fortunately, the Cochran amendment we adopted last night by voice vote makes it clear that nothing in the Dorgan amendment can take effect unless the Secretary finds that the provision: first, poses no additional risk to the public health and safety; or, second, will result in a significant reduction in the drug costs.

My preference is for no Dorgan amendment at all. But if his language is adopted, it is essential that we have the Cochran correcting proviso so that the American public can be protected against unsafe drugs.

I agree with my friend, JOHN DINGELL, the Dean of the House of Representatives, and author of the 1988 Prescription Drug Marketing Act, PDMA, that helped put rigorous safety controls in the U.S. drug distribution system. Mr. DINGELL said, "the very existence of a market for reimported goods provides the perfect cover for foreign counterfeits."

Representative DINGELL's Energy and Commerce Committee produced a report that succinctly explained why the PDMA was needed: "[R]eimported pharmaceuticals threaten the public health in two ways. First, foreign counterfeits, falsely described as reimported U.S. produced drugs, have entered the distribution system. Second, proper storage and handling of legitimate pharmaceuticals cannot be guaranteed by U.S. law once the drugs have left the boundaries of the United States."

This view is consistent with the testimony that the experts at FDA have given before Congress numerous times.

As the FDA's senior associate commissioner for policy, planning, and legislation, Bill Hubbard, has warned: "Even if the Canadian system is every bit as good as ours . . . the Canadian system is every bit as good as ours . . . the Canadian system is open to vulnerabilities by people who will try to enter the U.S. market . . . because that is where the money is."

A bipartisan group of some 10 former FDA Commissioners have voiced their concern about the safety of reimported pharmaceuticals. So has the Drug Enforcement Administration.

We are told by the experts that the number of counterfeit cases is on the rise. FDA has opened more than 70 counterfeit drug cases since October 1998, including 26 arrests and 20 convictions through last June. In the last two months, FDA has issued alerts on counterfeit Lipitor. In March, the FDA found that doctored EPO—a product vital to patients fighting cancer and other deadly diseases—has been the target of counterfeiters in previous instances.

Let us remember the sage counsel we were all taught in elementary school—safety first. Unfortunately, the Dorgan amendment conflicts with this important lesson.

To summarize, my primary reason for opposing this amendment is a concern expressed by many public health and safety experts: Opening up the current closed U.S. drug distribution system to products of unknown pedigree will result in disaster down the road.

I know that Senator DORGAN and the other cosponsors of the amendment are motivated only by their desire to do right by their constituents and other Americans trying to obtain affordable pharmaceuticals. We all share in that goal. This is why we are working in a bipartisan fashion to craft a $400 billion Medicare drug benefit program. Let us focus on the Medicare drug benefit during this debate and not get sidetracked on ill-conceived measures like the Dorgan reimportation amendment.

Let me close by saying this to my friend from North Dakota, with whom I serve on the Finance Committee: We have worked together on several trade issues involving Canada. We have struggled with how to respond effectively to the problems associated by the influx of protected Canadian softwood lumber and the actions of the less-than transparent Canadian Wheat Board.

My friend from North Dakota does not like it when the actions of the Canadian government unfairly benefit Canadian producers of wood and wheat relative to American loggers and farmers. This is so even if the preferentially-treated Canadian products can undercut the prices offered by American producers to American consumers.

In this debate on drugs, we often hear heart-wrenching stories of seniors being forced to choose between paying for drugs or paying for food or paying the rent. When it comes to weighing the interests of loggers and farmers versus the lowest cost goods, my friend from North Dakota carefully, and appropriately, factors in the long term interests of preserving vital U.S. industries. He does not automatically support policies that result in U.S. consumers, particularly our seniors, paying the lowest possible prices for such essential products as bread and wood.

Not so with price-controlled Canadian drugs. First, the Canadian government ratchets down the prices of drugs for its citizens. Comes now the Dorgan amendment that acts to pass on these controlled prices to U.S. consumers. If passing on Canadian government-controlled prices is such a good policy for drugs, then I ask why it is so bad when the Canadian government acts to artificially hold down the price of wheat and lumber and pass these savings along to the American consumer?

Let us face facts. Money is fungible. If the proper response to easing the choice among food, medicine and shelter is always to end up with the lowest prices then why should we not applaud equally the Canadian Wheat Board and the Canadian drug price control agency?

My answer is that government price controls, subsidy programs, and preferential treatment are never the preferred policy option—whether we are talking about food, medicine or the mortgage.

Let me close by saying that my fundamental objection to the Dorgan amendment is the safety risks it would engender. In addition, I have concerns over embarking on a policy that has the effect of imposing government price controls on a product highly dependent on investment capital, and let the Canadian government do the price controlling to boot.

I only hope that we can some day break the cycle of passing a piece of legislation with a circuit breaker provision that will always be tripped and ensure the underlying language, thankfully, will never take effect. Enough of Groundhog Day.

Mr. FRIST. Mr. President, I rise to oppose the Dorgan amendment on importation of foreign drugs. It is essential that my colleagues understand the gravity of what we are about to vote on today. My colleagues yesterday passed the Cochran second degree amendment by voice vote, ensuring that none of the provisions in the Dorgan amendment would become effective unless the Secretary of Health and Human Services certifies to Congress that the implementation of the Dorgan amendment would (1) pose no additional risk to public health and safety, and (2) result in a significant cost savings for Americans.

While this safety and cost savings certification threshold determines whether the Dorgan importation language would ever become effective in the first place, I believe that in this era of increasing bioterrorist threats, now more than ever, we should not pass new drug importation legislation at all. Allowing the importation of drugs from Canada by pharmacists and wholesalers would simply encourage further proliferation of schemes to use Canada as a transshipment point for sending unapproved, expired, counterfeit or otherwise dangerous drugs to American consumers. The Assistant Deputy Minister of Health Canada clearly stated in a May 9 letter this year that, "The Government of Canada has never stated that it would be responsible for the safety and quality of prescription drugs exported from Canada into the United States, or any other country for that matter."

Allowing pharmacists and wholesalers to import drugs directly from sources outside the U.S. will further encourage the proliferation of purportedly "Canadian" Internet Pharmacies that are not from Canada. A 2003 Global Options report stated that 33 percent of so-called "Canadian" internet pharmacies are not from Canada. One was "Canadarxfree.com" and the actual country of origin was Mexico. Another, "Trustedcanadianpharmacy.com" had Barbados as the actual country of origin.

Another troubling real-life example cited by Bill Hubbard, the Senior Associate Commissioner for Policy, Planning and Legislation at FDA during a June 12, 2003 hearing before the house Government Reform Subcommittee was, ". . . we have an example of an 82-year-old gentleman who bought two drugs from a website.—[H]e was told on that website and when he made the phone call that he was getting a U.S. produced drug, sold in Canada and sold back to him. He got Indian drugs that are not approved, have no labeling, no information and he called the FDA and was outraged why are we letting this stuff in." The FDA determined the drugs were counterfeit.

The so-called documentation requirements in the Dorgan amendment could easily be circumvented, forged and lack verification standards. In July 2002, the Department of HHS sent a letter to Senator COCHRAN that described the problems with allowing pharmacists and wholesalers and even individuals to import drugs from Canada, "Since counterfeits can easily be commingled with authentic product, either by the case, by the bottle or by the pill, there is no sampling or testing protocol sufficient to protect against the grave public harm they pose."

All of my concerns about importation and risks to the health and safety of Americans that I have expressed do not even include the reasons I believe this Dorgan amendment is truly unnecessary. We are in the midst of debating and passing a landmark Medicare prescription drug bill. Through this historic legislation we will provide our seniors with affordable access to medicines, without exposing them to the very real risks of counterfeit, subpotent, unapproved, adulterated, or misbranded drugs from importation. We have also gone a step further in addressing the affordability of medicines by overwhelmingly supporting the Gregg-Schumer amendment yesterday, which will allow generics to enter the market faster. Together with the President's recently issued final rule, this amended bill will save Americans money by improving access to more affordable generic drugs. I commend the President for proposing in this 2004 budget request, an unprecedented increase of $13 million in spending for FDA's generic drug programs. By increasing the program's size by almost one-third of its current size, FDA will be able to hire more generic drug application reviewers and approve generics faster.

With all of the new information we now have about the dangers of importation and fraudulent websites, we owe it to our seniors to pass a meaningful, comprehensive Medicare drug benefit without exposing them to the very real risk of obtaining counterfeit imported medicines.

I again urge my colleagues to vote "no" on the Dorgan amendment, even as modified by my second degree amendment.

The PRESIDING OFFICER. Who yields time in opposition?

Mr. FRIST. I yield 2 minutes to the Senator from Mississippi.

Mr. COCHRAN. Mr. President, even though we adopted the Cochran amendment by voice vote, which requires certification that drugs imported through Canada are safe, and that they significantly reduce costs to American consumers, if the Dorgan amendment passes, it creates a new opportunity, a new source for importation of drugs into our country from other countries besides Canada. There are manufacturing facilities right now in India, in France, and in China, where drugs are being manufactured to look like American drugs that have been approved in this market but are counterfeit drugs. Some are truly unsafe because of the unsanitary conditions under which they are manufactured. Some do not contain anything like the ingredients the labels say they contain.

Mr. President, this is a new threat to the security and safety of American citizens. We don't have the Food and Drug Administration inspectors, U.S. Postal Service inspectors, or the U.S. Customs Service agents to monitor the new importation that will flood into this country from Canada—but not necessarily manufactured in Canada, not necessarily manufactured in the U.S. and sold in Canada and reimported, which is the purpose of this amendment. But it opens a new door, a new opportunity, and it is a new threat to the security of the people of this country. I urge that we vote no on the Dorgan amendment.

I yield time to the Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I love this idea that we are going to let markets work and have free trade. What the Senator doesn't tell you is the reason the price is $1 instead of $10 is that Canada sets the price. Canada says: If you want to sell drugs here, fine, here is what we will pay. If you don't agree, you cannot sell the drug. If we really want to sell your drug, we will steal your patent and we will make the drug up here and sell it for the price we want.

That is the law in Canada. So if you want free trade, great, we will have them set the price for all the agricultural products up there and be able to set that and send it back here and call that free trade.

Mr. DORGAN. Mr. President, we have price controls on prescription drugs in this country. It is just that the prescription drug manufacturers control the price. My friends want to have a debate we are not having. The only access to prescription drugs we are talking about is from licensed pharmacies or distributors—accessing prescription drugs from a licensed pharmacist or distributor in Canada and that would be FDA-approved. We are not talking about counterfeit drugs.

Mr. FRIST. Mr. President, on my leader time, I rise to speak in opposition to the Dorgan amendment on the importation of foreign drugs. Before the vote, I want to let my colleagues know that I do believe this amendment has the potential for opening doors that would be dangerous in this day and time. I say this in spite of us passing by voice vote the Cochran amendment yesterday, which does two things. It says none of the provisions of the underlying Dorgan amendment would become effective unless the Secretary of Health and Human Services says it poses no additional risk to public health and safety and, two, results in significant cost savings for Americans.

I supported that amendment. We all did; it was a voice vote. That is very important. It does change the threshold a bit, but I will vote against the Dorgan amendment because I believe in this era of increased bioterrorist threats, we, now more than ever, should not open the door and pass new drug importation legislation at all. The reason I say that, very quickly, is the Canadian Government has stated:

> The government of Canada has never stated that it would be responsible for the safety and quality of prescription drugs exported from Canada into the United States, or from any other country.

If we open this door, Canada has the potential for—first of all, they cannot certify safety but, secondly, become a transshipment port for other countries if we open this door to Canada. There are a number of statements that have been made. The other concern I have is on the documentation requirements. I am afraid, in the Dorgan amendment, they could be forged or circumvented, and there is a lack of verification standards, I believe.

Lastly, it is important we understand our underlying bill to which the Dorgan amendment is being applied has as its purpose to make drugs more affordable and lower that burden overall. I am hopeful we will accomplish that with the vote at the end of next week—drugs that are certified to be safe, that have gone through the FDA approval. I will be voting against the Dorgan amendment. I encourage my colleagues to do likewise.

Mr. DASCHLE. Mr. President, I yield 3 additional minutes of my leader time to Senator DORGAN.

Mr. DORGAN. Mr. President, to respond, we had 2 minutes equally divided and I think it is important, perhaps, to have the time truly equally divided. Let me respond by saying, if you think the U.S. consumer ought to pay the highest prices in the world for prescription drugs, then you ought to vote against my amendment. If you believe it is unfair that we pay the highest prices in the world for prescription drugs and we ought to have downward pressure on drug prices, vote for my amendment.

Don't believe this nonsense about counterfeit drugs and transshipments. It is not the case. Let me describe why. Let me do it in just the circumstance of one transaction.

A pharmacist from Grand Forks, ND, under this new law, would be able to go to Winnipeg, Canada, and buy FDA-approved prescription drugs only from a licensed pharmacist or a licensed distributor in Canada. The Congressional Research Service has researched both chains of supply and said they are almost identical in the United States and Canada.

We do not hear questions about drug safety in Canada. Why? Because they have exactly the same system we have from the pharmaceutical manufacturer to the distributor to the pharmacist. The control chain of supply of the same pill put in the same bottle by the same manufacturer assures safety in Canada and safety in the United States.

A licensed pharmacist in the United States can and should be able to acquire a lower priced supply of exactly the same drug in Canada and pass that savings along to the American consumer. Yes, in fact, it is the market at work.

If my colleagues do not believe in the market and they believe our country ought to pay the highest prices in the world for prescription drugs, then vote against this. Just vote against this. I understand. But if my colleagues believe we ought to put downward pressure on prescription drugs and we ought to have a free trade agreement with Canada and they believe in markets and free trade, then they should support this amendment.

I yield the floor.

Mr. GRASSLEY. Mr. President, the Dorgan amendment has been amended to further enhance the safety precautions included in the bill. The amendment now gives the Secretary of Health and Human Services the authority to certify that reimportation would be both safe and would save the hard-earned money of U.S. consumers. The HHS Secretary would also have the authority to terminate the program if for some reason it is not working.

The fact is, pharmaceutical manufacturers here in the United States are reimporting these very same drugs that seniors are forced across the border to obtain. But if it's safe enough for the manufacturers to do, then it should be safe enough for local pharmacies as well.

After all, these drugs are manufactured in factories that meet FDA standards. And it shouldn't matter whether these drugs come from New Jersey, Alberta, or Atlanta. In fact, a Congressional Research Service study found United States and Canadian drug development, manufacturing, and distribution systems have the same high level of integrity.

If this amendment is accepted and the bill is enacted, Americans will no longer have to drive through an international checkpoint to check out their prescription drugs. Instead, they will have the potential to save an estimated $38 billion out of the $100 billion Americans spend every year on their prescription drugs.

Consider the savings: A month's supply of Coumadin, a blood-thinning drug, costs $40 here in the United States and just $7 in Canada.

The emphysema drugs, upon which some seniors rely to breathe, can cost $1,700 for a 6-month supply in the United States and just $800 in Canada.

Again, let me say that, while the Dorgan amendment provides a step we can take right now to help seniors afford their medication, it is only a stopgap—not a solution. For the long-term, there is no substitute for passing a comprehensive Medicare prescription drug benefit. We need to accomplish this goal so that every senior in America has access to affordable prescription drugs.

With that, I want to again thank the Senator from North Dakota, Mr. DORGAN, for his leadership on this issue, and call on the Senate to accept this amendment and move forward to pass S. 1 to create a comprehensive Medicare prescription drug benefit without delay.

Mr. FIRST. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 946, as amended. The clerk will call the roll.

Mr. MCCONNELL. I announce that the Senator from Utah (Mr. BENNETT), the Senator from Colorado (Mr. CAMPBELL), the Senator from Nebraska (Mr. HAGER), the Senator from Indiana (Mr. LUGAR), and the Senator from Ohio (Mr. VOINOVICH) are necessarily absent.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from North Carolina (Mr. EDWARDS), the Senator from Hawaii (Mr. INOUYE), the Senator from Massachusetts (Mr. KERRY), and the Senator from Vermont (Mr. LEAHY) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) and the Senator from Vermont (Mr. LEAHY) would each vote "yea."

The PRESIDING OFFICER (Mr. CHAFEE). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 62, nays 28, as follows:

[Rollcall Vote No. 232 Leg.]

YEAS—62

Akaka
Allard
Baucus
Bingaman
Boxer
Brownback
Burns
Byrd
Cantwell
Carper
Chafee
Chambliss
Clinton
Coleman
Collins
Conrad
Corzine
Craig
Crapo
Daschle
Dayton
Dodd
Dole
Dorgan
Durbin
Ensign
Feingold
Feinstein
Fitzgerald
Graham (FL)
Grassley
Gregg
Harkin
Jeffords
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Levin
Lieberman
Lincoln
McCain
Mikulski
Miller
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Sessions
Smith
Snowe
Specter
Stabenow
Talent
Warner
Wyden

NAYS—28

Alexander
Allen
Bayh
Bond
Breaux
Bunning
Cochran
Cornyn
DeWine
Domenici
Enzi
Frist
Graham (SC)
Hatch
Hollings
Hutchison
Inhofe
Kyl
Lott
McConnell
Murkowski
Nickles
Roberts
Santorum
Shelby
Stevens
Sununu
Thomas

NOT VOTING—10

Bennett
Biden
Campbell
Edwards
Hagel
Inouye
Kerry
Leahy
Lugar
Voinovich

The amendment (No. 946), as amended, was agreed to.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. I rise today to address the matter we are debating in the Senate. I believe this legislation to provide a Medicare prescription drug benefit holds tremendous promise and also tremendous peril.

I applaud the leaders of this effort, Chairman GRASSLEY and ranking member BAUCUS, for bringing this bill to the floor and working in a collegial, bipartisan manner to present it to the Senate and to the American people. It is absolutely essential we finally deliver on the promise many have made for years that we will pass a prescription drug benefit and make it available and absolutely secure to our seniors.

However, 3 weeks ago this Chamber learned a very important lesson. We learned about the importance of details and how a very small change in a very large piece of legislation in a conference report can mean 12 million children would be left out of a child tax credit. Therefore, I think it is imperative we spend the time to ask the hard questions about this legislation and that we exercise caution. So much is at stake for the people we represent.

For example, right now this bill excludes the lowest income seniors who are eligible for both Medicare and Medicaid. In my own State, 219,000 seniors and New Yorkers with disabilities fall into that category. We leave them at risk of a State's decision to curtail or limit or even eliminate certain Medicaid drug coverage and long-term care coverage.

Now we are all in a rush to try to do this to help our seniors, but we do not want to rush through this legislation at the expense of getting it tragically wrong. We have to go over this bill line by line and word by word. The details are changing every minute.

The Congressional Budget Office says one thing, committee staff say another thing. We do not know how much it is going to cost. We do not know exactly what all of the elements will end up being, particularly when we look at what the House has passed. Speaking for New York, that is totally unacceptable. Then we read today in the newspaper the President has a very different idea about two central features of this Senate proposal.

Let's address the real problems and not gloss over them and not rush to some judgment because we are going out on recess in a week. My constituents, from the 80-year-old widow in Utica to the 85-year-old man living in a nursing home in the Bronx, are counting on me to go over this process with care and to cast my vote in a way that will help them, not hurt them.

As I have been talking with my colleagues and certainly as I have been reading the commentary in the press, there is a lot of confusion about this bill. The question is, what exactly does this bill do? How does it work for our seniors? I bet we would get many different answers if I were to ask that on the floor of the Senate.

My constituents and people all over America are trusting us to examine this bill carefully and to gauge the consequences. If we do not take the time to do it, how will we know we are doing what is right?

I am deeply concerned in this case that old saying about haste making waste could certainly come true. For starters, why is this plan so complicated? Why would we purposefully create what I call a new Medicare maze instead of establishing a solid, straightforward foundation for generations to come? We have to look at how this would actually work for the people we say we are trying to help.

I have tried to map it out. Here is the question: How do you get prescription drugs under this plan? I have tried to put myself in the position of a senior, a person with a disability. It quickly became clear this will be a very confusing and in some instances a discouraging process for the vast majority of our seniors.

Here is where we should start in looking at how to answer this question. How do you get your prescription drug benefits under this plan? Let's start with the fact that if you are a senior or a person with disabilities, you are out of this process—no Medicare benefit for nursing home residents, for seniors. Who needs a Medicare benefit more than people in our nursing homes? They are the ones frailest, most at risk; they need more help in order to keep alive and have some quality of life, but they are gone. They are not in this program. If you are in a nursing home and you are getting support through Medicaid right now, you are not eligible. Instead, they would have to rely on what they do now, which is Medicaid. But they would be in an entirely different system, totally at the mercy of the individual States.

I don't know about other States, but in New York we have certainly made an effort to keep faith with these frailest people, seniors in nursing homes, people with chronic and life-threatening and debilitating disabilities, but we are not taking care of them in this plan. They drop out of the Medicaid maze before they even get started.

This plan is really for a senior who has to choose between traditional fee for service with a private drug plan or Medicare Advantage, the private PPOs.

We have created a new Government agency. I don't think a lot of people recognize that. This new Medicare Advantage will be administered by a new agency, the Center for what is called Medicare Choices, created under this bill. So we have ourselves a new bureaucracy. We are going to be spending money on bureaucrats and administrators, instead of on drugs, instead of taking care of our poorest seniors in nursing homes. Even before any benefit is available, this new bureaucracy gets built up and drains scarce resources out of what we can spend for our seniors.

To go back to our seniors here, our seniors have to choose between multiple plans. As you can see, they might have a PPO, with a $45-a-month premium, or an HMO, with a $32-a-month premium. They may have private plans that are available to them. They have to make these choices. Certainly I am all for choice, but we know, from what drug companies themselves have said, there will be many regions of our country where there will not be a lot of choice. So before seniors make that choice, they will need to register how the prescription drug benefits differ under each of these various proposals and whether the drug they need—this is a very personal consideration—whether the drug they need will be covered under the plan they are analyzing.

If a senior looked for the lowest premium—and I can guarantee most seniors will look for the lowest premium because most of our seniors are hard pressed, on fixed incomes, and they are going to be trying to save their dollars, so they will look for the lowest premium—the senior would choose the HMO at $32 a month.

But suppose this HMO doesn't cover the senior's doctor, someone the senior has relied on and trusted for years, but that doctor is not in the HMO? So the senior turns to the plan with the next lowest premium. On here, that would be private plan 2, where the premium is $37. But suppose the formulary used in this private plan doesn't cover the drug the senior needs. Let's assume the senior is on a drug for high cholesterol, and assuming the senior read the fine print, assuming the senior has informed help—which I think is a leap of faith in many parts of our country—the senior may sign up for this plan and not really know it does not cover the drug that has been prescribed for his or her condition.

So what does the senior do? She is in the plan. She finds out it doesn't provide the drug. She has a grievance procedure she can go to. Imagine, we have an 80- or 85-year-old widow. She is trying to understand this. She is in the plan. She gets to keep her doctor, but she doesn't get the drug the doctor wants her to take. The doctor says: In my professional judgment, this is the best drug for you, but I am sorry, the plan you are in doesn't include it on the formulary—the list of drugs that are permitted.

So what can the senior do? The senior can take a drug off the formulary, whether or not the doctor thinks that is the right thing, or the senior can file a grievance and can go through this grievance process, with a hearing, to try to get the drug that the senior's doctor tells her she should be taking for her high cholesterol.

If we do that, we know we have consumed valuable time. We have created yet another bureaucracy. Not only have we created this new Government agency to run this program, now we have created a whole grievance process, putting lawyers to work, putting advocates to work, to try to figure out how to get the drug the woman wants or get the doctor the senior wants. So we have used up a lot of paper, used up a lot of time, and unfortunately taken hard-to-have, scarce resources out of doing what we all want them to do; namely, get the drugs paid for that our seniors require.

Let's suppose we go from year 1—because this doesn't go into effect until 2006, so we are not quite sure how it is all going to work, but suppose we go from year 1 to year 3. I could not get everything on the chart, so we will skip 2007; we will go to 2008. These private plans are new. They have not refined all their business models. We know when the State of Nevada tried something similar, drug companies said: Wait a minute, there is no money in this for me. I don't want to provide drugs to the sickest, oldest people in America. I can't make anything on that. So they dropped out.

I think it is fair to assume that at the end of those first 2 years when a plan's contract expires, it may decide to drop out, just as Medicare HMOs have dropped out. As I am sure all of us have heard from our constituents, the number of Medicare+Choice plans has decreased by over half in the last 5 years, leaving thousands of seniors in the lurch when they pull out of the markets where the seniors live.

Those who did not pull out, they stayed but at a huge increase in price. They cut back benefits and raised premiums—15.5 percent last year alone. So all of a sudden, now, we have what used to be a $32 plan being a $47 plan. This is a monthly premium.

Let's say our senior waited it out, finally got the prescription drug she needed through a grievance hearing, but then after 2 years the plan she was in with the drug she needed did not find the market profitable and chose to pull out. The Government would have to be sure there was a Federal fallback in place, so our senior might then go into the Federal fallback. The Federal fallback would guarantee, for a limited period of time, that the senior would get the drug and the doctor of her choice. But this would only be for a limited time, only until this new Government agency could negotiate with private plans—and they can potentially subsidize up to 99.9 percent of their risks—in order to get two plans back into the marketplace.

Our senior would then have a plan at a higher price, with the Government basically subsidizing—some might argue, bribing—the private plan to come back into the marketplace. But by year 4, our senior might again have to change plans for the very same reasons, about coverage, including doctors, including drugs, and as you can tell, this is the most streamlined version I could put on one chart of what it is we are debating.

I think it is important to recognize that this new Government agency is giving a huge gift in a subsidy to these private plans, but it is giving another very large gift because it is basically saying you come into our plan and we will waive all State insurance regulation.

I don't know about you, but people who have dealt with insurance companies of all kinds sometimes have problems with them, and they go to their State insurance commissioner who is close to the problem, and they try to get it worked out and get some support. That will be gone. You will not have the right to go to your State insurance commissioner because this new Government agency up here will have said: All bets are off. We beg you to come into the market. We will pay you to come into the market. And guess what the sweetener is. We are not going to hold you to any of the regulations with which you would otherwise have to comply.

Last year, we passed in this body a prescription drug benefit known as Graham-Miller. It was simple, had the same premiums, deductibles, and copays, and there were no dropoffs. It was over 50 percent more generous than the bill before us today.

I know many of my colleagues prefer this Medicaid maze because they are such strong supporters of competition. So am I. Goodness gracious, competition, the free market, we all know that is one of the pillars of American success.

But I don't champion competition for the sake of championing it when it comes to health care and when it comes to the elderly and the frail and people who use the bulk of prescription drugs in our country. I champion it when it actually produces a good result.

Competition on a skewed playing field that excludes certain plans from staying in the market and creates inefficient administrative and transaction costs could actually leave customers less informed, less well off, and spend these scarce health care dollars on creating a new bureaucracy whose primary purpose is to somehow subsidize insurance companies.

I think drug plans should not compete for profits by attracting only the healthiest of people and dumping seniors they consider bad risks. They should not compete by cutting corners in quality. They should compete with each other on quality and price. Of course, the way to do that is to set some uniform benefit package to try to have a uniform premium so you can compare apples to apples and not apples to oranges to kumquats or bananas or whatever else is in the fruit basket. The Senate bill has taken some steps to try to rationalize its system. The House of Representatives' bill lacks even the basic protection for seniors. It lacks what we call a Federal fallback; that is, when your HMOs or PPOs or drug insurance programs pull out on you and don't give you the drug you need or won't let you see your doctors, then you can go into what is called the Federal fallback. The House doesn't even have that. They somehow magically assume—although we have seen no evidence of it and it defies common sense—that there are going to be all of these drug companies and all of these insurance plans competing to take care of that elderly woman or that elderly man with all of these drug costs.

As I mentioned, New York State has 219,000 low-income seniors who qualify for both Medicare and Medicaid. They are excluded. I fear they are being put at risk because they are going to have to rely on State programs in these times of big budget problems.

There are also some other people I worry about when I look at this Medicaid maze. For example, retirees who bargain for and obtain health care benefits for their retirement. The Congressional Budget Office says a third of Medicare retirees with drug benefits would lose coverage under this bill. In our State, that is 365,000 people.

Then we have another. New York has put into place its own prescription drug plan to help people who have incomes up to $50,000. If you go to New York and you have friends or families in New York, you know we have a higher cost of living. In our State, middle-class people with big drug costs pay for those costs. There are 317,000 who are enrolled in the State's EPIC prescription drug program, and nearly 900,000 are excluded because they are in nursing homes or they have disabilities and under the calculations may have their retiree benefits put at risk, or who are going to have their State prescription guarantee also put at risk—one in three Medicare recipients in New York. Never in the history of the Medicare program has a Medicare beneficiary been denied access to a covered benefit. I am just so troubled that we are excluding our lowest income seniors. I don't know how we justify that.

I have a letter from our Republican Governor which I ask unanimous consent to have printed in the RECORD.

There being no objection, the material was ordered to be printed in the Record, as follows:

State of New York,
June 12, 2003.

Dear New York Congressional Delegation Members: Prescription drug costs continue to strain the budgets of the nation's senior citizens. I applaud your efforts this year to address this important issue. As you begin consideration of legislation to provide prescription drug coverage to all senior citizens, please consider two issues vitally important to New York State.

First, New York taxpayers continue to support a significant cost for prescription drug coverage for its dual eligible population. The dual eligibles are elderly and disabled individuals who qualify for both the Medicare and Medicaid programs. Medicaid is required to provide medical services not covered by Medicare—including prescription drugs.

More than 600,000 New Yorkers are considered dual eligibles and each year New York's Medicaid program spends nearly $1.5 billion on prescription drugs for the dual eligible population alone. We have always believed that these costs should be borne by the federal government and strongly support efforts to federalize prescription drug costs for the dual eligible population.

In addition, New York administers the nation's largest prescription drug program for seniors, EPIC. Today, more than 300,000 seniors are enjoying the significant benefits EPIC offers and saving thousands of dollars each on vitally important medicines. Costs for this program exceed $600 million annually in State only dollars. Currently eighteen states have programs similar to New York's to provide prescription drug benefits to senior citizens.

Any federal program created this year to provide prescription drug coverage should recognize state efforts and allow seniors to choose their benefit plan (in New York, that choice would be between EPIC and the federal plan) while providing a direct Medicare subsidy to the state program for individuals that choose that option.

The Federal government has accepted responsibility of providing health care to senior citizens and I strongly urge an expansion to include prescription drug coverage. I applaud President Bush for his leadership on this issue and our congressional delegation for its commitment to our seniors.

Your efforts on this important legislation could dramatically improve the health of a segment of our population that has given so much to New York's and America's safety and prosperity. We urge you to work with us to ensure that our seniors get the prescription drug coverage they deserve, and that the federal government assumes its rightful role in supporting services for our dual-eligible population.

Very truly yours,
George E. Pataki,
Governor.

Mrs. CLINTON. Mr. President, Governor Pataki has written to ask that in this plan Medicare cover the drug costs of these seniors and New Yorkers with disabilities. The Governor's record explains the importance of including these people who are called, in the jargon, "low-income dual eligibles."

Furthermore, I believe we should eliminate the penalty against retirees. By refusing to count retiree benefits as out-of-pocket expenses, this bill assures that 365,000 New Yorkers will never make it through the coverage gap. We should also try to support States such as New York that are putting their own money into programs to provide for continuing coverage.

The gap in coverage is very disconcerting. I don't even really get to that on this Medicaid maze.

I think it is important to recognize there is on average a $275 deductible and at least a $35 monthly premium that could certainly vary widely. As we have seen in these examples, depending upon where you live, and depending upon who is available, there is a 50-percent subsidy until your costs are $4,500. And then you go cold turkey. Some people call that a doughnut hole. That is not my image. There is a brick wall which you run into. Spend your money, and after that you get no help—none at all—until you get to what is called the catastrophic threshold of $5,813 in drug costs.

Many of us have heard from our constituents. In fact, we are deluged in my office with phone calls, e-mails, and other contacts from people asking, How is this going to affect me? What does this mean in my life? I think that is the real question. How do I get prescription drugs under this plan?

I want to talk about this one story, a woman named Arlene Francis. She lives in the Buffalo area. She was married to a Bethlehem Steel retiree who passed away. At one time, she had the retiree drug coverage that was part of her husband's contract with Bethlehem Steel. As we know, Bethlehem Steel went into bankruptcy and was bought by another company. All retirees and spouses of retirees lost their coverage.

Arlene takes Fosamax, a drug for osteoarthritis, which costs $68 a month. She has a hormone replacement patch. She takes antibiotics as needed. She is pretty healthy, when you think about it. That is not a lot for someone to be paying for prescription drugs and getting the coverage she needed. But it is a stretch for her because she has a very limited fixed income. Her drug costs total $998 a year. She relies on our New York program called EPIC, which covers seniors on a sliding scale up to $35,000 for singles, such as Arlene, who is a widow, and $50,000 for a couple. Under EPIC, her annual fee is $36 a year. Her copays are $3. Her share of her yearly $998 drug expense totals $336—roughly a third of what the cost would be.

But what happens under this proposal is very troubling to me. She would pay monthly premiums every month. Let us say we get it at the lowest level of $35 a month. That is $420 a year. She would pay a $276 deductible and a 50-percent copay. How much would she pay to get $998 in drugs? She would pay $1,157.

Arlene and many of my constituents aren't going to get anything from this bill. It is voluntary. You argue they don't have to go into it. But we are changing the incentive and the structure of delivering drug coverage for many people in a State such as ours which already tries to help people, which I believe will lead to the limitation or the elimination of the program we already have. Under this program, the Federal Government isn't lifting the States' costly burden of prescription drugs. It even adds some administrative costs on the State Medicaid offices that have to do all of these calculations.

Because a State will not receive reimbursement from the Medicare program for the benefits it provides up to the Medicare level, it very well could make a rational decision that it is just not going to continue doing that, and either cut back or end the program, which will be very bad news for the 360,000 seniors in our State, like Arlene, who rely on this very cost-effective way of getting their drugs covered.

When we have the Congressional Budget Office stating that seniors with prescription drug costs of $1,115 or less would end up paying more through premiums, deductibles, and cost sharing, they are not getting anything from this bill.

On the other end of the income and expenditure level, the bill falls short for patients with high drug costs as well. Even seniors who spend $5,000 will get only $1,700 in benefits. They have to manage 66 percent of the costs on their own.

I think we could do more to eliminate the gaps in coverage and to tear down the brick wall that stops people from getting help while they still pay for it until they reach the catastrophic level.

I will be introducing a series of amendments. But I think it is important to recognize the fundamental issues I am raising today about the Medicare maze are going to require all of us to work on it.

I am very pleased that one of the most important ways we can assure that competition is helpful instead of harmful is to ensure the plans actually do compete on quality.

So I appreciate that the bill includes a measure I have supported, along with Senator HATCH and others, to commission the Institute of Medicine to develop ways to think about paying for quality outcomes. I have also filed an amendment to encourage the development of quality standards so that our seniors have some basis of comparison to choose among different plans.

I believe it is important to provide information about the efficacy of drugs and their cost-effectiveness so that seniors and others can see for themselves whether we are getting our money's worth for this $400 billion investment. I would like that information on the Internet. I would like it made available through the long-term ombudsmen, the Medicare and Medicaid representatives in every State.

I started by saying I think this legislation does hold tremendous promise. But I have tried to outline some—not all but some—of the questions I am having to answer from my constituents who come to me with very specific issues, who ask me how this will affect their lives, whether this will make them better off or worse off financially.

I believe it is important for us to be able to really scrub this, understand what it does and what it does not do, and also recognize that on the other end of this Capitol the House has a very different approach. I applaud the work Senators GRASSLEY and BAUCUS have done. But let's not forget, this body tried to protect lower income working families by giving them the child tax credit—people who pay a higher proportion of their income in taxes than I do, but who were told, at the other end of this building, that because they may not pay income tax, they should not get help for their children.

I have to ask, if that is the attitude on the other end of this building, if they have already passed a bill that is not going to help many seniors but provides even more of a giveaway to drug companies to try to get them to offer these plans, how can we trust, at the end of the day, that the more thoughtful debate and version we are working on here in the Senate will be what comes out of this process?

I was very disappointed when it was reported in the papers today that the President has weighed in on the side of giving subsidies, increasing benefits to insurance companies—not in the Senate version, but in the House version—and that the President does not want a Federal fallback. This is a huge difference in philosophy, in ideology, and, I believe, in life experience.

Medicare has worked. Since 1965, it has removed not only so much of the concern and worry and anxiety about growing older, of facing acute and chronic health care problems, it has removed a lot of burden from the American family.

My mother just recently turned 84, and I feel very fortunate that I am in a position to be able to help her. But I know, very well, that a lot of other families trying to save for tuition, for college for their kids, trying to make ends meet, when it comes to mortgages and car payments, they may not be in that position. Therefore, they look to Medicare to really help spread the burden of taking care of our elderly from one generation to the next. It is part of our social contract in America. We have a basic bargain: If you work hard, if you are responsible, we are going to help, through our Government, to make sure you do not fall into poverty, that you are not left without health care. We are going to do that because that is the kind of people we are. Those are the values we have. This could be a giant step back from that commitment.

Let's not also forget that this $400 billion, which we are trying to set aside, comes at a time when we are looking at deficits and increasing debt, which will impose even more burdens in the future on middle-class Americans and their families. So I hope we are able to answer the questions and, most fundamentally, explain clearly and unequivocally how someone gets their prescription drug benefits.

I do not know that I could take this chart to a senior center, to a nursing home, and explain this. I do not understand why it has to be so complicated, why we have to create a new Government agency, why we have to waive insurance regulations, why we have to cause this level of confusion and uncertainty among people who should have the peace of mind in their later years that they do not have to worry about filing grievances, fighting for their drugs and their doctors. Why are we doing this? Why are we creating these obstacles, this Rube Goldberg system that is going to be extremely hard to explain and very hard to understand?

Finally, I do not understand, either, why we are waiting until 2006. Medicare went into effect within a year—a totally new system, with no new agency to administer it. We were able to do it in a year. President Johnson went to Independence, MO, and signed that bill with former President Harry Truman, who had been one of the first of our leaders to say: We need to take care of our seniors.

That bill was signed, it has worked well, and it has a very low administrative cost. Two to three cents out of your tax dollars, your contributions that go into Medicare, go into administration, go into any kind of costs that can be compared to the high percentage that these private insurance companies spend. Some of them spend 30 to 40 cents out of your dollar, not on taking care of you but on taking care of themselves.

So at the end of the day, Medicare has worked. I am very proud of our country for making that commitment. Yet I worry that what we are about to do is not only difficult to understand, difficult to administer, and confusing but may very well be the beginning of undoing traditional Medicare.

The report of the President's letter today certainly gives me pause that we would not even have a Federal fallback. Our people who live in rural States, live in poor urban areas—who are not the most attractive clients for insurance companies because—guess what—they get sicker, they are poorer—where will they get their care if our Government does not have that fallback to provide the safety net?

And what do we do as States are making these budget cuts to take care of the hundreds of thousands of our poor residents in nursing homes, our people with disabilities, who depend upon this program?

We cannot forget about the larger issue at hand. Our fundamental responsibility and our goal must be, as a nation, to help our seniors by providing a prescription drug benefit that is reliable and comprehensive. And if we are to go down the route of introducing competition, then let's make sure it is competition on cost and quality, not competition to eliminate more and more of the sickest of our elderly or the people with disabilities whom we are trying so hard to take care of.

Our goal is not just choice or competition, it is compassion; it is coverage for those who need it. We have a rare bipartisan opportunity to do this. Let's get it right in the Senate, and then let's fight with all of our energy to make sure it is not changed in a conference committee with the House, so that we can, in good conscience, tell our seniors we have done the best we can to make sure they get the benefit we promised.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, certainly we are dealing with an issue and a proposal where there are huge differences. And there have been huge differences for some time. The Senator from New York represents quite a different point of view from several years past.

What we are trying to do is to provide better service, provide some options, provide some modernization of a program that is 40 years old, that has never been changed. So the question really is, How do we best serve all of the people who are in need of service? The question is not, How do we maintain and grow a Federal program, and keep it all Federal? That is not really what most of us have in mind.

We want to look at some alternatives. We want to look for choice, where people who wish to stay in the program as it now exists may do that. And that is what this bill provides. But it also provides an opportunity to move to something that could be different, have some choices, could even in fact be more efficient, more effective. I am afraid it is hard for me to accept the idea that Government programs are more efficient than the private sector. I don't think there is much evidence of that. Certainly what we are talking about here is having some opportunities for a change, some opportunities for some alternatives. I understand there will be those who will be resisting those changes, but nevertheless we do have a bipartisan bill before us that incorporates that opportunity. We want to do it.

We are concerned, of course, about having services that reach out to everyone in rural areas. I think I am about as concerned about rural areas as anyone in this body. I come from one of the most rural States. I have to tell you how pleased I am that we have in this bill a substantial program for rural health care, one, by the way, that was turned down by many of the folks who are now worried about the rural areas in the tax bill. But it is here, and it will respond to the needs of rural constituents and rural beneficiaries. And that, of course, is of vital importance to all of us.

With respect to dual eligibles, the Senator, the speaker just recently, has raised a concern about how S. 1 treats seniors who are eligible for both Medicare and Medicaid programs. Those are known as dual eligibles. Under S. 1, these seniors will continue to receive their prescription drug benefit through the Medicaid program.

It is alleged that by having dual eligibles remain in the Medicaid program, Congress is treating them as second-class citizens and subjecting them to lower quality benefits. I don't believe this to be the case, nor is there evidence that it is the case. We worked diligently on the development of this package and reflected these concerns that were raised all the time during last year's debate. Learning from these lessons, we decided it was most beneficial to seniors to continue to build off existing Medicare and Medicaid low-income assistance programs as far as to offer a seamless benefit.

We do not want to divert scarce resources available for this benefit toward the development of a new government bureaucracy. I am confident S. 1 establishes this new benefit in a manner that will provide high quality, accessible care through a system that is familiar to seniors and easy to navigate.

It is also important to note that the Medicaid program is considered by most advocates and beneficiaries to be quite generous and far superior to the current Medicare program. Recognizing that this is a program for persons with low income, the Federal Government only allows States to charge nominal copayments to receive the drug benefit. Further dual eligibles have been and should continue to remain the joint responsibility of State and Federal Governments. However, in recognizing that the Federal Government should play a dominant role in delivering this vitally important benefit, we provide in this bill $14 billion in additional Federal dollars to help pay for increased costs associated with the new prescription drug standards included in the bill.

This is because the bill provides minimum standards to ensure that benefits provided through Medicaid are the same high quality as those provided through Part B of the Medicare program. For these reasons I am confident and I think our committee was confident that dual eligibles will continue to have access to prescription drugs that they deserve.

Some argue we should do more, perhaps even serve this population differently, but this bill was developed in a manner that we believe utilizes scarce dollars efficiently and helps to deliver care that is consistent with the current law and easy for seniors to navigate.

This is a discussion that has already been held to a great extent, how you deal with low income and to do it in a way that is consistent with what we have had in the past and was equal in benefits to what we have had in the past. That is the process that is designed here.

So as we move on, I hope we can continue to provide the things that are really the purpose of this whole bill. And there are two at least. One is to provide, of course, drugs, pharmaceuticals to seniors and do it in several different ways so that it meets the needs of those seniors somewhat dependent on income. The other is to provide some opportunities to improve the distribution system for Medicare, again, a program that has been in place for 40 years, has had relatively little, if any, change. And now we have an opportunity to give some choices to the beneficiaries and develop programs that are more efficient than what we have had in the past.

So it is kind of discouraging to have people stand and want not to change whatever we have had going on for 40 years. We are not talking about changing the benefits. We are not talking about the quality. We are talking about making a distribution system that meets the needs of the changes that have taken place in our society and be able to do that in a way that people would like to and will want to have choices.

So as we talk about these various amendments that will be raised, I hope we will continue to take a look at what it is we have as a goal here, to be able to do these things that have been described and focus on getting the kind of results we really have in mind when we put together this proposal and continue to have bipartisan support for the bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. ALEXANDER). Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I will take a moment to review the schedule under the previous order. Under the previous order, the following Senators are to be recognized to offer the following amendments:

Senator GRASSLEY on rural provisions; Senator HARKIN on mammography; Senator CONRAD on fallbacks;

Senator KERRY on a grant program; Senator CLINTON on a study; and Senator GRAHAM has one with respect to premiums.

Republican Senators could offer amendments in an alternating fashion between Democratic amendments. A number of these Senators have chosen to offer amendments at a later time.

Thus, I ask unanimous consent that this order remain the order under which Senators would be recognized to offer amendments, except that the Senator from Florida, Mr. GRAHAM, now be recognized to offer his amendment, and immediately following Senator GRAHAM, the Democratic leader be recognized for whatever amount of time he wishes to speak, and that the pending amendments be temporarily laid aside so the Senator from Florida may offer his amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. THOMAS. Mr. President, I agree with what the Senator just said. I ask unanimous consent that the order of amendments provide that when a Republican amendment is offered, it be considered in an alternating fashion with the Democrat amendments; provided further, that it be in order for the amendment to be offered in any Republican slot.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

AMENDMENT NO. 956

Mr. GRAHAM of Florida. Mr. President, I am here this morning to offer an amendment to the Prescription Drug and Medicare Improvement Act of 2003. This amendment has as its goal to repeal the "sick tax," which is part of the pending legislation.

I send the amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Florida [Mr. GRAHAM] proposes an amendment numbered 956.

Mr. GRAHAM of Florida. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill, and for other purposes)

On page 107, between lines 19 and 20, insert the following:

"(d) BENEFICIARY NOT RESPONSIBLE FOR PAYING APPLICABLE PERCENT OF THE MONTHLY NATIONAL AVERAGE PREMIUM WHILE THE BENEFICIARY IS IN THE COVERAGE GAP.—

"(1) IN GENERAL.—Notwithstanding subsection (c), if an individual, with respect to any period of a year, has reached the initial coverage limit under paragraph (3) of section 1860D–6(c) for the year but has not reached the annual out-of-pocket limit under paragraph (4) of such section for the year, the applicable percent under subsection (c) during such period shall be zero.

"(2) PROCESS.—The Administrator shall establish a process for carrying out paragraph (1). Under such process, the Administrator shall—

"(A) require eligible entities offering Medicare Prescription Drug plans, MedicareAdvantage organizations offering MedicareAdvantage plans that provide qualified prescription drug coverage, and entities with a contract under section 1860D–13(e) to furnish the Administrator with such information as the Administrator determines necessary to carry out paragraph (1); and

"(B) furnish the Commissioner of Social Security with such information as the Administrator determines necessary to collect the appropriate monthly beneficiary obligation pursuant to section 1860D–18.

At the end of subtitle C of title IV, insert the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

Mr. GRAHAM of Florida. Mr. President, I have many concerns with this legislation. Probably at its core is the fact that we are about to adopt a prescription drug benefit for 39 million older and disabled Americans, of which there is no current model. Virtually every question about this legislation has to be answered at a theoretical level because we cannot say the Federal health insurance plan that covers Federal employees, or a Blue Cross/Blue Shield plan, or any other plan has provisions to dispense prescription drugs through a prescription drug-only insurance policy.

In my judgment, that is a very fundamental concern that we should share. Understand that we are about to conduct a gigantic social experiment on 39 million Americans, many of whom are the sickest, most frail, most vulnerable of our citizens.

I am here today to talk about a specific troubling aspect of this legislation, and that is what has been referred to as the "sick tax." What do we mean by that? This bill includes what has come to be known as either the donut hole or the benefit shutdown.

I think it is more like a black hole. Here is how that hole would develop. Seniors who sign up for this new benefit will face a gap in those benefits. Once a senior has reached $4,500 in drug spending, the Medicare prescription drug benefit evaporates, the senior falls into the black hole and gets no help with his or her prescriptions for the next $1,312.50.

I know of no insurance plan that has such a gap in coverage. The Federal Employees Health Benefits Plan, which has often been touted as the model we should use for Medicare, does not have such a gap in its benefit structure. If it is not bad enough that Medicare beneficiaries will get no help from Medicare during this gap, any contributions from the senior's former employer would not count to closing that gap. In many instances, individuals were members of unions and they negotiated a collective bargaining agreement under which they understood they were going to reduce their current income in order to get other benefits that would be paid at the point of their retirement.

Frequently, one of those benefits was some assistance in the payment of their prescription drugs. So they have already paid once for that benefit by not getting that raise that they had anticipated or not getting as much of a raise as they anticipated, and now they are going to be penalized a second time by not allowing those employer payments that contribute to covering the cost of prescription drugs to count toward narrowing the hole; that is, if a senior has a retiree prescription benefit, that benefit cannot be used to reach the catastrophic limit.

The final insult is that during this gap—when the senior is paying 100 percent of the cost—every penny of prescription drugs purchased during this period in the black hole will be paid by the senior beneficiary. But the senior will still have to keep paying the monthly premium.

This legislation suggests that is going to be $35 a month. Most people believe that number is likely to be exceeded in 2006. It certainly will be exceeded as medical and particularly prescription drug inflation takes hold in future years. The senior will have to continue to write that check every month, although they get absolutely no benefit.

Let me be perfectly clear. During months in which seniors are not getting any assistance whatsoever, they will continue to pay the monthly premium. Collecting monthly premiums, while a senior has fallen into this black hole, is the equivalent of levying a tax on the sick. They are asked to pay into the program without receiving any benefit.

The average Medicare beneficiary today spends a little over $2,000 a year on prescription drugs. We are talking about people who have already spent well over twice that to get to the $4,500 level. So we are talking about seniors who have significantly poorer health and, therefore, higher prescription drug costs, and that is a group of seniors we are going to discontinue from benefits until they have paid out of their pocket another $1,300-plus of prescription drug costs.

Why would there be this gap in prescription drug coverage? Why do we do what no other insurance policy in America does today? Surely, none of my colleagues can believe this gap is a good insurance policy or good medicine for seniors. So let's call this gap what it is: a gimmick that is designed to lower the cost of this legislation at the expense of seniors who are most in need of the drugs.

What does the gap in coverage mean for a senior? I would like to take a few minutes to spell it out so that we will know exactly what we are voting for if we approve this legislation.

The gap with the black hole begins at $4,500 in total drug spending. Beneficiaries have to reach a point where their total spending—the spending of the beneficiary, the Federal Government, and any other source—reaches a level of $4,500, over twice the average Medicare beneficiary's annual prescription drug cost.

Once you reach that point, you receive no assistance for your prescription drugs until you have spent out of your own pocket—not counting any contribution made by your former employer—until you have spent $3,700.

How does the math work? To get to the $4,500 level, the out-of-pocket expenditures by the beneficiary will be, first, a $275 deductible. You have to pay that before you get any assistance. Incidentally, you are also paying the monthly premium during the time you are meeting that deductible requirement. Then between $275 and $4,500, you pay half, the Federal Government pays half. You would pay $2,112.50, and the Federal Government would pay $2,112.50. By the time the combined expenditures reached $4,500, you would have paid $2,387.50 out of your pocket. That is the deductible plus your coshare of prescriptions purchased. At this point, you would fall into the gap. You would receive no assistance.

In order to get out of this black hole, you have to have total expenditures out of your pocket of an additional $1,312.50 beyond the $2,387.50 you have already paid. So you will have to pay a total of $3,700 before you can escape. While you are in the black hole, you are continuing every month to pay the premium for a policy for which you are getting no benefit.

The sponsors of this legislation say the monthly premium is $35. However, look through the hundreds of pages of this legislation and you will not find a $35 number. It is going to be up to the private drug-only insurers to actually decide whether the premium will be $35. It could certainly be higher.

Again, we have no example of this type of prescription-drug-only insurance we can point to and say: Here is how we as Federal employees have been treated, or here is how a group of public or private employees under another standard plan have been treated. The reason is that there is no example of what we are about to impose on America's older citizens.

All of this talk of math and gaps may sound theoretical, but the gap will affect the lives of real human beings. Let me give one real example.

There are nearly 3 million Medicare beneficiaries in my State of Florida. One of those is an 89-year-old woman by the name of Virginia. Virginia, a widow of 11 years, is nearly blind. She lives in an assisted living facility. Her income is significantly below the median income. Her monthly income is $1,535, or $18,420 on an annual basis.

Virginia recently moved in with a roommate because she could no longer afford her own apartment. She could not afford last Christmas to buy her grandchildren presents. During her working years, Virginia was an editor and columnist for a smalltown newspaper. She was also a poet.

Virginia is one of the many Medicare beneficiaries in dire need of a Medicare prescription drug benefit. She suffers from high blood pressure, stomach irritation, pains in her joints, anxiety disorder, osteoporosis, hypothyroidism, trouble sleeping, and difficulty with her vision.

This chart lists her conditions. These are the medications that have been prescribed. This is the cost per month based on today's cost inflated by 3.6 percent per year to reach an estimated cost in the year 2006 when this plan will commence.

She is spending $489.22 a month, or $5,870.64 a year, to get the drugs she needs. Each day, she needs three medicines for her blood pressure and seven others to treat her other conditions. These medicines are necessary to reduce her pain and to prevent further health complications.

I would like to be able to tell Virginia the Senate is considering a bill that will give her a comprehensive, affordable Medicare prescription drug benefit. But I cannot do that. No Member of this Senate can tell its citizens, such as Virginia, that we are providing them with a comprehensive, affordable Medicare prescription drug benefit. Why? Because if this bill is approved, I will have to tell Virginia that after she has spent $275 before she gets any help to meet the deductible, then beginning on January 18, when her deductible has been met, until October 7, 2006, Virginia would expect to pay 50 percent of the cost of each prescription.

This chart shows the $35 estimated monthly premium and the out-of-pocket costs Virginia would have to pay. After spending $275, she will spend another $2,112.50 for her 10 medications. Those are the blue bars on this graph. Then what happens? If this bill is approved, I would have to tell Virginia that after October 7, while the $35 premium continues at the same level, she would receive no benefit. All of these black bars are what Virginia would have to pay, 100 percent out of her pocket. She still needs all the medications on October 8 and 9, throughout the rest of the year. Her needs have not diminished.

On October 7, she falls into the black hole. She would stay there until December 27. I am guessing she will not be sending any Christmas presents to her grandchildren in 2006, either.

To make matters worse, I would have to tell Virginia that in addition to paying 100 percent of the cost of her prescriptions, she would still have to pay the $35 every month and get nothing in return. How do I explain to this senior in my State that she would be getting no help from the drug benefit but would still be paying the premium? She would get no help for nearly 3 months but would pay the premium anyway.

Between the premiums, which are getting her nothing, and the full cost of her medicines, Virginia would have to spend 34 percent of her income to get the medications that she needs. Let me repeat that. Between the $35 a month premiums and the full cost of medicines that she would have to pay while she is in the black hole, Virginia would be spending 34 percent of her annual income on prescription drugs.

I do not think Virginia will believe this is a very adequate prescription drug benefit. It is neither comprehensive nor affordable.

At an absolute minimum, Virginia should not be asked to pay a monthly premium during the time that she is getting no benefit.

This gap is bad medicine. The gap is a gimmick that lowers the cost of the plan but at the expense of our seniors. One of the many pieces of information we need from the Congressional Budget Office in order to make an informed judgment on this bill is the number of Medicare beneficiaries who would fall into this gap. However, like so many other aspects of this legislation, we not only do not have any practical experience, we do not have the theoretical estimates of the Congressional Budget Office.

According to the administrator of the Medicare Program, CMS, 12 percent of the almost 40 million beneficiaries would fall into this black hole. I believe that number reflects the number of beneficiaries who would fall into the gap today, in June of 2003. By the time we get to 2006, however, when the bill would actually become effective, data from the Kaiser Family Foundation suggests that more than 20 percent of the beneficiaries would fall into this gap.

This debate would certainly be informed by more information from the Congressional Budget Office, but in the absence of CBO numbers I will use the CMS and Kaiser numbers. If CMS is correct, nearly 5 million Medicare beneficiaries would fall into the benefit gap if the benefits were available today. If the Kaiser projections for 2006 are correct, nearly 8 million Medicare beneficiaries would fall into the black hole in the first year of this program. Eight million seniors and people with disabilities would be forced to pay a premium when they are getting absolutely no benefit in return.

I do not believe we should tax those 8 million Medicare beneficiaries whose prescription drugs are high enough to place them in this black hole.

In my own State of Florida, it is estimated that there will be 600,000 Medicare beneficiaries who would fall into this black hole. I do not want to go home and tell 600,000 of my constituents that instead of getting a comprehensive, affordable Medicare prescription drug benefit, they are going to get a meager benefit run by private insurance, and to top it off they will have to pay the "sick tax" imposed upon them when they need the benefit the most.

One goal of a Medicare prescription drug benefit, which I believe is commonly shared, is that seniors will find it in their best interest to voluntarily enroll in this new program. Last week, we debated a provision that would have given greater choice to seniors. They could have elected either to stay in the plan that is now being imposed, albeit a plan that has no history of a drug-only insurance policy, or they could make an election to stay with standard Medicare fee for service. That proposal was rejected. In my judgment, that is going to suppress voluntary participation in this prescription drug program.

Surely, the success of any program depends on a high participation rate. The "sick tax" would be an even further discouragement and could doom the program to failure. We know seniors will reject a plan that does not provide them the benefits they need. We have already seen that with the passage and then the quick rejection of catastrophic Medicare benefits in the late 1980s.

People like Virginia will not enroll in a program that requires them to make a monthly payment while they get nothing in return.

This amendment to suspend the payment of premiums once a beneficiary's drug utilization is within the gap in coverage would eliminate the unfair provision under which beneficiaries with high drug costs would continue to pay premiums while receiving no benefit.

In summary, the amendment that is before us would say if a beneficiary is in the black hole, if they are not receiving any benefits, they would not have to pay the monthly premium.

I bring to the attention of my colleagues that there has been some defense given of this legislation which says we cannot vote for any amendment which would change the basic structure of the bill; that would change, in my judgment, the unwise reliance on an unproven, drug-only insurance benefit. I want to emphasize, this does not change the structure. Rather, this removes a clear inequity but maintains the fundamentally flawed structure of this legislation. Yes, it has a cost. Again, we do not know what the cost is from CBO, but I am going to suggest an offset which will be more than adequate to pay the cost.

There are some who say we cannot afford any amendments which would increase the benefits of this program. That reminds me of the old story about the child who shot his mother and his father and then threw himself at the mercy of the court because he was an orphan. The fact is, we shot a legitimate prescription drug benefit for Medicare by passing a reckless tax cut that has absorbed the resources that would have enabled us to provide a legitimate benefit.

The offset that I am offering is an amendment which would secure the savings attributable to a clarification of the Medicare secondary payment provisions. For most of the history of Medicare, the assumption has been that if a person had double coverage, the primary payer would be that payer other than Medicare, and Medicare would wrap around that primary payer. A recent court opinion has reversed that assumption.

There is a provision, which is included in Chairman TAUZIN's House Energy and Commerce Committee mark, supported by the Justice Department, that would clarify the circumstances in which Medicare is the secondary payer.

I ask unanimous consent to have printed in the RECORD a letter dated January 17 from the Assistant Attorney General, William E. Moschella, outlining the Department of Justice support for this offset.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. DEPARTMENT OF JUSTICE, OFFICE OF LEGISLATIVE AFFAIRS, OFFICE OF THE ASSISTANT ATTORNEY GENERAL,

Washington, DC, June 17, 2003.

Hon. W.J. (BILLY) TAUZIN,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act, set forth in Title III, Section 301, which would protect the integrity of the Medicare Trust Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services ("HHS") in numerous court cases.

Congress enacted the Medicare Secondary Payer ("MSP") statute in 1980 to protect the fiscal integrity of the Medicare program by making Medicare a secondary, rather than a primary, payer of health benefits. To ensure that Medicare would be secondary, Congress precluded it from making payment when a primary plan has already made payment or can reasonably be expected to pay promptly. Congress recognized, however, that in contested cases, payments under such plans would be delayed. To protect, providers, suppliers, and beneficiaries, Congress authorized Medicare to make a "conditional" payment when prompt resolution of a claim cannot reasonably be expected. The Medicare Trust Fund must be reimbursed, however, once the primary insurer's obligation to pay is demonstrated.

Some recent court decisions have held, however, that Medicare has no right to reimbursement unless the primary insurer could reasonably have been expected to make prompt payment at the outset. *See e.g.*, *Thompson v. Goetzmann* 315 F.3d 457 (5th Cir. 2002). These rulings make the statute's reimbursement mechanism inoperative in some jurisdictions. Section 301 of this legislation would end this costly litigation and provide clear legislative guidance regarding Medicare's status as a secondary payer of health benefits. The technical changes in Section 301 make clear that Medicare may make a conditional payment when the primary plan has not made or is not reasonably expected to make prompt payment.

The technical amendments of Section 301 clarify other provisions of the MSP statute, as well. They make clear that a primary plan may not extinguish its obligations under the MSP statute by paying the wrong party (*i.e.*, by paying the Medicare beneficiary or the provider instead of reimbursing the Medicare Trust fund. The Section clarifies that a primary plan's responsibility to make payment with respect to the same item or service paid for by Medicare may be demonstrated, among other ways, by a judgment, or a payment conditioned upon the recipient's compromise, waiver or release of items or services included in the claim against the primary plan or its insurer; no finding or admission of liability is required. In addition, section 301 makes clear that an entity will be deemed to have a "self-insured plan" if it carries its own risk, in whole or in part. Finally, the Section makes clear that the Medicare program may seek reimbursement from a primary plan, from any or all of the entities responsible for or required to make payment under a primary plan, and additionally from any entity that has received payment from the proceeds of a primary plan's payment. These provisions of Section 301 will resolve contentious litigation and are designed to protect the fiscal integrity of the Medicare program.

We hope that this information is helpful. The Office of Management and Budget has advised that there is no objection to this report from the standpoint of the Administration's program. Please let us know if we may be of additional assistance.

Sincerely,

WILLIAM E. MOSCHELLA,
Assistant Attorney General.

Mr. GRAHAM of Florida. This amendment is endorsed by the National Committee to Preserve Social Security and Medicare. I ask unanimous consent that their letter of endorsement be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE,
Washington, DC, June 16, 2003.

U.S. Senate,
Washington, DC.

DEAR SENATOR: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare (NCPSSM), I am writing in support of Senator Graham's "No Premium in the Gap" amendment to "The Prescription Drug and Medicare Improvement Act of 2003."

We understand that the amendment would suspend the payment of premiums once a beneficiary's drug utilization is within the gap in coverage. Charging seniors a monthly premium without offering any benefit in return is the equivalent of levying a tax on the sick.

The amendment would improve the "The Prescription Drug and Medicare Improvement Act of 2003" by eliminating the unfair provision under which beneficiaries with high drug costs would continue to pay premiums while receiving no benefit.

We applaud your efforts and dedication on behalf of America's seniors, and appreciate your continued leadership on these issues. Please support Senator Graham's "No Premium in the Gap" amendment and we look forward to continuing to work with you.

Cordially,

BARBARA B. KENNELLY,
President and CEO.

Mr. GRAHAM of Florida. I urge my colleagues to join me in amending this legislation and repeal the "sick tax."

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. THOMAS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. THOMAS. Mr. President, I will comment on the amendment, the no premium on the donut amendment.

First, let me say that I wish we did not have a gap in coverage. Unfortunately, eliminating the gap in coverage could add as much as $200 billion to the cost of this proposal. As we all know, we are working within a budget of $400 billion and this bill targets those funds to those who need it most.

Most seniors, however, will not be affected by the gap in coverage at all. This is because their drug spending will not reach limit, or because they qualify for the additional assistance in the low-income benefit, or because they have additional coverage from a retiree health plan, or coverage they have purchased themselves.

Most seniors will not have drug spending in a year that exceeds the benefit limit. According to the Congressional Budget Office, 80 percent of seniors will not even have prescription drug spending that exceeds the $4,500 benefit limit.

That means that right off the bat only one senior in five would even have drug spending high enough to be affected by the gap in coverage at all.

Now, the drug benefit package for lower income seniors does not have a gap in coverage. In drafting this bill we have targeted resources to those who need it most. We made it a priority not to have any gap in coverage for lower income seniors.

This means that beneficiaries with incomes below about $15,000 and couples with incomes below about $20,000 in 2006 will have no gap in coverage. That is 41 percent of Medicare beneficiaries who are completely unaffected by the benefit limit.

In addition, beneficiaries who have coverage from a retiree health plan will not be affected by the benefit limit when the plan provides that additional coverage. Today, about 32 percent of beneficiaries have retiree coverage and this bill provides generous Federal assistance to retiree-sponsored plans so that they can continue to offer coverage to their former workers.

Other seniors will be able to purchase additional prescription drug coverage from their prescription drug plan or through their MedicareAdvantage plan. This additional drug coverage will be seamlessly integrated into their drug benefit package and will ensure that seniors who want additional coverage will be able to get it.

As a result of the elimination of the gap for 44 percent of seniors who have lower incomes and the fact that many seniors have additional coverage, we estimate that only about 2 to 12 percent of seniors will ever be affected by the gap in coverage.

Now every single beneficiary who enrolls in the drug benefit will have comprehensive coverage including coverage against catastrophic drug costs. That coverage is present even for those 2 to 12 percent who are in the gap in coverage. These seniors are always protected against higher drug costs.

Any enrollee will have 90 percent of their prescription drug costs covered if they have $3,700 in out of pocket spending on prescription drugs in a year.

Now Senator GRAHAM calls the benefit limit a sick tax because he believes that seniors should not pay a premium for the coverage for catastrophic costs if they hit the benefit limit. This is like saying that you should not pay for fire insurance if your house isn't on fire.

But of course that is not how insurance works. People purchase insurance to protect them against unfortunate events like a house fire, an accident, or some other tragedy.

To get the coverage in your insurance policy, you pay an insurance premium. If you do not pay the premium, then your insurance policy is not going to give you the coverage.

That is the same idea here with coverage for prescription drugs. Any senior who wishes to enroll in the voluntary benefit will pay a monthly premium for that coverage. The coverage is voluntary and the premium is an affordable $35 per month. And 44 percent of beneficiaries with lower incomes will have very low or no premium at all for the coverage offered in this bill.

Finally, if we were to close the gap in coverage for seniors at higher income levels it could cost over $200 billion, which would require us to take benefits away from the seniors with the lowest incomes. Personally, I cannot justify that action.

Of course, today's seniors receive no assistance from Medicare for outpatient prescription drugs, and this bill changes that by adding a new comprehensive prescription drug benefit to the program. The average senior will save at least 53 percent, about $1,700, off their prescription drug costs after paying an affordable monthly premium of $35. And lower income seniors will have 80 to 90 percent of their drug costs covered.

We have worked hard to minimize the gap in coverage within the resources available for the proposal. We have done that. Most seniors will not have spending that hits the benefit limit, and for those who do, many of those will have coverage above the limit through the low-income benefit package, from retiree plans or from additional coverage provided by their plan.

I urge my colleagues to vote against the Graham amendment.

I urge we not consider the Graham amendment, that, in fact, this has been covered and is covered in the bill as it now exists and is designed to help those beneficiaries with the lower incomes.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DASCHLE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DASCHLE. Mr. President, I wish to alert my colleagues this morning to an important new study that has just been published by the Institute of Medicine entitled "Hidden Costs, Value Lost: Uninsurance in America."

According to the Institute's findings, the United States economy loses between $65 billion and $130 billion each year because of the cost of the undiagnosed or untreated illnesses of those Americans who lack insurance. In short, the report found that the cost of not providing insurance is higher than the cost of providing insurance.

If these findings are borne out, this would represent an astonishing fact that should force the Congress to rethink our approach to the health care and insurance, policies in the country today. The report also examined the effect being uninusured has on individuals and their families.

It states:

> Unisured individuals and families bear the burden of increased financial risk and uncertainty as a consequence of being uninsured. Although the estimated *monetary* value of the potential financial losses that those without coverage bear is relatively *small*, the psychological and behavioral implications of living with financial and health risks and uncertainty may be significant.

Recently, I was home in South Dakota meeting with citizens. I saw firsthand the effect that the lack of insurance and the fear of losing insurance has on the people of my State.

Day after day, too many South Dakotans know that they are one layoff, one bad crop, one accident, or one illness away from being totally unprotected. I met with veterans who are picking up a greater share of their health care costs, because cuts to their health benefits are causing longer waits and worse care in the VA system.

I met with self-employed people, small business owners and farmers, who buy their own insurance and as a result face premium costs as high as $20,000 a year. I met with the families of National Guard members who just a few weeks ago were afraid that their loved ones might get hurt in the line of duty in Iraq. Today, they were worried that their husbands or wives will lose their health coverage when they return home. And I met with citizens from all walks of life who can't afford the high cost of insurance and live in constant fear that an illness or an injury could throw them and their family into bankruptcy.

I recently heard from a couple in Springfield, SD, who own a small business, but who do not have insurance. The husband is a veteran and he has been on the waiting list to receive benefits for himself through Veterans Health Administration for a year-and-a-half. In the meantime, he has looked for health insurance for both for he and his wife. But, the only policy they could find had monthly premiums of $800 and deductible of $2,500. In addition, the insurance would not cover the couple's pre-existing conditions. This policy was too expensive, so they are forced to live without coverage of any kind until the Veterans Administration is able to provide it. They may wait for as long as 2 years.

To bring resources for Veterans health more in line with the overwhelming need, many of us introduced a bill, S. 19, that would change the funding process for the Veterans Health Administration. The bill would mandate increased funding to correspond to any increase in the number of patients. This section, which is identical to S. 50, the Veteran Health Funding Guarantee Act introduced by Senator JOHNSON, would help ensure that the VA can provide medical services to every eligible veteran.

Our failure to provide coverage to veterans is one of the most glaring examples of the unfairness in our health care system. But the problem extends throughout our entire country. Forty-one million Americans lack health insurance today, and high costs are driving that number even higher. With the release of the Institute of Medicine's report, we learn that doing what's right is in fact less costly for our country than doing nothing. We can do better. This is a national problem and it demands national leadership to fix it.

We have an obligation to focus on the troubles of our economy and the Americans who are struggling to work and raise families. We certainly want to do everything we can to keep the Senate's attention focused on the crisis in health care. Our citizens are asking for our leadership, and we have an obligation to answer their call.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, as we did with the Graham amendment, I would now like to allow consideration of the Kerry amendment, and thus I ask unanimous consent that all the terms of the previous order remain in place except that the pending amendments be temporarily set aside, and that the Senator from Massachusetts be recognized to offer his amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Massachusetts.

AMENDMENT NO. 958

Mr. KERRY. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

> The Senator from Massachusetts [Mr. KERRY] proposes an amendment numbered 958.

Mr. KERRY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

> (Purpose: To increase the availability of discounted prescription drugs)
>
> On page 204, after line 22, insert the following:
>
> **SEC. . ACCESS TO DISCOUNTED PRESCRIPTION DRUGS.**
>
> (a) IN GENERAL.--From amounts made available under subsection (c), the Secretary of Health and Human Services shall award grants to covered entities described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) to enable such entities to pay the start-up costs associated with the establishment of pharmacies to provide covered drugs under such section 340B.
>
> (b) APPLICATION.—To be eligible to receive a grant under subsection (a), a covered entity shall prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(c) FUNDING.—The following sums are appropriated, out of any money in the Treasury not otherwise appropriated to the Prescription Drug Account established under section 1860DD-25 of the Social Security Act, $300,000,000 to carry out this section. Amounts made available under this subsection shall become available October 1, 2004, and shall remain available until expended.

Mr. KERRY. Mr. President, I thank the distinguished ranking member and congratulate both him and Senator GRASSLEY on what is obviously an extraordinarily important, complicated, and difficult road—to try to move toward prescription drug coverage for seniors in America. I wish to share a few words, if I may, at the outset, before moving specifically to the amendment, and to talk generally about the bill itself.

Obviously, all across our country we have accomplished an extraordinary service for seniors through what we have achieved through Medicare. It is one of the great social programs of the United States of America. I can remember years ago a shared responsibility by Republicans and Democrats alike. I think it was President Nixon who signed the enormous proportion of it into law in the beginning of the 1970s. We lifted a great many seniors in this country out of poverty as a consequence. It has benefited millions of Americans who would otherwise go without quality health care and otherwise either be forced into poverty or remain in poverty. The face of poverty in the United States of America changed because of this program.

I might add that it is a Government program. Often, the Government comes under great criticism. But the truth is that this is a program that has worked, a program that has made a difference in the lives of our fellow Americans, and a program that a large proportion of America appreciates, respects, and doesn't want to see destroyed. I think we have a duty to try to strengthen and improve the program by adding a comprehensive, affordable, and guaranteed prescription drug benefit to Medicare.

Notwithstanding the very best efforts of the chairman and ranking member and others on the committee on which I serve, there are still questions as to whether this in fact does that at this point in time.

That doesn't mean it isn't perhaps for some people worth voting for. I haven't made a final decision with respect to final passage. That may depend somewhat on what we achieve over the course of these days. But we need to put to the test the question of what we are doing versus what we could do. This is a fair standard for us to try to measure.

My concern today is that the underlying bill as currently drafted is a good start, it is a good foundation, but it doesn't fulfill the full measure of the promise of comprehensive, affordable, and guaranteed in ways in which I think we could do it. Our Nation's seniors, I fear, will experience a very severe case of sticker shock when they learn how far the bill falls below their expectations for relief.

Also, I wish we did not have to wait until 2006. I have serious questions about why, given it took us only 11 months to set up Medicare itself, it takes us 2½ years to set up the Medicare drug benefit. Frankly, it is beyond my acceptance of what is a legitimate reason. I know the reasons. I have heard the reasons. But think about that: We set up the entire Medicare Program in about 11 months, and now we are told to add a benefit within it, we ought to wait about 2½ years. I think it has far more to do about budgets and far more to do about elections than it does with the realities of what we need to do.

Seniors, obviously, need this relief. Nearly 40 percent of Medicare beneficiaries report having no—zero—prescription drug coverage. And the average amount they pay out of their own pocket for prescription drugs has increased from $644 in the year 2000 to $996 in 2003. These expenses are projected to grow to $1,147 in 2004 and $1,454 by 2006, which is the year when the benefit actually gets implemented. So we are talking about a much larger bill than we have today.

People who are measuring this bill by what we have today are actually measuring it short of what the need is because the need is going to be the year of implementation, 2006, and then we will have more than doubled the amount that individuals are paying for prescription drugs. That means the average annual out-of-pocket spending by seniors for prescription drugs will have doubled over that period. And I think seniors are to going to question: Well, if they all knew that, why am I still having such a hard time paying for prescription drugs?

Now, again, I want to underscore, I know how hard it is for the chairman and Senator BAUCUS to try to do this. And the reason it is so hard is because we have been given an arbitrary number. And I will say something more about that in a minute.

Let me say, for a moment, what I think is good that we have accomplished. No. 1, we have rejected President Bush's efforts to force seniors into private plans. We have rejected the President's plan to disadvantage seniors who want to stay in traditional Medicare and to keep the same doctors they have now. We have rejected the President's plan to give a windfall of incentives to PPOs to encourage their participation in the program. And we have adopted certain longstanding Democratic principles that include significant cost-sharing protections for low-income beneficiaries, a guaranteed fallback plan, and some key efforts that are targeted at improving the traditional fee-for-service benefits under Medicare.

But there are concerns I expressed in my "no" vote in the Finance Committee, and I want to express those concerns now on the Senate floor.

First of all, there are crucial areas I would hope we would try to find a way to improve. The most important of those is this gap in the coverage, in the donut hole as it is called, where seniors are charged a premium, but they do not get anything for the premium.

It seems to me there ought to be adequate protection to ensure, also, that employer coverage is not substituted or dropped. We do not want to create a situation where employers are covering people today, but because you have a fallback situation, they may decide, OK, we are going to drop that coverage, and, in fact, people are downgraded in what is available to them because there are not enough private people coming in to make up for that; therefore, the fallback is what they get. In addition, we must improve the stability of the fallback plans to minimize confusion and inconvenience to seniors.

Finally, I think we have to protect lowest income seniors by making sure they, too, can get the Medicare benefit. We ought to guarantee—or do our best to guarantee—a uniform national premium, somehow, for that benefit, and try to eliminate the new increases in beneficiary cost sharing under traditional Medicare and be more aggressive about providing additional benefits under the program.

But the stark reality is, all of these constraints are not the fault of Senator BAUCUS or Senator GRASSLEY. There is a reason we are operating under this straitjacket where we have had to tell a bunch of seniors they are going to pay a premium, they can buy insurance, they get to buy insurance up to $3,000—whatever it is—$4,500, and then they stop, but they continue to pay premiums. They continue to pay, but they are not going to get any benefit. They have to go back and start paying their full premium. But then when they get up to the $5,800 of catastrophic level, it begins to cut back in.

The reason we are there is fundamentally that $400 billion is all the Congress was given to deal with this—the arbitrary: Let's pick a number. Here is what we will put into prescription drugs.

I think every American has a right to ask—and they will ask over the course of the next years—why they were limited to $400 billion when the U.S. Congress chose to take $3 trillion off the table in tax cuts that went to upper income Americans over the course of the last 2 years.

Now, that is a fair question. That is the choice in America today. We make choices. People sent us here to make choices. And the choice made on behalf of the American people is that it is more important to reward people earning $315,000 a year than to make certain a lot of seniors don't have a donut hole in their coverage in prescription drugs.

When I heard Senator CRAIG THOMAS a moment ago say not that many seniors are going to be left out, I said, well, that is interesting because in the next breath he said we can't afford it because it is going to cost $200 billion. Well, if it costs $200 billion, it sounds to me as if somebody is being left out to a pretty large amount of money.

You cannot have it both ways. If it is expensive, it means it is meaningful to a lot of people. And if it is meaningful to a lot of people, we ought to be thinking about why we are not doing it.

Warren Buffett—the second richest man in the United States of America—wrote a letter a couple weeks ago where he said: Well, I own my own company. And now that I own my own company, and I've been given this very nice dividend benefit by the Republicans, I can pay myself $1 billion. And when I pay myself $1 billion, I'm not going to have tax, in this first year, on $365 million of it. It's tax free. That's it. He said he thought it would have been better to give 365,000 families in America $1,000 each. He did not think he ought to get that benefit.

Now, I think it is going to be fair for a lot of seniors in this country to ask the question, as we go forward, why Warren Buffett thinks that, and a whole bunch of people here think it is OK to do something else.

So if we are going to offer a prescription drug benefit that stands the test of time, the test of coverage, the test of fairness, and ultimately the test of the compact that Medicare created with our seniors, I think we ought to try to eliminate the coverage gap in this bill.

I think it is hard to turn to a senior at some point in time and say: Look, we want to help you buy drugs, but we are only going to help you up to the point where it gets really expensive. Then, when it gets really expensive, you are going to have to start carrying the bigger weight until it gets really, really expensive, and then we will come back and help you. It seems to me a lot of seniors are going to be asking questions about that choice.

I think we also could do better in protecting seniors with retiree coverage. The current bill contains a flawed definition for the true out-of-pocket costs by prohibiting any drug spending payments made on behalf of Medicare beneficiaries by an employer-sponsored plan from counting toward the stop-loss threshold.

In other words, they have an employer. That employer has given them a plan as a retiree, and they retire. They are qualified for Medicare. They paid into their retiree plan. It is their deal. But that is not now going to count toward their out-of-pocket expense. So they could, in fact, be left without the coverage that they deserve as a consequence of this definition. And that means that retirees covered under employer-sponsored plans will likely never reach the stop-loss threshold, and they will effectively be denied benefits under the catastrophic portion of the Medicare plan, even though they qualify for Medicare and worked just like everybody else for retirement and put money into the system.

Seniors who have retiree prescription drug coverage from their former employer worked a lifetime. They made wage concessions over the years, with the expectation they were going to receive those benefits. This bill comes along and, in effect, denies them benefits and treats them unequally in the context of the Medicare plan. It is unfair to change those rules after the fact. We ought to try to change it and reward employers who do the right thing and provide retiree coverage for their employees.

We also ought to try to strengthen the guarantee of a fallback plan and provide seniors with more stability and less confusion. Under the current bill, when a fallback program is available, it may not be available for very long. Medicare beneficiaries who are in the fallback program and like it will have to leave that program if two private insurers decide later to serve their region. In other words, the bill says there is only a fallback if you don't have two providers. But the minute you have two providers in a region, people who may have gone into the fallback program will have to turn around and leave the fallback program because there are now two providers, even if the two providers are providing more expensive premiums than they had in the fallback. So they will be forced out of their fallback into a more expensive plan which a lot of seniors are going to find both oppressive as well as very confusing to them as to why they have to do that.

Some people are going to argue there is another area of concern. That is how we treat low-income seniors in this bill. These are our most vulnerable and poorest seniors. They are eligible for both Medicare and Medicaid. But under the bill, they are going to get their benefit from the Medicaid Program. They won't be allowed to go into the Medicare Program because they are poor.

Some people are going to come to the floor and say: Wait a minute, a lot of States offer a better benefit in Medicaid. It is true. Some do. But we are not offering them an option. We are telling them they have to get it from Medicaid. And the problem is a whole bunch of States have a very limited Medicaid drug benefit. For instance, in the State of Texas, the benefit covers only three prescriptions. That is not a lot of protection. So we are forcing people into Medicaid in a State where, because they are poor, they have to take Medicaid, and they may only have three prescriptions available to them in the whole program. We are asking for trouble if that stays the way it is.

Moreover, we all know a lot of States are facing the worst deficits in a generation. That means States are beginning to cut back their benefits. There isn't one of us who hasn't seen a State where a Governor is forced to start to clip back on Medicaid. That means we are going to see higher copayments. We will have tighter formularies, more bureaucracy, and we will not necessarily be achieving the goal we are seeking.

Requiring low-income seniors to stay in a Medicaid prescription program is a bad deal for seniors because of the States that provide an inferior prescription drug benefit in Medicaid. We are now essentially creating the very thing we have always tried not to do. We are creating a second-class tier of citizens based on their income within the Medicare Program. We will for the first time say to seniors who paid into Medicare through a lifetime that just because now in their old age, because of their low income, they are going to have to accept a lesser benefit. That is wrong. For the first time in the history of the Medicare Program, seniors will be denied a benefit simply because of their income. It is a terrible precedent. It strains the social compact that was the foundation of Medicare in the first place.

Another concern in the underlying bill is the lack of the guaranteed premium or uniformity of it. Under this legislation, insurance companies providing the new drug benefit have the freedom to design their prescription drug plan. That is great. I am for the marketplace. I am all for companies offering a private prescription plan to the degree they want to or choose to or can. They can decide what premiums and copayments they want to charge. But the point is, under Medicare, we have always decided there was a fundamental compact with seniors for which they could pay and which ought to have some uniformity of treatment in essence. What we are doing now is throwing that whole sense of the system into the competitive structure of sometimes very limited choices which may ratchet up prices in a way that is going to become very complicated for a lot of Senators and Congressmen to explain to seniors who are used to the Medicare plan being something different in the context of the compact.

The bill promises an "average premium" of about $35 per month. But premiums are obviously going to vary from region to region in the country which means some seniors may pay $39 a month in Alabama, maybe $40 a month in Tennessee, but be charged $160 in New York. I believe we have to be very sensitive and thoughtful about what happens to people on fixed incomes. This is not your average marketplace. This is not a place where people even have the same set of choices.

When a senior on a fixed income winds up with high blood pressure, diabetes, perhaps prostate cancer or a mastectomy, any number of different problems that seniors cope with, they are forced into an economic status, not choosing to get into one. The question is whether we are going to do our best to try to protect them from that kind of volatility.

It is estimated in the first year of the program, approximately 35 percent of the Part D beneficiaries are going to pay more in premiums and out-of-pocket cost sharing than they will save from the new drug benefit; 35 percent will pay more than they are going to save from the new benefit. And to add insult to injury in that context, the bill doesn't just fail to provide an affordable, comprehensive drug benefit, but it also increases cost sharing for other Medicare benefits.

In that context, there are two troublesome cost-sharing requirements. It increases the Medicare Part B deductible from $100 to $125. And then it indexes it by inflation and permits a new coinsurance for clinical laboratory services. That means Medicare beneficiaries will be asked to carry the burden of an additional $24 billion in new cost-sharing requirements over the next 10 years. Wait until your grandmother finds out about that one.

For all of my concerns, we have certainly come closer than we have been at any time in recent years to trying to achieve the great goal of putting prescription drugs into some kind of Medicare benefit. I believe with additional persistence, with additional negotiations between us and the administration, we could make those concerns I just expressed go away or we could mitigate them. We could diminish them. I intend to support a number of amendments on the floor seeking to do that.

I have an amendment I have just called up that seeks to do one part of that. Let me explain it very quickly. I want to talk about an amendment I have and I will get to the one I just called up in a moment.

We have talked for a long time in the Senate about mental health parity. It is a goal we really want to achieve in this country. Senator DOMENICI has been a champion for it. There have been bipartisan efforts to try to get there. I would like to see us end the discriminatory practice of charging seniors in Medicare a 50 percent copay for mental health services, when we only charge a 20 percent copay for the other physician services. Too many seniors have mental illnesses that go untreated, and we should try not to make that worse by making it harder for people to be able to get the care.

I have an amendment to bring parity for mental health services for seniors. I am also working with Senator SUNUNU to try to improve the Medicare benefit by adding vision rehabilitation services to the list of covered services.

I am also pleased to join with Senator HUTCHISON and Senator KENNEDY as a lead cosponsor of an amendment to increase the Medicare indirect medical education—so-called IME—payments for teaching hospitals. I appreciate very much the efforts of Senator BAUCUS and Senator GRASSLEY to try to accommodate us to find a way to deal with this issue. It is a critical issue. Teaching hospitals incur a different set of costs, and you cannot measure the Medicare reimbursement against the expenses of the hospital in the same way.

Fifty percent of the doctors in Montana were taught at hospitals in, I think, 11 or 12 States, including Massachusetts, New York, California, and a few others in the country. So 11 or 12 States are spending money in their teaching hospitals to provide the benefit to the rest of the country of that quality medical education. When 50 percent of the doctors in Montana were educated in 11 or 12 States, Montana has a benefit, but it is not measured in the Medicare reimbursement. We need to make up that difference so we can continue to have the quality medical instruction and education in our country from which every American benefits.

In the spirit of improving this legislation, the amendment I offer today, which has bipartisan support, would dramatically improve the bill for some of the things I said I think are problems. It does it for very little money.

My amendment will help seniors who are in the coverage gap. What it does, it doesn't fill the whole "donut," but it will offer significant help to seniors who fall into the donut by expanding access to the existing prescription drug safety net.

The Federal Government currently sponsors a discount prescription drug program for those qualifying entities, such as a community health center or a public hospital or the Ryan White grantees, and others. Under this program, which is known as the 340(b) covered entities program, they have access to discounted prescription drug pricing for their patients in the program. In other words, if you have a community health center and your community health center has an in-house pharmacy, they could fill the prescriptions for seniors at discounted rates. They are allowed to do it. We have already had that under law. The problem is, we know a whole bunch of community centers and public health hospitals don't have the in-house pharmacies.

The benefit of this is to provide drugs that are significantly lower than the retail and wholesale prices. Based on a recent analysis of 200 very popular drugs, under 340(b) prices, on average, those drugs were 54 percent lower than the average wholesale price. Another recent survey showed that 340(b) prices were 24 percent lower than those available to groups purchasing as group organizations. So it is a sound program, but it is underutilized. Not all health centers and hospitals have an in-house pharmacy.

One of the biggest barriers to participating in 340(b) for many of the qualifying entities is the very expensive upfront capital cost of putting in place a pharmacy in their facility. So what I would do is establish a $300 million grant fund from the prescription drug trust fund created under the bill for HHS to award grants to health centers, hospitals, and other qualifying 340(b) institutions to help them with the startup costs associated with establishing a pharmacy in their entity. CBO scoring of this bill showed there is about a $10 billion surplus available in the current scoring, and so we have come in under the $400 billion. We have some cushion here. If we took that $300 million and made it available to these in-house entities to create those discount drug centers, then we could have those people who fall into the donut hole go to those centers, get the discount drugs, and significantly reduce the impact of the donut, which I think is a worthwhile effort.

We estimate there are up to 2,000 organizations in communities all across the country who would be assisted to set up in-house pharmacies as a result of this amendment. That will mean seniors all across the country who find themselves in the coverage gap will be able to purchase their prescription drugs for as much as 50 percent below the wholesale price. That savings is very significant in the context of what we are facing here.

My amendment is endorsed by the National Association of Community Health Centers, the National Association of Public Hospitals, and the Public Hospital Pharmacy Coalition. I hope it can earn the support of my colleagues so we can address one of the unintended consequences of dealing with only a $400 billion benefit, such as we are today.

I thank my colleagues for the opportunity to share these thoughts with them. I hope we can pass this amendment or have it accepted at the appropriate time.

I yield the floor and suggest the absence of a quorum.

The assistant legislative clerk proceeded to call the roll.

Mr. THOMAS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. THOMAS. Mr. President, as we hear more and more about this bill, of course, it causes us to reflect on it and that is the purpose of having conversation, that is the purpose of having debate. There will be much more of that, of course, but it is interesting to listen to what is being discussed, much of it based on the fact we need more money for this and more money for that, when we are adding to Medicare $400 billion, continuing to support the basic Medicare Program as it is financially, and adding to it this additional amount.

Medicare will be improved in every way as this happens. So I know it is a logical time to talk about how we might do more, how we might provide a Government program, as the Senator from New York talked about this morning, for everyone; take all the payments out, and that is a point of view.

I think, however, the concept of this business of Medicare is one in which we all pay into it, we pay something for it. Obviously, one of the principles of health care is for the recipient to pay something. We have found when they do not, it is out of control entirely.

We have a lot of worrisome times about Medicaid where there is no initial payment and we have overutilization. These are all part of the elements that go into it. I know it is great to talk about giving everything to everyone, but the fact is, that is not what is going to happen.

We have to get a balanced program that does what we really want to do. We talk about the gaps and helping people. The fact is, there is no gap for people who are below 160 percent of poverty. If we are going to assist someone, we assist those who are less able to assist themselves. That is what it is all about. That is what we seek to do.

Is it perfect? Of course not. If there were 100 of us sitting here working on the plan, we would probably have 100 different ideas as to how to do it, but we have to come to some consensus as to what our goals are and how we can best achieve those goals. Over time, it is something that is useful.

We have to keep that in mind as we go forward. Obviously, there are all different kinds of ideas, such as the fact we had a tax reduction and, therefore, we should be able to spend more. We had a tax reduction because we have an economic problem. We are trying to fix the economy—that is why we had a tax reduction—along with terrorism and other needs. To say we should pay more because we already had a tax reduction is not relative. That is not where we are.

Out-of-pocket expenses, of course, are always important, and should be. That is one of the keys. Here we have a program on which we have a certain amount of money we can legitimately spend. How do we best do that? How can we deal with everyone the same? Do we do more for those with low income and those who are less able to afford it? Of course. The true out-of-pocket limit targets the drug benefit to those who need it the most. That is what it is about.

The purpose of out of pocket is to protect seniors from high out-of-pocket costs. It is that simple. Spending that counts toward the out-of-pocket limit spending by the beneficiary. If the beneficiary drug is covered by some other source, such as a retiree's health plan, that money does not count out of pocket.

Seniors with additional coverage are not penalized for having additional coverage. They are protected if they have $3,700 out-of-pocket spending. In addition, they continue to benefit from additional drug coverage beyond that point, of course.

In addition to out-of-pocket spending by the beneficiary, spending by family members or friends also counts toward the out-of-pocket limit, as does spending by State pharmacy assistance programs, by State pharmacy plus programs. These programs target resources to lower income seniors who need additional assistance. They are in place now.

Allowing this spending to count toward the out-of-pocket limits allows these lower income seniors to receive additional assistance and still be protected against prescription drug costs that are not covered by Medicare drug benefits.

We should care about what the individual beneficiary has to pay, not what others pay on their behalf. This is the purpose of out-of-pocket limits in the proposal. Those who reach the amount of spending available will have 90 percent of their drug costs covered.

The House and Senate bills encourage employers to continue providing benefits by allowing them to avail themselves of 100 percent of the subsidies for offering standard benefit. If employers want to provide more, they are free to do so.

These are tough issues as to how we deal with some limitation on the spending and how we distribute it. We will hear more about it, and, indeed, we should.

There will be finally some principles involved as to the best way to spend the amount of money that is legitimately available. I hope we continue to focus primarily on those who are in that category of 160 percent of poverty level, and that is where it will continue to be.

Mr. President, we will continue to hear more. We certainly should hear more. We will continue to have more amendments, and that is fine. The Senator from Massachusetts was a member of the committee. We worked on it in the first place, and he has had an opportunity for input. Many of these proposals have already been voted on in the committee. Of course, if they are being proposed again, they were not successful in committee. Nevertheless, they should be brought up to this body, and they will.

Again, my hope is we can take a look at where we want to be in the year 2006, but what we want the result to be and make the adjustments that are necessary to get us to that point and not be taking up issues that are not even a part of debate. We are going to have to be very careful that we keep it limited to the issues that do impact Medicare and are in this area. I know we will continue to do that.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, we are now awaiting the arrival of Senator LINCOLN from Arkansas who has two amendments she wishes to offer. She will be arriving shortly. Until she arrives, I have a few words about a particular provision in the bill. It is called MARCIA, Medicare Appeals Regulatory and Contracting Improvements Act. Last year I joined my colleagues, Senator GRASSLEY, Senator KERRY, and now-Governor Murkowski, in introducing what we called the Medicare Appeals Regulatory and Contracting Improvements Act, otherwise know as MARCIA.

Today this bill is an essential part of our Medicare improvement proposal, the underlying bill. The purpose of the provision is to make Medicare a better business partner to providers, a smarter purchaser of services for our taxpayers, and a more customer-friendly organization for our beneficiaries. MARCIA will strengthen and improve Medicare and will help bring the program's administration into the 21st century.

The provisions provide for regulatory improvements. I have heard from hundreds of doctors, as I know all in this body have, and many providers who complain that the sheer number and complexity of Medicare regulations can drive them crazy and, at times, drive them out of business.

While we cannot make Medicare into a simple program, this bill would make and does take some helpful steps in the right direction.

For one thing, it will require the Secretary on a regular basis to review the thousands of pages of statutes and regulations to see if there are any inconsistencies in Medicare's many requirements.

Just a couple of days ago, the majority leader from Tennessee held up a book which showed the Medicare requirements back, I think it was 1965. It was a fairly thick volume, actually. Then alongside that he also held up a book with the current Medicare regulations, which was a gigantic volume. It is similar to the problems we face in the Tax Code, as we all know.

I am not standing here to say the provisions of this bill are going to make Medicare simple and easy, that we are going to cut the number of pages down to half. But I am saying we are trying to do our very best, and the provisions in this bill should help reduce some of the inconsistencies and the complexities that do now occur in the Medicare regulations. At least we are focusing on that problem and requiring the Secretary to address that, specifically giving that direction.

Second, our legislation would cut down on the CMS practice of using so-called interim final rule authority to impose major new regulations without even giving the public an opportunity to comment. It just stands to reason that the public should have an opportunity to comment on rules because it is more likely if they do, the rules are going to be better rules or, on the other side of the coin, if there is not an opportunity for the public to comment, there is going to be a tendency over time for CMS or any agency to be a little less sensitive to what that is really all about, which is about serving people because, after all, we are all public servants, including CMS personnel. Our real job is to serve the people in the country, and I think this will help move CMS in that direction.

The third provision would make sure that new regulations cannot be applied retroactively. Intuitively, I think it makes sense that it does not apply retroactively. I think these new requirements are just a simple matter of fairness.

The underlying bill, as we are talking about the regulatory provisions, would also make improvements to the Medicare appeals system. In the year 2001, on average it took 441 days to complete an appeal before an administrative law judge. The next level of appeal took almost 2 years. It is true certain provisions in the 2000 law that we passed tried to speed up the appeals process, but unfortunately that law did not provide the resources or the realistic timeframes necessary to make these changes work.

MARCIA, the regulatory provisions, would make some important improvements to get this appeals system back on track so our Medicare beneficiaries and providers can get justice more quickly. Clearly, 441 days for the first level of appeal and 2 years for the second is not right, for a whole host of obvious reasons.

The bill also requires CMS to submit a plan to develop and train a group of dedicated Medicare ALJs, administrative law judges. This plan would ensure that administrative law judges remain truly independent, which I think is a crucial feature of any fair appeals system.

Medicare contractors will also have to bid and compete for contracts under this bill. That is a very significant change from current practice. Essentially, under the current practice, Medicare contractors, especially talking about the intermediaries, are essentially nominated by the intermediaries. They themselves nominate who it is going to be, and there is no limit to how long a contracting period can be. I think it tends to be a little bit too close and there is not enough fresh air to help assure, at least the best we can, that the contractor selection process is one that provides more efficiency and better service to our people.

The Medicare contractors will have to bid now. They are going to have to compete for contracts under this bill—that is new—thereby assuring that the Medicare Program and the taxpayers are getting the best service for the lowest price the market will allow.

In assessing the bids, CMS will have to consider customer service and accuracy. That is required when CMS is now selecting contractors and getting bids from contractors. Again, we are talking generally about the so-called intermediaries who are the ones who deal directly with providers. They deal between the providers and the beneficiaries and the Government.

In assessing the bids, CMS will have to consider customer service and accuracy, as I said, and contractors will also have to provide much more information to providers and to beneficiaries. If the providers raise questions about Medicare claims or policies, contractors will have to answer them in writing. That, too, is new.

The bill also would require the Secretary to standardize the way in which Medicare conducts audits, the way it conducts prepayment and postpayment reviews of provider claims. We often hear of great, almost gross, inconsistencies among different parts of the country, different regions. It makes sense to standardize this a little bit better. I am encouraged that CMS has already taken steps in this direction to make the audit process more fair but to ensure that providers are treated fairly and consistently, I believe the law has to require it.

Finally, I am pleased this bill also contains money for continued strong enforcement against waste, fraud, and abuse in the Medicare Program. I have long believed the Medicare integrity programs must be firm, but they must also be fair. This bill takes important steps to ensure honest dealing with taxpayer money and fair treatment for the professionals who serve our seniors every day.

Essentially, these are provisions that hopefully address a good part of the regulatory complaints, the legitimate complaints that all of us in this body have been hearing about from doctors and hospitals as they try to do their very best job in providing care, in this case, to seniors. I think these are good, solid provisions.

Turning to another matter, as we did for Senator GRAHAM and Senator KERRY, I would now like to make it possible for the Senator from Arkansas to offer her amendments. I ask unanimous consent that the pending amendments be temporarily set aside and that the Senator from Arkansas be recognized to offer up to three amendments in succession.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Arkansas.

Mrs. LINCOLN. Mr. President, I begin by complimenting my colleagues from the Finance Committee: Senator GRASSLEY, our chairman; the ranking member, Senator BAUCUS; and all of the other members on the committee who have really focused on what is most important to the American people, and that is to get a good, commonsense product out of the Senate that encourages our seniors and lets them know that we do understand that this is a critical issue. It is critical not only in terms of the quality of life for our seniors but also in regard to economics. We want them to understand we can provide cost savings not only to our Nation but to our aging families by providing a prescription drug package which will allow them to be healthier individuals; to not cause or create greater costs for this country and for the other parts of the health care system in this great Nation through acute care or difficulties in long-term care, in nursing homes and emergency rooms, but being able to have a quality of life and providing a good economic way to deal with the aging process.

As we went through this bill in committee, we talked an awful lot about ways that we could improve Medicare; looking at coordination of care, at how we could provide a better, commonsense way of administering health care to our elderly in this country not only through a prescription drug package but recognizing that disease management is an enormous part of what we are doing for our elderly, and that with the multiple diseases they are dealing with, if we can manage that disease management of multiple diseases and have a coordination of care, we are going to get a better bang for our buck in Medicare.

I am excited about the possibilities and want to compliment my colleagues on a lot of hard work that has been done, particularly recognizing that rural areas of our Nation also have great needs. I certainly applaud the chairman and the ranking member on that.

Today I bring up several of the amendments I have to offer. Many of these amendments we discussed in the committee. In my approach in the committee I was willing to visit with the chairman and the ranking member and say I hoped we could work through whatever we needed to in order to get these passed and get them in part of the bill. Those discussions are ongoing and I compliment my colleagues for working with me on these critical issues.

Hopefully we can resolve them without going to a vote, but I want these amendments placed and filed and in the queue so my colleagues have an opportunity to comment on them and work with me in order to get them done.

AMENDMENT NO. 934, AS MODIFIED

First is amendment 934 which has already been filed. Medicare Part B does not currently cover insulin or syringes used to inject insulin for the majority of enrollees in the Medicare Program. This is a horrific oversight in a program that should be designed to deal with our elderly but, more importantly, dealing with, again, some of these diseases that are predominantly in our aging population, especially when we see that of the 7 million or so Americans over 65 with diabetes, 40 percent inject insulin every day to control their diabetes.

Providing syringes for insulin will go a long way to helping seniors keep their diabetes in control: It is a fabulous preventive measure. It is obviously a critical area of need for our seniors. The management of blood glucose levels for diabetes helps prevent long-term complications like kidney failure, blindness, amputation, and a multitude of other chronic illnesses and problems that arise when diabetes is not kept in check.

Syringes are required to inject insulin because there is no oral or inhaled form of insulin. The lack of coverage for syringes means syringe purchases will not count toward their yearly maximum out-of-pocket expenses and their copayments. This will lead to the reuse of syringes that are not FDA approved for more than one use. We recognize it is a very minimal cost to the overall package and makes a huge difference.

I encourage my colleagues to take a look at this amendment. I compliment the ranking member and the chairman for being willing to work with me as we go through this process. I hope it is something we can get accepted. If it is not, I hope my colleagues will recognize for this very small amount of money we can make an enormous difference in a huge population of our elderly who are suffering from diabetes. I look forward to working with my colleagues on that.

I call up amendment 934 as modified.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN], Ms. COLLINS, and Mr. MILLER, proposes an amendment numbered 934, as modified.

(Purpose: To ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin)

On page 8, line 12, insert "(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator)" before the semicolon.

On page 174, line 14, insert "(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Secretary)" before the comma.

Mrs. LINCOLN. I ask unanimous consent to lay that amendment aside to proceed to the next amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 935

Mr. President, the next amendment I bring up has to do with the graduate medical education 2-year program in geriatrics. One of the provisions of my geriatric care act bill pertains to the Medicare graduate medical education financing of this second year of a geriatrics fellowship training. It clarifies that geriatric training programs are eligible for 2 years of fellowship support. This can be done administratively. We have worked with Tom Skully at CMS, and he is interested in making something such as this happen.

The fact is, out of 125 medical schools in this great country, only three have a department of geriatrics. At a time when we are getting ready to see 41 million Americans over the age of 65 blossom into well over 70 million Americans over the age of 65, it is not just a critical measure to provide a prescription drug package.

We have to be prepared with the types of physicians and medical technicians who can care for our aging population, who understand what coordination of care actually means in bringing together this disease management. In understanding that it is not just one medical visit, but that has to be coordinated with a nutritionist, perhaps dealing with depression, a psychologist, they have to deal with orthopedics, they have to deal with a multitude of other disease management areas.

If we can include that 2 years of funding for geriatric training, then we will be able to not only train the geriatricians we need, but we will also be able to maintain the level of academic geriatricians who will be the ones teaching geriatric medicine and geriatricians for the future. It is a critical part of what we have to do.

We worked out a compromise in the committee after having come through the committee, and in talking to CMS they suggested some changes. These are only technical changes. I don't think anyone will have a problem with them. I hope not. I want to make sure I get them out there and make sure we can work through those differences. I look forward to working with the chairman on that.

I call up that amendment, which is amendment 935.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN] proposes an amendment numbered 935.

(Purpose: To clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs)

Strike section 410 and insert the following:

SEC. 410. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.

Mrs. LINCOLN. I ask unanimous consent that amendment be laid aside for my next amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 959

Mrs. LINCOLN. The next amendment is amendment numbered 959. I am offering this amendment that authorizes a 3-year, five-State demonstration project of direct access to outpatient physical therapy services within the Medicare Program without the sometimes burdensome requirement of seeking a physician referral.

This is not a new concept. Several health professionals currently enjoy practice without referral under Medicare for their respective scopes of practice—dentists, podiatrists, chiropractics, optometrists, nurse practitioners. They all practice independent physician referral.

Non-Medicare citizens in my State of Arkansas and 36 other states, including Iowa, Utah, Maine, Arizona, Wyoming, Pennsylvania, the home State of our Presiding Officer, Tennessee, Oregon, Kentucky, Montana, West Virginia, South Dakota, North Dakota, Florida, New Mexico, and Massachusetts, all of which have Senators represented on this committee, allow direct access to licensed physical therapists as authorized by their State law.

However, Medicare requires its beneficiaries in my home State and yours to obtain a referral in order to access the services of a physical therapist. I certainly believe it is time to study the example of the States in a demonstration project to see if the referral requirement is indeed necessary. We are talking about seniors who are striving so diligently to claim the final years of quality of life. Physical therapy, occupational therapy, vocational therapy, all of these therapies are the tools that allow these individuals to go back into their home and to live their life, with the quality of life, with the dignity they want in their end-of-life years. It is so critical they can get the necessary access to these services in order to be able to do that.

I encourage my colleagues and certainly the ranking member, Senator BAUCUS, and our chairman, Senator GRASSLEY, to work with me on this program. I believe it is budget neutral. It simply is moving forward on the concept that many of our States have already embarked on. It is very practical on behalf of the aging community that we are working on right now.

With that, I call up amendment 959.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN] proposes an amendment numbered 959.

(Purpose: To establish a demonstration project for direct access to physical therapy services under the medicare program)

At the end of subtitle B of title IV, add the following:

SEC. . MEDICARE DEMONSTRATION PROJECT FOR DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the impact of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services on—

(1) costs under the medicare program under title XVIII of the Social Security Act; and

(2) the satisfaction of beneficiaries receiving such services.

(b) DEADLINE FOR ESTABLISHMENT; DURATION; SITES.—

(1) DEADLINE.—The Secretary shall establish the project not later than 1 year after the date of enactment of this Act.

(2) DURATION; SITES.— The project shall—

(A) be conducted for a period of 3 years;

(B) include sites in at least 5 States; and

(C) to the extent feasible, be conducted on a statewide basis in each State included under subparagraph (B).

(3) EARLY TERMINATION.—Notwithstanding paragraph (2)(A), the Secretary may terminate the operation of the project at a site before the end of the 3-year period specified in such paragraph if the Secretary determines, based on actual data, that the total amount expended for all services under this title for individuals at such site for a 12-month period are greater than the total amount that would have been expended for such services for such individuals for such period but for the operation of the project at such site.

(c) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program under title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary to conduct the demonstration project.

(d) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—

(A) IN GENERAL.—The Secretary shall conduct interim and final evaluations of the project.

(B) FOCUS.—The evaluations conducted under paragraph (1) shall—

(i) focus on the impact of the project on program costs under title XVIII of the Social Security Act and patient satisfaction with health care items and services for which payment is made under such title; and

(ii) include comparisons, with respect to episodes of care involving direct access to physical therapy services and episodes of care involving a physician referral for such services, of—

(I) the average number of claims paid per episode for outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services;

(II) the average number of physician office visits per episode; and

(III) the average expenditures under such title per episode.

(2) INTERIM AND FINAL REPORTS.—The Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives reports on the evaluations conducted under paragraph (1) by—

(A) in the case of the report on the interim evaluation, not later than the end of the second year the project has been in operation; and

(B) in the case of the report on the final evaluation, not later than 180 days after the closing date of the project.

(3) FUNDING FOR EVALUATION.—There are authorized to be appropriated such sums as may be necessary to provide for the evaluations and reports required by this subsection.

(e) DEFINITIONS.—In this section:

(1) COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—Subject to paragraph (2), the term "comprehensive outpatient rehabilitation services" has the meaning given to such term in section 1861(cc) of the Social Security Act (42 U.S.C. 1395x(cc)).

(2) DIRECT ACCESS.—The term "direct access" means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

(A) without regard to any requirement that—

(i) an individual be under the care of (or referred by) a physician; or

(ii) services be provided under the supervision of a physician; and

(B) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

(i) certification and recertification; and

(ii) establishment and periodic review of a plan of care.

(3) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term "fee-for-service medicare beneficiary" means an individual who—

(A) is enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.); and

(B) is not enrolled in—

(i) a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.);

(ii) a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm);

(iii) a program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee); or

(iv) a social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

(4) OUTPATIENT PHYSICAL THERAPY SERVICES.—Subject to paragraph (2), the term "outpatient physical therapy services" has the meaning given to such term in section 1861(p) of the Social Security Act (42 U.S.C. 1395x(p)), except that such term shall not include the speech-language pathology services described in the fourth sentence of such section.

(5) PHYSICIAN.—The term "physician" has the meaning given to such term in section 1861(r)(1) of such Act (42 U.S.C. 1395x(r)(1)).

(6) QUALIFIED PHYSICAL THERAPIST.—The term "qualified physical therapist" has the meaning given to such term for purposes of section 1861(p) of such Act (42 U.S.C. 1395x(p)), as in effect on the date of enactment of this Act.

Mrs. LINCOLN. I ask unanimous consent that amendment be laid aside so I can bring up my final amendment.

The PRESIDING OFFICER. Without objection; it is so ordered.

Mrs. LINCOLN. Before I get to my final amendment, I want to touch on one other issue and that is the issue of our rural ambulance providers. I see my colleague, Senator THOMAS. He and many others who are in the rural health caucus have done a tremendous job in working through this bill and providing great access issues for our rural areas. I am encouraging my colleagues, as well as the ranking member and the chairman, to work with us on the issue of the rural ambulance providers.

We do not have an amendment as of yet and I am hoping we can work through some of those details as we move forward in this piece of legislation. I encourage them to work with us and hopefully we can finish that on Monday and move expeditiously on a piece of legislation that will benefit all of the seniors across the Nation.

AMENDMENT NO. 963

My last amendment is an amendment we have brought on the fallback issue, which is a critical piece of this bill. I think it is absolutely essential, as we look toward making sure private industry can play a role in providing a Medicare prescription drug package. We have seen, over the course of many past years, where private industry has certainly the option, even today, to participate in Medicare and the application of it. In some of our areas across this great Nation they are reluctant to do so because the profitability is not there for them.

We want to make sure there is every opportunity for private industry to come in and provide a product for everyone across this Nation. But if, in fact, in the time it takes to implement this program certain areas of our Nation find themselves in the same predicament they are today, which is private industry does not find it quite profitable enough to come in there, we want to make sure there is a fallback. We don't want anyone left behind. We think all seniors in this great Nation are equally important. We are going to make sure, across this great Nation, if for some reason there is an area that does not meet the test for private industry, there is a fallback.

In that fallback we want to make sure they have the same contract benefit the private industry does. We have talked a little about this issue in the past. We want to make sure, as we move forward on all these issues, again, that the fallback measure that is going to be there in some of our less populated areas is going to have that 2-year contract ability.

In the Finance Committee, when we brought the bill up, we found in many instances it primarily affects our rural States, and primarily rural areas. We want to make sure we offer them the same opportunity we do in private industry.

It improves stability, provides a more stable benefit by reducing year-to-year variability in premiums and cost sharing, and provides better assurances that needed medications and local pharmacists will be covered. It improves choice. After all, that is what we are here to do, to provide our seniors with as much choice as we possibly can.

It provides that once seniors are in a fallback plan, they have the option to remain in that plan for 2 years. One of the concerns we have had in our State is that when we have seen private plans come in, they come in and then they leave and then they come back. Seniors do not know what they can depend on. They have to make different decisions. Each year, because there is no standard design here, their choices are going to be different. They are going to have different premiums, different formularies, different pharmacies they can go to. So we want to make this the least confusing possible. Providing them the ability to have the same stability in the fallback as they do in the private plans I think is very important. And I think it is fair. Therefore, we do improve on fairness, providing the seniors in the fallback plan the same rights given to seniors who are in a drug-only plan, the opportunity to stay in for that same 2 years.

Continuing the first bidding rights for drug-only plans—maintaining first bidding rights for the drug-only plans, allowing fallback plans to enter a region only after it has been determined the two private drug-only plans will not be available—I encourage my colleagues to look at this. If there are two private plans, there is no fallback. You do not have to worry about a 2-year contract. You do not have to worry about a 1-year contract. That is because the fallback doesn't even exist. These are just emergency measures, to make sure individuals in rural areas are going to get the same benefit and they are going to be covered. We are not asking anything more of a Government fallback plan than we are of private industry. If private industry is there, you do not have to worry about it because the fallback is not going to exist.

I encourage my colleagues to take a look at this. It comes at a very minimal cost. It adds substantial stability to the system and, certainly, by not costing much more in dollars.

We again plead with our colleagues to make sure those seniors in rural States will have the same benefit there as have other seniors across this great country. We look forward to working with them if there are any concerns they have.

Mr. President, I appreciate your patience in allowing me to bring before the Senate my amendments to this very important bill and to encourage my colleagues. These are probably some of the most important policy decisions we will be making. As we embark on this journey to provide a critical component of health care to an enormous population in our Nation, as far as I am concerned, one of the most important as well as the most vulnerable, I think it is critical for all of us to look at ways we can improve this bill. Once this bill is passed, once it is signed into law, are changes going to be easy to make? No, they are not. So it is critical for each of us to take the time and recognize where we can make these slight changes and improvements in a bill. It is going to make a remarkable difference in the lives of the elderly of this Nation.

I encourage my colleagues to take a look at these very simple amendments that I think will be improving amendments to a bill that is moving down the pathway, something we encourage everyone to support in the coming days as we come to completion on a remarkable piece of legislation and a remarkable help to the seniors of this Nation.

I thank the Chair and my colleagues for their indulgence today and for being able to offer these amendments.

The PRESIDING OFFICER. Did the Senator offer her last amendment?

Mrs. LINCOLN. I do so now.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Arkansas (Mrs. Lincoln), for herself, Mr. Conrad, Mr. Miller and Mr. Carper, proposes an amendment numbered 963.

The amendment is as follows:

(Purpose: To allow medicare beneficiaries who are enrolled in fallback plans to remain in such plans for two years by requiring the same contracting cycle for fallback plans as Medicare Prescription Drug plans)

On page 83, strike lines 1 through 7, and insert the following:

"(5) Contract to be available in designated area for 2 years.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

"(A) The contract shall be for a 2-year period.

"(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

"(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

Mrs. LINCOLN. I yield the floor.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. LINCOLN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 963 WITHDRAWN

Mrs. LINCOLN. Mr. President, there seems to be some confusion as to the last amendment which I submitted. At this point, I ask unanimous consent to withdraw that amendment, and I will reintroduce it on Monday.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. LINCOLN. Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 964

Mr. BAUCUS. Mr. President, on behalf of the Senator from Vermont, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] for Mr. JEFFORDS, proposes an amendment numbered 964.

The amendment is as follows:

(Purpose: To include coverage for tobacco cessation products)

Beginning on page 8, strike line 1 and all that follows through page 9, line 2, and insert the following:

"(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2);

"(ii) a smoking cessation agent that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act as a non-prescription drug and is dispensed upon a prescription;

"(iii) a biological product described in clauses (i) through (iii) of subparagraph (B) of section 1927(k)(2); or

"(iv) insulin described in subparagraph (C) of such section;

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—

"(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraphs (E) and (G) thereof insofar as they relate to smoking cessation agents, or under section 1927(d)(3).

Mr. BAUCUS. Mr. President, I ask unanimous consent, again, that all pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 965

Mr. BAUCUS. Mr. President, I send a second amendment to the desk on behalf of the Senator from Vermont and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] for Mr. JEFFORDS, proposes an amendment numbered 965.

Mr. BAUCUS. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To establish a Council for Technology and Innovation)

At the end of subtitle B of title IV, add the following:

SEC. . COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395ee), as amended by section 534, is amended—

(1) by adding at the end of the heading the following: ": COUNCIL FOR TECHNOLOGY AND INNOVATION"; and

(2) by adding at the end the following new subsection:

"(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

"(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (as appointed or designated under paragraph (4)).

"(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes with respect to new technologies and procedures, including new drug therapies, under this title in order to expedite patient access to new technologies and therapies.

"(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title, and shall prepare reports to Congress required under section 1869(f)(7).".

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. NELSON of Florida. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NELSON of Florida. Mr. President, I wanted to come to the floor and offer some comments about the Medicare prescription drug bill. I wanted to give my accolades to the chairman and ranking member of the Finance Committee for how they have so expertly crafted a bill in a bipartisan fashion which is how this body ought to be operated, and so often we are operating exactly the opposite way. There are just too many partisan votes around here. They have shown, Senators GRASSLEY and BAUCUS, that the spirit of bipartisanship in fact does live and that good work products can be accomplished.

ANTISPAM LEGISLATION

Before I make my remarks on the legislation, I want to recall to mind another bipartisan work product that was produced out of the Commerce Committee yesterday and will be coming to the floor. It is the antispam legislation. I have reserved for the floor to offer a major amendment to it. It is very possible that we will work out and the prime sponsors of the bill will accept my amendment, but it has to do with the question of spam, which is all of that unwanted e-mail everybody gets on their computer.

I was just absolutely dumbfounded: One day I went in my Tampa office and I said: How about printing out for me the e-mail we received today, just one day. And they produced a full letter-sized sheet, single spaced, of e-mail that we did not want, that had come anyway. Of those e-mail messages, two of them were pornographic which, if that is happening in the office of a Senator, you can imagine what is happening all across the country. That is exactly what is happening.

People are fed up. They want the Federal Government to do something about it. Fortunately, we have finally gotten the political will now that we are going to do something about it.

I bring this up not only as an example of bipartisanship reflecting what Senator BAUCUS has done with this masterful crafting of a legislative package, but I wanted to alert the Senate to the fact that the antispam bill is going to come. I am going to have an amendment that will improve it.

In the bill the only penalty is a misdemeanor. What I want to do is to strengthen that penalty and to give the prosecutors the tools so that the violation of sending unwanted and undisclosed in its address e-mail becomes an element that will trigger the Racketeer Influenced Corrupt Organization act, RICO.

What that does is give prosecutors the tools to go after the criminal enterprise and then take their assets. Let me tell you what is in this morning's paper. Here is a good example of an e-mail scam that used a retailing giant's name in an attempt to capture credit card numbers and other personal data on a nationwide basis. They sent out millions of these e-mails. What they did is, they took a retailer, Best Buy, and they sent a message that said they wanted to offer something on Best Buy. Of course, it was all fraudulent. It was claiming to be Best Buy's fraud department. They said they were informing people their credit card number had supposedly been used in a suspicious purchase through Best Buy dot com. And then it instructed the card holders to go to a special Web link to help resolve the problem.

Then when those Best Buy customers went to that Web link, they offered their credit card number and then "Katie bar the door."

Here is obviously a deceptive scheme, taking the advantage of a legitimate business, using a deceptive message in order to obtain credit card numbers which they then will use fraudulently to bilk people of millions of dollars. And because they send out hundreds of millions of these e-mail messages, it is time for us to get serious and not just come in with an antispam bill that is going to spank people on the hand with a misdemeanor but is going to go after the assets of the criminal enterprise under the RICO Act.

I bring this to the attention of the Senate. That debate will be coming up hopefully fairly quickly. I must say, ever since I happened to talk about this down in Tampa that day I just checked my e-mail in the Tampa office, I have gotten so many calls and letters to say: Right on, Bill, right on.

We can't even use our computer and our e-mail anymore, because we are so cluttered up with e-mail. It is time for the Federal Government to do something about it.

We have a crime against mail fraud. The Presiding Officer, as a former U.S. Attorney, knows all about prosecuting mail fraud. If you did that kind of scheme I just showed you in today's Orlando Sentinel, and instead you used the mails and you sent out 100 letters like this same thing, posing as a department store, saying we have reason to think your credit card has been stolen, give us your card number so we can correct this—of course, it is a deceptive scheme; it gets your credit card number so they can charge—you would prosecute under the mail fraud statute. But that is sending out a hundred letters—my goodness gracious—through e-mail—snap, just like that, 175 million e-mail messages. Think how many people are going to bite and how many credit card numbers are going to be stolen—just in this particular case.

That is why we have to give them strong penalties in the bill that is going to be considered by the Senate. That is why we have to be able to hook it as one of the elements that triggers the RICO Act—the Racketeer Influenced and Corrupt Organization Act—so that the prosecutors can go after the assets of the organized criminal thug ring.

PRESCRIPTION DRUGS

Mr. NELSON of Florida. Mr. President, I came to talk today about this prescription drug bill. I certainly support this bill, and I am going to vote for it. I commend the chairman and the ranking member for how they have crafted this legislation. I commend the Finance Committee for how it has put it together. If I had my druthers, we would have passed those amendments that we would have had in the last few days that we didn't pass because, clearly, giving an option for seniors to go directly through Medicare for a prescription drug benefit is, in my opinion, keeping faith with the seniors. So many of us have already suggested that we wanted to modernize Medicare from a 1965 health insurance system funded by the Federal Government for senior citizens—modernize that to the year 2003.

If you were writing Medicare today instead of in 1965, 38 years ago, would you include a prescription drug benefit? Of course you would because the miracles of modern medicine, the miracles of prescription drugs so often today will take care of the ailments and the chronic problems; so that when the Medicare system was set up in 1965—38 years ago—the state of the art of medical care was centered around a hospital and doctors. But hospitals and doctors have new tools today. Some of those tools, by the way, that I will share with you sometimes come directly out of America's space program. They are the spinoffs of technology. Some of them have come out of the State of the Presiding Officer at the Marshall Space Flight Center. I am telling you, there is some miracle equipment that has come out of the space program.

Part of the miracle of modern health care is prescription drugs. For that, I give great commendation to NIH, to our universities, and all the research institutions, and to the research departments of the pharmaceutical companies that are producing these new wonder drugs of today. But we ought to be modernizing Medicare with a prescription drug benefit that is a part of Medicare. The problem is, we cannot get the votes to do that.

So what the Finance Committee has done is fashion a plan whereby you can offer in the private sector, through a preferred provider organization—a PPO is a managed care kind of concept—and they will provide it or the senior citizen can go and get two separate drug plans and directly there. But if they fail, there is a backup of the Federal Government doing its own prescription drug plan, according to the elements in the outline of what they have done in the legislation.

I would prefer it if a senior citizen could, in fact, go to the private sector or have the choice of getting their prescription drugs directly from Medicare. That would be the senior citizen's choice. But we could not get the votes for that amendment.

So we are proceeding on with the bill, and I am certainly going to support the bill because it is a major first step along the way to providing prescription drugs for senior citizens. We need to keep faith with those seniors. This is what a lot of us have talked about and said we wanted to do, and this is a first major step to do it. Since the Senator from Montana has come back in, I have been commending him on this package saying that I wish we had adopted a couple of the amendments that were offered over the last couple of days, but that I support the package. I commend him. This is a major first step on the road to keeping faith with our seniors. I appreciate what he has done.

I would like to take a few moments to critique some parts of the bill.

Mr. BAUCUS. Mr. President, before the Senator critiques the bill, if the

Senator from Florida will yield. I very much appreciate his kind remarks. As virtually every Senator knows, this is not the perfect bill. Each Senator would like to change it a little bit. This Senator, in particular, would like to have had more money, frankly. We have $400 billion over 10 years. If we had a little more, maybe we could accommodate many of the provisions to which the Senator is referring. They are good ideas. But I think this legislation is a good first step, a chapter in a very long Medicare book. Chapter 1 was in 1965, when it was first enacted. There will be many more chapters as we work to improve Medicare, so that our senior citizens get the benefits they rightly deserve.

I thank the Senator very much for his working with us. He has given us some great ideas. I think over time, in the next couple to 3 years, we will have another chance. I thank the Senator.

Mr. NELSON of Florida. Mr. President, I think the Senator from Montana is "Merlin the Magician" to finally be able to craft a package that will get through in a bipartisan fashion with a huge number of votes in this Chamber. And I think if it is appropriate with the ranking member—and I believe parliamentary-wise, it is appropriate—I will lay down a couple of amendments now that can be taken up at a separate time, and then I will discuss them.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside so the Senator from Florida may proceed to offer up to two amendments.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 938

Mr. NELSON of Florida. Mr. President, I send to the desk amendment No. 938.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Florida (Mr. NELSON) proposes an amendment numbered 938.

Mr. NELSON of Florida. I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for a study and report on the propagation of concierge care)

At the end of subtitle B of title IV, add the following:

SEC. . GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) CONCIERGE CARE.—In this section, the term "concierge care" means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

AMENDMENT NO. 936

Mr. NELSON of Florida. Mr. President, I send another amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Florida (Mr. NELSON) proposes an amendment numbered 936.

Mr. NELSON of Florida. I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for an extension of the demonstration for ESRD managed care)

At the end of subtitle C of title II, add the following:

SEC. . EXTENSION OF DEMONSTRATION FOR ESRD MANAGED CARE.

The Secretary shall extend without interruption, through December 31, 2007, the approval of the demonstration project, Contract No. H1021, under the authority of section 2355(b)(1)(B)(iv) of the Deficit Reduction Act of 1984, as amended by section 13567 of the Omnibus Reconciliation Act of 1993. Such approval shall be subject to the terms and conditions in effect for the 2002 project year with respect to eligible participants and covered benefits. The Secretary shall set the monthly capitation rate for enrollees on the basis of the reasonable medical and direct administrative costs of providing those benefits to such participants.

Mr. NELSON of Florida. Mr. President, I will tell you just very briefly about these amendments, and I want to make comments basically on the underlying bill. I think these amendments are such that it is my understanding that they may be accepted—perhaps even in a managers package. But one of them involves extending the Federal role in the end stage renal disease demonstration project, which is a project that we have in Florida. I will speak about it later. It will stand on its merit.

The other is amendment No. 938 to require a GAO study to examine the extent of how concierge care has been expanded in the country and what we need to do about it. I am working with Senator BREAUX on this particular amendment.

What is happening is we have a Federal health insurance system for senior citizens that is available to all senior citizens if they qualify on the age. Lo and behold, a practice is arising around the country where some physicians are saying: I will no longer serve you unless you pay me a dollar amount per patient per year—in the case of some physicians in Florida, $1,500 per year. At the same time they are cutting the number of patients they see, they are saying: For this $1,500 entrance fee that you pay, we are going to give you specialized treatment, same day appointments, hot towels; you can call us at any time of the night—all of that personalized concierge care for $1,500 a year per patient. But if you do not pay us that, you cannot be my patient, and, oh, by the way, I still want to receive reimbursement from the Federal Government for the reimbursable services I am giving to you, the senior citizen.

That was not how Medicare was set up. Medicare was set up for all senior citizens, not just those who can pay $1,500 a year to see the doctor.

This concierge care popped up here and in several other States. This amendment is to require a GAO study to examine the extent to which this might ultimately be a destructive force against the Medicare reimbursement system and the entire Medicare system because the logical conclusion of this kind of concierge care is we would have completely two tiers of service within Medicare. We would have those who could pay the $1,500 per year, and, by the way, that is just in one case. There is another case in California where they are having to pay $24,000 per year per patient just to be under the care of that particular doctor. So we would have two tiers under Medicare. We would have the Medicare recipients, the senior citizens, who qualify, and they would pay that money and would go to certain doctors, and the doctors who were not going to charge that, who would be left over, would get all the rest of the Medicare patients who could not afford to pay the fee.

That is not the way Medicare was set up, and that is not how Medicare is intended to deliver health care services to senior citizens that are paid for by the Federal Government.

Instead of just coming in here and breaking down the door, I took the suggestion of the senior Senator from Louisiana. In this bill, he has a special provision having to do with speciality hospitals, but he first did a GAO study to show the extent to which those speciality hospitals were being utilized. That became the basis for changing the law. That is what I will be doing by offering this amendment No. 938 which we will discuss at a future time.

I inquire of the Senator from Montana—I am just getting ready to get into my comments about the bill—does the Senator from Montana know of somebody else who wishes to speak and, if so, can he give me an indication of how long he would like me to speak? I yield to the Senator.

Mr. BAUCUS. Mr. President, I ask the Senator from Florida how long he wishes to entertain us and to educate us.

Mr. NELSON of Florida. With the enormity of this subject, Mr. President, I could go all the way from 5 minutes to 55 minutes. So what is the pleasure of the Senator from Montana?

Mr. BAUCUS. I was expecting a longer speech, frankly. I suggest the Senator speak for, say, 10, 15 minutes or whatever time the Senator wishes to take.

Mr. NELSON of Florida. I yield to the distinguished majority leader.

Mr. FRIST. Mr. President, for scheduling this afternoon, in 15 or 20 minutes I am going to speak for 20, 25 minutes, and then Senator BYRD is going to come over later as well. We have plenty of time, but if sometime in the next 30 minutes or so I may have the floor for 20 or 30 minutes, that will be helpful.

Mr. NELSON of Florida. I thank my colleagues. I was actually willing to step down and let the distinguished majority leader go ahead. He is very kind.

I would like to point out some critiques. I want it nailed down that I support this package. I think we can improve it, but at the end of the day, if we have not been able to improve it by the amendment process, it is my intention to vote for it because I think it is a major step in the right direction. Over the course of time, we are going to be able to add to the law and improve it so that at the end of the day, perhaps in a year or two down the road, we are going to have a prescription drug benefit under Medicare for senior citizens.

This legislation does many things, not the least of which is the most comprehensive attempt at expanding one of our Government's most successful experiments, this Medicare Program.

Today, almost 80 percent of our seniors take at least one prescription drug a day and over half of them take an average of four prescription drug medications each day. Prescription drugs are responsible for keeping people out of the hospital and helping them maintain their health. Spending money on medicines not only reduces the suffering of millions but it also reduces their health-care-related costs.

Let me give an example. There is a lady named Ms. Rita Salls from Sebring, FL. She takes at least 12 medications each day and sometimes even more than that. Those medicines are what allow her to continue to live on her own, an independent life.

Like many of our colleagues, when we first ran for the Senate, we talked to our constituents—and we still do—and we said we were going to try to enact this prescription drug benefit under Medicare.

What do many of our seniors without the prescription drug coverage do? They have to skip doses to make their prescriptions last longer or they have to spend less on food. Can you imagine in the year 2003 in the United States of America that there are senior citizens who are having to make a choice between food or their medicine because they do not have enough money? In some cases, they are completely unable to fill a prescription solely based on its cost. The need for this benefit has never been clearer.

While this legislation is certainly an exceptional effort to fulfill our promise for a prescription drug benefit, it does fall short in some categories.

My first concern is as it relates to the provider of the drug benefit. Given Medicare's mixed experience with Medicare HMOs—what we call Medicare+Choice; it is an HMO created under Medicare— we have not had too good of an experience with that because those Medicare HMOs have folded up and are cancelling out beneficiaries all across the country, particularly in rural areas such as Montana, and many of the rural counties in my State. How do I know that? Before I came to the Senate, I was the elected State insurance commissioner of Florida and I saw in county after county, as the regulator, where I had to go beg, cajole, and wheedle when a Medicare HMO stopped serving a rural county to get another Medicare HMO to come in and fill that role.

Should these companies come in, I still believe there should be the Government's fallback provision in the bill. It is certainly a very important provision. I wish it were in place permanently as the first option a senior could go to, but that amendment from a couple of days ago did not pass. In other words, I believe all seniors should have the option of receiving their drug benefit through Medicare rather than just through the private insurer. I think that ought to be the senior citizen's choice and yet that is not the case with the bill.

Another worry I have is how this plan is going to treat low-income seniors. In my State of Florida, over one-third of the seniors have incomes low enough to qualify for the low-income benefit of this legislation. This is especially true in Florida because the State pharmacy assistance plan in the State of Florida provides only a very limited benefit and is only available to a very small fraction of low-income seniors in Florida.

This Grassley-Baucus compromise provides premium and deductible assistance to seniors well above what Medicaid is required to do and what my own State is doing, but under the bill, some low-income seniors will not be eligible for the Medicare benefit because the plan insists that they continue to receive their benefit through Medicaid. Furthermore, beneficiaries will be subjected to an asset test in order to qualify for the benefit, which could deter some eligible beneficiaries from seeking the assistance in the first place.

Another grave concern I have is the coverage gap faced by the seniors under this legislation. Beneficiaries with drug costs in excess of $4,500 a year will find themselves continuing to pay a premium while not getting any benefit until the catastrophic provision kicks in, which is around $5,700. It is as if we are penalizing the sicker beneficiaries who depend on more prescription drugs.

Assistance to seniors should focus on individuals like Mr. and Mrs. Lomax of Longwood, FL. Mr. Lomax is 67 years old. He cannot afford to quit working because he and his wife would not be able to afford their prescription drug costs. So he continues to provide them coverage through his employer, because the cost of his medications add up to over $600 per month. Under this bill, Mr. Lomax would be required to pay over $4,200, over 40 percent of his annual drug costs.

Another critique I would make of the bill is it fails to address an issue not only affecting our Nation's seniors but anyone who has to purchase prescription drugs. I have talked to my former chairman of the Finance Committee and now the ranking member, Senator BAUCUS, about this. We realize these are the hard realities because nothing in the bill today guarantees that when Medicare or private plans on behalf of Medicare purchase their drugs from manufacturers that they get the very lowest possible price. If taxpayers are going to have to face the long-term burden of ensuring a viable prescription drug benefit for years to come, we should make certain the Government uses its purchasing power to the best of its ability.

That is a question that no doubt will be answered over the years as this new bill becoming law begins to be added to and perfected over the course of time.

In addition to expanding coverage of drugs in Medicare, this legislation does include some very worthy provisions aimed at easing the States' increasing burden of providing care to our Nation's immigrants. Immigrants and Florida, the two so often go hand in hand because of the desirability of coming to this wonderful country of ours. Where do so many of them come? To the shores of the State of Florida.

In this bill, by allowing the States the option to cover legal immigrant children and pregnant women through Medicaid and the State Children's Health Insurance Program, SCHIP, States will finally be able to obtain Federal dollars to offset the States' costs for immigrants. Similarly, increases in Federal reimbursement for providers of emergency treatment to undocumented aliens is welcome.

Florida ranks fifth among States with the highest population of illegal immigrants. Providing uncompensated care to illegal and legal immigrants is a major and growing problem for many of our hospitals in Florida. This provision in the bill will go a long way in helping to ease that situation.

Another major component of this proposal would increase funding to rural health care providers by more than $30 billion over the next 10 years, but I must say I am troubled by the way this bill pays for necessary increases in provider reimbursements by passing along their costs to Medicare's beneficiaries. They are already struggling to pay for their share of the health care costs. Their share of these costs can often exceed 45 percent of the total. So I think it is unconscionable to think that as we ask them to pay an additional $35 per month for drug coverage and an increased deductible we would ask them to pay for things they have not had to pay for in the past such as new deductibles and copayments on such things as outpatient lab services.

Furthermore, we are again threatening the ability of some of our sickest beneficiaries to receive the care they so desperately need. While we all agree that the method for payment of anticancer agents should be reformed, reducing the reimbursement from 95 to 85 percent of the average wholesale price without appropriate increases in payments for essential patient services could further jeopardize access to quality cancer care in a physician's office setting.

I, along with my colleagues, will do all we can over the course of the next several days to improve this legislation with amendments ensuring that the Government maximizes its purchasing power and ensuring a beneficiary's coverage is stable. They will, hopefully, be accepted. It will strengthen this legislation.

This is a starting point. We must also ensure that is a solid foundation for a comprehensive benefit that fulfills our promises to America's seniors.

Mr. BAUCUS. I know the people in Florida very much appreciate the hard work the Senator does. Part of that is on behalf of senior citizens.

I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 967

Mr. BAUCUS. Mr. President, on behalf of the Senator from Iowa, Mr. HARKIN, I send an amendment to the desk with respect to approving access to mammography services.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. HARKIN, proposes an amendment numbered 967.

(Purpose: To provide improved payment for certain mamography services)

At the end of subtitle B of title IV, add the following:

SEC. . IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 13951(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 968

Mr. BAUCUS. On behalf of Senator HARKIN, I send a second amendment to the desk restoring certain reimbursements for nursing home services.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. HARKIN, proposes an amendment numbered 968.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To restore reimbursement for total body orthotic management for non-ambulatory, severely disabled nursing home residents)

At the end of subtitle B of title IV, add the following:

SEC. . REIMBURSEMENT FOR TOTAL BODY ORTHOTIC MANAGEMENT FOR CERTAIN NURSING HOME PATIENTS.

(a) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall issue product codes that qualified practioners and suppliers may use to receive reimbursement under section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) for qualified total body orthotic management devices used for the treatment of nonambulatory individuals with severe musculoskeletal conditions who are in the full-time care of skilled nursing facilities (as defined in section 1861(j) of such Act (42 U.S.C. 1395x(j))). In issuing such codes, the Secretary shall take all steps necessary to prevent fraud and abuse.

(b) QUALIFIED TOTAL BODY ORTHOTIC MANAGEMENT DEVICE.—For purposes of this section, the term "qualified total body orthotic management device" means a medically-prescribed device which—

(1) consists of custom fitted individual braces with adjustable points at the hips, knee, ankle, elbow, and wrist, but only if—

(A) the individually adjustable braces are attached to a frame which is an integral component of the device and cannot function or be used apart from the frame; and

(B) the frame is designed such that it serves no purpose without the braces; and

(2) is designed to—

(A) improve function;

(B) retard progression of musculoskeletal deformity; or

(C) restrict, eliminate, or assist in the functioning of lower and upper extremities and pelvic, spinal, and cervical regions of the body affected by injury, weakness, or deformity,

of an individual for whom stabilization of affected areas of the body, or relief of pressure points, is required for medical reasons.

Mr. BAUCUS. I ask that all pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is ordered.

AMENDMENT NO. 969

Mr. BAUCUS. On behalf of the Senator from Connecticut, Mr. DODD, I send an amendment to the desk permitting open enrollment on a drug benefit for 2 years.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana (Mr. BAUCUS), for Mr. DODD, proposes an amendment numbered 969.

(Purpose: To permit continuous open enrollment and disenrollment in Medicare Prescription Drug plans and MedicareAdvantage plans until 2008)

At the end of subtitle C of title II, add the following:

SEC. . PERMITTING CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT UNDER MEDICARE PARTS C AND D UNTIL 2008.

(a) UNDER MEDICARE PRESCRIPTION DRUG PLANS.—Subclause (II) of section 1860D-3(a)(1)(A)(i), as added by section 101, is amended to read as follows:

"(II)(aa) during 2006 and 2007, may change an election under this clause at any time; and

"(bb) during 2008 or a subsequent year, may make an annual election to change the election under this clause.".

(b) UNDER MEDICAREADVANTAGE PLANS.—Section 1851(e) (42 U.S.C. 1395w-21(e)), as amended by section 201, is amended—

(1) in paragraph (2)(A), by striking "THROUGH 2005" and "December 31, 2005" and inserting "THROUGH 2007" and "December 31, 2007", respectively;

(2) in the heading of paragraph (2)(B), by striking "DURING 2006" and inserting "DURING 2008";

(3) in paragraph (2)(B)(i), by striking "2006" and inserting "2008" each place it appears;

(4) in paragraph (2)(C)(i), by striking "2007" and inserting "2009" each place it appears;

(5) in paragraph (2)(D), by striking "2006" and inserting "2008"; and

(6) in paragraph (4), by striking "2006" and inserting "2008" each place it appears.

Mr. BAUCUS. Mr. President, I ask that all pending amendments be laid aside temporarily.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 970

Mr. BAUCUS. I send an amendment on behalf of Senator DODD expanding low-income protections to 250 percent of poverty.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. DODD, proposes an amendment numbered 970.

(Purpose: To provide 50 percent cost-sharing for a beneficiary whose income is at least 160 percent but not more than 250 percent of the poverty line after the beneficiary has reached the initial coverage gap and before the beneficiary has reached the annual out-of-pocket limit)

Section 1860D–19(a) of the Social Security Act, as added by section 101, is amended by adding at the end the following new paragraph:

"(5) REDUCTION OF COST-SHARING FOR ADDITIONAL LOW-INCOME BENEFICIARIES.—

"(A) IN GENERAL.—In the case of an additional low-income beneficiary (as defined in subparagraph (B)), such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 50.0 percent.

"(B) ADDITIONAL LOW-INCOME BENEFICIARY.—Subject to subparagraph (H), the term 'additional low-income beneficiary' means an individual—

"(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

"(ii) whose income is at least 160 percent, but not more than 250 percent, of the poverty line; and

"(iii) who is not—

"(I) a qualified medicare beneficiary;

"(II) a specified low-income medicare beneficiary;

"(III) a qualifying individual;

"(IV) a subsidy-eligible individual; or

"(V) a dual eligible individual.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 942

Mr. BAUCUS. Mr. President, I call up amendment No. 942 on behalf of the Senator from Washington, Ms. CANTWELL.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Ms. CANTWELL, proposes an amendment numbered 942.

(Purpose: To prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a MedicareAdvantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements)

On page 204 after line 22, insert the following:

SEC. 133. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

(a) MEDICARE.—Subpart 3 of part D of title XVIII of the Social Security Act (as added by section 101) is amended by adding at the end the following new section:

"PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS

"SEC. 1860D–27. Notwithstanding any other provision of law, an eligible entity offering a Medicare Prescription Drug plan under this part or a MedicareAdvantage organization offering a MedicareAdvantage plan under part C shall not enter into a contract with any pharmacy benefit manager (in this section referred to as a 'PBM') to manage the prescription drug coverage provided under such plan, or to control the costs of such coverage, unless the PBM satisfies the following requirements:

"(1) The PBM is not owned by a pharmaceutical manufacturing company.

"(2) The PBM agrees to pass along any cost savings negotiated with a pharmacy to the Medicare Prescription Drug plan or the MedicareAdvantage plan.

"(3) The PBM agrees to make public on an annual basis the percent of manufacturer's rebates received by the PBM that is passed back to the Medicare Prescription Drug plan or the MedicareAdvantage plan on a drug-by-drug basis.

"(4) The PBM agrees to provide, at least annually, the Medicare Prescription Drug plan or the MedicareAdvantage plan with all financial and utilization information requested by the plan relating to the provision of benefits to eligible beneficiaries through the PBM and all financial and utilization information relating to services provided to the plan. A PBM providing information under this paragraph may designate that information as confidential. Information designated as confidential by a PBM and provided to a plan under this paragraph may not be disclosed to any person without the consent of the PBM.

"(5) The PBM agrees to provide, at least annually, the Medicare Prescription Drug plan or the MedicareAdvantage plan with all financial terms and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer or labeler, including formulary management and drug-switch programs, educational support, claims processing and pharmacy network fees that are charged from retail pharmacies and data sales fees.

"(6) The PBM agrees to disclose the retail cost of a prescription drug upon request by a consumer.".

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

"SEC. 714. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

"The provisions of section 1860D–27 of the Social Security Act shall apply to a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.".

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following:

"Sec. 714. Pharmacy benefit managers transparency requirements.".

(3) EFFECTIVE DATES.—The amendments made by this subsection shall apply with respect to plan years beginning on or after the date of enactment of this Act.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following:

"SEC. 2707. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

"The provisions of section 1860D–27 of the Social Security Act shall apply to a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan, in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to group health plans and health insurance issuers in connection with group health plans for plan years beginning on or after the date of enactment of this Act.

(d) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.—

(1) IN GENERAL.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.) is amended—

(A) by redesignating such subpart as subpart 2; and

(B) by adding at the end the following:

"SEC. 2753. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

"The provisions of section 1860D–27 of the Social Security Act shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.".

(2) EFFECTIVE DATE.—The amendment made by subsection (c)(1)(B) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.

(e) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by inserting after section 9812 the following:

"SEC. 9813. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

"The provisions of section 1860D–27 of the Social Security Act shall apply to a group health plan in the same manner as they apply to an eligible entity offering a Medicare Prescription Drug plan under part D of title XVIII of the Social Security Act or to a MedicareAdvantage organization offering a MedicareAdvantage plan under part C of title XVIII of that Act.".

(2) CLERICAL AMENDMENT.—The table of contents for chapter 100 of such Code is amended by inserting after the item relating to section 9812 the following:

"Sec. 9813. Required coverage of young adults.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after the date of enactment of this Act.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, on this Friday we have had a number of speakers come forward over the course of the morning and the afternoon on the topic of how best to improve Medicare, strengthen Medicare, preserve it, and build upon what we have learned in the past to bring it up to date and to give seniors the opportunity to receive the type of health care available today of which most people in the private sector are able to take advantage but to which, because of the structure of Medicare today, seniors simply do not have access in a way they really deserve: Things such as prescription drugs, which, as we heard debated 20 or 30 minutes ago by the distinguished Senator from Florida, are so absolutely critical to the health care toolbox, to the armamentarium out there today to take care of seniors and individuals with disabilities to prevent more serious illness for people on those pills that keep their blood pressure down at a reasonable level, that prevent debilitating strokes, prevent massive heart attacks; if they do not take that pill, those acute diseases that become chronic diseases occur, or episodic acute diseases occur.

There is such a high barrier for prescription drugs that they are less likely to reach out and get the drugs. The whole purpose is to reverse the burden in a way that is sustainable over time. As politicians, we want to help people, we want to help them now. But if we do it in a shortsighted way, we can create bigger problems for people 3 years out, 5 years, 10, 15, 20 years out, or at this time we must think 30 years out.

In the next few minutes, I will again step back and look at where we are in health care, what we are doing. Then we will be able to come back in next week and look at a lot of the individual amendments. They can be very technical. They involve a lot of terms that are unfamiliar to even a lot of Senators but also to the public at large.

In the next few minutes, I want to take this big-picture look and introduce the demographic challenge that should be the backdrop for all of our discussions when we look at health care for seniors, for promises we are making today that we are writing into legislation to make sure we are doing it in a way that can be sustained over time. This is talking to seniors but, even probably more directly, to the near seniors and to the younger generation because it is their health care we are talking about. It is their money we are using, in large part, to pay for the health care security for seniors today. Thus, I think we have to look at it in this intergenerational way.

In the big picture, the U.S. health expenditures for the dollars spent in 2001 and 2002 are similar, although this chart shows the most recent data for today of all health care dollars spent in the United States of America. The red on the chart is public expenditures, public programs—what is government—and the blue is the private sector. It is an interesting chart because it shows about half of the health care dollars run through government programs—Federal, State, and local—and half of the health care dollars are spent in the private sector.

What we have the opportunity to do now is marry these two with public-private partnerships, to take care of one segment of these health care dollars, and that is this 17 percent, this bright red 17 percent—almost a quadrant—but 17 percent of the overall health care dollar which is spent on and for and by senior citizens and individuals with disabilities, about 40 million people. That is 17 percent.

What we were concentrating on the last week, really the last several months, is this part of the pie. Medicaid, which is lower income, other Federal programs, other State and local programs are the other public programs—46 percent of the overall pie.

What we are going to be doing is capturing the very best out of the private sector, in terms of health care delivery, technology, prescription drugs—which, remember, are not up in this red sector—capture the best of the private sector with the best of the public sector, marry the two, and thereby give the seniors who fall into this sector here, this piece of the pie, better health care, better value that can be sustained over time. We are capturing the best of this section with the best of this section, marrying public and private.

It is a new concept. Traditionally, Medicare has been command and control. Washington, DC-based: we dictate; we say what is in it, what is not in it. We dictate, micromanage the decisions. The problem with health care today, with the advances in health care delivery, with the new innovations, with the human genome project, with the new technology, it is not being adopted into this sector. To me, that is sort of the big picture I want to begin with.

The challenge, if we are looking long term, if one of the goals of what we do now is we must be responsible for the future, we need to recognize what the demographic backdrop is. What does the future look like? The future looks different now, from a demographic standpoint—demographic being numbers of people, ages of people, genders of people. That is what I am talking about when I am talking about demographics. That backdrop is changing more radically than ever, than at any time in the history of this country. I will tell you why shortly. It is changing in several ways.

This chart is the number of Medicare beneficiaries. That 17 percent I just showed you was of the overall health care dollar, how many people fall in that section of that pie chart. Just look at two bars on this: This is the year 2000; this is in the year 2030. The important thing is there are 40 million beneficiaries—beneficiaries just means seniors, people who are in the program in the year 2000. You see it goes up, but just jump over and you can see it is 77 million in the year 2030. It seems like a long time from now, but it is not. That is not very long from now. But from this green bar to this green bar is a doubling in the number of seniors.

Historically, we did not have that. I will show why we had this doubling that we have to face up to if we are responsible legislators.

No. 1 is the baby boom. I love this chart because it is the way I view the baby boom. You see, it really is a baby boom. This, along this Y axis, is births per woman. You can see how it has changed over time. This is 1940, 1950, 1960, 1970, 1980, 1990, 2000—so we are about where this dotted line is now.

You can see that we had this baby boom, this fertility curve, this increase in population right after 1945, up to about 1970, with the peak around 1959, 1960. You just add 60 or 65 years to this part of the chart and you quickly get out to 2010, 2015, 2020. That is what we need to look for. In other words, this fertility curve, this baby boom, this increase in the population has just moved right across this chart, and this baby boom is going to begin to hit us in about 2008—5, 6, 7 years from now. It just begins to hit, and then over the next 5, 10, 15 years it peaks and then goes back down. But it goes back down over a period of about 30 years. So we are talking 2010 out to 2040, 2050.

The big thing is this anomaly is unprecedented in entitlement programs. This is what we have to prepare for.

If this is the Medicare system here, and we are taking care of seniors, we are going to have a doubling in the number of seniors. One of the reasons is because of the baby boom. The other reason—and I am proud of this reason. I think we all are. I am, as a physician, because physicians focus their lives on health care and improving length of lives as well as quality of life. This is probably, to me, the easiest way of looking at the fact that people are living longer now than they did 10 or 15 years ago, and as we improve health care, as we do better with preventive care and better technology and get people to eat better and exercise more, we are going to continue to have these seniors—which are already doubling in number—live longer. Let's just take an example.

This is what it was like in 1940, 1950, 1960. What this means is—let's say I am 65 years old. If I am 65 years old, in the year 2000 I would be predicted to live another 20 years. This is years of life remaining at age 65. That is pretty good.

Let's say if it were for me, 60 years old, I would be 65 plus 15 is 80.2 years of age. If I were a woman, I would be able to say I am 65 years of age, and I am going to live 20 more years. That is pretty interesting.

But the good news is that when Medicare started, when you were 65, say, back in 1965, if I was 65 years of age, they would say I am only going to live 13 more years. But because health care has gotten better now, I am going to live 15 more years, and if I am out in 2030, I am going to live 17 more years.

You have not only more seniors but each one of those seniors is living longer. Thus they are going to be in the Medicare system for a longer period of time than what we would have thought or predicted back, either in 1965, the year 2000, or 2030.

If we are good, which I think we are in terms of science, technology, health care, this is going to increase more and more. I don't know where it is going to stop. Nobody really knows, in terms of how long people will live. But it is interesting, doubling the number of seniors because of the fertility curve, and each one of those seniors will live longer, of which we are all proud.

As an aside, this differential between women and men is pretty remarkable. If I am talking to a woman 65 years of age, I say you are going to live 20 more years. If I am talking to a man, you are only going to live 15 years. Why is that? There are a lot of hypotheses, and we don't fully know why the difference, why it is. But the point is they both are going to live longer.

This is sort of a summary chart. In 1970, we had 20 million people. Now we have 40 million people. You are going to see this line break. In 2030, we are going to have 77 million people. Again, the summary chart: A lot more people coming out of the system. That is one component.

Let's say this is the Medicare system. We say trust fund but it is not really a trust fund like in a bank or the way you envision money accumulating and then paying it out. That is just not the way it happens. It is a pay-go system, which means for every senior over here taking out for health care, you have workers—that is most of the people who are probably listening to me right now, people who have been working—who have to support it. The moneys they pay on April 15, or whenever they pay their taxes, go out to support these seniors. The money we are spending is not money seniors paid in in the past; it is a pay-go system. That is why this trust fund is not really a trust fund.

What is interesting there, not only do we have a doubling of the number of seniors, but we have fewer workers paying into the system, which the very next day are paying out to support an increasing number of seniors. This is fascinating because it, too, is a part of that fertility curve, in the 1940s and 1950s.

You will see in 1970 there were 7 of these individuals, 7.3 to be exact—paying taxes to support every senior in the system. What is interesting is that in the year 2000 that has come way down. Instead of having 7 people over here working to support each senior, you have 3.9—say 4. You have these 4 working. So, therefore, they are having to work twice as hard or pay twice as much for taxes, or work twice as many hours a day than they were working in the past because you have fewer of them supporting each worker—for health care.

Again, with the fertility boom, as it comes through, this is going to fall, by 2030, to only 2 or 2.4 workers, and they are going to have to work that much harder to support whatever we promise and whatever health care we give to seniors.

All of sudden, we saw a huge challenge. We can promise so many things right now. We can promise to improve their benefit. We can promise to give them whatever they ask for and what they want. But in doing so, if we fulfill our obligation to both this generation and also the next generation, we need to do so in a way that can be sustained. We have a doubling of the number of seniors with fewer people paying in, which compounds the challenge of technology and adding benefits and the challenge of looking at chronic care.

The product of that is, if we didn't change the law at all—if we just kept the Medicare law as it is, which is not realistic because it will change no matter what—we are spending about $226 billion a year now. In 2030—not with this bill—we are going to be spending $448 billion and fewer people are going to be paying into that system to expend the $448 billion that we have today. That is why you will hear again and again from Members such as the Senator from Oklahoma, Mr. NICKLES, and also the Senator from New Hampshire, Mr. GREGG. They will again and again remind me and our colleagues in our caucus that whatever we do, we need to do it in a way that can be sustained over time. We can't be making promises that cannot be in any way upheld or fulfilled in the future by putting an unnecessary and unfair burden on that next generation.

This is a chart which I almost hesitate showing. This summarizes and puts things in perspective why we have to address Medicare now.

No. 1, because seniors deserve better health care security. It is just too obvious to me that without prescription drugs, and without preventive care and disease management within Medicare today, they are not getting what they deserve.

The second issue is as important as Social Security. At some point we need to come back and address Social Security as well as the cost of the demographic shift because of our responsibility to seniors and that next generation.

But if we look—this is the financial challenge—at the unfunded promises over the next 75 years—I am not going any further out than 75 years, but it is important having gone out 30 years to mention the next 75 years—if you add up all of the unfunded promises, promises that are made, mandates that are in the law but we haven't determined how to best pay for them; as comparison, the debt held by the public of $3.6 trillion, just for comparison purposes—if we look over the next 75 years for Social Security, what is the shortfall there? That is why we have to come back and address it at some point, and I am not sure when it will be. But it is $3.6 trillion, and somebody is going to pay for it. We are going to have to address that.

But Medicare and health care for our seniors—this is not the bill on the floor; this is today, the current law as it exists—there is a $13.3 trillion Medicare shortfall over the next 75 years.

That is one of the reasons I think it is important for us to address Medicare now, relatively early in this Congress, why we should not delay, why we do need to finish the bill next week, and have the House do the same, have the President sign it as soon as possible, but also stress the point that we have to get this thing right. We have to do it responsibly because what we are doing as a product of modernizing Medicare is making sure we get the very best value, that it is an efficient system, that it is adding a brandnew benefit of prescription drugs which even isn't calculated in this. This $13.3 trillion is Medicare as we have it today.

One of the things we are going to do is add the $400 billion benefit over a 10-year period—not 75 but a 10-year period on top of this already $13.3 trillion Medicare shortfall. We are going to add a benefit on top of that. That is why we can't just add a benefit on top without addressing Medicare overall. That is why you heard the President from day 1 say yes, we have to have prescription drugs; yes, we have to improve the nature of the benefits; but at the same time we have to address reform because not to do so would be irresponsible as the leader of the United States of America. And the same thing goes on in this body today.

That is why the bill we have brought to the floor is not just a Medicare package and not just a bill that says let us promise pills to seniors, but says, yes, those medicines are critical and vital, but at the same time we have to address the overall integrated delivery of health care which, I would argue, allows us to have a more efficient system, a system that has more value, and a system that allows us to address, as we look out to the future, this huge unfunded promise we have made in the past.

When we are in the middle of talking about each of these individual amendments and the technical nature of materials, it is hard to back up and look at some of these principles that underlie doing this thing right—doing it in a bipartisan way, allowing ample time, as we have had all week, to fully debate the amendment process.

This is the issue Senator DORGAN talks about a lot, and he talks about the Finance Committee a lot. And we are beginning to talk about it a lot on the floor. I don't want to get into the debate, but it will be a backdrop for much of the discussion next week.

If you look at Medicare beneficiaries and a pie chart of 40 million people, all of those 40 million people are not very expensive in what they actually expend in terms of health care expenditures.

Over here, these are all the beneficiaries. This is 100 percent of the 40 million people. Over here is health care expenditures.

The point of this is, if you just focus on the orange, 6 percent of all Medicare beneficiaries, about one in two—if this whole body were filled right now, there would be only about five or six of them in the whole body, just six desks, who would be responsible for 50 percent of all the money we put in Medicare. Of that $220 billion which we put in, only six desks—you probably see these six desks around me—would be responsible for half of that money. Why? Because they are sicker; they have more chronic diseases.

Right now, I think as we say in approaching a program that is sustainable that gives very good care, wouldn't it be great to be able to identify this 6 percent which accounts for 50 percent of these expenditures—or it could be the top 15 percent or 14 percent—this 6 percent, and the 8 percent which accounts for 76 percent—wouldn't it be great if we made absolutely sure that in that population we gave them the very best care possible in terms of prevention, in terms of management, in terms of coordination, in terms of an integrated way of taking care of their health care problems and making sure they are treated and cared for?

I am absolutely convinced—and I say this having taken care of thousands of Medicare patients, which I was blessed to be able to do before coming here—if we had the data system to be able to identify who they are and had them in the appropriate system to manage their care, they would be better cared for with a better value for the dollar.

But this is a fascinating chart on which very few people have focused. We will get back to it I think in the debates next week.

I mentioned Senator DORGAN. He and I have been discussing the same charts many times. This chart is very similar to the prescription drug expenditures as well. We can focus on certain populations.

This is an extension of Senator DORGAN's conversation, and my conversation with him. These "CCs" are "chronic conditions." A chronic condition is something such as congestive heart failure. Congestive heart failure is when the heart gets big, it just does not pump quite as well. It is like water behind a dam; it begins to fill up in the body. It fills up in your lungs. You get short of breath and swelling in your feet. If you see people who are a little short of breath, typically it is an element of congestive heart failure, if they have heart disease at all.

But what is interesting is, if you look at Medicare expenditures, for people who only have one chronic condition such as heart failure, they account for about 4 percent of expenditures. If they have two chronic conditions—say, heart failure and diabetes—they would account for an additional 7 percent of expenditures. If they have three or four or five chronic conditions, they account for about 65 percent of expenditures.

What I am suggesting is, if you could identify people with five chronic conditions or four chronic conditions—and right now, it is amazing, because in Medicare, in our data base, you really cannot do that, but in a newer system, an up-to-date system, if you could identify these people and then manage them better, to make sure you had integrated care, coordinated care—maybe it would be a phone call from a nurse once a week, to say: Have you weighed yourself today to see if you picked up any weight? If you have picked up weight, you better come in and see us because your lungs are filling up with water. But in a newer system we could catch it before they are hospitalized, and all of a sudden you have saved the hospitalization or maybe someone's life.

That sort of integrated care is just not a part of Medicare today, and it should be. Thus, if we better manage these people—and "management" is not a great word. If we better treat them, if we better care for them, we would cut overall costs and improve the quality of care. We simply cannot do that in the Medicare program today.

Thus—and this comes to what this bill is all about—how do you address some of those issues? The bill on the floor allows us to address each of the issues I have mentioned.

In 2006, seniors, after having had access to a prescription drug card—and every senior could have a drug card in about 9 months from now. If we can pass this bill next week, get it through conference, have the President sign it, probably 6 to 8 months after that every senior could have a prescription drug card that would give them some benefit in terms of lowering the cost of their prescription drugs. That is a pretty good, immediate response, if we can get this bill through on time.

In the year 2006, though, the prescription drug card begins to be replaced by three options an individual senior would have. They could keep what they have today—traditional Medicare—and with that they could have access to an insurance drug package; No. 2, they could take advantage of Medicare+Choice, which is a coordinated care, integrated care type program; or, No. 3, they could take advantage of a PPO, which is an integrated health care, coordinated health care delivery system that includes prescription drugs, preventative care, and that chronic disease management.

Thus, as we look ahead in designing this program—and this, as shown on the chart, is sort of the general outlay of the bill itself—you will hear about a lot of amendments over the next week, and those amendments will talk about, for example: Well, what about the size of the drug package in each? A decision in the bill was made to have this same drug benefit under traditional Medicare and Medicare+Choice, which, by the way, has 5 million people in it. And this other program has 35 million people in it today. This prescription drug benefit is the same.

Some people might say: Well, we ought to change the benefit. Some people will say: Let's make sure this is a truly competitive model that takes advantage of what we know in the private sector works, which has more market-based principles—yes, that is highly regulated by the Government—to make sure those benefits are delivered; and those benefits have to be a part of each PPO that comes forth and bids, but let's make this more competitive. And Monday and Tuesday and Wednesday we are going to hear a lot about how to make this a really up-to-date system and as competitive as possible, which would improve quality and improve the value of each dollar put into the system.

So you will hear about market-based competition. It will be maximized in this area, as shown on this part of the chart. Again, people will be able to keep exactly what they have today. So I say to seniors who are listening, you do not have to worry about things being taken away from you or the question: What is Government going to do? Are they going to come in and take away benefits you already have? No. You are going to get access to additional benefits, even if you stay in traditional Medicare. You will be able to take advantage, like 5 million people do, of an HMO.

People start running when they hear that word HMO, but let me tell you, 5 million people who are in these HMOs are pretty pleased because they have access to prescription drugs today or people can choose this PPO model, which is the model that works best in the private sector today. It is the model most people who have employer-sponsored insurance today have. It definitely is the model of the future because of this continuity of care delivered in a seamless way as we look to the future.

Mr. President, I am going to cover just one more little bit different concept as a preface to what we will be talking about next week in the Medicare debate, and that is on what is called the donut. Now I am coming back down from 35,000 feet to about 5,000 feet to look at what will be one of the hot topics and an issue that will be debated in terms of what is called a gap or a donut. I guess those are the two words that are used mainly.

The concept is that people will get a lot of assistance, especially if you are under the poverty level or under 160 percent of the poverty level. There is no donut for 44 percent of all seniors. There is no gap. There is no donut. I will come back and talk a little about what the donut is. If you are under 160 percent of poverty—that is about $16,000, $17,000, if you are married, of income every year as a senior—there is no donut, there is no gap.

This chart I show you deals with those individuals who are below 100 percent of the Federal poverty level. What this chart shows, in the blue, is the percent of your total expenses in a year that is paid for by the plan. The green is the amount that is paid for by the beneficiary.

So if you have $1,000 of drug expenses a year, and you are below the poverty level, you will have almost 98 percent of all of your drug expenses paid for by the plan, and you will pay $25—very little. It is a very generous benefit.

I will have one more chart that goes above the poverty level to 160 percent of the poverty level.

If you have $2,000 of expenditures in drugs a year, again, if you are below the poverty level, the plan pays for 98 percent of all your drug expenses. If you have $3,000 of expenditures a year, again, the plan pays for about 95 or 98 percent of all your drug expenses. You can see that goes up. If you have $7,000 of drug expenditures a year, again, the plan pays about 98 percent of that.

And this is one of the beauties. Remember, none of these people get prescription drug coverage through Medicare today. I do not know what it is below the poverty level, how some of them get it through other plans. In fact, if you look at all seniors, about two-thirds do get some element of prescription drug coverage somewhere. And we have to be very careful because we do not want to have everybody coming to a Government program.

But the point I want to make is, if you are under the poverty level or indeed at 160 percent of the poverty level, the plan itself is very generous. We are going to hear on the floor next week the question: Is that too generous? Or maybe it is not generous enough. It is hard to argue it is not generous enough, given the fact that 44 percent of all seniors are going to have no donut and get a very generous benefit, and everybody is going to get a benefit.

Referring to the same chart again, for example, this shows, for an individual who has $1,000 of drug expenses or $2,000 of drug expenses, how much they are going to pay for those prescription drugs. So whoever is listening to me right now, they would be able to know how much they could spend on drugs every day and know where they are going to fall.

For example, if you were a heart transplant patient of BILL FRIST 10 years ago, you would have probably had about $7,000 in drug expenses every year. Every time I transplanted a heart or a lung, the patient would have anywhere from $5,000 to $7,000 of drug expenses every year. Drugs are expensive and can take your life savings. For every patient I had who had a heart or a lung transplant, they did not go through that procedure without expending $6,000 to $7,000 on prescription drugs every year.

Most of them are seniors. That is one of the reasons why this plan means so much to me. I have a personal interest in that these are people whose faces I have looked into and eyes I have looked into over the years.

Let me go above 160 percent and you see it looks different. What I want to focus on, of the 40 million people out there, of the seniors, the 50 percent richest, 50 percent highest income people. They still get a lot of help. Just graphically look at it. Remember in blue and gray here is the percent paid by the plan. This is 100 percent at the top. So you can see it is anywhere from 30 to 50 percent coming all the way through. This chart, you can look at it all sorts of different ways, but the point I want to make, in the bill, when we talk about gap, it doesn't mean you will be left out. If you fall into what is called a donut or gap, you benefit all the way up until that level, and then through that gap you pay for your prescription drugs. But then at the other side of the gap you are picked up again.

Thus, at the end of a year, what happens? The gap is right about $4,500 to about $5,800. I am looking to my staff member because the figures have changed a little bit as we tried to narrow the gap over the last several weeks. But that means the gap is somewhere right around $4,500 to this bar here, this is $6,000. But, remember, if you are an individual and you are listening to me and you have $4,500 in expenditures, still about 45 percent of all your expenditures are paid for by the plan. And if you are in the gap, the so-called donut, it is little bit less, it is a couple percentage points less, but still right at 42 percent, at $5,000. And then if you are into $6,000, you are back up around 40 percent, $6,000, $7,000, $8000, coming up. The reason why I show this chart is because I have seniors calling me now and saying: What about if I am in the hole of that donut? What about if I am in that gap? Does that mean the Government excludes me, doesn't help me? The answer is absolutely no. You just pick where you are on here and graphically you can see that these are for the wealthiest seniors, and the bar graph I showed you for the poor. I am showing you the two ends, the two extremes. But above 160 percent of poverty, this is the gap right here. So still you are getting huge assistance at the end of the year.

Again, probably the best example, because the gap is between $4,500 and $5,800, would be the $6,000 that at the end of the year you are in the gap between $5 and $6,000, and you are still getting about 40 percent of your drugs paid for. Some people say it should be higher; some people say lower. The point is, on the gap itself, it doesn't mean you are left out in the cold. Over time we tried to minimize it and keep it as small as possible.

We will come back to that later. It is a concept that takes a little bit of time to explain. Depending on who is arguing which side in terms of the gap, there will be some, as you try to make the point, who make that gap sound real bad. Others might minimize it. The reality is, you will be helped wherever you are, even if you are in the gap. You will get huge help as you go forward.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators speaking for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, I see the Senator from West Virginia. I have about 10 more minutes. I know he has been around all afternoon. These Friday afternoons give an opportunity for people like you and me to make some points where you are not rushed and it is real pleasant to be able to stand back and look at issues that are terribly important. When you have so much going on during the day, it is a little bit harder to do. Let me take a couple more minutes and then we will be happy to yield the floor to the Senator from West Virginia.

CHILDHOOD OBESITY

Mr. FRIST. Mr. President, an issue outside of Medicare but one that has been in the news, one that deserves more attention, is an issue that is changing a little bit, like the demographics I just went to, in an unprecedented way. That is childhood obesity. This is flipping from Medicare, where we are talking about seniors, all the way to the other end of the spectrum as we look at an epidemic occurring in children that we have never seen before. It is a medical issue. It is an issue I first became aware of as a physician, but it has gotten worse. Many of us saw the release by the Centers for Disease Control and Prevention from this past weekend which led me to want to restate the importance of addressing this issue.

Historically childhood obesity was thought of in moral terms, there was an unfair stigma to obesity.

But what we have become aware of in medical science only recently, and that is childhood obesity is a serious condition that has implications not just to the child as a child or as an adolescent but has grave lifelong complications. The kids, are not just at risk for developing bad habits but now we know they are at risk of adult diseases, of developing evolving adult diseases because of that childhood obesity, because of that inactivity.

It was last weekend, Friday or Saturday, that the CDC released statistics which were alarming even to me. I have been studying this and writing legislation on it. It has to do with a type of diabetes called type 2, adult onset diabetes. What this new research showed is that one in three Americans born right now—the date was from the year 2000, but one in three Americans who are born in the year 2000 will develop diabetes in their lifetime. That is higher than any estimate we have known to date in medical literature. In fact, the American Diabetes Association had an estimate which was generally accepted broadly, based on good data. This is three times that. One in three Americans born right now will develop diabetes.

The good news is that doesn't have to be the case. Things can be done that can reverse that. I am very interested and will continue to focus on health disparities between gender, men, women, between ethnicity, between race. And if you look at this data in terms of African Americans and Hispanic children, nearly half will develop diabetes. Women are at higher risk than men, and the disease is striking at younger ages. It used to be a little bit older. Now it is younger and younger that this type of type 2 diabetes strikes.

The number of diagnosed cases among the population as a whole has jumped 50 percent in the last 10 years hitting over 11 million in the year 2000. That figure will skyrocket to 165 percent by 2050, putting the number of Americans with type 2 diabetes at 29 million. The implications of this are severe. Diabetes leads to a whole host of chronic illnesses. It is the leading cause of kidney disease, heart disease, amputations, and blindness.

The good news is these high rates of diabetes are not inevitable. Type 2 diabetes can be prevented. That is because the leading cause of type 2 diabetes is obesity and lack of exercise.

Walking for 30 minutes a day, losing a few pounds can literally cut a persons's risk by more than half.

You don't have to be a marathon runner, an iron man participant, but following that mantra of moderate exercise and moderate, even minimal weight loss can make a huge difference. You can reap huge health rewards.

That is why Senator BINGAMAN, Senator DODD, and I and many others on both sides of the aisle introduced a piece of legislation called the INPACT Act, the Improved Nutrition and Physical Activity Act, with obesity rates double what they were 30 years ago. And we are learning a lot about obesity disease scientifically almost every day. Americans need, more than ever, to be able to make and be encouraged to make healthy decisions about nutrition and physical activity. On the House side, I am pleased that Representatives MARY BONO and KAY GRANGER, along with other cosponsors, introduced companion legislation earlier this year. I will not go into the legislation now.

I encourage my colleagues who are not cosponsors to look at it so we can pass that in the future. It is a multifaceted approach. It emphasizes youth education to jump-start healthy habits early on, to prevent a future struggle with weight. It funds demonstration projects to find innovative, creative ways of improving eating and developing good exercise habits. It includes rigorous evaluations so we can learn what works best. What it does not do is outlaw certain "bad" foods in any way.

It doesn't attempt to micromanage or regulate what Americans eat or drink. It does have a modest price tag, consistent with what the appropriate role of the Federal Government should be. It doesn't attempt to replicate a billion dollar diet industry or the fitness industry that is out there. I know—we all know—there is no single solution to this growing epidemic of obesity. We know it is an epidemic. We know it is getting worse. We do know that leadership on our part can make a difference, can increase awareness of the serious medical consequences, in particular for children.

As the adults in this situation, we can and indeed we must show our determination to keep them safe by keeping them fit.

NOMINATION OF C. STEWART VERDERY, JR.

Mr. HATCH. Mr. President, I rise in support of the Senate's confirmation of the nomination of C. Stewart Verdery, Jr. to be Assistant Secretary for Border and Transportation Security Policy at the Department of Homeland Security. At a time when the new Department of Homeland Security needs to have all vacancies filled, having Mr. Verdery confirmed will fill a vital position from which he will develop policy related to immigration, customs and trade, transportation security and international security issues.

As a counsel working for me on the Senate Judiciary Committee and working with me and my staff when he served for the Senate leadership, Mr. Verdery demonstrated superior political and legal skills which will serve the Department of Homeland Security and the country well.

After working for me as unit head of the Crime and Drug Policy Unit, which handles all matters related to law enforcement, including Federal crime and drug legislation and terrorism, Stewart has an invaluable knowledge of the issues which may confront him in the Border and Transportation Security Directorate. Mr. Verdery served with distinction for me and the committee at large and I know he will take his talents to the Department.

In sum, I believe that Mr. Verdery will be a valuable assistant to the President and to the Secretary for Homeland Security, and the administration will be well served by his confirmation. I thank my colleagues for their support of this nomination.

BUYING A HANDGUN FOR SOMEONE ELSE

Mr. LEVIN. Mr. President, researchers at the University of California at Los Angeles published a study in the June issue of Injury Prevention entitled "Buying a Handgun for Someone Else: Firearm Dealer Willingness to Sell." The study found that more than half of gun dealers are willing to ignore or sidestep the law to sell a firearm. The researchers performed their test on 120 dealers in 20 cities. According to the study, the researchers at UCLA posed as potential buyers giving different reasons for wanting to buy guns. The researchers found that when they said they wanted to buy guns for an individual who needs it, 52 percent of dealers were willing to make the sale.

In addition to the first round of phone calls, the researchers randomly chose 20 dealers and again posed as prospective buyers. In the second round of calls, the researchers said they needed to buy guns for their boyfriend or girlfriend because he or she was not allowed to purchase a firearm. In 16 followup calls, the dealers responded with unequivocal nos and indicated that the purchases would be illegal. In the remaining four cases, the dealers agreed to sell the guns, but indicated to the customer that it was illegal. The researchers also interviewed law enforcement officials who concluded that such sales would amount to illegal straw purchases. A straw purchase involves a buyer with a clean record purchasing a gun for someone who is prohibited by law from doing so.

Some gun manufacturers and dealers know their practices facilitate criminal access to firearms but they do nothing about it. The Lawful Commerce in Arms Act, which recently passed the House and has been referred to the Senate Judiciary Committee, would shield such negligent and reckless gun dealers and manufacturers from many legitimate civil lawsuits. Certainly, those in the industry who conduct their business negligently or recklessly should not be shielded from the consequences of their actions. This study contributes further evidence that there are some in the gun industry who could potentially avoid responsibility for their business practices under such legislation.

TRIBUTE TO BONNY O'NEIL

Mr. COCHRAN. Mr. President, I am pleased to join the three other sitting Senators who have served as chairman of the Committee on Agriculture, Nutrition and Forestry, to salute a dedicated public servant, Ms. Bonny O'Neil, who is retiring after more than 34 years of meritorious service in the U.S. Department of Agriculture.

As the senior career official in the Department in charge of the Food Stamp Program, Ms. O'Neil is responsible for national oversight of policy and operations for a program that serves over 20 million people each month at an annual cost of over $20 billion.

Ms. O'Neil came to the Department in November of 1968 following graduation from Ohio Wesleyan University where she majored in politics and government. She has spent the majority of her career in various positions with the Food Stamp Program, with the exception of 6 years that were spent in the agency's Office of Regional Operations. She has been USDA's main career official on all Food Stamp Program legislation since 1984.

Since that time, Ms. O'Neil has worked closely with Congress to help craft food stamp legislation. She has been available at any hour of the day, including weekends, to provide her wise counsel. She spent countless hours and worked tirelessly to assist the Agriculture Committee on significant legislation, including numerous farm bills and the landmark 1996 welfare reform bill.

In 2003, due to Ms. O'Neil's exemplary work, she received a Presidential Rank Award recognizing her contribution to the reauthorization of the Food Stamp Program.

In her years of Federal service, Ms. O'Neil has overseen many program improvements, including replacing paper coupons with electronic benefit delivery, setting records for payment accuracy and extending many policy options to States to improve customer service.

Ms. O'Neil is a native of New Jersey and now resides in Alexandria, VA.

I commend Ms. Bonny O'Neil for her many years of devoted service to the U.S. Department of Agriculture and for the outstanding work she has done throughout her distinguished career. I congratulate her on the occasion of her retirement and extend my best wishes for much happiness and satisfaction in the years ahead.

Mr. HARKIN. Mr. President, I too wish to pay tribute to the accomplishments of Ms. Bonny O'Neil and thank her for her many years of dedicated service to the U.S. Department of Agriculture. Ms. O'Neil has done an outstanding job as the senior career official responsible for the Food Stamp Program. Under her very capable leadership, this important program has been greatly improved.

During the writing of the recent farm bill, which took almost 2 years, Ms. O'Neil worked tirelessly with the Committee on Agriculture, Nutrition, and Forestry on the food stamp provisions. Her expertise in this area was invaluable and she was always available to provide assistance. After the Farm Security and Rural Investment Act of 2002 was signed into law, Ms. O'Neil worked to implement the food stamp provisions, including the large number of State flexibility sections contained in the act.

The quality of her efforts in this regard are obvious. In the one year since the farm bill passed, numerous States have already implemented or are planning to implement important State options that significantly improve the Food Stamp Program. As a result, we are helping working Americans in their efforts to enter and stay in the workforce and also making sure that, for millions of American children, the shadow of hunger does not loom so darkly.

In always remembering that her job is to serve Americans and to better their lives, rather than just to run a program from an office in Washington, Bonny meets and surpasses the highest ideals of civil service.

I thank Ms. O'Neil for her years of service to our Nation and wish her well in her retirement.

Mr. LUGAR. Mr. President, I join my colleagues in expressing my sincere gratitude to Ms. Bonny O'Neil for her more than 34 years of devoted service to the U.S. Department of Agriculture. As a result of her wealth of knowledge and experience with the Food Stamp Program, Ms. O'Neil was an invaluable resource to the entire Congress as we crafted the 1996 welfare reform law. Ms. O'Neil's wisdom, patience and good humor were vitally important during the long process of writing that landmark legislation.

I thank Ms. O'Neil for her many accomplishments and for her honorable service to this Nation.

Mr. LEAHY. Mr. President, I, too, join my colleagues today to recognize and honor Ms. Bonny O'Neil upon her retirement from the Federal Government. Ms. O'Neil is a true public servant—in all the best sense of that phrase—diligent, hardworking, attentive to details, willing to dig in and truly analyze both sides of each issue, smart, totally honest, a woman of her word, and driven by a desire to do the right thing.

She is to be commended for serving her Nation and the U.S. Department of Agriculture so well. She also served the Congress well by providing us with clear and informative answers, and guiding us through complex issues. I know that she worked closely with my nutrition counsel Ed Barron for many years—both when he was at USDA and while he worked for me starting in 1987. On many occasions late at night during a conference, I would hear someone say: "Let's call Bonny to get the facts."

Bonny spent all but six of those years in various positions with the Food Stamp Program, where she currently serves as the Associate Deputy Administrator.

Ms. O'Neil provided valuable assistance during our work on nutrition programs, food stamp amendments and several farm bills. Anyone who has ever worked on a farm bill knows that it is an extremely complicated task that requires many long hours, including nights and weekends. Her attention to detail and willingness to be available at any time, day or night, was most appreciated.

I thank Ms. Bonny O'Neil for her distinguished service to the public good and wish her well in her retirement.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in Farwest, WA. On September 13, 2001, a Sikh cab driver was stopped by a 21-year-old man who had hailed his cab. Once inside the cab, the passenger verbally accosted the driver accusing him of being a terrorist and that he had no right to be in the United States. The passenger subsequently grabbed the driver around the neck and choked him. Before the driver was able to escape, the passenger punched the victim in the face, grabbed fistfuls of his beard and ripped off parts of his turban. The attacker was eventually arrested by a passing police officer.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

ORBIT ACT

Mr. BURNS. Mr. President, I would like to take a few moments to comment on H.R. 2312, which allows for some technical corrections to the ORBIT Act. Although neither Inmarsat nor Intelsat has yet conducted the IPO that the ORBIT Act provided for, there is one satellite provider that has fulfilled the ORBIT Act's original requirements in this regard. That provider is New Skies Satellites, which has separated itself from its one-time parent Intelsat, conducted an IPO under challenging market conditions, substantially diluted its shareholder base through both the IPO and a recent 10 percent share buyback, and become a full-fledged competitor in the satellite marketplace. New Skies has asked that we consider some amendments to the Act that would acknowledge and recognize its fully independent status. While the abbreviated process leading to the Senate's consideration of this bill today did not permit full consideration of those issues, I am open to listening to the arguments for such changes in the context of a broader review of the ORBIT Act and its implementation.

WEST VIRGINIA DAY

Mr. ROCKEFELLER. Mr. President, today I rise to commemorate the 140th birthday of the great State of West Virginia. On this day, 140 years ago, West Virginia was born amidst the conflict of the Civil War.

In 1964, I came to West Virginia as a VISTA worker and spent 2 years in Emmons, WV. Those 2 years changed my life and I decided to make West Virginia my home and make public service my career. Over the years, I have been proud to serve the people of West Virginia in various ways and I feel very privileged to represent West Virginia in the Senate.

On West Virginia Day, I believe it is important to reflect upon our State's rich history, scenic beauty, and its hard-working, independent citizens who truly reflect our State motto, "Mountaineers are always free."

West Virginia's scenic trails and winding roads make it one of the most beautiful States in the country. Its mountainous terrain, breathtaking scenery, and raging rivers make it perfect for hiking, skiing, biking, rafting, fishing, and many other types of recreation. West Virginia truly earns the travel slogan of "wild and wonderful".

The small farms and growing industry of early West Virginia set it apart from the tobacco plantations of eastern Virginia. West Virginia was made up of large numbers of immigrants, along with rugged, hard-working frontiersmen and women who instilled the values and ideals that West Virginians embody today.

The people of West Virginia remain its greatest asset. West Virginians are industrious, ambitious, open, and fun-loving people. They value equality and liberty which tie them to both our State and country. West Virginians have been some of the most innovative and creative people, contributing to all aspects of American society and culture.

After his family left Virginia and slavery for a better life west of the mountains, Booker T. Washington was raised in Malden, Kanawha County, WV, and began working in the salt furnaces at the age of seven. He rose up from slavery and illiteracy to become the foremost educator and leader of Black Americans at the turn of the 20th century. He founded the Tuskegee Normal and Industrial Institute, later known as Tuskegee University.

Jerry West was born in Cabin Creek, WV and attended West Virginia University, where he was a two time All-American basketball player. After he won a gold medal for the U.S. Olympic team in Rome in 1960, he moved west to play for the Los Angeles Lakers. He excelled throughout his playing career, gaining a reputation as a perfectionist. He helped the Lakers win a championship in 1972 and was elected to the Basketball Hall of Fame in 1979.

Col. Ruby Bradley, a native of Spencer, WV, was the most highly decorated woman ever to serve in the U.S. military. Her military record included 34 medals and citations of bravery, including two Legion of Merit medals, two Bronze stars, two Presidential Emblems, the World War II victory medal, and the U.N. Service Medal. She was also the recipient of the Florence Nightingale Medal, the highest distinction given by the International Red Cross. She was a U.S. Army nurse and a POW for 2 years in the Philippines and was known as the "Angel in Fatigues" at Santo Tomas Internment Camp in Manila. On July 2, 2002, she was laid to rest at Arlington National Cemetery.

These three West Virginians are but a few representative examples of the kind of talented, successful, courageous, and independent people in our great State. Their lives and stories provide a glimpse into the spirit of our State, and they also serve as an inspiration to the young people in our State today.

The natural beauty, the people of West Virginia, and their countless achievements should be celebrated and remembered every day. As we strive to promote our economic growth, I hope we will also be mindful of our responsibilities to preserve what makes our state so special, the values and character of its people.

I hope all Americans have the opportunity to experience some of West Virginia's beautiful vistas and to meet the wonderful people I have come to know and love throughout my service to West Virginia.

I am proud to represent my home State of West Virginia and am honored to be able to recognize the 140th anniversary of the Mountain State.

ADDITIONAL STATEMENTS

COMMENDING THE SERVICE OF DANIEL P. BURNHAM

● Mr. KENNEDY. Mr. President, today I would like to take a moment to recognize the dedication and professionalism of Daniel P. Burnham, chairman and chief executive officer of Raytheon Co. in Lexington, MA. On July 1, 2003, Dan will step down from his position after 5 years at the helm at the company.

Dan worked tirelessly to make Raytheon the hallmark company it is today. He came to the company from Allied Signal, bringing his long history in the defense industry. He introduced a management tool known as Six Sigma to improve Raytheon's efficiency. Sigma Six is a testament to Dan's ingenuity, allowing the company to decrease waste, and at the same time, increase productivity. Dan's unwavering commitment to excellence is clearly demonstrated in his ability to streamline the company while preserving its quality.

Dan improved customer relations while presiding over a transformation and realignment of Raytheon. Under Dan's leadership, the company made valuable acquisitions that increased its capabilities. He concentrated on customer-focused initiatives and disciplines to ensure that Raytheon provided our men and women in uniform some of the most important defense systems ever developed—many of which were demonstrated recently in Operation Iraqi Freedom.

One example of this is the PATRIOT Missile, manufactured by the Raytheon Co. The PATRIOT Missile protected our troops and allies in the Middle East from the threat of Iraqi missiles that our military believed had the potential to carry deadly chemical or biological weapons. The PATRIOT Missile is a valuable tool in our arsenal to assure swift victory in Iraq and save countless lives.

Under Dan's leadership, Raytheon won a U.S. Navy contract to develop and produce the next generation of naval vessels. The DD(X) destroyer, with its cutting edge technology will ensure that the United States maintains its tactical and technological superiority on the high seas.

Admiral Vern Clark, the Chief of Naval Operations, described the DD(X) destroyer as "the future of the surface force in the United States Navy." The DD(X) will truly be the ship of the 21st century. The Raytheon Co., in no small part, is responsible for providing the United States Navy with this unparalleled vessel.

The Tomahawk Cruise Missile, produced by Raytheon and first used in Operation Desert Storm in 1991 has become the premier weapon in the U.S. military's conventional arsenal. Launched from the air, or from the sea, Tomahawk has evolved with the Navy's needs and proved invaluable in Operation Desert Fox, 1998, and was once again the weapon of choice for "shock and awe" in Operation Iraqi Freedom this year. Under Dan Burnham, Raytheon has provided the U.S. Navy with an unequaled precision strike capability offering long-range strike capability against heavily defended targets.

Although Dan will continue to hold the position of nonexecutive chairman for some time, his leadership at the helm of a company he made strong will be dearly missed. I believe the Commonwealth of Massachusetts and especially, brave men and women of our Armed Services have benefited from Dan Burnham's keen sense of right and relentless pursuit of excellence.

We wish him, his wife, Meg, and his family every success in this new and exciting chapter of his life. We bid him "Fair winds and following seas."●

SALUTE TO CHARLESTON'S PHILIP SIMMONS ON HIS 91ST BIRTHDAY

● Mr. HOLLINGS. Mr. President, my hometown of Charleston, SC, maintains a special relationship with history. Rather than keeping history in books and museums for occasional viewing, the Charleston community celebrates its cultural heritage everyday, be it through our downtown district, our vibrant Market, or the skyline full of church steeples.

This month, Charleston marks the 91st birthday of a man famous for his dedication to preserving our historic personality. Master blacksmith and legendary craftsman Philip Simmons practiced the art form of traditional ironwork throughout the 20th century. As he has been known to say, "If you see ironwork curve like that, it's either two hundred years old, or I did it."

Though he retired in 1990, Mr. Simmons now spends most of his time ensuring the tradition of classical ironwork lives on in South Carolina. John Paul Huguley, president of the Charleston School of the Building Arts, says what separates a craft worker from Mr. Simmons is that Mr. Simmons has a "love for the trade and the desire to educate the next generation of artisans."

Indeed, that is the case. Mr. Simmons was at the forefront of creating the School of the Building Arts. He now teaches classes there, and within 2 years the school will be open full time. Mr. Simmons also instructs at his blacksmith shop, and travels to lecture at southern art and building conferences.

He has received numerous accolades over the years, including a "lifetime achievement award" from the South Carolina Legislature. He received a National Heritage Fellowship from the National Endowment for the Arts. His work has been displayed in the Natural Museum of American History, here in Washington.

I hope members of this Chamber join me in recognizing and celebrating the birthday of a great man. No question, his role in the Charleston community, and beyond, is a standard for artistic excellence and public service that can be an example for us all.●

225th ANNIVERSARY OF GRAY, MAINE

● Ms. COLLINS. Mr. President, I rise today to express my congratulations to the town of Gray, Maine, as it celebrates its 225th anniversary. This charming town of 7,000 people boasts the first woolen mill in the United States. But even more important is Gray's contribution to our country during the Civil War. Gray sacrificed a greater percentage of men to this cause than any other town in the State of Maine. The Gray Celebration Days festival begins today, and I am pleased to acknowledge this special event, which celebrates the history of this outstanding Maine community.●

TRIBUTE TO BETHPHAGE AND MARTIN LUTHER HOMES

● Mr. HAGEL. Mr. President, I rise today to congratulate Bethphage and Martin Luther Homes, which will join hands to become Mosaic on July 1, 2003. For a combined 168 years, Bethphage and Martin Luther Homes have been dedicated to helping disabled children and adults achieve their full potential. Together as Mosaic, will they serve 900 Nebraskans.

By merging their resources and expertise to form Mosaic, Bethphage and Martin Luther Homes will strengthen their reach to the disabled. Mosaic will support and advocate for more than 3,700 people with disabilities in 16 States, Great Britain, and Latvia. Through participation in an international alliance called IMPACT, Mosaic will work with the disabled in emerging democracies around the world.

Guided by the principle that "every individual is a person of worth," Mosaic will continue the work begun by Bethphage and Martin Luther Homes by serving disabled individuals at every stage of life.

Mr. President, I congratulate and thank Mosaic for its service to the disabled.●

NOTICE STATING THAT THE EMERGENCY DECLARED WITH RESPECT TO THE WESTERN BALKANS IS TO CONTINUE IN EFFECT BEYOND JUNE 26, 2003—PM 41

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Banking, Housing, and Urban Affairs:

To the Congress of the United States:

Section 202(d) of the National Emergencies Act (50 U.S.C. 1622(d)) provides for the automatic termination of a national emergency unless, prior to the anniversary date of its declaration, the President publishes in the Federal Register and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. Consistent with this provision, I have sent the enclosed notice, stating that the Western Balkans emergency is to continue in effect beyond June 26, 2003, to the Federal Register for publication. The most recent notice continuing this emergency was published in the Federal Register on June 25, 2002, 67 Fed. Reg. 42703.

The crisis constituted by the actions of persons engaged in, or assisting, sponsoring, or supporting, (i) extremist violence in the Former Yugoslav Republic of Macedonia, and elsewhere in the Western Balkans region, or (ii) acts obstructing implementation of the Dayton Accords in Bosnia or United Nations Security Council Resolution 1244 of June 10, 1999, in Kosovo, that led to the declaration of a national emergency on June 26, 2001, has not been resolved. Subsequent to the declaration of the national emergency, acts obstructing implementation of the Ohrid Framework Agreement of 2001 in the former Yugoslav Republic of Macedonia, have also become a concern. All of these actions are hostile to U.S. interests and pose a continuing unusual and extraordinary threat to the national security and foreign policy of the United States. For these reasons, I have determined that it is necessary to continue the national emergency declared with respect to the Western Balkans and maintain in force the comprehensive sanctions to respond to this threat.

GEORGE W. BUSH.
THE WHITE HOUSE, *June 20, 2003.*

PERIODIC REPORT ON THE NATIONAL EMERGENCY WITH RESPECT TO THE WESTERN BALKANS AND FINAL REPORT ON EXPENSES INCURRED WITH RESPECT TO TERMINATED EMERGENCIES REGARDING THE FORMER FEDERAL REPUBLIC OF YUGOSLAVIA (SERBIA AND MONTENEGRO)—PM 42

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Banking, Housing, and Urban Affairs:

To the Congress of the United States:

Consistent with section 401(c) of the National Emergencies Act, 50 U.S.C. 1641(c), and section 204(c) of the International Emergency Economic Powers Act, 50 U.S.C. 1703(c), I transmit herewith a 6-month report prepared by my Administration on the national emergency with respect to the Western Balkans that was declared in Executive Order 13219 of June 26, 2001.

GEORGE W. BUSH.
THE WHITE HOUSE, *June 20, 2003.*

MESSAGE FROM THE HOUSE

At 1:09 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bill, without amendment:

S. 1276. An act to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

The message also announced that the House has passed the following bills in which it requests the concurrence of the Senate:

H.R. 660. An act to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees.

H.R. 1528. An act to amend the Internal Revenue Code of 1986 to protect taxpayers and ensure accountability of the Internal Revenue Service.

ENROLLED BILLS SIGNED

The message also announced that the Speaker has signed the following enrolled bills:

H.R. 389. An act to authorize the use of certain grant funds to establish an information clearinghouse that provides information to increase public access to defibrillation in schools.

H.R. 519. An act to authorize the Secretary of the Interior to conduct a study of the San Gabriel River Watershed, and for other purposes.

H.R. 788. An act to revise the boundary of the Glen Canyon National Recreation Area in the States of Utah and Arizona.

The enrolled bills were signed subsequently by the President pro tempore (Mr. STEVENS).

The following enrolled bill, previously signed by the Speaker of the House, was signed on today, June 20, 2003, by the President pro tempore (Mr. STEVENS):

S. 703. An act to designate the regional headquarters building for the National Park Service under construction in Omaha, Nebraska, as the "Carl T. Curtis National Park Service Midwest Regional Headquarters Building".

MEASURES REFERRED

The following bills were read the first and second times by unanimous consent, and referred as indicated:

H.R. 660. An act to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees; to the Committee on Health, Education, Labor, and Pensions.

H.R. 1528. An act to amend the Internal Revenue Code of 1986 to protect taxpayers and ensure accountability of the Internal Revenue Service; to the Committee on Finance.

MEASURE PLACED ON THE CALENDAR

The following bill was read the second time, and placed on the calendar:

H.R. 8. An act to make the repeal of the estate tax permanent.

ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on today, June 20, 2003, she had presented the President of the United States the following enrolled bill:

S. 703. An act to designate the regional headquarters building for the National Park Service under constructino in Omaha, Nebraska, as the "Carl T. Curtis National Park Service Midwest Regional Headquarters Building".

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. STEVENS, from the Committee on Appropriations:

Special Report entitled "Special Report: Allocation to Subcommittees of Budget Totals from the Concurrent Resolution for Fiscal Year 2004" (Rept. No. 108–77).

By Ms. COLLINS, from the Committee on Governmental Affairs, without amendment:

H.R. 825. A bill to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the "Michael J. Healy Post Office Building".

H.R. 917. A bill to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the "Floyd Spence Post Office Building".

H.R. 925. A bill to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the "Cesar Chavez Post Office".

H.R. 981. A bill to designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the "James R. Merry Post Office".

H.R. 985. A bill to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the "Delbert L. Latta Post Office Building".

H.R. 1055. A bill to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the "Dr. Roswell N. Beck Post Office Building".

H.R. 1368. To designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the "Norman D. Shumway Post Office Building".

H.R. 1465. A bill to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the "General Charles Gabriel Post Office".

H.R. 1596. A bill to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the "Timothy Michael Gaffney Post Office Building".

H.R. 1609. A bill to redesignate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the "Admiral Donald Davis Post Office Building".

H.R. 1740. A bill to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the "Dr. Caesar A.W. Clark, Sr. Post Office Building".

H.R. 2030. A bill to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building".

S. 508. A bill to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the "Floyd Spence Post Office Building".

S. 708. A bill to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the "Michael J. Healy Post Office Building".

S. 867. A bill to designate the facility of the United States Postal Service located at 710 Wick Lane in Billings, Montana, as the "Ronald Reagan Post Office Building".

S. 1145. A bill to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building".

S. 1207. A bill to redesignate the facility of the United States Postal Service located at 120 East Ritchie Avenue in Marceline, Missouri, as the "Walt Disney Post Office Building".

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BROWNBACK (for himself, Mr. NELSON of Florida, and Mr. NICKLES):

S. 1303. A bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration services, and chemotherapy support services; to the Committee on Finance.

By Ms. SNOWE (for herself and Ms. MIKULSKI):

S. 1304. A bill to improve the health of women through the establishment of Offices of Women's Health within the Department of Health and Human Services; to the Committee on Health, Education, Labor, and Pensions.

By Mr. BINGAMAN (for himself, Mr. HATCH, Mr. BAUCUS, Mr. CONRAD, Mr. BREAUX, Ms. SNOWE, Mrs. LINCOLN, and Mr. SMITH):

S. 1305. A bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain motor vehicle dealer transitional assistance; to the Committee on Finance.

By Mrs. BOXER (for herself and Mrs. FEINSTEIN):

S. 1306. A bill to introduce the efforts of the California Missions Foundation to restore and repair the Spanish colonial and mission-era missions in the State of California and to preserve the artworks and artifacts of these missions, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SMITH:

S. 1307. A bill to authorize the Secretary of the Interior, acting through the Bureau of Reclamation, to assist in the implementation of fish passage and screening facilities at non-Federal water projects, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. WYDEN (for himself and Mr. SMITH):

S. 1308. A bill to authorize the Secretary of the Interior to pursue and complete actions related to the implementation of a U.S. District of a U.S. District Court Consent Decree; to the Committee on Energy and Natural Resources.

By Mrs. LINCOLN (for herself and Mr. PRYOR):

S. 1309. A bill to provide emergency assistance to producers that have suffered crop losses due to disasters; to the Committee on Agriculture, Nutrition, and Forestry.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. DODD:

S. Res. 178. A resolution to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate wing of the Capitol and Senate office buildings for personal use; to the Committee on Rules and Administration.

ADDITIONAL COSPONSORS

S. 56

At the request of Mr. JOHNSON, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 56, a bill to restore health care coverage to retired members of the uniformed services.

S. 253

At the request of Mr. LEAHY, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 253, a bill to amend title 18, United States Code, to exempt qualified current and former law enforcement officers from State laws prohibiting the carrying of concealed handguns.

S. 300

At the request of Mr. MCCAIN, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 300, a bill to award a congressional gold medal to Jackie Robinson (posthumously), in recognition of his many contributions to the Nation, and to express the sense of Congress that there should be a national day in recognition of Jackie Robinson.

S. 397

At the request of Mr. ENSIGN, the name of the Senator from Idaho (Mr. CRAIG) was added as a cosponsor of S. 397, a bill to amend the Internal Revenue Code of 1986 to allow a deduction for the old-age, survivors, and disability insurance taxes paid by employees and self-employed individuals, and for other purposes.

S. 486

At the request of Mr. DOMENICI, the names of the Senator from Illinois (Mr. FITZGERALD) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. 486, a bill to provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits.

S. 504

At the request of Mr. REID, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 504, a bill to establish academies for teachers and students of American history and civics and a national alliance of teachers of American history and civics, and for other purposes.

S. 537

At the request of Mr. CRAPO, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 537, a bill to ensure the availability of spectrum to amateur radio operators.

S. 656

At the request of Mr. REED, the name of the Senator from Rhode Island (Mr. CHAFEE) was added as a cosponsor of S. 656, a bill to provide for the adjustment of status of certain nationals of Liberia to that of lawful permanent residence.

S. 822

At the request of Mr. KERRY, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 822, a bill to create a 3-year pilot program that makes small, nonprofit child care businesses eligible for SBA 504 loans.

S. 875

At the request of Mr. KERRY, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 875, a bill to amend the Internal Revenue Code of 1986 to allow an income tax credit for the provision of homeownership and community development, and for other purposes.

S. 882

At the request of Mr. BAUCUS, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 882, a bill to amend the Internal Revenue Code of 1986 to provide improvements in tax administration and taxpayer safe-guards, and for other purposes.

S. 950

At the request of Mr. ENZI, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 950, a bill to allow travel between the United States and Cuba.

S. 970

At the request of Mr. DODD, his name was added as a cosponsor of S. 970, a bill to amend the Internal Revenue Code of 1986 to preserve jobs and production activities in the United States.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 985

At the request of Mr. DODD, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 985, a bill to amend the Federal Law Enforcement Pay Reform Act of 1990 to adjust the percentage differentials payable to Federal law enforcement officers in certain high-cost areas, and for other purposes.

S. 1000

At the request of Mr. GRAHAM of South Carolina, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1000, a bill to amend title 10, United States Code, to revise the age and service requirements for eligibility to receive retired pay for non-regular service; to provide TRICARE eligibility for members of the Selected Reserve of the Ready Reserve and their families; to amend the Internal Revenue Code of 1986 to allow employers a credit against income tax with respect to employees who participate in the military reserve components and to allow a comparable credit for participating reserve component self-employed individuals, and for other purposes.

S. 1046

At the request of Mr. HOLLINGS, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1126

At the request of Mr. KERRY, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1126, a bill to establish the Office of Native American Affairs within the Small Business Administration, to create the Native American Small Business Development Program, and for other purposes.

S. 1141

At the request of Mr. LAUTENBERG, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1141, a bill to amend title 23, United States Code, to increase penalties for individuals who operate motor vehicles while intoxicated or under the influence of alcohol.

S. 1218

At the request of Mr. HOLLINGS, the names of the Senator from Hawaii (Mr. INOUYE) and the Senator from Louisiana (Mr. BREAUX) were added as cosponsors of S. 1218, a bill to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program.

S. CON. RES. 53

At the request of Mr. LEVIN, the name of the Senator from Ohio (Mr. VOINOVICH) was added as a cosponsor of S. Con. Res. 53, a concurrent resolution honoring and congratulating chambers of commerce for their efforts that contribute to the improvement of communities and the strengthening of local and regional economies.

S. RES. 109

At the request of Mr. FEINGOLD, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. Res. 109, a resolution expressing the sense of the Senate with respect to polio.

S. RES. 169

At the request of Mrs. CLINTON, the names of the Senator from Colorado (Mr. ALLARD) and the Senator from Wisconsin (Mr. FEINGOLD) were added as cosponsors of S. Res. 169, a resolution expressing the sense of the Senate that the United States Postal Service should issue a postage stamp commemorating Anne Frank.

AMENDMENT NO. 934

At the request of Ms. COLLINS, her name was added as a cosponsor of amendment No. 934 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 934

At the request of Mr. MILLER, his name was added as a cosponsor of amendment No. 934 proposed to S. 1, supra.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BROWNBACK (for himself, Mr. NELSON of Florida, and Mr. NICKLES):

S. 1303. A bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration services, and chemotherapy support services; to the Committee on Finance.

Mr. BROWNBACK. Mr. President, I rise today for the purpose of introducing the Quality Cancer Care Preservation Act. This bill is aimed at sending reinforcements to those on the front lines of the war on cancer. While there are millions of researchers, policy makers, and advocates fighting against cancer around the country, we cannot forget that the real battles are won in the cancer center, where the care is delivered. The war on cancer will be won by nurses, patients, and physicians—one survivor at a time.

For years, bureaucrats at Medicare have overpaid for cancer drugs, but underpaid for cost of administering the therapy. Unfortunately, many in Washington have advocated fixing the overpayment for the drugs and ignored the underpayment for administering the drug. Well, as any cancer patient knows, while cancer therapies may be a miracle, it is the oncology nurses that are the angels. That is why my colleagues and I are offering this legislation, which we believe will bring about fair reimbursement for chemotherapy drugs and administration.

I know that the managers of this bill have committed to work with, and are working with the cancer community to find a reasonable solution to this issue in the context of the Medicare bill that is on the floor. On behalf of cancer patients around the country, I thank my colleague for their dedication. I also thank my friend from Oklahoma for his comments during the markup of S. 1 and for his dedication to ensure proper reimbursement for cancer treatment.

My hope in introducing this bill at this time is that it can serve to help my colleagues in their pursuit of fair reimbursement.

With that, I thank my colleagues.

By Ms. SNOWE (for herself and Ms. MIKULSKI):

S. 1304. A bill to improve the health of women through the establishment of Offices of Women's Health within the Department of Health and Human Services; to the Committee on Health, Education, Labor, and Pensions.

Ms. MIKULSKI. Mr. President, I rise to introduce the Women's Health Office Act with my colleague, Senator OLYMPIA SNOWE. The Women's Health Office Act authorizes and strengthens women's health offices or officers at Federal health agencies in the Department of Health and Human Services. This legislation will make sure that men and women get equal benefit from Federal investments in medical research and health care services.

Today, doctors, scientists, Members of Congress, and the American public know that women and men have different bodies and different health care needs. Diseases like ovarian cancer and endometriosis affect only women. High blood pressure is two to three times more common in women than men. Women are four times more likely to develop osteoporosis than men. The number of uninsured women has grown three times faster than the number of uninsured men over the past 5 years. Women make three-quarters of all health care spending decisions for themselves and their families.

For decades, despite these differences, men's health needs set the standard for our health care system and our health care research agenda. Women were systematically excluded from medical research because decisionmakers said that our hormone cycles complicated the results. One study on heart disease risk factors was conducted on 13,000 men—and not 1 woman. But the results of studies like these were applied to both men and women. This neglect put women's health and lives at risk.

That's why my colleagues and I took action. More than a decade ago, I worked with OLYMPIA SNOWE, TED KENNEDY, TOM HARKIN, and other women in the House to get an Office of Research on Women's Health at the National Institutes of Health, NIH. In 1993, I worked with these same women and Galahads in Congress to make sure that the women's health office would stay at NIH by putting it into law.

This office at NIH has made a real difference in how women are treated for certain illnesses. We now know that men and women often have different symptoms before a heart attack. Women's symptoms are more subtle, like nausea and back pain. Knowing these systems means women can get to the hospital sooner and can be treated earlier. That's turning women's health research into life-saving information.

I am proud that there are now women's health offices or officers at nearly every Federal health agency at the Department of Health and Human Services. Like the one at NIH, women's health offices mean that women's health needs are always at the table. These offices at the Food and Drug Administration, (FDA), the Centers for Disease Control and Prevention, (CDC), and the Health Resources and Services Administration, (HRSA) make sure women are included in clinical drug trials, reach out to low-income and minority women to make sure they are getting vaccines and cancer screenings, and work with health care providers to put research on women's health into practice. Recent questions about the risks and benefits of mammography and hormone replacement therapy remind us that women's health offices are as important as ever.

Right now, many of these offices and the important work they do could be eliminated or cut back without the consent of Congress. That is why this bill is so important. This bill would put women's health offices into our Nation's law books.

The Women's Health Office Act does more than protect the status quo. It keeps us moving forward on women's health. It gives women's health offices a clear, consistent framework throughout the Department. By writing them into law, it gives women's health offices the stature they need to be strong, effective advocates for women's health within the Federal Government. This legislation coordinates women's health activities within each agency, to identify needs and set goals. The women's Health Office Act centralizes overall coordination throughout the Department of Health and Human services, to clarify lines of accountability and chart a clear course on women's health. Finally, it authorizes funding for these women's health offices or officers, to make sure that we put our Nation's priorities in the Federal checkbook as well as the Federal law books.

This bill has strong bipartisan support. During the 107th Congress, the Women's Health Office Act passed the Senate Health, Education, Labor, and Pensions, HELP, Committee unanimously as part of a comprehensive women's health bill that would have expanded women's health research and improved women's access to health care. It also passed the House of Representatives overwhelmingly during the 107th Congress. I am disappointed that Congress was not able to pass this bipartisan legislation, but I am hopeful that last year's momentum will help us get to women's Health Office Act signed into law this year.

I would like to thank Senator OLYMPIA SNOWE for leading the way on this important legislation. As Dean of the Senate women, I will continue to fight to get this bill signed into law and to make progress to improve the health of American women.

By Mr. BINGAMAN (for himself, Mr. HATCH, Mr. BAUCUS, Mr. CONRAD, Mr. BREAUX, Ms. SNOWE, Mrs. LINCOLN, and Mr. SMITH):

S. 1305. A bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain motor vehicle dealer transitional assistance; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I am introducing legislation today with Senators HATCH, BAUCUS, CONRAD, BREAUX, SNOWE, LINCOLN and SMITH that will provide thousands of our Nations' automobile dealerships with needed additional flexibility to re-invest franchise termination payments so that taxes are not unfairly imposed. This legislation has bipartisan support in both the House and the Senate and was included in the Chairman's modified mark in last year's small business tax bill.

At the end of 2000, GM notified their 2,801 Oldsmobile dealers that they were phasing out the 100 year-old Oldsmobile brand and its complete line-up of vehicles shortly after the dealers had signed a new agreement with a commitment of up to five years on this product line. With this surprising elimination of the Oldsmobile product line, many family-owned dealerships are facing an increased threat to the viability of other product lines at their dealerships and, in some cases, a complete loss of their business.

GM is in the process of compensating these dealers to minimize the impact, as many of these dealers are facing a significant and previously unforeseeable financial burden, through no fault of their own, in connection with their efforts to continue in the automobile retail business. The legislation we are introducing today seeks to lessen that burden by allowing these dealerships up to two years to re-invest their GM's financial assistance payments in other dealership properties and defer payment of taxes under IRC Section 1031. Under current law, the dealerships would only have 6 months to identify and purchase a similar business or property. This time restriction would make it difficult, if not impossible, for most of these businesses to re-invest these payments because, as is the case with most franchises, there are very few businesses or investments that are similar enough to be considered "like kind" and hence qualify for tax deferral. The failure to do so results in the owner paying taxes on the payment, even if they are ultimately re-invested in a business that would have qualified. Since the dealers did not want to forfeit their rights to sell Oldsmobiles, this seems like a particularly harsh result.

In rural States like New Mexico, family-owned businesses supply the majority of jobs and services in the State. This legislation gives these small businesses an opportunity to continue their family-owned businesses and, at the same time, give a boost to the local economy. I look forward to working with my colleagues on advancing this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1305

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MOTOR VEHICLE DEALER TRANSITIONAL ASSISTANCE.

(a) IN GENERAL.—For purposes of subtitle A of the Internal Revenue Code of 1986, in the case of a taxpayer who elects the application of this section and who was a party to a motor vehicle sales and service agreement with a motor vehicle manufacturer who announced in December 2000 that it would phase-out the motor vehicle brand to which such agreement relates—

(1) amounts received by such taxpayer from such manufacturer on account of the termination of such agreement (hereafter in this section referred to as "termination payment") are considered to be received for property used in the trade or business of a motor vehicle retail sales and service dealership, and

(2) to the extent such termination payment is reinvested in property used in a motor vehicle retail sales and service dealership located within the United States, such property shall qualify as like-kind replacement property to which section 1031 of the Internal Revenue Code of 1986 shall apply with the following modifications:

(A) Such section shall be applied without regard to subparagraphs (A) and (B)(ii) of subsection (a)(3).

(B) The period described in section 1031(a)(3)(B) of such Code shall be applied by substituting "2 years" for "180 days".

(b) RULES FOR ELECTION.—

(1) FORM OF ELECTION.—The taxpayer shall make an election under this section in such form and manner as the Secretary of the Treasury may prescribe and shall include in such election the amount of the termination payment received, the identification of the replacement property purchased, and such other information as the Secretary may prescribe.

(2) ELECTION ON AMENDED RETURN.—The Secretary of the Treasury shall permit an election under this section on an amended tax return for taxable years beginning before the date of the enactment of this Act.

(c) STATUTE OF LIMITATIONS.—Notwithstanding the provisions of any other law or rule of law, the statutory period for the assessment for any deficiency attributable to any termination payment gain shall be extended until 3 years after the date the Secretary of the Treasury is notified by the taxpayer of the like-kind replacement property or an intention not to replace.

(d) EFFECTIVE DATE.—This section shall apply to amounts received after December 12, 2000, in taxable years ending after such date.

Mr. BAUCUS. Mr. President, I am proud to support Senator BINGAMAN's legislation to ensure equitable tax treatment for Oldsmobile dealers impacted by General Motors' sudden decision to eliminate the Oldsmobile from its product line. General Motors did agree to partially compensate Oldsmobile dealers for their loss.

Senator BINGAMAN's bill ensures that like-kind exchange treatment, which defers the gain on the exchange of business or investment property until it is ultimately sold, is also available for motor vehicle dealers who receive payments when the brand of automobile they carry is eliminated by the manufacturer. The proposal allows such reinvested payments to be treated as a like-kind exchange of property if exchanged within 2 years from receipt of the payments, thus deferring the tax consequences. As such, the proposal encourages capital investment by recognizing that a longer period of time is required for dealers to obtain a new franchise or establish a new car sales business.

The manufacturer, not the automobile dealer, makes the unilateral decision to eliminate vehicle brands. Nonetheless, the dealer is the one who invests years of hard work in bringing a particular brand to his or her local community. When a manufacturer decides to eliminate a brand, many family-owned dealerships face a complete loss of business as well as an increased threat to the viability of other brands located in the same facility.

Approximately one-third of the 2,801 Oldsmobile dealers across the country are expected to reinvest the GM payments into another franchise or other retail motor vehicle sales business. Many of the 27 Oldsmobile dealers in Montana have expressed their interest in reinvesting the GM payments they received, if this legislation becomes law. These Montanans have been stripped of a source of income at a time when the economy is not too forgiving.

I urge my colleagues to support this important legislation.

By Mrs. BOXER (for herself and Mrs. FEINSTEIN):

S. 1306. A bill to introduce the efforts of the California Missions Foundation to restore and repair the Spanish colonial and mission-era missions in the State of California and to preserve the artworks and artifacts of these missions, and for other purposes; to the Committee on Energy and Natural Resources.

Mrs. BOXER. Mr. President, I am pleased to be introducing a bill today that will provide the necessary resources to protect the 21 historic California missions for future generations. I am pleased to be joined in this effort by my colleague from California, Senator FEINSTEIN.

The California missions represent some of our Nation's oldest historical treasures. Furthermore, they are important illustrations of the historical, cultural and architectural heritage of the State of California. Yet, until recently, little had been done to preserve the missions and their artifacts. They are in dire need of structural repair and restoration.

The California missions are the most visited historic attractions in the State, drawing more than 5 million tourists a year. The missions also serve an important role in educating our children in the history and the early settlement in California. We must make restoration and protection of the missions a priority.

In 1998, the California Missions Foundation, a charitable corporation, was established in the State of California to fund the restoration and repair of the California missions and the preservation of the Spanish colonial and mission-era artworks and artifacts of the California missions. The Foundation is leading a statewide campaign to raise funds to repair the missions and preserve their precious artworks and artifacts. But they need help.

My legislation would provide $10 million for the restoration of the California missions through a Department of the Interior grant program to be administered over 5 years. These funds would supplement the private and State funds that have been dedicated to preservation of the missions.

The House version of the bill has been introduced by Representatives SAM FARR and DAVID DREIER. It has the support of a majority of the California congressional delegation. It is my hope that this legislation can move forward quickly, so we can restore and protect these national treasures.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "California Missions Preservation Act".

SEC. 2. FINDINGS.

Congress finds the following:

(1) The California missions represent some of our Nation's oldest historical treasures.

(2) The first of the California missions was founded in 1769, and eventually a chain of 21 missions and various sub-missions extended along the coast of California on El Camino Real.

(3) The California missions contribute greatly to the rich historical, cultural, and architectural heritage of California and the American West.

(4) The knowledge and cultural influence of native California Indians made a lasting contribution to the early settlement of California and the development of the California missions.

(5) More than 5,300,000 people visit the California missions annually, and the historical importance of the California missions extends worldwide as they have become a frequent destination for foreign visitors to the United States.

(6) The history of the California missions is an important educational component in California schools, and the study of the California missions is part of the Statewide fourth grade curricula on California history.

(7) Restoration and repair of the California missions, and the preservation of the Spanish colonial and mission-era artworks and artifacts of the California missions, for the public enjoyment will ensure that future generations also have the benefit of experiencing and appreciating these great symbols of the spirit of exploration and discovery in the American West.

SEC. 3. SUPPORT FOR THE RESTORATION AND PRESERVATION OF THE CALIFORNIA MISSIONS.

(a) DEFINITIONS.—In this section:

(1) CALIFORNIA MISSIONS.—The term "California missions" means the following historic Spanish missions located in the State of California and designated as California Registered Historical Landmarks:

(A) Mission La Purisima Concepcion, Lompoc.

(B) Mission La Soledad, Soledad.

(C) Mission San Antonio de Padua, Jolon.

(D) Mission San Buenaventura, Ventura.

(E) Mission San Carlos Borromeo del Rio Carmelo, Carmel.

(F) Mission San Diego Alcala, San Diego.

(G) Mission San Fernando Rey de Espana, Mission Hills.

(H) Mission San Francisco de Asis, San Francisco.

(I) Mission San Francisco Solano, Sonoma.

(J) Mission San Gabriel Arcangel, San Gabriel.

(K) Mission San Jose, Fremont.

(L) Mission San Juan Bautista, San Juan Bautista.

(M) Mission San Juan Capistrano, San Juan Capistrano.

(N) Mission San Luis Obispo de Tolosa and its Asistencia (sub-mission) of Santa Margarita de Cortona, San Luis Obispo.

(O) Mission San Luis Rey de Francia and its Asistencia (sub-mission), Oceanside.

(P) Mission San Miguel Arcangel, San Miguel.

(Q) Mission San Rafael Arcangel, San Rafael.

(R) Mission Santa Barbara Virgen y Martir, Santa Barbara.

(S) Mission Santa Clara de Asis, Santa Clara.

(T) Mission Santa Cruz, Santa Cruz.

(U) Mission Santa Ines Virgen y Martir, Solvang.

(V) Asistencia San Antonio de Pala, Pala.

(2) CALIFORNIA MISSIONS FOUNDATION.—The term "California Missions Foundation" means the charitable corporation established in the State of California in 1998 to fund the restoration and repair of the California missions and the preservation of the Spanish colonial and mission-era artworks and artifacts of the California missions. The Foundation is exempt from State franchise and income tax and is organized and operated exclusively for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986.

(3) SECRETARY.—The term "Secretary" means the Secretary of the Interior.

(b) GRANTS AUTHORIZED.—The Secretary of the Interior may make grants to the California Missions Foundation to support the efforts of the California Missions Foundation to restore and repair the California missions and to preserve the artworks and artifacts associated with the California missions. As provided in section 101(e)(4) of the National Historic Preservation Act (16 U.S.C. 470a(e)(4)), the Secretary shall ensure that the purpose of a grant under this section is secular, does not promote religion, and seeks to protect those qualities that are historically significant.

(c) APPLICATION.—In order to receive a grant under this section for the preservation of the California missions, the California Missions Foundation shall submit to the Secretary an application that includes—

(1) a status report on the condition of the infrastructure and artifacts for each of the California missions; and

(2) a comprehensive program for restoration, repair, and preservation of such infrastructure and artifacts, including prioritized preservation efforts to be conducted over a 5-year period and the estimated costs of such preservation efforts.

(d) MATCHING FUND REQUIREMENT.—The Secretary shall require the California Missions Foundation to match grant funds provided under this section.

(e) REPORT.—As a condition of a grant under this section, the California Missions Foundation shall submit to the Secretary an annual report on the status of the preservation efforts undertaken using grant funds provided under this section. The Secretary shall submit a copy of each report to Congress.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary a total of $10,000,000 during the five-fiscal year period beginning October 1, 2003, to make grants under this section. Funds appropriated pursuant to the authorization of appropriations in this section shall be in addition to any funds made available for preservation efforts in the State of California under the National Historic Preservation Act.

By Mr. SMITH:

S. 1307. A bill to authorize the Secretary of the Interior, acting through the Bureau of Reclamation, to assist in the implementation of fish passage and screening facilities at non-Federal water projects, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. SMITH. Mr. President, today I am introducing legislation to provide the Bureau of Reclamation, an agency of the Department of the Interior, with limited off-site mitigation authority in the Columbia River Basin. This legislation, if enacted, would enhance Reclamation's ability to comply with the provisions of the December 2000 biological opinion for operations of the Federal Columbia River Power System.

This legislation is similar to an Administration proposal that was submitted to the Congress on October 30, 2002, but never introduced during the 107th Congress. Prior to the introduction of this bill, I have sought comments from numerous stakeholders in the Pacific Northwest and have addressed any concerns raised whenever possible.

While there has been a recent court ruling on the 2000 biological opinion that found certain aspects of the opinion to the arbitrary and capricious, it is important to move forward with the reasonable and prudent alternatives, including fish passage improvements. The Administration is currently working to address the deficiencies in the biological opinion. I remain committed to working with my colleagues, the Northwest governors, and the Administration to keep salmon recovery on track, while preserving the multiple benefits for the Pacific Northwest of the Federal Columbia River Power System.

The good news in our region is that over the past few years there have been robust salmon runs on the Columbia and Snake Rivers. Promising new technologies, such as removable spillways, have also been tested in recent years. I know that the Administration remains committed to taking actions throughout the salmon's life cycle to recover salmon runs in the Columbia and Snake Rivers. This important legislation, if enacted, will provide yet another tool in addressing the complex issues of salmon recovery. I urge my colleagues to join me in supporting this legislation, and will press for its consideration in a timely manner.

By Mr. WYDEN (for himself and Mr. SMITH):

S. 1308. A bill to authorize the Secretary of the Interior to pursue and complete actions related to the implementation of a U.S. District of a U.S. District Court Consent Decree; to the Committee on Energy and Natural Resources.

Mr. WYDEN. Mr. President, I rise today to introduce the Savage Rapids Dam Act of 2003, for myself and my friend and colleague from Oregon, Senator GORDON SMITH.

This legislation is another good example of the Oregon way: bringing together varied interests to get win-win results for all stakeholders. Born out of controversy concerning the detrimental effects of the Savage Rapids Dam on fish passage and survival, this legislation is now supported by the Grants Pass Irrigation District, Waterwatch, Oregon's Governor, Trout Unlimited, and various Oregon river guide and sport fishing concerns.

This legislation simply authorizes the Secretary of Interior, acting through the Bureau of Reclamation, and the Secretary of Commerce, acting through National Oceanic and Atmospheric Administration Fisheries, to undertake activities identified for Federal implementation, including construction, in accordance with U.S. District Court Consent Decree "United States, et al., v. Grants Pass Irrigation District, Civil No. 98-3034-HO", August 27, 2001.

This legislation has been years in the making. Senator SMITH and I introduced a related measure in the 106th Congress. As we return to this legislation in the 108th Congress, I look forward to working with my colleagues in the Senate and the stakeholders at home to make this legislation and this process work for the Grants Pass Irrigation District and the environment.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1308

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 1. AUTHORIZATION TO PARTICIPATE IN IMPLEMENTATION OF CONSENT DECREE.

The Secretary of the Interior, acting through the Bureau of Reclamation, and the Secretary of Commerce, acting through National Oceanic and Atmospheric Administration Fisheries, are hereafter authorized to implement, and enter into financial assistance or other agreements as may be necessary to undertake activities identified for Federal implementation (including construction) in accordance with U.S. District Court Consent Decree "United States, et al., v. Grants Pass Irrigation District, Civil No. 98-3034-HO" (August 27, 2001)

SEC. 2. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this Act.

By Mrs. LINCOLN (for herself and Mr. PRYOR):

S. 1309. A bill to provide emergency assistance to producers that have suffered crop losses due to disasters; to the Committee on Agriculture, Nutrition, and Forestry.

Mrs. LINCOLN. Mr. President, I rise today to introduce the Emergency Agriculture Assistance Act of 2003 on behalf of farmers throughout the state of Arkansas.

Last month, my State was hit with devastating storms that produced at least three dozen tornadoes and as much as 20 inches of rain fall. These natural disasters occurred at the worst possible time for farmers, at the beginning of the planting season, when they need to get their crops into the ground.

This is a particularly vulnerable time for farmers, since freshly planted crops are highly susceptible to severe weather conditions.

A single day of heavy rains and high winds can undo a months worth of hard work, forcing producers to start over from scratch and replant entire fields or even entire farms.

Recently I was home in east Arkansas and saw much of this damage firsthand. To take just one example: In Mississippi County in northeast Arkansas, where Clark Long farms with his two sons, Clark Jr. and Nathan, 11 inches of rain fell in a two day period. As a result, the Longs were forced to replant 1400 cotton acres. Other farmers I have talked to are on their second or even third plantings.

Similar conditions abound throughout Mississippi County and northeast Arkansas, where historic planting deadlines have now passed. As a rule of thumb, a cotton farmer wants to have his crop planted no later than May 20th in order to maximize yields and to avoid having to harvest his crop in October. Farmers can typically expect yield reductions of up to two percent per day beyond this deadline, since late crops are generally more susceptible to weed and insect infestation and harsher weather conditions.

Cotton farming, as well as farming commodities such as soybeans, wheat, and rice, is an expensive and labor intensive process. These severe weather conditions exacerbate that situation greatly and place our farmers at serious risk.

We're going to monitor conditions throughout the year, guarding against further threats from severe weather, such as further tornadoes or even drought.

I urge my colleagues to join Senator PRYOR and me in passing this bill and protecting our farmers in this time of need.

Mr. PRYOR. Mr. President, I rise today along with my good friend and colleague from Arkansas, Senator LINCOLN, in support of the Emergency Agricultural Assistance Act of 2003 to assist those in the agriculture community who have been devastated by natural disaster across our country.

I hold in my hand a June 19th article from the Arkansas Democrat-Gazette that describes one of the countless stories of farmers across my State and the hardships they have faced due to unusually large amounts of rainfall their farms have received during the absolute worst possible time. In the past month, some areas have received in excess of twenty inches of rain. Arkansas, along with many other States across the Midwest and South, has been pelted continuously by rain and numerous tornadoes. As many as three dozen tornadoes have touched down in Arkansas alone. Bob Bevis, a farmer in Lonoke County, AR hasn't been able to work for three weeks due to soggy fields. In the meantime, wheat crops that were expected to bring record yields rot in the field, waiting for water to recede before the wheat can be harvested. Over fifty percent of Arkansas' wheat crop remains in the field, and with every passing day, the prospects for a successful harvest of wheat diminish. If current weather conditions abate, our farmers may be able to harvest five hundred fifty thousand acres, the lowest total in over seventeen years.

The harvest of winter wheat has been greatly affected by weather. But winter wheat, generating $112.1 million in sales last year, represents only the fourth largest field crop in Arkansas. Rice, soybeans, and cotton represent our top three field crops. During the time wheat is being harvested, these other crops are being planted. Thus, while wheat has been affected, soybeans, cotton, rice, and numerous other crops have been devasted just as they are being put into the ground. Fields are under water. Crops that were planted early have been wiped out. Over 1.3 million acres of farmland across Arkansas have been affected by the excessive rainfall. Many of these acres had to be replanted, and just as quickly as our farmers began to have hopes of a decent crop, those hopes were dashed by disasters beyond their control. As you and many of our colleagues know, this is the critical time for planting crops. The later crops get in the ground, the later they will be harvested. The later they are harvested, the greater the chance insect problems, weed problems, and a whole host of other problems will damage these crops become likely. Yields will be dangerously low. Our farmers cannot suffer this burden alone. Our farmers provide our citizens around the country with an abundant food supply, greater than any other country in the world. We have the safest, least expensive food in the world, because farm families who are suffering through excessively tough times now work from dawn to dusk in the fields to make sure that we do. As a country, and as a government, I hope that my colleagues will show these dedicated Americans the support they deserve. They need our help, and they have asked for our help. I consider this a matter of national and homeland security, and I hope that my colleagues will see it this way as well.

This bill will provide farmers in disaster areas designated by the President who experience a thirty-five percent yield loss with disaster assistance. I would like to thank my colleague from my home state for her hard work and collaboration on this bill. I look forward to working with my colleagues to ensure our farmers get the support and help they need to keep America's food supply safe, inexpensive, and the best in the world.

SUBMITTED RESOLUTIONS—June 19, 2003

[CORRECTED TEXT]

SENATE RESOLUTION 177—TO DIRECT THE SENATE COMMISSION ON ART TO SELECT AN APPROPRIATE SCENE COMMEMORATING THE GREAT COMPROMISE OF OUR FOREFATHERS ESTABLISHING A BICAMERAL CONGRESS WITH EQUAL STATE REPRESENTATION IN THE UNITED STATES SENATE, TO BE PLACED IN THE LUNETTE SPACE IN THE SENATE RECEPTION ROOM IMMEDIATELY ABOVE THE ENTRANCE INTO THE SENATE CHAMBER LOBBY, AND TO AUTHORIZE THE COMMITTEE ON RULES AND ADMINISTRATION TO OBTAIN TECHNICAL ADVICE AND ASSISTANCE IN CARRYING OUT ITS DUTIES

Mr. DODD submitted the following resolution; which was referred to the Committee on Rules and Administration:

S. RES. 177

Whereas the reception room in the Capitol outside of the Senate Chamber was originally designed to contain scenes of American history, to be painted in lunette spaces on the reception walls;

Whereas only one such lunette space in the Senate reception room has been completed;

Whereas it is in the public interest to accomplish the original objective of the design of the Senate reception room by selecting important events of American History to be painted in the remaining unfilled lunette spaces;

Whereas on July 16, 1787, the framers of the United States Constitution, meeting at Independence Hall, reached a supremely important agreement, providing for a dual system of congressional representation, such that in the House of Representatives, each State would be assigned a number of seats in proportion to its population, and in the Senate, all States would have an equal number of seats, an agreement which became known as the “Great Compromise” or the “Connecticut Compromise”; and

Whereas an appropriate scene commemorating the Great Compromise of our forefathers establishing a bicameral Congress with equal State representation in the United States Senate should be placed in the lunette space in the Senate reception room immediately above the entrance into the Senate chamber lobby: Now, therefore, be it

Resolved,

SECTION 1. COMMEMORATION OF THE GREAT COMPROMISE.

(a) IN GENERAL.—The Senate Commission on Art, established under section 901 of the Arizona-Idaho Conservation Act of 1988 (40 U.S.C. 188b) (in this section referred to as the “Commission”) shall select an appropriate scene commemorating the Great Compromise of our forefathers, to be placed in the lunette space in the Senate reception room immediately above the entrance into the Senate chamber lobby.

(b) CONSULTATION AUTHORIZED.—The Commission is authorized to seek the advice of and recommendations from historians and other sources in carrying out this section, and to reimburse such sources for travel expenses, in accordance with Senate Travel Regulations.

(c) TIMING.—The Commission shall make its selection pursuant to this section, and shall commission an artist to begin work, not later than the close of the 2d session of the 108th Congress.

(d) DELEGATION AUTHORITY.—For purposes of making the selection required by this section, a member of the Commission may designate another Senator to act in place of that member.

(e) FUNDING.—The expenses of the Commission in carrying out this section shall be made available from appropriations under the subheading “MISCELLANEOUS ITEMS” under the heading “CONTINGENT EXPENSES OF THE SENATE”, on vouchers signed by the Secretary of the Senate and approved by the Committee on Rules and Administration.

SEC. 2. TECHNICAL ADVICE AND ASSISTANCE.

(a) IN GENERAL.—The Chairman of the Committee on Rules and Administration may seek technical advice and assistance to the Committee in carrying out its duties from individuals from the public and private sectors, who shall serve without compensation, at the pleasure of the Chairman.

(b) NON-GOVERNMENTAL STATUS.—Individuals providing advice and assistance described in subsection (a) shall not be deemed to be—

(1) Members, officers, or employees of the Senate; or

(2) providing services to the Senate, for purposes of the Senate Code of Official Conduct.

(c) EXPENSES.—Upon submission to the Committee on Rules and Administration of a routine voucher for actual transportation expenses incurred in the performance of providing advice and assistance to the Committee, individuals described in subsection (a) may be reimbursed in accordance with Senate Travel Regulations.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 178—TO PROHIBIT MEMBERS OF THE SENATE AND OTHER PERSONS FROM REMOVING ART AND HISTORIC OBJECTS FROM THE SENATE WING OF THE CAPITOL AND SENATE OFFICE BUILDINGS FOR PERSONAL USE

Mr. DODD submitted the following resolution; which was referred to the Committee on Rules and Administration:

S. RES. 178

Resolved, That (a) a Member of the Senate or any other person may not remove a work of art, historical object, or an exhibit from the Senate wing of the Capitol or any Senate office building for personal use.

(b) For purposes of this resolution, the term "work of art, historical object, or an exhibit" means an item, including furniture, identified on the list (and any supplement to the list) required by section 4 of Senate Resolution 382, 90th Congress, as enacted into law by section 901(a) of Public Law 100–696 (2 U.S.C. 2104).

(c) For purposes of this resolution, the Senate Commission on Art shall update the list required by section 4 of Senate Resolution 382, 90th Congress (2 U.S.C. 2104) every 6 months after the date of adoption of this resolution and shall provide a copy of the updated list to the Committee on Rules and Administration.

AMENDMENTS SUBMITTED AND PROPOSED

SA 951. Mr. ALEXANDER proposed an amendment to the bill S. 504, to establish academies for teachers and students of American history and civics and a national alliance of teachers of American history and civics, and for other purposes.

SA 952. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table.

SA 953. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 954. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 955. Mr. CORZINE submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 956. Mr. GRAHAM, of Florida proposed an amendment to the bill S. 1, supra.

SA 957. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 958. Mr. KERRY proposed an amendment to the bill S. 1, supra.

SA 959. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra.

SA 960. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 961. Mrs. MURRAY submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 962. Mr. SMITH (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 963. Mrs. LINCOLN (for herself, Mr. CONRAD, Mr. MILLER, and Mr. CARPER) proposed an amendment to the bill S. 1, supra.

SA 964. Mr. BAUCUS (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, supra.

SA 965. Mr. BAUCUS (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, supra.

SA 966. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 967. Mr. BAUCUS (for Mr. HARKIN) proposed an amendment to the bill S. 1, supra.

SA 968. Mr. BAUCUS (for Mr. HARKIN) proposed an amendment to the bill S. 1, supra.

SA 969. Mr. BAUCUS (for Mr. DODD) proposed an amendment to the bill S. 1, supra.

SA 970. Mr. BAUCUS (for Mr. DODD) proposed an amendment to the bill S. 1, supra.

SA 971. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 972. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 973. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 974. Mr. GRASSLEY (for himself, Mr. LEAHY, Ms. CANTWELL, Mr. DURBIN, and Mr. KOHL) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 951. Mr. ALEXANDER proposed an amendment to the bill S. 504, to establish academies for teachers and students of American history and civics and a national alliance of teachers of American history and civics, and for other purposes; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "American History and Civics Education Act of 2003".

SEC. 2. DEFINITIONS.

In this Act:

(1) AMERICAN HISTORY AND CIVICS.—The term "American history and civics" means the key events, key persons, key ideas, and key documents that shaped the institutions and democratic heritage of the United States of America.

(2) CHAIRMAN.—The term "Chairman" means the Chairman of the National Endowment for the Humanities.

(3) EDUCATIONAL INSTITUTION.—The term "educational institution"—

(A) means—

(i) an institution of higher education;

(ii) an educational institution created by a legislative act of a State for the express purpose of teaching American history and civics to elementary school and secondary school students; or

(iii) a nonprofit educational institution, library, or research center; and

(B) includes a consortium of entities described in subparagraph (A).

(4) INSTITUTION OF HIGHER EDUCATION.—The term "institution of higher education" has the meaning given the term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

(5) KEY DOCUMENTS.—The term "key documents" means the documents that established or explained the foundational principles of democracy in the United States, including the United States Constitution and the amendments to the Constitution (particularly the Bill of Rights), the Declaration of Independence, the Federalist Papers, and the Emancipation Proclamation.

(6) KEY EVENTS.—The term "key events" means the critical turning points in the history of the United States (including the encounter of Native Americans with European settlers, the American Revolution, the Civil War, the world wars of the twentieth century, the civil rights movement, and the major court decisions, legislation, literature, and the arts) that established democracy and extended its promise in American life.

(7) KEY IDEAS.—The term "key ideas" means the ideas that shaped the democratic institutions and heritage of the United States, including the notions of liberty, equal opportunity, individualism, laissez faire, the rule of law, federalism and e pluribus unum, the free exercise of religion, the separation of church and state, and a belief in progress.

(8) KEY PERSONS.—The term "key persons" means the men and women who led the United States as Founding Fathers, Native American leaders, elected officials, scientists, inventors, pioneers, advocates of equal rights, entrepreneurs, and artists.

(9) STATE.—The term "State" means each of the 50 States and the District of Columbia.

(10) TEACHERS OF AMERICAN HISTORY AND CIVICS.—The term "teachers of American history and civics" means kindergarten through grade 12 teachers who teach American history, government, or civics, or who incorporate such subjects into their teaching.

SEC. 3. PRESIDENTIAL ACADEMIES FOR TEACHING OF AMERICAN HISTORY AND CIVICS.

(a) ESTABLISHMENT.—From amounts appropriated under subsection (j), the National Endowment for the Humanities shall award grants, on a competitive basis, to educational institutions to establish Presidential Academies for Teaching of American History and Civics (in this section referred to as "Academies") that shall offer workshops for teachers of American history and civics—

(1) to strengthen such teachers' knowledge of the subjects of American history and civics; and

(2) to learn how better to teach such subjects.

(b) APPLICATION.—

(1) IN GENERAL.—An educational institution that desires to receive a grant under this section shall submit an application to the National Endowment for the Humanities

at such time, in such manner, and containing such information as the National Endowment for the Humanities may require.

(2) Contents.—An application submitted under paragraph (1) shall—

(A) include the criteria that will be used to determine which teachers will be selected to attend workshops offered by the Academy;

(B) identify the individual the educational institution intends to appoint to be the primary scholar at the Academy;

(C) include a description of the curriculum to be used at workshops offered by the Academy; and

(D) provide an assurance that the recruitment plan for which teachers will be selected to attend workshops offered by the Academy will include teachers from schools receiving assistance under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.), particularly those schools with high concentrations of students described in section 1124(c) of such Act.

(c) Number of Grants.—The National Endowment for the Humanities shall award not more than 12 grants to different educational institutions under this section.

(d) Distribution.—The Chairman shall encourage equitable distribution of grants under this section among the geographical regions of the United States.

(e) Grant Terms.—Grants awarded under this section shall be for a term of 2 years.

(f) Use of Funds.—

(1) Workshops.—

(A) In general.—An educational institution that receives a grant under this section shall establish an Academy that shall offer a workshop during the summer, or during another appropriate time, for teachers of American history and civics—

(i) to strengthen such teachers' knowledge of the subjects of American history and civics; and

(ii) to learn how better to teach such subjects.

(B) Duration of workshop.—A workshop offered pursuant to this section shall be approximately 2 weeks in duration.

(2) Academy staff.—

(A) Primary scholar.—Each Academy shall be headed by a primary scholar identified in the application submitted under subsection (b) who shall—

(i) be accomplished in the field of American history and civics; and

(ii) design the curriculum for and lead the workshop.

(B) Core teachers.—Each primary scholar shall appoint an appropriate number of core teachers. At the direction of the primary scholar, the core teachers shall teach and train the workshop attendees.

(3) Selection of teachers.—

(A) In general.—

(i) Number of teachers.—Each year, each Academy shall select kindergarten through grade 12 teachers of American history and civics to attend the workshop offered by the Academy.

(ii) Flexibility in number of teachers.—Each Academy shall select not more than 300 and not less than 50 teachers under clause (i).

(B) Teachers from public and private schools.—An Academy may select teachers from public schools and private schools to attend the workshop offered by the Academy.

(g) Costs.—

(1) In general.—Except as provided in paragraph (2), a teacher who attends a workshop offered pursuant to this section shall not incur costs associated with attending the workshop, including costs for meals, lodging, and materials while attending the workshop, and may receive a stipend to cover such costs.

(2) Travel costs.—A teacher who attends a workshop offered pursuant to this section shall use non-Federal funds to pay for such teacher's costs of transit to and from the Academy.

(h) Evaluation.—

(1) In general.—At the completion of all of the workshops assisted in the third year grants are awarded under this section, the National Endowment for the Humanities shall conduct an evaluation and submit a report on its findings to the relevant committees of Congress.

(2) Content of evaluation.—The evaluation conducted pursuant to paragraph (1) shall—

(A) determine the overall success of the grant program authorized under this section; and

(B) highlight the best grantees' practices in order to become models for future grantees.

(i) Non-Federal Funds.—An educational institution receiving Federal assistance under this section may contribute non-Federal funds toward the costs of operating the Academy.

(j) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $7,000,000 for each of fiscal years 2004 through 2007.

SEC. 4. CONGRESSIONAL ACADEMIES FOR STUDENTS OF AMERICAN HISTORY AND CIVICS.

(a) Establishment.—From amounts appropriated under subsection (j), the National Endowment for the Humanities shall award grants, on a competitive basis, to educational institutions to establish Congressional Academies for Students of American History and Civics (in this section referred to as "Academies") that shall offer workshops for outstanding students of American history and civics to broaden and deepen such students' understanding of American history and civics.

(b) Application.—

(1) In general.—An educational institution that desires to receive a grant under this section shall submit an application to the National Endowment for the Humanities at such time, in such manner, and containing such information as the National Endowment for the Humanities may require.

(2) Contents.—An application submitted under paragraph (1) shall—

(A) include the criteria that will be used to determine which students will be selected to attend workshops offered by the Academy;

(B) identify the individual the educational institution intends to appoint to be the primary scholar at the Academy;

(C) include a description of the curriculum to be used at workshops offered by the Academy; and

(D) include a description of how the educational institution will—

(i) inform students from schools receiving assistance under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.), particularly those schools with high concentrations of students described in section 1124(c) of such Act, of the Academy; and

(ii) provide such students with information on how to apply to attend workshops offered by the Academy so that such students may attend the workshops.

(c) Number of Grants.—The National Endowment for the Humanities shall award not more than 12 grants to different educational institutions under this section.

(d) Distribution.—The Chairman shall encourage equitable distribution of grants under this section among the geographical regions of the United States.

(e) Grant Terms.—Grants awarded under this section shall be for a term of 2 years.

(f) Use of Funds.—

(1) Workshops.—

(A) In general.—An educational institution that receives a grant under this section shall establish an Academy that shall offer a workshop during the summer, or during another appropriate time, for outstanding students of American history, government, and civics to broaden and deepen such students' understanding of American history and civics.

(B) Duration of workshop.—A workshop offered pursuant to this section shall be approximately 4 weeks in duration.

(2) Academy staff.—

(A) Primary scholar.—Each Academy shall be headed by a primary scholar identified in the application submitted under subsection (b) who shall—

(i) be accomplished in the field of American history and civics; and

(ii) design the curriculum for and lead the workshop.

(B) Core teachers.—Each primary scholar shall appoint an appropriate number of core teachers. At the direction of the primary scholar, the core teachers shall teach the workshop attendees.

(3) Selection of students.—

(A) Number of students.—Each year, each Academy shall select between 100 and 300 eligible students to attend the workshop offered by the Academy.

(B) Eligible students.—A student shall be eligible to attend a workshop offered by an Academy if the student—

(i) is recommended by the student's secondary school principal (or other head of such student's academic program) to attend the workshop; and

(ii) will be a junior or senior in the academic year following attendance at the workshop.

(g) Costs.—

(1) In general.—Except as provided in paragraph (2), a student who attends a workshop offered pursuant to this section shall not incur costs associated with attending the workshop, including costs for meals, lodging, and materials while attending the workshop.

(2) Travel costs.—A student who attends a workshop offered pursuant to this section shall use non-Federal funds to pay for such student's costs of transit to and from the Academy.

(h) Evaluation.—

(1) In general.—At the completion of all of the workshops assisted in the third year grants are awarded under this section, the National Endowment for the Humanities shall conduct an evaluation and submit a report on its findings to the relevant committees of Congress.

(2) Content of evaluation.—The evaluation conducted pursuant to paragraph (1) shall—

(A) determine the overall success of the grant program authorized under this section; and

(B) highlight the best grantees' practices in order to become models for future grantees.

(i) Non-Federal Funds.—An educational institution receiving Federal assistance under this section may contribute non-Federal funds toward the costs of operating the Academy.

(j) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $14,000,000 for each of fiscal years 2004 through 2007.

SEC. 5. NATIONAL ALLIANCE OF TEACHERS OF AMERICAN HISTORY AND CIVICS.

(a) Establishment.—

(1) In general.—From amounts appropriated under subsection (e), the National Endowment for the Humanities shall award 1 or more grants to organizations for the creation of a national alliance of elementary school and secondary school teachers of American history and civics.

(2) Purpose.—The purpose of the national alliance is—

(A) to facilitate the sharing of ideas among teachers of American history and civics; and

(B) to encourage best practices in the teaching of American history and civics.

(b) Application.—An organization that desires to receive a grant under this section shall submit an application to the National Endowment for the Humanities at such time, in such manner, and containing such information as the National Endowment for the Humanities may require.

(c) Grant Term.—A grant awarded under this section shall be for a term of 2 years and may be reapplied after the initial term expires.

(d) Use of Funds.—An organization that receives a grant under this section may use the grant funds for any of the following:

(1) Creation of a website on the Internet to facilitate discussion of new ideas on improving American history and civics education.

(2) Creation of in-State chapters of the national alliance, to which individual teachers of American history and civics may belong, that sponsors American history and civics activities for such teachers in the State.

(3) Seminars, lectures, or other events focused on American history and civics, which may be sponsored in cooperation with, or through grants awarded to, libraries, States' humanities councils, or other appropriate entities.

(4) Coordinate activities with other nonprofit educational alliances that promote the teaching or study of subjects related to American history and civics.

(e) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, and for any administrative costs associated with carrying out sections 3 and 4, $4,000,000 for each of fiscal years 2004 through 2007.

SA 952. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1 to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 76, line 20, strike "The" and insert "Except to the extent necessary to provide eligible beneficiaries already enrolled in a Medicare Prescription Drug plan with the choice of avoiding disruption by remaining enrolled in that plan, the".

SA 953. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 608, between lines 10 and 11, insert the following:

SEC. . TRAINING FOR LONG-TERM CARE OMBUDSMAN.

(a) In General.—The Secretary of Health and Human Services, acting through the Director of the Administration on Aging and in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall authorize a program, to be developed and implemented by the National Long-Term Care Ombudsman Resource Center, for the training of long-term care ombudsmen in the use of quality of care information.

(b) Training.—Under the program developed under subsection (a), training shall be provided to long-term care ombudsman to enable such ombudsman to educate consumers concerning—

(1) nursing home quality of care issues;

(2) available nursing home quality of care reports, including existing quality data that the Administrator of the Centers for Medicare & Medicaid Services has released for use by the public in choosing long-term care facilities; and

(3) the manner in which an individual can successfully integrate quality information into health care decision making regarding nursing home decisions.

(c) Duties of Resource Center.—The National Long-Term Care Ombudsman Resource Center shall—

(1) develop and maintain a curriculum for ombudsmen;

(2) develop, produce, and maintain training materials;

(3) conduct train-the-trainer programs at regional and national levels; and

(4) act as a clearinghouse for best practices in communicating the significance of nursing home quality indicators to residents and their caregivers.

(d) Pilot Programs.—The Secretary of Health and Human Services shall award grants for the establishment of 1-year pilot demonstration programs in 10 States using long-term care ombudsmen to educate consumers regarding home health care quality. Such pilot demonstration programs shall test the effectiveness of having a committed position within the State dedicated to helping consumers use home health care quality indicators.

(e) Report.—Not later than 18 months after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report concerning the effectiveness of the program established under this section, including the benefits of providing for dedicated staff who are responsible for educating consumers to use home health quality indicators in their health care decision-making.

(f) Authorization.—In addition to any other amounts authorized to be appropriate for long-term care ombudsman programs, there are authorized to be appropriated to carry out this section $4,000,000 for fiscal year 2004 (of which $1,000,000 shall be used to carry out subsection (d)), and $2,000,000 for each fiscal year thereafter.

SA 954. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 46, between lines 13 and 14, insert the following:

"(i) Health Literacy Standards.—

"(1) In general.—For purposes of assisting eligible entities in providing quality assurance measures as described in subsection (c)(1)(B), the Secretary, acting through the Director of the Agency for Healthcare Research and Quality, the Administrator of Health Resources and Services Administration, the Director of the National Library of Medicine, and the Commissioner of Food and Drugs, shall develop standardized materials that pharmacists may use to assist non-English speaking or functionally illiterate patients in the safe and appropriate use of prescription drugs. Such materials may include the use of pictures and the development of standardized translations in multiple languages of prescription labels and bottle labels and other patient safety initiative information. Such materials shall be available electronically for direct access by pharmacists.

"(2) Authorization of appropriations.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2004 and 2005.

SA 955. Mr. CORZINE submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title I, add the following:

SEC. . CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

(a) Permitting FQHCs to Fill Prescriptions.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(1) in subparagraph (A), by striking "and" after the comma at the end;

(2) in subparagraph (B), by inserting "and" after the comma at the end; and

(3) by adding at the end the following new subparagraph:

"(C) drugs and biologicals for which payment may otherwise be made under this title.".

(b) Elimination of Per Visit Limit.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting ", except that such regulations may not limit the per visit payment amount with regard to drugs and biologicals described in section 1861(aa)(3)(C) and purchased under section 340B of the Public Health Service Act" after "the Secretary may prescribe in regulations".

SA 956. Mr. GRAHAM of Florida proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 107, between lines 19 and 20, insert the following:

"(d) Beneficiary Not Responsible for Paying Applicable Percent of the Monthly National Average Premium While the Beneficiary is in the Coverage Gap.—

"(1) IN GENERAL.—Notwithstanding subsection (c), if an individual, with respect to any period of a year, has reached the initial coverage limit under paragraph (3) of section 1860D–6(c) for the year but has not reached the annual out-of-pocket limit under paragraph (4) of such section for the year, the applicable percent under subsection (c) during such period shall be zero.

"(2) PROCESS.—The Administrator shall establish a process for carrying out paragraph (1). Under such process, the Administrator shall—

"(A) require eligible entities offering Medicare Prescription Drug plans, MedicareAdvantage organizations offering MedicareAdvantage plans that provide qualified prescription drug coverage, and entities with a contract under section 1860D–13(e) to furnish the Administrator with such information as the Administrator determines necessary to carry out paragraph (1); and

"(B) furnish the Commissioner of Social Security with such information as the Administrator determines necessary to collect the appropriate monthly beneficiary obligation pursuant to section 1860D–18.

At the end of subtitle C of title IV, insert the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 957. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place insert the following:

SEC. . LIMITATION ON PRESCRIPTION DRUG BENEFITS OF MEMBERS OF CONGRESS.

(a) LIMITATION ON BENEFITS.—Notwithstanding any other provision of law, during calendar year 2004, the actuarial value of the prescription drug benefit of any Member of Congress enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the actuarial value of any prescription drug benefit under title XVIII of the Social Security Act passed by the 1st session of the 108th Congress and enacted in law.

(b) REGULATIONS.—The Office of Personnel Management shall promulgate regulations to carry out this section.

SA 958. Mr. KERRY proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 204, after line 22, insert the following:

SEC. . ACCESS TO DISCOUNTED PRESCRIPTION DRUGS.

(a) IN GENERAL.—From amounts made available under subsection (c), the Secretary of Health and Human Services shall award grants to covered entities described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) to enable such entities to pay the start-up costs associated with the establishment of pharmacies to provide covered drugs under such section 340B.

(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a covered entity shall prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(c) FUNDING.—The following sums are appropriated, out of any money in the Treasury not otherwise appropriated to the Prescription Drug Account established under section 1860DD-25 of the Social Security Act, $300,000,000 to carry out this section. Amounts made available under this subsection shall become available October 1, 2004, and shall remain available until expended.

SA 959. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . MEDICARE DEMONSTRATION PROJECT FOR DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the impact of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services on—

(1) costs under the medicare program under title XVIII of the Social Security Act; and

(2) the satisfaction of beneficiaries receiving such services.

(b) DEADLINE FOR ESTABLISHMENT; DURATION; SITES.—

(1) DEADLINE.—The Secretary shall establish the project not later than 1 year after the date of enactment of this Act.

(2) DURATION; SITES.— The project shall—

(A) be conducted for a period of 3 years;

(B) include sites in at least 5 States; and

(C) to the extent feasible, be conducted on a statewide basis in each State included under subparagraph (B).

(3) EARLY TERMINATION.—Notwithstanding paragraph (2)(A), the Secretary may terminate the operation of the project at a site before the end of the 3-year period specified in such paragraph if the Secretary determines, based on actual data, that the total amount expended for all services under this title for individuals at such site for a 12-month period are greater than the total amount that would have been expended for such services for such individuals for such period but for the operation of the project at such site.

(c) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program under title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary to conduct the demonstration project.

(d) Evaluations and Reports.—

(1) Evaluations.—

(A) In general.—The Secretary shall conduct interim and final evaluations of the project.

(B) Focus.—The evaluations conducted under paragraph (1) shall—

(i) focus on the impact of the project on program costs under title XVIII of the Social Security Act and patient satisfaction with health care items and services for which payment is made under such title; and

(ii) include comparisons, with respect to episodes of care involving direct access to physical therapy services and episodes of care involving a physician referral for such services, of—

(I) the average number of claims paid per episode for outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services;

(II) the average number of physician office visits per episode; and

(III) the average expenditures under such title per episode.

(2) Interim and final reports.—The Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives reports on the evaluations conducted under paragraph (1) by—

(A) in the case of the report on the interim evaluation, not later than the end of the second year the project has been in operation; and

(B) in the case of the report on the final evaluation, not later than 180 days after the closing date of the project.

(3) Funding for evaluation.—There are authorized to be appropriated such sums as may be necessary to provide for the evaluations and reports required by this subsection.

(e) Definitions.—In this section:

(1) Comprehensive outpatient rehabilitation services.—Subject to paragraph (2), the term "comprehensive outpatient rehabilitation services" has the meaning given to such term in section 1861(cc) of the Social Security Act (42 U.S.C. 1395x(cc)).

(2) Direct access.—The term "direct access" means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

(A) without regard to any requirement that—

(i) an individual be under the care of (or referred by) a physician; or

(ii) services be provided under the supervision of a physician; and

(B) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

(i) certification and recertification; and

(ii) establishment and periodic review of a plan of care.

(3) Fee-for-service medicare beneficiary.—The term "fee-for-service medicare beneficiary" means an individual who—

(A) is enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.); and

(B) is not enrolled in—

(i) a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.);

(ii) a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm);

(iii) a program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee); or

(iv) a social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

(4) Outpatient physical therapy services.—Subject to paragraph (2), the term "outpatient physical therapy services" has the meaning given to such term in section 1861(p) of the Social Security Act (42 U.S.C. 1395x(p)), except that such term shall not include the speech-language pathology services described in the fourth sentence of such section.

(5) Physician.—The term "physician" has the meaning given to such term in section 1861(r)(1) of such Act (42 U.S.C. 1395x(r)(1)).

(6) Qualified physical therapist.—The term "qualified physical therapist" has the meaning given to such term for purposes of section 1861(p) of such Act (42 U.S.C. 1395x(p)), as in effect on the date of enactment of this Act.

SA 960. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title V, add the following:

SEC. . STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) In General.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) Reduction in Regulations.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) Application of the Paperwork Reduction Act.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act") to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

SA 961. Mrs. MURRAY submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title II, add the following:

SEC. . IMPROVEMENTS IN MEDICAREADVANTAGE BENCHMARK DETERMINATIONS.

(a) Revision of National Average Used in Calculation of Blend.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting "who are enrolled in a MedicareAdvantage plan" after "the average number of medicare beneficiaries".

(b) Change in Budget Neutrality.—Section 1853(c) (42 U.S.C. 1395w–23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) Inclusion of Costs of DOD and VA Military Facility Services to Medicare-Eligible Beneficiaries in Calculation of Medicare+Choice Payment Rates.—

(1) For purposes of calculating medicare+choice payment rates.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) Inclusion of costs of dod and va military facility services to medicare-eligible beneficiaries.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(2) For purposes of calculating local fee-for-service rates.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(B) by adding at the end the following new subparagraph:

"(C) Inclusion of costs of dod and va military facility services to medicare-eligible beneficiaries.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(d) Effective Date.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

SA 962. Mr. SMITH (for himself and Mr. BINGAMAN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) Reimbursement.—

(1) In general.—Section 1833(a)(3) (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

‘‘(3) in the case of services described in section 1832(a)(2)(D)—

‘‘(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

‘‘(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

‘‘(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if ‘100 percent’ were substituted for ‘80 percent’ in such subparagraph) for such services if the individual had not been so enrolled; exceeds

‘‘(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);’’.

(b) Continuation of MedicareAdvantage Monthly Payments.—

(1) In general.—Section 1853 (42 U.S.C. 1395w–23), as amended by this Act, is amended by adding at the end the following new subsection:

‘‘(j) Payment Rule for Federally Qualified Health Center Services.—If an individual who is enrolled with a MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

‘‘(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

‘‘(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).’’.

(2) Conforming amendments.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w–21(i)(1)), as amended by this Act, are each amended by inserting ‘‘1853(j),’’ after ‘‘1853(i),’’.

(B) Section 1853(c)(5) is amended by striking ‘‘subsections (a)(3)(C)(iii) and (i)’’ and inserting ‘‘subsections (a)(3)(C)(iii), (i), and (j)(1)’’.

(c) Additional MedicareAdvantage Contract Requirements.—Section 1857(e) (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

‘‘(3) Agreements with federally qualified health centers.—

‘‘(A) Payment levels and amounts.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

‘‘(B) Cost-sharing.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).’’.

(d) Safe Harbor From Antikickback Prohibition.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in subparagraph (E), by striking ‘‘and’’ after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ‘‘; and’’; and

(3) by adding at the end the following new subparagraph:

‘‘(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).’’.

(e) Effective Date.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

SA 963. Mrs. LINCOLN (for herself, Mr. CONRAD, Mr. MILLER, and Mr. CARPER) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 83, strike lines 1 through 7, and insert the following:

‘‘(5) Contract to be available in designated area for 2 years.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

‘‘(A) The contract shall be for a 2-year period.

‘‘(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

‘‘(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary’s Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ‘‘promptly (as determined in accordance with regulations)’’;

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

‘‘(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.’’.

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ‘‘An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.’’;

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ‘‘A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.’’; and

(B) in the final sentence, by striking ‘‘on the date such notice or other information is received’’ and inserting ‘‘on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received’’; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following:

"In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 964. Mr. BAUCUS (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Beginning on page 8, strike line 1 and all that follows through page 9, line 2, and insert the following:

"(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2);

"(ii) a smoking cessation agent that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act as a non-prescription drug and is dispensed upon a prescription;

"(iii) a biological product described in clauses (i) through (iii) of subparagraph (B) of section 1927(k)(2); or

"(iv) insulin described in subparagraph (C) of such section;

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—

"(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraphs (E) and (G) thereof insofar as they relate to smoking cessation agents, or under section 1927(d)(3).

SA 965. Mr. BAUCUS (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395ee), as amended by section 534, is amended—

(1) by adding at the end of the heading the following: "; COUNCIL FOR TECHNOLOGY AND INNOVATION"; and

(2) by adding at the end the following new subsection:

"(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

"(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (as appointed or designated under paragraph (4)).

"(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes with respect to new technologies and procedures, including new drug therapies, under this title in order to expedite patient access to new technologies and therapies.

"(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title, and shall prepare reports to Congress required under section 1869(f)(7).".

SA 966. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place in title VI, insert the following:

SEC. . RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DEFINITIONS.—In this section:

(1) CLERICAL ERROR.—The term "clerical error" means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) TRUST FUND.—The term "Trust Fund" means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) CORRECTION OF TRUST FUND HOLDINGS.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) APPROPRIATION.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

SA 967. Mr. BAUCUS (for Mr. HARKIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

SA 968. Mr. BAUCUS (for Mr. HARKIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . REIMBURSEMENT FOR TOTAL BODY ORTHOTIC MANAGEMENT FOR CERTAIN NURSING HOME PATIENTS.

(a) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall issue product codes that qualified practioners and suppliers may use to receive reimbursement under section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) for qualified total body orthotic management devices used for the treatment of nonambulatory individuals with severe musculoskeletal conditions who are in the full-time care of skilled nursing facilities (as defined in section 1861(j) of such Act (42 U.S.C. 1395x(j))). In issuing such codes, the Secretary shall take all steps necessary to prevent fraud and abuse.

(b) QUALIFIED TOTAL BODY ORTHOTIC MANAGEMENT DEVICE.—For purposes of this section, the term "qualified total body orthotic management device" means a medically-prescribed device which—

(1) consists of custom fitted individual braces with adjustable points at the hips, knee, ankle, elbow, and wrist, but only if—

(A) the individually adjustable braces are attached to a frame which is an integral component of the device and cannot function or be used apart from the frame; and

(B) the frame is designed such that it serves no purpose without the braces; and

(2) is designed to—

(A) improve function;

(B) retard progression of musculoskeletal deformity; or

(C) restrict, eliminate, or assist in the functioning of lower and upper extremities and pelvic, spinal, and cervical regions of the body affected by injury, weakness, or deformity,

of an individual for whom stabilization of affected areas of the body, or relief of pressure points, is required for medical reasons.

SA 969. Mr. BAUCUS (for Mr. DODD) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle C of title II, add the following:

SEC. . PERMITTING CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT UNDER MEDICARE PARTS C AND D UNTIL 2008.

(a) UNDER MEDICARE PRESCRIPTION DRUG PLANS.—Subclause (II) of section 1860D–3(a)(1)(A)(i), as added by section 101, is amended to read as follows:

"(II)(aa) during 2006 and 2007, may change an election under this clause at any time; and

"(bb) during 2008 or a subsequent year, may make an annual election to change the election under this clause.".

(b) UNDER MEDICAREADVANTAGE PLANS.—Section 1851(e) (42 U.S.C. 1395w–21(e)), as amended by section 201, is amended—

(1) in paragraph (2)(A), by striking "THROUGH 2005" and "December 31, 2005" and inserting "THROUGH 2007" and "December 31, 2007", respectively;

(2) in the heading of paragraph (2)(B), by striking "DURING 2006" and inserting "DURING 2008";

(3) in paragraph (2)(B)(i), by striking "2006" and inserting "2008" each place it appears;

(4) in paragraph (2)(C)(i), by striking "2007" and inserting "2009" each place it appears;

(5) in paragraph (2)(D), by striking "2006" and inserting "2008"; and

(6) in paragraph (4), by striking "2006" and inserting "2008" each place it appears.

SA 970. Mr. BAUCUS (for Mr. DODD) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Section 1860D–19(a) of the Social Security Act, as added by section 101, is amended by adding at the end the following new paragraph:

"(5) REDUCTION OF COST-SHARING FOR ADDITIONAL LOW-INCOME BENEFICIARIES.—

"(A) IN GENERAL.—In the case of an additional low-income beneficiary (as defined in subparagraph (B)), such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 50.0 percent.

"(B) ADDITIONAL LOW-INCOME BENEFICIARY.—Subject to subparagraph (H), the term 'additional low-income beneficiary' means an individual—

"(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

"(ii) whose income is at least 160 percent, but not more than 250 percent, of the poverty line; and

"(iii) who is not—

"(I) a qualified medicare beneficiary;

"(II) a specified low-income medicare beneficiary;

"(III) a qualifying individual;

"(IV) a subsidy-eligible individual; or

"(V) a dual eligible individual.

SA 971. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. . CARVING OUT DSH PAYMENTS FROM PAYMENTS TO MEDICARE+CHOICE AND MEDICAREADVANTAGE ORGANIZATIONS AND PAYING THE AMOUNTS DIRECTLY TO DSH HOSPITALS ENROLLING MEDICARE+CHOICE AND MEDICAREADVANTAGE ENROLLEES.

(a) REMOVAL OF DSH PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(1) UNDER MEDICARE+CHOICE.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3) and as amended by section 203) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)".

(B) by adding at the end the following new subparagraph:

"(E) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).".

(2) UNDER MEDICAREADVANTAGE.—Section 1853(a)(5) (as amended by section 203) is amended by adding at the end the following new subparagraph:

"(C) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).".

(3) EFFECTIVE DATES.—The amendments made—

(A) by paragraph (1) shall apply to plan years beginning on and after January 1, 2004 and shall continue to apply to plan years beginning on and after January 1, 2006; and

(B) by paragraph (2) shall apply to plan years beginning on and after January 1, 2006.

(b) ADDITIONAL DSH PAYMENTS FOR MANAGED CARE ENROLLEES.—Section 1886(d)(5)(F) ((42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking "clause (ix)" and inserting "clauses (ix) and (xvi)"; and

(2) by adding at the end the following new clause:

"(xvi)(I) For portions of cost reporting periods occurring on or after January 1, 2004, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that is a disproportionate share hospital (as described in clause (i)).

"(II) For purposes of this clause the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with a eligible organization under section 1876 and who is entitled to benefits under part A and any individual who is enrolled with a Medicare+Choice organization or a MedicareAdvantage organization under part C.

"(III) The amount of the payment under this clause with respect to any applicable discharge shall be equal to the estimated average per discharge amount that would otherwise have been paid under this subparagraph if the individuals had not been enrolled as described in subclause (II).

"(IV) The Secretary shall establish rules for paying an additional amount for any hospital reimbursed under a reimbursement system authorized under 1814(b)(3) if such hospital would qualify as a disproportionate share hospital under clause (i) were it not so reimbursed. Such payment shall be determined in the same manner as the amount of payment is determined under this clause for disproportionate share hospitals.".

SA 972. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) REIMBURSEMENT.—

(1) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

"(3) in the case of services described in section 1832(a)(2)(D)—

"(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

"(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

"(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

"(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);".

(b) Continuation of MedicareAdvantage Monthly Payments.—

(1) In general.—Section 1853 (42 U.S.C. 1395w-23), as amended by this Act, is amended by adding at the end the following new subsection:

"(j) Payment Rule for Federally Qualified Health Center Services.—If an individual who is enrolled with a MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

"(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

"(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).".

(2) Conforming amendments.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w-21(i)(1)), as amended by this Act, are each amended by inserting "1853(j)," after "1853(i),".

(B) Section 1853(c)(5) is amended by striking "subsections (a)(3)(C)(iii) and (i)" and inserting "subsections (a)(3)(C)(iii), (i), and (j)(1)".

(c) Additional MedicareAdvantage Contract Requirements.—Section 1857(e) (42 U.S.C. 1395w-27(e)) is amended by adding at the end the following new paragraph:

"(3) Agreements with Federally qualified health centers.—

"(A) Payment levels and amounts.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

"(B) Cost-sharing.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).".

(d) Safe Harbor From Antikickback Prohibition.—Section 1128B(b)(3) (42 U.S.C. 1320a-7b(b)(3)) is amended—

(1) in subparagraph (E), by striking "and" after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).".

(e) Effective Date.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

SA 973. Mr. BINGAMAN submitted an amendment to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, insert the following:

SEC. . AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) In General.—Section 1880(e) (42 U.S.C. 1395qq(e)) is amended—

(1) in paragraph (1)(A), by striking "for services described in paragraph (2)" and inserting "for all items and services for which payment may be made under such part";

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) Effective Date.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

SA 974. Mr. GRASSLEY (for himself, Mr. Leahy, Ms. Cantwell, Mr. Durbin, and Mr. Kohl) submitted an amendment to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the amendment, insert the following:

TITLE —DRUG COMPETITION ACT OF 2003

SEC. 01. SHORT TITLE.

This title may be cited as the "Drug Competition Act of 2003".

SEC. 02. FINDINGS.

Congress finds that—

(1) prescription drug prices are increasing at an alarming rate and are a major worry of many senior citizens and American families;

(2) there is a potential for companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs to enter into financial deals that could tend to restrain trade and greatly reduce competition and increase prescription drug expenditures for American citizens; and

(3) enhancing competition among these companies can significantly reduce prescription drug expenditures for Americans.

SEC. 03. PURPOSES.

The purposes of this title are—

(1) to provide timely notice to the Department of Justice and the Federal Trade Commission regarding agreements between companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs; and

(2) by providing timely notice, to enhance the effectiveness and efficiency of the enforcement of the antitrust and competition laws of the United States.

SEC. 04. DEFINITIONS.

In this title:

(1) ANDA.—The term "ANDA" means an Abbreviated New Drug Application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(aa)).

(2) Assistant attorney general.—The term "Assistant Attorney General" means the Assistant Attorney General in charge of the Antitrust Division of the Department of Justice.

(3) Brand name drug.—The term "brand name drug" means a drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)).

(4) Brand name drug company.—The term "brand name drug company" means the party that received Food and Drug Administration approval to market a brand name drug pursuant to an NDA, where that drug is the subject of an ANDA, or a party owning or controlling enforcement of any patent listed in the Approved Drug Products With Therapeutic Equivalence Evaluations of the Food and Drug Administration for that drug, under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)).

(5) Commission.—The term "Commission" means the Federal Trade Commission.

(6) Generic drug.—The term "generic drug" means a product that the Food and Drug Administration has approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(7) Generic drug applicant.—The term "generic drug applicant" means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(8) NDA.—The term "NDA" means a New Drug Application, as defined under section 505(b) et seq. of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b) et seq.)

SEC. 05. NOTIFICATION OF AGREEMENTS.

(a) In General.—

(1) Requirement.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(2)(vii)(IV)) and a brand name drug company that enter into an agreement described in paragraph (2), prior to the generic drug that is the subject of the application entering the market, shall each file the agreement as required by subsection (b).

(2) Definition.—An agreement described in this paragraph is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the subject of the generic drug applicant's ANDA;

(B) the manufacture, marketing or sale of the generic drug that is the subject of the generic drug applicant's ANDA; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(B)(iv)) as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) Filing.—

(1) AGREEMENT.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any such agreement, except that the generic drug applicant and the brand-name drug company shall not be required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

(2) OTHER AGREEMENTS.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any other agreements not described in subsection (a)(2) between the generic drug applicant and the brand name drug company which are contingent upon, provide a contingent condition for, or are otherwise related to an agreement which must be filed under this title.

(3) DESCRIPTION.—In the event that any agreement required to be filed by paragraph (1) or (2) has not been reduced to text, both the generic drug applicant and the brand name drug company shall file written descriptions of the non-textual agreement or agreements that must be filed sufficient to reveal all of the terms of the agreement or agreements.

SEC. 06. FILING DEADLINES.

Any filing required under section 5 shall be filed with the Assistant Attorney General and the Commission not later than 10 business days after the date the agreements are executed.

SEC. 07. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Assistant Attorney General or the Commission pursuant to this title shall be exempt from disclosure under section 552 of title 5, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. 08. ENFORCEMENT.

(a) CIVIL PENALTY.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this title shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this title. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) COMPLIANCE AND EQUITABLE RELIEF.—If any brand name drug company or generic drug applicant fails to comply with any provision of this title, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Commission.

SEC. 09. RULEMAKING.

The Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5 United States Code, consistent with the purposes of this title—

(1) may define the terms used in this title;

(2) may exempt classes of persons or agreements from the requirements of this title; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this title.

SEC. 10. SAVINGS CLAUSE.

Any action taken by the Assistant Attorney General or the Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this title shall not bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant at any time under any other provision of law, nor shall any filing under this title constitute or create a presumption of any violation of any antitrust or competition laws.

SEC. 11. EFFECTIVE DATE.

This title shall—

(1) take effect 30 days after the date of enactment of this title; and

(2) shall apply to agreements described in section 05 that are entered into 30 days after the date of enactment of this title.

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON RULES AND ADMINISTRATION

Mr. LOTT. Mr. President, I wish to announce that the Committee on Rules and Administration will meet on Tuesday, June 24, 2003, at 9:30 a.m., in room 301 of the Russell Office Building, to consider the markup of pending legislative and administrative business, including any other items that may be ready for consideration.

For further information concerning this meeting, please contact Susan Wells at 202-224-6352.

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. COCHRAN. Mr. President, the Committee on Agriculture, Nutrition and Forestry will hold a full committee hearing on Thursday, June 26, 2003, at 9 a.m., in SR-328A, Russell Senate Office Building. The purpose of this hearing is to review H.R. 1904, the Healthy Forests Restoration Act of 2003. Witnesses to be announced at a later date.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. THOMAS. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Friday, June 20, 2003, at 9:30 a.m., in closed session to receive briefing on Iraqi reconstruction and humanitarian assistance activities.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGE OF THE FLOOR

Mr. GRAHAM. Mr. President, I ask unanimous consent that Mr. James Holloway, Derrick Walters, and Mindy Yergin, interns and members of my staff, be granted floor privileges during the consideration of this legislation.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE PLACED ON CALENDAR—H.R. 8

Mr. FRIST. Mr. President, I understand that H.R. 8 is at the desk and is due for a second reading.

The PRESIDING OFFICER. The clerk will read the bill for a second time.

The assistant legislative clerk read as follows:

> A bill (H.R. 8) to make the repeal of the estate tax permanent.

Mr. FRIST. I ask unanimous consent that the Senate proceed to the measure and I object to further proceeding.

The PRESIDING OFFICER. Objection is heard. The bill will be placed on the calendar.

AMENDING THE COMMUNICATIONS SATELLITE OF 1962

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of H.R. 2312.

The PRESIDING OFFICER. The clerk will state the bill by title.

The assistant legislative clerk read as follows:

> A bill (H.R. 2312) to amend the Communications Satellite of 1962 to provide for an orderly dilution of the ownership interest in Inmarsat by former signatories to the Inmarsat Operations Agreement.

There being no objection, the Senate proceeded to the bill.

Mr. FRIST. Mr. President, I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 2312) was read the third time and passed.

AUTHORIZING PRINTING OF BROCHURES ENTITLED "HOW OUR LAWS ARE MADE"

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H. Con. Res. 139, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

> A concurrent resolution (H. Con. Res 139) authorizing printing of the brochures entitled "How Our Laws Are Made in Our American Government" and so forth.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, and the motion to reconsider be laid upon the table, with no intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 139) was agreed to.

POISON CONTROL CENTER ENHANCEMENT AND AWARENESS ACT AMENDMENTS OF 2003

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of calendar No. 133, S. 686.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will state the bill by title.

The assistant legislative clerk read as follows:

A bill (S. 686) to provide assistance for poison prevention and to stabilize the funding of regional poison control centers.

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Health, Education, Labor, and Pensions, with an amendment to strike all after the enacting clause and inserting in lieu thereof the following:

[Strike the part shown in black brackets and insert the part shown in italic.]

S. 686

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[SECTION 1. SHORT TITLE.

[This Act may be cited as the "Poison Control Center Enhancement and Awareness Act Amendments of 2003".

[SEC. 2. FINDINGS.

[Section 2 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14801) is amended to read as follows:

["SEC. 2. FINDINGS.

["Congress finds the following:

["(1) Poison control centers are our Nation's primary defense against injury and deaths from poisoning. Twenty-four hours a day, the general public as well as health care practitioners contact their local poison centers for help in diagnosing and treating victims of poisoning and other toxic exposures.

["(2) Poisoning is the third most common form of unintentional death in the United States. In any given year, there will be between 2,000,000 and 4,000,000 poison exposures. More than 50 percent of these exposures will involve children under the age of 6 who are exposed to toxic substances in their home. Poisoning accounts for 285,000 hospitalizations, 1,200,000 days of acute hospital care, and 13,000 fatalities annually.

["(3) Stabilizing the funding structure and increasing accessibility to poison control centers will promote the utilization of poison control centers, and reduce the inappropriate use of emergency medical services and other more costly health care services.

["(4) The tragic events of September 11, 2001, and the anthrax cases of October 2001, have dramatically changed our Nation. During this time period, poison centers in many areas of the country were answering thousands of additional calls from concerned residents. Many poison centers were relied upon as a source for accurate medical information about the disease and the complications resulting from prophylactic antibiotic therapy.

["(5) The 2001 Presidential Task Force on Citizen Preparedness in the War on Terrorism recommended that the Poison Control Centers be used as a source of public information and public education regarding potential biological, chemical, and nuclear domestic terrorism.

["(6) The increased demand placed upon poison centers to provide emergency information in the event of a terrorist event involving a biological, chemical, or nuclear toxin will dramatically increase call volume.".

[SEC. 3. MAINTENANCE OF A NATIONAL TOLL FREE NUMBER.

[Section 4 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14803) is amended—

[(1) by striking the section heading and inserting the following:

["SEC. 4. MAINTENANCE OF A NATIONAL TOLL-FREE NUMBER.";

[and

[(2) in subsection (c), by inserting "and $2,000,000 for each of fiscal years 2005 through 2009" after "2004".

[SEC. 4. NATIONWIDE MEDIA CAMPAIGN.

[Section 5 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14804) is amended—

[(1) by striking the section heading and inserting the following:

["SEC. 5. NATIONWIDE MEDIA CAMPAIGN TO PROMOTE POISON CONTROL CENTER UTILIZATION.";

[and

[(2) in subsection (c), by inserting "and $1,500,000 for each of fiscal years 2005 through 2009" after "2004".

[SEC. 5. POISON CONTROL CENTER GRANT PROGRAM.

[Section 6 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14805) is amended—

[(1) by striking the section heading and inserting the following:

["SEC. 6. MAINTENANCE OF THE POISON CONTROL CENTER GRANT PROGRAM.";

[(2) by striking subsection (b) and inserting the following:

["(b) OTHER IMPROVEMENTS.—The Secretary shall also use amounts received under this section to—

["(1) develop standardized poison prevention and poison control promotion programs;

["(2) develop standard patient management guidelines for commonly encountered toxic exposures;

["(3) improve and expand the poison control data collection systems;

["(4) improve national toxic exposure surveillance;

["(5) expand the toxicologic expertise within poison control centers; and

["(6) improve the capacity of poison control centers to answer high volumes of calls during times of national crisis";

[(3) by striking subsection (d)(2) and inserting the following:

["(2) RENEWAL.—The Secretary may renew a waiver under paragraph (1).

["(3) LIMITATION.—In no instance may the sum of the number of years for a waiver under paragraph (1) and a renewal under paragraph (2) exceed 5 years. The preceding sentence shall take effect as if enacted on February 25, 2000."; and

[(4) in subsection (h), by inserting "and $30,000,000 for each of fiscal years 2005 through 2009" after "2004".

[SEC. 6. NATIONWIDE TOXICOSURVEILLANCE OF POISON CENTER DATA TO PROMOTE HAZARD DETECTION.

[The Poison Control Enhancement and Awareness Act (42 U.S.C. 14801 et seq.) is amended by adding at the end the following:

["SEC. 7. NATIONWIDE TOXICOSURVEILLANCE OF POISON CENTER DATA TO PROMOTE HAZARD DETECTION.

["(a) IN GENERAL.— The Secretary shall assist in the implementation and maintenance of continuous national toxicosurveillance of poison control center data to detect new hazards from household products, pharmaceuticals, traditionally abused drugs, and other toxic substances.

["(b) CONTRACT FOR SERVICES.—The Secretary may enter into a contract with appropriate professional organizations for the collection and analysis of poison center data described in subsection (a) in real time.

["(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $2,500,000 for each of fiscal years 2005 through 2009.".]

SECTION 1. SHORT TITLE.

This Act may be cited as the "Poison Control Center Enhancement and Awareness Act Amendments of 2003".

SEC. 2. FINDINGS.

Section 2 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14801) is amended to read as follows:

"SEC. 2. FINDINGS.

"Congress finds the following:

"(1) Poison control centers are our Nation's primary defense against injury and deaths from poisoning. Twenty-four hours a day, the general public as well as health care practitioners contact their local poison centers for help in diagnosing and treating victims of poisoning and other toxic exposures.

"(2) Poisoning is the third most common form of unintentional death in the United States. In any given year, there will be between 2,000,000 and 4,000,000 poison exposures. More than 50 percent of these exposures will involve children under the age of 6 who are exposed to toxic substances in their home. Poisoning accounts for 285,000 hospitalizations, 1,200,000 days of acute hospital care, and 13,000 fatalities annually.

"(3) Stabilizing the funding structure and increasing accessibility to poison control centers will promote the utilization of poison control centers, and reduce the inappropriate use of emergency medical services and other more costly health care services.

"(4) The tragic events of September 11, 2001, and the anthrax cases of October 2001, have dramatically changed our Nation. During this time period, poison centers in many areas of the country were answering thousands of additional calls from concerned residents. Many poison centers were relied upon as a source for accurate medical information about the disease and the complications resulting from prophylactic antibiotic therapy.

"(5) The 2001 Presidential Task Force on Citizen Preparedness in the War on Terrorism recommended that the Poison Control Centers be used as a source of public information and public education regarding potential biological, chemical, and nuclear domestic terrorism.

"(6) The increased demand placed upon poison centers to provide emergency information in the event of a terrorist event involving a biological, chemical, or nuclear toxin will dramatically increase call volume.".

SEC. 3. MAINTENANCE OF A NATIONAL TOLL FREE NUMBER.

Section 4 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14803) is amended—

(1) by striking the section heading and inserting the following:

"SEC. 4. MAINTENANCE OF A NATIONAL TOLL-FREE NUMBER.";

and

(2) in subsection (c), by inserting "and $2,000,000 for each of fiscal years 2005 through 2009" after "2004".

SEC. 4. NATIONWIDE MEDIA CAMPAIGN.

Section 5 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14804) is amended—

(1) by striking the section heading and inserting the following:

"SEC. 5. NATIONWIDE MEDIA CAMPAIGN TO PROMOTE POISON CONTROL CENTER UTILIZATION.";

and

(2) in subsection (c), by inserting "and $1,500,000 for each of fiscal years 2005 through 2009" after "2004".

SEC. 5. POISON CONTROL CENTER GRANT PROGRAM.

Section 6 of the Poison Control Enhancement and Awareness Act (42 U.S.C. 14805) is amended—

(1) by striking the section heading and inserting the following:

"SEC. 6. MAINTENANCE OF THE POISON CONTROL CENTER GRANT PROGRAM.";

(2) by striking subsection (b) and inserting the following:

"(b) Other Improvements.—The Secretary shall also use amounts received under this section to—

"(1) develop standardized poison prevention and poison control promotion programs;

"(2) develop standard patient management guidelines for commonly encountered toxic exposures;

"(3) improve and expand the poison control data collection systems;

"(4) improve national toxic exposure surveillance;

"(5) expand the toxicologic expertise within poison control centers; and

"(6) improve the capacity of poison control centers to answer high volumes of calls during times of national crisis";

(3) by striking subsection (d)(2) and inserting the following:

"(2) Renewal.—The Secretary may renew a waiver under paragraph (1).

"(3) Limitation.—In no instance may the sum of the number of years for a waiver under paragraph (1) and a renewal under paragraph (2) exceed 5 years. The preceding sentence shall take effect as if enacted on February 25, 2000."; and

(4) in subsection (h), by inserting "and $30,000,000 for each of fiscal years 2005 through 2009" after "2004".

SEC. 6. NATIONWIDE TOXICOSURVEILLANCE OF POISON CENTER DATA TO PROMOTE HAZARD DETECTION.

The Poison Control Enhancement and Awareness Act (42 U.S.C. 14801 et seq.) is amended by adding at the end the following:

"SEC. 7. NATIONWIDE TOXICOSURVEILLANCE OF POISON CENTER DATA TO PROMOTE HAZARD DETECTION.

"(a) In General.—The Secretary shall assist in the implementation and maintenance of continuous national toxicosurveillance of poison control center data to detect new hazards from household products, pharmaceuticals, traditionally abused drugs, and other toxic substances.

"(b) Competitive Grant or Contract for Services.—The Secretary may enter into a competitive grant or contract with a university, academic center, or other appropriate professional organization for the collection and analysis of poison center data described in subsection (a) in real time.

"(c) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, $2,500,000 for each of fiscal years 2005 through 2009.".

Mr. FRIST. Mr. President, I ask unanimous consent that the committee amendment be agreed to, the bill, as amended, be read the third time and passed, the motion to reconsider laid upon the table, and that any statements relating to the bill be printed in the Record.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendment in the nature of a substitute was agreed to.

The bill (S. 686), as amended, was read the third time and passed.

A PRODUCTIVE WEEK

Mr. FRIST. Mr. President, as I mentioned earlier, we have had a productive week. We have moved forward and we have debated and we have amended the prescription drug Medicare bill. We have discussed such issues as asset testing, generic drugs, and appropriate premiums. Yesterday we discussed drug reimportation and the issue surrounding pharmacies and mail order prescriptions. We have made good progress over the last 5 days on this legislation. I want to express my sincere appreciation to my colleagues for their attention and for their very diligent participation. If we look back over the last several days, we see some other things we have been able to accomplish at the same time we have been on this bill.

Indeed, the Senate has had H.R. 389, which will help increase public access to defibrillation in schools. We passed a series of bills reported by Chairman Domenici and the Energy Committee relating to historic sites and trails to watershed studies and to recreation areas. We passed S. 1276, which strengthens the AmeriCorps program and allows our national volunteer program to be more efficient.

This week we were able to adopt a conference report to accompany S. 342, the Keeping Children and Families Safe Act. This bill will assist in the dissemination of information of child abuse programs and the availability of psychological services for child victims.

The Senate also agreed to conference with the House on the child tax credit legislation, allowing that bill to move forward and differences between this body and the House to be worked out.

Lastly—this reminds me that on tomorrow, summer begins officially—with the approach of summer, I would be remiss if I did not mention that the Senate passed S. 1015, the Mosquito Abatement for Safety and Health Act. This legislation authorizes grants for mosquito control programs to prevent mosquito-borne diseases.

This morning—again, I have great delight because it was on behalf and at the instigation of and with the leadership of my colleague from the great State of Tennessee, Senator Alexander, who brought forth the bill—the American History and Civics Education Act passed unanimously on a rollcall vote.

Next week we will resume the prescription drug/Medicare bill, and hopefully we will pass that—not hopefully, I am confident we will pass that bill prior to the beginning of the July 4 recess.

I thank all of my colleagues.

ORDERS FOR MONDAY, JUNE 23, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 2 p.m., Monday, June 23. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of S. 1, the prescription drug benefits/Medicare bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Mr. President, for the information of all Senators, on Monday the Senate will resume consideration of S. 1, the prescription drug benefits bill. Several Senators have indicated they will be available during Monday's session to offer amendments. As of now, we have 14 pending amendments that are being reviewed. On Monday, we will continue to process amendments and hopefully begin the scheduling of votes on those amendments that have been offered. Our next rollcall vote will begin at approximately 5:30 p.m. on Monday. I anticipate the vote will be in relation to an amendment to the prescription drug benefits bill. As always, we will notify Members once that vote is scheduled.

ORDER FOR ADJOURNMENT

Mr. FRIST. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order following the remarks of Senator Byrd for up to 60 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from West Virginia.

Mr. BYRD. Mr. President, I thank the distinguished majority leader for his courtesy in arranging for me to speak briefly. When I say "briefly," that means perhaps an hour.

Mr. FRIST. If the Senator from West Virginia will yield.

Mr. BYRD. Yes, I yield.

Mr. FRIST. People are going to begin saying the same thing about me, that laughter coming as we are here on Friday afternoon. I say I am going to speak briefly, and I go on for 45 minutes. I have a feeling I am following in Senator BYRD's footsteps.

Mr. BYRD. I thank the majority leader.

TRIBUTE TO SENATOR RUSSELL B. LONG

Mr. BYRD. Mr. President, Cicero was asked which of Demosthenes' speeches he most admired. Cicero's answer was: The longest. By the way, Demosthenes committed suicide. He carried some poison in a bracelet and he committed suicide. While I admire Demosthenes, I do not hope to follow his course in that regard.

The greatest oration that was ever delivered was the Oration on the Crown by Demosthenes. In that oration, he asked the question: Who deceives the State? He answered his own question. He who does not speak what he thinks.

God, give us men!
A time like this demands strong minds,
great hearts, true faith, and ready hands.
Men whom the lusts of office do not kill;
Men whom the spoils of office cannot buy;
Men who possess opinions and a will;
Men who have honor; men who will not lie.
Men who can stand before the demagogue
And brave his treacherous flatteries without winking.
Tall men, sun-crowned;
Who live above the fog,
In public duty and in private thinking.
For while the rabble with its thumbworn creeds,
It's large professions and its little deeds, mingles in selfish strife,
Lo! Freedom weeps!
Wrong rules the land and waiting justice sleeps.
God, give us men.
Men who serve not for selfish booty;
But real men, courageous, who flinch not at duty.
Men of dependable character;
Men of sterling worth;
Then wrongs will be redressed, and right will rule the earth.
God, give us Men!

Mr. President, those lines by J. G. Holland call my reflections to a man who served in the Senate with me a good many years ago. For 38 years, Russell B. Long was a giant among the giants of the U.S. Senate. Although not a large man, his mere presence on the Senate floor was overpowering. His accomplishments were enormous, and I am confident in saying that his legacy will prove to be long lasting. He was a Senator's Senator.

He sat here in this row of seats where I now stand. Mr. Mansfield sat in the chair at the desk just in front of me. The greatest Senator of all, in my public career, was another Southerner whose name was Richard Brevard Russell, and he sat at the seat which I now have the honor to fill. At the desk behind me was Russell B. Long.

He was a man of powerful intellect. He was a walking history blessed with common sense and a sharp, clear mind. He could keep one entertained for hours with his down-home stories, his folksy humor, and memories of his remarkable and controversial family.

His father, Huey P. Long, was called the Kingfish in Louisiana. His father was the legendary populist Governor and Senator from Louisiana, Huey Long. Russell's self-effacing mother, Rose, who Russell Long said was the "nearest thing I knew to an angel"—now that is putting it right. "The nearest thing I knew to an angel." That was Russell Long's way of referring to his mother.

His mother served briefly in the U.S. Senate following the assassination of her husband. So here you have the husband, the wife, and the son all serving in the U.S. Senate at different times, of course.

Born in Shreveport, LA, in 1918, Russell B. Long received his undergraduate and law degrees from Louisiana State University. He served as a naval officer during World War II and practiced law after the war.

On November 2, 1948, he was elected to the U.S. Senate. I was in the West Virginia House of Delegates at that time. So Russell Long was elected to the U.S. Senate 1 day before his 30th birthday, making him the sixth person to be elected to the Senate under the age of 30. When he retired from the Senate in 1986, he had served longer than all but three other Senators in history at that time.

His love for this institution and his respect for this institution's traditions were always evident. He opposed television coverage in the U.S. Senate. He and I were both together in feeling that way about it at that particular time. We both opposed television coverage in the Senate at that point.

He opposed the efforts to limit Senate filibusters. I opposed them with him. I joined in filibusters with him. And I today oppose efforts to eliminate the filibuster in the U.S. Senate, and I always will oppose those efforts.

He did so, meaning he opposed the elimination of the filibuster and any efforts to eliminate it, because he cared so much about preserving the unique role of the U.S. Senate in American Government and American society.

During his tenure in the Senate, Russell Long served on a number of important committees, including the Commerce, Science, and Transportation Committee, the Banking and Currency Committee, and the Armed Services Committee.

In 1965, his Democratic colleagues elected him—and I was here at that time to cast my vote for him—to serve as the Senate Democratic whip, the post he held until 1969. I was the secretary of the Democratic conference at that particular time, and I believe I sat on the back row over here.

It was on January 10, 1966, that another legend was born, and that was the day that Senator Long became chairman of the Senate Finance Committee, a position he held for 15 years, the longest continuous service in the history of that committee. As chairman of this powerful Senate committee, Senator Long displayed such a command of the subject matter and demonstrated such skillful management abilities that during floor debates Senators would line up at his desk seeking his encyclopedic memory and knowledge about complicated tax provisions. In fact, on most of the landmark tax and trade legislation during that time one can see the imprint of this remarkable Senator, Russell Long.

His was a powerful voice on health care finance and Social Security. His genius fathered ESOP, the employee stock ownership plan concept, which enabled the workers and management at Weirton Steel in Weirton, WV, to keep the plant from closing in 1982. Russell Long went with me, and with the late Senator Jennings Randolph, my colleague at the time, to Weirton Steel and talked with the employers and employees, the people, the citizens, about the ESOP plan. That plan was applied and it preserved the jobs of 8,500 employees.

Russell Long's legislative achievements included the 1972 and 1976 Federal revenue sharing laws and the 1969 and 1976 tax reform laws. I wish he were here today. Indeed, his work on the Nation's tax laws continued throughout his years in the Senate. In 1986, his last year in this Chamber, he helped to write a major simplification of income tax law.

President Jimmy Carter liked to say that he was elected President and came to Washington to run the country but that when he got here, he discovered that Russell Long was already running it.

Senator Long's colleague from Louisiana at that time, Senator Bennett Johnson, used to point out that President Carter was probably exaggerating but not by much.

Russell Long's success as a Senator is largely attributable to his skills as a debater and speaker, and his skills as a technician and craftsman in the writing of tax laws. These are skills which he likely inherited from his dynamic father. Those skills included his formidable ability as one of the Senate's best negotiators.

President John F. Kennedy once told him:

> You traded me a biscuit for a barrel of flour and I didn't even get a biscuit.

Following the Republican landslide of 1980 in which Ronald Reagan was elected President and the Republican

Party gained the majority in the Senate, Senator Howard Baker, who had become the new Senate majority leader, telephoned Senator Robert Dole to congratulate Senator Dole on his new role as chairman of the Senate Finance Committee. The story goes that Senator Dole responded:

> Howard, that is great, but who is going to tell Russell Long?

I enjoy that story. It demonstrates both the power and the respect that Senator Russell Long commanded as a U.S. Senator and as chairman of the Senate Finance Committee. No wonder the Wall Street Journal once referred to Russell Long as the fourth branch of Government. Journalists, as well as Presidents and Senators, revered and enjoyed this colorful man, and brilliant Senator. During his 38 years in the Senate, Russell B. Long truly became an institution within this institution.

I missed Russell Long when he left the Senate. Erma and I missed his lovely wife Carolyn. I called Carolyn a few minutes ago to speak with her about her late husband Russell Long. I told her I was going to have a few words to say about Russell, and I asked her to listen in if she liked.

I close this short statement about Russell Long with a poem by Thomas Moore, that great Irishman. The title of the poem is "The Light of Other Days."

I dedicate these words by Thomas Moore to Carolyn, and in so doing, of course, I think about my own service in this Chamber with Russell Long.

Oft, in the stilly night,
Ere slumber's chain as bound me,
Fond memory brings the light
Of other days around me:
The smiles, the tears,
Of boyhood's years,
The words of love then spoken:
The ayes that shone,
Now dimm'd and gone,
The cheerful hearts now broken.
Thus, in the stilly night,
Ere slumber's chain has bound me,
Sad memory brings the light
Of other days around me.
When I remember all
The friends, so link'd together,
I've seen around me fall
Like leaves in wintry weather,
I feel like one
Who treads alone
Some banquet-hall deserted,
Whose lights are fled,
Whose garland's dead,
And all but he departed.
Thus, in the stilly night,
Ere slumber's chain has bound me,
Sad Memory brings the light
Of other days around me.

HAPPY 140TH BIRTHDAY, WEST VIRGINIA

Mr. BYRD. Mr. President, today is the 140th birthday of West Virginia:

West Virginia, how I love you!
Every streamlet, shrub and stone,
Even the clouds that flit above you
Always seem to be my own.

Your steep hillsides clad in grandeur,
Always rugged, bold and free,
Sing with ever swelling chorus:
Montani, Semper, Liberi!

Always free! The little streamlets,
As they glide and race along,
Join their music to the anthem
And the zephyrs swell the song.

Always free! The mountain torrent
In its haste to reach the sea,
Shouts its challenge to the hillsides
And the echo answers "FREE!"

Always free! Repeats the river
In a deeper, fuller tone
And the West wind in the treetops
Adds a chorus all its own.

Always Free! The crashing thunder,
Madly flung from hill to hill,
In a wild reverberation
Makes our hearts with rapture fill.

Always free! The Bob White whistles
And the whippoorwill replies,
Always free! The robin twitters
As the sunset gilds the skies.

Perched upon the tallest timber,
Far above the sheltered lea,
There the eagle screams defiance
To a hostile world: "I'm free!"

And two million happy people,
Hearts attuned in holy glee,
Add the hallelujah chorus:
"Mountaineers are always free!"

It is that time of year again.

It is that time when the flowers are in full bloom and birds are chirping the sweetest and the loudest. It is that time when you feel most like breathing the clean, fresh air blowing in from the Appalachian mountains. The time of year when you feel most like taking your loved one by the hand and strolling, arm in arm, through your favorite park knowing that all is right with the world—and all is right with the world because it is West Virginia Day!

June 20 is West Virginia Day. I am celebrating this glorious day. It was 140 years ago that West Virginia became a State. It was on June 20, 1863, the Reverend J.T. McLure offered the State's inaugural prayer. Referring to the fact that the State was created in the middle of the American Civil War, he prayed:

> We pray Thee, almighty God, that this State, born amidst tears and blood and fire and desolation, may long be preserved and from its little beginning may grow to be a might and a power that shall make those who come after us look upon it with joy and gladness and pride of heart.

I am pleased and proud to say, 140 years later, that I can look upon my West Virginia with "joy and gladness and pride of heart." On this West Virginia Day, I again want to speak about the people of West Virginia, the hardest-working and most patriotic people in the United States. They have endured hardships, poverty, and floods of biblical proportions, but have remained loyal to their State and our Nation. Whenever the country has needed them, in war or in peace, they have always been there, and I have always been so proud to represent them in the United States Senate.

On this West Virginia Day, I again speak about the splendors of my State—truly one of the most beautiful states in the Nation. With its rushing, trout-filled mountain streams, its majestic rolling green hills, picturesque villages and towns, magnificent forests, scenic state parks—no wonder the State has been depicted in song and verse as being "almost heaven." There are the State's natural beauties like Seneca Rocks and the New River Gorge. I hope the pages will go and see these scenic beauties in this State that is almost heaven. There are the State's natural wonders like Cranberry Glades, Hawks Nest, and Berkeley Springs.

You can go camping in West Virginia's beautiful parks like Cooper's Rock State Forest, Babcock, Pipestem, or Watoga. You can go fishing in the Greenbrier River, Holly River, and Tygart Lake. You can take a ski trip in the wondrous Canaan Valley, or go white-water rafting down the magnificent Cheat River, go hiking along the awesome Appalachian Trail.

Simply drive around the State and enjoy a pace and a view far different than the drives most of us suffer through daily. I invite my colleagues, I invite the media, I invite the people in the galleries, people everywhere, to take a drive in West Virginia. You will love it. You will never forget it. There is nothing like it elsewhere in the world. West Virginia. Almost heaven.

I invite the Democratic pages and the Republican pages, our staffs. I have often spoken enthusiastically of the "wild and wonderful" scenery of West Virginia. Therefore, on this, the 140th anniversary of my great and glorious State, I want to tell you about its history.

Some of my State's history is well-known and well-documented: like the fact that it is the only State created from another State without the parent State's permission, and that it is the only State to achieve statehood by the proclamation of a president, Abraham Lincoln. It can be argued that the first battle of the American Revolution took place at Point Pleasant and that the last battle of the Revolution was fought at Fort Henry, in Wheeling. The State is rich in Civil War history: at Harpers Ferry, John Brown began the bloody quest to finally eliminate the scourge of slavery from this nation, and the first significant land battle of the Civil War took place at Phillipi, on June 3, 1861.

But there is another, lesser known, side to my State's history that I want to talk about today—a history that shows what a unique, diversified, and fascinating state West Virginia really is.

Most of my colleagues are aware that West Virginia's political history includes providing the Senate's Majority Leader, the Senate's Minority Leader, the chairman of the Senate Appropriation's Committee, and the second longest serving Senator in American history—and that was all one person—who? Me. But I proudly point out that my State's political history includes the first African American woman, Minnie Buckingham Harper of Welch, to ever serve in a State legislature. That was in 1928. In 1934, West Virginians elected one of the youngest persons ever elected by popular vote to the United States Senate—Rush D. Holt. His son, Rush Holt, now represents the State of New Jersey in the House of Representatives.

Most people are aware of the importance of coal to West Virginia, and the importance of West Virginia coal to the Nation. For nearly a century, West Virginia coal helped fuel America's industries, heat our homes and power our battleships. But West Virginia's natural resources have also included America's first natural gas well, in 1815, near Charleston, and the world's largest gas well, "Big Moses" in Tyler County, which was drilled in 1894 and produced 100,000,000 cubic feet of gas per day. In 1941, the first and largest synthetic rubber plant in the United States began operation near Charleston.

There is so much to see and do in West Virginia. Come on down. Come on down to West Virginia. There is nature. There is beauty. There is history. And the State's modern highway system. I can remember when, while serving in the West Virginia Legislature in 1947, seeing that State as a State without a single mile of divided 4-lane highway on the 1947 highway map. Think of that. A 1947 highway map shows not a single mile, not one in the whole State, of divided 4-lane highway. Oh, but what a change.

With the State's modern highway system, you can drive to Weirton, WV, and see the only city in the United States that stretches from a State's eastern border all the way to its western border.

At Grafton, WV, you can visit Andrews Church, which, on May 10, 1908, was the site of the first celebration of Mother's Day. Just a few hours away, near Thomas, WV, is a unique, picturesque little church, Our Lady of the Pines, once considered the smallest church in the United States.

You can travel to Charles Town, WV, and see where rural free mail delivery began in 1896 and see the Court House in which more than 500 coal miners went on trial for treason and insurrection in 1922.

Speaking of labor history, drive over to Martinsburg and see where the great railroad strike of 1877 began, or down to Logan County, WV, and view the site of the largest labor uprising in American history, the Battle of Blair Mountain.

West Virginia also has a fascinating business history. The first trust in the United States was the salt trust organized in 1817 by the salt manufacturers along the Kanawha River.

The first patent for a soda fountain—if you have ever taken your girl to the soda fountain? What a great memory that is. I used to walk 3 miles to take my girlfriend at that time—she's my wife now, after 66 years—I took her to the soda fountain. And I would buy a quart of ice cream. It just cost 5 cents in those days.

The first patent for a soda fountain was granted to George Dulty, of Wheeling, WV, in 1833 and outdoor advertising had its origins in that same city in 1908. The first municipally owned parking building in the United States opened in Welch—that is in Dowell County. The very Southern point of West Virginia—in 1941.

Sports history, West Virginia has that too. Colliers, WV, on June 1, 1880, was the site of the first barenuckles heavyweight championship fight. At Burnsville, in 1960, Danny Heater scored 135 points in a single basketball game, for which he is in the Guinness Book of World Records. Can you believe that, 135 points in a basketball game?

Finally, let me invite you to drive over to Ritchie County, WV, and see where history was made when a Mountain was made from a Mole Hill—literally. It actually happened. It happened when the good people of the town of Mole Hill, WV, decided to change the name of their town to Mountain. They changed it from a "molehill' into a "mountain."

On this the 140th anniversary of West Virginia, we will welcome you.

On this, the 140th anniversary of West Virginia, I say happy birthday, West Virginia. Come on down to West Virginia. Congratulations, West Virginia.

"Born amidst tears and blood and fire and desolation," in the words of Reverend Mr. McLure, from a "little beginning" you have grown "to be a might and a power" that has made us look upon you "with joy and gladness and pride of heart."

This was no land for lily-fingered men
Who bowed and scraped and danced a neat quadrille,
In towns and cities far beyond the ken
Of mountaineers—who loved each rock and rill.

It was a place for lean, tall men with love
For freedom flowing strongly in their veins,
For those attuned to vagrant stars above,
To rugged peaks, deep snows and June-time rains.

And so our State was whelped in time of strife
And cut its teeth upon a cannon ball;
Its heritage was cleaner, better life,
Within the richest storehouse of them all.

With timber, oil and gas and salt and coal,
It bargained in the world's huge marketplace.
The mountain empire reached a mighty goal;
It never ran a pauper's sordid race.

And best of all, it sired a hardy flock
Whose fame will grow with centuries to be,
Tough as a white-oak stump or limestock rock,
The mountaineers—who always shall be free.

CLEARING AWAY THE MUD AND MUCK

Mr. BYRD. Mr. President, Mother Nature has once again, as I have seen so many times, dealt West Virginia a heavy blow. For more than a week, heavy rains have spawned flash floods and mudslides. The storms have resulted in millions of dollars in damages to homes and businesses in Central and Southern West Virginia, damage so significant that yesterday Governor Bob Wise requested a Federal disaster declaration for the counties.

His request seeks Federal aid for Boone, Cabell, Kanawha, Lincoln, Logan, Mason, McDowell, Mingo, Putnam, and Wayne counties.

The need for help is abundantly clear. Hundreds and hundreds of homes have been washed away or significantly damaged because of the storms. Mudslides continue to threaten communities nestled along West Virginia's many mountains, mudslides that could be triggered with just a little more rain or a little more wind. Thousands of West Virginians have been without power, without telephone service, and without utility service. Bridges and roads have literally been wiped off the map, isolating communities that already are working to pick themselves up from this devastation.

Make no mistake, West Virginians are committed to rebuilding.

So many times I have seen them after a flood, if the homes were still standing, go right back into those homes, or, if the homes were gone, building another home and going right back into those homes.

So they are committed to rebuilding their lives. But they need help to get back on their feet.

As I have just indicated, today is West Virginia Day—a day normally set aside to celebrate the anniversary of the Mountain State becoming a full-fledged partner in this union of States. There will not be much celebrating today in these storm-ravaged counties. But we do celebrate the West Virginia spirit that has shined throughout the years, and in that same spirit that has shined throughout this disaster. It is a spirit that can never be washed away, no matter how heavy the rains come, and no matter how deep the floods.

Thousands of Mountain State residents have taken part in the recover effort. I applaud them. Like so many before them among those West Virginia hills, they have filled sandbags and carried pets to safety. They have pulled people from homes just before the onrushing waters came rolling in. It is no surprise. Helping neighbors in need is the West Virginia way.

It is with regret that I inform the Senate that that West Virginia spirit may have cost one man his life. In Lincoln County, in the town of Spurlockville, 37-year-old Joey Roberts was trying to give a hand to a friend whose car had stalled in waist-high water. The friend was trying to cross the Mud River in an area that normally is shallow enough for passage. But not on this day. The waters were just too much. When trying to help, Mr. Roberts slipped and fell. His body was recovered some time later. Our thoughts and prayers are with his family, and with all of the families who are struggling to regain some sense of safety and normalcy amid these storms.

I hope that the request for Federal disaster assistance is approved quickly. Every moment counts in the recovery efforts, and every little bit of help is crucial.

Mr. President, I yield the floor.

ADJOURNMENT UNTIL 2 P.M., MONDAY, JUNE 23, 2003

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 2 p.m. on Monday.

Thereupon, the Senate, at 3:56 p.m., adjourned until Monday, June 23, 2003, at 2 p.m.

EXTENSIONS OF REMARKS

RECOGNIZING GAIL L. WARDEN

HON. SANDER M. LEVIN

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. LEVIN. Mr. Speaker, I rise today to recognize Gail L. Warden, who will receive the Lifetime of Idealism award from City Year at City Year Detroit's annual Ripples of Hope Dinner on June 19, 2003.

The Lifetime of Idealism award is the highest award City Year bestows. Previous recipients of this coveted award include former President William Jefferson Clinton and Senator JOHN MCCAIN. This year, Gail Warden will be honored for fulfilling City Year's mission of "building democracy through national service" because of his long and distinguished career in the field of health care and his involvement in his community.

Gail Warden graduated from Dartmouth College and earned a master's degree in health care management from the University of Michigan. He received an honorary doctorate in public administration from Central Michigan University. Gail Warden has recently retired from the positions of president and chief executive officer of Henry Ford Health System, which serves approximately 70,000 patients each year.

Gail Warden's dedication to healthcare is exemplary. He is an elected member of the Institute of Medicine of the National Academy of Sciences, and he has served on its Governing Council and on its Board of Health Care Services and its Committee on Quality Health Care in America.

Gail Warden chairs the National Forum on Health Care Quality Measurement and Reporting, the Healthcare Research and Development Institute, and the National Center for Healthcare Leadership. In 1995 Gail Warden chaired the American Hospital Association Board of Trustees, and in 1997 President Clinton appointed him to the Federal Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

It is important to note that this list, though long, represents only part of the service Gail Warden has rendered to others. Indeed all that he has achieved in the field of healthcare, including being named one of Modern Healthcare's "100 Most Powerful People in Healthcare" in 2002 or one of Modern Health Care Magazine's top 25 individuals in the industry over the past 25 years in 2001, show only part of his character.

True to his nature, upon learning that he might be named for the Lifetime of Idealism award, he insisted that others were far more deserving. In the words of one of his colleagues, Gail Warden "seeks no recognition and argues that what we consider to be his extraordinary contributions . . . are a privilege unworthy of comment." It is, however, precisely this attitude which entitles him to our admiration and our thanks.

I have been privileged to witness Gail Warden's good works on many occasions, each of which has only increased my admiration for him. I ask my colleagues to join me in offering a heartfelt tribute to Gail Warden for all his work on behalf of our community and citizens.

* * *

A CALL FOR ACTION: GEOGRAPHIC ADJUSTMENT OF PHYSICIAN WORK NEEDS TO BE ADDRESSED IMMEDIATELY

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. BEREUTER. Mr. Speaker, this Member wishes to announce that the Rural Equity Payment Index Reform Act, a bill that will address the significant differential in reimbursement levels to urban and rural skilled health care professionals, now has 72 bipartisan cosponsors.

The Centers for Medicare and Medicaid Services defines "physician work" as the amount of time, skill and intensity a physician puts into patients' visits. Rural physicians put in as much or even more time, skill, and intensity into a patient visit as do physicians in urban areas. Yet, rural physicians are paid less for their work. This is not only unfair, it is discriminatory.

Nebraska physicians and other health professionals are currently being shortchanged by about $8.7 million annually in Medicare payments. If a Member represents a rural locality, their District's physicians and skilled health professionals are likely being short-changed as well. Physician work should be valued equally, irrespective of the geographic location of the physician.

Mr. Speaker, this Member urges his colleagues to support the Rural Equity Payment Index Reform Act and asks for language to be included in any comprehensive Medicare reform bill that is considered on the House floor. The legislation would gradually phase-in a floor to adjust the reimbursement upward for rural physicians without lowering pay in other areas.

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INTRODUCTION OF FAIRNESS TO ALL VIETNAM VETERANS ACT

HON. ROB SIMMONS

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. SIMMONS. Mr. Speaker, I rise today with my colleague from Long Beach, CA, Ms. JUANITA MILLENDER-MCDONALD to introduce the "Fairness to All Vietnam Veterans Act." This legislation directs the Secretary of Defense to report to Congress an appropriate way to recognize and honor Vietnam veterans who died in service of our Nation, but whose names are not listed on the Vietnam Veterans Memorial Wall. Our retired colleague, Steve Horn, championed this legislation in the 107th Congress, and I am honored to carry on his good work.

I was moved when I learned the story of the 74 Navy men who died on the destroyer USS *Frank E. Evans* who are not listed on the Vietnam Veterans' Memorial Wall.

For those who are not familiar with this story, in the spring of 1969, the destroyer *Evans* sailed from the Port of Long Beach, CA to Vietnam. After experiencing fierce combat off the coast of Vietnam, the *Evans* was sent to a brief training exercise called "Operation Sea Spirit" with over 40 ships of the Southeast Asia Treaty Organization.

On the morning of June 3, 1969, the crew of the *Evans* awoke to the sounds of its hull splitting in half. Inexplicably the Australian carrier, *Melbourne*, had rammed the American destroyer *Evans*. The forward half of the ship sank within 3 minutes, taking 74 sailors with it. Although they were in the South China Sea, these lost sailors have been excluded from the wall because their sunk vessel was just outside the designated combat zone that determines inclusion on the Vietnam Veterans' Memorial Wall.

Although these men did not die in direct combat, they were instrumental in forwarding American objectives in Vietnam and participated in conflict just days before the collision that claimed their lives. In reviewing the historical and personal records of the *Evans*, I see a story of valor and patriotism, and, for 74 sailors, the ultimate sacrifice for their country.

Mr. Speaker, examining the important role these men played in the Vietnam conflict, I believe my colleagues will agree that those who died deserve the honor of being listed on the Vietnam Veterans' Memorial Wall.

Unfortunately, the case of the *Evans* does not just pertain to the families of the 74 soldiers who perished in June of 1969. Those who were stationed on the *Evans*, including eastern Connecticut's Bill Thilbeault of Norwich, are proud survivors of the accident and look forward to the day when their shipmates are finally given their recognition of service and sacrifice on the Wall.

My colleague Ms. MILLENDER-MCDONALD and I believe it is time for the Department of Defense to examine current policies for placement on the Vietnam Veterans' Memorial Wall. Our legislation asks for a complete study of the current standards and for an examination of those who died, such as the 74 sailors on the *Evans*, which seem appropriate for inclusion on the wall.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

The Fairness to All Vietnam Veterans Act has the support of the Frank E. Evans Association, as well as hundreds of family members across the country, hoping to see loved ones properly recognized. And Senator BEN NIGHTHORSE CAMPBELL of Colorado champions companion legislation in the Senate. I urge my colleagues to support and pass this bipartisan and long overdue piece of legislation.

TRIBUTE TO BRYANNE SALAZAR

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, it is a great honor to rise before this body of Congress and this nation to recognize the accomplishments of Bryanne Salazar of Grand Junction, Colorado. Several years ago, Bryanne founded Mothers Inc. to assist other mothers in the difficult and important task of child rearing and to provide a forum in which mothers around the country could share their advice, experiences and support one another financially and socially.

Mothers Inc. provides many forms of assistance to mothers, including financial aid, job training, food, clothing and opportunities to meet and form bonds with other mothers. Mothers Inc. is a non-profit organization that raises money through bake sales, garage sales, and the sale of t-shirts and aprons. Her efforts truly embody the spirit and greatness of this nation. Through Mothers Inc., Bryanne has contributed greatly to the welfare of many women and children and served as an inspiration to those with whom she has come in contact.

Mr. Speaker, it gives me a profound pleasure to stand before this body of Congress today to pay tribute to Bryanne Salazar, a remarkable woman who has worked to improve the lives of so many families. The children whom Bryanne has helped are the future of this nation and it is comforting to know they are in such good hands. Bryanne, thank you for your many contributions to the mothers and children of Colorado and for your persevering spirit that has inspired so many.

JUNETEENTH

HON. JEB HENSARLING

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. HENSARLING. Mr. Speaker, today Texans and people across America celebrate Juneteenth.

On this day in 1865, Union soldiers, led by Major General Gordon Granger, landed at Galveston, Texas with news that the war had ended. Two and a half years after President Lincoln's Emancipation Proclamation, Texas slaves heard for the first time they were free.

Mr. Speaker, there is no other land on earth like America, but we've had our share of failings. And we've had no greater failing than allowing slavery to exist in the land of the free.

Here we are, 140 years later. And although we have made great progress, we still live in a color conscious society.

We should all remember and aspire to the dream of Dr. Martin Luther King . . . to live in a nation where our children will not be judged by the color of their skin but by the content of their character.

Juneteenth reminds us to live our lives toward that dream. To make a more perfect Union by making America more free.

50TH ANNIVERSARY OF THE SCHOOL OF UKRAINIAN STUDIES

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. KUCINICH. Mr. Speaker, I rise today to honor and in recognition of the 50th Anniversary of the School of Ukrainian Studies in Cleveland, Ohio.

For more than fifty years, the School of Ukrainian Studies has educated thousands of Americans regarding all facets of the Ukraine—its language, culture, history, customs, religion and art. The School fosters a sense of diversity and continuity between the old country and new and reflects a vital cultural component that defines our Cleveland community—a community that is home to countless Americans whose lifelines originate from points around the world—reaching across borders, time and distance.

The School of Ukrainian Studies ensures that the culture of the Ukraine remains a conscious and vibrant aspect of the fabric of our American community, handed down through the children of each new generation. For decades, Ukrainian immigrants have understood the significance of assimilation, yet they also share an equally strong focus on preserving the ideals and tradition of their beloved Ukraine.

Mr. Speaker and colleagues, please join me in honoring the administrators and students of the School of Ukrainian Studies of Cleveland, as they celebrate fifty years of Ukrainian education. Cultural diversity is the foundation and light of America—adding color; depth and life to our Cleveland community—bridging old world and new, connecting our past to today. As Americans, our shared commitment to celebrate and preserve our many lands of origin unites us.

RECOGNIZING MR. YASHVANT PATEL AND MATRI, INC.

HON. FRANK PALLONE, JR.

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. PALLONE. Mr. Speaker, I rise today to laud the accomplishments of Mr. Yashvant Patel, and the organization he created, Matri, Inc. Mr. Patel and Matri, Inc. have created a unique and important forum where Gujarati youth can uphold their traditional values while searching for a life partner using more modern methods. This forum has been the starting ground for many happy couples, and has provided a much-needed service to America's young Gujarati people.

Mr. Patel founded Matri, Inc. in 1995 with a specific vision of a forum where Gujarati youths could uphold their traditional values while searching for a life partner. The first Matri was hosted by Anand Pragati Mandal in Kearny, NJ, and it had less than 100 attendees. In the last nine years the event has grown drastically and become a professional non-profit organization, providing annual conventions with over 300 participants.

Matri serves an important role in the unique Gujarati youth culture. Although it is a matrimonial forum, it does not force ideas of marriage but instead encourages networking and meeting with people who share similar ideas and principles, who may become lifelong friends or even marriage partners in the future. It is their belief that similarities in dharma, poshaak and khorak (religion, dress and food) are necessary to create a successful marriage. Matri allows Gujarati parents to fulfill their duty to pave the way for their children and give them a prosperous and happy life by honoring Gujarati traditions.

Matri is actually the Sanskrit term for friendship, which is a key element in any successful marriage. Since the participants are allowed to meet without the pressure of parents, the event gives them the opportunity to meet other people and develop relationships. Matri estimates that approximately 15 percent of all participants meet with success each year.

Once again, Mr. Speaker, I would like to congratulate Mr. Patel and his organization for the fine and important work they have done over the past eight years. His organization is doing an enormously important service to an important group of our nation's citizens, and we thank him for it.

LIBERIA

HON. CHRIS VAN HOLLEN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. VAN HOLLEN. Mr. Speaker, after six years in power and over a decade as a regional warlord there are signs that Liberian President Charles Taylor, one of the worst violators of human rights in the world may be leaving power. On June 17, the Associated Press reported that the Liberian Defense Minister Daniel Chea committed Taylor to step down as part of a peace agreement with rebel groups fighting his government. Taylor's rule has been marked by human rights violations on a massive scale.

Currently Liberia is enmeshed in a vicious civil war. According to the Associated Press, "The past three years of rebellion have uprooted more than 1.3 million Liberians, sending hundreds of thousands of them fleeing into neighboring countries." His rule has not only brought death and destruction to Liberia but undermined stability throughout West Africa. He sponsored the Revolutionary United Front (RUF) in Sierra Leone, a rebel group which conducted a gruesome campaign of murders, rapes and kidnappings. The RUF became known for chopping off the arms, lips and hands of their victims. Taylor has supported rebel groups in Cote d'Ivoire, Guinea and Burkina Faso as well.

Last week a U.N.-backed war crimes court in Sierra Leone indicted Taylor accusing him of "bearing the greatest responsibility for war crimes, crimes against humanity and serious violations of international humanitarian law" during Sierra Leone's civil war. As the brave men and women of our armed forces work to bring peace and stability to the peoples of Afghanistan and Iraq it is important to point to other victims of human rights abuses in other parts of the world that do not receive as much media attention. The Bush administration has spoken about the importance of promoting human rights and democracy, but has done little to support the aspirations for freedom on the part of the Liberians despite Liberia's deep historical ties to the United States. We can and should do all that we can to support the peaceful removal from power of Charles Taylor and ensure that he faces the charges brought against him by the U.N.-backed court.

TRIBUTE TO DIANNE PARKISON OF UNION CITY, MICHIGAN, EXCEPTIONAL TEACHER

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. SMITH of Michigan. Mr. Speaker, education is the key for our Nation's future prosperity and security. The formidable responsibility of molding and inspiring young minds to the avenues of hope, opportunity and achievement rests partly in the hands of our teachers. Today I would like to recognize a teacher from Union City, MI that most influenced and motivated exceptional students in academics and leadership that were winners of the LeGrand Smith scholarship.

Dianne Parkison teaches history at Union City High School. She is credited for instilling in students an enthusiasm for the subject and for life itself. In one student's own words, "Not only has Mrs. Parkison taught me a better respect for the struggles that have been endured throughout the history of the United States, she has taught me a lot about life." The respect and gratitude of her students speaks well of Mrs. Parkison's ability to challenge young minds to stretch the mental muscles and strive to achieve the best that is in them.

Dianne Parkison's excellence in teaching challenges and inspires students to move beyond the teenage tendency toward surface study and encourage deeper thought and connections to the real world. No profession is more important in its influence and daily interaction with the future leaders of our community and our country, and Dianne Parkison's impact on her students is certainly deserving of recognition.

On behalf of the Congress of the United States of America, I am proud to extend our highest praise to Mrs. Dianne Parkison as a master teacher. We thank her for her continuing dedication to teaching and her willingness and ability to challenge and inspire students for leadership and success.

TRIBUTE TO AVRMC

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress and this nation to pay tribute to a hospital with a long history of service. The Arkansas Valley Regional Medical Center in La Junta, Colorado is celebrating its 75th anniversary, and I am honored today to recognize this outstanding facility.

The hospital began as a treatment clinic for tuberculosis 99 years ago, before becoming a full-service hospital in 1928. Although the facility was much smaller and operated under a different name then, it still gave the best quality care possible, just as it does today.

Medicine has changed significantly in the 75 years since the hospital first opened its doors, with numerous innovations improving the manner in which we care for the ill. However, the Arkansas Valley Regional Medical Center has always kept up-to-date with the latest medical procedures. After 75 years, the Arkansas Valley complex now includes a health clinic, veteran's clinic, and doctor's offices in addition to the hospital itself.

Mr. Speaker, it is my privilege to pay tribute to the Arkansas Valley Regional Medical Center. Its outstanding care and commitment to the citizens of the Arkansas Valley deserves the praise and recognition of this body of Congress. Congratulations on 75 great years, and thank you for your service to the people of Colorado.

TRIBUTE TO MISS LEONIE BARRETT

HON. DONALD M. PAYNE

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. PAYNE. Mr. Speaker, it is with the greatest pride that I rise today to recognize an outstanding young citizen in my district, Miss Leonie Barrett. A thirteen year-old student at the Oliver Street School in Newark, New Jersey, Leonie has certainly made a significant impact on our world community.

In February 2002, Leonie and her classmate Jennifer were introduced to Mr. Harry Ettlinger. A survivor of the Holocaust, Mr. Ettlinger is a participant in the "Adopt-a-Survivor" program, a program that pairs Holocaust survivors with young members of the community. Through this match, the first made in the program which is sponsored by the Holocaust Council of the United Jewish Communities of MetroWest, Mr. Ettlinger shared his story with Leonie. To have your voice heard and to continue to remember is a very important aspect of Holocaust history. By continuing to tell their stories, survivors of the Holocaust remind us so that we will never forget, so that history will never repeat itself, and that the voices of those who lost their lives will not be forgotten. Leonie is now a part of this commitment, to tell Mr. Ettlinger's story so that it will not be forgotten. She has committed to tell that story until 2045, the 100th anniversary of the liberation of the Nazi death camps.

To say that Mr. Ettlinger and Leonie have significantly impacted each others lives would seem to not do justice to their relationship. In addition to committing to tell his story, Leonie has also helped to reconnect Mr. Ettlinger with his past and a dear friend, Hanne Hirsch, whom he had not seen or heard from since Nazi occupation of their small town of Karlsruhe, Germany. On a trip to the U.S. Holocaust Memorial Museum here in Washington, Leonie noticed that one of the identity cards that are issued to visitors, recounting the lives of individuals who were involved in the Holocaust, was from Mr. Ettlinger's hometown. The two had been separated for sixty-four years, not knowing the fate of the other. With the help of Leonie the two were reunited and have been able to share their stories with each other and with Leonie.

As a member of the International Relations Committee here in the U.S. House of Representatives and a former Social Studies teacher, I understand the significance of the relationship between Mr. Ettlinger and Leonie as well as the commitment and dedication both have given to this important and significant personal history. I know that my colleagues here in the U.S. House of Representatives not only join me today in recognizing this tremendous friendship but also in commending Leonie for her own personal dedication to continuing the voice of Mr. Ettlinger and ensuring that the stories of Holocaust survivors are not lost to future generations.

TRIBUTE TO CATHERINE McDERMOTT SMITH OF SHARON, CT

HON. NANCY L. JOHNSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mrs. JOHNSON of Connecticut. Mr. Speaker, I rise today to pay tribute to the life and memory of Catherine McDermott Smith, of Sharon, Connecticut. Catherine was a dedicated citizen and leader in the Sharon community. Her untimely death is an enormous loss to her family and to our entire community.

Catherine Smith and her five-year-old youngest son John Forrester Smith died from injuries sustained in an automobile crash late last summer. They were en route to their home in Connecticut after dropping off her oldest son for freshman orientation at the University of Virginia. Mrs. Smith is survived by her husband Frank Smith, daughters Mary and Katherine and son Tony all of Sharon, Connecticut; her parents Mary and Anthony McDermott of Glen Cove, New York; six brothers, many nieces and nephews. In addition, she is survived by a multitude of friends and associates garnered through the years from her "people oriented love," politics.

A native of Oyster Bay, New York, Cathy graduated from Hofstra University and New

York University. She became involved in politics as a child and eventually ran many campaigns and fundraising events. This prompted a move to the Washington area where she started an extremely effective direct mail solicitation company. Her appointments to various state boards and commissions have been numerous. She worked as speech writer, communications director, and chief of staff to numerous national office holders. Having long enjoyed Connecticut's lovely northwest corner as a family vacation spot, she and her family moved there just over 2 years ago. Already she was an active member of the community.

Catherine Smith was an outgoing, articulate, competitive person that demanded much more of herself than of others. She was most capable of analyzing a problem, finding the solution, and then doggedly pursuing the correction until conquered. While firm, she was compassionate and obliging; along with her trade mark of a smile, twinkle and a laugh, she was able to unselfishly motivate the people she loved and befriended.

Mr. Speaker it is with sadness that we remember the life and memory of Catherine and her son, Jack. As family and friends mourn their passing, I would like to recognize the wonderful life Cathy lived. She will be missed.

RECOGNIZING MS. MINNIE LOPEZ-BAFFO

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Ms. SOLIS. Mr. Speaker, I rise today to pay tribute to Ms. Minnie Lopez-Baffo, the first Latina appointed to serve on the California Contractors State Licensing Board, as she completes her last term on the Board.

As a member of the California Contractors State Licensing Board since 1995, Ms. Lopez-Baffo has worked on legislation and consumer education committees utilizing her knowledge and expertise to educate and protect California consumers. While she served as Board Chair from July 2001 through June 2002, Ms. Lopez-Baffo was known as a fair and impartial leader and a dedicated guardian of the rights of consumers.

Ms. Lopez-Baffo is an exemplarily leader whose diligent work and dedication to her community inspired others to work hard. I am honored to call her my friend and I commend her for her vision and dedication to advocate on behalf of California's consumers.

TRADE ADJUSTMENT ASSISTANCE

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Ms. ESHOO. Mr. Speaker, on July 27th of last year this body made a bipartisan commitment to American workers who lose their jobs on account of international competition.

Part of this commitment was that the government would provide for 65 percent of their healthcare costs.

Another part of this commitment was that an insurer could not deny them coverage on account of their age, pre-existing conditions or any other arbitrary reason.

The bill under consideration today undermines these protections and allow insurers to arbitrarily avoid covering them.

The consumer protections that are law ensure everyone eligible for the tax credit can actually claim it, regardless of their age or health status.

Many who will qualify for the TAA benefit are older workers and retirees who are more likely to have significant health care needs.

Today's bill is particularly awful because it strips healthcare coverage from those who need it most.

This is not the time to revisit TAA, when commitments to the current program share broad bipartisan support and the current law has yet to be fully implemented.

I urge you to oppose this bill and reaffirm your commitment to the American worker.

TO HONOR JUNETEENTH

HON. NICK LAMPSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. LAMPSON. Mr. Speaker, I rise today to honor Juneteenth. The freedom to have a family. The freedom to live anywhere. The freedom, simply, to have a last name. Those freedoms arrived June 19, 1865, to black slaves in Texas. While we celebrate Juneteenth in 2003, it is helpful to look back at our history to fully appreciate the great obstacles that many faced in their struggle to pursue life, liberty, and happiness.

While President Abraham Lincoln technically ended the right to own another human being in 1863, most slaves gained their freedom only when Union troops took control of Confederate territory and released them from forced bondage. It took two and one-half years after the Emancipation Proclamation for the Union army to reach Texas. Union General Gordon Granger rode into Galveston and announced to the State's 200,000 slaves that they were free. They immediately erupted into a jubilant celebration, much like the Fourth of July.

Although Juneteenth originated in Texas, it is being celebrated throughout our Nation. Today, Juneteenth commemorates African-American freedom and emphasizes education and achievement. It is a time for reflection and rejoicing. It is a time for assessment, self-improvement and for planning the future.

Part of that assessment means looking at where we stand today. Americans, including African-Americans, face ever growing challenges. We face economic crisis and a lack of access to healthcare for millions of Americans. We must work together to make sure that workers make a living wage and that children get the healthcare they need.

As we look ahead, I challenge all of you to take this opportunity, while we honor the rich history of this celebration of freedom, to rededicate ourselves to the value of equal opportunity for all Americans. That is at the heart of Juneteenth and the American ideal.

INTRODUCTION OF THE STRENGTHEN AMERICORPS PROGRAM ACT OF 2003

HON. CHRIS VAN HOLLEN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. VAN HOLLEN. Mr. Speaker, today I am introducing the Strengthen AmeriCorps Program Act of 2003, to strengthen the Corporation for National and Community Service's AmeriCorps program. This bill will not only address the Corporation's recent accounting problems, but more importantly, it will protect and expand volunteer service opportunities in my State of Maryland and across our Nation. It is identical to S. 1276, which the Senate passed yesterday. S. 1276 was introduced by Senator Christopher Bond of Missouri and my colleague from Maryland, Senator Barbara Mikulski, and I appreciate their leadership. We must act now to save this important program.

The President has asked every American to volunteer in their communities and has made the AmeriCorps program a central vehicle in meeting volunteer needs. The AmeriCorps program can play an important and effective role in improving the lives of many Americans and communities it serves.

But I have heard from many of my constituents who are concerned about the potential cuts to the AmeriCorps program. If we fail to act, next year's Maryland program will be slashed from 452 AmeriCorps members to 52 members. Nationwide the number of AmeriCorps members will be radically cut as well.

Maryland's 8th District, which I am proud to represent, has a highly successful AmeriCorps program, Project CHANGE. Project CHANGE was developed in conjunction with the President of Montgomery College, Charlene Nunley, the Superintendent of Schools for Montgomery County, Jerry Weast, and leaders from the County's non-profit, immigrant and business communities. If we don't act, it is likely that Montgomery County will lose Project CHANGE together with the great work that its 20 AmeriCorps members are performing on behalf of our neediest students and families.

So what happened? The reason is simple—last year, the Corporation over-enrolled the AmeriCorps program by more than 20,000 and the Bush Administration took money from the National Service Education Trust, which is used to pay the education stipends of AmeriCorps members following their service. The OMB and GAO have declared that this money must be paid back using the coming year's appropriated funds.

The GAO has identified several factors that led to the Corporation's incorrect accounting practice. The factors included inappropriate obligation practices, little or no communication among key Corporation executives, too much flexibility given to grantees regarding enrollments, unreliable data on the number of AmeriCorps participants, and not following the law in recording its legal liabilities.

This legislation will help address the AmeriCorps problem, at least in the short term. It creates a budgeting mechanism that ensures the Corporation has the funds needed to pay educational awards. Under this bill, the Corporation would be able to enroll about 50,000 AmeriCorps members, without the need for additional funds.

We now know that recording obligations based on the approved level of AmeriCorps members in the program does not reflect the true performance of the program. Not all AmeriCorps volunteers successfully complete service, and not all AmeriCorps members who do complete service use their educational award benefit. Accordingly, this bill allows the Corporation to fund AmeriCorps grants based on estimates of the number of members who will likely complete and use their education award. Further, the bill requires an annual actuarial audit of the National Service Trust to ensure that the Federal Government is able to meet its liabilities. The bill also requires the chief executive officer to certify that the Corporation has properly recorded and tracked its obligations.

We should pass this legislation as quickly as possible. Without it, uncertainty and disagreement will delay and limit the enrollment of AmeriCorps volunteers. Considering the demand and the need for this program, we cannot afford to wait.

But I need to emphasize that this is not a permanent solution. We must restore the proper level of funding to allow AmeriCorps to operate at full strength. We must restore funding for both the National Service Education Trust and the AmeriCorps program. America's communities need AmeriCorps today more than ever, and the talented and dedicated AmeriCorps members need to receive their education stipends following their service.

TRIBUTE TO TINA ROBLES

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress and this nation today to pay tribute to a remarkable woman from my district. Tina Robles of Grand Junction, Colorado just celebrated her 87th birthday, and as her family and friends mark the occasion, I would like to honor Tina here today.

Tina and her family embody the American dream. As Mexican-Americans, Sarah and her late husband Antonia raised their family to believe in the undying spirit of our great nation. They are proud of their dual heritage and have taught their kids that in order to succeed in America you need dedication, patience, and perseverance. At the same time, the family has maintained pride in their culture as Mexican-Americans, enriching this country while celebrating their diverse heritage. Today, Tina is the matriarch of a sizable extended family. With 14 children, 52 grandkids, 60 great-grandchildren, and even 5 great-great grandkids, there is plenty of love to go around. However, even with so many relatives, Tina holds a special place in each of their hearts—I know they each join me in celebrating her 87 years.

Mr. Speaker, Tina Robles's ability to raise a large, loving, and successful family exemplifies the characteristics that helped build this great country. I am truly honored to recognize her here today. I congratulate Tina for her success, wish her a happy birthday, and thank her for being such an outstanding role model for today's families.

TRIBUTE TO DR. ROSE J. CAMPBELL

HON. DONALD M. PAYNE

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. PAYNE. Mr. Speaker, it is with great pride that I rise today to recognize an outstanding educator and dear friend, Dr. Rose J. Campbell. An exceptional constituent and a dedicated member of the education community, Dr. Campbell is a true shining star.

Receiving her Bachelors Degree from Florida A&M University, her Masters in Education from William Patterson College, and her Doctorate from Nova Southeastern University, Dr. Campbell has succeeded in every facet of education. From 1968 to the present, Dr. Campbell has been an active member of the Newark Public School System. Beginning her career as a classroom teacher and moving through the ranks to her current position within the Administration as Assistant Executive Superintendent with a specialty in supervision and curriculum, Dr. Campbell has dedicated her life to education.

In addition to her dedication within the classroom, Dr. Campbell has also involved herself with giving back to the community in many other ways. Dr. Campbell is President of the Florida A&M University Alumni Association New Jersey Chapter, President of the New Jersey Unit of the National Association of Negro Business and Professional Women's Clubs Inc., President of the Board of Directors for Day Nurseries Inc. as well as a member of Trinity/St. Phillips Cathedral Church. In each of her civic and community endeavors, Dr. Campbell makes a difference by her devoted and committed participation.

As a member of the Education & the Workforce Committee here in the U.S. House of Representatives I am extremely aware of the growing need for quality educators in our public school systems. Dr. Campbell sets a shining example for our younger generations of the success they can achieve and of the way in which they too can one day aspire to give back to their community.

Mr. Speaker, I know that my colleagues here in the U.S. House of Representatives join me today is saluting Dr. Rose J. Campbell for her many years of dedicated service as an educator and in wishing her the very best for the future.

TRIBUTE TO MR. KIM SPALSBURY OF GRAND LEDGE, MICHIGAN, EXCEPTIONAL TEACHER

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. SMITH of Michigan. Mr. Speaker, education is the key for our Nation's future prosperity and security. The formidable responsibility of molding and inspiring young minds to the avenues of hope, opportunity and achievement rests partly in the hands of our teachers.–Today I would like to recognize a teacher from Grand Ledge, Michigan that most influenced and motivated exceptional students in academics and leadership that were winners of the LeGrand Smith scholarship.

Mr. Kim Spalsbury teaches government and American literature at Grand Ledge High School. He is credited for instilling in students an enthusiasm for the subject and for life itself. In one student's own words, "Mr. Spalsbury is dynamic, knowledgeable and puts forth a lot of extra effort." The respect and gratitude of his students speaks well of Mr. Spalsbury's ability to challenge young minds to stretch the mental muscles and strive to achieve the best that is in them.

Kim Spalsbury's excellence in teaching challenges and inspires students to move beyond the teen-age tendency toward surface study and encourage deeper thought and connections to the real world. No profession is more important in its influence and daily interaction with the future leaders of our community and our country, and Kim Spalsbury's impact on his students is certainly deserving of recognition.

On behalf of the Congress of the United States of America, I am proud to extend our highest praise to Mr. Kim Spalsbury as a master teacher. We thank him for his continuing dedication to teaching and his willingness and ability to challenge and inspire students for leadership and success.

INTRODUCING THE EMERGENCY WARNING ACT OF 2003

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mrs. MALONEY. Mr. Speaker, today I introduce legislation, the Emergency Warning Act of 2003, which would require the Department of Homeland Security and the Department of Commerce to ensure that comprehensive, easily understood emergency warnings reach every American who may be at risk in any type of disaster. The bill instructs Commerce and DHS to work with the government agencies that currently issue warnings, with first responders, with private industry, and with the media to ensure that our emergency warning system informs the public when a disaster occurs.

We don't always know when a disaster will occur. However, we do know that we are all at risk for a natural disaster like a hurricane, or a man-made disaster like a terrorist attack. With the advances in technology, we can no longer rely on our televisions or radios to inform us if we need to evacuate our homes or businesses. It's time to utilize the available technology to ensure that all forms of communication are used to inform the public about emergency warnings.

DEATH TAX REPEAL PERMANENCY ACT OF 2003

SPEECH OF

HON. TOM UDALL

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 18, 2003

Mr. UDALL of New Mexico. Mr. Speaker, today, we are once again debating a tax bill that hopefully will never see the light of day in the other body. Here in the House, we have repeatedly cut taxes for the wealthiest few, while our deficit has exploded and we have ignored the countless priorities that our nation currently faces.

That's what this debate is really about. It's about priorities. Their priority is to help the wealthiest few. I am proud to say that I do not share the Majority's priorities.

My priorities include our disabled veterans. If we didn't pass this bill, we could possibly pass the concurrent receipt legislation.

My priorities include a fair Child Tax Credit to help the working poor who make between $10,000 and $27,000.

My priorities include providing decent housing and a quality education for our military families.

My priorities include a fiscally sound economic growth plan that creates more jobs by building more roads, bridges and updating our crumbling schools.

Unfortunately, by passing H.R. 8, we cannot begin to address the nation's real priorities.

Mr. Speaker, while I support reducing the tax burden on working families whenever possible, I believe H.R. 8 badly misses the mark. As written, H.R. 8 would add $80 billion per year to the ever-growing federal deficit. While we are permanently eliminating the tax paid on the largest 2 percent of estates, we are contributing yet again to the exploding national debt—a debt our children and grandchildren must pay. In essence, H.R. 8 is a stealth tax on future generations.

The federal estate tax should be reformed, not repealed. I support the plan offered by Mr. POMEROY of North Dakota that would have provided immediate estate tax relief in a responsible manner. I support Mr. POMEROY's attempt to exempt estates up to $3 million (and $6 million for couples) from all federal estate taxes. This plan would exempt 99.6 percent of all estates in the country. In fact, only 400 estates nationwide would pay the estate tax under the Pomeroy plan. Not only is this plan fairer, it would be fully paid for by eliminating unnecessary corporate tax shelters.

Although supporters of H.R. 8 use family farmers and small business owners as the rationale for the bill, this claim is just a myth. There already are special provisions in the tax code to ease the burden on small businesses and family farms. In 1998, only 1.4 percent of all returns that paid the estate tax had farm assets that were taxed. Even with the changes made to the estate tax during the 107th Congress, the Congressional Research Service has estimated that less than one percent of small businesses and farms would be forced to liquidate assets to pay the tax. Our plan would have helped these families. Sadly, H.R. 8 will not.

I urge my colleagues to vote yes on the Pomeroy substitute and no on final passage.

NCCA D-II MEN'S GOLF CHAMPIONS

HON. JOHN M. SPRATT, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. SPRATT. Mr. Speaker, I rise today to congratulate the newly crowned NCAA Division II Men's Golf Champions, the Francis Marion University Patriots. On May 23, at the Crosswater Golf Club course in Sunriver, Oregon, the Patriots claimed victory in a four-day tournament over 18 of the best golf teams in the country. But, Mr. Speaker, they did not just win. In what can only be described as a true team effort, Francis Marion ran away with the title, ending the tournament with a 3 under par 1,149, which defeated second-place Rollins College by an amazing 14 strokes!

In golf, more so than in other sports, an outstanding team starts with outstanding individuals; and Francis Marion's squad was most definitely a collection of outstanding individuals. The team was led by coach Jonathan Burnett, a native of Florence, South Carolina who just finished his sixth season with the team. The players were anchored by Junior Fredrik Ohlsson from Goteborg, Sweden and Senior Dylan Keylock from Johannesburg, South Africa, who finished fifth and sixth respectively in the individual standings at the National Championship. Also playing key roles on the team were Senior Matt Dura from Sumter, South Carolina, Senior Juan Pablo Bossi from Alta Gracia, Argentina, and Junior Per Hallberg from Ytterby, Sweden, who finished an impressive 14th, 24th, and 44th respectively at the National Championship. Junior Luke Wilcox and Freshmen Adam Hart, Luke Hart, and Battle Hartman also contributed to the team's successes this season.

For their efforts, Ohlsson was chosen as a first team All American, Dura and Keylock were selected as third team All Americans, and Bossi and Hallberg gained honorable mention recognition. Keylock and Ohlsson also earned Peach Belt Conference All-Conference honors for the second time, and Dura earned Peach Belt Conference All-Tournament Team honors for the second time in three years.

Though these gentlemen excelled on the links, perhaps more impressive was the fact that they simultaneously excelled in the classroom. In addition to their athletic accolades, Ohlsson, Dura, Keylock, and Bossi also earned 2003 academic All-America honors in marketing, management, finance, and business economics respectively. Only two other student athletes from Francis Marion have ever earned both athletic and academic All-America honors in the same year. I am encouraged to know that long after their collegiate golf careers are over, these young men will still be striving as economic leaders in our country. That is truly something worthy of the title "All American".

Mr. Speaker, I am honored to have the opportunity to speak to you about these extraordinary young men and their extraordinary achievements. It is truly a privilege to represent a state that turns out such talented students.

IN RECOGNITION OF THE CINCINNATI TENNIS CLUB

HON. ROB PORTMAN

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. PORTMAN. Mr. Speaker, I rise today to recognize the Cincinnati Tennis Club, which is celebrating its 120th anniversary. The Club was founded in 1880, just 5 years after tennis was introduced in the United States. It has a rich history.

The Cincinnati Tennis Club played a central role in making the sport of tennis a success in our Nation, and has operated from its East Walnut Hills location for over 100 years. It was one of our nation's first venues for tennis, and, because of its historic impact on the game, was listed in 1983 in the National Register of Historic Places by the U.S. Department of the Interior for its leadership in the development and advancement of the sport of tennis in Cincinnati and the Ohio Valley Area.

Over the years, the Club has been the place where several nationally and internationally recognized tennis players, including legendary greats such as Tony Trabert and Bill Talbert, developed their games. The Club also has been the home club for numerous leaders of the sport and leaders of our country, including William Howard Taft, 27th President of the United States and later Chief Justice of the U.S. Supreme Court; Potter Stewart, Justice of the U.S. Supreme Court; and Neil McElroy, Secretary of Defense in the Eisenhower administration.

The Club has hosted a number of tournaments and events for the Cincinnati area. For 28 years, it has served as the venue for the National Father and Son Clay Court Championships and also served as the original home of what became the ATP Masters Tournament, one of the top professional men's tennis events in the world.

Mr. Speaker, the Cincinnati Tennis Club has had a significant, positive impact on the sport of tennis and the Cincinnati area. We are proud to have had such a distinguished club in our area for the past 120 years and look forward to many more years. I hope my colleagues will join me in recognizing its unique and invaluable contributions to the game and Cincinnati community.

TRIBUTE TO KATHY DeNIRO

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, it is my privilege today to recognize an outstanding educator from my district. Dr. Kathy DeNiro of Pueblo, Colorado is my state's recipient of the 2003 MetLife/National Association of Secondary School Principals Middle Level Principal of the Year Award. Kathy's peers selected her for the award based on her leadership, ability to solve problems, developmental skills, and community service.

Kathy has worked as a teacher and administrator in her school district since 1975 and has served as principal of Corwin Middle School in Pueblo since 1999. In addition, Kathy doubles as Director of Middle Schools in her district. Her dedication to her profession, her students, and her community is extraordinary. A visionary leader, Kathy's innovations at Corwin Middle School include a math and reading program, an academic and recreational-based after-school program, a discipline program, and an academic center for at-risk students with reading problems.

Mr. Speaker, the students at Corwin Middle School include many impoverished, minority youth. Kathy DeNiro's innovation and hard work has greatly improved their chance of success in the classroom and in life. Kathy has made Pueblo and the state of Colorado proud, and I am truly honored to recognize her here today. Congratulations, Kathy, and good luck with your future endeavors.

COMMITMENT TO WORLD PEACE

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. DAVIS of Illinois. Mr. Speaker, I rise today to express my commitment to world peace and to stress the importance of establishing dialogue and understanding among all people. It is in recognition of this need that on Tuesday, June 24th, at 6:30 p.m. in Rayburn room B3338–340, the American Leadership Initiative will hold a special awards ceremony to honor great Americans from all 50 states who have demonstrated a commitment to peace.

Many of my prestigious colleagues will join with me and co-chair Congressman KURT WELDON in giving tribute to some of the outstanding Americans from our districts. Members of the clergy, legislators, educators, and business and community leaders will be among those honored with the "Ambassadors for Peace Award—Excellence in Leadership" award. These committed citizens have been working to renew and strengthen our families and marriages, restore our communities, and rebuild our nation and world. We are grateful to the founders of the Ambassadors for Peace, the Rev. and Mrs. Sun Myung Moon, for promoting the vision of world peace and we commend them for their work.

These Ambassadors for Peace have become increasingly effective and relevant in their communities since the tragedy of 9/11. They have been working together to promote understanding among all faiths, particularly with Muslim, Jewish and Christian leaders. With the realization that many of the tensions currently facing the world cannot be addressed without consideration of the religious implications involved, the Ambassadors for Peace have formed an American Interreligious Council. This council seeks to support and advise our Nation's leaders concerning the issues and challenges of seeking lasting peace. The American Interreligious Council is also a part of the effort to create an international council of religious leaders. The members of this council will support the leaders of the United Nations as they work to resolve conflicts throughout the world. This body will provide a direct link between international leaders and the various religious peoples in their constituencies. This will help to ensure that peace agreements are embraced by the diverse communities these leaders represent.

Today, though crisis is at our doorstep, we must maintain an unwavering hope for peace. It has become clear that the establishment of a lasting peace throughout the world will only come to full fruition through the ongoing dialogue and cooperation of religious and political leaders. The Ambassadors for Peace are working tirelessly to bring about international cooperation and are to be commended for their leadership in this great effort.

INTRODUCTION OF A PRIVATE BILL FOR THE RELIEF OF JUNIOR ANTHONY FRANCIS

HON. CHRIS VAN HOLLEN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. VAN HOLLEN. Mr. Speaker, today I am introducing a private bill to make Junior Anthony Francis a permanent resident of the United States to put an end to deportation proceedings that are pending against him by the Bureau of Immigration and Customs Enforcement (BICE).

Junior has lived in the United States for 40 years and has six American-born children. He has been working and supporting his family and living as normal a life as anyone else. He is being considered for deportation not because of any crime that may be part of his past, but because after many years it was discovered that his immigration papers are not in order. But Junior had taken steps, in good faith, to make sure his papers were in order. He may have received bad legal advice that brought him to this point, but he certainly should not be deported because of it.

It is absolutely wrong to deport Junior and break up his family, who are the real victims in this matter. That is why I am fighting for him. Junior's employer has recruited a new legal team with whom I have been working to keep Junior and his family together in the United States.

We should pass this bill to prevent this injustice from breaking up Junior's family. At the very least, I hope introducing this private bill will help convince federal authorities to be lenient in this case because it is the right thing to do.

TRIBUTE TO THE COUNTY OF MARQUETTE ON RECEIVING THE ALL-AMERICA CITY AWARD

HON. BART STUPAK

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. STUPAK. Mr. Speaker, perhaps you know of my fondness for spending as much time as possible in my First Congressional District of Michigan, which I can, without any bias whatsoever, say is the most beautiful in the nation.

I rise today to give special recognition to one community in my –district, Marquette, which lies on the southern shore of Lake Superior in Michigan's Upper Peninsula.

On June 14, 2003, Marquette County was selected as one of ten communities in the United States to receive an All-America City designation from the National Civic League at a ceremony in Washington, D.C.

The National Civic League has been recognizing civic excellence for 53 years and evaluates how well a community exemplifies grass roots citizen involvement and cross-sector problem solving requiring collaboration among citizens, government, business and nonprofit organizations.

Marquette County was one of thirty candidates who sent hundreds of delegates to Washington to compete in hearings before ten All-America City judges. Forty of those delegates represented Marquette.

While Marquette County is not technically a city, its civic programs and civic efforts are not limited by city-county boundaries. The collaboration that was so important to Marquette's success in the All-America City competition is county wide.

In addition to a well organized substantive presentation, the Marquette delegation also included the Lake Superior Theatre Association which presented dramatic vignettes of cultural life in current day Marquette and Marquette history. The delegation also serenaded the judges, impressing them with enthusiasm and harmony, literally and as a demonstration of the harmonious civic cooperation that was recognized in their selection.

The judges noted that Marquette County's presentation contained more substance than hype, according to Marquette Mining Journal managing editor David Edwards. They cited programs such as the Marquette Medical Care Access Coalition and juvenile restorative justice efforts in announcing their decision.

Marquette's efforts were spear-headed by the Lake Superior Community Partnership, whose chairman, Monsignor Louis Cappo accepted the award in front of a cheering crowd.

Mr. Speaker, this award shows how strong Marquette County's civic spirit is. The true measure of community is not necessarily coffee bars, good restaurants and well lit streets, although Marquette has all of those. Nor is it natural beauty and a close connection between people and their environment, although Marquette has that in huge measure.

Rather, the best example of true community is shown by Marquette County's programs that help people live happy, productive and engaged lives, supported by and supporting their neighbors. Marquette County's richness in these efforts made it possible for this small, thinly populated piece of God's Country to be named an All-America City in its very first attempt.

I have co-sponsored a House Concurrent Resolution congratulating Marquette County and all ten of the All-America cities for their efforts and successes. It is a small token of recognition for a very large effort. All of Marquette County should be proud.

I certainly am. I ask that my House colleagues join me in extending congratulations to Marquette County, a 2003 All-America City.

A TRIBUTE TO DR. AL BEST

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. FILNER. Mr. Speaker and colleagues, I rise to salute Al Best as he is being honored at the "Sixth Annual Community Tribute Banquet" on June 22, 2003. He is being recognized for his tireless activism and community service on behalf of San Diego's Gay and Lesbian community.

Al was born and raised in Colorado, was hired at the age of 18 by United Airlines, and in 1960 became United's Regional Convention Representative. During this time, he received his BS degree at the University of Colorado. In 1963, Al joined Frontier Air Lines as Southwest Regional Manager, based in Albuquerque, and two years later, he was named to the New Mexico State Aviation Board. He received his Masters' Degree from the University of New Mexico and his Ph.D from New Mexico State University.

When Al first arrived in San Diego in 1975, he immediately became active in the community by volunteering and raising money for outstanding organizations such as The Center and the Metropolitan Community Church. He was one of the founders of Stepping Stone, a non-profit alcohol and drug recovery agency. In 1979, he made history by being the first openly gay person to run for the San Diego City Council. Even though he was largely outspent and outraised by his opponents, he finished 5th out of 11 in the campaign.

In 1985, Al became the first president of the Harvey Milk Democratic Club. In 1989, he was the first openly gay person appointed to San Diego's Equal Employment Opportunity Commission. He was also a member of Mayor Maureen O'Connor's Violent Crime Task Force. In 1990, he was the first openly gay person sworn into the San Diego Civil Service Commission and became its first openly gay president in 1992. In 1993, he was a co-chair for the Human Rights Campaign milestone March on Washington. He currently serves as Vice Chairman of Something Special Food Pantry, a volunteer organization that distributes food to men, women, children and families who have HIV/AIDS.

Dr. Al Best has set an outstanding precedent for gay and lesbians in San Diego and has paved the way for future generations to come. He is truly one of the best in San Diego. I offer my congratulations to him on being honored at the "Sixth Annual Community Tribute Banquet."

TRIBUTE TO STEVE MOORE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, it is my great privilege to stand before this body of Congress and this nation to pay tribute to Steve Moore, a police officer from Grand Junction, Colorado, whose optimism and courage have rightfully garnered him the Optimist Officer of the Year Award. Steve has spent most of his adult life serving his community, working with determination to protect his fellow citizens in Grand Junction.

Steve has been involved in law enforcement for 17 years, and has spent the last five with the Grand Junction Police Force. Steve loves working as a member of the Motor Department because he enjoys being around people and spending his time outdoors. Fellow officer Sergeant David Krouse, who describes Steve as an excellent officer, coach, co-worker, friend, and father, nominated him for the Optimist Officer of the Year.

When not protecting the streets of Grand Junction, Steve volunteers his time to make a difference in the community. He is currently developing a safe-driving program for local high schools in hopes of educating teens as they take the wheel. In an effort to improve community safety, Steve instructs traffic violators in a program called Traffic School. When not teaching Traffic School, Steve spends much of his time with teenagers, and relishes the positive impact he makes on their lives. With a role model like Steve, teens become confident in their ability to make the right choice the first time.

Mr. Speaker, I am honored to stand before this body of Congress and this nation today to pay tribute to Steve Moore. His hard work and determination in the Grand Junction community have helped create safer streets and smarter students. Steve certainly deserves the respect and admiration of this body and it is clear he is deserving of the Optimist Officer of the Year Award. Thank you, Steve, for your outstanding service to the community.

IN HONOR OF MR. LLOYD MONSERRATT

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. BECERRA. Mr. Speaker, we, Ms. ROYBAL-ALLARD, Ms. SOLIS, and myself, rise today with emotions mixed with fond memories and profound sadness to pay tribute to a dear friend and people's champion, Mr. Lloyd Monserratt. Six months ago, on January 9, 2003, Lloyd unexpectedly passed away. His loss was a sudden and tragic one for all of us—we lost an inspirational leader. This upcoming Sunday, June 22, 2003, we will have an opportunity to remember Lloyd and honor his life when the community gathers to break ground for The Lloyd Monserratt Pleasant House, a transitional living program designed to prevent foster youth from becoming homeless by providing them with a stable and secure environment; a fitting tribute to a great man.

After 36 short but accomplished years of life, Lloyd Monserratt is survived by his mother, Olga Monserratt; his brother, Ernie Monserratt; his grandmother Consuelo Recalde; and his fiancé, Michele Ramos. Lloyd was predeceased by his father, Carlos Monserratt.

Those of us who are fortunate to have called Lloyd a friend remember him as a man who had passion for life, as a gentle man, and as someone who was always there for you with an enormous smile and a warm embrace. He devoted his life to helping others in the greater Los Angeles area and across the country. By using politics as a vehicle for change, Lloyd labored tirelessly to empower poor and underrepresented individuals to work together and make a difference in their own communities. Lloyd treated everyone with respect and made it his personal mission to provide opportunities, training and jobs for youth. Through his work and boundless love, Lloyd gave life to countless people. The lessons Lloyd shared and example he set will continue to live on—through the many family members, friends, young people, community activists and elected officials whose lives Lloyd touched—long after he has left us.

Mr. Speaker, on behalf of all who loved and respected him, we respectfully submit into the CONGRESSIONAL RECORD the following tribute to Lloyd Monserratt, shared by his family at his funeral on January 18, 2003, at All Souls Church in Alhambra, CA.

> Los Angeles has lost an angel—Lloyd Monserratt, altar boy, eagle scout, soccer coach, umpire, community organizer, chief of staff, and young political leader.
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> Lloyd Monserratt, the child of Carlos and Olga Monserratt, was born on December 3, 1966 at California Hospital in Los Angeles, California. A love and respect for the community was instilled in Lloyd early in life. As a 9-year old, Lloyd attended his first protest alongside his father in his hometown of Alhambra.
>
> Lloyd was born to lead; he ran his first political campaign while in the seventh grade where he was successful in getting himself elected to be All Souls Elementary School Student Body President. As a boy scout, he reached the rank of Eagle Scout with Boy Scout Troop #203, and while in college Lloyd became one of the few Latino USAC Presidents at UCLA. An active member of the University of California Student Association, he organized students across the state.
>
> Lloyd was a role model. He was an altar boy at All Souls Church. He was a member of several of All Souls' sports teams. He played T-ball, little league, and West Valley AYSO soccer. Lloyd was the assistant coach of his brother Ernie's soccer team. He later became a little league umpire for several years for West Alhambra Little League. As an All Souls Panther, Lloyd earned MVP honors for "B" basketball and took his team to the city championship.

Lloyd attended Saint Francis High School where he was an honor student. As a senior in high school, Lloyd applied to only one college—UCLA. Lloyd was proud to be a Bruin. He was a leader in the student movement, as a student commissioner and later student President, and as a MEChA leader and cofounder of MEChA class.

Lloyd was the community. He created the Parents Institute while working for Los Angeles School Board Member Vicki Castro, and designed the National Association for Latino Elected and Appointed Officials (NALEO) national program for newly elected and appointed officials. Widely respected and admired by all who met him, Lloyd gave people the tools to change their lives. He made a difference in the lives of youth, seniors, and residents across the state. A community organizer and political veteran, he managed and directed political campaigns from San Diego to San Francisco and beyond. As a Latino Campaign Director for the Democratic Congressional Campaign Committee, he led all six of his congressional candidates to victory simultaneously. As a chief of staff to Los Angeles City Councilman Nick Pacheco, he impacted countless people across the eastside and northeast Los Angeles. Lloyd can be remembered as a motivator, a peace keeper, a visionary, and a gentle man. Lloyd was the heart of the district, and the heart of Councilman Pacheco's office. He was the visionary, the mover, the motivator and the implementer.

Lloyd made a lasting impact on everyone he met. Lloyd accomplished more in 36 years than many others accomplish in three lifetimes. Lloyd was a leader of his generation. We will miss him greatly.

Mr. Speaker, the voice of family always speaks with conviction and from the heart. The sentiments expressed by Lloyd's family are also ours. We, too, know them to be true. We wish to thank Father Richard Estrada of Jovenes, Inc., for our newly named The Lloyd Monserratt Pleasant House. June 22 offers us another chance to commemorate the life of our friend Lloyd Monserratt.

Mr. Speaker, we ask that all of our colleagues join with us today to salute Mr. Lloyd Monserratt and honor his life. He will forever remain in our thoughts.

TRIBUTE TO CAMILLE FIELDS

HON. STEPHANIE TUBBS JONES

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mrs. JONES of Ohio. Mr. Speaker, on Saturday, June 14, 2003, at the NAACP Freedom Fund Dinner in Cleveland, OH, Camille Fields, the daughter of Helen and Darryl Fields and the granddaughter of Mary and George Forbes, President of the Cleveland Chapter of the NAACP, delivered the following address:

"Imagine 250 years ago: you must get up at 5:00 a.m. to go to the fields and farm. After farming, you go home at about 7 or 8:00 p.m. Can't imagine it? Well this was the normal life of an African-American slave during the antebellum period. Day in and day out, African-Americans worked harder than anyone of us will probably ever know. Enslaved in the slave trade, black slaves brought to the Americas spent their days working, picking cotton, farming and cooking for their white masters. Despite their everlasting work and the building of America, African-Americans were never paid the dues that they were owed. Payments or reparations should be given to African-American slave descendants for that painful period in history that some people want to forget, but should always remember.

"Reparations are payments to repair or right the wrongs of past injustices. African-Americans are owed reparations because of the work and pain that they had to endure during and after slavery. Reparations have been around since emancipation. A form of reparations was the idea of 40 acres and a mule. This was the idea that all slaves would receive 40 acres and mule after slavery to get them started for their own lives. Slavery and its benefactor, the white masters hurt black Americans. To this day, black Americans are living the legacy of slavery. In slavery, if blacks were to refuse to work or proceed to run away, they were punished. The form of punishment was almost always beatings or being whipped. Slavery was a horrible time for the black race, there were 250 years of pain and labor with no compensation for it and that is not fair. Slavery was, 'America's Black Holocaust.' Because of the effect slavery has brought on to African-Americans, blacks deserve to be compensated. After all, everyone else has.

"In 1987, people began to hear the word reparations a lot, but the discussion was not directed towards benefiting African-Americans. Instead, the United States government passed a law to conduct a national apology to Japanese-Americans and to pay them $20,000 apiece for their internment during World War II. The Japanese-Americans are not the only ones who received reparations. Last year, European insurance companies were allowing Holocaust survivors to apply for reparations; $275 million are being split up into accounts. Of this, 100 million will be for expenses and other 175 million will be available for Holocaust survivors and charities. This agreement will be fully enforced at the end of next year. Seven-thousand, eight-hundred forty-four people have made claims for Holocaust reparations in Germany and 18,200 people have made claims in other European countries. Israel Singer, the chairman of the World Jewish Congress stated, 'this is a great victory for justice. This is part of a massive effort at restitution that is very late, but fortunately not too late for hundreds of thousands of Holocaust survivors still alive, many of whom are in great need.' Jewish and Japanese people have been compensated for the past injustices done against their religion and race, so many African-Americans are raising the question, 'Why haven't I been compensated for slavery?' So as a result many African-Americans go to court.

"Reparations Activist Deadria Farmer-Paellman has been the spokesperson for African-Americans who are suing various corporations for their part in slavery. She files lawsuits against companies and as Paellman states, 'These are corporations that benefited from stealing people, from stealing labor, from forced breeding, from torture, from committing numerous horrendous acts and there's no reason why they should be able to hold onto assets they acquired through such horrendous acts.'

"In one lawsuit, Aetna Insurance Company is being held accountable for the act of insuring white masters, if their slaves ran away. They have apologized for insuring masters with money for their slaves. In 1998, Imari Obadele and two other people filed a claim that slavery was worse than Japanese internment and blacks should be paid. Their claim was turned down. The judge ruled against them, Chief Judge Lawrence Baskir of the U.S. Court of Federal Claims wrote 'make no mistake, the plaintiffs have made a powerful case for redress that could form the basis of future legislation providing for reparations for slavery.' In the late 1990s, President Clinton played with the idea of reparations and an apology, but he rejected it.

"Every year, the government does nothing to help out and further the idea of reparations, but one city is making a change toward the better. Last year on October 2, 2002, history was made in Chicago. The Chicago Council passed a law called the Slavery Era Insurance Disclosure. This law was the first one of its kind for a well known city. With the law, before they do business with the city, companies will have to disclose their ties with slavery. This law could affect anyone's company who can trace their ties back to slavery. Here in Cleveland, NAACP president George Forbes wants to have that same law passed here. His proposal wasn't asking for money, but as he states, 'We're not advocating reparations, we just want to discuss it. We want to take it out of the emotional context and show how slavery goes into all corners of Cleveland life.' Many people are advocating and pushing the need for reparations, because so many people need them.

"Some people might raise the question, 'is black poverty the legacy of slavery?' Well it is. After slavery, African-Americans had to start their lives from scratch and they were poor and uneducated. So the cycle continues from one generation to another. The poverty rate is higher for African-Americans than for other minorities. The rate has stayed the same since the last census. Twenty-two point seven percent of African-Americans are living in poverty. While the poverty rate for whites is 7.8 percent. Black people still suffer from economic, political and social falls from slavery. Martin J. Katz, author of The Economics of Discrimination says, 'Whites will be allowed to retain an advantage, which they did not earn and blacks will continue to lag behind as a result of acts which, although they may not be amenable to documentation, no one denies were performed in contempt of individuality. Racism has made race relevant to productivity. Treating race as if it were irrelevant will not help to make it any less relevant.' Slavery's everlasting mark is black poverty, so therefore, because of slavery and its dent on society, African-Americans deserve reparations.

"The saying 'let bygones be bygones' is often referred to the subject of reparations and slavery. The excuses include 'it ended 140 years ago before any of us were born,' or 'There's nothing I can do about it; my family never owned slaves.' But did people say that in 1987 when the government had to pay Japanese Americans? Would anyone say, 'I was never really there when the Japanese were interned, so why should I have to pay them.' I believe the answer would be no. And no one has actually taken the heat for slavery. No one has even acknowledged the aftermath, even today. Some people just don't know how to go about giving reparations. Some ideas were to setup a trust fund that would be used for economic and educational resources. Whites benefited from slavery while at the same time, blacks didn't. In a recent poll conducted by blackvoices.com, 75.4 percent believed that reparations should be given to African-Americans.

"Reparations are a growing movement in today's society. The government should pay African-Americans the money that they are owed. Even though millions of dollars will not make up for the past injustices of America, reparations is a start toward the better. African-Americans went through hell 250 years ago. America needs to understand that. Reparations should be an obligation to America, not a privilege for African-Americans."

Camille is a student at Hawken school. She prepared this presentation for her chapel talk.

JAMES G. MILLS' RETIREMENT

HON. MARK E. SOUDER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. SOUDER. Mr. Speaker, it is with great pleasure that I rise today to recognize James G. Mills' retirement as Chairman of the National Association of Federal Credit Unions (NAFCU). My colleagues may recall when I recognized my constituent Mr. Mills when he first became Chairman of NAFCU in June of 2000. With more than 37 years' experience in the credit union community, there is no doubt in my mind that our good friends at NAFCU will feel a great void once Mr. Mills steps down.

As a long time resident of Fort Wayne, Indiana, Mr. Mills has been the President and Chief Executive Officer of Three Rivers Federal Credit Union since 1985. For the past three years, Mr. Mills has been balancing his time as NAFCU Chair in addition to his leadership at Three Rivers FCU. However, one element has remained constant—he has always given selflessly of his time to promote and enhance the lives of credit union members in the great State of Indiana, as well as across the nation. Mr. Mills facilitated financial literacy education for the underserved in the Fort Wayne area and across Indiana's 3rd District. He has always championed efforts to provide financial services to all communities.

As Chairman of the NAFCU Board of Directors, Mr. Mills worked tirelessly to enhance the federal credit union charter by working with Congress for regulatory relief legislation for credit unions. He has also helped maintain NAFCU's status as a leading credit union trade association.

I rise today to congratulate Mr. Jim Mills on all of his fine work throughout his tenure as Chairman of NAFCU. I have worked with Mr. Mills on issues that are important to the credit union community in the past and I am committed to continuing to do so. Congratulations to Jim Mills on his retirement from the NAFCU Board. Please join me in thanking Jim for his many years of dedicated service.

TRIBUTE TO COLORAMO FEDERAL CREDIT UNION

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, I am honored to stand before this body of Congress and this nation today to pay tribute to a business that has given more than 50 years of service to the community of Mesa County, Colorado. Coloramo Federal Credit Union is a non-profit organization that provides the citizens of Mesa County with essential banking services. Coloramo recently celebrated its 50th Anniversary and I am happy to recognize its service to the Mesa Community today.

Coloramo first opened its doors in 1953 and was built to serve employees of the Colorado Raw Materials Office. The company then grew to accommodate all federal employees and eventually opened its doors to all Mesa County residents in 2002. Since then, the company has continued to grow and recently opened a new state of the art building.

The Credit Union operates with a unique ownership system: when customers open an account, they pay a fee that makes them a part owner. This allows Coloramo to better serve its customers because of its non-profit, customer-owned status. The company stands by its mission statement, which is "to build lifelong member relationships based on quality service, integrity, solid financial management and education." With hard work and dedication, Coloramo has become an exemplary member of the Colorado business community.

Mr. Speaker, it gives me great joy to recognize the Coloramo Federal Credit Union. Its customer owned philosophy has provided the people of Mesa County with excellent service for many years. Congratulations on 50 years of service.

INTRODUCTORY STATEMENT FOR H.R. 2518, THE VETERANS AFFAIRS REORGANIZATION ACT OF 2003

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. SMITH of New Jersey. Mr. Speaker, today I am introducing H.R. 2518, the "Veterans Affairs Reorganization Act of 2003". This bill would make organizational changes in several programs for veterans in order to improve the delivery of vital benefits and services to America's former servicemen and women.

The first two sections of this legislation provide for the consolidation and improvement of programs to assist homeless veterans. Specifically, Section 2 of the bill would create a new office in the Department of Veterans Affairs to manage a number of assistance programs for homeless veterans. Section 3 of the bill would transfer the functions of the Homeless Veterans Reintegration Program from the Department of Labor to Department of Veterans Affairs and include this program in the responsibilities of the newly created office.

There are at least a quarter-million homeless veterans on the streets of America every night. With the passage of the Homeless Veterans Comprehensive Assistance Act of 2001, Public Law 107–95, Congress established a goal to end chronic homelessness among veterans within 10 years. More than 2 years have passed since the President signed our legislation into law, but in this Committee's oversight activities we find that the Department of Veterans Affairs is making insufficient progress to achieve this ambitious goal.

Today, VA provides a range of services for homeless veterans including outreach, case management, clinical care, residential treatment and rehabilitation, managed residential placement, care for serious mental illnesses and substance-use disorders and supported housing. However, the delivery of these services has been hindered by a lack of focus and direction within the Department of Veterans Affairs, and frankly, a lack of will to commit the necessary funding to accomplish this mission.

The legislation I am introducing today would create a new Office of Homeless Veterans Assistance Programs within the Department of Veterans Affairs. The Director of this office would be given authority to consolidate and coordinate all homeless assistance services to help homeless veterans get back on their feet with a hand up, not a hand-out. The new Office of Homeless Veterans Assistance would be enhanced by transferring the Homeless Veterans Reintegration Program, a program now embedded in the Department of Labor, into VA. This transfer of responsibility for program administration would enable VA to better coordinate health care, financial benefits and employment services for homeless veterans. By moving all programs specifically designed for homeless veterans into VA and consolidating them, we expect to deliver better services in a more timely and cost-efficient manner.

Finally, Section 4 of this legislation would transfer the operational responsibility for the Military Personnel Records facility of the National Personnel Records Center (NPRC) to the Secretary of Veterans Affairs. Approximately 80 million military records are on file at NPRC, located in the federal records repository in St. Louis, Missouri. For the last 25 years, each service branch has been producing microfilm of each record and more recently has been keeping records on microfiche. The NPRC has been a source of major frustration for the Veterans Benefits Administration which has a daily need to search these records to help veterans establish claims for disability and other benefits.

While the NPRC has made good faith efforts to be responsive to VA, it continues to fall short of providing VA with timely and reliable records retrieval. As a consequence, VA's claims process has been delayed, and disabled veterans wait months, sometimes years, for service medical records or other information before their records are found. For the week ending June 6, 2003, VA had 3,051 requests pending for more than 30 days and 3,432 requests pending for more than 90 days. This is simply unacceptable.

My legislation would transfer responsibility for managing the NPRC to VA. The National Archives, which currently has final responsibility for maintenance of vital federal records, would be required to execute a Memorandum of Understanding to allow the Secretary of Veterans Affairs to assume the day-today management of the NPRC. Once this transfer of management responsibility is completed, VA will be in a better position to control its own fate in processing veterans' disability claims, and in turn, Congress will be able to hold one executive agency accountable for responsiveness to these disabled veterans who have waited far too long for the resolution of their claims.

Mr. Speaker, I believe these changes will improve the delivery of benefits and services to our nation's veterans. I hope that my colleagues on both sides of the aisle will carefully study this legislation and join with me in this effort.

HONORING TALMAGE V. BURKE FOR OVER 50 YEARS OF SERVICE TO THE CITY OF ALHAMBRA

HON. ADAM B. SCHIFF

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. SCHIFF. Mr. Speaker, I rise today to honor Mayor Talmage Burke. In the year that marks the City of Alhambra's 100th anniversary, Mayor Talmage Burke is setting a record of his own. On May 27, the 85-year old Talmage Burke took the oath of office as the Mayor of Alhambra for the 15th time. This achievement affords him the longest record of publicly elected service of any official in the State of California and certainly one of the longest records of public servitude in the Nation.

Talmage Burke was born in November 1917 and graduated from Alhambra High School in 1935. He went on to USC, graduating with a Bachelor of Arts degree. He continued his studies at USC Law School, graduating with Juris Doctor and Masters of Laws degrees. Prior to being elected to the Alhambra City Council in 1952, he served as the city's first prosecutor and deputy city attorney.

The Burke family has served the City of Alhambra for over 70 of its nearly 100 years. Talmage Burke, a life-long resident of Alhambra, lives with his wife, of 45 years Lisa, in the same house that his father, Montivel A. Burke, built in 1927.

One of the most outstanding and well-known civic accomplishments of Talmage Burke was his involvement in the lowering of the railroad tracks in Alhambra during the mid-1970s. Along with the improved system of tracks, the nearby Alhambra Municipal Golf Course gained an addition of nine holes from the excavated soil from the lowered tracks.

As a member of the Rotary Club, he has a record of perfect attendance for the past 52 years! He has served as President of the San Gabriel Valley Bar Association and is the Founding Director of the Legal Aid and Public Defender Program of the San Gabriel Valley. He was also a Trustee of the University of Redlands for 18 years.

Talmage Burke and his wife have two children: a son, Montivel A. Burke II, an attorney, and a daughter, Karen M. Brown, R.N. The Burkes also have six grandchildren.

It is with great pleasure that I ask all Members to join me in congratulating the Honorable Talmage V. Burke for his truly remarkable and lifelong dedication to the City of Alhambra.

TRIBUTE TO THE HOTCHKISS ELKS LADIES AUXILIARY

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, I am honored to stand before this body of Congress and this nation today to pay tribute to the Hotchkiss Elks Ladies Auxiliary, who have served their community in Colorado for over 50 years. The women of the Hotchkiss Elks Ladies Auxiliary have worked hard to create a friendly, positive atmosphere in their community and I am proud to pay tribute to them here today.

Through many years of distinguished service, the Ladies Auxiliary have contributed to all aspects of their community, raising and contributing money to Laradon Hall, the Sunshine School, various clothing drives, the March of Dimes, a cancer fund, a polio fund, the AIDS project, and the Hotchkiss High School Band. They also put on several community parties, allowing citizens the opportunity to relax and have some fun over the holidays.

The ladies have done more for their community than raise money; they have provided the town of Hotchkiss with the opportunity to have fun. Their hard work and dedication produces events that entertain the community, helping to bring joy into the lives of its residents. They are famous for their Christmas and Halloween parties. They have Easter egg hunts, Chili cookouts, and a Charity Ball.

Mr. Speaker, the Hotchkiss Elks Ladies Auxiliary has provided my district with over 50 years of selfless service. Their distinguished efforts in the Hotchkiss community are certainly deserving of praise before this body and this nation. I am honored to offer my sincere thanks and gratitude to the Hotchkiss Elks Ladies Auxiliary and congratulate them on 50 years of outstanding contribution.

RESULTS OF THE ATTACK ON IRAQ: WHAT HAVE WE DISCOVERED?

HON. RON PAUL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. PAUL. Mr. Speaker, (1) After more than two months of searching, no Weapons of Mass Destruction have been discovered in Iraq. While it is not impossible that something may be discovered, the fact that no WMD were used during the war and none have yet been discovered afterward indicates that Iraq did not pose a threat to the United States.

(2) Assuming that no WMD are discovered in Iraq, it appears that Iraq may have actually been following the various UN resolutions that demanded the destruction of this weapons material.

(3) Before the attack on Iraq, it was claimed that Iraq would destroy its oil wells. Though some explosives may have been found at some sites, it is clear that there was no coordinated Iraqi effort to demolish its oil facilities.

(4) Before the attack, it was claimed that the Iraqi government would blow up dams to slow down invading troops. It did not do so.

(5) Despite claims before the attack, there is no evidence of sustained, high-level contacts between the Iraqi government and the Al-Qaeda terrorist network.

(6) US troops and defense planners were shocked that the Iraqi army simply melted away as the US attack pressed toward Baghdad. An army that cannot even defend its own territory is hardly a threat to its neighbors—or to the United States 6,000 miles away.

(7) Considering the apparent lack of WMD and the total failure of the Iraqi army, claims that Iraq was a threat to United States national security appear to have been inaccurate. I publicly doubted such claims before the attack.

(8) Ending Saddam Hussein's rule over Iraq hasn't solved much. Even with Saddam removed from power, we are told that that "regime change" as such is not enough: there must be a "process" of regime change where the end-goal is to remake Iraq and Iraqi society in our own image. This is otherwise known as "nation-building."

(9) Chaos and lawlessness prevails across Iraq. There is no functioning police force other than American troops. Anger toward the United States occupying force continues to increase.

(10) There is little chance of anything resembling democracy emerging in Iraq any time soon. Any real "democracy" that emerges will likely have a fundamentalist Islamic flavor and will be hostile to other religious and ethnic groups in Iraq.

(11) American soldiers are still getting killed on a regular basis. More organized forces seeking to kill American troops appear to be springing up across Iraq. Frustration with the American occupation of Iraq seems to be adding to the ranks of these organized anti-occupation forces, multiplying the threat to American troops.

(12) There are more US troops being sent to Iraq now that major hostilities have ended. Troops that were supposed to be coming home have been told they must remain in Iraq because of the continued chaos and danger to American forces.

(13) Though it was claimed before the US attack that proceeds from the sale of Iraqi oil would be sufficient to rebuild the country, it is now obvious that this will not be the case. The brunt of the burden of Iraqi reconstruction will therefore fall on the American taxpayer. Much of the damage is the result of our own bombing of that country.

(14) At a time when the US economy continues to falter, costs of occupation and reconstruction of Iraq have skyrocketed. Money spent rebuilding Iraq is money not available to help the US economy recover.

(15) The credibility of the United States overseas is at an all time low.

(16) The US intelligence community is being increasingly questioned over the quality of intelligence provided, while others suspect that the intelligence provided had been manipulated somewhere in the process to support a pre-determined policy.

(17) Hatred toward the United States is on the increase in the Arab world, making terrorism more likely against us than before the attack—as the CIA predicted.

(18) Nation-building—from creating a healthcare system to organizing trash pick-up to running the Iraqi media—has become our number one goal in Iraq.

(19) Yet, supporters of this war are already planning for the next war—possibly against Iran, Syria, North Korea, Cuba . . . or who knows where . . .

(20) In Washington, a foreign policy of noninterventionism, as advanced by the Founders and supported by the Constitution, is not considered a reasonable option, though millions of Americans would welcome it.

SENSE OF CONGRESS THAT CONGRESS SHOULD PARTICIPATE IN AND SUPPORT ACTIVITIES TO PROVIDE DECENT HOMES FOR THE PEOPLE OF THE UNITED STATES

HON. RAHM EMANUEL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 17, 2003

Mr. EMANUEL. Mr. Speaker, I rise today in strong support of S. Con. Res. 43, expressing the sense that Congress should participate in and support activities to provide decent homes for working Americans.

As we recognize National Home Ownership Month this June, I believe that the "Congress Building America" program will go a long way toward improving the lives of our constituents. In the spirit of President Carter's Habitat for Humanity, this legislation inspires volunteerism. When people see their public servants living up to that title and building houses side by side with the people who will be living in them, they will want to help others provide decent housing for those in need.

My wife, Amy, and I look forward to leading by example and showing our children how working together can make a meaningful difference in the lives of our fellow Americans. Expanding the "Congress Building America" program beyond Washington to each of our districts is an important goal toward helping Americans find decent shelter and owning their own homes.

My district is home to thousands of historic bungalows, many of which, sadly, are in disrepair. I am working with public and private agencies to provide bungalow owners with both financial and technical assistance to restore their homes. These bungalows are not only a national treasure, but also one of few affordable choices for thousands of homeowners.

Mr. Speaker, I strongly encourage my colleagues to vote in favor of S. Con. Res. 43 and continue supporting improved access to affordable housing in America.

TRIBUTE TO MILLIE HARMON

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress and this nation today to pay tribute to Millie Harmon of Lake City, Colorado. Millie will soon retire from the National Weather Service, where she has been a distinguished volunteer for the past 30 years. As she nears her retirement, I would like to recognize her many years of service to her community.

Millie began her career with the National Weather Service at the same time that her husband Hal was embarking on his position as the Superintendent of Santa Maria Reservoir. At the Weather Service, Millie was responsible for measuring and reporting several important weather statistics, including precipitation amounts and snow depth. Millie then began to measure the depth, runoff, and water speed of the Lake Fork River. Millie always worked her hardest to provide the Weather Service with accurate information. She was known to snowshoe into the mountains to get her readings, a difficult task at well over 9,000 feet. For her dedication and many years of hard work, she was recently honored with a certificate of achievement from the U.S. Department of Commerce.

Mr. Speaker, I am honored to stand before this Congress and this nation to recognize the accomplishments of Millie Harmon. Her hard work and dedication provided the Weather Service with important, accurate information. Volunteering is a noble calling, and Millie's 30 years with the Weather Service is truly a very impressive accomplishment. Thank you, Millie, for the service you have provided our community.

JUNETEENTH, 2003

HON. TOM DeLAY

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. DELAY. Mr. Speaker, on June 19, 1865, Major General Gordon Granger of the United States Army rode into Galveston, Texas and issued General Order 3, informing the state of the Emancipation Proclamation.

Thus, more than two months after the surrender at Appomattox, the last slaves in the Confederacy were granted their freedom. The Civil War was over, America was one nation again, and Lincoln's rebirth of freedom was realized.

Every year since, Americans of all races have celebrated the events of that date, a holiday that has come to be known as Juneteenth.

Though more than 200 cities across the nation commemorate Juneteenth, the largest celebration is in Galveston, where festivities have been going on all week.

Texas is the only state in the Union that recognizes Juneteenth as an official holiday, so our citizens and students are better informed about its history and legacy.

But that legacy warrants greater appreciation because of its relevance today.

For despite generations of progress, the dark scourges of oppression, hatred, and human cruelty survive . . . but they will not win.

Juneteenth teaches us one thing above all else: mankind will live in freedom.

The people of the United States—of all races, religions, and ethnicities—have sacrificed too much and won too many victories to turn our backs now on the universal hopes of man: peace, justice, and freedom.

Just as the oppressed now are powerless and voiceless, so too were one in eight Americans not so long ago.

Yet now African Americans thrive. They contribute daily to the American experiment, and to the cause of freedom around the world, fulfilling the promise of Paul Laurence Dunbar, one of the first prominent African American poets:

> Never again shall the manacles gall you
> Never again shall the whip stroke defame!
> Nobles and Freemen, your destinies call you
> Onward to honor, to glory and fame.

That is the legacy of Juneteenth: a universal commitment to human freedom.

It's a legacy Americans should honor all year around, and I offer my best wishes to those in Galveston—and across the country—celebrating that legacy today.

REMEMBERING THE LIFE OF OFFICER TONY ZEPPETELLA OF THE OCEANSIDE POLICE DEPARTMENT

HON. DARRELL E. ISSA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. ISSA. Mr. Speaker, I rise this evening to remember the life and service of Officer Tony Zeppetella of the Oceanside Police Department. Tony was killed in the line of duty this past Friday, June 13, just two days before he would have celebrated his first Father's Day with his six-month-old son. My heart goes out to Tony's wife, Jamie, and his young son, Jakob, who will never have the opportunity to play catch or go fishing, or learn to ride a bike with his father. Jakob will only know of his father as a hero, who died in service to his community and his country. This is a tragedy.

It is unfair that such a good young man like Tony should have his life taken by a violent gang member with a long history of criminal behavior. Tony was a well-respected and promising young member of the Oceanside police force. Friends and relatives of Tony say that he was a terrific father, a man deeply committed to raising his son well, and looking forward to his first Father's Day.

After graduating from high school, Tony enlisted in the Navy for six years, serving as a Fire Controlman 2nd class. Tony also attended college while serving in the Navy, and then graduated from the Police Academy in October, 2002. Tony's friends describe him as a man deeply committed to community service, with a strong passion for police service. Capt. David Heering of the Oceanside Police Department said of Tony: "[He] had said it was his lifelong dream to become an officer—it's unfortunate his dream was cut short and ended so tragically."

This murder has not only split apart a family—it has terrorized a community. Tony Zeppetella was the first police officer to be killed in the line of duty in Oceanside since 1916. This Friday, June 20, Tony's friends and family, the Oceanside Police Department, and the community of Oceanside, will come together for a memorial service to honor the life of Tony Zeppetella. I join with them in remembering this fine young man. Tony's murder has hurt all of us. He gave the ultimate sacrifice as a public servant and protector of our freedoms.

INTRODUCTION OF THE COMPACT IMPACT RECONCILIATION ACT

HON. MADELEINE Z. BORDALLO

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Ms. BORDALLO. Mr. Speaker, today I am introducing a bill to amend the Organic Act of Guam to authorize the Secretary of the Interior to reduce, release, or waive amounts owed by the Government of Guam to the United States Government to offset unreimbursed Compact impact expenses. This bill is cosponsored by my colleagues, Mr. GALLEGLY, the Republican Co-Chairman of the newly established House Caucus on Insular and International Affairs, Mr. RAHALL, the Ranking Democratic Member of the House Committee on Resources, Mr. FALEOMAVAEGA, the Ranking Democratic Member of the House Subcommittee on Asia and the Pacific and the Democratic Co-Chairman of the House Caucus on Insular and International Affairs, Mr. REHBERG, Mr. ABERCROMBIE, and Mr. CASE. I am also pleased to have the support of the Governor of Guam, The Honorable Felix P. Camacho, for this legislation.

Guam is the closest neighbor to the Federated States of Micronesia and the Republic of Palau, two former trust territories of the United States, who as a result of the Compacts of Free Association with the United States established independence and became sovereign states.

One of the major concerns for Guam is the reimbursement of costs incurred by Guam due to the Compacts, which were entered into force in 1986. In enacting the Compact of Free Association Act (Public Law 99–239), Congress authorized unrestricted migration from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau to the United States, including its territories. This law states that if any adverse consequences to Guam resulted from implementation of the Compacts of Free Association, the Congress would act sympathetically and expeditiously to redress those adverse consequences.

The Government of Guam has incurred significant costs over the past 17 years due to this migration and the Government of Guam has been inadequately reimbursed by the United States Government. The General Accounting Office has reported that such migration permitted under the Compacts of Free Association has had a significant impact on Guam. But placing demands on local government for health, educational, and other social services, migration under the Compacts of Freely Association has adversely affected the budgetary resources of the Government of Guam. The Government of Guam has provided health, educational, and other social services to the citizens of these Freely Associated States in good faith with the expectation that such incurred costs would be reimbursed by the United States Government.

Guam has experienced a severe economic crisis in recent years which has been exacerbated by Compact impact expenses. During this time, the Government of Guam has accrued significant obligations to the United States Government, including $9 million to the Department of the Navy for water consumption, $3 million to the Department of Education for the construction of a student housing facility at the Guam Community College, $40 million in local matching funds to the Federal Emergency Management Agency for disaster assistance in the aftermath of Typhoon Chata'an and Supertyphoon Pongsona, and $105 million to the Department of Agriculture for telephone infrastructure improvements. These are some of the few obligations that the Government of Guam has been unable to meet in part because of budgetary commitments it has fulfilled in providing health, educational, and other social services to citizens of the Freely Associated States.

The Compact Impact Reconciliation Act would grant the Secretary of the Interior some flexibility to address the unreimbursed Compact impact expenses of Guam. The legislation would allow the Secretary of the Interior to forgive Guam of some of its debt owed to the United States Government in exchange for the United States Government reimbursing Guam for expenses incurred as a result of the Compact's immigration provisions. Reconciliation of amounts owed by the Government of Guam with the Compact impact expenses is in the national interest and would promote good will in the future renewal of the Compacts of Free Association and the economic recovery of Guam, which hosts some of our Nation's most strategically important military bases.

I am hopeful that as Congress reauthorizes the Compacts of Free Association this year that this legislation will be merited serious consideration. I look forward to working with Chairman POMBO and Ranking Member RAHALL of the House Committee on Resources to secure a hearing for this bill and to move this legislation to eventual passage.

SENATE—*Monday, June 23, 2003*

The Senate met at 2 p.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, the Reverend Greg St. Cyr, of the Bay Area Community Church in Annapolis, MD.

PRAYER

The guest Chaplain offered the following prayer:

Let us pray together.

God, I thank You for these men and women whom You have raised up to lead our Nation. Thank You for Your grace in their lives, for their gifts, for their talents, for their individual backgrounds, for their families, and for the States they represent. We acknowledge You as the Author and Sustainer of life. You are the God who holds us in the palm of Your hand, whose eye is always upon us, whose love is always with us.

We come before You now in need of You. You know all things. You know the present challenges we face, and You are intimately aware of our future. When King Solomon was newly crowned, he prayed to You asking that You would "Give Your servant an understanding heart to judge Your people to discern good and evil (1 Kings 3:9)." That request was pleasing in Your sight and You blessed him with wisdom. We come with a similar prayer.

Grant us supernatural wisdom to accomplish Your will and vision for our Nation this day. I pray Your blessing on each Senator, that they would have an understanding heart of wisdom to serve Your purposes today. Grant them godly leadership, wisdom, and courage. I ask this prayer in the name of Jesus Christ. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDING OFFICER (Mr. ROBERTS). The distinguished majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, today the Senate will immediately resume consideration of S. 1, the prescription drug benefits bill. We currently have 15 pending amendments from last week. As I have stated, these amendments are being reviewed, and we will begin the process of scheduling votes, as necessary, on some of these amendments. As previously announced, we will have a vote at 5:30 this evening on an amendment to S. 1. We will alert all Members shortly as to which of those amendments that will be. The managers will be discussing that shortly.

A number of Members have indicated they will be prepared to offer additional amendments during today's session. The two managers will be working with those Senators to set aside the pending amendments in order to consider further amendments over the course of the day. I am very pleased with what we accomplished last week, including last Friday, at which time we had a productive day in the offering and initial discussion of these amendments.

As we previously said, we will plan on completing action on this bill this week before the recess. We will have full days and, I am sure, late nights with votes until we complete action on this bill. We will complete this historic legislation prior to adjourning for the July Fourth recess. I do encourage all Members to prepare themselves for what will be a very busy and productive week. I do thank all Members in advance for their assistance this week and in participating with the managers to bring this bill to closure.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of S. 1, which the clerk will report.

The assistant legislative clerk read as follows:

> A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

Pending:

> Bingaman amendment No. 933, to eliminate the application of an asset test for purposes of eligibility for premium and cost-sharing subsidies for low-income beneficiaries.
>
> Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.
>
> Kerry amendment No. 958, to increase the availability of discounted prescription drugs.
>
> Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.
>
> Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.
>
> Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare Program.
>
> Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.
>
> Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.
>
> Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.
>
> Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.
>
> Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.
>
> Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.
>
> Baucus (for Dodd) amendment No. 969, to permit continuous open enrollment and disenrollment in Medicare Prescription Drug plans and MedicareAdvantage plans until 2008.
>
> Baucus (for Dodd) amendment No. 970, to provide 50 percent cost-sharing for a beneficiary whose income is at least 160 percent but not more than 250 percent of the poverty line after the beneficiary has reached the initial coverage gap and before the beneficiary has reached the annual out-of-pocket limit.
>
> Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

The PRESIDING OFFICER. The distinguished Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I see the Senator from West Virginia is in the Chamber.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside so the Senator from West Virginia can offer his amendments.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The distinguished Senator from West Virginia is recognized.

AMENDMENTS NOS. 975 AND 976

Mr. ROCKEFELLER. Mr. President, before offering my amendments, I am going to discuss both of them because they are being reviewed, at this point, in the majority cloakroom. But I am going to be offering two amendments this afternoon in order.

The first amendment I will offer is to ensure that all Medicare beneficiaries will be eligible for this new drug benefit, including low-income Medicare beneficiaries who are currently eligible for Medicaid and Medicare. They are known as dual eligibles.

The underlying bill precludes Medicare beneficiaries—makes it impossible for Medicare beneficiaries—who are eligible to receive a drug benefit through Medicaid from, in fact, enrolling in the Medicare drug benefit program.

This group is referred to as the dual-eligible group. They are the poorest seniors under Medicare. They are below 74 percent of poverty. That is their income level. A disproportionate share of them—to wit, 42 percent—are minorities. Women make up the majority of them all. Many are likely to have a poor education, live alone, and have more than two chronic illnesses.

The underlying bill precludes these folks that I have just talked about—these duel-eligible beneficiaries—from receiving the Medicare drug benefit. As a result, this prescription drug benefit is not, in fact, at all a universal bill. Now, that is important in a lot of ways. One is philosophical and the other is extremely practical.

The philosophical one is that in 1965, when we created Medicare, it was created as a universal benefit to all who qualify. It was the promise that society made to our seniors: That if you work, if you make your payroll contributions, then you, at the proper time, qualify for Medicare regardless of where you live, regardless of how old you might be, or your income.

As I have noted before, the underlying legislation, for the first time in the history of the Medicare Program, would prohibit some Medicare beneficiaries from receiving a Medicare benefit.

My amendment would make the Medicare prescription drug benefit a universal benefit by adopting the provisions that were, in fact, contained in the tripartisan proposal introduced last summer.

It would eliminate the exclusion of Medicaid beneficiaries and make the new Medicare Part D drug benefit—that is the new part we are creating—available to all Medicare beneficiaries regardless of income. Medicaid would be the secondary payer for Medicare beneficiaries eligible for Medicaid wrapping around this new Part D drug benefit and its low-income protections.

Again, this is exactly the same construction the majority of my Republican colleagues supported in the Grassley-Snowe-Hatch-Jeffords-Breaux Medicare bill that was voted on by the full Senate last summer. The National Governors Association sent a letter to Chairman GRASSLEY and Senator BAUCUS which said the following about the exclusion of some of these seniors, that is, the dual-eligible seniors, those at 74 percent or below the poverty level, from Medicare:

> The nation's Governors oppose this approach. It is not good health policy. It is not good precedent. A major reason that States currently have a long-run structural problem in their fiscal outlook is that they have absorbed responsibility for dual eligibles.

They go on to say:

> This provision will continue to shift appropriate federal costs to the states.

Governors Patton of Kentucky and Kempthorne of Idaho went on to say:

> If the dual eligible populations continue to be a joint responsibility, states will be forced to cut the optional (Medicaid) benefits and populations—mostly women and children—which are a key investment in the future.

The President agrees. In a speech he recently gave on Medicare, he said:

> And all low-income seniors should receive extra help so that all seniors will have the ability to choose a Medicare option that includes a prescription drug benefit.

The Medicare prescription drug legislation being considered by the House of Representatives would shift the entire drug bill to Medicare. It is not on a frequent day that Chairman THOMAS and I are in full agreement. But he does say such a shift "ensures that all seniors across the country will have access to affordable prescription drugs, while alleviating much of the burden that states now confront." I say to my colleagues, as I indicate, I am not always in agreement, but we are going forward directly together on this policy, I hope.

The current system is uncoordinated and sometimes conflicting in terms of coverage policies. It actually creates worse health outcomes for people on both Medicaid and Medicare, either one. Fully integrating a key benefit for prescription drugs into Medicare is a critical first step toward improving the current system's flaws.

It needs to be clearly understood by my colleagues that Medicaid in the hands of Governors, which I had the honor of being at one point, is subject to whatever their whims might be. It is subject to budget pressures. Remember, they have to balance the budget. We don't; they do. And they frequently do it on the backs of Medicaid beneficiaries—that is, that part of these Medicare-Medicaid dual eligibles—so they can increase the number of prescription drugs which are available under Medicaid in their State. They can change it in many ways because the programs vary widely. Not only is it unfair to exclude the poorest seniors from part of the Medicare program, it is a raw deal for some of our neediest seniors.

Prescription drugs are, as I said, an optional benefit under Medicaid. States can and do limit the number of prescriptions. Some States only cover three drugs or they could charge any copayments they want. Remember, what we are looking at here is a group of people who are below 74 percent of poverty which is clearly in single-digit gross income. So the patchwork of the benefits varies tremendously from State to State. For seniors who have worked all their lives, paid into the Medicare system, it is not fair for them to be at the mercy of State coverage decisions.

If you look around the country right now, the fastest growing expense of any State is Medicaid, part of this dual-eligible conundurm, and those programs are being cut. You can see it, read about it, and hear about it. So it is highly volatile, and it is not safe health care policy.

Medicare has failed in its efforts to provide comprehensive prescription drug coverage to seniors ever since the repeal of the Medicare Catastrophic Act in 1988. Virtually all advances in drug coverage for seniors since then have been delivered not by us but by the States. While at the same time the States have been cutting back in recent years, they have also made improvements. We have done nothing. They have done whatever has been done.

Without some long-term restructuring of the State-Federal partnership for this population, this dual-eligible, 74-percent-of-poverty-minus population, much of the advances the States have made will be lost. All Medicare beneficiaries deserve to receive Medicare benefits. There should be no exceptions for drugs. It would be very bad precedent to make Medicaid pay for items that are clearly the responsibility of Medicare except at the present and in this bill for one particular discrete population.

The intention is for this amendment to be budget neutral. I would like to say it is budget neutral, but I cannot in that I asked CBO for a cost estimate last week and I do not yet have one.

This is a concern and an agony shared by many. Once we have this estimate, we will either conclude that we can go ahead because we will know it is budget neutral or I will be happy to work with the chairman and ranking member on appropriate offsets.

I urge my colleagues to provide all the seniors in their States with the benefit of real Medicaid drug benefit by supporting this amendment.

I will at the appropriate time ask that it be acted upon. I am awaiting a particular series of sheets of paper but in the meantime, in the minute or so that will require, I send to the desk an amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from West Virginia [Mr. ROCKEFELLER], for himself, Ms. MIKULSKI, and Mrs. CLINTON, proposes an amendment numbered 975.

The amendment is as follows:

(Purpose: To make all Medicare beneficiaries eligible for Medicare prescription drug coverage)

On page 10, lines 12 and 13, strike "(other than a dual eligible individual, as defined in section 1860D–19(a)(4)(E))".

On page 21, strike lines 22 through 25, and insert "title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.

On page 107, line 3, strike "30 percent" and insert "27.5 percent".

On page 116, line 10, insert "and" after the semi-colon.

On page 116, line 12, strike "; and" and insert a period.

On page 116, strike lines 13 through 17.

On page 116, line 24, insert "and" after the semi-colon.

On page 117, line 2, strike "; and" and insert a period.

On page 117, strike lines 3 through 7.

On page 117, line 13, insert "and" after the semicolon.

On page 117, line 17, strike "; and" and insert a period.

On page 117, strike lines 18 through 23.

On page 118, line 6, insert "and" after the semicolon.

On page 118, in line 13, insert "or" after the semi-colon.

On page 118, line 14, strike "; or" and insert a period.

On page 118, strike line 15.

Beginning on page 118, strike line 16 and all that follows through page 119, line 9.

On page 119, line 10, strike "(F)" and insert "(E)".

On page 119, line 15, strike "(G)" and insert "(F)".

On page 119, line 19, strike "(C), (D), or (E)" and insert "(C), or (D)".

On page 120, line 3, strike "(H)" and insert "(G)".

On page 120, lines 5 and 6, strike "who is a dual eligible individual or an individual".

Beginning on page 121, line 24, strike "dual eligible" and all that follows through "and" on page 122, line 1.

On page 146, line 6, insert before the period "and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c)".

Beginning on page 146, strike line 23 and all that follows through page 149, line 21, and insert the following:

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

"(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f)) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

"(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

"(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) PHASE-OUT PROPORTION.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

"(i) 2006 is 95 percent;

"(ii) 2007 is 90 percent;

"(iii) 2008 is 85 percent;

"(iv) 2009 is 80 percent;

"(v) 2010 is 75 percent; or

"(vi) 2011, 2012 and 2013 is 70 percent.

"(d) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan.

Beginning on page 152, strike line 3 and all that follows through page 153, line 15, and insert the following:

"(f) DEFINITION.—For purposes of this section, the term 'subsidy-eligible individual' has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).".

(C) CONFORMING AMENDMENTS.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(c)(1) for the State and the quarter".

(2) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

Beginning on page 157, strike line 21 and all that follows through page 158, line 4.

On page 173, beginning on line 15, strike "that is not" and all that follows through "includes" on line 18 on that page, and insert "that includes but is limited solely to".

On page 190, in line 18, strike "and".

On page 190, between lines 18 and 19, insert the following:

"(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and".

On page 190, line 19, strike "(B)" and insert "(C)".

Mr. ROCKEFELLER. Mr. President, I also have the amendment for which I just spoke. I ask unanimous consent that that be brought to the desk for its consideration and the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection to setting aside the amendment?

Mr. GRASSLEY. Reserving the right to object, and I shall not object, I would like to remind the Members of my caucus we do have an arrangement between the two parties that every other amendment offered could be offered by a Republican and then in turn by a Democrat. We have several Democrat amendments pending. There is nothing wrong with that. It hasn't hurt the process at all. But I think it would be fair for me to remind the Members of the Republican caucus if they have amendments to propose, come over and do it. It will speed up the process and I think be considered a little more fair by everybody here. I will not object.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from West Virginia [Mr. ROCKEFELLER], for himself, Mr. CARPER, Mr. GRAHAM of Florida, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DODD, proposes an amendment numbered 976.

Mr. ROCKEFELLER. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To treat costs for covered drugs as incurred costs without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs)

On page 51, strike lines 15 through 25 and insert the following:

"(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Mr. ROCKEFELLER. Mr. President, I wish to proceed with the amendment I was going to offer first but which will be my second amendment. That also will await the decision of the leadership.

Mr. President, I come to the floor again to offer an amendment that will ensure that contributions made on a beneficiary's behalf by their former employers count toward that beneficiary meeting the catastrophic limit. Let me just say, as I begin this, in our Finance Committee deliberations, it was this amendment which caused more stir, more angst, more sense of, oh, my heavens, we have not really done this, have we? We could not have made this mistake involving this many people. The amendment was handled in Finance—without success, from my point of view. Nevertheless, I was urged by colleagues on both sides of the aisle to bring this amendment to the floor because it has enormous implications. That will become apparent, hopefully, as I complete my statement.

This amendment is needed to protect the existing coverage of literally millions and millions of retirees who have earned drug coverage through their employer. That means they have been employed much of their lives by their employer and they have now retired and they are Medicare beneficiaries and the employer gave retiree benefits. We are accustomed to this in chemical, steel, and many other industries. But there is a problem that has arisen.

As much as we want to provide a new drug benefit for these seniors, we should not disrupt the basically foundational employer-provided drug coverage so many seniors have today. It is the largest source of drug coverage in the country and it is an honorable and a good one. It would be a very great mistake for my colleagues to walk away from this system and one that we would all very much regret.

Mr. President, in saying that employer-sponsored retiree health benefits are the largest single source of coverage for retirees, I simply say that one in every three Medicare beneficiaries is affected by the amendment I am now discussing. They will either lose their coverage or they will not, depending upon how this amendment is disposed.

Drug costs constitute 40 to 60 percent of employers' retiree health care costs. That is a lot. And steep price increases are prompting employers to, one, eliminate drug benefits in some circumstances; secondly, cap their contributions; thirdly, drop retiree coverage altogether. We all know this is a phenomenon of American life that has been going on in recent years.

Employers need immediate relief for their retiree prescription drug costs. A Medicare prescription drug benefit should relieve some of the burden on employers by covering a retiree's cost after a certain catastrophic limit. I recognize this gets technical, but it is profound. Instead, this benefit extends the amount of time before a retiree reaches that catastrophic benefit of about $4,000 by not being able to count as the employee's contribution—in fact, the employer's contribution toward that end is very substantial. Therefore, the employer receives no real relief from this benefit and is forced to drop the coverage they currently provide their retirees, leaving Medicare to pay the entire cost.

I think I do not have to explain that that means the Federal Government has to pick up even more of the cost of Medicare and prescription drugs than would otherwise be the case, for example, if this amendment were to pass.

The bill we are considering on the floor today exacerbates the current downward trend in retiree benefits by extending the amount of time the beneficiary relies on the employer before reaching the catastrophic limit. What does that say? It says if you extend the amount of time the employee has to keep paying and paying toward his catastrophic limit for a much longer time, there is therefore much more out-of-pocket costs to the employee.

This legislation discriminates against Medicare beneficiaries with employer-provided coverage with a trick definition—that is what is used—of out-of-pocket costs known, uninterestingly, as the "true" out-of-pocket costs. This plan would not allow any spending by employers to count toward meeting the catastrophic limit. In this way, the underlying legislation limits the overall spending by the Medicare Program at the expense of employers who offer retiree coverage.

The result is CBO estimates, as I indicated, that 37 percent of beneficiaries currently receiving a drug benefit from their employee will lose that coverage. Additionally, it extends the amount of time, as I have indicated, a beneficiary has to reach the catastrophic limit, exposing them to additional and more and more costs. I think we should all agree that one of the goals of this legislation should be to encourage employers who are currently providing drug coverage to their retirees to continue, in fact, to do so. It should reward and strengthen those employers because the benefit they are providing goes a long way toward helping American seniors afford prescription drugs. The legislation should not force employers to drop their coverage by making their contribution on a beneficiary's behalf meaningless or, rather, by not concluding that the employer's contribution as part of the retiree's expenditures counts toward the catastrophic limit. In other words, simply take what the employer contributes to this, include that on top of what the employee contributes, and you have a much better count toward the money that is spent toward getting to the catastrophic limit and the rate at which you get there.

Without adoption of my amendment, this plan penalizes employers who are trying to do the right thing by providing retiree health benefits. It is not in anybody's best interest for employers to decide that contributions for prescription drug coverage just keep retirees from reaching the catastrophic drug limit. Without modifying how employer contributions are treated under this legislation, we are ultimately threatening retiree coverage and driving millions more seniors to obtain Medicare coverage from their employers.

My amendment removes the so-called true out-of-pocket concept and replaces it with a real out-of-pocket concept which better reflects the seniors' true drug spending. According to CBO, the true out-of-pocket approach is a significant component of why employers drop coverage. Again, the underlying bill is the reason why 37 percent of those covered by their employers will be dropped. That I am trying to eliminate. Therefore, eliminating the true out-of-pocket expenses will go a long way toward keeping employers in the business of providing drug coverage for their retirees.

Mr. President, I urge my colleagues to adopt this amendment. I expect that the retirees in our States may well end up with a less comprehensive or more expensive prescription drug benefit as a result of this legislation should we fail to adopt this amendment.

I thank the Presiding Officer and yield the floor.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The distinguished Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, the Senator from West Virginia raises an important point in his amendment. In the underlying bill from the Senate Finance Committee, beneficiaries who are enrolled in both Medicaid and Medicare—and this is the group we call dual eligibles—would continue to receive drug coverage under the Medicaid Program.

Some of my colleagues have argued that by having dual eligibles remain in the Medicaid Program, Congress is thus treating these vulnerable seniors as second-class citizens and subjecting them to lower quality benefits. I strongly disagree with that point of view.

I have worked closely with my Finance Committee colleagues on the development of this package, and we had an opportunity during this debate to reflect on the concerns that were raised by the Senator from West Virginia and also by others during the debate last summer of the so-called tripartisan bill, meaning the bill that was before the Senate in 2002.

All of us authoring the underlying bill took these concerns to heart. We made the decision that it was most beneficial to these seniors to continue to build off the existing Medicare and Medicaid low-income assistance programs that they know and understand.

That said, I remind my colleagues that the intent of this legislation is to expand prescription drug coverage to our senior citizens who do not have access to the prescription drugs and who are faced with paying a large share of their income for their drug coverage.

About two-thirds of the citizens of the United States today have some coverage for prescription drugs. Retirees from major corporations have prescription drugs paid for in their retirement plans. We have people who are in Medicare plus their Medigap policies that also have some coverage, and then we have lower income people who are dual eligibles who are covered under both Medicare and Medicaid. This makes up 60-some percent of the seniors of America who have some drug coverage.

We want to fill in the gap for those who do not have drug coverage or might have inadequate drug coverage. Quite frankly, for people who already have drug coverage, particularly those who have lower incomes, who are covered by State Medicaid Programs, we felt it was best not to upset their coverage, not to give that group any angst about how they might be covered in the future while the debate on this legislation was going on and how it might be put in motion, so we decided just to leave those as is.

The Senator from West Virginia believes it would be better if we would cover them under our plans that are meant for people who have no coverage whatsoever.

We are in a situation where coverage experienced by those who are dual eligible is the issue before us. These seniors currently have drug benefits through the Medicaid Program. In fact, many advocates and beneficiaries describe these benefits as very generous. Medicaid beneficiaries have come to know their drug benefits, along with its nominal levels of cost sharing. We should not require seniors to leave coverage with which they are comfortable.

Further, I remind my colleagues that we are discussing populations eligible for both Medicare and Medicaid. Medicaid was created to assist individuals who do not have the means to pay for their share of health care costs. That is a responsibility that is shared by the Federal Government and by State governments. Medicaid pays for many benefits that Medicare does not.

Is the purpose of the prescription drug bill before us to grant fiscal relief to the States, which would be what the amendment of the Senator from West Virginia would do? I do not believe that is what we should be doing.

We all know the purpose of the prescription drug bill is to provide prescription drugs to seniors who do not currently have access to drugs or otherwise would be paying extremely high drug costs and, hence, the provisions of our legislation for catastrophic coverage.

However, recognizing the costs associated with covering the cost of providing prescription drug coverage to dual-eligible populations, the bill before us does provide nearly $18 billion in new Federal dollars to compensate States for some of these additional costs, mostly because it is a fast growing part of the Medicaid budgets of most States.

The funding we provide in this bill will be channeled to States by federalizing the cost of Part B premiums for dual eligibles in a subclass called qualified Medicare beneficiaries. This is because the prescription drug bill before us provides minimum standards that ensure the benefit provided through Medicaid is at the same high quality that is being provided through Part D of our Medicare Program.

As is usually the case, the argument would be made yet that we should still do more and perhaps serve this population differently than we do. But, in fact, we developed the underlying bill to best utilize the availability of $400 billion, an absolute figure that we must be in; otherwise, we are subject to a point of order and, in a sense, instead of 51 votes it takes to pass this body, one could argue it would take 60 votes. If we exceeded the $400 billion, we would have to have 60 votes.

Our approach helps to deliver care that is consistent with current law but, most important, familiar to vulnerable beneficiaries.

A prime rationale behind our legislation is it really does not make seniors do anything they do not want to do. We set up a new Medicare Program that is closer to what baby boomers have in the workplace today. They can choose that or they can choose to stay in the 1965 model Medicare.

People who want to stay in the 1965 model Medicare can choose voluntarily to join a prescription drug program. They do not have to. We wanted to help those who are in Medicaid to stay in Medicaid if they wanted to. They do not have to go into these new programs.

Finally, I remind my colleagues that the adoption of this amendment will not expand coverage at all. It will simply shift the cost to the Federal Government and, in time, to other Medicare beneficiaries.

So after careful thought, because at one time we did debate internally the substance of the amendment by the Senator from West Virginia to federalize all dual eligibles, we thought maybe we should include that in the program, but we figured it raised a lot of questions from people who are already adequately covered and who seemed to be very satisfied.

Also, there are some additional costs that would subtract from what we could do for those who have no coverage for prescription drugs whatsoever, and in order to get the most bang for the dollar within the $400 billion that is in the budget for this program, we decided to leave the dual-eligible program alone. That is why I suggest we defeat Senator ROCKEFELLER's amendment when it comes to a vote.

I yield the floor.

Mr. ROCKEFELLER. Will the Senator yield?

Mr. GRASSLEY. Mr. President, the Senator will try to answer a question, yes.

Mr. ROCKEFELLER. I thank the Senator, and this is in the form of a question. I fully understand the constraints of the $400 billion, as the chairman of the Finance Committee indicates, and I think we all understood that to do a full prescription drug benefit, it was going to take substantially more than that, particularly if one included other matters. But would the Senator not agree that there are really two ways of looking at dual eligibles and their dependence now upon Medicaid which is paid by the States?

Up until the fairly recent past, States were doing very well and Medicaid benefits, to some degree, were expanding. I reflected on that as to my State. The other way of looking at it is to look at what is happening to Medicaid now in the States because of the balanced constitutional amendment requirements and because of the fiscal condition of the States, which is getting worse every single day, and the fact that Medicaid is the fastest rising cost in any State government budget, and the fact that the States have complete control over what happens to the Medicaid benefit.

So would the Senator from Iowa not agree that if a State using Medicaid, which is a combination of State and Federal funds, nevertheless decides to cut—since that is optional within the State, under the Government's control, that the Governor can cut that and indeed has done so, as we have been reading and hearing about, and indeed can limit coverage, cap coverage and therefore cut back tremendously on the so-called drug coverage that the chairman of the Finance Committee was extolling?

I agree that if we were in a flush time and the States were able to afford a good drug benefit under Medicaid and use it for that particular dual-use population, the Senator is right, but I think we are looking now at a period of a number of years where we are not going to be in that situation. I think that puts the dual eligibles, 74 percent or less of poverty, at terrible risk, and that is not something I associate with my understanding of the values of the Senator from Iowa, whom I so much respect.

Mr. GRASSLEY. Mr. President, I cannot disagree with the Senator from West Virginia, but I think the answer is that there are 50 different answers to his question from the standpoint of there being 50 different States with 50 different budget situations. So there is not just one answer to his question.

Another way to say it is I would have to understand the situation in 50 different States and then, in a sense, give 50 different answers. But there is a recognition on the part of the Congress of what the Senator from West Virginia says and a response by the Federal Government to that, albeit a temporary response, when over a 2-year period of time we decided to put $20 billion of State aid to the States, and we did that through the tax bill recently signed by the President of the United States, of which $10 billion was earmarked for Medicaid solely because the Congress understood the problems the Senator from West Virginia has adequately described, and then another $10 billion of other State aid that a State is free to use for Medicaid or anything else.

I assume some States that have very bad Medicaid fiscal problems might take some more of that additional $10 billion to use for Medicaid.

In further answer to my colleague's question, what we face is the issue of about $16 billion a year just for drug costs. Multiply that times the 10 years we have to look ahead. That is about $160 billion, I believe, of the $400 billion which would go then for groups who are already covered, detracting then from the 30-some percent of people who have no prescription drug coverage.

We would like to fill in the gap of those who have no coverage as opposed to some who have very good coverage. I know it varies from State to State how Medicaid might cover certain groups of seniors with prescription drugs, but I think the Senator would say they have had a better program for sure than most people—except maybe those who are on a corporate retirement plan, which is only about 30 percent of our people—than anybody else, particularly those who have no coverage whatsoever.

In further answer to the question of the Senator from West Virginia, it is a case of priorities. We have suggested those who already have some coverage, and very good coverage, we would basically leave untouched and then would try to use our resources for those who have no coverage whatsoever.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. I apologize for not speaking through the Presiding Officer before, but will the Senator from Iowa yield for only one additional question?

Mr. GRASSLEY. I yield for an additional question.

The PRESIDING OFFICER. The Senator is recognized.

Mr. ROCKEFELLER. The Senator has responded simply by saying he would have to answer it in 50 different ways because there are 50 different States. To that I say yes, and all of them are either in the process of or will be in the process of cutting Medicaid and, therefore, the dual beneficiaries.

I ask the Senator from Iowa, is there not a further consideration, and that is when we are dealing with this maximum poor number of people under Medicare, or Medicaid in the case of the dual eligibles, we are also dealing with something which has not been discussed on this floor or indeed was not discussed in the Finance Committee at any length at all, and that is a really frightening problem of assets that, for example, one can apply, one can be under this program up to 130 percent of poverty. Then there is another one that says you can be under this Part B plan up to 160 percent of poverty, but if your assets reach over $4,000, assets which you maintain, you are then kicked from the lower to the upper bracket without any discussion. There is enormous penalty, for example, for owning a car, for owning anything. You would not be living in rural Calhoun in West Virginia without a car. Your home is exempted but nothing else is.

At one point I was thinking of offering an amendment—and I may still do so—exempting burial plots from the asset test that would be applied to poor people.

I ask the Senator from Iowa if he would say a word on this whole question, adding to the dual eligibles and deciding if—as he said, we have to pick our priorities—we are going to leave it to the States, even though I argue that States will cut that. Is it not also bringing up this whole subject of the assets of the poor families and the effect on them if they become ineligible for the bracket in which they belong and, therefore, cannot afford prescription drugs.

Mr. GRASSLEY. Mr. President, I will answer the Senator's question by giving some detail about the issue of the asset test. It is a legitimate point of discussion as we deal with this legislation. Rather than just speaking specifically to his question, I answer it more generally with how we try to respond to the issues he brought up.

The asset test in the underlying bill is the same asset test currently used for determining eligibilities for the qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, and qualified individuals. Those are three separate categories of low-income people that I just described.

S. 1 provides a generous low-income subsidy for those who are below 160 percent of the Federal poverty level. Currently, in order for some individuals under 160 percent of poverty to receive limited Medicaid protections, there must be both an income test and an asset test. In the underlying bill, we simply follow the same rules in order for low-income beneficiaries to see assistance with their prescription drug coverage. By including the Medicaid asset test for Medicare prescription drug subsidies, we are providing beneficiaries with seamless health coverage. We are not confusing beneficiaries, and we are not adding additional administrative burdens to the States.

I will give some background on the current asset test included in the Medicaid Program. The group called qualified Medicare beneficiaries are individuals below 100 percent of poverty. In 2006, the annual income limit is $9,670 for individuals and $13,051 for couples. This qualified Medicare beneficiary group is allowed to have assets below $4,000 for individuals and $6,000 for couples. That is exactly what the Senator from West Virginia asked me about and implied some limitations because of that.

Yes, there are limitations because of that, but they are legitimate limitations within the priorities of our $400 billion budget limit.

Then we have the category of specified low-income Medicare beneficiaries, and then the qualified, and those are people with incomes between 100 percent of poverty and 135 percent of poverty. In 2006, the annual income limits of this group, $13,054 for individuals, $17,618 for couples, these two groups are allowed to have assets below $4,000 for individuals and $6,000 for couples. Beneficiaries between 136 percent of poverty and 159 percent of poverty will have annual income limits of $15,472 for individuals and $20,881 for couples in 2006. Beneficiaries between 136 and 159 percent of poverty would not be subject to those asset rules.

Current law establishes resource limits for low-income elderly or disabled individuals. Let me emphasize, this is not a newly added restriction on certain low-income Medicare beneficiaries. However, current law also provides States with the flexibility to choose to disregard all or part of these resources.

The issue of changing this asset test is one that would very drastically increase the number of eligible beneficiaries. Understand that the question the Senator from West Virginia raised about changing the asset test would very dramatically increase the number of people eligible.

Now, again, we get back to the priorities of fitting in the $400 billion in the budget. Give more help to this group of people that already have some help from our legislation, then there is less for other people, particularly less for people who have no help whatever.

A study was prepared by the Kaiser Family Foundation estimating this group could be as many as 11 million individuals if the asset test were eliminated and obviously to a lesser extent if it were increased by some amount.

S. 1 currently includes a provision requiring the General Accounting Office to conduct a study and make recommendations to Congress by the year 2007 regarding the extent to which drug utilization and access to covered drugs differs between qualifying dual eligibles who receive subsidies and individuals who do not qualify solely because of the application of the asset test.

This report ensures that there will be opportunities in the future to debate the question raised by the Senator from West Virginia.

There is a limited number of dollars available for the Medicare drug benefit. In the writing of this bill, we made a conscious decision to devote excess dollars to filling the gap in coverage—which means what we commonly refer to around here as the donut hole—rather than eliminating or changing to some extent the asset test the Senator from West Virginia is asking me about.

This bill already provides generous coverage to low-income seniors. This amendment will not only cost more money, it will add more confusion to both States and Medicare beneficiaries.

I hope I have sufficiently explained the rationale behind our bill. I may not have directly answered the question of the Senator from West Virginia, but I thought I should take time to explain the rationale behind our bill.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I would like to say a couple of words about one of the two amendments offered by the distinguished Senator from West Virginia regarding the true out-of-pocket expenses, where the employers' contributions to retirees' health care plans be considered in calculating the out-of-pocket expense that would determine when a senior citizen reaches the stop loss provisions of this bill.

This may sound like a fairly arcane point, but it is a very important one.

Let me just describe the provisions of the bill. Under the bill, after a $275 deductible, the provisions of this bill require that employees would receive a contribution from the Government of 50 percent of each prescription he or she filled, up to $4,500 in drug expenses. After that amount, $4,500, then seniors would pay 100 percent of the costs until the beneficiary's spending reached $3,700. This should not be confused with total spending, of which the beneficiary spent $3,700 out of his pocket. It would be $5,812.

Anyway, after the beneficiary spends $3,700 out of pocket, the total stop loss coverage kicks in and the Government picks up 90 percent of the beneficiary's drug spending and the beneficiary, him or herself, pays 10 percent.

The real question is, What about the employers' contributions? Would they count toward the stop loss coverage? Under the underlying bill, all spending must be provided by the beneficiary, not on behalf of the beneficiary. As a consequence, employers' contributions would not count. The CBO estimates up to 37 percent of retiree health coverage would therefore be dropped by employers.

Just to recapitulate, the amendment offered by the Senator from West Virginia basically provides that the stop loss amounts in the underlying bill should be based on out-of-pocket costs, and the employers' contribution towards retiree health benefits could count towards that stop loss computation.

What about this? Frankly, I have a lot of sympathy for the Senator's amendment. That is, as it currently stands, the beneficiary, a senior citizen, would have to spend $3,700 before the stop loss would be calculated. Under the amendment offered by the Senator from West Virginia, that amount would be quite a bit lower.

I mentioned earlier that CBO estimates about 37 percent of retirees who now are covered by health plans under their employer health coverage would no longer receive drug coverage because those employers would drop coverage. Or, to say it differently, CBO estimates that, because the employer's contributions do not now count towards stop loss, about 11 percent of the seniors generally would lose their employer-sponsored health coverage.

As I mentioned, I share my colleague's desire to prevent the loss of employer-sponsored coverage; that is, to the extent possible. We have our work cut out for us because retiree coverage is already on the decline. According to the Kaiser Family Foundation/Hewitt Study, that was released last December, one in five large employers is likely to eliminate retiree health coverage for future retirees in the next 3 years.

That is a lot. That is irrespective of the provisions of this bill with respect to prescription drug coverage. If one out of five large employers in fact does eliminate retiree health coverage for their retirees within the next 3 years, it is going to have a huge impact, clearly, on those retirees, and also on the portion of the health care system that is not paid for by larger companies.

That study also found that nearly 80 percent of large employers are likely to increase the amount paid directly by their employees for health care. That is, most—four-fifths of all employers—are likely to have their employees pay more than they, the employers, are paying. We know about the negotiations between General Electric and its employees not too long ago, where both agreed to shift more of the rising cost of health care to employees. Clearly, we should be doing all we can to ensure that a bad situation does not get worse.

The chairman of the committee, Senator GRASSLEY, and I have been looking for ways to address concern about employer-sponsored coverage. We are looking at ways to make employers' participation in the new Part D benefit more manageable, so employers have flexibility with respect to the offering of these benefits. I, certainly, personally am willing to entertain proposals that would allow more employer coverage, and also help address the out-of-pocket situation the Senator from West Virginia would like to cover with his amendment.

The slight problem we have, as most of us know, is that we are working within the confines of $400 billion over 10 years. If the amendment offered by the Senator from West Virginia were to be agreed to, according to CBO, that would cost approximately $65 billion. That is $65 billion, generally, over the $400 billion that has been set aside for this bill. Senator GRASSLEY and I are working with various groups in and out of the Senate, trying to address the potential loss of employer retiree coverage. It is a great concern of ours. There have been several proposals offered as to how we might deal with that, in addition to the ones contained in the amendment by the Senator from West Virginia. I am hopeful that during the next several days, before the final passage of this bill—hopefully before the weekend—we will be able to significantly address this issue. So far, we do not have it nailed down. But as you might expect, this and a lot of other issues are kind of hovering about as we try to find ways to fit the pieces together so we can get a very good bill passed.

I also remind my colleagues who are slightly concerned about the complexity of this bill—and this bill is somewhat complex—there was an interesting piece in, I think it was today's New York Times; it might have been yesterday's. In any event, it was about the complexity of the bill and how bewildered some people are because of the complexity. I think the article did a good job in explaining why major social policy, almost by definition, is complex; that is, it is a result of compromises.

In this case, the big compromise is between about half of this body, who wants to provide prescription drug benefits under Medicare, and about half of this body, who wants prescription drug benefits to be provided under private competition. It is difficult to put those two pieces together. It is the attempt to put those two pieces together that has caused a lot of the complexity that does exist in this bill.

I might say, however, that Medicare itself is already quite complex. They could come back and say: Why make something complex even more complex? But it has to be weighed against another factor. That is, do we want to provide a prescription drug benefit to seniors or not? The choice at the end of this week is going to be, do we want something that is a little bit complex but provides prescription drug benefits for seniors—and does a good job doing so? Maybe with not as many benefits as some seniors would like and some Members of this body would like, but still does a pretty good job and is a bit complex. Or, on the other hand, do we want to do nothing? Do we want to let senior citizens today, who do not have prescription drug coverage, remain without coverage? That is basically the question we are going to be facing later on this week.

To ask the question, I think, is to answer it. Namely, we should do a pretty good job, trying to get a pretty good bill passed, even though there is some complexity, even though there are some tradeoffs, rather than have nothing.

I suspect this body is always going to be somewhat split. I do not think one party is going to be totally in control at one time or the other party is going to be totally in control at another time. I think it is the nature of the American body politic that people want to hedge their bets, that they want to have both Democrats and Republicans working together. Certainly, our Founding Fathers set up our Government that way under our Constitution. They absolutely distrusted power. They distrusted it almost absolutely. That is why we have power dispersed by definition. That means in order to get something of consequence passed, there is going to have to be some compromise. In this bill there certainly is a lot of compromising.

A final point contained in that article—and I thought it was a pretty good article—is that when we, in this country, have passed other major social policy—let's say Medicare and Social Security—it has been based somewhat on faith, and we have worked to fix it, to make it even better after it has been passed. But you have to start somewhere. And I think, certainly, we have to start somewhere with respect to prescription drug benefits, and certainly, we should provide prescription drug benefits for seniors.

So I urge my colleagues to keep that in mind as we are working on amendments, which are designed to make this bill better. We can accept some amendments, but some in this body will not accept others. Nevertheless, all of us are generally working together toward the same goal.

In that vein, Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside so the Senator from Hawaii may offer two amendments in sequence.

The PRESIDING OFFICER (Mr. SUNUNU). Is there objection?

Without objection, it is so ordered.

The Senator from Hawaii.

AMENDMENTS NOS. 980 AND 979

Mr. AKAKA. Mr. President, I rise today to offer amendment No. 980 to restore Medicaid and State Children's Health Insurance Program eligibility for children and pregnant women who are citizens from the Freely Associated States and reside in the United States lawfully. The United States entered into a Compact of Free Association with the Federated States of Micronesia and the Republic of the Marshall Islands in 1986, and with the Republic of Palau in 1994.

The political relationship between the United States and the FAS is based on mutual support. In exchange for the United States having strategic denial and a defense veto over the FAS, the United States provides military and economic assistance to the RMI, FSM and Palau with the goal of assisting these countries in achieving economic self-sufficiency following the termination of their status as U.N. Trust territories. Pursuant to the Compact, FAS citizens are allowed to freely enter the United States and are not considered immigrants.

Legal immigrants and FAS citizens lost many of their public benefits as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. I appreciate the work done by my colleague from Florida, Senator GRAHAM, to restore the eligibility for Medicaid and SCHIP for legal immigrants who are children and pregnant women.

The language that has been included in S. 1, the Prescription Drug and Medicare Improvement Act, would give States the option to provide this coverage and allow them to use Federal resources to do so.

However, the current text does not restore these benefits to citizens from the FAS lawfully residing in the United States. Arguably, FAS citizens have strong ties with the United States as they come from the countries that are perpetually bound to the United States in free association.

It is important for Congress to restore these benefits for FAS citizens that were taken away from a relatively small but important population. The Congressional Research Service estimates that 11,500 FAS citizens have migrated to the United States since the Compact was enacted. They have come to the United States to seek economic opportunity, education, and access health care.

The State of Hawaii, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands have supported FAS citizens with necessary health care services, but not without significant and increasing costs. The Federal Government must provide matching resources to help States meet the health care needs of FAS citizens and to meet the obligations of the Federal commitment.

I urge my colleagues to support this amendment to restore a portion of the benefits that were taken away from FAS citizens in 1996.

Mr. President, I have another amendment, amendment No. 979, to offer to S. 1.

The PRESIDING OFFICER. Does the Senator wish to offer both amendments?

Mr. AKAKA. The amendments are at the desk.

The PRESIDING OFFICER. The Senator will be advised, neither amendment has been reported by the clerk.

Without objection, the clerk will report both amendments.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. AKAKA] proposes amendments numbered 980 and 979.

Mr. AKAKA. Mr. President, I ask unanimous consent that reading of the amendments be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT 980

(Purpose: To expand assistance with coverage for legal immigrants under the Medicaid program and SCHIP to include citizens of the Freely Associated States]

On page 636, line 16, insert "and citizens of the Freely Associated States, which include the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, lawfully residing in the United States" after "Act".

AMENDMENT 979

(Purpose: To ensure that current prescription drug benefits to medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished)

At the appropriate place, insert the following:

SEC. . NEGOTIATIONS BY THE OFFICE OF PERSONNEL MANAGEMENT.

The Office of Personnel Management may not negotiate a prescription drug benefit for any health benefits plan under chapter 89 of title 5, United States Code, that would provide a prescription drug benefit to a medicare eligible enrollee in that plan that is of lesser actuarial value, based on 2003 constant dollars, than the prescription drug benefit available to a medicare eligible enrollee of such plan on the date of enactment of this Act.

Mr. AKAKA. Mr. President, amendment No. 979 would ensure that the Federal Employees Health Benefits Program could not reduce the level of prescription drug coverage available to Medicare-covered Federal civilian annuitants. I thank my colleague from Maryland, Senator MIKULSKI, for cosponsoring the amendment.

I strongly support the creation of a prescription drug benefit for Medicare beneficiaries. Thirty-eight percent of Medicare beneficiaries report that they do not have prescription drug coverage. Far too many seniors are unable to afford the medications that they need, and the establishment of a prescription drug benefit will provide much needed access to medications that our seniors desperately need.

However, the Congressional Budget Office believes that Medicare drug coverage authorized by this bill is likely to act as an incentive for employers to drop their employer-sponsored drug benefits. An estimated 37 percent of retired workers with employer-sponsored drug benefits could lose their coverage under this bill according to CBO. I am troubled that older Americans who already have earned coverage through an employer-sponsored plan could lose their existing benefits. We have seen over the past few years that there has been a disturbing trend of reducing benefits for retirees. Creating this voluntary benefit could only accelerate this trend.

The intent of the legislation is to expand prescription drug coverage for seniors, not merely to shift the financial burden of existing coverage to the Federal Government. If Medicare beneficiaries lose their employer-based coverage, they may have to pay more for a Medicare drug benefit that provides less comprehensive coverage.

We must encourage employers to maintain their current coverage, and I will support efforts to do so. We should not shift the existing costs of prescription drug coverage to the Medicare program. If this occurs, there will be fewer resources available to pay for the medications of those who currently need insurance.

My amendment will ensure that present and future Federal retirees retain their current level of prescription drug coverage. They should not face a situation in which they must rely on Medicare. My amendment requires the FEHBP to preserve current-level drug coverage for Federal retirees and survivors. The Government health care plan stands as a model employer-sponsored health care plan, and my amendment protects the Nation's Federal annuitants and their survivors. Accepting this amendment sends a message to other employer-sponsored plans that the Federal Government stands behind its commitment to retired workers.

I ask unanimous consent that letters from the National Association of Retired Federal Employees and the National Treasury Employees Union in support of my amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE NATIONAL
TREASURY EMPLOYEES UNION,
June 23, 2003.

RE: S.1, Medicare Drug Proposal

DEAR SENATOR: On behalf of the more than 150,000 federal employees and retirees represented by the National Treasury Employees Union (NTEU), I am writing concerning S.1, legislation to provide prescription drug coverage under Medicare.

NTEU believes legislation to provide prescription drug coverage for Medicare beneficiaries is long overdue, however, we have serious reservations concerning the way that this benefit has been structured. The proposed new benefit would provide a substantially less valuable benefit to Medicare beneficiaries than many private sector employers already provide for their retirees. Employers must not be permitted to diminish the prescription drug coverage they provide to former employees as a result of passage of this new Medicare benefit. Although we do not believe that is the intent of this legislation, steps must be taken to prevent this unintended consequence from occurring.

The federal government provides health insurance benefits, including prescription drug coverage, to its employees and retirees through the Federal Employees Health Benefits Program (FEHBP). Any proposal that would encourage, or result in, the federal government moving away from its commitment to its employees and retirees in this area would be strongly opposed. The fact that the Congressional Budget Office has reported that as many as 37 percent of retired workers would lose their employer-provided drug coverage as a result of passage of S.1 provides serious cause for concern.

Senator Akaka plans to offer an amendment that seeks to address this issue. His amendment would prohibit the Office of Personnel Management (OPM) from negotiating a prescription drug benefit for Medicare-eligible FEHBP enrollees that is less valuable than the benefit available to those enrollees on the date of enactment of the pending Medicare drug proposal. The Akaka amendment makes sense and is consistent with the intent of the Medicare legislation—that employers already providing prescription drug benefits to their retirees continue to offer their existing benefits packages.

Our goal is two fold: to provide Medicare beneficiaries with the best possible drug benefit while at the same time ensuring that retirees who enjoy prescription drug coverage through employer-sponsored plans retain that coverage. I urge your support for the Akaka amendment.

Sincerely,

COLLEEN M. KELLEY,
National President.

NATIONAL ASSOCIATION OF
RETIRED FEDERAL EMPLOYEES,
Alexandria, VA, June 24, 2003.

Hon. DANIEL K. AKAKA,
Senate Office Building,
Washington, DC.

DEAR SENATOR AKAKA: On behalf of the 400,000 member National Association of Retired Federal Employees (NARFE), I am writing to endorse your amendment to S. 1, the Prescription Drug and Medicare Improvement Act of 2003, that would ensure that the Office of Personnel Management (OPM) could not reduce the level of Federal Employees Health Benefits Program (FEHBP) prescription drug coverage currently available to Medicare-covered Federal civilian annuitants through negotiations with participating carriers.

NARFE strongly supports the creation of a Medicare drug benefit for our senior citizens who have no drug coverage. But at the same time, we want to ensure that no harm is done to older Americans who already have earned such coverage through an employer-sponsored plan. As you know, the Congressional Budget Office estimates that 37 percent of retired workers with employer sponsored drug benefits could lose it under S. 1.

The CBO believes that Medicare drug coverage authorized by this bill could act as an incentive to employers to drop their employer-sponsored drug benefits. If that occurred, retirees would be forced to pay an additional monthly premium for a Medicare drug benefit that would be limited and more costly than what is currently available through many employer-sponsored health plans, including the FEHBP. The last thing Medicare reform should do is encourage employers to break promises made to their retirees regarding their earned health security.

While the Medicare reform bill that is eventually enacted may provide subsidies and tax credits to private employers who retain existing drug benefits for their retirees, such incentives would not apply to the Federal government, and thus provides no guarantee of the FEHBP drug benefit for the government's own annuitants. If FEHBP is the model for this reform, the Federal government itself must not drop or reduce drug benefits for FEHBP enrollees. Your amendment recognizes this principle of fairness and would help to ensure that S. 1 does no harm to those men and women who have served and continue to do so much for our nation. NARFE commends you for valuing the importance of the earned health security of the more than 4 million Federal workers and annuitants and we give our strongest endorsement to your amendment.

Sincerely,

CHARLES L. FALLIS,
President.

Mr. AKAKA. Mr. President, I urge my colleagues to support my amendment and look forward to working with them to ensure drug coverage for retirees under other plans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be temporarily set aside so the Senator from Arkansas may offer an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Arkansas.

AMENDMENT NO. 981

Mr. PRYOR. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arkansas [Mr. PRYOR] proposes an amendment numbered 981.

Mr. PRYOR. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide equal access to competitive global prescription medicine prices for American purchasers)

At the appropriate place, add the following:

SEC. . EQUAL ACCESS TO COMPETITIVE GLOBAL PRESCRIPTION MEDICINE PRICES FOR AMERICAN PURCHASERS.

(a) DEFINITION OF COVERED PRODUCT.—In this section, the term "covered product" has the meaning given the term in section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

(b) PROHIBITION.—It shall be unlawful for the manufacturer of a covered product or any other person that sells a covered product to refuse to sell to any wholesaler or retailer (or other purchaser representing a group of wholesalers or retailers) of covered products in the United States on terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other term that effectively reduces the cost to the manufacturer of supplying the drug) that are not substantially the same as the most favorable (to the purchaser) terms on which the person has sold or has agreed to sell the covered product to any purchaser in Canada.

(c) ENFORCEMENT.—The Secretary of Health and Human Services, or any wholesaler or retailer in the United States aggrieved by a violation of subsection (b), may bring a civil action in United States district court against a person that violates subsection (b) for an order—

(1) enjoining the violation; and

(2) awarding damages in the amount that is equal to 3 times the amount of the value of the difference between—

(A) the terms on which the person sold a covered product to the wholesaler or retailer; and

(B) the terms on which the person sold the covered product to a person in Canada.

(d) EFFECTIVENESS OF SECTION.—This section takes effect on the date that is 2 years after the date of enactment of this Act, except that this section shall not be in effect during any period after that date in which there is in effect a final regulation promulgated by the Secretary of Health and Human Services permitting the importation or reimportation of prescription drugs under section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

Mr. PRYOR. Mr. President, I rise to address the Chamber about my proposed amendment that fits very neatly with an amendment that passed last week 62 to 28. It is a fallback amendment to that Dorgan-Cochran proposal.

The way I view this amendment—I hope the way my colleagues will understand it—it is really an antiprice gouging amendment as we go through the process and hopefully add a prescription drug benefit to Medicare that so many people in the country want and deserve.

We all know the stories about drugs that are produced in this country that are made at certain plants and certain places. And when they leave the plant, one truck will go to one of our home States and the other truck will go to Canada. Unfortunately, what happens all too often is when the drugs get to Canada, they are about one-half or one-third or one-quarter the price that people can buy those drugs in the United States. In my opinion, there is no valid reason for that. There is no valid justification for those drugs to be priced in that way.

We also know the Senate has tried to address this problem on at least a couple occasions—in the year 2000 and in the year 2002. This very Chamber voted to allow the reimportation of pharmaceuticals from other countries. Of course, the reimportation of drugs would be FDA-approved drugs coming out of FDA-approved facilities. In fact, for the third time in 4 years, the Senate voted this past Friday to allow the same thing.

Currently, the law is reimportation can come from a list of countries. There is a designated list. That has been somewhat cumbersome. And the FDA has not seen fit and has not been able yet to approve this process because they can't certify or verify that the drugs are safe. One thing I like about the Dorgan-Cochran amendment is it limits the scope of reimportation only to Canada. That is a significant advancement because we all know that Canada has very high medical standards and that they are very concerned about their populous and the veracity of medication in their society.

My proposal also is limited just strictly to Canada. One advantage is that they have a very similar, almost identical set of standards for handling drugs to make sure that there is a chain of custody, proper testing, et cetera. They build in the safeguards just as we do. A lot of countries don't do that. But with Canada we have a certain degree of confidence—maybe not absolute; I guess you can never have an absolute degree of confidence—that drugs are going to be safe. We have a very high degree of confidence that the drugs will, in fact, be safe and they will meet U.S. standards.

Let me briefly address my amendment. It is only three pages—very simple, very straightforward. In terms of the definition of covered product, we adopt the existing law. Therefore, there is no surprises, no monkey business or games played with the definition. When it comes to the prohibition in section B, which is found on page 2 of the amendment, in summary—I will delete all the commas and the parenthetical phrases, but in summary it says: It shall be unlawful for the manufacturer of a covered product to refuse to sell to any wholesaler or retailer—and that is key—on terms that are not substantially the same as that of any purchaser in Canada.

Let me run through that very quickly, if I may. One of the keys is that it is for wholesalers and retailers. What that means is that wholesalers and retailers in this country can reimport from Canada.

We all know if our local pharmacist could somehow work out an arrangement with wholesalers and retailers in Canada, they could actually buy the products in Canada, have them shipped to the United States, and sell them cheaper here than they can buy them wholesale in this country.

One of the keys is that American wholesalers and retailers are subject to all the FDA rules and regulations and requirements.

Therefore, this amendment will only allow the reimportation of safe FDA-approved products made at FDA-approved facilities. When it comes to enforcement, this amendment would allow the Secretary of Health and Human Services, as well as any wholesaler or retailer in this country that is aggrieved by some unfairness—the thing I like about that and I hope my colleagues understand—it allows both the Government sanction, the ability to enforce this, but also the free market. We all know the free market works very well, and when a free market can regulate itself, I think we are all better off. It has the ability for the Government to enforce this if necessary.

In the last bit, on page 3 of the amendment, it deals with the timeframe. That is a 2-year provision from the enactment of this act that this will take effect. In other words, the way this works is, once we pass this legislation, the President signs it, it becomes effective 2 years after it is enacted. Then it will trigger this act if the FDA has not issued its final regulations. Then we will be able to purchase these drugs at the same prices they get in Canada. In other words, it is an antiprice-gouging mechanism that I think is critical to this legislation and to its long-term success.

I very much applaud the leadership in this Chamber, especially coming from Chairman GRASSLEY and Senator BAUCUS, Senator FRIST, Senator KENNEDY, Senator DASCHLE, Senator GRAHAM, and, of course, Senators DORGAN and COCHRAN have shown leadership not just on this issue but on prescription drugs generally. I thank them for getting this to the Senate floor and allowing this very important debate and allowing these important amendments to be considered.

I do believe very strongly that when the bill came to the floor, it was a bill definitely worth our consideration. But I also think and believe very strongly that the bill has improved since it has been on the floor. I think these amendments are making the bill stronger and better for the American public.

For example, the Enzi amendment, which I like quite a bit, makes sure that people will still have access to use their local pharmacists. Not only are many pharmacists pillars of the community, not only do they do great things in their communities, but so often patients getting prescription drugs need to talk to their pharmacist about drug interactions, expiration dates, and details of how to take it. It is very important for the effectiveness of the drug that people talk to a local pharmacist and have access thereto. So I thank Senator ENZI for doing that.

The Gregg-Schumer-McCain-Kennedy amendment closes loopholes to allow name-brand drug manufacturers to unfairly extend their monopolies and overcharge American patients. This has been going on for a long time and it is something, when I was Attorney General, we worked on very hard to try to stop from the litigation standpoint. But now Congress has taken action, and I am so pleased that they are stopping this legislatively.

We have mentioned the Dorgan amendment, with the Cochran second-degree amendment, and how that has strengthened the bill and how, hopefully, that will cause prices to stabilize and, in fact, hopefully, come down over time. I think there is still some work to be done on this bill, and I think during the course of this week there will be a lot of great amendments to consider. I hope I can vote for some of those. When I believe it will make this bill better, I will support it.

Let me run through the chart very quickly. What we see is a graph with two lines. You can see that this lower line says "health." If you were to look at the consumer price index, or one of the other indexes, it would be even lower than this green line, but it would go up slightly. That is, of course, the inflation rate, and it goes up 2, 3 percent a year.

Right here, we see the health care costs. If you go back to 1994—our baseline year—the price, the cost of health care, in just these 7 or 8 years has gone up 63.6 percent. One thing we all hear from our constituents is how much health care costs are increasing. For a lot of people, they have increased 10, 15 percent—sometimes more—a year. It is strangling people.

If you look inside the numbers and you look at the No. 1 cause of health care costs going up, it is the cost of prescription drugs. That is what this red line indicates. Again, you can see the rapid growth that is outpacing the costs of health care and inflation, and it is pulling health care costs up and in a very dramatic fashion. I think pretty much everyone who has looked at this nationally agrees that it is the high cost of prescription drugs that is the primary reason—there are other factors—why health care costs are going up so dramatically.

In this proposal—not in my amendment but in the actual bill—we are talking about having a $250 deductible and a stop loss protection that kicks in, paying 90 percent of drug costs after $3,700 of out-of-pocket spending. Well, one thing the American public needs to understand, and all of us Senators need to remember, is that these are percentages and they will go up as the costs of prescription drugs go up. So one thing we need to be very mindful of is, as we watch this red line, the top numbers on this particular chart, go up—in fact, CBO says about 12 percent a year, and they are taking average numbers. They have been going up more than 12 percent per year in the last few years. If we say more than 12 percent a year, after 5 years that deductible of $250 becomes a deductible of $485. In fact, the stop loss threshold goes from $3,700 to $6,521. Both of these adjust based on cost of prescription drugs—not based on the cost of health care or on the cost of an increase in inflation but based on the cost of prescription drugs. What that means is that in 10 years the deductible will go to $854, and the stop loss in 10 years will be $11,492.

Now, what this amendment is designed to do is to try to get ahold of these runaway costs of prescription drugs. As long as these numbers go up like this, the problems in this bill—things that we as Senators don't like about this bill, like the gap in coverage, the deductibles, and the stop losses—are going to get worse. It is going to do nothing but get worse over time.

So what this amendment and what the Dorgan-Cochran amendment are designed to do is to try to somehow keep prescription drug costs down in a very reasonable way. That is why reimportation is so critical because reimportation, in the strange world of prescription drugs, introduces competition into the marketplace. Suddenly, the drug costs here are competing with the drug costs in Canada, and what that will result in, necessarily, is lower drug costs if free market principles are allowed to apply.

While I am 100 percent convinced the administration can and should implement Senator DORGAN's and Senator COCHRAN's amendment, I am not 100 percent sure they will do it. Recently, we received a letter in the Senate from the FDA from one of the Commissioners, Mr. McClellan. Let me quote, if I may, from Mr. McClellan's letter. I may have to put on my reading glasses to do this because that is what happens when you get old, Mr. President. I know I am quite a bit older than the occupant of the Chair. When you get my age, you need these.

THIS is a letter to Senator THAD COCHRAN, and it is from Mark B. McClellan, FDA Commissioner, sent earlier this month, on June 19, 2003. It says:

> The overall quality of drug products that consumers purchase from the United States pharmacies is very high, and the American consumer can be confident that the drugs they use are safe and effective.

That is a key point because we have a very safe marketplace for drugs. In fact, one of the things I did when I was attorney general of my State—and I left there 6 months ago—I sent out periodical consumer alerts to Arkansans about being very careful about buying drugs over the Internet, using mail order companies, and toll-free numbers because sometimes, under some circumstances, you are not sure what you are getting.

We always advise people to be very careful when they do that. I have a bias and a preference for using a local pharmacist.

Let me continue. I am skipping around:

> In FDA's experience, many drugs obtained from foreign sources that either purport to be or appear to be the same as U.S.-approved prescription drugs are, in fact, of unknown quality.

That is something we found in the attorney general's office in Arkansas when I was there.

The letter goes on to say:

> These outlets may dispense expired, subpotent, contaminated, or counterfeit products, the wrong or contraindicated product in an incorrect dose or medication unaccompanied with adequate direction for use. The labeling of the drug may not be in English and important information regarding doses and side effects may not be available. In addition, the drugs may not have been packaged and stored under proper conditions to avoid degradations.

That is true. That definitely happens. We have seen that time and again around this country. But that is one of the great points about the Dorgan amendment. In fact, the Dorgan amendment that was adopted last week with 62 votes has a provision—I am not going to read it all—on page 3 that makes it very clear that we can only reimport FDA-approved drugs at FDA-approved facilities. There has to be documentation; there has to be testing. The safeguards are there.

Also what Mr. McClellan is talking about here is a very serious problem, but by the very same standards he is referring to in his letter, he cannot guarantee that American drugs are safe because we all know in the marketplace there are some problems—a very small percentage in the United States but there are some problems. He goes on to say FDA cannot guarantee the safety of Canadian drugs. As I said, really in a true sense, we cannot guarantee the safety of American drugs either, but the FDA does a very good job.

Interestingly enough, my staff, as we were preparing to be here this afternoon, went on Lexis-Nexis and did a search to find all the reported cases in recent years from Canada related to counterfeit drugs. They could not find one case, one newspaper article, one incident, anything that was reported about counterfeit drugs in Canada. That is using the Lexis-Nexis search. The truth is, we found a number of those in the United States, but we did not find any in Canada.

Lastly, Mr. McClellan's letter to Senator COCHRAN says:

> At this time, the agency simply cannot assure the American public that drugs imported from foreign countries are the same as products approved by the FDA and that they are safe and effective.

Again, our bill fixes this problem because my amendment, along with Senator DORGAN's and Senator COCHRAN's amendment, says it only applies to FDA-approved drugs and it is only from Canada. We have a much more confident sense about the Canadian marketplace for prescription drugs than we do about a number of other countries.

Back when President Bush was running for office in 2000, he had the same impression as most of us when we think about this issue for the first time. He said "it made sense" to allow prescription drugs that were sold overseas to come back. I think he was right about that. It does make sense, as long as we build in the proper safeguards. Again, I think the amendment Friday and my amendment today will do that.

Some say that doing anything to make prescription drugs more affordable will reduce investment in research and development. I disagree. There are many factors that go into research and development, and two of those—and I hope people understand this—two of the major reasons drug companies come here to do their research and development are:

First, we make a huge public investment through the NIH, the National Institutes of Health. They do a lot of the basic research that the drug companies then build on and actually produce prescription drugs.

Second, this country provides a research and development tax credit, and the drug companies take advantage of that, and they should. It is there for them to take advantage. That is why we have it. It is good for the country. It is good for the economy. It is good for our health. I am supportive of those tax credits.

But those are two taxpayer-funded—I do not know if you want to call them subsidies. Call them what you want but those are two taxpayer incentives for these big drug companies to do research and development: The huge public investment we make for NIH, and the research and development tax credit.

One item I read recently that is a little disturbing to me is that the research and development dollars by the big pharmaceutical companies went up by 8 percent. That is good. It is good they are increasing their dollars for research and development. But did you know that their lobbying budget went up by 23 percent? Right now in this country, in this city, there are more lobbyists for the pharmaceutical industry than there are Members of Congress, and they have increased it another 23 percent. I am a little bit disturbed by that. My sense is, the only groups out there, as far as I know—maybe I am wrong; I have not seen anything to the contrary. As far as I know, the only groups out there opposed to reimporting safe drugs from Canada, FDA-approved drugs and FDA-approved facilities from Canada, the only group I know opposed to that is the pharmaceutical industry.

I read a recent story in the New York Times that said somewhere between $2 million and $2.5 million the pharmaceutical industry is giving out to research and policy organizations "to build intellectual capital and generate a higher volume of messages from credible sources."

We saw this happen many years ago with the tobacco industry. I give a little bit of caution here to the pharmaceutical industry. I hope they do not repeat some of what tobacco did that got them into so much trouble. Tobacco actually went out and funded sham research. They funded research that actually said tobacco was not harmful to their health when they knew it was and they had the research to say it was. They funded research to come out and say to the contrary, even though the research could not be validated. I certainly hope that is not what the pharmaceutical industry is doing today, but it sounds as if they are drifting in that direction.

It is definitely in the interest of the American public and of patients who need medical care in this country that we allow the safe importation of drugs from Canada. I think it will help people afford drugs, and it will help make drugs more affordable in this country.

As long as I am talking about the pharmaceutical industry, let me be very clear. I am proud of the pharmaceutical industry. I am proud of what they do. It is amazing some of the accomplishments we have achieved in medicine in the last 100 years. It is even more dramatic than the aeronautics industry. One hundred years ago, the Wright brothers launched at Kitty Hawk. Now, today, you know what we have been able to accomplish in the last 100 years.

The gains have been even more dramatic in the world of prescription drugs. It is amazing. It is critical for the United States to have an industry that is high tech, such as that industry, and that is on the cutting edge, is innovative, and is the world leader.

We want to try to be the leader in anything we can. I will continue to support NIH funding for research and development of prescription drugs. I think that is critical. I think that helps everybody. It is a win/win. It is not always cheap, but it is a win/win. It helps the industry. It helps the public. It helps medicine.

I will continue to support the tax credit for research and development. In fact, I am a cosponsor of a bill that will do that because I believe very strongly American business should have the incentive to invest in research and development because it helps the economy so much in the long term.

I see the prescription drug industry as in a little bit different category than most industries because they have a patent. The fact is that the Federal Government gives them a patent—another word for that would be a "monopoly"—the Federal Government gives them a monopoly for a certain number of years to sell their drugs, but implicit in that monopoly is a public trust.

I think it is incumbent upon the people who hold those patents and the companies which hold those patents that they understand they have a special relationship with the public, because nothing less than the public's health is at stake.

Also, when I am looking at the pharmaceutical industry, I have to observe what Fortune Magazine came out with in the last I think it has been 3 or 4 years running now, that there are three different ways to measure the profitability of an industry. All three ways it is measured, the pharmaceutical industry by any standard is the most profitable industry in America.

The other thing about these companies is we talk about them as if they are our own companies but in fact many of them—maybe the majority, the big guys—are actually foreign corporations doing business in America. Most of these big companies are huge conglomerates that have different divisions and product lines. We need to remember most of these are global companies. They are doing research all over the world and they are selling these drugs all over the world, not just to the American marketplace. I think it is important we not segment the American marketplace at the expense of everything else.

I will talk about three of my experiences as attorney general for Arkansas. I know there are 49 other attorneys general who have had similar experiences, but these were important experiences I had with the pharmaceutical industry. Again, I am proud of the industry. I am very supportive of some of the things they do, but when I was attorney general we had one case where we found out they had secured a monopoly on certain key ingredients to two or three drugs. Without these key ingredients the drugs could not be made, and even the generic companies were buying these key ingredients from this one manufacturer. They purchased that manufacturer and before long, guess what, generic drugs went up because the name-brand company was jacking up the prices to the generics. That is not fair. That is not right. That is not allowing the marketplace to work in the way it should.

We had another case where a pharmaceutical company out and out lied about research. They told the Government they had tests that showed their name-brand product was better than the generic product. Another test came in later and showed they were absolutely the same. Unfortunately, for a number of years they were able to charge more for their product, much more than the generic, because people were convinced the generic was not as good.

When I was attorney general, we found there were a few companies that were playing games with the patent laws and with the FDA regulations and through various maneuvers they were able to extend the life of their patents and monopolies. Again, I did not come to name names and embarrass companies for some of the wrongdoings. I will be glad to visit with any Senator individually who would like to talk about these things. The pharmaceutical industry is a great industry overall. It does great things and I am very supportive of most of the things they do, but sometimes we have to call it like we see it. They do not always come into this debate with the cleanest of hands.

In my amendment, I am proposing a 2-year period of time in which to allow the Health and Human Services Department to establish their regulations in final form. I believe that is ample time. In fact, if it were up to me I would give them 30 days, but I think realistically they need time to verify and certify that the Canadian market is safe. I think they have actually been working on this since the year 2000. The fact the Dorgan amendment passed last week will really narrow their focus. Now that they only have to focus on Canada, I think that will help them quite a bit to bring veracity to these tests and to the marketplace.

Again, my proposal would not take effect if the regulations are finalized, and even if it does take effect in 2 years and then the regulations are finalized at a later time, mine immediately goes out of effect. What it would, in effect, do is make sure we are not paying more for drugs in America than they are in Canada. That is really not too much to ask, considering the U.S. Government will be far and away the largest purchaser of prescription drugs in the world.

The amendment says if the FDA has not implemented reimportation within 2 years of implementation of this law, it will become illegal for drug manufacturers to discriminate against American purchasers compared to our Canadian counterparts. Really, that is what it is all about. It is about price discrimination. I said a few moments ago it is about price gouging. If the prices are justified in Canada, then they are justified here, and we need to make sure we get a price we are comfortable with.

In closing, I say that the consequences of not protecting American patients are too high. Uninsured patients cannot afford the prescription medicines they need today. Drug prices are fueling health care costs in a way we have seen on that previous chart. One thing we see time and time again is employers dropping health care coverage because they cannot afford prescription drugs. The skyrocketing drug costs have a tremendous potential to make the Medicare coverage we are considering erode significantly over time. What I mean by that is, as these deductibles go up, as the stop losses go up, as the gap in coverage widens, this proposed prescription drug benefit is going to make less sense over time because it is going to have so many problems.

Lastly, I want to show my colleagues this chart. We have seen bits and pieces of this already in this debate from last week, but in the first column this chart lists I believe it is nine of the most popular drugs in this country. It lists what they are used for. There are a lot of folks who are looking at this list and seeing big name-brand drug names. They probably use these drugs. Probably a lot of people in this Chamber use these drugs. This column shows what they are used for and then this third column is really critical. It is the U.S. price. It is what people pay in the U.S.

We are basing this on some Web sites. We know these are prices that can be charged here. This next column shows the price in Canada, what we know they can be charged there because we looked at Web sites that sell them. We can see the big difference on every single one of these nine drugs. The drug in Canada is much cheaper—in fact, 39 percent cheaper, 33 percent cheaper, on down the line. This one is 43 percent cheaper in Canada.

Bear in mind that a lot of these drugs are made in the very same plants. They are made in the very same places. One drug goes up to Canada and the other goes to Arkansas, Texas, Georgia, or wherever it may be. These are the very same drugs coming out of the very same plants. They meet all the same standards. In Canada, they are a lot cheaper.

What we are trying to do is get these prices in this column to go down to be a lot closer to the price in the Canadian column. It is not only good for the citizens but good for the taxpayers because as we add this prescription drug benefit we want to see these lower prices because that means tax dollars will go a lot further, and we, as a Nation, will be able to provide many more drugs through Medicare than we otherwise could.

I ask the Senate very respectfully to support this amendment to simply ensure Americans are treated fairly.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside so the Senator from New Mexico can offer three amendments in sequence.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BINGAMAN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 984

Mr. BINGAMAN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 984.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To carve out from payments to Medicare+Choice and MedicareAdvantage organizations amounts attributable to disproportionate share hospital payments and pay such amounts directly to those disproportionate share hospitals in which their enrollees receive care)

At the end of subtitle C of title II, add the following:

SEC. . CARVING OUT DSH PAYMENTS FROM PAYMENTS TO MEDICARE+CHOICE AND MEDICAREADVANTAGE ORGANIZATIONS AND PAYING THE AMOUNTS DIRECTLY TO DSH HOSPITALS ENROLLING MEDICARE+CHOICE AND MEDICAREADVANTAGE ENROLLEES.

(a) REMOVAL OF DSH PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(1) UNDER MEDICARE+CHOICE.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3) and as amended by section 203) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)".

(B) by adding at the end the following new subparagraph:

"(E) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).".

(2) UNDER MEDICAREADVANTAGE.—Section 1853(a)(5) (as amended by section 203) is amended by adding at the end the following new subparagraph:

"(C) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).".

(3) EFFECTIVE DATES.—The amendments made—

(A) by paragraph (1) shall apply to plan years beginning on and after January 1, 2004 and shall continue to apply to plan years beginning on and after January 1, 2006; and

(B) by paragraph (2) shall apply to plan years beginning on and after January 1, 2006.

(b) ADDITIONAL DSH PAYMENTS FOR MANAGED CARE ENROLLEES.—Section 1886(d)(5)(F) ((42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking "clause (ix)" and inserting "clauses (ix) and (xvi)"; and

(2) by adding at the end the following new clause:

"(xvi)(I) For portions of cost reporting periods occurring on or after January 1, 2004, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that is a disproportionate share hospital (as described in clause (i)).

"(II) For purposes of this clause the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with a eligible organization under section 1876 and who is entitled to benefits under part A and any individual who is enrolled with a Medicare+Choice organization or a MedicareAdvantage organization under part C.

"(III) The amount of the payment under this clause with respect to any applicable discharge shall be equal to the estimated average per discharge amount that would otherwise have been paid under this subparagraph if the individuals had not been enrolled as described in subclause (II).

"(IV) The Secretary shall establish rules for paying an additional amount for any hospital reimbursed under a reimbursement system authorized under 1814(b)(3) if such hospital would qualify as a disproportionate share hospital under clause (i) were it not so reimbursed. Such payment shall be determined in the same manner as the amount of payment is determined under this clause for disproportionate share hospitals.".

Mr. BINGAMAN. Mr. President, this amendment deals with the issue of safety net hospitals. That is a label we have put on what are, in fact, called in the law Medicare· disproportionate share hospitals, or DSH. The payments we make for DSH are intended to support these safety net hospitals. By adopting my amendment, we ensure we are not unintentionally reducing the payments to these safety net hospitals.

By "safety net hospitals," in general terms, we are talking about hospitals that provide medical services to a great many individuals who do not have health care coverage. That is where the phrase "disproportionate share" comes from, saying they have a disproportionate share of the uninsured coming to their hospitals seeking medical treatment. We have set up a system through Medicare and also a separate system through Medicaid to provide additional funds to those safety net hospitals.

Since DSH payments are made as add-on adjustments to fee-for-service reimbursements, those payments to hospitals are reduced as Medicare beneficiaries choose to enroll in private health plans and the money is instead logically wrapped into payments by the Federal Government to the private health plans.

We had some testimony before the Finance Committee. Tom Skully testified that he estimates enrollment in private health plans will increase from 10 percent, where it is today, up to 43 percent by the year 2008. Tom Skully, of course, is in charge of administering these programs. His opinion is extremely important in this debate.

If he is right, that would result in an average reduction in the Medicare DSH payments—that is, the payments to the safety net hospitals—of about 37 percent. Clearly, this is not the intent of Congress in this legislation. We are not setting out in this legislation, which is intended to provide a prescription drug benefit to seniors, to intentionally reduce the payments to safety net hospitals. The bill itself, in fact, increases DSH payments to rural safety net hospitals. That is a provision Chairman Grassley and the ranking member, Senator BAUCUS, and I very strongly support.

The Medicare Payment Advisory Commission, which advises the Congress on Medicare policy, has said in their report "plans are overpaid"—private plans, they are talking about—"to the extent they do not pass on DSH payments to the appropriate hospitals."

Congress recognized this program in the past and intentionally carved out graduate medical education, or GME, payments from health plans and made provisions so those payments would go directly to the teaching hospitals. That policy is included in S. 1, but unfortunately the disproportionate share payments were not addressed in the underlying bill.

Also, in the case of Medicaid, Congress required a carve-out of DSH payments under Medicaid to health plans in 1997 when Congress authorized the substantially greater use of managed care in the Medicaid Program. The intent was clear, that Congress did not want to unintentionally harm the safety net hospitals as they had more people move into Medicaid managed care.

We are essentially trying to do the very same thing here. The same recognition and the same policy should apply in the case of Medicare DSH payments that we applied in the case of Medicaid DSH payments.

Our Nation's important public hospitals lost an estimated $527 million in treating Medicare patients in the year 2001. That was with 88 percent of those public hospitals reporting losses on Medicare. They cannot afford additional Medicare cuts. That would be exactly what we would be enacting if we passed the underlying bill without including the amendment I provide here. Now is the time to protect and carve out the amendments intended to go to safety net hospitals to ensure they actually do go to the safety net hospitals even once this program is put in place.

I hope very much my colleagues will support this amendment. I hope it can be adopted and included in the legislation before it passes the Senate.

AMENDMENT NO. 972

Mr. President, I have another amendment numbered 972, and I ask unanimous consent that the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 972.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide reimbursement for Federally qualified health centers participating in medicare managed care)

At the end of title VI, insert the following:

SEC. . REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) REIMBURSEMENT.—

(1) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

"(3) in the case of services described in section 1832(a)(2)(D)—

"(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

"(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

"(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

"(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);".

(b) CONTINUATION OF MEDICAREADVANTAGE MONTHLY PAYMENTS.—

(1) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23), as amended by this Act, is amended by adding at the end the following new subsection:

"(j) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with a MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

"(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

"(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).".

(2) CONFORMING AMENDMENTS.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w–21(i)(1)), as amended by this Act, are each amended by inserting "1853(j)," after "1853(i),".

(B) Section 1853(c)(5) is amended by striking "subsections (a)(3)(C)(iii) and (i)" and inserting "subsections (a)(3)(C)(iii), (i), and (j)(1)".

(c) ADDITIONAL MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—Section 1857(e) (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

"(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

"(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

"(B) COST-SHARING.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).".

(d) SAFE HARBOR FROM ANTIKICKBACK PROHIBITION.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in subparagraph (E), by striking "and" after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

Mr. BINGAMAN. As we proceed with this consideration of S. 1—and I believe firmly that it will be passed through the Senate this week—we need to be very careful not to create unintended consequences as a result of our legislation.

The previous amendment I discussed tries to head off some unintended and certainly undesirable consequences for safety net hospitals. This amendment tries to do the very same thing with regard to community health centers. Let me explain what this amendment does.

First, I am concerned about the implications that passing this underlying legislation as it now is pending in the Senate could have on the Nation's community health centers. Community health centers have enjoyed broad bipartisan support in Congress. They have enjoyed strong support from the President. The President and the Congress have committed to doubling the funding for community health centers over a 5-year period. That is an encouraging development. Health centers provide care to over 13 million people annually, nearly 1 million of whom are low-income Medicare beneficiaries. They receive section 330 Federal Public Health Service Act grant funds to support care for the uninsured and for low-income patients.

To ensure that those grant dollars are spent for the purposes intended, Congress has specifically taken action to ensure that both Medicare and Medicaid are fully reimbursing the health centers for the costs associated with the care those health centers provide to Medicare and Medicaid beneficiaries.

Simply put, funding intended for low-income and uninsured people should not be diverted and used to subsidize Medicare underpayments. Therefore, health centers are reimbursed by Medicare under a cost-based system.

The amendment I am offering, amendment No. 972, would simply extend this same requirement to the new Medicare Advantage Programs by ensuring that community health centers are provided with a wraparound, or a supplemental payment equal to the difference between the payments they now receive under Medicare generally and the payments they would receive from Medicare Advantage plans.

This concept is not new. In 1997, when Congress allowed States to dramatically increase the number of patients enrolled in Medicaid managed care, we recognized the potential impact on community health centers, and we required the Medicaid Program to provide this wraparound, or supplemental payment, for the difference between the managed care organization's payment and the health center's reasonable cost. We need to do the same thing here, with my amendment, in the Medicare Program.

According to testimony, again, from Tom Scully, which I referred to just a minute ago, the hearing we had in the Finance Committee indicated there are widely differing estimates for how many Medicare beneficiaries would actually enroll in private health plans. Those estimates range from 9 percent to 43 percent, a fivefold difference.

Dr. Holtz-Eakin's words were that:

> These are honest differences in trying to read a very uncertain future.

All of us want to reduce that uncertainty. If Mr. Scully is correct, then health centers will lose their guarantee of cost-based reimbursement to 43 percent of their Medicare patients, and that potentially will result in centers having to dip into their Federal grant funds, which is money that was intended to provide care to the uninsured to make up for losses to their Medicare patients.

The Nation's safety net is already a fragile one. We should take this action. We should adopt this amendment to ensure we are not jeopardizing that safety net even further by passing the underlying legislation without the amendment.

Again, this Congress and the President have made a commitment to these community health centers to deal with the growing number of uninsured in the country. In light of this, the amendment is, in my view, vital to the health of these health centers and ensuring the health centers are not forced to decide whether to subsidize the Medicare Program with their grant dollars or refuse to provide services to the 1 million Medicare beneficiaries to whom they currently provide those services.

Just as I indicated with the previous amendment, I think this will substantially improve the bill. I urge my colleagues to support this amendment, and I hope, when we come to consideration of it and a vote on it, that the Senate will endorse this amendment. It will avoid a consequence that I know is not intended by any of my colleagues here in the Senate.

I ask this amendment I have just been discussing, amendment No. 972, be set aside so I may off another amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 973

Mr. BINGAMAN. Mr. President, I ask amendment No. 973 be called up for immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

> The Senator from New Mexico [Mr. BINGAMAN], proposes an amendment numbered 973.

Mr. BINGAMAN. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all medicare part B services furnished by certain Indian hospitals and clinics)

At the end of subtitle B of title IV, insert the following:

SEC. . AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) IN GENERAL.—Section 1880(e) (42 U.S.C. 1395qq(e)) is amended—

(1) in paragraph (1)(A), by striking "for services described in paragraph (2)" and inserting "for all items and services for which payment may be made under such part";

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

Mr. BINGAMAN. Mr. President, this amendment deals with Indian Medicare Part B services. The Indian Health Service, of course, operates hospitals and clinics in various parts of the country, several in my State. Those hospitals and clinics provide health care to American Indians on or near reservations and to Alaska Natives. In many cases, those are hospitals and clinics that currently are unable to bill for all of the Medicare Part B services they are providing. In effect, the Indian Health Service under current law is subsidizing the Medicare Program because those services which would otherwise be paid for by Medicare, if it were a different provider other than the Indian Health Service—are having to be paid by the Indian Health Service itself.

I think we in the Senate are all aware that the Indian Health Service, year after year, has been substantially underfunded. In 2000, Indian Health Service hospitals and clinics were made eligible for services of physicians and certain other practitioners, but there were real limits put on the services that were provided. Specifically, they were denied payment, the Indian Health Service hospitals and clinics were denied payment for the following important items that I will call to the attention of my colleagues so they may realize what the Indian Health Service is not permitted to be reimbursed for in the current law: Durable medical equipment. This includes such items as wheelchairs, as well as blood testing strips, blood monitors for diabetes patients—which is a severe problem among Native Americans throughout this country.

The second item is home and some institution dialysis supplies and equipment. Since the prevalence of diabetes in the Native-American population and among Alaska Natives is three times the rate in the general U.S. population, Indian people experience a high rate of renal disease, including end-state renal disease. Clearly these are expenses, these are supplies, this is equipment that should be reimbursed.

Third, cancer screening.

Next, Pap smears, glaucoma screening, clinic and hospital-based ambulance services, prosthetic devices, covered vaccines, including hepatitis B, pneumococcal and influenza, chemotherapy and antigen drugs, and clinical laboratory services.

The amendment I am offering would simply make these Indian health facilities and providers eligible for payment for all of the Part B Medicare-covered items, and individuals, to the same extent other providers are eligible for payment for those supplies and services.

The amendment assures that Native Americans would have the same access to health services as any other American. If the Indian Health Service providers are unable to bill for those services, as they currently are, then the Indian Health Service budget shortfalls wind up resulting in the rationing or delaying of treatment to many of our Native-American citizens. For some of these individuals, it means going out of the Indian Health Service system in order to get more prompt service because other providers, in fact, do get reimbursed and can get reimbursed on Medicare for providing those services.

Native Americans and Indian Health Service providers should not be subject to such barriers to care and to payment. Similarly, they should not be subject to such complexity as they are only prohibited from billing and receiving payment for certain services and not for others.

It needs to be noted that the Medicare Advantage payments are based in part on fee-for-service expenditures in the defined region. For those areas with large numbers of Native Americans—such as my State—payment rates are skewed downward if the Indian Health Service providers are unable to bill appropriately for the full range of services. We have lower reimbursement rates for Medicare in my State than many of the surrounding areas. One of the factors—not the only one, but one of the factors that is causing that is this problem I am trying to address with the amendment, the problem that the Indian Health Service is unable to be reimbursed. Accordingly, the amount Medicare is paying is skewed downward. Accordingly, that affects Medicare payments throughout the region.

There is absolutely no policy rationale for limiting the payment to the Indian Health Service hospitals and clinics for only certain of the Medicare Part B services.

I urge the Senate to end this unfortunate discrimination that has been built into the statutes under which we currently operate.

I hope, again, this amendment will be favorably acted upon by the Senate when it comes to a vote. I believe it will substantially improve the legislation and will correct an inequity that is in current law that needs to be corrected.

AMENDMENT NO. 933

Mr. President, let me at this point move to another amendment. We do not need to move off the current amendment, but I wish to discuss a different amendment that is pending that I am not calling up for a vote at this time but one I offered sometime earlier.

The amendment I wish to speak about briefly now relates to the assets test. It is a proposal I have made to repeal the assets test.

First, I compliment Chairman GRASSLEY and the ranking member, Senator BAUCUS, for making significant progress and improvement with respect to the low-income benefit as compared to similar legislation that was considered last year. The bill, although improving the low-income benefit and reducing the impact of the assets test, still leaves in place an assets test of just $4,000 for an individual and $6,000 for a couple.

This assets test has two very important consequences. By explaining these consequences, I think I will be able to explain what I mean by an "assets test."

First of all, for those who have incomes below the poverty level, if you own as much as $4,100 in a whole range of different assets combined—it can be savings accounts, bonds, savings bonds, burial plots, insurance policies, a car, the net worth of your car, livestock, whatever you happen to own—if the combined value of these categories adds up to $4,100, then your cost sharing under the bill increases and you do not get the full benefit of this low-income prescription drug benefit we are talking about as part of this legislation.

Your cost sharing under the bill increases by 400 percent if you fail this assets test compared to similarly situated low-income people. If your income is between 100 and 135 percent of poverty, then the assets test increases cost sharing by 200 percent; that is, you have to pay twice as much if, in fact, your total assets add up to more than $4,100.

The result is, Congress has effectively established a policy that encourages low-income seniors or people with disabilities to further impoverish themselves—that is, dispose of their property, sell their property off—in order to get the full benefit that is advertised.

What kind of sense does this really make, to ask low-income and vulnerable seniors and people with disabilities to get rid of the very minimal savings they have in order to get the full low-income benefit?

Let me talk about the other aspect of this that I think is particularly significant and needs to be discussed here. I think more and more, as people have been reading this legislation—this legislation goes on for more than 600 pages, so anyone who thinks we are doing something simple here by just giving people a prescription drug benefit has not spent the time to try to understand this legislation and read it.

One of the aspects of the assets test that is most troublesome is the enormously cumbersome and bureaucratic procedure we put in place that affects so many of our low-income seniors who want to benefit from this prescription drug benefit we are adding. Also, there is a very substantial invasion of people's lives involved. Let me explain that in a little more detail.

Any of you who do not think this is a complex, cumbersome, bureaucratic process we are setting up for low-income seniors, I urge you to just read the Pennsylvania 16-page application for low-income Medicare beneficiaries who want to qualify for assistance with premiums and copayments and deductibles that will also be the basis for qualifying for the low-income benefit in this bill. I question whether many of us in Congress would be able to fill out that application.

What I have on this easel is not the Pennsylvania 16-page application. This is a much shorter, so-called streamlined 4-page application from the State of Ohio.

To comply with the assets test requirement, as shown on this chart, in the State of Ohio they ask you to detail in this form all that you own in an enormous number of categories. Let me just go through this: your savings accounts, your checking accounts, anything you have with a credit union, any promissory notes, any stocks and bonds, any tax shelter accounts, any certificates of deposit, automobiles, 401(k)s, trust funds, Christmas clubs, vehicles of any kind other than an automobile—if you happen to have a pickup—money market funds, life insurance, land contracts, IRAs, Keogh plans, revocable burial accounts, irrevocable burial accounts, and other assets.

So if you own a cow or you own a horse, whatever you own, they want to know about it. Then they add up the total value of those assets to see whether you have $4,100 there. If you do have $4,100 there, you have just failed the assets test.

There are some 20 items here for low-income seniors or disabled Medicare beneficiaries to report just to apply for the prescription drug low-income benefit. It is a test, as I indicated, which many of us in Congress would have trouble passing without the assistance of a lawyer or an accountant. It is a major barrier, it is a burden we are imposing on these very individuals whom we say we are trying to help.

I bring this to the attention of the Senate because I do not think many of us know the extent to which these applications are both difficult—difficult to complete—and also a terrible invasion of privacy.

The Georgia application reads—and let me put that provision on the easel. We have a blowup of the application, which I am sure very few can read. But just to make the point, we have tried to blow it up so people can see it. I will read from the Georgia application. It says:

> I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records.

Oklahoma's application goes even further. It reads:

> I authorize the release of any necessary information, documents, or forms to the [Oklahoma department] from individuals, businesses, schools, banking institutions, data brokers, public or private organizations, Oklahoma state agencies, including personal and/or business income tax returns from the Oklahoma Tax Commission, or federal agencies to determine my eligibility for assistance or to determine the accuracy of any payments to vendors on my behalf.

The Pennsylvania application—unfortunately, I do not have that blown up here; it would take more easels than we have available—requires the applicant to consent to:

> . . . fully cooperate in the finger, photo, and signature imaging process.

It requires the reporting of any changes in the number of people in the household, any changes in the resources of the individual, and it adds—and this is a quotation from the report; this is the Pennsylvania report—"you must report any plans to leave the state, even temporarily." So if you want to come from Pennsylvania down to Washington, DC, to see your Senator, you have to notify the folks in Pennsylvania that you are leaving the State if you are, in fact, eligible for this benefit.

The burden of the application ought to be something that would scare off a lot of individuals. Here is a line that is in the application of many States:

> State and Federal law provides for fine, for imprisonment, or both for any person who withholds or gives false information—

I note that it does not include anything about intentionally giving false information.

> in order to obtain assistance to which he or she is entitled.

The application from Georgia reads:

> I understand the questions on this application—

which I would attest is virtually impossible for a lot of folks unless they do get professional help in understanding all of this—

> and I certify under penalty of perjury that the information given by me on this form is correct and complete to the best of my knowledge.

The result of this assets test, this barrage of paperwork presented to people when they come in and ask for the benefits, is what the Congressional Budget Office is telling us. Their estimate is that only 50 percent of Medicare beneficiaries who are eligible for the low-income benefit under this bill will actually get the benefit. I find it shocking, after reading these applications, that the number could even be that high. It is a testament to the Nation's seniors and disabled that so many people go through the bureaucratic maze to get the benefit we are talking about.

On the implementation of the Children's Health Insurance Program—a different program but one that also had a similar assets test—a number of States initially imposed assets tests on the families before they allowed children to get health care coverage. Over time most of those States have repealed those tests.

Our experience with the assets test in the case of the Children's Health Insurance Program should be instructive. The Denver Post wrote at the time:

> It seems the system is penalizing people for trying to build better lives. The message is that you must stay poor. If you have a decent running car that will get you to where you need to go, you will lose your health care coverage.

The Rocky Mountain News added:

> Jumping through the hoops might be a whole lot easier for some families than filling out the required forms which rival the renowned handiwork of the Internal Revenue Service for clarity and ease of compliance. The logic of erecting such paperwork obstacles escapes us. Government doesn't have to offer insurance to the children of working poor but having made the decision to do so, it is hardly fair then to smother the program beneath layers of red tape.

These last two quotes relate to the Children's Health Insurance Program, not to the Medicare prescription drug benefit. But the same problem pointed out when we had the assets test applied in the case of the Children's Health Insurance Program is true and exists with respect to this prescription drug coverage for our Nation's low-income elderly and disabled citizens. We are not only smothering them beneath layers of red tape, but the applications threaten their privacy and further threaten fines or imprisonment if those individuals who apply provide false information even if it is unintentional in some cases.

I raise these points because very few, if any, Senators have taken the time to understand the application process, and they would be appalled if they really did take the time to understand the difficulties we are placing in the way of a senior getting access to this low-income benefit. I urge each of them to attempt to fill out their own State's application. Clearly that would be a good way to acquaint themselves with the difficulty of the problem we are putting in the way of people.

Before closing, let me point out the assets test was established in 1988. It has never been updated for inflation. Nor does the bill update the assets test for inflation.

Not only was the assets test established in 1988 at this level of $4,000 and $6,000 per couple, and it has never been updated for inflation, but it has built in it a marriage penalty. If you get married, a couple can only have a combined net worth of $6,000. If you remain single, you can have a net worth of $4,000. Everyone who gives speeches about the importance of eliminating the marriage penalty will want to support the amendment for that reason.

The bill does update the amount of the deductible. The amount of the deductible increases. It does update the catastrophic limit by an inflation factor pegged to increases in drug spending which the Congressional Budget Office estimates will increase on average

12 percent a year over the next 10 years. But we do nothing to index or update the amount of this assets test.

While I completely respect the position of the chairman that he would place a priority on using any additional funds to close the coverage gap in the bill—I certainly favor closing that coverage gap myself—we need to protect our Nation's most vulnerable, the poorest and the sickest among us first. If we provide a low-income benefit, as the bill does, it should be unacceptable to us to have only half of those who are eligible for that benefit actually access the benefit. This is similar to the Children's Health Insurance Program in that we are not required to provide this benefit, but now that we are choosing to do so and we are choosing to do so on a bipartisan basis, we need to be sure those who are intended to benefit from it can in fact do so. We are about to impose on these individuals an avalanche of bureaucratic red tape when they try to access the benefit.

The underlying legislation has contained in it 69 pages of language that is designed to give health care providers a whole range of regulatory relief. Here we have some of that detail on this chart. The appeals process is being reformed—expedited review procedures, provider ombudsman, a variety of things to try to help providers. But we have nothing to give beneficiaries any relief from the burden I have described.

One Senator said last week that the amendment I have offered to eliminate the assets test would cost money. It would increase State administrative costs. Frankly, that statement could not be more inaccurate. In fact, if we dramatically reduce the paperwork burden, the bureaucratic paperwork, States would not have to increase administrative costs. They would actually be able to reduce those costs. It is not the amendment that is increasing these costs. It is the underlying bill. It is not the amendment that is imposing the burden upon States. It is the underlying bill itself.

All the amendment does is significantly reduce the amount of bureaucratic paperwork that must be dealt with in order for this benefit to be provided. Some States have actually found that it costs more to administer the assets test than they save by disqualifying people who fail the test.

In addition, Senator HATCH's comments on the amendment were right in saying it would increase costs. But the estimate is that it would increase costs by $4 billion over the 10-year period for which the Congressional Budget Office calculates.

This is well within the budget limitations Congress established for this drug benefit. There are $19.3 billion remaining in the budget for fiscal years 2009 through 2013. My amendment provides those are the years that this assets test would be eliminated.

The amendment also does so by eliminating the false advertising we are engaged in as we tout a low-income benefit when, in fact, only 50 percent of eligible beneficiaries are going to receive it. In fact, CBO estimates that another 1 million low-income seniors who are eligible for this low-income benefit will in fact be able to access it if this amendment is adopted.

If we eliminate the bureaucratic red-tape, who are the 1 million people who would benefit from this assets test? The Commonwealth Fund has studied that. They have said in a recent report:

> Compared to other Medicare beneficiaries, low-income Medicare beneficiaries are older, they are more likely to be women, they are more likely to be single, and more than twice as likely to be widowed or divorced or separated. Low-income Medicare beneficiaries are almost twice as likely to report that their health is either fair or poor.

I think it is these people who need to be our first priority. The amendment I have to eliminate the assets test will help us to provide a genuine benefit to these people. I hope my colleagues will support this effort. It will substantially improve the underlying bill and substantially simplify the providing of this benefit we are all hoping occurs.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I thank the Senator from New Mexico. I think he has a very good point. The current assets test is degrading, unworkable. It is just not good policy. It is also extremely complicated. Currently, assets tests apply to various kinds of benefits—sometimes Medicaid or Medicare, or certain categories of Medicare. It defies logic, it is so complicated. Frankly, if this Senator had his way, we would repeal a lot of the assets tests which have not been updated for a good number of years—since 1987 or 1989. We are talking about $9,000 a year or something like that. On the other hand, we are dealing with $400 billion in this bill. A total repeal of the assets test on drugs only would be—I don't know the cost, but it would be expensive.

The Senator from New Mexico, in his good-faith effort to try to deal with unnecessary complications—which is bad public policy—is trying to modify a repeal of the assets test to a smaller category. Frankly, it has a lot of appeal. But as the Senator knows very well, probably as well if not better than most Members of this body, that would only go part way toward correcting some of the inequities caused by the assets test. Even if the Senator's amendment to totally repeal the asset test applying to drugs would go into effect, nevertheless, the asset test with respect to the rest of the categories would still apply under Medicare. That is low-income categories that are mandatory.

It is incredibly complex, which is to say I am very sympathetic with the Senator and I am hopeful we get this score back from CBO on the Senator's asset test amendment, that it is one that certainly can work within the $400 billion limit we are operating under. I, for one, believe it should pass. I thank the Senator very much for persistently and very forthrightly, with a lot of good information, bringing this up to be dealt with.

Mr. President, I ask unanimous consent that all pending amendments be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 985

Mr. BAUCUS. On behalf of Senator EDWARDS, I send an amendment to the desk with respect to consumer advertising.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

> The Senator from Montana [Mr. BAUCUS], for Mr. EDWARDS, himself, and Mr. HARKIN, proposes an amendment numbered 985.

Mr. BAUCUS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To strengthen protections for consumers against misleading direct-to-consumer drug advertising)

At the end, add the following:

TITLE —DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. 01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following "(including whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)"; and

(2) in subsection (d)(5)—

(A) by inserting "(A)" after "will"; and

(B) by inserting after "thereof" the following: " or (B) offer a benefit with respect to safety, effectiveness, or cost (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug".

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after "effectiveness" the following: "(including effectiveness in comparison to other drugs for substantially the same condition or conditions)".

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to side effects and contraindications; and

(ii) information relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions);

(B) any advertisement present a fair balance between—

(i) aural representations and visual representations (such as large-print or full-screen text) relating to side effects and contraindications; and

(ii) aural representations and visual representations relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions);

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

"(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

"(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

"(A) the Secretary provides the person written notice of the violation; and

"(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

"(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

"(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

"(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

"(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).".

SEC. 03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. 04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendment be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 986

Mr. BAUCUS. Mr. President, I send to the desk an amendment on behalf of Senator LAUTENBERG with respect to moving the effective date of this legislation 1 year forward.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. LAUTENBERG, for himself, Mr. REED, Mrs. CLINTON, and Mr. CORZINE, proposes an amendment numbered 986.

Mr. BAUCUS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To make prescription drug coverage available beginning on July 1, 2004)

At the end of title I, insert the following:

SEC. . IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under D of title XVIII beginning on July 1, 2004.

Mr. BAUCUS. Mr. President, those are two amendments which Senators have offered. That means, as a practical consequence, that they are more likely to be considered than amendments that have not been offered. These are amendments that I will now call CBO and get scores on. It is difficult to get scores from CBO on amendments if they are not pending. If Senators have not told me they are going to offer amendments, I cannot put them on the list. This is a roundabout way of saying to Senators who wish to offer amendments, it behooves them to do it now and get them into the queue. Then I can call CBO and tell them we need a score on this or that amendment. CBO cannot score all amendments that will be potentially filed, because it has limited resources. It can only do it as they become real. I urge Senators to come forward with amendments so we can deal with them.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. BURNS). Without objection, it is so ordered.

AMENDMENT NO. 981

Mr. SANTORUM. Mr. President, I rise in opposition to the Pryor amendment which I understand was debated just a few minutes ago. I do so in strongest terms. We had a debate last week on the issue of reimportation of drugs from Canada. The Senate spoke and said that if the Secretary of Health and Human Services would declare that such reimportation was safe, we could then bring these drugs across the border at a reimported price.

Many on this side of the aisle, and I am sure a few on the other side of the aisle, voted for that amendment, as amended, by Senator COCHRAN for that safety measure basically concluding that the Health and Human Services Secretary would never determine that these drugs would be considered safe, since the Canadian Government itself said they could not guarantee they were safe. We have all sorts of problems today with counterfeit drugs, drugs getting shipped in from other countries, leading to a variety of health problems. There was a great amount of comfort.

The Pryor amendment goes one step further, according to my understanding, saying if the Secretary does not say the drugs are safe within a period of time—I believe it is 2 years—then prices of drugs in this country will be set by the Canadian Government, which I find a startling concession of authority of this Government to a foreign country; that we are going to have a foreign country and a board in a foreign country set prices for drugs in the United States of America.

It is a remarkable concession for the Senate. I know we have a great desire to control many things in the United States. We would like to set prices, I am sure, on lots of different items. We do it in the Agriculture bill all the time. Now we are going one step further. If you cannot win price controls by having the Senate pass a price control bill, delegate the Canadian Government to control the prices for you.

Maybe we should choose different countries. Why Canada? Maybe there are other countries that set even lower prices than Canada. I suspect there are countries that would set lower prices than Canada. Why not choose them if we really want to save consumers money?

If this amendment is adopted, I would probably offer amendments that we should have chicken prices set by the Canadian Government, wheat prices set by the Canadian Government, and lumber and timber prices set by the Canadian Government. Maybe it would just be good to have the Canadian Government set all our prices in this country for those items we think are important. Obviously, they are very thoughtful in Canada, and they know what is best for us here, and we should just go ahead and let them set our prices for us.

We are not talking about the Canadian marketplace setting prices. We are talking about the Canadian Government. Let me explain how the Canadian Government operates. The Canadian Government operates as follows: You want to sell your drug in Canada? Fine, you have to get it approved, get it on the formulary.

By the way, you have no other place to sell drugs other than drugs approved by the Canadian Government. Remember, they have a Government-run health care system up there. My understanding is that the Canadian Government actually sets their own drug prices. I do not think they go to another country to get drug prices set and use those. I think they set their own.

Assuming they are setting their own drug prices, what they do is say to the drug company, take Pfizer: OK, you want to sell your drug here? Great. We will pay you $1 a pill.

Pfizer says: This costs us $1 billion to research. It is a great drug. It solves all sorts of problems. We sell it in America for $10 because of the enormous cost of the research and testing to make sure it is safe and efficacious, and it cost us a lot of money, and we only have a short patent by which to recoup the investment dollars. We have a lot of drugs we tested along the way to find a cure for this problem, and we have to recoup those costs; otherwise, we cannot stay in business, we cannot continue to research. The Canadian Government says: That is nice; a dollar.

Pfizer says: No, we can't sell it for a dollar.

The Canadian Government says: Fine, you can't sell your drug here.

So Pfizer loses out on a market of 16 million people—I do not know how many people are in Canada—16 million people, something like that.

Pfizer says: No, we won't sell.

Or what they say is: You know what. It only costs us 50 cents to make this pill. Yes, we are not going to make any money on it, but this is a drug that is an important drug so we will make it available in Canada for a dollar.

The other alternative is they just say, no, we are not going to sell it in Canada. Under Canadian law, the Canadian Government has the right to steal Pfizer's patent, issue that patent, that formulary or formula, whatever the drug is, to a generic drug manufacturer in Canada for them to produce at the dollar price that Canada is willing to pay for it. So they can steal a patent that a company in this country spent millions of dollars, potentially a billion dollars, to come up with and set a price in Canada at the level they so choose.

The Senator from Arkansas wants to condone that behavior and say we have to charge the same price in this country.

I cannot imagine anything that would be more damaging to an industry that does more than any industry in America to solve our health problems. They spend more on research and development than any group of companies that exist, and they bring through drug after drug and therapy after therapy to extend lives, to increase the quality of life, and to cure diseases.

So the reward in the Senate is that we are going to have a foreign government set prices for an industry that does not exist in Canada but it does exist in the United States. The majority of the new drugs in the world are researched and developed in the United States.

Yes, we do pay more for drugs in this country. I will concede that to the Senator from Arkansas. We pay more for drugs here, and the reason we pay more for drugs here is that we do not regulate prices, as most other countries around the world do.

I think the Senator from Arkansas is on to something. We need to do something about those prices around the world, but it is not to adopt them in this country; it is to get the trade administrator to start putting these issues on the table when it comes to negotiating free trade deals. They have to put on the table the pirating of our patents, with our free trade partners such as Canada and Mexico. They have to put on the table the prices they pay for drugs that are researched in this country that our people in this country subsidize. Yes, we do.

In fact, we subsidize the world's research in pharmaceuticals, admitted.

So the Senator from Arkansas says we are going to stop doing that. We are going to do what Canada does, which is not subsidize one nickel of the cost of researching these new drugs—what Germany does, what England does, what most of the developed world does. Yes, they piggyback on America, and so the Senator from Arkansas is saying let's just piggyback on Canada.

Well, what are the consequences? I do not think it takes an expert in pharmaceuticals to figure out exactly what happens. We will squeeze the research dollars out of the drugmaking industry because we will be reimbursing them based on their cost of manufacturing. So the dollars for research to attract investment dollars to spend on research and development for that next generation of drugs will be gone.

Maybe that is a good idea. Maybe it is more important to have people get their drugs inexpensively today than to find that cure for cancer, diabetes, or Parkinson's, or develop a new drug to ease symptoms of HIV. Maybe it is more important for someone to have their drugs a little cheaper today. But there are millions of Americans, and there are even more millions of people around the world, waiting for that little pill that is yet to be discovered that will extend their life so they can see their daughter or grandchild being born, waiting for someone to cure that disease they are saddled with today, to give them just a few more months or a few more years, and we will say to them, anyone who votes for this amendment, when that person walks in their office and says, I am here for NIH research dollars for diabetes, or, I am here for NIH research dollars for AIDS, Parkinson's, cancer, or heart disease, I want that Senator to say to them, I voted for this amendment and, yes, we are going to have lots of research dollars, but no one is going to take that research and do much with it because we have just squeezed every dollar we can for research and development out of the pharmaceutical industry, which would take that research and do something with it to put it to commercial practice and make that drug available.

We will say to them that even though we are passing a prescription drug benefit that is going to extend pharmaceutical benefits to make drugs less expensive, that was not good enough. No, it was not good enough to cover people's drug benefits. We have to take a bite out of the hide of those nasty pharmaceutical companies that get beaten up with frequency. I understand. They get beaten up a lot, until they are needed, until they extend your wife's life or they save your child's life; then the rhetoric tones down quite a bit.

We are shooting with real bullets. This is a Medicare pharmaceutical package that will pass and turn into law, and anybody who thinks this is a free vote, that we can go back home and campaign and say, gee, I am going to get you cheap drugs, understand what this vote means. When that 7-year-old diabetic walks in your office, understand what you have done. It is as real as denying them the cure that is sure to come.

I know this is not a popular issue, to stand up for pharmaceutical companies. Maybe we should do to them what we have done to a lot of industries that have been successful in America: Beat them up, tax them, take their profits away, until they become dependent upon us, and then we will give them loan guarantees and bail them out. Then it will be a really popular thing because they will be losing money and we will have to help them. I think that is a very bad approach.

The right approach is to provide coverage for those who are in need of insurance to help them with their prescription drug bills while at the same time allowing one of the most vibrant industries we have in this country to survive and thrive. That is the balanced approach. It is not attacking the very organizations, the companies, that are providing lifesaving drugs for millions of Americans and millions around the world.

Mr. PRYOR. Will the Senator yield for a question?

Mr. SANTORUM. I am happy to yield for a question.

Mr. PRYOR. Mr. President, I have a lot of respect for my colleague from Pennsylvania, but I would like to ask if he is familiar with this statement by Gerald J. Mossinghoff, president of Pharmaceutical Manufacturers Association. He says:

> Canada, in a move away from the system that hindered innovation, improved the patent law for medicines in 1988. Two weeks ago, it further strengthened the law by eliminating compulsory licenses for drugs approved after December 20, 1991. Drug research in Canada has increased sharply since 1988.

This is his testimony to Congress dated February 22, 1993.

What I ask the Senator is, in view of this statement, is he still maintaining that Canada can steal drug companies' patents?

Mr. SANTORUM. Yes, I do. I say that because there has been a lot of work that has been done since then. According to many legal scholars I have talked with, they still believe Canada has that ability to continue to steal licenses and give those patents away to drug companies in Canada. I will be happy to provide that documentation, but I do not have it with me. I had it last week, but the issue did not come up. I will be happy to share that.

Mr. PRYOR. If the Senator will yield for another question, Canada does take the position, as any nation would, that under its national sovereignty, it can in extreme situations take over a patent. I am sure the United States has the same provision in its law. I have not looked at the law books recently, but I know after September 11 and the anthrax scare, Canada did make the statement that it reserved the right to produce its own vaccines using existing patents.

I am guessing without knowing all the details of your statement, the policy and their intentions—by the way they did not do this—I am guessing they would have paid the pharmaceutical industry something based on manufacturing its patent, but they were doing it in their own national interest to protect their citizens.

So my question is, you pretty much imply that they routinely have the ability to steal patents; they routinely threaten that, but as best we know there has only been one example, extreme example after September 11, where they talk about the possibility of doing this.

Mr. SANTORUM. What I said in several speeches is as follows: Where there is competition, there are like classes of drugs. They use the exclusion, they use a formulary to exclude or drive down prices. If you have 10 arthritis drugs, they pick two or three, which is what a formulary is all about, and they will pick those based on the cheapest price available and patent medicines. And they will exclude others so they do not have access to the market.

I have never said in those cases the Canadian Government would use their authority to steal a patent. In fact, I have been very clear. I have said in the cases they would use it is where this is a unique drug. And if this is a unique drug, a breakthrough drug, or something that has no other competition, if you do not go along—we used the example of, I think, Cipro they were using as an example that is relevant to the case I made in the past—where there is a drug that does not have competition, that is, in fact, what they do. Leverage. In the other cases where there is competition, they have other leverage and they will not use the licensing of a patent or the stealing of a patent as a recourse.

There are two different competitive or anticompetitive maneuvers by the Government of Canada: One having to do with drugs of which there are a variety in that class and a separate, the patent issue having to do where there is a drug with no real competitor.

This is the case I have made repeatedly, not just last week but in years past. If I was not clear on that today, I may not have been in my explanation. I apologize but that is what I have said.

Mr. PRYOR. Mr. President, I ask one additional question. A few moments ago—I know the Senator was being facetious—you talked about the nasty pharmaceutical companies and how easy it is for some to come in and impugn them and pick on them and try to punish them in some way. I don't know if you heard my comments earlier in the day, but I talked about how proud I was of a lot of what the pharmaceutical industry does in this country and around the world. In fact, I compared the advances in medicine to the advances in aeronautics in the last 100 years. The advances in medicine have been more remarkable than those of aeronautics. It is critical to have a robust industry on the cutting edge but at the same time two of the reasons the pharmaceuticals like to do their research in this country is because of the large amounts of money we fund to NIH. They do very valuable research that the pharmaceutical companies operating here can take advantage of, and we give them a very hefty research and development tax credit. I am for that credit. I am a cosponsor to continue that credit. I think it is critical for the industry.

I hope the Senator was not implying that I am a big critic of pharmaceutical companies. Bear in mind, I don't think they always have clean hands. I have seen in my work as attorney general and reading the newspapers some business practices I wish they would change. We dealt with those at the State level when I was attorney general. The Senate is starting to deal with some of those.

Mr. SANTORUM. I was not in any way suggesting you, individually, with respect to pharmaceutical companies. I was suggesting the amendment is very damaging to that research.

The Senator mentioned we subsidized through NIH research, as we do a variety of other fields, not just pharmaceuticals, as well as providing research and development tax credit, which, of course, we do not just for pharmaceuticals but for a variety of different industries. What we also do is have the FDA process which is the most expensive and cumbersome existing in the world. It takes months, and in most cases years, longer to get a drug to market, and that cap starts from the time you file, not from the time of FDA approval. The fact we had a year or 2 or 3 or more, when drugs are available in other countries and not available here, it makes the time to recoup the investment shorter. That is one of the reasons our prices are high, because of the shorter time drug companies have as an opportunity to recoup their investment. They have a longer period of time in places such as Canada, which does not require the testing we do and the trials we do.

The other reason is we also have a very expensive litigation system in this country. Pharmaceutical companies, not surprisingly, because they deal in the area of health care, are in court a lot for adverse reactions to their pharmaceutical products. Other countries do not have nearly the lucrative civil justice system, medical liability system, that we have in this country. Therefore, the costs associated with selling pharmaceuticals in this country because of our litigation system are disproportionately higher than they are in places such as Germany, Canada, and others that do not have the same kind of rewards we see in this country for harm done to people that ingest the drugs.

It is not just what we do to subsidize. Canada would say they probably provide a percentage of money in there to help research, and I am sure the other countries would say they do the same; that they contribute a share toward research, too.

As much as we subsidize, we probably cost them when it comes to the existing structure of the FDA and the legal system in this country. I argue that, yes, we may help, but we probably give with one hand and take with the other.

The bottom line is, this amendment delegates to the country of Canada the authority to set drug prices in this country. I don't know whether the Senator from Arkansas has considered whether drugs that are not set by formulary in Canada, whether those prices would not be set in this country, or only those on the formulary are set. In the end, if this would pass, you would have a lot of drug companies probably not selling drugs in Canada because by doing that, they give up this market.

My guess is the folks who are probably against this more than any other U.S. Senator, including myself, are probably the people in Canada who, if this were to pass, we probably would not find one pharmaceutical company willing to sell the drug in Canada if they would lose their market here. That may not be your intention, but I suspect that would be the consequence because it is a pretty small market up there compared to here. It is not profitable up there compared to here. My guess is you would have the undesirable effect of affecting the health care of millions of Canadians when it comes to the ability to get new drugs; or conversely you would be requiring the Canadian Government, and maybe this would be good, to raise the reimbursements for their drugs. That may be the desirable impact. That is not something I would be willing to take a chance with, as to whether the Canadian Government would respond in a favorable fashion, at least to my understanding, to this amendment by actually increasing drug prices over there so they could keep some level of new pharmaceuticals within their country.

I understand we are not going to be voting on this immediately, this is going to be voted on tomorrow at some point. But I did want to come to the floor and just urge my colleagues, even if you are for reimportation, this is a fundamentally different thing. This is just completely changing the drug pricing structure of the United States of America and delegating it to a foreign entity. I strongly suggest if you want to do that, if you want to set drug prices, let's have an amendment to set drug prices. My goodness, let's not delegate it to the people of Canada to set our drug prices. Even if you are for reimportation, even if you are for cheaper drug prices, don't let the Canadian Government do it. Get the glory of setting it ourselves, if we want to do something.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

AMENDMENT NO. 933

Mr. GRASSLEY. Mr. President, I ask for the regular order with respect to the Bingaman amendment, No. 933.

The PRESIDING OFFICER. The regular order is amendment No. 933.

Mr. GRASSLEY. Mr. President, I move to table the amendment, and ask for the yeas and nays, to have the vote occur at 5:30 and that the time between now and 5:30 be evenly divided.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. GRASSLEY. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

Mr. KENNEDY. Mr. President, could I ask, now do we have 3 minutes or so on each side?

Mr. BAUCUS. Yes, we do.

Mr. KENNEDY. Could I have one of the 3 minutes?

Mr. BAUCUS. Absolutely. How many minutes does the Senator want?

Mr. KENNEDY. Can I have a minute and a half? I see others who want to address this issue.

Mr. BAUCUS. I yield the Senator 2 minutes.

The PRESIDING OFFICER. The Senator is recognized for 2 minutes.

Mr. KENNEDY. Mr. President, I hope this amendment will not be tabled. First, I commend the chairman of the committee and the ranking minority member of the committee. They have made a major step forward in reducing what we call the asset test.

Under the assets test, any senior who managed to scrape together more than $4,000 in a savings account wouldn't qualify for the most generous benefit. Those elderly persons with a minimum amount of possessions, even if they are just above the very minimum wouldn't qualify. We are even talking about limits to the amounts that can be set aside for a burial plot or the value of personal items like jewelry or a car.

This bill we have before us has reduced the asset test in a very significant and dramatic way for seniors who have income above 135 percent of poverty. But it still remains for those who are poorest of the poor. The Bingaman amendment costs only about $3 billion, but would substantially benefit the neediest of our seniors.

In addition, the paperwork for the assets test is demeaning and an additional burden on senior citizens. I looked over the form in Georgia, for example, and it is about 10 pages long. In another State it is 16 pages long. We are talking about a test which will effectively reduce the availability of absolutely needed prescription drugs for the seniors who are the poorest of the poor.

The bill before us has made very substantial progress in helping our neediest seniors. The Bingaman amendment would just finalize it and effectively say we are not going to use an asset test as a condition to be able to participate in the prescription drug program.

I do not see my friend and colleague, the Senator from New Mexico, here on the floor. But I want the Senator to know that it is a thoughtful amendment and it will assure that low income seniors have access to the special assistance they need without pauperizing themselves or undergoing this demeaning procedure. A senior with income below the poverty line and who didn't pass the assets test under the current bill would pay 10 percent of the cost of the drugs, whereas under the Bingaman amendment she will have to pay only 5 percent. That doesn't sound like a lot of money around here but it is a lot of money for some of the most needy senior citizens.

I commend the committee for what they have done. I hope we will continue to make progress in this area and not table the Bingaman amendment.

Mr. GRASSLEY. Before I yield 3 minutes to the Senator from Pennsylvania, I ask unanimous consent Senator MURRAY's amendment be the first in order after the vote, and that any other amendment in order be laid aside.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. GRASSLEY. I yield 3 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I understand the point which the Senator from New Mexico is trying to accomplish. We do this in Pennsylvania. We do not have an asset test for our PACE Program. If you asked anybody up there now, Pennsylvanians dealing with this PACE Program, with the budget shortfall, one thing they would like to have put back in the box is this asset test.

You could have, conceivably, somebody who has a $1 million house and has all their investments in a house or has other assets that are not income producing and they could qualify for a very rich drug benefit under this amendment. It really does encourage people to put their money into nonproducing assets to qualify, particularly those who are sick, to qualify for a drug benefit. I just think these asset tests are a way of recognizing that income is not the only measure of what you can afford to pay when it comes to drugs. We have to look at what people own and the assets they have.

You can have someone who has very high asset value and very low income. We run into that all the time. That is the reason we have a variety of different taxes, to make sure we get at different ways in which people accumulate wealth and hold assets or live off income.

So I just say while this is well intentioned, it opens up a Pandora's box to have people who have, frankly, lots of resources—potentially lots of resources to be able to provide for themselves and also would lead, I would argue, to unwise public policy to encourage people toward planning when they retire to put their assets in nonperforming or nonincome-producing assets at a time when they probably should do otherwise.

While it is well intentioned, it could lead to a variety of problems. It is also a very expensive amendment and opens it up to millions more people, and this is already a bill that many believe is very generous to people who have a substantial amount of money. We should not be expanding this program in the subsidies to people who have a lot of assets that may not be income producing.

I reserve the remainder of my time.

Mr. KENNEDY. Mr. President, if there is no one else on our side I would like to speak for another minute, if I could. Do we have the time?

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the author of the amendment is not here. I think he was caught a bit off guard when it was announced the vote would be on his amendment at 5:30. I understand he is on his way over here. I think it is only fair he be allowed to speak for a couple or 3 minutes at least on his amendment.

I ask consent the vote on the Bingaman amendment not be at 5:30 but at 5:40, and the remaining 10 minutes be equally divided.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Reserving the right to object, might I inquire of the Chair what is the procedure after the vote?

The PRESIDING OFFICER. Under a previous order, the first amendment will be that of the Senator from Washington, Senator MURRAY.

Mr. KENNEDY. Mr. President, could I ask the floor manager, if Senator BINGAMAN is not here, could I have the remaining minute?

Mr. BAUCUS. I yield to the Senator from Massachusetts, but inform Senators when the time has expired I am going to suggest the absence of a quorum.

Mr. KENNEDY. Mr. President, we are not talking about individuals who have $1 million homesteads. We are talking about seniors who have $10,000 in income. We are talking about poorest of the poor of our senior citizens. This idea people are going to be able to circumvent it because they have $1 million and $10,000 in income is ridiculous on its face. Perhaps that individual is saving $5,000 in order to fix the roof in 2 or 3 years. They will not be eligible to be able to qualify under the program here.

This is really the poorest of the poor, and we are talking about incomes of $10,000 or less. That is what this amendment is about. At least I hope it would not be tabled. And if there is some kind of condition in terms of the value of their home, as the Senator from Pennsylvania has outlined, we can work that out. But we are talking about the poorest of the poor. If that is the kind of protection the Senator from Pennsylvania is interested in, Senator BINGAMAN is interested in, we are interested in, let's work it out, but let's not table the amendment.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, do I have time remaining?

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, if the Senator wants to focus on the poorest of the poor, he should leave the assets test in place because that is exactly what it does. It says that you have low income and low assets. So we have, in fact, covered exactly what the Senator from Massachusetts is attempting to do.

What the Bingaman amendment does is leave open the possibility of the poorest of the poor not being the most heavily subsidized, that people who do have a big house, or other property, or amassed antiquities of some sort that may be very valuable—a coin collection, who knows that they would be focused in on as much as people who simply have nothing, have no place else to turn. So the assets test is very important for these scarce resources to be focused on those who need them most.

If you really do care about focusing on the poorest of the poor, and not just opening this up to people who may not need the assistance as badly, you would vote against the Bingaman amendment.

The PRESIDING OFFICER. The Chair advises the time has expired.

The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Senator BINGAMAN be allowed to speak for 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico is recognized for 2 minutes.

Mr. BINGAMAN. Thank you very much, Mr. President. And I thank the Senator from Montana.

First, Mr. President, I understand there is an intent to try to table this amendment at this point. Obviously, I would object to that. And I believe there are others who want to speak. I would like to try to accommodate any real concerns the majority has. So at this point, I ask unanimous consent that I be allowed to withdraw the amendment until it can be perfected in a way the majority would support.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Nevada.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent to speak for 30 seconds.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. Mr. President, I do not know if the motion is going to be to table this. I assume so. If it is, it is our recommendation we all move to table this, and Senator BINGAMAN will just offer this again tomorrow.

Mr. BINGAMAN. Mr. President, do I still have any time?

The PRESIDING OFFICER. The time has expired.

Mr. BINGAMAN. Mr. President, I ask for 30 seconds to explain my vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I am going to go ahead and vote with the manager of the bill to table my own amendment now in order that we can bring this back here tomorrow. I will plan to reoffer the amendment, and hope that if there are real problems with it, those can be brought to my attention before we reoffer the amendment tomorrow. It is a very important issue. It is one we need to deal with in a responsible way. I urge all colleagues to go ahead and vote to table at this time.

Mr. GRASSLEY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll to ascertain the presence of a quorum.

The legislative clerk proceeded to call the roll.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 933 WITHDRAWN

Mr. BINGAMAN. Mr. President, I renew my request that I be allowed to withdraw the amendment that I have related to the assets test at this time and reoffer it tomorrow after I have had a chance to consult with more of my colleagues.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is withdrawn.

Mr. BINGAMAN. I ask unanimous consent to add Senator DOMENICI as a cosponsor of the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The majority leader.

Mr. FRIST. Mr. President, for information of our colleagues, because we initially set a vote for 5:30 tonight, for clarification, we will not have any votes tonight. We will not be voting because the amendment was just withdrawn. That decision was just made in the last 15 minutes. I know a lot of people had planned the course of the day to be voting tonight. Right now, other amendments have been introduced in the last few hours, and suggestions have been made, well, let's go to those amendments. In truth, a lot of people are showing up right at 5:30. I am uncomfortable having Senators come in and all of a sudden voting on those amendments.

I think the best thing, after talking to the managers, is not to have a vote tonight at this juncture but to have people continue to offer their amendments. We will continue the debate, and we will begin the orderly voting on amendments under the direction of the two managers tomorrow.

The PRESIDING OFFICER. Who yields time? The Senator from Montana.

Mr. BAUCUS. Mr. President, it is my understanding that under the unanimous consent request, it is in order for the Senator from Washington, Mrs. MURRAY, to offer an amendment. Accordingly, I ask unanimous consent that all pending amendments be temporarily laid aside so she may offer her amendment.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Reserving the right to object, I did not hear the request.

Mr. BAUCUS. Mr. President, if I might repeat the request, that all pending amendments be temporarily set aside so the Senator from Washington may offer her amendment.

Mr. HARKIN. Mr. President, I have no objection. I ask unanimous consent that I be permitted to offer my amendment which will only take a few minutes after the Senator from Washington finishes her amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Washington.

AMENDMENT NO. 990

Mrs. MURRAY. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Washington [Mrs. MURRAY] proposes an amendment numbered 990.

Mrs. MURRAY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To make improvements in the MedicareAdvantage benchmark determinations)

At the end of subtitle A of title II, add the following:

SEC. . IMPROVEMENTS IN MEDICAREADVANTAGE BENCHMARK DETERMINATIONS.

(a) Revision of National Average Used in Calculation of Blend.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w-23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting "who are enrolled in a MedicareAdvantage plan" after "the average number of medicare beneficiaries".

(b) Change in Budget Neutrality.—Section 1853(c) (42 U.S.C. 1395w-23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) Inclusion of Costs of DOD and VA Military Facility Services to Medicare-eligible Beneficiaries in Calculation of MedicareAdvantage Payment Rates.—

(1) For purposes of calculating medicare+choice payment rates.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) Inclusion of costs of dod and va military facility services to medicare-eligible beneficiaries.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(2) For purposes of calculating local fee-for-service rates.—Section 1853(d)(5) (42 U.S.C. 1395w-23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(B) by adding at the end the following new subparagraph:

"(C) Inclusion of costs of dod and va military facility services to medicare-eligible beneficiaries.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(d) Effective Date.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

Mrs. MURRAY. Mr. President, Congress is about to update Medicare to finally help seniors with prescription drugs, and while I have some real concerns about the way this bill would provide drug coverage, I am convinced that after 5 years of stalemate, it is time to pass a drug benefit now to begin to get seniors the help they need.

Mr. President, I have been working to improve this bill by providing additional funding in the Budget Committee, by supporting various amendments, and by offering my own amendment.

I want to make sure that the drug benefit we create will help as many seniors as possible. Before we add a new benefit to Medicare, we have to remember that there's a serious problem with Medicare today that penalizes seniors based on where they live. The problem is in the payment formula that Medicare uses, and it hurts many seniors.

Today under Medicare, some seniors can get fewer services—and pay higher premiums—just based on where they live. Every senior pays the same amount into Medicare, but some seniors get much fewer benefits based on geography. That's not fair to seniors in my State and in other States.

For the past few years, I've been working to fix that problem. Last year, I introduced the MediFair Act to bring all States up to the national average in Medicare payments. We are still working to fix this disparity in Medicare today. The problem is that this new drug benefit would follow that same old, unfair formula. It means that seniors in States such as Washington will have few choices and pay higher premiums.

That's why I'm offering my amendment today—to give seniors more choices and lower premiums as they get healthcare and prescription drugs.

As we improve Medicare, we shouldn't build on the unfair polices of the past. While I am still working to fix the underlying formula that's hurting seniors in my State, we can at least avoid perpetuating an unfair system in this new benefit. I am proud to report that we have made some progress recently to fix the regional disparity that penalizes many Medicare patients. I am pleased to have joined with Senators GRASSLEY and BAUCUS in closing the rural versus urban gap in reimbursements.

And, earlier this year, the Budget Committee unanimously adopted the Feingold-Murray-Johnson amendment, which modified the Medicare reserve fund to allow legislation to promote geographic equity in Medicare payments.

Back in 1997, when we expanded Medicare+Choice, we took some steps to make it fairer. Since the Medicare+Choice rate was based on the fee-for-service rate, it was important to provide some guaranteed level for states with low reimbursements. We did two things. First, we set a minimum payment—known as a floor—so that no county would fall below a certain level. Second, we tweaked the funding formula to provide greater equity across the country for everyone on Medicare. That approach is known as a "blend" because it takes the regional formula and blends it with the national average. Those were both good steps. There was only one problem: Congress never provided the funding to revise the formula. So we put a fix in the law, but we never funded it. We have not been able to fund it until now because it has to be budget neutral.

Today, my amendment would finally fund that technical correction and give seniors better access to care. Specifically, my amendment fully funds the Medicare+Choice blend formula starting in 2006 for determining the Medicare Advantage benchmark. If we don't fix this problem, we will deny many seniors access to coordinated care.

PPO's and HMO's will only go into those regions already at the higher end of per beneficiary reimbursement. We should—at the very least—try to create a level playing field for all regions of the country. It is unfair to talk about competition when some regions will receive hundreds of dollars more per beneficiary than others.

During this debate, I have listened to my colleagues talk about the benefits of PPO's and HMO's as part of their new Medicare Advantage. Senator FRIST has spoken several times on the benefit of a coordinated care approach for improving disease management and keeping seniors healthier longer. While I still have some concerns about how these new plans will operate, I want to be sure that seniors in Washington State and other States with low Medicare reimbursement can take advantage of Medicare Advantage. I also want to point out that is not about increasing payments to insurance plans. It's about ensuring that seniors in all regions of the country have access to competitive Medicare Advantage plans.

My amendment is similar to language adopted in the House Ways & Means Committee mark. However, I do not fully fund the blend in my amendment until 2006. The House proposes the change starting in 2004. I also point out that my amendment doesn't force plans in any State or region to do anything. If they want to base Medicare Advantage on either the current fee-for-service rate—or the Medicare +Choice rate—they are free to do so. My amendment gives plans a third option that could be more fair and could help more seniors.

Finally—in an effort to truly measure the cost of providing care to all seniors—my amendment directs the Department of Health and Human Services to determine the costs of care provided to Medicare beneficiaries at DoD or VA facilities. Since Medicare assumes the reimbursement, these beneficiaries should be counted in the equation.

Failing to account for the cost of this care has resulted in lower fee for service per beneficiary costs. Those lower fee-for-service rates means significant inequities in Medicare reimbursement. We should correct this existing flaw before we build a new drug benefit around it.

I have been trying to get HHS to take this step since 1997 and supported language in BIP A2000 directing HHS to report to Congress on recommendations for correcting this inequity. Unfortunately, HHS remains unwilling or unable to properly determine the actual cost of care in any given region or State.

Mr. President, I want to take just a moment to update my colleagues on another amendment that I will be offering soon with Senator CONRAD and Senator SMITH. It relates to a new, exciting group of drugs known as self-injected biologics, and it's a chance to give Medicare patients access to the benefits these new drugs offer. Senator CONRAD offered a similar amendment during the Senate Finance Committee mark up and received a commitment from the Chair to work with us on this effort. As a result of this commitment, Senator CONRAD withdrew the amendment. We have been working with CBO and Senator BAUCUS' staff to address any concerns.

Currently, Medicare will only cover biologics if they are administered in a physician's office or clinical setting. That means patients must travel to the physician's office to receive treatment. That's not easy for many patients who have Rheumatoid Arthritis or MS—two diseases that can severely limit a person's mobility.

Fortunately, there are versions of these drugs that a patient can take in their own home. It's a great innovation that will improve a patient's access. Unfortunately, Medicare won't cover biologics that are administered in the home. That just doesn't make sense. I have been working to correct this inequity for the past two Congresses. The Murray-Conrad-Smith amendment would provide two years of coverage, under Part B, for those self injected biologics that replace treatments currently available only in a physician's office. We allow for two-year coverage to bridge the gap to implementation of a Medicare prescription drug benefit.

We have received a CBO score for the two years and believe that we can find room in 2004 and 2005 to provide this important coverage for MS and RA patients. This legislation is strongly endorsed by the Arthritis Foundation and will provide additional coverage to all four MS self-injected or self-administered treatments. For MS, only one treatment is covered under Medicare, provided in a physician's office.

I am hopeful that the managers of this legislation will be able to accept our amendment and end this discriminatory practice in Medicare.

Let me close by returning to the amendment currently before the Senate. For those Senators concerned about the inequities in the current Medicare reimbursement rates, I urge you to support this amendment. Fully funding the blend—as a third option in determining the Medicare Advantage benchmark—will provide greater equity and ensure that all seniors in all regions have access to a competitive, managed and coordinated care approach. Let's finally stop an unfair system and give seniors the access they deserve. It's the right thing to do, and I urge its immediate passage.

I yield the floor.

The PRESIDING OFFICER. Who seeks time?

The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that we set aside the pending amendment so Senator HARKIN can offer his amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 991

(Purpose: To establish a demonstration project under the Medicaid program to encourage the provision of community-based services to individuals with disabilities)

Mr. HARKIN. Mr. President, I have an amendment at the desk and ask for its consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. HARKIN] proposes an amendment numbered 991.

Mr. HARKIN. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER (Mr. CHAMBLISS). Without objection, it is so ordered.

(The amendment is printed in the RECORD under "Text of Amendments.")

Mr. HARKIN. Mr. President, I am proposing this amendment, which would enact into law the "Money Follows the Person" rebalancing demonstration project. This project was part of President Bush's 2004 budget request. It is a critical component of President Bush's new freedom initiative.

This really is about freedom. It is about the freedom of people with disabilities to enjoy the same opportunities for employment and community living that are available to all Americans.

A number of years ago after the passage of the Americans with Disabilities Act, a number of us began working on what we considered to be the next step in trying to provide for a more open environment for people with disabilities. And that was to get more people out of confined living—nursing homes and institutions—and put them into community-based living arrangements.

The bill we have been working on to do that is called MiCASSA, which is the shorthand for the Medicaid Community Attendant Services and Support Act. I have been working on the bill for 10 years. In fact, I note for the record that the first introduction of this bill took place in the House in 1997 and was introduced by none other than the Speaker of the House Newt Gingrich. It was first introduced in the Senate in 1999, and I was the chief sponsor of it at that time.

My amendment basically would take what the President suggested in his budget and make it operable. My amendment would take the President's proposal for giving grants to States to transition individuals into community-based living under the existing Medicaid program.

Under the President's proposal, the Centers for Medicaid and Medicare would give out to States $350 million per year for 5 years. This money would pay 100 percent of the cost for community-based services for the first year after individuals with disabilities move out of an institution or a nursing home. After that time, the Federal Government would pay its regular Medicaid rate.

This amendment and the President's proposal was for a demonstration program for 5 years. So the total cost of this will be $1.75 billion over 5 years, and it will end because then the States would go back to their normal process and procedure. The idea behind this is to give States the upfront money they needed to get people with disabilities out of nursing homes and get them into community-based living.

I believe the President proposed this initiative because he recognized that, unfortunately, under current Federal Medicaid policy, the deck is stacked in favor of living in an institution. For example, right now under Medicaid, States are required to provide nursing home care, but they are not required to provide home and community-based services.

Data from 2001 indicates that 70 percent of Medicaid funds are now being spent on institutional care and only 30 percent for community-based care. That is a shameful statistic that needs to change. As the administration's documents state, this initiative would "level the playing field."

Some might argue this is a Medicare bill and we should not include a Medicaid initiative. However, there are other Medicaid provisions in this Medicare bill, presumably because they are important to some of our colleagues.

This amendment, I believe, is just as worthy, and I would argue more so because it helps fulfill our goals in passing the Americans with Disabilities Act 13 years ago. In fact, the 13th anniversary of the Americans with Disabilities Act is coming up on this July 26. Thirteen years ago we made specific findings about institutionalization and the continued segregation of individuals with disabilities.

I was one of the leading sponsors of the Americans with Disabilities Act, and I know firsthand the effects of segregation of people with disabilities. I told the story often about my brother Frank. When he was a young boy, he became deaf because he had spinal meningitis. He became totally deaf. They picked him up, took him away from home, and sent him halfway across the State to a segregated school for the deaf. The people referred to it as a school for the deaf and dumb. As my brother always said, I may be deaf, but I am not dumb. That is what it was like in those days. It continues on today, that people with disabilities are segregated and sent to live in institutions.

A couple of years ago, 1999, a very famous case made its way to the Supreme Court. It is referred to as the Olmstead case. The Supreme Court ruled in 1999 that confinement in an institution is discrimination. The Supreme Court stated that when you segregate someone, as was being done in Georgia—and this case just happened to originate in Georgia. I am not picking on that State, but it happens in all other States. This Olmstead case just happened to originate in Georgia. When the Supreme Court looked at the case, they said when you segregate someone, you are telling them they are "unworthy to participate in community life." That is the Supreme Court decision.

That Supreme Court decision said that States must offer the least restrictive environment to people with disabilities. The problem is, 4 years later after the Supreme Court ruling, there are still countless Americans with disabilities institutionalized, needlessly institutionalized.

This amendment is a win-win program. It would not only help offer more choices to people with disabilities, it would provide the resources to States during a very difficult fiscal time. Studies have shown States that rebalance their long-term services system can realize substantial savings. The Lewin Group did a study of three States that increased their use of home and community-based waivers instead of nursing homes in the early nineties. In one year, Colorado saved $42 million, Oregon saved $49 million, and Washington saved $74.5 million.

The researchers explained these States were able to get such high cost savings by targeting people with disabilities who were very likely to go into a nursing home. In our amendment, we are targeting those who are already in an institution or nursing home. So States are already spending large sums of money on these people.

Based on data provided by the Congressional Research Service, nursing homes cost approximately $57,000 per year per person. Institutions for individuals with mental retardation cost $88,000 per person per year. Home and community-based waivers are roughly $30,000 to $50,000 cheaper per person than these institutional cases.

The problem is States cannot afford the upfront costs that are needed to move people out of institutions and into community-based living. For example, housing may need to be modified to be accessible. That costs money. An individual may need some education and services to get ready to move out of an institution, especially if they have been there a long time, say, 20 years or more. The State may need resources to develop sufficient community providers and rebalance its long-term service program.

There are a lot of upfront costs a State would have to do to get someone with a disability out of a nursing home, out of a State institution, and into a community-based living environment.

The amendment I am offering implements President Bush's own budget request for 2004. It will be an upfront investment to help these States do that transition. It is a demonstration program for 5 years to those States that need the help.

I applaud the President for proposing this program as part of his new freedom initiative because it really is about freedom: The freedom to live with family and friends, not with strangers; the freedom to take a walk in one's own neighborhood, not just on their ward; the freedom to be a person and not a patient.

No one should have to sacrifice their freedom to participate in society because they need help getting out of the house in the morning or assistance with personal care or some other basic service. Think about it. That is what happens to people with disabilities. They sacrifice their freedom to participate in society because they may need a little help in the morning, a little bit of help at night, or a little bit of attendant services.

As taxpayers, we know it is cheaper for us to provide that kind of home-based, community-based service rather than putting people in institutions. But back when we built the institutions, when we started the nursing home care for people with disabilities that is what we believed, that people ought to be segregated.

We have changed as a society, and I think we have changed for the better. It is not unusual now to see people with disabilities in all walks of life, working on the Senate floor, in our court systems, on the shop floor, running businesses, shopping in the store, eating in a restaurant, going to an amusement park. I argue what is unusual is that in the year 2003, to say we are going to take taxpayer money and we are going to institutionalize someone with a disability who does not want to be institutionalized, who would rather live in the community, who would like to go out for a walk in the daytime, who might want to go down to the corner store and purchase some things, who might want to go to a movie now and then.

Recently, I received a letter from someone who had been moved to community-based living. She said she went to a movie for the first time in 3 years. Think about that. It was the first time in 3 years because she had been in an institution and she could not go to the theater. Now she can go to the movie theater.

I hope Senators will think about this. As I said, it is in the President's budget. He has requested it. I have offset it. So I can see no reason we should not take this step to make sure people with disabilities can get back into the community where they belong and where they want to be, with their family and friends, and not shut up with strangers, with people they may not know, segregated from society.

I urge my colleagues to act now. Freedom does not need a lot of debate and discussion. The freedom for people with disabilities ought to be happening right now.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside so the Senator from Minnesota may offer up to three amendments in succession.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Minnesota.

AMENDMENT NO. 957

Mr. DAYTON. I thank the Senator from Montana, and I will call three amendments up at this time. The first is amendment No. 957.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Minnesota [Mr. DAYTON] proposes an amendment numbered 957.

Mr. DAYTON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide that prescription drug benefits for any Member of Congress who is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the level of prescription drug benefits passed in the 1st session of the 108th Congress, and for other purposes)

At the appropriate place insert the following:

SEC. . LIMITATION ON PRESCRIPTION DRUG BENEFITS OF MEMBERS OF CONGRESS.

(a) LIMITATION ON BENEFITS.—Notwithstanding any other provision of law, during calendar year 2004, the actuarial value of the prescription drug benefit of any Member of Congress enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the actuarial value of any prescription drug benefit under title XVIII of the Social Security Act passed by the 1st session of the 108th Congress and enacted in law.

(b) REGULATIONS.—The Office of Personnel Management shall promulgate regulations to carry out this section.

Mr. DAYTON. I ask unanimous consent that amendment be set aside and we proceed to the next amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 960

Mr. DAYTON. I call up amendment No. 960.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Minnesota [Mr. DAYTON] proposes an amendment numbered 960.

Mr. DAYTON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require a streamlining of the medicare regulations)

At the end of subtitle A of title V, add the following:

SEC. . STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act") to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

Mr. DAYTON. Mr. President, I ask unanimous consent that the amendment be set aside in order to bring up the third amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 977

Mr. DAYTON. Mr. President, I call up amendment No. 977.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Minnesota [Mr. DAYTON] proposes an amendment numbered 977.

Mr. DAYTON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require that benefits be made available under part D on January 1, 2004)

On page 134, strike line 9 and insert the following:

under paragraph (1).

"(d) IMPLEMENTATION OF PART D.—Notwithstanding section 1860D–1(a)(4) or any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part on January 1, 2004. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part. The Secretary shall not implement sections 1807 and 1807A.

Mr. DAYTON. I thank my colleagues for the opportunity to discuss these three amendments this evening. They will be voted on later this week, and we will be calling them up for that purpose at that time.

During my campaign for the Senate in 2000, I promised a good prescription drug coverage program for senior citizens would be one of my very first priorities. In December of 2000, after my election but just before I took office, I went up to Duluth, MN, up in the northeastern part of our State, and met with a group of senior citizens. At the end of the meeting, an elderly woman, who was about half my size and twice my age, stood up and said: Mr. DAYTON, if you do not keep your promises, I am going to take you out behind the woodshed for an old-fashioned thrashing.

It has been then with some trepidation that I have visited Duluth in the months that followed, and it is not just Duluth. Everywhere in Minnesota our elderly citizens, and actually all of our other Medicare beneficiaries who stand to benefit from this legislation, have been waiting. They have been waiting patiently and they have been waiting impatiently for the Senate, the House, and the White House to reach an agreement on a bill, pass it, and then have the President sign it into law.

During the last several years, our seniors have watched the Senate pass a bill but not the House; the House act but not the Senate; both bodies fail to pass anything; both the House and the Senate pass a bill yet be unable to agree on one and nothing passed. Meanwhile, every year that Congress and the President did nothing, our senior citizens paid the price, and then they paid another price and then another.

Prescription drug prices have risen higher and higher in this country while nothing was being done to help. The financial burdens then fell harder on people with limited and fixed incomes. People who worked hard all of their lives, saved up a bit, retired, and did not have many other earning opportunities, were literally destroyed by the rapid escalation of prescription drug medicine, medicines they cannot afford not to have, medicines they cannot afford to have.

People's peace of mind was shattered. Hopes and plans had to be abandoned, ones that had been months and years in the making. Even modest comforts and simple enjoyments had to be sacrificed to pay this ravaging beast of the pharmaceutical industry that wanted more profits out of pockets, out of the sweat and blood of senior citizens and other Americans.

The financial security and the protections from destitution and despair, which Social Security and Medicare have provided our elderly for several decades and which was one of the great accomplishments of this society, was being rapidly eradicated by drug companies' greed and Congress's and the administration's inaction.

I thought on the day when we finally acted and passed a prescription drug coverage bill for senior citizens and other beneficiaries it would be cause for real celebration and satisfaction, and I could go back to Duluth. Well, it appears that this Friday may very well be that day where we will pass in the Senate prescription drug legislation, but the way it looks now I will not be celebrating the passage of the bill that is before us right now.

It is usually true that something is better than nothing, and the bill that is before us now is barely enough of something to be better than nothing. I will probably vote for it for that reason, but I will not be celebrating because there is not enough in this bill to be worthy of celebration. For starters, it does not even begin until January 1 of the year 2006. It is unbelievable there would be a 2½ year delay from the time this bill is signed into law before it is operational.

To let that stand is a violation of the Constitution which prohibits cruel and unusual punishment for American citizens. It is cruel and unusual punishment for the senior citizens of Minnesota and their counterparts of this country who have waited this long, year after year, waiting for this legislation, bills mounting. Finally something is passed and they are told they have to wait another 2½ years for the Federal Government and the insurance industry to set up this program. Shame on us if we do not move the development of this program from the sleepwalking mode into overdrive.

Proponents of this bill say the approach using subsidized insurance plans to provide this coverage is one of the advantages—they have postulated in the Senate and committee—because it is more efficient. The insurance companies are in the business of designing and selling insurance policies. How could they need 2½ years to develop this? If they do, it seems to me that is a very compelling reason to look for a different delivery system. Some believe that would be good for other reasons, as well.

My first amendment is named the bureaucracy booster to require whatever program we pass and whatever the President signs into law to be fully operational by January 1 of 2004, 2 years earlier than the President's schedule calls for. It would be 6 months after we pass our bill later this week. It took 6 months for our armed services to assemble their forces and prepare for the war against Iraq. They were ready to go when General Franks gave his order. If this country can get ready to win a war in 6 months—and actually the war against the Taliban in Afghanistan was assembled in about 6 weeks—it certainly can start to save our senior citizens in that same amount of time.

I am also troubled by the quality of the program which will hopefully be available to everyone on Medicare, if my amendment passes, next January 1. The coverage in the bill before the Senate is not very good. I don't fault the leaders of this bill who took it through the committee process. It was a very difficult task, with Members from all over the country. They were constrained by the budget this body passed earlier this year. You can slice and dice the programs and the delivery and the structuring but the bottom line is you will get what you pay for. Maybe it is better one way or the other but the bottom line is you get what you pay for. The Finance Committee had $400 billion over 10 years and they did the best they could, but the fact is that is not enough to provide the kind of coverage the senior citizens of this country have a right to expect. It provides only half the coverage we Members of the Senate and our colleagues in the House get through the Federal employees plan.

The bill before the Senate requires a $35 a month premium and a $275 deductible, so an enrollee pays $695 each year before receiving a single dollar of assistance. From that point, for all of his or her nonreimbursement prescription drugs above the $275 deductible, up to $4,500 in 1 year, the program would pay half. At that point, incredibly, the program pays nothing then for drug costs that exceed $4,500 for one person in one year, all the way up to $5,800. I understand that was done for the purpose of fitting within this budget cap. But it seems unfair to have a 50 percent program up to one point, then have the program disappear entirely for $1,300 of expenditures, but come back after $5,800, for the balance of the year, when the program pays 90 percent. The next year it starts all over again. For the first $5,800 in annual prescription drug costs out-of-pocket payments, nonreimbursed, a senior citizen of Minnesota or America has to pay $3,688 plus they have to pay $4,200 in monthly premiums. So the total payment for the senior citizen is $4,108 and the program will pay $2,012. The senior pays almost twice as much as the program assistance. So hundreds and thousands of dollars of expenses will be paid by a very limited and fixed-income senior citizen.

It is not a good deal. It is not what we ought to be providing for our seniors. It is not as generous as the alternative bill which our colleague, the Senator from Illinois, Senator DURBIN, has offered as an alternative amendment which I am proud to work on and cosponsor. That is the kind of program I would want my mother or father to be on. It is as good a program as members of the Senate have. It would have no deductible and pay for 70 percent of the costs from the very first $1 owed up until $5,000 and 90 percent above that. That is a much better administrative feature.

What the pharmaceutical industry wants to the death to oppose is the Federal Government CMS, the Medicare administrators getting involved in negotiating down the prices. They have free and clear now, unlike virtually any other country in the world, ability to just raise prices for prescription drugs and raise them and raise them. They are making huge profits. Most of their worldwide profits are made in the United States of America not only with our seniors but all citizens because this body and the House and White House will not stand up and do something about it. Senator DURBIN's amendment would do something. I expect the pharmaceutical industry to oppose it to the death.

I have a second amendment which I call the taste of our own medicine amendment which says if the program we pass for Medicare beneficiaries is less advantageous than the one we receive under the Federal employees health plan, the coverage for all Members of Congress, the Senate and the House, will be reduced to the same level as the coverage provided for senior citizens and others under Medicare. If it is good enough for the seniors of America, it is as good as we should do for ourselves.

My third amendment is what I call my bureaucracy buster. Earlier I had bureaucracy booster to get the program operating early. This applies to all of Medicare. It would apply, I am told by the CEO of Mayo Clinic, to 130,000 pages of rules and regulations that make up the governance of Medicare. I was going to bring 130,000 pages over here as a graphic illustration, but it is a violation of Senate rules for decency and decorum. If anyone ever saw 130,000 pages piled up, they would agree. It is bigger than all the Harry

Potter books, a lot bigger than anyone involved in Medicare had a chance to look at either to apply to their hospital or clinic or to enforce, and it is one piece of this epidemic of verbiage, duplicative regulation, multiple reporting requirements we have placed on doctors, hospitals, administrators, special education teachers, school superintendents, small business, large business, this plague of ever more and more and more regulations, more complicated, more lengthy, more time consuming. We are burying our society, burying our economy, burying our delivery systems to other people and we have to start turning that around.

This amendment requires the Secretary of Health and Human Services to come back to Congress by October 1 of 2004 with a revision to the Medicare regulations and rules that amounts to two-thirds of all the words that are now being used for those purposes. It would be a two-thirds reduction in the amount of regulation and reporting. That means we have to squeeze everything down into 45,000 pages. It will just have to be done.

If my colleagues will join me in agreeing to this amendment, once it has proven to be a viable idea, it is something I would like to apply to other regulatory and reporting mechanisms in the Federal Government as well.

I yield the floor.

Mr. BAUCUS. Mr. President, I ask unanimous consent the pending amendments be temporarily set aside.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

AMENDMENT NO. 992

Mr. BAUCUS. Mr. President, on behalf of Senator STABENOW, I send an amendment to the desk regarding State rebate agreements.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Ms. STABENOW, for herself and Ms. SNOWE, proposes an amendment numbered 992.

Mr. BAUCUS. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To clarify that the medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the medicaid program)

On page 158, between lines 4 and 5, insert the following:

(f) CLARIFICATION OF STATE AUTHORITY RELATING TO MEDICAID DRUG REBATE AGREEMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended by adding at the end the following:

"(l) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State from—

"(1) directly entering into rebate agreements (on the State's own initiative or under a section 1115 waiver approved by the Secretary before, on, or after the date of enactment of this subsection) that are similar to a rebate agreement described in subsection (b) with a manufacturer for purposes of ensuring the affordability of outpatient prescription drugs in order to provide access to such drugs by residents of a State who are not otherwise eligible for medical assistance under this title; or

"(2) making prior authorization (that satisfies the requirements of subsection (d) and that does not violate any requirements of this title that are designed to ensure access to medically necessary prescribed drugs for individuals enrolled in the State program under this title) a condition of not participating in such a similar rebate agreement.".

AMENDMENT NO. 993

Mr. BAUCUS. Mr. President, I ask unanimous consent all pending amendments be temporarily set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. On behalf of Senator DORGAN, I offer an amendment with respect to coverage of cardiovascular screening tests. I send that to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. DORGAN, proposes an amendment numbered 993.

Mr. BAUCUS. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the medicare program)

At the appropriate place in title IV, insert the following:

SEC. . COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V)(iii), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) cardiovascular screening tests (as defined in subsection (ww)(1));".

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Cardiovascular Screening Tests

"(ww)(1) The term 'cardiovascular screening tests' means the following diagnostic tests for the early detection of cardiovascular disease:

"(A) Tests for the determination of cholesterol levels.

"(B) Tests for the determination of lipid levels of the blood.

"(C) Such other tests for cardiovascular disease as the Secretary may approve.

"(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

"(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Iowa is recognized.

AMENDMENT NO. 974

Mr. GRASSLEY. I am going to call up my amendment numbered 974, which I filed on Friday. I am pleased to offer the Drug Competition Act of 2003.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for himself, Mr. LEAHY, Ms. CANTWELL, Mr. DURBIN, and Mr. KOHL, proposes an amendment numbered 974.

The amendment follows:

(Purpose: To enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs)

At the appropriate place, insert the following:

TITLE —DRUG COMPETITION ACT OF 2003

SEC. 01. SHORT TITLE.

This title may be cited as the "Drug Competition Act of 2003".

SEC. 02. FINDINGS.

Congress finds that—

(1) prescription drug prices are increasing at an alarming rate and are a major worry of many senior citizens and American families;

(2) there is a potential for companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs to enter into financial deals that could tend to restrain trade and greatly reduce competition and increase prescription drug expenditures for American citizens; and

(3) enhancing competition among these companies can significantly reduce prescription drug expenditures for Americans.

SEC. 03. PURPOSES.

The purposes of this title are—

(1) to provide timely notice to the Department of Justice and the Federal Trade Commission regarding agreements between companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs; and

(2) by providing timely notice, to enhance the effectiveness and efficiency of the enforcement of the antitrust and competition laws of the United States.

SEC. 04. DEFINITIONS.

In this title:

(1) ANDA.—The term "ANDA" means an Abbreviated New Drug Application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(aa)).

(2) Assistant Attorney General.—The term "Assistant Attorney General" means the Assistant Attorney General in charge of the Antitrust Division of the Department of Justice.

(3) Brand name drug.—The term "brand name drug" means a drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)).

(4) Brand name drug company.—The term "brand name drug company" means the party that received Food and Drug Administration approval to market a brand name drug pursuant to an NDA, where that drug is the subject of an ANDA, or a party owning or controlling enforcement of any patent listed in the Approved Drug Products With Therapeutic Equivalence Evaluations of the Food and Drug Administration for that drug, under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)).

(5) Commission.—The term "Commission" means the Federal Trade Commission.

(6) Generic drug.—The term "generic drug" means a product that the Food and Drug Administration has approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(7) Generic drug applicant.—The term "generic drug applicant" means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(8) NDA.—The term "NDA" means a New Drug Application, as defined under section 505(b) et seq. of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b) et seq.)

SEC. 05. NOTIFICATION OF AGREEMENTS.

(a) In General.—

(1) Requirement.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(2)(vii)(IV)) and a brand name drug company that enter into an agreement described in paragraph (2), prior to the generic drug that is the subject of the application entering the market, shall each file the agreement as required by subsection (b).

(2) Definition.—An agreement described in this paragraph is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the subject of the generic drug applicant's ANDA;

(B) the manufacture, marketing or sale of the generic drug that is the subject of the generic drug applicant's ANDA; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(B)(iv)) as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) Filing.—

(1) Agreement.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any such agreement, except that the generic drug applicant and the brand-name drug company shall not be required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

(2) Other agreements.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any other agreements not described in subsection (a)(2) between the generic drug applicant and the brand name drug company which are contingent upon, provide a contingent condition for, or are otherwise related to an agreement which must be filed under this title.

(3) Description.—In the event that any agreement required to be filed by paragraph (1) or (2) has not been reduced to text, both the generic drug applicant and the brand name drug company shall file written descriptions of the non-textual agreement or agreements that must be filed sufficient to reveal all of the terms of the agreement or agreements.

SEC. 06. FILING DEADLINES.

Any filing required under section 5 shall be filed with the Assistant Attorney General and the Commission not later than 10 business days after the date the agreements are executed.

SEC. 07. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Assistant Attorney General or the Commission pursuant to this title shall be exempt from disclosure under section 552 of title 5, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. 08. ENFORCEMENT.

(a) Civil Penalty.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this title shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this title. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) Compliance and Equitable Relief.—If any brand name drug company or generic drug applicant fails to comply with any provision of this title, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Commission.

SEC. 09. RULEMAKING.

The Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5 United States Code, consistent with the purposes of this title—

(1) may define the terms used in this title;

(2) may exempt classes of persons or agreements from the requirements of this title; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this title.

SEC. 10. SAVINGS CLAUSE.

Any action taken by the Assistant Attorney General or the Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this title shall not bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant at any time under any other provision of law, nor shall any filing under this title constitute or create a presumption of any violation of any antitrust or competition laws.

SEC. 11. EFFECTIVE DATE.

This title shall—

(1) take effect 30 days after the date of enactment of this title; and

(2) shall apply to agreements described in section 05 that are entered into 30 days after the date of enactment of this title.

Mr. GRASSLEY. This is the Drug Competition Act of 2003. I filed it as an amendment to S. 1. I do it in a bipartisan way with Senator LEAHY and many others.

Our amendment will help Federal regulators ensure that antitrust laws are not being violated and that there is full and unfettered access to competition for prescription drugs under the law.

What I want to do is make sure American consumers—and in the case of prescription drugs for Medicare, senior citizens—are able to get the lifesaving drugs they need and to do it in a competitive manner with resulting lower prices.

Our patent laws provide drug companies with incentives to invest in the research and development of new drugs, but the law also provides that generic drug companies have the ability to get their own drugs on the market so there can be price competition and lower prices for prescription drugs. We have a legal system in place that provides such a balance; that is, the Hatch-Waxman law. Ultimately, we want consumers and seniors to have more choices and to get drugs at lower prices.

So I was concerned when I heard reports that the Federal Trade Commission had brought enforcement actions against brand-name and generic drug manufacturers that had entered into anticompetitive agreements, resulting in the delay of the introduction of lower priced drugs. Our amendment targets this problem.

I would like to explain in a little more detail the problem. Under the Hatch-Waxman Act, manufacturers of generic drugs are encouraged to challenge weak or invalid patents on brand-name drugs so that consumers can benefit from lower generic drug prices. Current law gives temporary protection from competition to the first generic drug manufacturer that gets exclusive permission to sell a generic drug before the patent on the brand-name drug expires. This gives the generic firm, then, a 180-day head start on all other generic companies.

However, the FTC discovered that some companies were exploiting this law by entering into secret deals, which allowed the generic drugmakers to claim a 180-day grace period, and to block, then, other generic drugs from entering the market, while at the same time getting paid by the brand-name manufacturer for withholding sales of generic versions of the drug. Quite a sweet deal.

This meant, then, under this sweet deal, that consumers continued to pay high prices for drugs rather than benefiting from more competition and consequently lower prices.

The Federal Trade Commission brought antitrust law enforcement actions against the brand-name and generic drug companies that had engaged in this anticompetitive behavior. In addition, the Federal Trade Commission conducted a comprehensive review of agreements that impacted the 180-day exclusivity period. The FTC found that there are competition problems with some of these agreements that potentially delayed generic drugs entering the market—just the opposite of what the FTC wanted to happen. So the FTC made this recommendation:

> Given this history, we believe that notification of such agreements to the Federal Trade Commission and the U.S. Department of Justice is warranted. We support the Drug Competition Act of 2001, introduced by Senator LEAHY, as reported by the Committee on the Judiciary.

As the Federal Trade Commission has indicated in its report, the Grassley-Leahy amendment, the Drug Competition Act of 2003, is a simple solution to the 180-day exclusivity period and the problems the FTC has identified. Our amendment would require drug companies that enter into agreements relating to the 180-day period to file documents, those very documents with the FTC and the Department of Justice. Our amendment would impose sanctions on companies that do not provide timely notification. This process would facilitate agency review of the agreements. It would do it to determine whether they have anticompetitive effects. Making sure the agreement between the generic and brand-name drug companies is in compliance with the law is good for the American consumer because it guarantees free, full, and fair competition.

Both Senator LEAHY and I worked with the Federal Trade Commission and the Department of Justice, the generic and brand-name drug companies, and other interested groups in crafting the language contained in this amendment, and I think we have a very good work product that I am offering the Senate. We tried to address everyone's concerns and we tried to limit the scope of the act. We also made every attempt to ensure that the notification requirement did not unnecessarily burden industry.

I am not aware of any opposition to this language. In fact, the Drug Competition Act, passed out of the Judiciary Committee and the full Senate last year by unanimous consent, and the Federal Trade Commission report came out in full support of the Grassley-Leahy amendment as a way to help preserve healthy and open competition in the drug markets.

The Grassley-Leahy amendment will ensure that consumers ultimately are not hurt by secret, anticompetitive contracts, so the consumer can get competition and lower drug prices almost immediately. I urge my colleagues to support the Grassley-Leahy amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, it is my understanding a number of Senators have offered amendments. I assume they have been sending them to the desk and setting them aside. Is that correct?

That is what I would like to do before we adjourn this evening.

AMENDMENT NO. 994

Mr. President, this is an amendment I have discussed with my colleagues and have spoken about on the Senate floor a few times. It is in the nature of a substitute to the underlying bill.

Let me say, though I have had many differences with my friend from Iowa about a variety of different matters we have worked on over the years, I congratulate both him and Senator BAUCUS for their leadership. I think what they have done is bring the Senate to this moment in our history where we are seriously considering a prescription drug program that will benefit the tens of millions of seniors across America. And this conversation is long overdue.

I think what they have proposed is a worthy start for a commitment that needs to be made. I think there isn't a Senator who comes to this floor who has not been back to his or her State to hear of the tales and stories of families and the struggles they are going through in paying for prescription drugs.

I was back in my hometown of Springfield, IL, over the weekend for a wedding, and out of nowhere people started coming up to me and talking about prescription drug costs: I know you are debating this in Washington.

I think this is a timely discussion. I hope, at the end of the discussion, we will have a bill that really does achieve what we hope to achieve. I think making a national commitment to a prescription drug program under Medicare is the right thing to do, but I think we need to do it with our eyes wide open.

There are several facts we should consider. Let me give you illustrations. One of them is the cost of prescription drugs is going to continue to rise dramatically unless we address it, and address it head on. They say the cost of prescription drugs goes up 10 to 20 percent a year. You can ask any senior or family and they can tell you that story.

What troubles me about the underlying bill is it does not have competitive forces that will bring these costs down. It provides for a percentage helping hand to seniors to pay for their prescription drug bills, but that percentage becomes less and less as the overall cost of prescription drugs continues to grow out of hand. The substitute amendment which I am offering is going to address this, I hope, in a meaningful way.

Just last Friday—I guess a surprise vote to some—we decided to allow America's seniors to import drugs from Canada. Why did we do that? Because everybody knows the story: The very same American drug companies that make these products in America, when they turn to sell them in Canada, give them a deep discount. Why? Because the Canadian Government says to them: If you want to sell drugs in Canada, then you have to discount the cost to Canadian citizens.

So here we are, in our States bordering Canada, just a few miles away from pharmacies in Canada selling identical drugs to those sold in America at a fraction of the cost. Now, of course, that is a benefit to Canadian citizens. And we decided last Friday we would make certain that benefit was there for American citizens.

We can reimport drugs—in other words, made in the United States, shipped to Canada for sale. We will now, under the amendment we adopted by Senator DORGAN of North Dakota, allow Americans to repurchase the drugs from Canadian pharmacies to bring them back into the United States. Isn't that an awkward, clumsy, and convoluted way to provide a discount to America's seniors? It certainly is. But we voted for it on a pretty substantial rollcall. I think over 60 Senators supported it because we understand for many seniors that Canadian discount makes all the difference in the world.

Unfortunately, this reimportation from Canada is temporary, and it is not a permanent part of what we are debating here. In fact, there are few, if any, elements in this underlying legislation that give seniors in America a fighting chance to get anywhere near the discounted prices being offered to families in Canada for the prescription drugs they need. In other words, we are offering a helping hand from the Government to pay for your prescription drugs, but offering no force or no element—certainly very little—within this bill to try to reduce and control prices.

You may think: Is Canada that powerful that they can dictate to the American drug companies they have to discount their prices? Well, I can tell you, the Canadian market represents about 2 percent—2 percent—of the sales by American drug companies, whereas the United States market represents 53 percent. If we, as a nation, turned to these same drug companies that have bargained with Canada and said: "We want the same thing for Americans," you can bet we would achieve it. But this bill does not do that. The Grassley-Baucus bill does not do this. It does not create this force for competition and this force for bringing down costs.

Some will come to the floor and say: Durbin, this amendment is nothing short of socialism. You are trying, with a radical idea, to change the market structure in America, take away the free market competition, and dictate prices, and that is just unfair. We should not do it. And that is not American.

Well, I would ask them to place a call to the Veterans' Administration because the Veterans' Administration already does the same thing. The Veterans' Administration bargains for our veterans so the prescription drugs they receive are at a reduced cost. Why, if our Government will stand up for our veterans to get reduced costs for prescription drugs, is that any different than saying, under this bill, we should also be bargaining to make certain we can bring down prescription drug costs across the board? It will mean the program is more affordable for seniors. It will also mean the money we dedicate to the program will be with us for a while, a lot longer than as proposed under this bill.

So we do several things in this substitute amendment. I am not going to take any further time other than to just say a few words about this amendment, who supports it, and what it stands to achieve.

It is being offered on my behalf, as well as Senators CORZINE, HARKIN, BOXER, STABENOW, DAYTON, and BYRD. It has been endorsed, to this point—we think other endorsements will come—by the Alliance for Retired Americans as well as the National Committee to Preserve Social Security and Medicare.

Here is what it does. It defines the benefits in statute. The underlying bill does not. It eliminates the coverage gap. The underlying bill has a coverage gap, where, after a senior has spent a certain amount of money for prescription drugs, there is no coverage until it reaches a catastrophic level over $5,000. It eliminates the deductible of $275 proposed by this bill because we found with price competition we can bring down the overall cost. It increases cost sharing. It guarantees a stable fallback. In other words, if there is not a private prescription benefit pharmacy manager offering alternatives to seniors, we allow Medicare itself to offer a prescription drug plan. That is a fallback always available under our bill. You do not have to be eliminated from the one to offer the other. This is always a fallback. And it allows employer coverage to count toward out-of-pocket spending.

The average cost for prescription drugs for seniors in this year is expected to be approximately $2,300. Under this bill we are considering on the floor today, seniors could get back maybe one fourth of that, $600. Every dollar counts and I commend my leaders in the Finance Committee for bringing this to us, but it is $600. Under the MediSAVE plan, my substitute amendment, seniors will have no deductible, lower cost-sharing, and face no coverage gap. The average senior can save up to 50 percent of the cost of those $2.300 in drugs, almost double what is offered by the underlying bill.

There is no guaranteed benefit for seniors in the underlying bill, and premiums are left up to insurance companies to decide. Under the MediSAVE plan, which I will offer, the Medicare-delivered benefit is outlined in statute so all seniors who choose to receive their benefit through Medicare will be guaranteed the same package, the same premium, no matter where they live in America.

As I said before, we address skyrocketing drug prices whereas the underlying bill does not. Incidentally, the Veterans' Administration has saved about $943 million in the past 6 years because it has bargained with the drug companies on behalf of seniors.

We also maintain choice. I see some of my Republicans friends have sent a letter to the President saying: We have to allow for innovation. We have to allow for competition. Agreed. We say: Fine, private groups and insurance companies can offer the prescription drug benefit as an option, seniors get to choose. But they always have a Medicare fallback they can choose.

Some say: We don't want this Government agency running this. Why do we want a Government agency in charge of it? Well, because Medicare has no profit motive. Medicare has a low administrative cost. If the VA runs the program for veterans and we don't consider that socialism, what is wrong with the idea of having Medicare in here competing with these private insurance companies. Eighty-nine percent of seniors today stick with Medicare rather than going to some HMO choice plan and/or private plan under Medicare. That tells you they like Medicare better. Why should we deny them this chance under prescription drugs.

MediSAVE creates a reliable fallback that is Medicare, and I think that is good for seniors. And MediSAVE will incentivize employers to maintain benefits. This is a fear we have. We don't want to do anything that will hurt the employers currently helping retired seniors, and we want to make certain we encourage their continued participation.

Under S. 1, funds employers put toward retiree costs don't count toward the retiree's Medicare out-of-pocket cost. Under MediSAVE, they would count.

Mr. President, I know it is late. I know a number of amendments have been offered. But at this point I would like to send my amendment to the desk and ask that it be read and then held at the desk.

Mr. GRASSLEY. Mr. President, reserving the right to object, I assume he asked unanimous consent to set the amendments aside.

Mr. DURBIN. Which I will do. I will send the amendment to the desk. I don't know if it should be reported at this moment, but I ask it be set aside.

Mr. GRASSLEY. Could I say this: If you would allow me, rather than reserving the right to object, when he asks unanimous consent to set aside an amendment to offer his amendment, I am not going to object to that. But the leader has asked we have no more amendments tonight. So I would then be forced to object to any other amendments from either side that would come up.

The PRESIDING OFFICER. Does the Senator object to this amendment at this time, or does anybody else object to it?

Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Illinois [Mr. DURBIN], for himself, Mr. CORZINE, Mr. HARKIN, Mrs. BOXER, Ms. STABENOW, Mr. DAYTON, and Mr. BYRD proposes an amendment numbered 994.

The amendment is as follows:

(Purpose: To deliver a meaningful benefit and lower prescription drug prices)

Beginning on page 48, strike line 13 through page 50, line 2 and insert the following:

"(1) NO DEDUCTIBLE.—

"(A) IN GENERAL.—The coverage provides for benefits without the application of a deductible.

"(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply section 1860D–19(a)(3)(A)(ii).

"(2) LIMITS ON COST-SHARING.—

"(A) IN GENERAL.—The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under paragraph (4)) that is equal to 30 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 30 percent of such costs.

"(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a). 2

On page 50, line 15, strike "$3,700" and insert "$1.500".

On page 51, strike lines 15 through 25 and insert the following:

“(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Beginning on page 77, strike line 10 and all that follows through page 84, line 7, and insert the following:

“(e) MEDICARE OPERATED PLAN OPTION.—

“(1) ACCESS.—The Administrator shall establish and operate a national plan to provide any eligible beneficiary enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage, enrolled in a MedicareAdvantage plan) electing such plan with standard prescription drug coverage. Under such plan, the Administrator shall negotiate with pharmaceutical manufacturers with respect to the purchase price of covered drugs and shall encourage the use of more affordable therapeutic equivalents to the extent such practices do not override medical necessity as determined by the prescribing physician. To the extent practicable and consistent with the previous sentence, the Administrator shall implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, to reduce the purchase cost of covered drugs. Eligible beneficiaries enrolled under this part shall have the option of enrolling in such plan or in a Medicare Prescription Drug plan or a MedicareAdvantage plan available in the area in which the beneficiary resides.

“(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

“(A) IN GENERAL.—In the case of an eligible beneficiary enrolled in the plan operated by the Administrator under paragraph (1), the monthly beneficiary obligation of such beneficiary for such enrollment shall be—

“(i) for months in the first year of implementation, $35; and

“(ii) for months in a subsequent year, the lesser of—

“(I) the amount determined under this paragraph for months in the previous year, increased by the annual percentage increase described in section 1860D–6(c)(5) for the year involved; or

“(II) in the case of months in years prior to 2014, the specified amount.

“(B) SPECIFIED AMOUNT.—For purposes of this paragraph, the term ‘specified amount’ means—

“(i) for months in the second year of implementation, $37;

“(ii) for months in the third year of implementation, $40;

“(iii) for months in the fourth year of implementation, $43;

“(iv) for months in the fifth year of implementation, $46;

“(v) for months in the sixth year of implementation, $51;

“(vi) for months in the seventh year of implementation, $54; and

“(vii) for months in the eighth year of implementation, $59.

“(3) NO AFFECT ON ACCESS REQUIREMENTS.—The plan operated by the Administrator under paragraph (1) shall be in addition to the plans required under subsection (d)(1).

“(4) REQUIREMENT TO PREVENT INCREASED COSTS.—If the Administrator determines that Federal payments made with respect to eligible beneficiaries enrolled in the plan operated by the Administrator under paragraph (1) exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan (with respect to qualified prescription drug coverage), the Administrator shall adjust the requirements or payments under such a contract to eliminate such excess.

“(f) TWO-YEAR CONTRACTS.—A contract approved under this section for a Medicare Prescription Drug plan shall be for a 2-year period.

“(g) IMPLEMENTATION OF PART D.—Notwithstanding any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part as soon as practicable after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, but in no case later than January 1, 2006. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part.

On page 134, strike line 9 and insert the following:

under paragraph (1).

“(d) SPECIAL RULES FOR STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

“(1) IN GENERAL.—Notwithstanding any other provision of this part, in the case of the sponsor of a State pharmaceutical assistance program that seeks to offer a Medicare Prescription Drug plan under this part, the following special rules apply:

“(A) WAIVER OF LICENSURE.—Section 1860D–7(a)(1) shall not apply.

“(B) PERMITTING LIMITATION ON ENROLLMENT.—The sponsor may restrict eligibility to enroll in the plan to those low-income individuals who qualify (or meet the standards for qualification) for the State pharmaceutical assistance program.

“(C) OTHER REQUIREMENTS.—The Administrator may waive such other requirements of this part as the Administrator finds appropriate to promote the role of State pharmaceutical assistance programs under this part.

“(2) DEFINITION.—For purposes of this part, the term ‘State pharmaceutical assistance program’ means a program, in operation as of the date of enactment of this title, that is sponsored or underwritten by a State, that was established pursuant to a waiver under section 1115 or otherwise, and that provides financial assistance with out-of-pocket expenses with respect to covered outpatient drugs for individuals in the State who meet income-related qualifications specified under such program.

“(3) CONSTRUCTION.—Nothing in this subsection shall affect the provisions of subsection (b).”.

At the end of title VI, add the following:

SEC. . NEED FOR RENEWAL.

(a) IN GENERAL.—Notwithstanding any other provision of law, the provisions of, and amendments made by, this Act shall remain in effect but shall be superseded by the Director of the Office of Management and Budget on the date that the total of the increased Federal expenditures by reason of such amendments and provisions has reached $400,000,000,000.

(b) APPLICATION.—Any provision of law amended or effected by this Act shall be applied and administered after the date described in subsection (a) as if the provisions of, and amendments made by, this Act had never been enacted.

(c) NOTIFICATION.—The Director of the Office of Management and Budget shall notify Congress 6 months prior to the date that the provisions of, and amendments made by, this Act will be superseded pursuant to subsection (a).

Mr. DURBIN. I thank the Senator from Iowa and my colleagues.

Mr. REID. Before the Senator yields the floor, would the Senator yield for a question?

Mr. DURBIN. Yes.

Mr. REID. This is a little off point, but we are talking about jobs. Is the Senator from Illinois aware that the Bureau of Labor Statistics issued its latest unemployment figures today?

Mr. DURBIN. I did not see those.

Mr. REID. Would the Senator be surprised that under this administration, which is always talking about what a great job they are doing with the economy, we now have the highest unemployment rate in 106 months; it has jumped up now to over 6 percent? Is the Senator surprised at that number?

Mr. DURBIN. I wish I was, but we have lost 2 million jobs under this administration already. So it is no surprise we continue to lose jobs in America. I am sure it is tough in Nevada. It is tough in Illinois. We have lost good paying jobs. I run into a lot of people who, frankly, have no place to turn in this economy.

Mr. REID. Highest unemployment in 106 months.

Mr. DURBIN. I would just suggest to the Senator from Nevada, it is curious to me that the President, with his tax cut program for stimulating the economy, had his first chance at it. The Senator can refresh my memory. Two years ago didn't we cut taxes, as the President suggested, primarily for the higher income individuals?

Mr. REID. For job creation.

Mr. DURBIN. Wasn't that about $1 trillion or more in tax cuts we were proposing for job creation?

Mr. REID. I would respond to my friend, if the last tax cut we had creates as many jobs as the first tax cut, we are in big trouble.

Mr. DURBIN. I would say there is that old adage that once you are in a hole, the first thing you do is stop digging. If I am not mistaken, didn't this administration come back and want to dig that tax cut hole deeper within the last few months, and still we see these job statistics telling us this is a failed economic policy?

Mr. REID. My friend is right. The Bureau of Labor Statistics found that national unemployment had increased in April to more than 6 percent, highest unemployment in 106 months.

Mr. DURBIN. I would like to ask the Senator from Nevada, was he aware of the fact we are now proposing the creation of jobs in Iraq, and some people have said we are going to create jobs where frankly we will give money to the people of Iraq, but they don't to have show up for work for a while? That might go over pretty well in my State if we would like to create a program like that. But I would like to ask the Senator, we are talking about the fact that this President took over after the economy had grown at a record pace for 7 or 8 years under first his father and then under President Clinton.

Mr. REID. I respond to my friend there is some dispute as to what the 10-year surplus was when he took office. Some say $7.1 trillion. Some say 6.2. But trillions of dollars over 10 years. And in fact, the last 3 years of the Clinton administration we had been spending less money than we were taking in. We were retiring the debt. But we are not worried about that anymore. We will have this year, some say, a debt as much as $600 billion, of course, not counting the Social Security surpluses which are used to disguise this. So I don't know where all this great economy is. It is not in Nevada.

Mr. DURBIN. I ask the Senator, would that $600 billion debt, if that is what we end up with, would that break the record under the Reagan administration which I believe was in the hundred billion dollar range?

Mr. REID. The debt this year will be the largest in the history of the world, not only the United States.

Mr. DURBIN. I would like to ask the Senator from Nevada, a lot of the fiscal conservative Republicans used to say you had to have fiscal discipline, get your house in order. Is he hearing the same thing I am hearing from those same fiscal conservative Republicans now, that deficits don't count, debt doesn't count?

Mr. REID. We not only have statements that would fill volumes about how bad the deficit was. And, in fact, I can remember Alan Greenspan telling us the most important thing we could do—he appeared before the Appropriations Committee—was get rid of the annual deficits. We followed his advice and did that. He is still chairman of the Federal Reserve. I wonder why he is not talking now along those same lines.

Mr. DURBIN. It is a curious thing. I recall when President Clinton was preparing to take office, that same Chairman Greenspan came to Little Rock in the transition and said: The most important thing you can do for the long-term economy is to reduce the long-term interest rates which means get serious about the deficit. President Clinton took that to heart. I think the Senator, was in the Senate, and I was in the House when President Clinton came in with his budget, which didn't get a single Republican vote in the House or the Senate. It passed in the Senate with the tie-breaking vote by Vice President Gore and then, because the Democrats stood up and did what was right for the economy, we saw this dramatic period of economic growth where people's savings were growing, retirement plans were growing, where we created some 22 million new jobs, inflation was under control, new housing starts, new businesses. And we are not talking about the deep dark recesses of American history. This was just a few years ago.

Now in 2½ years, it is amazing what this President has achieved. He has managed to lose jobs at a faster pace than any President in history and create the largest deficit in the history of the United States, all in the name of fiscal conservatism. It is really hard to imagine anyone can say with a straight face that is a conservative, disciplined approach to dealing with the budget.

I am sure in Nevada and Illinois the people don't like this economic policy and what it has meant.

Mr. REID. This is something I can't understand, why there is so much silence on the other side of the aisle about these huge annual deficits he has created, especially since when he took office we were spending less money than we were taking in. To think that the country is in such deep trouble. Does the Senator realize parts of our national parks are actually closing because of a state of disrepair, our great national parks? We have money in our highway trust fund that people pay when they go to the gas pump, but this money is not being used for highways. We are trying to come up with a highway bill, but the President is not allowing us to spend the money on highways. He wants to spend it on jobs in Iraq. I don't know what he wants to spend it on.

I didn't answer the one question the Senator asked about Iraq. Not only are they trying to create jobs in Iraq, they are now talking about paying Saddam Hussein's army for back pay while they were fighting Americans. Is the Senator aware of that?

Mr. DURBIN. I was not aware of that. I certainly want to see stability in Iraq. We all do, because otherwise it could disintegrate into another vacuum, a terrorist training ground. We don't want that to happen.

But it is curious to me, when it comes to the military cost of that war and the cost of reconstruction, there is no end in sight. It doesn't seem to bother people from the administration to continue to call for billions of dollars for this purpose.

But I would like to ask the Senator from Nevada this. He was serving here, as I was, when this President came in with something called No Child Left Behind, where we were going to send money to the schools across America for accountability and testing and upgrading of teacher skills. If I am not mistaken, this President had a White House bill signing ceremony, with Democrats and Republicans all applauding his No Child Left Behind. Yet when we look at the budget that was sent to us by this President, he is not providing the resources that we know will be needed for these schools. The Senator's State, I think, may be leading the Nation in the growth of school enrollment. In my State, we are struggling with our own deficit and cutbacks of State assistance to school districts.

So here we have President Bush's new mandates in No Child Left Behind, with no money to pay for them, while the local sources of revenue, from State sources and local property taxes, cannot keep up with demand. So what the President has done by saying we are going to focus this money on other things and tax cuts is shortchange education.

Mr. REID. Mr. President, I spoke to our State legislature and I said the President's No Child Left Behind Act is leaving lots of children behind. There was a little criticism for my having said that. But I was right.

In the State of Nevada, as we speak, the Clark County School District, which is the fifth largest school district in America, is talking about cutting back the school week to 4 days. Some of the good programs, such as the athletic programs, which I believe in, and programs dealing with the band and drama they are talking about eliminating, and they are talking about doing away with the programs for the academically talented. In fact, unless the legislature can get some resources from the State of Nevada—they don't expect anything from the Federal Government—the Clark County School District is talking about stopping all-year-around school. We have a year-round school district. They have been talking about closing schools. Well, talk about leaving some kids behind; that is it.

Mr. DURBIN. I don't think many Americans would argue that our children are overeducated. I know the State of Oregon closed their schools earlier this year, and the idea that we would eliminate part of the school year, afterschool programs, and summer school programs, to me, means these young people are not going to be given the chance they need to improve themselves.

I know the Senator from Nevada, probably more than anybody in this Chamber, has focused on the dropout issue. If we don't really have a sensitivity to the number of kids dropping out, we should not be surprised at what is happening to them. They end up with lives that are not as productive as they could be, and sometimes they end up in tragedy. If you are going to cut back on the school year, a child who really needs a helping hand to be a good student is more likely to be discouraged and less likely to be educated. How can that be good for our Nation? I know the Senator has focused on the dropout rate in the past.

Mr. REID. Senator BINGAMAN and I worked for a number of years to try to create within the Department of Education an education czar because children who drop out of school are never what they could be. We have so many students dropping out of school, and it is a shame. Those children who drop out of school will be relegated to menial work for the rest of their lives—if they are fortunate to be able to have any kind of work.

So the afterschool programs, which the Senator from Illinois and Senator BOXER have worked on for years, are programs that, in most States, they are not even considering anymore.

Mr. DURBIN. Is it unfair, then, to bring this together and say if we are going to see this President continue to put unfunded mandates on schools and not put the Federal dollars into education, and we are going to see education cut back at the State and local level, that is going to lessen the opportunity for children to pick up the skills and education they want? This is no way to deal with an unemployment problem. Frankly, it is a way to guarantee that that problem is going to become chronic and long term because we are not investing in making young people productive and educated.

So the No Child Left Behind program and the unfunded mandate by the Bush White House really was lost to this whole argument about tax cuts. The President says we need tax cuts for jobs and growth. It just hasn't worked. As the Senator from Nevada reported today—I forget the number—it has been over 100 months since we have had such high unemployment.

Mr. REID. It has been 106 months.

Mr. DURBIN. So that is somewhere a little less than 9 years to go back to a period of time with the unemployment that high. It doesn't appear that the President's first tax cut has kicked in. If it has, it kicked a lot of people out of work. We ought to think long and hard about whether we continue down this path.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. FITZGERALD). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that at 11 a.m. on Tuesday, June 24, the Senate proceed to a vote in relation to the Rockefeller amendment No. 976, provided that immediately following that vote and 2 minutes of debate equally divided, the Senate then proceed to vote in relation to the Bingaman amendment No. 984; further, at 2:15 there be 10 minutes equally divided prior to the vote in relation to the Dodd amendment No. 969, with no second-degree amendments in order to the above mentioned amendments prior to the vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

TRIBUTE TO BEVERLY RICHARDSON

• Mr. BUNNING. Mr. President, I rise today to pay tribute to Mrs. Beverly Richardson of Hancock County, KY, for her legacy of service to others. Her contributions to our Commonwealth as director of the Hancock County Career Center have made all the difference in the lives of countless Kentuckians.

In 1997, when the Hancock County Career Center was initially established, Beverly Richardson, who is a proud Western Kentucky University graduate, took on the role as director, enabling her the opportunity to shape the lives of many unemployed individuals who are now working. Throughout her tenure as director, she has improved the lives of a variety of people from high school dropouts seeking to earn a general education degree, to unemployed workers in need of greater job skills to increase their competitiveness in the job market. The values and beliefs Beverly brought to the Hancock County Career Center aided her in facing the challenges she met and the opportunities each day brought as a coordinator of the center's activities.

While assisting Kentucky residents in gaining more job skills and greater confidence was a wonderful accomplishment in her life, no achievement was more notable than that of raising her four children with her husband Wendell. Together, they raised four college graduates who have paved career paths of their own and given her and Wendell many grandchildren.

Beverly Richardson's devotion to education and job training has improved the vitality of Kentucky's economy, enhanced the capabilities of so many workers, and strengthened the character of individuals and families. Employers and employees alike throughout Kentucky owe her a debt of gratitude. Her example should be emulated across America. I thank the Senate for allowing me to recognize Ruth and voice her praises. She is Kentucky at its finest.•

LOCAL LAW ENFORCEMENT ACT OF 2003

• Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred at Fort Campbell, KY. A little after 3 in the morning on July 5, 1999, PFC Barry L. Winchell was forced outside his barracks where he was stationed and brutally beaten with a baseball bat by another Army private. Winchell died of his injuries the following day. Army officials and sources close to Winchell believe that his death was motivated by antigay bias.

I believe Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.•

HONORING FRANK A. DuBOIS

• Mr. DOMENICI. Mr. President, I rise before you today to pay respect and to commend the accomplishments of a great New Mexican.

Frank A. DuBois has given the past 30 years of his life serving the agricultural producers and citizens of New Mexico. His vision and philanthropic attitude is clear when looking back to the deeds accomplished by this great man.

On June 1st, Mr. DuBois retired from his position as director of the New Mexico Department of Agriculture after 15 years. During this time, Mr. DuBois also served as cabinet secretary for four Governors. Throughout his tenure with the New Mexico Department of Agriculture, Frank worked as a field inspector, agricultural policy specialist, assistant director and, finally, director.

In addition to these great accomplishments, Frank also worked as my legislative assistant and then went on to serve as the Deputy Secretary for Land and Water Resources with the U.S. Department of the Interior.

Frank has also dedicated a large part of his life to the rodeo. In fall 2000, Frank set up the Dubois Rodeo Scholarship to help aspiring rodeo athletes at New Mexico State University. To date, 18 students from NMSU have received financial aid to help them focus more on school and their rodeo activities, rather than having to worry about meeting the financial burdens of college life.

The most amazing aspect of Frank DuBois is that for the past 13 years, he has been living with multiple sclerosis. And yet this debilitating disease has not stopped Frank from accomplishing so much. In December 2000, Frank received the DreamMaker Award from the Going the Distance for MS Research Foundation. He was diagnosed with MS in 1990 but has not wavered in his dedication to the people he serves.

Frank's life should be an inspiration to us all. Even living with MS, Frank refuses to give in. He has received six prestigious awards for his unwavering dedication to New Mexico since 1995.

I could not stand here and talk about Frank without also honoring his loving wife Sharon, who has been on my staff for many years in my Las Cruces office. Sharon has stood beside her husband through the toughest of times. She has devoted her love and time to help Frank realize his dreams and those who know her personally are greatly appreciative.

Frank's retirement from public service will most definitely be felt by New Mexico, and he will be greatly missed. He has dedicated a great portion of his life to the advancement of the heritage of New Mexico, and even in his retirement, Frank has committed to help develop his Rodeo Scholarship and to focus on his own personal health.

Frank, although your retirement will be felt by many, I thank you for your past dedication and your promise for a continued commitment to the youth of NMSU.●

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2818. A communication from the Director, Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a report concerning CBO estimates compared to OMB estimates for P.L. 108–11, the 2003 Emergency Wartime Supplemental Appropriations Act; to the Committee on the Budget.

EC–2819. A communication from the Director, Financial Management and Assurance, General Accounting Office, transmitting, pursuant to law, a report on the financial statements of the Capitol Preservation Fund for the fiscal years ended September 30, 2002 and 2001; to the Committee on Rules and Administration.

EC–2820. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Bureau of Labor Statistics April 2003 Department Store Price Indexes" (Rev. Rul. 2003–68) received on June 9, 2003; to the Committee on Finance.

EC–2821. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Viruses, Serums, Toxins, and Analogous Products; Standard Requirements for Determination of Residual Free Formaldehyde Content of Biological Products" (Doc. No. 01–091–2) received on June 16, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2822. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Exotic Newcastle Disease; Removal of Areas from Quarantine" (Doc. No. 02–117–8) received on June 16, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2823. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Removal of Cold Treatment Requirement for Ya Pears Imported From Hebei Province in China" (Doc. No. 02–084–2) received on June 16, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2824. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Tuberculosis Testing in Imported Cattle" (Doc. No. 00–102–2) received on June 16, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2825. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Azoxystrobin; Pesticide Tolerance" (FRL7311–2) received on June 18, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

C–2826. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Buprofezin; Pesticide Tolerance" (FRL7310–7) received on June 18, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2827. A communication from the Director, Corporate Policy and Research Department, Pension Benefit Guaranty Corporation, transmitting, pursuant to law, the report of a rule entitled "Benefits Payable in Terminated Single-Employer Plans; Allocation of Assets in Single-Employer Plans; Interest Assumptions for Valuing and Paying Benefits" received on June 9, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2828. A communication from the Director, Regulations Policy and Management, transmitting, pursuant to law, the report of a rule entitled "Food Additive Permitted in Feed and Drinking Water for Animals Feed-Grade Biuret" (Doc. No. 02F–0327) received on June 19, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2829. A communication from the Director for Standards and Guidance, Occupational Safety and Health Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled "Powered Industrial Trucks—Technical Amendment (Correction)" received on June 16, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2830. A communication from the Regulations Coordinator, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Applications for FDA Approval to Market a New Drug: Patent Submission and Listing Requirements and Application of 30-Month Stays on Approval of Abbreviated New Drug Applications Certifying that a Patent Claiming a Drug is Invalid or Will Not Be Infringed" (RIN0910–AC48) received on June 18, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2831. A communication from the United States Railroad Retirement Board, transmitting, pursuant to law, the Twenty-Second Actuarial Valuation of the Assets and Liabilities Under the Railroad Retirement Acts as of December 31, 2001; to the Committee on Health, Education, Labor, and Pensions.

EC–2832. A communication from the Administrator, Energy Information Administration, Department of Energy, transmitting, pursuant to law, the International Energy Outlook for 2003; to the Committee on Energy and Natural Resources.

EC–2833. A communication from the Administrator, Energy Information Administration, Department of Energy, transmitting, pursuant to law, the Uranium Industry Annual Report for 2002; to the Committee on Energy and Natural Resources.

EC–2834. A communication from the Deputy Secretary of Defense, transmitting, pursuant to law, a report concerning the payment to the Czech Republic Government in the amount of $0.930 million to reimburse it for military support provided to U.S. military operations in connection with the global war on terrorism; to the Committee on Armed Services.

EC–2835. A communication from Under Secretary of Defense, Personnel and Readiness, transmitting, the approval of a retirement; to the Committee on Armed Services.

EC–2836. A communication from the Assistant Secretary of the Navy, Department of Defense, transmitting, pursuant to law, a report concerning the study of certain functions performed by military and civilian personnel in the Department of the Navy for possible performance by private contractors; to the Committee on Armed Services.

EC–2837. A communication from the Deputy Secretary of Defense, transmitting, pursuant to law, a report concerning chemical agent destruction operations at the Anniston Chemical Agent Disposal Facility in Anniston, Alabama; to the Committee on Armed Services.

EC–2838. A communication from the Assistant Director, Executive and Political Personnel, Department of the Army, transmitting, pursuant to law, the report of a vacancy and the designation of acting officer in the position of Secretary of the Army; to the Committee on Armed Services.

EC–2839. A communication from the Office of the Secretary of Defense, Administration and Management, transmitting, pursuant to law, a report concerning the certification of the total cost for the planning, design, construction, and installation of equipment for the renovation of Wedges 2 through 5 of the Pentagon; to the Committee on Armed Services.

EC–2840. A communication from the Director, Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled "Transportation of Supplies by Sea—Commercial Items" (DFARS Case 2002–D019) received on June 19, 2003; to the Committee on Armed Services.

EC–2841. A communication from the Under Secretary of Defense, Acquisition, Technology and Logistics, transmitting, pursuant to law, the 2003 Annual Report and Performance Plan for the Chemical and Biological Defense Program

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. KERRY:

S. 1310. A bill to amend the Internal Revenue Code of 1986 to provide that the harbor maintenance tax is applied to certain ports that import cargo exceeding $100,000,000 in value per year; to the Committee on Finance.

By Mrs. CLINTON (for herself and Mr. SCHUMER):

S. 1311. A bill to establish the Hudson-Fulton-Champlain 400th Commemoration Commission, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. INOUYE (for himself and Mr. AKAKA):

S. 1312. A bill to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system; to the Committee on Finance.

By Mr. HOLLINGS:

S. 1313. A bill to establish the Congaree Swamp National Park in the State of South Carolina, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. BINGAMAN (for himself, Mr. DASCHLE, Mrs. MURRAY, and Ms. CANTWELL):

S. 1314. A bill to expedite procedures for hazardous fuels reduction activities on National Forest System lands established from the public domain and other public lands administered by the Bureau of Land Management, to improve the health of National Forest System lands established from the public domain and other public lands administered by the Bureau of Land Management, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. CRAIG (for himself, Mr. CRAPO, and Mr. SMITH):

S. 1315. A bill to amend the Federal Land Policy and Management Act of 1976 to provide owners of non-Federal lands with a reliable method of receiving compensation for damages resulting from the spread of wildfire from nearby forested National Forest System lands or Bureau of Land Management lands, when those forested Federal lands are not maintained in the forest health status known as condition class 1; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. FRIST (for himself and Mr. DASCHLE):

S. Res. 179. A resolution to authorize testimony and legal representation in State of New Hampshire v. Donald Johnson; considered and agreed to.

By Mr. DODD:

S. Res. 180. A resolution to set standards for the naming of any part of the Senate wing of the Capitol Building Complex; to the Committee on Rules and Administration.

ADDITIONAL COSPONSORS

S. 13

At the request of Mr. KYL, the name of the Senator from Tennessee (Mr. ALEXANDER) was added as a cosponsor of S. 13, a bill to provide financial security to family farm and small business owners by ending the unfair practice of taxing someone at death.

S. 50

At the request of Mr. JOHNSON, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 50, a bill to amend title 38, United States Code, to provide for a guaranteed adequate level of funding for veterans health care, and for other purposes.

S. 171

At the request of Mr. DAYTON, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 171, a bill to amend title XVIII of the Social Security Act to provide payment to medicare ambulance suppliers of the full costs of providing such services, and for other purposes.

S. 300

At the request of Mr. KERRY, the names of the Senator from Washington (Ms. CANTWELL), the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Arizona (Mr. KYL) were added as cosponsors of S. 300, a bill to award a congressional gold medal to Jackie Robinson (posthumously), in recognition of his many contributions to the Nation, and to express the sense of Congress that there should be a national day in recognition of Jackie Robinson.

S. 493

At the request of Mrs. LINCOLN, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 493, a bill to amend title XVIII of the Social Security Act to authorize physical therapists to evaluate and treat medicare beneficiaries without a requirement for a physician referral, and for other purposes.

S. 518

At the request of Ms. COLLINS, the names of the Senator from Maryland (Ms. MIKULSKI) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 518, a bill to increase the supply of pancreatic islet cells for research, to provide better coordination of Federal efforts and information on islet cell transplantation, and to collect the data necessary to move islet cell transplantation from an experimental procedure to a standard therapy.

S. 557

At the request of Ms. COLLINS, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 557, a bill to amend the Internal Revenue Code of 1986 to exclude from gross income amounts received on account of claims based on certain unlawful discrimination and to allow income averaging for backpay and frontpay awards received on account of such claims, and for other purposes.

S. 640

At the request of Mr. LEAHY, the names of the Senator from Idaho (Mr. CRAPO) and the Senator from Louisiana (Mr. BREAUX) were added as cosponsors of S. 640, a bill to amend subchapter III of chapter 83 and chapter 84 of title 5, United States Code, to include Federal prosecutors within the definition of a law enforcement officer, and for other purposes.

S. 648

At the request of Mr. REED, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 648, a bill to amend the Public Health Service Act with respect to health professions programs regarding the practice of pharmacy.

S. 752

At the request of Mr. BINGAMAN, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of S. 752, a bill to amend the Internal Revenue Code of 1986 to treat distributions from publicly traded partnerships as qualifying income of regulated investment companies, and for other purposes.

S. 780

At the request of Mr. LOTT, the name of the Senator from Louisiana (Mr. BREAUX) was added as a cosponsor of S. 780, a bill to award a congressional gold medal to Chief Phillip Martin of the Mississippi Band of Choctaw Indians.

S. 820

At the request of Mrs. BOXER, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 820, a bill to amend the Federal Water Pollution Control Act to establish a perchlorate pollution prevention fund and to establish safety standards applicable to owners and operators of perchlorate storage facilities.

S. 853

At the request of Ms. SNOWE, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 853, a bill to amend title XVIII of the Social Security Act to eliminate discriminatory copayment rates for outpatient psychiatric services under the medicare program.

S. 857

At the request of Mr. ROCKEFELLER, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 857, a bill to amend the Internal Revenue Code of 1986 to provide a tax incentive to individuals teaching in elementary and secondary schools located in rural or high unemployment areas and to individuals who achieve certification from the National Board for Professional Teaching Standards, and for other purposes.

S. 894

At the request of Mr. WARNER, the names of the Senator from Kentucky (Mr. BUNNING), the Senator from Oklahoma (Mr. INHOFE) and the Senator from North Carolina (Mrs. DOLE) were added as cosponsors of S. 894, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 230th Anniversary of the United States Marine Corps, and to support construction of the Marine Corps Heritage Center.

S. 950

At the request of Mr. ENZI, the names of the Senator from Washington (Ms.

CANTWELL) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 950, a bill to allow travel between the United States and Cuba.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 1037

At the request of Ms. SNOWE, the names of the Senator from Kansas (Mr. ROBERTS) and the Senator from New York (Mrs. CLINTON) were added as cosponsors of S. 1037, a bill to amend title XVIII of the Social Security Act to provide for coverage under the medicare program of all oral anticancer drugs.

S. 1046

At the request of Mr. HOLLINGS, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1090

At the request of Mr. VOINOVICH, the name of the Senator from Arizona (Mr. KYL) was added as a cosponsor of S. 1090, a bill to amend title 23, United States Code, to increase the minimum allocation provided to States for use in carrying out certain highway programs.

S. 1091

At the request of Mr. DURBIN, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 1091, a bill to provide funding for student loan repayment for public attorneys.

S. 1129

At the request of Mrs. FEINSTEIN, the names of the Senator from New York (Mrs. CLINTON) and the Senator from Pennsylvania (Mr. SPECTER) were added as cosponsors of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1208

At the request of Ms. COLLINS, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 1208, a bill to amend the Cooperative Forestry Assistance Act of 1978 to establish a program to provide assistance to States and nonprofit organizations to preserve suburban forest land and open space and contain suburban sprawl, and for other purposes.

S. 1222

At the request of Mr. NELSON of Nebraska, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 1222, a bill to amend title XVIII of the Social Security Act to require the Secretary of Health and Human Services, in determining eligibility for payment under the prospective payment system for inpatient rehabilitation facilities, to apply criteria consistent with rehabilitation impairment categories established by the Secretary for purposes of such prospective payment system.

S. 1225

At the request of Mr. GREGG, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 1225, a bill entitled the "Greater Access to Affordable Pharmaceuticals Act".

S. 1226

At the request of Mrs. CLINTON, the name of the Senator from Tennessee (Mr. ALEXANDER) was added as a cosponsor of S. 1226, a bill to coordinate efforts in collecting and analyzing data on the incidence and prevalence of developmental disabilities, and for other purposes.

S. 1248

At the request of Mr. GREGG, the names of the Senator from Tennessee (Mr. ALEXANDER) and the Senator from Vermont (Mr. JEFFORDS) were added as cosponsors of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1255

At the request of Mr. KERRY, the name of the Senator from Delaware (Mr. CARPER) was added as a cosponsor of S. 1255, a bill to amend the Small Business Act to direct the Administrator of the Small Business Administration to establish a pilot program to provide regulatory compliance assistance to small business concerns, and for other purposes.

S. 1273

At the request of Mr. KENNEDY, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 1273, a bill to provide for a study to ensure that students are not adversely affected by changes to the needs analysis tables, and to require the Secretary of Education to consult with the Advisory Committee on Student Financial Assistance regarding such changes.

S. 1289

At the request of Mrs. MURRAY, her name was added as a cosponsor of S. 1289, a bill to name the Department of Veterans Affairs Medical Center in Minneapolis, Minnesota, after Paul Wellstone.

S. 1291

At the request of Mr. SANTORUM, his name was added as a cosponsor of S. 1291, a bill to authorize the President to impose emergency import restrictions on archaeological or ethnological materials of Iraq until normalization of relations between the United States and the Government of Iraq has been established.

S. 1298

At the request of Mr. AKAKA, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 1298, a bill to amend the Farm Security and Rural Investment Act of 2002 to ensure the humane slaughter of non-ambulatory livestock, and for other purposes.

S. CON. RES. 25

At the request of Mr. VOINOVICH, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. Con. Res. 25, a concurrent resolution recognizing and honoring America's Jewish community on the occasion of its 350th anniversary, supporting the designation of an "American Jewish History Month", and for other purposes.

AMENDMENT NO. 933

At the request of Mr. BINGAMAN, the name of the Senator from New Mexico (Mr. DOMENICI) was added as a cosponsor of amendment No. 933 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 956

At the request of Mr. GRAHAM of Florida, the names of the Senator from California (Mrs. FEINSTEIN) and the Senator from Maryland (Ms. MIKULSKI) were added as cosponsors of amendment No. 956 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. INOUYE (for himself and Mr. AKAKA):

S. 1312. A bill to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system; to the Committee on Finance.

Mr. INOUYE. Mr. President, today, Senator AKAKA and I are introducing legislation that would provide for 100 percent coverage under Medicaid for the payment of health services rendered to Native Hawaiians by either Federally qualified health centers or Native Hawaiian health care systems. This provision would treat our State's Native Hawaiians comparably with Alaskan Natives and American Indians under the current Medicaid law. We purposely focused upon Federally qualified health centers and Native Hawaiian health care systems, because they are highly cost effective ways of providing these extraordinarily necessary primary care and preventative services.

I ask unanimous consent that the text of this bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1312

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Native Hawaiian Medicaid Coverage Act of 2003".

SEC. 2. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ", and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider" before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

By Mr. HOLLINGS:

S. 1313. A bill to establish the Congaree Swamp National Park in the State of South Carolina, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. HOLLINGS. Mr. President, today I am introducing legislation that is particularly important to me, in that it culminates nearly 30 years of efforts to preserve the wilderness of South Carolina for future generations of Americans. This legislation proposes to raise the designation of the Congaree Swamp National Monument to the Congaree National Park, and to increase its size by 20 percent.

I still remember when my friend, Harry Hampton, enlisted my help to protect the big trees that were being destroyed 500 acres a year in the central part of my State. In 1976, Congress set aside 15,000 acres to establish the Congaree Swamp National Monument. In the late 1980s, we expanded it by another 7,000 acres. More recently, we've invested in a visitor center and this investment has far exceeded this Senator's expectations.

The attendance has ballooned to 120,000 visitors every year, including some 12,000 students, who use the forest as their classroom to nature. It has awakened an interest in the environment for these children. They cruise the Congaree, learning how to identify trees, birds, animals, and everything like that. All kinds of groups take hikes, nature walks and canoe trips to see the almost 1,000 different types of trees, plants, animals, and birds in the forest.

This is home to some of the tallest and rarest trees in the Eastern United States—some are 400 years old. It is home to the largest example of old growth southern hardwood forest in North America. All eight species of woodpeckers can be found here, including the endangered red-cockaded variety.

Yet had Congress not acted back in 1976, none of this may be around today. We were able to save at least a few thousand acres of what once covered vast portions of the east coast, so future generations of Americans can enjoy it. There is a lesson here. The Government can do good for the environment. It is in the interest of our nation to protect our nation's treasures.

My legislation, the Congaree National Park Act of 2003 continues the progress we have seen the last 25 years. It would add another 4,576 acres of ecologically rich land; and it would redesignate the Monument into a fullfledged National Park, which would be the first in South Carolina. The Congaree Swamp is widely recognized as one of the most unique and rare ecological habitats in the country. This designation not only recognizes the significance of this area but the wonderful job the National Park Service is doing to make this a growing attraction for local, State, national, and international visitors.

The project has received support from a number of organizations, and I ask unanimous consent that these letters of endorsement be printed in the RECORD. I hope to work on a bipartisan basis with my colleagues to pass the legislation this session.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

SOUTH CAROLINA DEPARTMENT OF
NATURAL RESOURCES,
Columbia, SC, June 23, 2003.

Hon. ERNEST F. HOLLINGS,
U.S. Senator, Russell Office Building,
Washington, DC.

DEAR SENATOR HOLLINGS: I want to take this opportunity to endorse the proposed legislation to establish the Congaree Swamp National Park in the State of South Carolina (Congaree National Park Act of 2003). We are delighted to see your continued commitment to the protection of important environmental properties in our State. The expansion of the Congaree Swamp National Monument to a "National Park" certainly continues the habitat protection vision that is embraced by the Board of the South Carolina Department of Natural Resources.

I have been in routine contact with your staff and many of our natural resource conservation partners as this important legislation was developed by your staff. We appreciate your staff's professional courtesy to us in seeking our agency's input. The expansion of this significant natural resource area certainly parallels the stated mission of our agency in proactively protecting the State's natural resources for the use and enjoyment by future generations of South Carolians.

Again, thank you for your commitment to our natural resources and to improving the quality of life of our citizens. You have been a strong supporter of our conservation initiatives and our citizens are certainly indebted to you for your leadership and vision.

Sincerely,

JOHN E. FRAMPTON,
Director.

THE TRUST FOR PUBLIC LAND,
Washington, DC, June 23, 2003.

Hon. ERNEST F. HOLLINGS,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR HOLLINGS: I am writing today on behalf of The Trust for Public Land in support of legislation to expand the boundaries of the Congaree Swamp National Monument and designate it as a National Park in the State of South Carolina.

As you know, the Congaree Swamp National Monument was authorized as a unit of the National Park Service in 1976. The park rests on a floodplain of the Congaree River and is recognized as an International Biosphere Reserve, National Natural Landmark, Wilderness Area, and "Globally Important Bird Area," with over 90 tree species including old growth loblolly pines and bald cypress. The Congaree hosts the nation's largest tract of old-growth bottomland hardwood forest, and contains some of the tallest trees in the eastern U.S., with some pines reaching over 160 feet. The Congaree's outstanding natural resources are frequented by outdoor enthusiasts who enjoy canoeing, kayaking, picnicking, camping, and fishing.

In 1994, the expansion area was the subject of a biological and hydrological evaluation to determine its resource value for protection and addition to the Congaree Swamp National Monument. The report concluded that expanding the National Monument to include this area would conserve a unique hydrological system integrally connected to the hydrology of the Congaree River and that of lands currently within the Congaree Swamp National Monument. Once protected, these lands would form a conservation corridor connecting the Congaree with other protected state and Federal lands further downstream.

Additional protection of the Congaree Swamp National Monument would not only play a critical role in enhancing South Carolina's recreation needs, it would further enrich South Carolina's impressive historic and cultural resources as well as its significant wildlife and ecological resources.

The Trust for Public Land commends your leadership on this matter and looks forward to working with you on enacting such legislation.

Sincerely,

ALAN FRONT,
Senior Vice President.

COLUMBIA AUDUBON SOCIETY,
Columbia, SC, June 23, 2003.

Hon. ERNEST F. HOLLINGS,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR HOLLINGS: I am writing to you on behalf of the 700+ members of Columbia Audubon Society. We want to express our full support for your legislation to change the Congaree Swamp National Monument to National Park and to expand the boundary.

No other area in the Southeast is of comparable geological and biological significance. The park has been recognized as a National Natural Landmark, an International Biosphere, Globally Important Bird Area, and a Wetlands of International Importance. Anything that can be done to raise awareness of this important resource and to protect it by boundary expansion is a positive step that we support.

Thank you once again for your efforts on behalf of our natural and national heritage.

Sincerely,

DANIEL L. TUFFORD,
President and Conservation Chair.

SIERRA CLUB,
SOUTH CAROLINA CHAPTER,
Columbia, SC, June 22, 2003.

Re Congaree Swamp National Monument.

Senator ERNEST HOLLINGS,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR HOLLINGS: The South Carolina Chapter of the Sierra Club supports your legislation to expand and reclassify the Congaree Swamp National Monument. We thank you for your preservation efforts regarding the Congaree Swamp and for your support of the environment generally.

The Congaree Swamp National Monument on the meandering Congaree River is a tranquil setting of world champion trees, primeval forest landscapes, and diverse plant and animal life. This 21,479-acre intact old-growth bottomland hardwood forest is a remnant of what much of the Southeast looked like 200-plus years ago. The opportunity to add 4,526-acres to this living ecological museum cannot be ignored.

We also believe that Congaree Swamp is more appropriately identified as a national "park." This designation, within the Park Service, will accord the "swamp" its appropriate status and possible funding within the Department of Interior.

The South Carolina Chapter of the Sierra Club was formed 25 years ago as a result of citizen involvement to form the Congaree Swamp National Monument in 1976. Our Sierra Club chapter could receive no better gift on our 25th birthday than the expansion and redesignation of this sanctuary for plants, animals, researchers, and hikers.

On behalf of the 5,200 Sierra Club members in South Carolina, again, we thank you and support your efforts.

Sincerely,

DELL ISHAM,
SC Chapter Director.

SOUTH CAROLINA
WILDLIFE FEDERATION,
Columbia, SC, June 17, 2003.

Hon. Ernest F. Hollings,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR HOLLINGS: The South Carolina Wildlife Federation (SCWF) applauds you for your continued commitment to the environment and to the rare and precious habitats found both nationwide and in South Carolina. It is your continued dedication to these valuable habitats and our mission to support conservation efforts that prompts us to write to you. The purpose of this letter is to express our position on your "Congaree National Park Act of 2003."

The SCWF considers this bill, to change the designation of the Congaree National Monument to the Congaree National Park and to expand the park to include the 4,576 acres, a profitable proposal. As is evidenced in the text of the bill, there are numerous reasons to protect, preserve and expand this area. The rarity of this wilderness area boasts the last and largest example of virgin, old-growth southern hardwood forest in North America. The Congaree National Monument and adjacent private land provide valuable opportunities to experience and learn about our natural, biological, geological, and cultural history. This wilderness is home to over 900 species of plants and animals, including rare, threatened and endangered species. Since habitat size plays such an important role in maintaining healthy communities and diverse gene pools of plant and animal species, this expansion and designation as a National Park are wonderful ways to preserve such an ecologically rich area.

In addition, Mr. Harry Hampton, the founder of this Federation, was also responsible for the recognition of the Congaree Swamp as a National Monument. In keeping with the vision of our founder it is with great eagerness that we support your efforts to have this bill enacted. The South Carolina Wildlife Federation commends you for introducing the "Congaree National Park Act of 2003." Please use this letter freely in the public record.

Sincerely,

ANGELA VINEY
Executive Director.

SOUTH CAROLINA COASTAL
CONSERVATION LEAGUE,
Columbia, SC, June 23, 2003.

Hon. Ernest F. Hollings,
U.S. Senate,
Washington, DC.

DEAR SENATOR HOLLINGS: I am writing to give the Coastal Conservation League's full support for the Congaree National Park Act of 2003. The Congaree Swamp National Monument is a tremendous asset for South Carolina and the nation, and has enjoyed ever-increasing numbers of supporters and visitors. It is definitely worthy of the level of protection that a National Park designation would provide.

This area has regional, national, and international significance. Regionally it stores waters that reduce downstream flooding, and improves water quality in the Congaree and Santee rivers. It is important on a national scale because it includes the largest intact tract of old growth area of virgin floodplain forest in the United States. And 20 years ago it earned global recognition as an International Biosphere Reserve. Because of its significance it has attracted visitors ranging from Richland County to around the world.

The expansion of the National Monument area by over 4,000 acres will greatly advance state conservation goals, as it will link two core areas identified by the South Carolina Landscape Mapping Project's Ecological Vision, namely the Congaree Swamp National Monument and the Upper Santee Swamp. In addition, the proposed expansion to include Fork Swamp within the proposed National Park boundaries accomplishes the objective of the Heritage Trust Board of the Department of Natural Resources. This body has recommended protection for Fork Swamp, where the Wateree and Congaree rivers from the headwaters of the Santee River.

The Congaree Swamp is indeed a national treasure that will be enjoyed by visitors from around the country for years to come. The Congaree National Park Act of 2003 is a fitting tribute to its importance. Thank you for all you continue to do to preserve South Carolina's unique natural treasures.

Sincerely,

DANA BEACH,
Executive Director.

THE RIVER ALLIANCE,
Columbia, SC, June 16, 2003.

Senator ERNEST F. HOLLINGS,
Russell Building, U.S. Senate, Washington, DC.

DEAR SENATOR HOLLINGS: Your guiding hand led the effort to protect the unique national treasure of the Congaree Swamp National Monument. We believe the addition of an additional 4,500 area and its redesignation as a National Park is a continuation of this stewardship. The River Alliance strongly supports the expansion of the Congaree Swamps' boundaries and its designation as the Congaree Swamp National Park.

As you may recall, the River Alliance is a public benefit organization tasked with connecting citizens to the region's rivers. The Congaree Swamp is the crown jewel of our region's 90 miles of river system. The Alliance sees this physical expansion as a high value environmental and recreational addition. It allows protection of the Running Lake Creek, Bates Old River and Fort Swamp areas. The Wateree River is the logical southern boundary for the expansion. It also allows inclusion of the Congaree River's edge between the existing federal boundary and the confluence with the Wateree. This brings the primary river access at South Carolina Highway 601 inside the park boundary. The expansion allows protection of additional cultural and environmental resources. It also provides a solid boundary for park management.

In 1997, the River Alliance initiated a major program to assist the Congaree Swamp in reaching its potential for visitation. With your help, physical outcomes were an improved access road, parking, and the Harry Hampton Visitors Center. Visitation has increased dramatically, but our analysis revealed an issue with its current designation as a "Monument." An inaccurate, but very real, public perception is "A Monument is less worthy of visitation than a National Park." The Congaree Swamp deserves the "National Park" designation, not only for its inherent national and intentional value, but to fully reach its potential to attract visitors. Congaree Swamp visitors leave with an embedded imprint of natural beauty. We wish that every citizen can have this experience. Visitors become advocates for the Swamp and for the National Park Service.

From the Alliance perspective, public ownership of the river's edge of the Congaree Swamp is a valuable commodity, the more the better. It allows public access by boat, canoe or kayak to the Swamp's bluffs, banks and creeks from the waters of the Congaree River. This offers visitors an unparalleled view of the ecosystem and access to the true wilderness. The record trees accessible from the water, are an awesome demonstration of the value of federal park protection. The expansion will extend the edge to the Wateree River. It will also allow the current Highway 601 access to become a true entry point to the Swamp with an opportunity for river-focused education and interpretation. As with the Harry Hampton Visitors Center project, the River Alliance is committed to assist in the creation of a visitor experience worthy of the environmental resource. The increased Congaree frontage sets the stage.

We know your action is forthcoming and we strongly support the expansion and redesignation. We will be happy to answer any questions, provide additional information, or testify to Congress as you desire. If you have any questions, feel free to contact me at (803) 765–2200.

Sincerely,
MICHAEL T. DAWSON,
Director.

FRIENDS OF CONGAREE SWAMP,
Columbia, SC, June 23, 2003.
Hon. ERNEST HOLLINGS,
Russell Senate Office Building, Washington, DC.

Re: Congaree Swamp—Boundary Expansion and National Park Designation

DEAR SENATOR HOLLINGS: For more than 25 years, you have provided outstanding leadership for Congaree Swamp National Monument. You were instrumental in establishing the monument in 1976 and expanding the monument in 1988. You have obtained funding for Congaree land acquisition, the entrance road, the Harry Hampton Visitor Center, and, recently, the maintenance facility.

Congaree Swamp's significance is affirmed by many studies and by its designations as a National Natural Landmark, a National Monument, and an International Biosphere Reserve. A nomination is prepared to recognize Congaree Swamp as Wetlands of International Importance.

The Friends of Congaree Swamp are delighted by your introduction of legislation to expand Congaree Swamp National Monument and to change its designation from National Monument to National Park.

Congaree boundary expansion is a significant step toward implementing several visions:

It implements part of the South Carolina Conservation Vision Map by linking two major core areas: Congaree Swamp National Monument and the Upper Santee Swamp Natural Area;

It implements part of the Fork Swamp Large Area Project, a landscape-scale conservation project approved more than two years ago by the SC Heritage Trust Advisory Board of the SC Dept. of Natural Resources; and

It supports legislation you introduced in 2002, and again in 2003, regarding a Southern Campaign of the Revolution Heritage Area in South Carolina.

"Timing is everything." This boundary expansion was proposed and studied extensively in 1994, but one of the two key landowners was hesitant at that time to include the tract in legislation. Now, in 2003, both key landowners (Riverstone Properties and the Beidler family) are willing to sell their tracts for addition to Congaree Swamp National Monument.

However, both key landowners will sell these tracts to other buyers if the Congaree expansion languishes. Both key landowners recognize the potential to subdivide and sell their tracts as smaller parcels. On such parcel has already been sold. This situation underscores the urgency to authorize Congaree's expanded boundary and appropriate funding to purchase both key tracts before they are subdivided and sold as multiple parcels, especially if the new owners of the multiple parcels are unwilling to include their land in the Congaree boundary.

We support Congaree's designation as a National Park. Congaree Swamp National Monument has received visitors from more than 90 countries. Visitation—from throughout the United States as well as internationally—will surely increase if Congaree's significance is further recognized by National Park status.

Currently, Congaree's old-growth forest is the principal theme interpreted by the National Park Service. We understand Congaree's cultural/historical resources would be interpreted as the second theme if Congaree becomes a National Park. Friends of Congaree Swamp can provide historical information for lands within this Congaree boundary expansion.

We recall your tremendous efforts in 1988, when you secured FY 1989 funding for Congaree land acquisition while simultaneously authorizing Congaree's 7,000-acre expansion. How wonderful if your Congaree expansion/park legislation can be authorized in 2003 and funding obtained promptly thereafter to purchase these Congaree tracts!

On behalf of our members and our Board of Directors, we are grateful for your continued leadership. Please do not hesitate to contact us for additional information and assistance.

Sincerely,
LABRUCE ALEXANDER,
President, Friends of Congaree Swamp.

By Mr. BINGAMAN (for himself, Mr. DASCHLE, Mrs. MURRAY, and Ms. CANTWELL):

S. 1314. A bill to expedite procedures for hazardous fuels reduction activities on National Forest System lands established from the public domain and other public lands administered by the Bureau of Land Management, to improve the health of National Forest System lands established from the public domain and other public lands administered by the Bureau of Land Management, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. BINGAMAN. Mr. President, today I am introducing comprehensive legislation to expedite forest thinning and improve forest health on our national forests and public lands. I am pleased that Senator DASCHLE is a cosponsor of this bill.

Everyone in the Senate wants to do what we can to reduce the threat of catastrophic wildfire. We all agree on the need to accelerate fuels reduction activities because the risk of severe fire is so high. Ongoing drought, past fire suppression policies, and overly-excessive harvesting of timber have all contributed to the problem. All of us also agree that it is much better to devote limited resources to proactive efforts to reduce fire risk rather than paying to fight fires once they occur.

I have tried for years to improve the Federal agencies' forest thinning program in a variety of ways. I am also a vocal proponent for spending Federal dollars conducting proactive forest restoration. Although some may contend that restoration costs too much money, over the long-term, it is much less expensive than fighting fires.

Every year, the Forest Service borrows funds from other accounts to pay for firefighting. It is clear that this practice substantially contributes to project delays and cancellations. For example, in 2002 alone, the Forest Service states that:

> some critical projects in New Mexico were postponed for up to one year as a result of fire borrowing. These include wildland-urban interface fuels projects on the Carson, Gila, Lincoln, and Santa Fe National Forests. A contract for construction of a fuelbreak around a community at risk on the Cibola National Forest was postponed for six months.

The legislation I am introducing today eliminates the current fire borrowing practice by authorizing the Forest Service, during years in which the agencies' firefighting costs exceed its budget, to borrow funds directly from the Treasury. I urge my colleagues to reject any bill purporting to decrease on the ground delays if it does not address this problem.

A 2002 report by the National Academy of Public Administration, and a letter to Congress from the Society of American Foresters dated November 2002, confirms that the main obstacle constraining us from increasing our efforts to reduce fire risk is a lack of adequate funding. Clearly, the Forest Service's fire borrowing practice contributes to this lack of funding. Ever since Congress first funded the National Fire Plan more than two years ago, I have continually emphasized the need to sustain a commitment to the FY 2001 funding levels over a long enough period of time to make a difference—at least 15 years.

Important programs that are part of the National Fire Plan, including economic action programs, community and private land fire assistance, and burned area restoration and rehabilitation have been drastically cut—and some have been zeroed out—by the Administration over the last three budget cycles. For some accounts included under the National Fire Plan, but not all, Congress has made up the difference. However, it would certainly be much easier to fully fund the National Fire Plan with the Administration's support.

Beyond funding constraints, some allege that administrative appeals and lawsuits limit our ability to reduce fire risk across the country. As set forth in my legislation, I am willing to provide new legal authorities and exemptions from administrative appeals to address this concern.

Let me briefly describe the expedited procedures provisions of our bill. We propose to exempt from National Environmental Policy Act analysis all forest thinning projects located near communities or in municipal watersheds that remove up to 250,000 board feet of timber or one million board feet of salvage timber. We prohibit administrative appeals on these projects, thereby saving 135 days in the process. In addition, we eliminate judicial review granted under NEPA for thinning projects within one-half mile of at risk communities or within certain municipal watersheds. The combination of these provisions would save between one and one-half to three and one-half years of process.

Targeting the expedited procedures to areas near communities and in municipal watersheds is consistent with a 2002 National Academy of Public Administration report recommending that the Federal Government conduct fuels reduction treatments near communities and municipal watersheds before treating more distant areas. We also require that seventy percent of forest thinning funds be spent within these critical areas.

We agree with, and included, some provisions similar to ones found in H.R. 1904. For example, our bill covers the same amount of Federal land, namely, up to 20 million acres. H.R. 1904 requires the Secretaries to select projects through a collaborative process and give priority to protecting communities and municipal watersheds. Moreover, H.R. 1904 requires that projects be consistent with applicable forest and resource management plans. I agree with all of these provisions.

Both bills establish systematic programs, in cooperation with colleges and universities, to gather information on insect infestations that can be applied to forest management treatments. However, our bill provides actual funds, $25 million annually, to implement the program whereas H.R. 1904 does not.

This bill differs from H.R. 1904 in some other important aspects. Our bill comprehensively addresses the issue of on the ground delay by doing away with the Forest Service's fire borrowing practice and exempting the Forest Service from the Competitive Sourcing Initiative.

Our legislation provides $100 million annually to reduce fire risk and restore burned areas on non-Federal lands. Forest Service researchers state that seventy-seven percent of all high risk areas are on non-Federal lands. In addition, the National Academy of Public Administration's 2002 report notes that forty-seven percent of acres burned each year are non-Federal lands and stated that decreasing fuels on all owners' lands is needed to address the large scope of the fire hazard problem. Moreover, given that the Administration has zeroed out funding for burned area restoration and rehabilitation, the secure funding provided by our bill is desperately needed to protect communities from landslides and other adverse effects of catastrophic wildfire.

The bill I am introducing today recognizes the role that forest dependent communities play in restoring our lands by requiring that at least thirty percent of hazardous fuels reduction funds be spent on projects that benefit small businesses that use hazardous fuels and are located in small, economically disadvantaged communities. In order to provide robust monitoring of new authorities, we require that an independent commission report to Congress on the results of the program and that the agencies establish a multiparty monitoring program. H.R. 1904 does not contain similar provisions.

Most fuel reduction projects will take several years to implement. It is critical that the agencies have reliable funding to complete the projects they start. If funding is obtained to thin trees the first year, but not to complete the slash disposal and reintroduce fire through prescribed burning the following years, short-term fire risk will be increased. Moreover, slash that is left on the ground increases the likelihood of beetle infestations. The bill I am introducing today ensures that agencies address long-term fuels management whereas H.R. 1904 does not contain any similar provision.

At this point in time, I do not believe we need to expedite judicial review beyond what we offer in this bill. The judicial review limitations in H.R. 1904 are excessive. In May 2003, GAO completed an analysis of Forest Service decisions involving fuel reduction activities. In the first two years of activity under the National Fire Plan, GAO found that only three percent of all of the decisions were litigated covering 100,000 acres. Decisions affecting the remaining 4.6 million acres treated in those two years proceeded without any litigation.

H.R. 1904 provides new legal authorities and judicial review limitations without regard to many independent analyses that have discovered numerous flaws with the agencies' existing implementation of the National Fire Plan. In November 2001, the Inspector General for the Department of Agriculture found that the Forest Service was inappropriately spending its burned area restoration funds to prepare commercial timber sales. Similarly, it was recently discovered that the Forest Service "misplaced" $215 million intended for wildland fire management due to an accounting error.

Finally, another GAO report concluded that, because the Forest Service relies on the timber program for funding many of its other activities, including reducing fuels, it has often used the timber program to address the wildfire problem. GAO states, "The difficulty with such an approach, however, is that the lands with commercially valuable timber are often not those with the greatest wildfire hazards. Additionally, there are problems with the incentives in the fuel reduction program. Currently, managers are rewarded for the number of acres on which they reduce fuels, not for reducing fuels on the lands with the highest fire hazards. Because reducing fuels in areas with greater hazards is often more expensive—meaning that fewer acres can be completed with the same funding level—managers have an incentive not to undertake efforts on such lands." GAO/RCED-99-65.

The parameters set forth in our bill will ensure that the agencies conduct forest thinning in a way that truly reduces the threat of fire and improves forest health. For example, we require the agencies to focus on thinning projects that remove small diameter trees. Too often, the Forest Service has cut large trees because of their commercial value instead of removing small-diameter trees that tend to spread fire. A group of respected forest fire scientists recently wrote President Bush a letter stating that, "thinning of overstory trees, like building new roads, can often exacerbate the situation and damage forest health."

Our bill prohibits new road construction in roadless areas whereas H.R. 1904 contains no similar provision. The National Forests already contain 380,000 miles of road, as a comparison, the National Highway System contains 160,000 miles of roads, and the deferred maintenance needs on these existing roads totals more than $1 billion. Forest Service analysis reveals that roads increase the probability of accidental and intentional human-caused ignitions.

Returning receipts to the Treasury is consistent with a provision in Senator WYDEN and Senator CRAIG's county payments legislation enacted two years ago and avoids existing perverse incentives. Numerous GAO reports reveal that existing agency trust funds provide incentives for the agency to cut large trees because it gets to keep the revenue. Cutting large trees will not reduce fire risk, therefore, we should direct receipts back to the Treasury. Jeremy Fried, a Forest Service Research specialist at the Pacific Northwest Research Station, states, "If you take just big trees, you don't reduce fire danger."

The provision in our bill stating that seventy percent of hazardous fuels reduction funds be spent within one-half mile of at risk communities or within municipal watersheds is necessary because GAO recently found that more than two-thirds of the Forest Service's decisions involving fuels reduction activities were targeted exclusively at lands outside of the wildland/urban interface. H.R. 1904 contains no similar provision.

In conclusion, our bill represents a comprehensive and balanced approach to expedite forest thinning and improve forest health. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

Be it enacted by the Senate and House of Representatives of the United States in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Collaborative Forest Health Act".

SEC. 2. DEFINITIONS.

As used in this Act:

(1) The term "at-risk community" means—

(A) an urban wildland "interface" or "intermix" community as those terms were defined by the Secretaries on January 4, 2001 (66 Federal Register 753), or

(B) consisting of a collection of homes or other structures with basic infrastructure and services, such as utilities, collectively maintained transportation routes, and emergency services;

(i) on which conditions are conducive to large-scale fire disturbance events; and

(ii) for which a significant risk exists of a resulting spread of the fire disturbance event, after ignition, which would threaten human life and property.

(2) The term "community protection zone" means an at-risk community and an area within one-half mile of an at-risk community.

(3) The term "Secretaries" means the Secretary of Agriculture with respect to National Forest System lands and the Secretary of the Interior with respect to public lands administered by the Bureau of Land Management.

(4) The term "1890 Institution" means a college or university eligible to receive funds under the Act of August 30, 1890 (7 U.S.C. 321 et seq.), including Tuskegee University.

(5) The term "Federal lands" means public lands as defined in section 103(e) of the Federal Land Policy and Management Act (43 U.S.C. 1702(e)) and the National Forest System as defined in section 11 (a) of the Forest and Rangeland Renewable Resources Planning Act (16 U.S.C. 1609(a)).

SEC. 3. EXPEDITED PLANNING AND IMPLEMENTATION PROCESS.

(a) CATEGORICAL EXCLUSION.—Subject to subsection (h), the Secretaries may find that a proposed hazardous fuels reduction project, including prescribed fire, that removes no more than 250,000 board feet of merchantable wood products or removes as salvage 1,000,000 board feet or less of merchantable wood products and assures regeneration of harvested or salvaged areas will not individually or cumulatively have a significant effect on the human environment and, therefore, neither an environmental assessment nor an environmental impact statement is required

(b) PUBLIC MEETING.—Prior to implementing a project pursuant to subsection (a), the Secretaries shall conduct a public meeting at an appropriate location proximate to the administrative unit of the Federal lands in which the project will be conducted. The Secretaries shall provide advance notice of the date and time of the meeting.

(c) COLLABORATION.—

(1) The Secretaries shall identify projects implemented pursuant to this section through a collaborative framework as described in the Implementation Plan for the 10-year Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risks to Communities and the Environment, dated May 2002, developed pursuant to the Conference Report to the Department of the Interior and Related Agencies Appropriations Act, FY 2001 (H. Rept. 106-646) to reduce hazardous fuels. Any project carried out pursuant to this section shall be consistent with the applicable forest plan, resource management plan, or other applicable agency plans.

(2) The Secretaries shall ensure that local level collaboration includes Tribal representatives, local representatives from Federal and State agencies, local governments, landowners, other stakeholders, and community-based groups.

(3) The Secretaries shall establish incentives or performance measures to ensure that Federal employees are committed to collaboration.

(d) ACREAGE LIMITATION.—In implementing this section, the Secretaries shall implement projects on an aggregate area of not more than 20 million acres of Federal lands. This amount is in addition to the existing hazardous fuels reduction program that implements projects on approximately 2.5 million acres each year.

(e) ADMINISTRATIVE APPEALS.—

Projects implemented pursuant to this section shall not be subject to the appeal requirements of section 322 of the Department of the Interior and Related Agencies Appropriations Act, 1993 (16 U.S.C. 1612 note) or review by the Department of the Interior Board of Land Appeals. Nothing in this section affects projects for which scoping has begun prior to enactment of this Act.

(f) CONCLUSIVE PRESUMPTION.—Within—

(1) the community protection zone; or

(2) municipal watersheds in which National Environmental Policy Act documentation and analysis has been completed and no new road construction is allowed, no timber sales are allowed, and no log skidding machines are allowed,

unless there are extraordinary circumstances, the decision of either Secretary that a proposed hazardous fuels reduction project authorized by subsection (a) is categorically excluded is conclusive as a matter of law and shall not be subject to judicial review. This conclusive determination shall apply in any judicial proceeding brought to enforce the National Environmental Policy Act pursuant to this section.

(g) EXCLUDED FEDERAL LANDS.—This section does not apply to any Federal lands—

(1) included in a wilderness study area or a component of the National Wilderness Preservation System; or

(2) where logging is prohibited or restricted by an Act of Congress, presidential proclamation, or agency determination.

(h) EXTRAORDINARY CIRCUMSTANCES.—For all projects proposed pursuant to this section, if there are extraordinary circumstances, the Secretaries shall follow agency procedures related to categorical exclusions and extraordinary circumstances consistent with Council on Environmental Quality regulations.

(i) REDUCE FIRE RISK AND IMPROVE FOREST HEALTH.—

(1) In order to ensure that the agencies are implementing projects pursuant to this section that reduce the risk of unnaturally intense wildfires and improve forest health, the Secretaries—

(A) shall not construct or reconstruct new temporary or permanent roads in inventoried roadless areas;

(B) shall maintain the integrity of mature and old growth stands appropriate for each ecosystem type and shall focus on thinning from below for all forest thinning projects;

(C) shall use integrated pest management techniques to forestall significant fuel loading in areas infested by native insects;

(D) shall require a slash treatment plan when thinning to reduce hazardous fuels in areas with insect mortality and limit timber salvage activity to areas with fifty percent or more mortality; and

(E) shall deposit in the Treasury of the United States all revenues and receipts generated from projects implemented pursuant to this Act.

(2) In addition to the requirements set forth in paragraph (1), the Secretaries shall ensure that projects implemented in municipal watersheds protect or enhance water quality or water quantity.

(3) The Secretaries shall not use goods-for-service contracting to implement projects pursuant to this section.

(j) LONG-TERM FUEL MANAGEMENT.—In implementing hazardous fuels reduction projects pursuant to this section, the Secretaries shall ensure that—

(1) funding to assure completion of all phases of the project be committed by the management unit before the project begins;

(2) a follow-up treatment plan describing the long-term maintenance activities to keep the treated areas within the historical range of variability, and the project costs, shall accompany all proposed projects; and

(3) a system to track the budgeting and implementation of follow-up treatments shall be used to account for the long-term maintenance of areas managed to reduce hazardous fuels.

(k) HAZARDOUS FUELS REDUCTION FUNDING FOCUS.—In order to focus hazardous fuels reduction activities on the highest priority areas where critical issues of human safety and property loss are the most serious and within municipal watersheds, the Secretaries shall expend at least seventy percent of the hazardous fuels operations funds provided annually only on projects within the community protection zone or within municipal watersheds.

(l) COMMUNITIES.—

(1) The Secretaries shall expend at least thirty percent of the hazardous fuels operations funds provided annually on projects that benefit small businesses that use small diameter material and woody debris removed in hazardous fuels reduction treatments and are located in small, economically disadvantaged communities.

(2) To conduct a project under this section, the Secretaries shall use local preference contracting and best value contracting. Best value contracting criteria includes—

(A) the ability of the contractor to meet the ecological goals of the projects;

(B) the use of equipment that will minimize or eliminate impacts on soils; and

(C) benefits to local communities such as ensuring that the byproducts are processed locally.

(m) MONITORING.—(1) The Secretaries shall jointly establish a commission to complete an assessment of the positive or negative impacts and effectiveness of projects implemented under this section. The commission shall be composed of 12 to 15 members with equal representation from conservation interests, local communities, and commodity interests. The Commission shall submit a report to Congress within 36 months after the date of enactment of this Act. The report must include identification of the total dollar value of contracts awarded to natural resource related small or micro enterprises, Youth Conservation Corps crews or related partnerships, entities that hired and trained local people to complete the contract or agreement, or local entities that meet the criteria to qualify for the Historically Underutilized Business Zone Program pursuant to section 32 of the Small Business Act (15 U.S.C. 657a).

(2) (A) The Secretaries shall establish a multiparty monitoring, evaluation, and accountability process in order to assess a representative sampling of the projects implemented pursuant to this section.

(B) The Secretaries shall ensure that monitoring data is collected and compiled in a way that the general public can easily access. The Secretaries may collect the data using cooperative agreements, grants, or contracts with small or micro-enterprises, Youth Conservation Corps work crews or related partnerships with State, local, and other non Federal conservation corps.

(3) Funds to implement this section shall be derived from hazardous fuels operations funds.

(n) SUNSET.—

The provisions of this section shall expire five years after the date of enactment of this Act, except that a project for which a decision notice, or memorandum in the case of a categorical exclusion, has been issued before the end of such period may continue to be implemented using the provisions of this Act.

SEC. 4. INSECT INFESTATIONS.

(a) During fiscal years 2004 through 2008, the Secretaries jointly shall make available from funds otherwise available in the Treasury, without further appropriation, $25,000,000 each fiscal year to conduct a systematic information gathering program on certain insect types that have caused large scale damage to forest ecosystems in order to complete research that can be applied to forest management treatments and product utilization.

(b) The Secretaries shall establish and carry out the program in cooperation with scientists from universities and forestry schools, State agencies, and private and industrial land owners. The Secretaries shall designate universities and forestry schools, including Land Grant Colleges and Universities and 1890 institutions, to carry out the program.

(c) The Secretaries shall ensure that the program includes research on:

(1) determining how to best use mechanical thinning and prescribed fire to modify fire behavior and reduce fire risk, and to improve the scientific basis for design, implementation and evaluation of hazardous fuels reduction treatments;

(2) gathering systematic information on insect types, including Emerald Ash Borers, Gypsy Moth, Red Oak Borers, Asian Longhomed Beetles, and Bark Beetles, that have caused large-scale damage to forest ecosystems, to establish early detection programs for insect and disease infestation in order to prevent massive breakouts, to determine the correlation between insect mortality and fire risk in specific forest types, and to test silvicultural systems that use integrated pest management; and

(3) developing new technologies and markets for value-added products that use the byproducts of insect infestation or hazardous fuels reduction treatments.

SEC. 5. FIREFIGHTER SAFETY AND TRAINING.

The Secretaries shall track funds expended for firefighter safety and training and include a line items for such expenditures in future budget requests.

SEC. 6. BORROWING AUTHORITY FOR FIRE SUPPRESSION.

(a) The Secretary of Agriculture may request up to $250 million in a fiscal year from the Secretary of the Treasury to cover fire suppression costs that exceed the amount of funding available to the Forest Service for fire suppression in a fiscal year.

(b) Upon such request, the Secretary of the Treasury shall make such sums available to the Secretary of Agriculture, without further appropriation.

(c) Upon amounts being appropriated by Congress to reimburse funds transferred to the Secretary of Agriculture pursuant to this section, such amounts shall be deposited in the Treasury.

SEC. 7. PROHIBITION ON THE COMPETITIVE SOURCING INITIATIVE.

The Competitive Sourcing Initiative and the Office of Management and Budget Circular No. A-76, dated May 29, 2003, shall not apply to the Forest Service.

SEC. 8. WILDFIRE RISK REDUCTION AND BURNED AREA RESTORATION.

(a) IN GENERAL.—During fiscal years 2004 through 2008, the Secretaries jointly shall make available from funds otherwise available in the Treasury, without further appropriation, $100,000,000 each fiscal year to reduce the risk of wildfire to structures and restore burned areas on tribal lands, nonindustrial private lands, and State lands using the authorities available pursuant to this section, the National Fire Plan and the Emergency Watershed Protection program.

(b) COST SHARE GRANTS.—In implementing this section, the Secretaries may make cost-share grants to Indian tribes, local fire districts, municipalities, homeowner associations, and counties, to remove, transport, and dispose of hazardous fuels around homes and property to—

(1) prevent structural damage as a result of wildfire, or

(2) to restore or rehabilitate burned areas on non-Federal lands.

(c) NON-FEDERAL CONTRIBUTION.—The non-Federal contribution may be in the form of cash or in-kind contribution.

(d) PRIORITY.—Priority for such funds shall be given to areas where the applicable local government has enacted ordinances for wildland areas requiring or promoting brush clearance around homes and requiring fire-retardant building materials for new construction.

(e) AVAILABILITY OF FUNDS.—Amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

Mr. DASCHLE. Mr. President, today I join Senators BINGAMAN, MURRAY, CANTWELL and others to introduce the Collaborative Forest Health Act to expedite forest thinning and improve forest health on our national forests and public lands. I thank Senator BINGAMAN for his leadership on this important issue.

Everyone in the Senate wants to do what we can to reduce the threat of catastrophic wildfire. There is agreement on the need to accelerate fuel reduction activities because of the risk of severe fire is so high. Ongoing drought, past fire suppression policies, and past forestry practices have all contributed to the problem. These problems have made fire management much more expensive for American taxpayers. It is important to devote limited resources to proactive efforts to reduce fire risk rather than paying to fight fires once they occur.

The risk of damage to human life and property from severe wildfires has increased in areas where rapidly expanding populations are intermingled with forested wildlands, and a primary purpose of the National Fire Plan is to reduce the risks of such fires. Last week, Governors Judy Martz of Montana, Bill Richardson of New Mexico, Janet Napolitano of Arizona, and Dirk Kempthorne of Idaho issued a letter to the Agriculture Committee and the Energy and Natural Resources Committee endorsing this approach stating that "priority in project selection should be given to projects that reduce fire risk in communities at risk and the watersheds that supply them."

This comprehensive legislation will assist communities from the threat of wildfire by expediting fuel reduction in high risk areas and target resources near communities and municipal watersheds. We propose to exempt from environmental review and analysis all forest thinning projects located within one-half mile of at risk communities or within certain municipal watershed. While these targeted exemptions from environmental review are warranted, the Senate should proceed with caution in considering any comprehensive changes to judicial review. On May 14, 2003, the General Accounting Office, GAO, issued a report on the Forest Service's fuel reduction activities. For fiscal year 2001 and fiscal year 2002, the GAO found that hazardous fuel reduction activities were conducted on 4.7 million acres. Only 3 percent of all the fuel reduction projects, covering only 100,000 acres, faced any legal challenge during this period.

In 2002, the National Academy of Public Administration issued a report recommending the Federal Government conduct fuels reduction treatments near communities and municipal watersheds before treating more distant areas. We also require that 70 percent of forest thinning funds be spent within these critical areas. Our bill authorizes projects on up to 20 million acres over 5 years.

The bill also recognizes the role that forest-dependent communities play in restoring our lands by requiring that at least 30 percent of the hazardous fuels reduction funds be spent on projects that benefit small businesses that use hazardous fuels and are located in small, economically disadvantaged communities.

It is widely known that approximately 80 percent of the land surrounding homes and communities is non-Federal land. Our legislation provides $100 million annually to States, tribal and private lands to reduce wildfire risk and restore burned areas.

In addition, our bill establishes a $25 million research program, in cooperation with colleges and universities, to gather information on insect infestations that can be applied to forest management treatments.

Our bill promotes wildfire management activities that maintain the integrity of our national forests and public lands. The bill requires protection of old and large trees, prevents new road construction in roadless areas, and protects municipal watersheds.

In conclusion, our bill represents a comprehensive and balanced approach to expedite forest thinning and improve forest health. I urge my colleagues to support this important legislation.

By Mr. CRAIG (for himself, Mr. CRAPO, and Mr. SMITH):

S. 1315. A bill to amend the Federal Land Policy and Management Act of 1976 to provide owners of non-Federal lands with a reliable method of receiving compensation for damages resulting from the spread of wildfire from nearby forested national Forest System lands or Bureau of Land Management lands, when those forested Federal lands are not maintained in the forest health status known as condition class 1; to the Committee on the Judiciary.

Mr. CRAIG. Mr. President, I rise today to introduce the Enhanced Safety from Wildfire Act of 2003. I am joined by my colleagues Mr. CRAPO and Mr. SMITH.

This morning, I awoke to the news that the Aspen fire near Tucson, AZ, made a significant run yesterday and damaged or destroyed an estimated 200 structures. The report also said firefighters could do nothing to stop the wall of fire from ripping through the middle of town. Sadly, this report is one of several such stories today and it is far from being the last.

It is only the middle of June and already the wildfire season is in full swing throughout the West. The loss of property as a result of wildfires on Federal land is unacceptable. I believe that our homes and the safety of our communities should never be put in harms way because of the mismanagement of our Federal land.

In short, the legislation we are introducing would amend the Federal Land Policy and Management Act of 1976 to make it possible for non-Federal land owners to receive compensation for a loss of property as a result of wildfire spreading from Federal land that has not been managed as Condition Class 1.

As we all know, in recent years, there has been a significant amount of injury and loss of property resulting from the spread of wildfire from Federal forested lands to non-Federal lands. Recent wildfires on Federal forested lands have shown that lands managed under approved forest health management practices are less susceptible to wildfire, or are subjected to less severe wildfire, than similarly forested lands that are not actively managed.

There is a continuing and growing threat to the safety of communities, individuals, homes and other property, and timber on non-Federal lands that adjoin Federal forested lands because of the unnatural accumulation of forest fuels on these Federal lands and the lack of active Federal management of these lands.

The use of approved forest health management practices to create forest fire "buffer zones" between forested Federal lands and adjacent non-Federal lands would reduce the occurrence of wildfires on forested Federal lands or, at least, limit their spread to non-Federal lands and the severity of the resulting damage.

This legislation requires the agencies to manage a "buffer zone" on Federal land, greater than 6,400 acres, that is adjacent to non-Federal land. When forested Federal lands adjacent to non-Federal lands are not adequately managed with a "buffer zone" and wildfire occurs, the legislation states the owners of the non-Federal lands are eligible for compensation for damages resulting from the spread of wildfire to their lands. The legislation sets minimum criteria for non-Federal land to be eligible for compensation.

Our Federal land management agencies need to take responsibility for the fatal impacts that occur on non-Federal land as a result of a lack of management on Federal land. As a society, we have come to expect that our neighbors take responsibility for their actions and I feel the Federal land management agencies should not escape this responsibility either.

In the next few weeks, the weather will continue to heat up, the drought ridden West will become drier, wildfire will continue to plague throughout, and the number of reports regarding the loss of property will continue to escalate. At the same time, the forest health debate will also heat up as the Senate considers the President's Healthy Forest Initiative.

I know this legislation may not be the answer to solving our Federal land management problems and I am willing to discuss other options, but I know that until we address the heart of this issue, homes, private land, and communities will continue to be at risk because of poor Federal land management. Being a good neighbor means being responsible for your actions.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1315

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act maybe cited as the "Enhanced Safety from Wildfire Act of 2003".

SEC. 2. UNITED STATES LIABILITY FOR DAMAGES RESULTING FROM THE SPREAD OF WILDFIRE FROM FORESTED PUBLIC LANDS.

(a) IMPOSITION OF LIABILITY FOR SPREAD OF WILDFIRE.—Title III of the Federal Land Policy and Management Act of 1976 is amended by inserting after section 318 (43 U.S.C. 1748) the following new section:

"Sec. 319. Liability for Damages Resulting From Spread of Wildfire From Public Lands or National Forest System Lands.

"(a) LIABILITY AS RULE OF LAW.—Except as provided in subsections (b), (c), and (d), and subject to the delayed effective date specified in subsection (h), any injury to or loss of property that occurs on non-Federal lands as a direct result of a fire that spread from forested Federal lands onto the non-Federal lands, either directly or by first spreading to other non-Federal lands, shall be deemed to be an injury or loss of property caused by the negligent or wrongful act or omission of an employee of the United States while acting within the scope of the employee's office or employment for purposes of section 1346 and chapter 171 of title 28, United States Code (commonly known as the 'Federal Tort Claims Act').

"(b) ADDITIONAL REQUIREMENT FOR CERTAIN NON-FEDERAL LANDS.—The owner or leasee of non Federal lands damaged by the spread of wildfire from forested Federal lands may not utilize the rule of law specified in subsection (a) when the non-Federal lands exceed 6400 acres and are used for the commercial production of timber, unless the owner or leasee proves that the damaged non-Federal lands were being managed to achieve or maintain the forest health status known as condition class 1 immediately before the fire. In the event of a dispute between the owner or leasee and the Secretary concerned regarding the status of the non-Federal lands before the fire, the determination of the State Forester of the State in which the lands are located shall control and any expenses associated with State Foresters determination shall be equally divided between the disputing parties.

"(c) EXCLUSION OF CONDITION CLASS 1 LANDS.—The rule of law specified in subsection (a) shall not apply if the forested Federal lands within the buffer zone adjacent to the Federal land boundary from which the fire spread to non-Federal lands were managed as condition class 1 immediately before the fire.

"(d) EXCLUSION OF OTHER FEDERAL LANDS.—The rule of law specified in subsection (a) shall not apply to the following Federal lands, even though wildfire may originate on such lands and spread to adjacent non-Federal lands:

"(1) A component of the National Wilderness Preservation System.

"(2) Federal lands where, by Act of Congress, Presidential proclamation, or land and resource management plan, the removal of vegetation is prohibited.

"(3) Areas of Federal lands that comprise less than 6,400 acres and are not contiguous to other Federal lands.

"(e) EXCEPTION FOR O&C LANDS.—The rule of law specified in subsection (a) shall apply to National Forest System lands and Bureau of Land Management lands administered under the authorities of the O&C Sustained Yield Act of 1937 and that do not meet the acreage limitation set forth in subsection (d) (3).

"(f) REPORT REGARDING STATUS OF BUFFER LANDS.—Not later than two years after the date of the enactment of this section, the Secretary concerned shall submit to Congress a report describing the forest health status of all buffer zones with non-Federal lands and the extent to which the buffer zones are in, or are being managed to achieve, the forest health status known as condition class 1.

"(g) DEFINITIONS.—In this section:

"(1) The term 'buffer zone' refers to those forested Federal lands that are within a prescribed distance of a Federal land boundary with non-Federal lands and comprise, or are part of a larger area of Federal lands comprising, 6,400 acres or more. The Secretary shall prescribe the actual buffer zone for a particular area of forested Federal lands based on the geography, topography, and forest cover of the lands.

"(2) The term 'condition class 1', with respect to an area of forested Federal lands or non-Federal lands, means that the lands are managed so that

"(A) fire regimes on the lands are within historical ranges;

"(B) vegetation composition and structure are intact; and

"(C) the risk of losing key ecosystem components from the occurrence of fire remains relatively low.

"(3) The term 'forested Federal lands' means public lands and National Forest System lands that contain trees as a significant component of the lands.

"(4) The term 'Secretary concerned' means the Secretary of the Interior (or the designee of that Secretary) with respect to public lands and the Secretary of Agriculture (or the designee of that Secretary) with respect to National Forest System lands.

"(h) Delayed Effective Date.—The rule of law specified in subsection (a) shall take effect at the end of the eight-year period beginning on the date of the enactment of this section and apply with respect to fires that spread from Federal lands onto non-Federal lands after the end of such period."

(b) Clerical Amendment.—The table of contents at the beginning of the Federal Land Policy and Management Act of 1976 is amended by inserting after the item relating to section 318 the following new item:

"Sec. 319. Liability for damages resulting from spread of wildfire from public lands or National Forest System lands.".

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 179—TO AUTHORIZE TESTIMONY AND LEGAL REPRESENTATION IN STATE OF NEW HAMPSHIRE v. DONALD JOHNSON

Mr. FRIST (for himself and Mr. Daschle) submitted the following resolution; which was considered and agreed to:

S. Res. 179

Whereas, in the case of State of New Hampshire v. Donald Johnson, pending in Concord District Court for the State of New Hampshire, testimony has been requested from Carol Carpenter, a staff member in the office of Senator Judd Gregg;

Whereas, pursuant to sections 703(a) and 704(a)(2) of the Ethics in Government Act of 1978, 2 U.S.C. §§288b(a) and 288c(a)(2), the Senate may direct its counsel to represent employees of the Senate with respect to any subpoena, order, or request for testimony relating to their official responsibilities;

Whereas, by the privileges of the Senate of the United States and Rule XI of the Standing Rules of the Senate, no evidence under the control or in the possession of the Senate may, by the judicial or administrative process, be taken from such control or possession but by permission of the Senate;

Whereas, when it appears that evidence under the control or in the possession of the Senate may promote the administration of justice, the Senate will take such action as will promote the ends of justice consistently with the privileges of the Senate: Now, therefore, be it *Resolved* That Carol Carpenter is authorized to provide testimony in the case of State of New Hampshire v. Donald Johnson, except concerning matters for which a privilege should be asserted.

Sec. 2. The Senate Legal Counsel is authorized to represent Carol Carpenter in connection with any testimony authorized in section one of this resolution.

SENATE RESOLUTION 180—TO SET STANDARDS FOR THE NAMING OF ANY PART OF THE SENATE WING OF THE CAPITOL BUILDING COMPLEX

Mr. DODD submitted the following resolution; which was referred to the Committee on Rules and Administration:

S. Res. 180

Resolved,

SECTION 1. STANDARDS FOR NAMING PORTIONS OF THE SENATE WING OF THE CAPITOL.

(a) Restriction.—The Senate shall not name any portion of the Senate wing of the Capitol Building Complex after any person unless not less than 5 years have passed since the death of that person.

(b) Duration.—

(1) In general.—Except as provided under paragraph (2), the naming, by the Senate, of any portion of the Senate wing of the Capitol Building Complex shall remain in force for a period not to exceed 25 years beginning on the date of enactment of the Act or resolution that established such name.

(2) Existing named areas.—Any portion of the Senate wing of the Capitol Building Complex that is named as of the date of adoption of this resolution shall no longer be so named after the date that is 25 years after the date of adoption of this resolution.

(c) Definition.—In this resolution, the term "Senate wing of the Capitol Building Complex" includes—

(1) the Senate wing of the United States Capitol Building;

(2) the Russell Senate Office Building;

(3) the Dirksen Senate Office Building;

(4) the Hart Senate Office Building; and

(5) spaces designated under the control of the Senate in the Capitol Visitor Center.

AMENDMENTS SUBMITTED & PROPOSED

SA 975. Mr. ROCKEFELLER (for himself, Ms. Mikulski, and Mrs. Clinton) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

SA 976. Mr. ROCKEFELLER (for himself, Mr. Carper, Mr. Graham, of Florida, Ms. Mikulski, Mrs. Clinton, and Mr. Dodd) proposed an amendment to the bill S. 1, supra.

SA 977. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 978. Mr. JEFFORDS (for himself, Mr. Kerry, Mr. Reid, Mr. Durbin, and Mr. Lautenberg) submitted an amendment intended to be proposed by him to the bill S. 14, to enhance the energy security of the United States, and for other purposes; which was ordered to lie on the table.

SA 979. Mr. AKAKA (for himself, Mr. Sarbanes, and Ms. Mikulski) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

SA 980. Mr. AKAKA proposed an amendment to the bill S. 1, supra.

SA 981. Mr. PRYOR proposed an amendment to the bill S. 1, supra.

SA 982. Mr. LAUTENBERG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 983. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 984. Mr. BINGAMAN proposed an amendment to the bill S. 1, supra.

SA 985. Mr. BAUCUS (for Mr. Edwards (for himself and Mr. Harkin)) proposed an amendment to the bill S. 1, supra .

SA 986. Mr. BAUCUS (for Mr. Lautenberg (for himself, Mr. Reed, Mrs. Clinton, and Mr. Corzine)) proposed an amendment to the bill S. 1, supra.

SA 987. Mrs. HUTCHISON (for herself, Mr. Kennedy, Mr. Durbin, Mr. Kerry, Mr. Talent, Mr. Reed, Mrs. Murray, Mr. Specter, Mrs. Feinstein, Mr. Corzine, Mr. Biden, Mr. Bond, and Mr. Schumer) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 988. Mr. THOMAS (for himself and Mrs. Lincoln) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 989. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 990. Mrs. MURRAY proposed an amendment to the bill S. 1, supra.

SA 991. Mr. HARKIN proposed an amendment to the bill S. 1, supra.

SA 992. Mr. BAUCUS (for Ms. Stabenow (for herself and Ms. Snowe)) proposed an amendment to the bill S. 1, supra.

SA 993. Mr. BAUCUS (for Mr. Dorgan) proposed an amendment to the bill S. 1, supra.

SA 994. Mr. DURBIN (for himself, Mr. Corzine, Mr. Harkin, Mrs. Boxer, Ms. Stabenow, Mr. Dayton, and Mr. Byrd) proposed an amendment to the bill S. 1, supra.

SA 995. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 996. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 997. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 998. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 999. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1000. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 975. Mr. ROCKEFELLER (for himself, Ms. Mikulski, and Mrs. Clinton) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 10, lines 12 and 13, strike "(other than a dual eligible individual, as defined in section 1860D–19(a)(4)(E))".

On page 21, strike lines 22 through 25, and insert "title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit."

On page 107, line 3, strike "30 percent" and insert "27.5 percent".

On page 116, line 10, insert "and" after the semi-colon.

On page 116, line 12, strike "; and" and insert a period.

On page 116, strike lines 13 through 17.

On page 116, line 24, insert "and" after the semi-colon.

On page 117, line 2, strike "; and" and insert a period.

On page 117, strike lines 3 through 7.

On page 117, line 13, insert "and" after the semicolon.

On page 117, line 17, strike "; and" and insert a period.

On page 117, strike lines 18 through 23.

On page 118, line 6, insert "and" after the semicolon.

On page 118, in line 13, insert "or" after the semi-colon.

On page 118, line 14, strike "; or" and insert a period.

On page 118, strike line 15.

Beginning on page 118, strike line 16 and all that follows through page 119, line 9.

On page 119, line 10, strike "(F)" and insert "(E)".

On page 119, line 15, strike "(G)" and insert "(F)".

On page 119, line 19, strike "(C), (D), or (E)" and insert "(C), or (D)".

On page 120, line 3, strike "(H)" and insert "(G)".

On page 120, lines 5 and 6, strike "who is a dual eligible individual or an individual".

Beginning on page 121, line 24, strike "dual eligible" and all that follows through "and" on page 122, line 1.

On page 146, line 6, insert before the period "and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c)".

Beginning on page 146, strike line 23 and all that follows through page 149, line 21, and insert the following:

"(c) Federal Assumption of Medicaid Prescription Drug Costs for Dually Eligible Beneficiaries.—

"(1) In general.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

"(A) Standard prescription drug coverage under medicare.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f)) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

"(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

"(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

"(B) State matching rate.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) Phase-out proportion.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

"(i) 2006 is 95 percent;

"(ii) 2007 is 90 percent;

"(iii) 2008 is 85 percent;

"(iv) 2009 is 80 percent;

"(v) 2010 is 75 percent; or

"(vi) 2011, 2012 and 2013 is 70 percent.

"(d) Medicaid as Secondary Payor.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan.

Beginning on page 152, strike line 3 and all that follows through page 153, line 15, and insert the following:

"(f) Definition.—For purposes of this section, the term 'subsidy-eligible individual' has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).".

(C) Conforming amendments.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(c)(1) for the State and the quarter".

(2) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

Beginning on page 157, strike line 21 and all that follows through page 158, line 4.

On page 173, beginning on line 15, strike "that is not" and all that follows through "includes" on line 18 on that page, and insert "that includes but is limited solely to".

On page 190, in line 18, strike "and".

On page 190, between lines 18 and 19, insert the following:

"(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and".

On page 190, line 19, strike "(B)" and insert "(C)".

SA 976. Mr. ROCKEFELLER (for himself, Mr. Carper, Mr. Graham of Florida, Ms. Mikulski, Mrs. Clinton, and Mr. Dodd) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 51, strike lines 15 through 25 and insert the following:

"(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

SA 977. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 134, strike line 9 and insert the following:

under paragraph (1).

"(d) Implementation of Part D.—Notwithstanding section 1860D–1(a)(4) or any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part on January 1, 2004. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part. The Secretary shall not implement sections 1807 and 1807A.

SA 978. Mr. JEFFORDS (for himself, Mr. Kerry, Mr. Reid, Mr. Durbin, and Mr. Lautenberg) submitted an amendment intended to be proposed by him to the bill S. 14, to enhance the energy security of the United States, and for other purposes; which was ordered to lie on the table; as follows:

On page 467, after line 16, add the following:

Subtitle I—Renewable Portfolio Standard

SEC. 192. RENEWABLE PORTFOLIO STANDARD.

Title VI of the Public Utility Regulatory Policies Act of 1978 (16 U.S.C. 2601 et seq.) is amended by adding at the end the following:

"SEC. 606. FEDERAL RENEWABLE PORTFOLIO STANDARD.

"(a) Renewable Energy Requirements.—

"(1) In general.—For each calendar year beginning in Calendar year 2006, each retail electric supplier shall submit to the Secretary, not later than April 30 of each year, renewable energy credits in an amount equal to the required annual percentage of the retail electric supplier's total amount of kilowatt-hours of non-hydropower (excluding incremental hydropower) electricity sold to retail consumers during the previous calendar year.

"(2) Carryover.—A renewable energy credit for any year that is not used to satisfy the minimum requirement for that year may be carried over for use within the next two years.

"(b) Required Annual Percentage.—Of the total amount of non-hydropower (excluding incremental hydropower) electricity sold by each retail electric supplier during a calendar year, the amount generated by renewable energy sources shall be not less than the percentage specified below:

Percentage of Renewable Energy

Calendar years:	*Each year:*
2006–2009	5
2010–2014	10
2015–2019	15
2020 and subsequent years	20

"(c) Submission of Renewable Energy Credits.—

"(1) In general.—To meet the requirements under subsection (a), a retail electric supplier shall submit to the Secretary either—

"(A) renewable energy credits issued to the retail electric supplier under subsection (e);

"(B) renewable energy credits obtained by purchase or exchange under subsection (f);

"(C) renewable energy credits purchased from the United States under subsection (g); or

"(D) any combination of credits under subsections (e), (f) or (g).

"(2) Prohibition on double counting.—A credit may be counted toward compliance with subsection (a) only once.

"(d) Renewable Energy Credit Program.—The Secretary shall establish, not later than 1 year after the date of enactment of this Act, a program to issue, monitor the sale or exchange of, and track, renewable energy credits.

"(e) Issuance of Renewable Energy Credits.—

"(1) In general.—Under the program established in subsection (d), an entity that generates electric energy through the use of a renewable energy resource may apply to the Secretary for the issuance of renewable energy credits.

"(2) Application.—An application for the issuance of renewable energy credits shall indicate—

"(A) the type of renewable energy resource used to produce the electric energy;

"(B) the State in which the electric energy was produced; and

"(C) any other information the Secretary determines appropriate.

"(3) Credit value.—Except as provided in subparagraph (4), the Secretary shall issue to an entity applying under this subsection one renewable energy credit for each kilowatt-hour of renewable energy generated in any State from the date of enactment of this Act and in each subsequent calendar year.

"(4) Credit value for distributed generation.—The Secretary shall issue three renewable energy credits for each kilowatt-hour of distributed generation.

"(5) Vesting.—A renewable energy credit will vest with the owner of the system or facility that generates the renewable energy unless such owner explicitly transfers the credit.

"(6) Credit eligibility.—To be eligible for a renewable energy credit, the unit of electricity generated through the use of a renewable energy resource shall be sold for retail consumption or used by the generator. If both a renewable energy resource and a nonrenewable energy resource are used to generate the electric energy, the Secretary shall issue renewable energy credits based on the proportion of the renewable energy resource used.

"(7) Identifying credits.—The Secretary shall identify renewable energy credits by the type and date of generation.

"(8) Sale under PURPA contract.—When a generator sells electric energy generated through the use of a renewable energy resource to a retail electric supplier under a contract subject to section 210 of the Public Utilities Regulatory Policies Act of 1978 (16 U.S.C. 824a-3), the retail electric supplier is treated as the generator of the electric energy for the purposes of this Act for the duration of the contract.

"(f) Sale or Exchange of Renewable Energy Credits.—A renewable energy credit may be sold or exchanged by the entity issued the renewable energy credit or by any other entity that acquires the renewable energy credit. Credits may be sold or exchanged in any manner not in conflict with existing law, including on the spot market or by contractual arrangements of any duration.

"(g) Purchase From the United States.—The Secretary shall offer renewable energy credits for sale at the lesser of three cents per kilowatt-hour or 110 percent of the average market value of credits for the applicable compliance period. On January 1 of each year following calendar year 2006, the Secretary shall adjust for inflation the price charged per credit for such calendar year.

"(h) State Programs.—Nothing in this section shall preclude any State from requiring additional renewable energy generation in the State under any renewable energy program conducted by the State.

"(i) Consumer Allocation.—The rates charged to classes of consumers by a retail electric supplier shall reflect a proportional percentage of the cost of generating or acquiring the required annual percentage of renewable energy under subsection (a). A retail electric supplier shall not represent to any customer or prospective customer that any product contains more than the percentage of eligible resources if the additional amount of eligible resources is being used to satisfy the renewable generation requirement under subsection (a).

"(j) Enforcement.—A retail electric supplier that does not submit renewable energy credits as required under subsection (a) shall be liable for the payment of a civil penalty. That penalty shall be calculated on the basis of the number of renewable energy credits not submitted, multiplied by the lesser of 4.5 cents or 300 percent of the average market value of credits for the compliance period.

"(k) Information Collection.—The Secretary may collect the information necessary to verify and audit—

"(1) the annual electric energy generation and renewable energy generation of any entity applying for renewable energy credits under this section;

"(2) the validity of renewable energy credits submitted by a retail electric supplier to the Secretary; and

"(3) the quantity of electricity sales of all retail electric suppliers.

"(l) Voluntary Participation.—The Secretary may issue a renewable energy credit pursuant to subsection (e) to any entity not subject to the requirements of this Act only if the entity applying for such credit meets the terms and conditions of this Act to the same extent as entities subject to this Act.

"(m) State Renewable Energy Grant Program.

"(1) Distribution to states.—The Secretary shall distribute amounts received from sales under subsection (g) and from amounts received under subsection (j) to States to be used for the purposes of this section.

"(2) Regional equity program.—

"(A) Establishment of program.—Within one year from the date of enactment of this Act, the Secretary shall establish a program to promote renewable energy production and use consistent with the purposes of this section.

"(B) Eligibility.—The Secretary shall make funds available under this section to State energy agencies for grant programs for—

"(i) renewable energy research and development;

"(ii) loan guarantees to encourage construction of renewable energy facilities;

"(iii) consumer rebate or other programs to offset costs of small residential or small commercial renewable energy systems including solar hot water; or

"(iv) promoting distributed generation.

"(3) Allocation preferences.—In allocating funds under the program, the Secretary shall give preference to

"(A) States in regions which have a disproportionately small share of economically sustainable renewable energy generation capacity; and

"(B) State grant programs most likely to stimulate or enhance innovative renewable energy technologies.

"(n) Definitions.—In this section:

"(1) Biomass.—

"(A) In general.—The term "biomass" means—

"(i) organic material from a plant that is planted for the purpose of being used to produce energy;

"(ii) nonhazardous, cellulosic or agricultural waste material that is segregated from other waste materials and is derived from—

"(I) a forest-related resource, including—

"(aa) mill and harvesting residue;

"(bb) precommercial thinnings;

"(cc) slash; and

"(dd) brush;

"(II) agricultural resources, including—

"(aa) orchard tree crops;

"(bb) vineyards;

"(cc) grains;

"(dd) legumes;

"(ee) sugar; and

"(ff) other crop by-products or residues; or

"(III) miscellaneous waste such as—

"(aa) waste pallet;

"(bb) crate; and

"(cc) landscape or right-of-way tree trimmings;

"(iii) animal waste that is converted to a fuel rather than directly combusted, the residue of which is converted to a biological fertilizer, oil, or activated carbon.

"(B) Exclusions.—The term 'biomass' shall not include—

"(i) municipal solid waste that is incinerated;

"(ii) recyclable post-consumer waste paper;

"(iii) painted, treated, or pressurized wood;

"(iv) wood contaminated with plastics or metals; or

"(v) tires.

"(2) Distributed generation.—The term 'distributed generation' means reduced electricity consumption from the electric grid due to use by a customer of renewable energy generated at a customer site.

"(3) Incremental hydropower.—The term 'incremental hydropower' means additional generation achieved from increased efficiency after January 1, 2003, at a hydroelectric dam that was placed in service before January 1, 2003.

"(4) Landfill gas.—The term 'landfill gas' means gas generated from the decomposition of household solid waste, commercial solid waste, and industrial solid waste disposed of in a municipal solid waste landfill unit (as those terms are defined in regulations promulgated under subtitle D of the Solid Waste Disposal Act (42 U.S.C. 6941 et seq.)).

"(5) Renewable energy.—The term 'renewable energy' means electricity generated from

"(A) a renewable energy source; or

"(B) hydrogen that is produced from a renewable energy source.

"(5) Renewable energy source.—The term 'renewable energy source' means—

"(A) wind;

"(B) ocean waves;

"(C) biomass;

"(D) solar;

"(E) landfill gas;

"(F) incremental hydropower; or

"(G) geothermal.

"(6) Retail electric supplier.—The term 'retail electric supplier' means a person or entity that sells retail electricity to consumers, and which sold not less than 500,000 megawatt-hours of electric energy to consumers for purposes other than resale during the preceding calendar year.

"(7) Secretary.—The term 'Secretary' means the Secretary of Energy.

SA 979. Mr. AKAKA (for himself, Mr. Sarbanes, and Ms. Mikulski) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . NEGOTIATIONS BY THE OFFICE OF PERSONNEL MANAGEMENT.

The Office of Personnel Management may not negotiate a prescription drug benefit for any health benefits plan under chapter 89 of title 5, United States Code, that would provide a prescription drug benefit to a medicare eligible enrollee in that plan that is of lesser actuarial value, based on 2003 constant dollars, than the prescription drug benefit available to a medicare eligible enrollee of such plan on the date of enactment of this Act.

SA 980. Mr. AKAKA proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 636, line 16, insert "and citizens of the Freely Associated States, which include the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, lawfully residing in the United States" after "Act".

SA 981. Mr. PRYOR proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, add the following:

SEC. . EQUAL ACCESS TO COMPETITIVE GLOBAL PRESCRIPTION MEDICINE PRICES FOR AMERICAN PURCHASERS.

(a) Definition of Covered Product.—In this section, the term "covered product" has the meaning given the term in section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

(b) Prohibition.—It shall be unlawful for the manufacturer of a covered product or any other person that sells a covered product to refuse to sell to any wholesaler or retailer (or other purchaser representing a group of wholesalers or retailers) of covered products in the United States on terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other term that effectively reduces the cost to the manufacturer of supplying the drug) that are not substantially the same as the most favorable (to the purchaser) terms on which the person has sold or has agreed to sell the covered product to any purchaser in Canada.

(c) Enforcement.—The Secretary of Health and Human Services, or any wholesaler or retailer in the United States aggrieved by a violation of subsection (b), may bring a civil action in United States district court against a person that violates subsection (b) for an order—

(1) enjoining the violation; and

(2) awarding damages in the amount that is equal to 3 times the amount of the value of the difference between—

(A) the terms on which the person sold a covered product to the wholesaler or retailer; and

(B) the terms on which the person sold the covered product to a person in Canada.

(d) Effectiveness of Section.—This section takes effect on the date that is 2 years after the date of enactment of this Act, except that this section shall not be in effect during any period after that date in which there is in effect a final regulation promulgated by the Secretary of Health and Human Services permitting the importation or reimportation of prescription drugs under section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

SA 982. Mr. LAUTENBERG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, insert the following:

SEC. . IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under part D of title XVIII beginning on July 1, 2004.

SA 983. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 676, after line 22, insert the following:

SEC. . PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b-2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking "The notice" and inserting "(1) The notice"; and

(3) by adding at the end the following:

"(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

"(B) In this section:

"(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

"(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.".

SA 984. Mr. BINGAMAN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle C of title II, add the following:

SEC. . CARVING OUT DSH PAYMENTS FROM PAYMENTS TO MEDICARE+CHOICE AND MEDICAREADVANTAGE ORGANIZATIONS AND PAYING THE AMOUNTS DIRECTLY TO DSH HOSPITALS ENROLLING MEDICARE+CHOICE AND MEDICAREADVANTAGE ENROLLEES.

(a) Removal of DSH Payments From Calculation of Adjusted Average Per Capita Cost.—

(1) Under medicare+choice.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3) and as amended by section 203) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)",

(B) by adding at the end the following new subparagraph:

"(E) Removal of payments attributable to disproportionate share payments from calculation of adjusted average per capita cost.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).".

(2) Under medicareadvantage.—Section 1853(a)(5) (as amended by section 203) is amended by adding at the end the following new subparagraph:

"(C) Removal of payments attributable to disproportionate share payments from calculation of adjusted average per capita cost.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).".

(3) Effective dates.—The amendments made—

(A) by paragraph (1) shall apply to plan years beginning on and after January 1, 2004 and shall continue to apply to plan years beginning on and after January 1, 2006; and

(B) by paragraph (2) shall apply to plan years beginning on and after January 1, 2006.

(b) Additional DSH Payments for Managed Care Enrollees.—Section 1886(d)(5)(F) ((42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking "clause (ix)" and inserting "clauses (ix) and (xvi)"; and

(2) by adding at the end the following new clause:

"(xvi)(I) For portions of cost reporting periods occurring on or after January 1, 2004, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that is a disproportionate share hospital (as described in clause (i)).

"(II) For purposes of this clause the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with a eligible organization under section 1876 and who is entitled to benefits under part A and any individual who is enrolled with a Medicare+Choice organization or a MedicareAdvantage organization under part C.

"(III) The amount of the payment under this clause with respect to any applicable discharge shall be equal to the estimated average per discharge amount that would otherwise have been paid under this subparagraph if the individuals had not been enrolled as described in subclause (II).

"(IV) The Secretary shall establish rules for paying an additional amount for any hospital reimbursed under a reimbursement system authorized under 1814(b)(3) if such hospital would qualify as a disproportionate share hospital under clause (i) were it not so reimbursed. Such payment shall be determined in the same manner as the amount of payment is determined under this clause for disproportionate share hospitals.".

SA 985. Mr. BAUCUS (for Mr. Edwards (for himself and Mr. Harkin)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end, add the following:

TITLE —DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. 01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) New Drug Application.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following "(including whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)"; and

(2) in subsection (d)(5)—

(A) by inserting "(A)" after "will"; and

(B) by inserting after "thereof" the following: "or (B) offer a benefit with respect to safety, effectiveness, or cost (including effectiveness with respect to a sub population or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug".

(b) Misbranding.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after "effectiveness" the following: "(including effectiveness in comparison to other drugs for substantially the same condition or conditions)".

(c) Regulations.—

(1) In general.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) Contents.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(B) any advertisement present a fair balance, comparable in depth, between—

(i)aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided that*, nothing in this section shall require explicit images or sounds depicting side effects and contraindication;

(i) information relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions); and

(ii) information relating to side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

"(h) Direct-to-Consumer Prescription Drug Advertising.—

"(1) In general.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

"(A) the Secretary provides the person written notice of the violation; and

"(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

"(2) Amount.—The amount of a civil penalty under paragraph (1)—

"(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

"(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

"(3) Procedure.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty undef paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).".

SEC. 03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. 04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) In General.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) Policy.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

SA 986. Mr. BAUCUS (for Mr. Lautenberg (for himself, Mr. Reed, Mrs. Clinton, and Mr. Corzine)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of title I, insert the following:

SEC. . IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under part D of title XVIII beginning on July 1, 2004.

SA 987. Mrs. HUTCHISON (for herself, Mr. Kennedy, Mr. Durbin, Mr. Kerry, Mr. Talent, Mr. Reed, Mrs. Murray, Mr. Specter, Mrs. Feinstein, Mr. Corzine, Mr. Biden, Mr. Bond, and Mr. Schumer) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) In General.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking "and" at the end; and

(2) by striking subclause (VII) and inserting the following new subclauses:

"(VII) during fiscal year 2003, "c" is equal to 1.35; and

"(VIII) on or after October 1, 2003, 'c' is equal to 1.6.".

(b) Conforming Amendment Relating to Determination of Standardized Amount.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking "1999 or" and inserting "1999,"; and

(2) by inserting ", or the Prescription Drug and Medicare Improvement Act of 2003" after "2000".jennifer

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SA 988. Mr. THOMAS (for himself and Mrs. Lincoln) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) Coverage of Services.—

(1) In general.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" after the semicolon at the end;

(B) in subparagraph (V)(iii), by inserting "and" after the semicolon at the end; and

(C) by adding at the end the following new subparagraph:

"(W) marriage and family therapist services (as defined in subsection (ww)(1)) and mental health counselor services (as defined in subsection (ww)(3));".

(2) Definitions.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

"(ww)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(2) The term 'marriage and family therapist' means an individual who—

"(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

"(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

"(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(4) The term 'mental health counselor' means an individual who—

"(A) possesses a master's or doctor's degree in mental health counseling or a related field;

"(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.".

(3) Provision for payment under part B.—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

"(v) marriage and family therapist services and mental health counselor services;".

(4) Amount of payment.—Section 1833(a)(1) (42 U.S.C. 1395*l*(a)(1)) is amended—

(A) by striking "and (U)" and inserting "(U)"; and

(B) by inserting before the semicolon at the end the following: ", and (V) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)".

(5) Exclusion of marriage and family therapist services and mental health counselor services from skilled nursing facility prospective payment system.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended in section 301(a), is amended by inserting "marriage and family therapist services (as defined in subsection (ww)(1)), mental health counselor services (as defined in section 1861(ww)(3))," after "qualified psychologist services,".

(6) Inclusion of marriage and family therapists and mental health counselors as practitioners for assignment of claims.—Section 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

"(vii) A marriage and family therapist (as defined in section 1861(ww)(2)).

"(viii) A mental health counselor (as defined in section 1861(ww)(4)).".

(b) Coverage of Certain Mental Health Services Provided in Certain Settings.—

(1) Rural health clinics and federally qualified health centers.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking "or by a clinical social worker (as defined in subsection (hh)(1))," and inserting ", by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (ww)(2)), or by a mental health counselor (as defined in subsection (ww)(4)),".

(2) Hospice programs.—Section 1861(dd)(2)(B)(i)(III) (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting "or a marriage and family therapist (as defined in subsection (ww)(2))" after "social worker".

(c) Authorization of Marriage and Family Therapists To Develop Discharge Plans for Post-Hospital Services.—Section 1861(ee)(2)(G) (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting "marriage and family therapist (as defined in subsection (ww)(2))," after "social worker,".

(d) Effective Date.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2004.

SA 989. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in subtitle C of title IV, insert the following:

SEC. . INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) In General.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

"(f) Increase in Payment for Services Furnished in a Rural Area.—

"(1) In general.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2003 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

"(2) Waiver of budget neutrality.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).".

(b) Payment Adjustment.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following:"Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.".

(c) Effective Date.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

SA 990. Mrs. MURRAY proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title II, add the following:

SEC. . IMPROVEMENTS IN MEDICARE-ADVANTAGE BENCHMARK DETERMINATIONS.

(a) Revision of National Average Used in Calculation of Blend.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w-23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting "who are enrolled in a MedicareAdvantage plan" after "the average number of medicare beneficiaries".

(b) Change in Budget Neutrality.—Section 1853(c) (42 U.S.C. 1395w-23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) Inclusion of Costs of DOD and VA Military Facility Services to Medicare-eligible Beneficiaries in Calculation of MedicareAdvantage Payment Rates.—

(1) For purposes of calculating medicare+choice payment rates.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w-23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(B) by adding at the end the following new subparagraph:

"(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

SA 991. Mr. HARKIN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

TITLE —MEDICAID DEMONSTRATION PROJECTS

SEC. 01. SHORT TITLE.

This title may be cited as the "Money Follows the Person Act of 2003".

SEC. 02. FINDINGS.

Congress makes the following findings:

(1) In his budget for fiscal year 2004, President George W. Bush proposes a "Money Follows the Person" rebalancing initiative under the medicaid program to help States rebalance their long-term services support systems more evenly between institutional and community-based services.

(2) The President, by proposing this initiative, and Congress, recognize that States have not fully developed the systems needed to create a more equitable balance between institutional and community-based services spending under the medicaid program.

(3) While a few States have been successful at achieving this balance, nationally, approximately 70 percent of the medicaid funding spent for long-term services is devoted to nursing facilities and intermediate care facilities for the mentally retarded. Only 30 percent of such funding is spent for community-based services.

(4) As a result, there are often long waiting lists for community-based services and supports.

(5) In the Americans with Disabilities Act of 1990, Congress found that individuals with disabilities continue to encounter various forms of discrimination, including segregation, and that discrimination persists in such critical areas as institutionalization.

(6) In 1999, the Supreme Court held in *Olmstead v. LC* (527 U.S. 581 (1999)) that needless institutionalization is discrimination under the Americans with Disabilities Act of 1990, noting that institutional placement of people who can be served in the community "perpetuates unwarranted assumptions that persons so isolated are unworthy of participating in community life." (Id. at 600). The Court further found that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." (Id. at 601).

(7) Additional resources would be helpful for assisting States in rebalancing their long-term services support system and complying with the *Olmstead* decision.

SEC. 03. AUTHORITY TO CONDUCT MEDICAID DEMONSTRATION PROJECTS.

(a) DEFINITIONS.—In this section:

(1) COMMUNITY-BASED SERVICES AND SUPPORTS.—The term "community-based services and supports" means, with respect to a State, any items or services that are an allowable expenditure for medical assistance under the State medicaid program, or under a waiver of such program and that the State determines would allow an individual to live in the community.

(2) INDIVIDUAL'S REPRESENTATIVE; REPRESENTATIVE.—The terms "individual's representative" and "representative" mean a parent, family member, guardian, advocate, or authorized representative of an individual.

(3) MEDICAID LONG-TERM CARE FACILITY.—The term "medicaid long-term care facility" means a hospital, nursing facility, or intermediate care facility for the mentally retarded, as such terms are defined for purposes of the medicaid program.

(4) MEDICAID PROGRAM.—The term "medicaid program" means the State medical assistance program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(5) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(6) STATE.—The term "State" has the meaning given such term for purposes of the medicaid program.

(b) STATE APPLICATION.—A State may apply to the Secretary for approval to conduct a demonstration project under which the State shall provide community-based services and supports to individuals—

(1) who are eligible for medical assistance under the medicaid program;

(2) who are residing in a medicaid long-term care facility and who have resided in such facility for at least 90 days; and

(3) with respect to whom there has been a determination that but for the provision of community-based services and supports, the individuals would continue to require the level of care provided in a medicaid long-term care facility.

(c) REQUIREMENTS.—A State is not eligible to conduct a demonstration project under this section unless the State certifies the following:

(1) With respect to any individual provided community-based services and supports under the demonstration project, the State shall continue to provide community-based services and supports to the individual under the medicaid program (and at the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) reimbursement rate), for as long as the individual remains eligible for medical assistance under the State medicaid program and continues to require such services and supports, beginning with the month that begins after the 12-month period in which the individual is provided such services and supports under the demonstration project.

(2) The State shall allow an individual participating in the demonstration project (or, as appropriate, the individual's representative) to choose the setting in which the individual desires to receives the community-based services and supports provided under the project.

(3) The State shall identify and educate individuals residing in a medicaid long-term care facility who are eligible to participate in the demonstration project (and, as appropriate the individual's representative) about the opportunity for the individual to receive community-based services and supports under the demonstration project.

(4) The State shall ensure that each individual identified in accordance with paragraph (3) (and, as appropriate, the individual's representative), has the opportunity, information, and tools to make an informed choice regarding whether to transition to the community through participation in the demonstration project or to remain in the medicaid long-term care facility.

(5) The State shall maintain an adequate quality improvement system so that individuals participating in the demonstration project receive adequate services and supports.

(6) The State shall conduct a process for public participation in the design and development of the demonstration project and such process shall include the participation of individuals with disabilities, elderly individuals, or individuals with chronic conditions who are part of the target populations to be served by the demonstration project, and the representatives of such individuals.

(7) The Federal funds paid to a State pursuant to this section shall only supplement, and shall not supplant, the level of State funds expended for providing community-based services and supports for individuals under the State medicaid program as of the date the State application to conduct a demonstration project under this section is approved.

(d) APPROVAL OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall conduct a competitive application process with respect to applications submitted under subsection (b) (taking into consideration the preferences provided under paragraph (2)) that meet the requirements of subsection (c). In determining whether to approve such an application, the Secretary may waive the requirement of—

(A) section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations;

(B) section 1902(a)(10)(B) of such Act (42 U.S.C. 1396a(a)(10)(B)) with respect to comparability; and

(C) section 1902(a)(10)(C)(i)(III) of such Act (42 U.S.C. 1396a(a)(10)(C)(i)(III)) with respect to income and resource limitations.

(2) Preference for certain applications.—In approving applications to conduct demonstration projects under this section, the Secretary shall give preference to approving applications that indicate that the State shall do the following:

(A) Design and implement enduring improvements in community-based long-term services support systems within the State to enable individuals with disabilities to live and participate in community life, particularly with respect to those practices that will ensure the successful transition of such individuals from medicaid long-term care facilities into the community.

(B) Design and implement a long-term services support system in the State that prevents individuals from entering medicaid long-term care facilities in order to gain access to community-based services and supports.

(C) Engage in systemic reform activities within the State to rebalance expenditures for long-term services under the State medicaid program through administrative actions that reduce reliance on institutional forms of service and build up more community capacity.

(D) Address the needs of populations that have been underserved with respect to the availability of community services or involve individuals or entities that have not previously participated in the efforts of the State to increase access to community-based services.

(E) Actively engage in collaboration between public housing agencies, the State medicaid agency, independent living centers, and other agencies and entities in order to coordinate strategies for obtaining community integrated housing and supportive services for an individual who participates in the demonstration project, both with respect to the period during which such individual participates in the project and after the individual's participation in the project concludes, in order to enable the individual to continue to reside in the community.

(F) Develop and implement policies and procedures that allow the State medicaid agency to administratively transfer or integrate funds from the State budget accounts that are obligated for expenditures for medicaid long-term care facilities to other accounts for obligation for the provision of community-based services and supports (including accounts related to the provision of such services under a waiver approved under section 1915 of the Social Security Act (42 U.S.C. 1396n)) when an individual transitions from residing in such a facility to residing in the community.

(e) Payments to States.—

(1) In general.—The Secretary shall pay to each State with a demonstration project approved under this section an amount for each quarter occurring during the period described in paragraph (2) equal to 100 percent of the State's expenditures in the quarter for providing community-based services and supports to individuals participating in the demonstration project.

(2) Period described.—The period described in this paragraph is the 12-month period that begins on the date on which an individual first receives community-based services and supports under the demonstration project in a setting that is not a medicaid long-term care facility and is selected by the individual.

(f) Reports.—

(1) In general.—Each State conducting a demonstration project under this section shall submit a report to the Secretary that, in addition to such other requirements as the Secretary may require, includes information regarding—

(A) the types of community-based services and supports provided under the demonstration project;

(B) the number of individuals served under the project;

(C) the expenditures for, and savings resulting from, conducting the project; and

(D) to the extent applicable, the changes in State's long-term services system developed in accordance with the provisions of subsection (d)(2).

(2) Uniform data format.—In requiring information under this subsection, the Secretary shall develop a uniform data format to be used by States in the collection and submission of data in the State report required under paragraph (1).

(g) Evaluations.—The Secretary shall use an amount, not to exceed one-half of 1 percent of the amount appropriated under subsection (h) for each fiscal year, to provide, directly or through contract—

(1) for the evaluation of the demonstration projects conducted under this section;

(2) technical assistance to States concerning the development or implementation of such projects; and

(3) for the collection of the data described in subsection (f)(1).

(h) Funding.—There is appropriated to carry out this section, $350,000,000 for each of fiscal years 2004 through 2008. Funds appropriated under the preceding sentence for a fiscal year shall remain available until expended, but not later than September 30, 2008.

SEC. 04. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority To Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 992. Mr. BAUCUS (for Ms. STABENOW (for herself and Ms. SNOWE)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 158, between lines 4 and 5, insert the following:

(f) Clarification of State Authority Relating to Medicaid Drug Rebate Agreements.—Section 1927 (42 U.S.C. 1396r-8) is amended by adding at the end the following:

"(l) Rule of Construction.—Nothing in this section shall be construed as prohibiting a State from—

"(1) directly entering into rebate agreements (on the State's own initiative or under a section 1115 waiver approved by the Secretary before, on, or after the date of enactment of this subsection) that are similar to a rebate agreement described in subsection

(b) with a manufacturer for purposes of ensuring the affordability of outpatient prescription drugs in order to provide access to such drugs by residents of a State who are not otherwise eligible for medical assistance under this title; or

"(2) making prior authorization (that satisfies the requirements of subsection (d) and that does not violate any requirements of this title that are designed to ensure access to medically necessary prescribed drugs for individuals enrolled in the State program under this title) a condition of not participating in such a similar rebate agreement.".

SA 993. Mr. BAUCUS (for Mr. DORGAN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place in title IV, insert the following:

SEC. . COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V)(iii), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) cardiovascular screening tests (as defined in subsection (ww)(1));".

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Cardiovascular Screening Tests

"(ww)(1) The term 'cardiovascular screening tests' means the following diagnostic tests for the early detection of cardiovascular disease:

"(A) Tests for the determination of cholesterol levels.

"(B) Tests for the determination of lipid levels of the blood.

"(C) Such other tests for cardiovascular disease as the Secretary may approve.

"(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

"(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SA 994. Mr. DURBIN (for himself, Mr. CORZINE, Mr. HARKIN, Mrs. BOXER, Ms. STABENOW, Mr. DAYTON, and Mr. BYRD) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Beginning on page 48, strike line 13 through page 50, line 2 and insert the following:

"(1) NO DEDUCTIBLE.—

"(A) IN GENERAL.—The coverage provides for benefits without the application of a deductible.

"(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply section 1860D–19(a)(3)(A)(ii).

"(2) LIMITS ON COST-SHARING.—

"(A) IN GENERAL.—The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under paragraph (4)) that is equal to 30 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 30 percent of such costs.

"(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a).

On page 50, line 15, strike "$3,700" and insert "$1,500".

On page 51, strike lines 15 through 25 and insert the following:

"(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Beginning on page 77, strike line 10 and all that follows through page 84, line 7, and insert the following:

"(e) MEDICARE OPERATED PLAN OPTION.—

"(1) ACCESS.—The Administrator shall establish and operate a national plan to provide any eligible beneficiary enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage, enrolled in a MedicareAdvantage plan) electing such plan with standard prescription drug coverage. Under such plan, the Administrator shall negotiate with pharmaceutical manufacturers with respect to the purchase price of covered drugs and shall encourage the use of more affordable therapeutic equivalents to the extent such practices do not override medical necessity as determined by the prescribing physician. To the extent practicable and consistent with the previous sentence, the Administrator shall implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, to reduce the purchase cost of covered drugs. Eligible beneficiaries enrolled under this part shall have the option of enrolling in such plan or in a Medicare Prescription Drug plan or a MedicareAdvantage plan available in the area in which the beneficiary resides.

"(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

"(A) IN GENERAL.—In the case of an eligible beneficiary enrolled in the plan operated by the Administrator under paragraph (1), the monthly beneficiary obligation of such beneficiary for such enrollment shall be—

"(i) for months in the first year of implementation, $35; and

"(ii) for months in a subsequent year, the lesser of—

"(I) the amount determined under this paragraph for months in the previous year, increased by the annual percentage increase described in section 1860D–6(c)(5) for the year involved; or

"(II) in the case of months in years prior to 2014, the specified amount.

"(B) SPECIFIED AMOUNT.—For purposes of this paragraph, the term 'specified amount' means—

"(i) for months in the second year of implementation, $37;

"(ii) for months in the third year of implementation, $40;

"(iii) for months in the fourth year of implementation, $43;

"(iv) for months in the fifth year of implementation, $46;

"(v) for months in the sixth year of implementation, $51;

"(vi) for months in the seventh year of implementation, $54; and

"(vii) for months in the eighth year of implementation, $59.

"(3) NO AFFECT ON ACCESS REQUIREMENTS.—The plan operated by the Administrator under paragraph (1) shall be in addition to the plans required under subsection (d)(1).

"(4) REQUIREMENT TO PREVENT INCREASED COSTS.—If the Administrator determines that Federal payments made with respect to eligible beneficiaries enrolled in the plan operated by the Administrator under paragraph (1) exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan (with respect to qualified prescription drug coverage), the Administrator shall adjust the requirements or payments under such a contract to eliminate such excess.

"(f) TWO-YEAR CONTRACTS.—A contract approved under this section for a Medicare Prescription Drug plan shall be for a 2-year period.

"(g) IMPLEMENTATION OF PART D.—Notwithstanding any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part as soon as practicable after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, but in no case later than January 1, 2006. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part.

On page 134, strike line 9 and insert the following:

under paragraph (1).

"(d) SPECIAL RULES FOR STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part, in the case of the sponsor of a State pharmaceutical assistance program that seeks to offer a Medicare Prescription Drug plan under this part, the following special rules apply:

"(A) WAIVER OF LICENSURE.—Section 1860D–7(a)(1) shall not apply.

"(B) PERMITTING LIMITATION ON ENROLLMENT.—The sponsor may restrict eligibility to enroll in the plan to those low-income individuals who qualify (or meet the standards for qualification) for the State pharmaceutical assistance program.

"(C) OTHER REQUIREMENTS.—The Administrator may waive such other requirements of this part as the Administrator finds appropriate to promote the role of State pharmaceutical assistance programs under this part.

"(2) DEFINITION.—For purposes of this part, the term 'State pharmaceutical assistance program' means a program, in operation as of the date of enactment of this title, that is sponsored or underwritten by a State, that was established pursuant to a waiver under section 1115 or otherwise, and that provides financial assistance with out-of-pocket expenses with respect to covered outpatient drugs for individuals in the State who meet income-related qualifications specified under such program.

“(3) CONSTRUCTION.—Nothing in this subsection shall affect the provisions of subsection (b).”.

At the end of title VI, add the following:

SEC. . NEED FOR RENEWAL.

(a) IN GENERAL.—Notwithstanding any other provision of law, the provisions of, and amendments made by, this Act shall remain in effect but shall be superseded by the Director of the Office of Management and Budget on the date that the total of the increased Federal expenditures by reason of such amendments and provisions has reached $400,000,000,000.

(b) APPLICATION.—Any provision of law amended or effected by this Act shall be applied and administered after the date described in subsection (a) as if the provisions of, and amendments made by, this Act had never been enacted.

(c) NOTIFICATION.—The Director of the Office of Management and Budget shall notify Congress 6 months prior to the date that the provisions of, and amendments made by, this Act will be superseded pursuant to subsection (a).

SA 995. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . ELIMINATION OF LIMITATION ON WORK GEOGRAPHIC ADJUSTMENT UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848(e)(1)(A)(iii) (42 U.S.C. 1395w-4(e)(1)(A)(iii)) is amended by inserting “(or, for purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, 100 percent)” after “¼”.

SA 996. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

In section 445(a) of the bill, strike paragraph (6) and insert the following:

“(6) an evaluation of the appropriateness of extending such adjustment or making such adjustment permanent;

“(7) an evaluation of the adjustment of the work geographic practice cost index required under section 1848(e)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(A)(iii)) to reflect ¼ of the area cost difference in physician work;

“(8) an evaluation of the effect of the adjustment described in paragraph (7) on physician location and retention in higher than average cost-of-living areas, taking into account difference in recruitment costs and retention rates for physicians, including specialists; and

“(9) an evaluation of the appropriateness of the ¼ adjustment for the work geographic practice cost index.”.

SA 997. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 401, between lines 4 and 5, insert the following:

“(C) EDUCATION AND OUTREACH CAMPAIGN.—

“(i) PROGRAM REQUIREMENTS.—

“(I) IN GENERAL.—The Office of Beneficiary Assistance, in collaboration with the Administrator of the Center for Medicare & Medicaid Services, shall conduct education and outreach programs that are designed to inform hard to reach populations, minority populations, and rural and frontier populations, about the medicare program, and particularly about the medicare fee-for-service program under parts A and B, and the prescription drug benefit established under part D and the plan options under that part, including the low-income subsidies provided under section 1860D–19.

“(II) DISSEMINATION.—Programs conducted under clause (i) shall produce and disseminate information in major languages, and shall conduct other outreach activities, including mailings and low-income subsidy enrollment assistance, in coordination with other appropriate Federal and State agencies.

“(III) SITES.—Outreach and enrollment assistance activities shall be conducted under such programs at sites that provide, determine eligibility for, or enroll, low-income individuals under other Federal, State, or local assistance programs, including such sites operated under Federal, State, or local low-income housing, energy, nutrition, health, and social services programs.

“(IV) COSTS.—The Administrator of the Center for Medicare Choices shall reimburse other Federal, State, and local agencies for the expenses such agencies incur that are attributable to providing coordination with the education and outreach programs conducted under this subparagraph. The Secretary shall determine the appropriate administrative expenses that are to be allocated between the Center for Medicare Choices and the Centers for Medicare & Medicaid Services as a result of the collaboration required under this clause.

“(ii) MODEL FORM.—

“(I) IN GENERAL.—The Office of Beneficiary Assistance, in coordination and cooperation with the Administrator of the Center for Medicare & Medicaid Services, shall devise a model application form for the premium and cost-sharing subsidies established under section 1860D–19 and shall make such form available for use by the States.

“(II) REQUIREMENTS.—The model form devised under subclause (I) shall be as simple as possible, shall be designed so that the form is capable of being completed without a face-to-face interview and of being filed electronically, and shall apply for multiyear periods, with beneficiaries required to report any disqualifying increases in income or assets to the Administrator of the Center for Medicare Choices.

SA 998. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 20, and insert the following:

“(2) AMOUNT OF PAYMENT.—The amount of the payment under paragraph (1) shall be an amount equal to the monthly national average premium for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

SA 999. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 389, between lines 6 and 7, insert the following:

SEC. . PRIORITY AREA QUALITY INDICATORS.

(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Quality Interagency Coordination Task Force, the Institute of Medicine, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, the American Health Quality Association, the National Quality Forum, and other individuals and organizations determined appropriate by the Secretary of Health and Human Services, shall assemble, evaluate, and, where necessary, develop or update quality indicators for each of the 20 priority areas for improvement in health care quality as identified by the Institute of Medicine in their report entitled “Priority Areas for National Action” in 2003, in order to assist medicare beneficiaries in making informed choices about health plans. The selection of appropriate quality indicators under this subsection shall include the evaluation criteria formulated by clinical professionals, consumers, data collection experts.

(b) RISK ADJUSTMENT.—In developing the quality indicators under subsection (a), the Director of the Agency for Healthcare Research and Quality shall ensure that adequate risk adjustment is provided for.

(c) BEST PRACTICES.—In carrying out this section, the Director of the Agency for Healthcare Research and Quality shall—

(1) assess data concerning appropriate clinical treatments based on the best scientific evidence available;

(2) determine areas in which there is insufficient evidence to determine best practices; and

(3) compare existing quality indicators to best clinical practices, validate appropriate indicators, and report on areas where additional research is needed before indicators can be developed.

(d) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Director of the National Institutes of Health a report concerning areas of clinical care requiring farther research necessary to establish effective clinical treatments that will serve as a basis for quality indicators; and

(2) submit to Congress a report on the state of quality measurement for priority areas that links data to the report submitted under paragraph (1) for the year involved.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $12,000,000 for fiscal year 2004, and $8,000,000 for each of fiscal years 2005 through 2009.

SEC. . STANDARDIZED QUALITY INDICATORS FOR FEDERAL AGENCIES.

(a) IN GENERAL.—In addition to other activities to be carried out by the Quality Interagency Coordination Taskforce (as established by executive order on March 13, 1998), such Taskforce shall standardize indicators of health care quality that are used in all Federal agencies, as appropriate.

(b) CONSULTATION.—In carrying out subsection (a), the Quality Interagency Coordination Taskforce shall consult with a public-private consensus organization (such as the National Quality Forum) to enhance the likelihood of the simultaneous application of the standardized indicators under subsection (a) in the private sector.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the progress made by the Quality Interagency Coordination Taskforce to standardizing quality indicators throughout the Federal Government.

SEC. . DEMONSTRATION PROGRAM FOR COMMUNITY HEALTH CARE QUALITY DATA REPORTING.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Quality and Research, shall award not to exceed 20 grants to eligible communities for the establishment of demonstration programs for the reporting of health care quality information at the community level.

(b) QUALITY INDICATORS.—

(1) IN GENERAL.—For purposes of reporting information under the demonstration programs under this section, indicators of health care quality may include the indicators developed for the 20 priority areas as identified by the Institute of Medicine in the report entitled "Priority Areas for National Action", 2003, or other indicators determined appropriate by the Secretary of Health and Human Services.

(2) TYPE OF DATA.—All quality indicators with respect to which reporting will be carried out under the demonstration program shall be reported by race, ethnicity, gender, and age.

(c) ELIGIBILITY.—The Secretary of Health and Human Services shall award grants to communities under this section based on competitive proposals and criteria to be determined jointly by the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality. Such criteria may include a demonstrated ability of the community to collect data on quality indicators and a demonstrated ability to effectively transmit community-level health status results to relevant stakeholders.

(d) TECHNICAL ADVISORY COMMITTEE.—The Secretary of Health and Human Services shall establish a technical advisory committee to assist grantees in data collection, data analysis, and report dissemination.

(e) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Congress a report on the results of the demonstration programs under this section; and

(2) make such reports publicly available, including by posting the reports on the Internet.

(f) EVALUATION.—The Secretary of Health and Human Services shall, upon awarding grants under subsection (a), enter into a contract for the evaluation of demonstration programs under this section. Such evaluation shall compare the effectiveness of such demonstration programs in collecting and reporting required data, and on the effectiveness of distributing information to key stakeholders in a timely fashion. Such evaluations shall provide for a report on best practices.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $25,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

SA 1000. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. . STUDY ON EFFECTIVENESS OF CERTAIN PRESCRIPTION DRUGS.

(a) IN GENERAL.—

(1) RESEARCH BY NIH.—The Director of the National Institutes of Health, in coordination with the Director of the Agency for Healthcare Research and Quality and the Commissioner of Food and Drugs, shall conduct research, which may include clinical research, to develop valid scientific evidence regarding the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(2) ANALYSIS BY AHRQ.—

(A) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, taking into consideration the research and data from the National Institutes of Health and the Food and Drug Administration, shall use evidence-based practice centers to synthesize available data or conduct other analyses of the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(B) SAFETY.—In any analysis of comparative effectiveness under this subparagraph, the Director of the Agency for Healthcare Research and Quality shall include a discussion of available information on relative safety.

(3) STANDARDS.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Commissioner of Food and Drugs, the Director of the National Institutes of Health, and with input from stakeholders, shall develop standards for the design and conduct of studies under this subsection.

(b) COVERED PRESCRIPTION DRUGS.—For purposes of this section, the term "covered prescription drugs" means prescription drugs that, as determined by the Director of the Agency for Healthcare Research and Quality in consultation with the Administrator of the Centers for Medicare & Medicaid Services, account for high levels of expenditures, high levels of use, or high levels of risk to individuals in federally funded health programs, including Medicare and Medicaid.

(c) DISSEMINATION.—

(1) ANNUAL REPORT.—Each year the Secretary shall prepare a report on the results of the research, studies, and analyses conducted by the National Institutes of Health and the Agency for Healthcare Research and Quality, and the Food and Drug Administration under this section and submit the report to the following:

(A) Congress.

(B) The Secretary of Defense.

(C) The Secretary of Veterans Affairs.

(D) The Administrator of the Centers for Medicare & Medicaid Services.

(E) The Director of the Indian Health Service.

(F) The Director of the National Institutes of Health.

(G) The Director of the Office of Personnel Management.

(H) The Commissioner of Food and Drugs.

(2) REPORTS FOR PRACTITIONERS.—As soon as possible, but not later than a year after the completion of any study pursuant to subsection (a)(2), the Director of the Agency for Healthcare Research and Quality shall—

(A) prepare a report on the results of such study for the purpose of informing health care practitioners; and

(B) transmit the report to the Director of the National Institutes of Health.

(3) FDA DRUG INFORMATION.—The Commissioner of Food and Drugs shall—

(A) review all data and information from studies and analyses conducted or prepared under this section; and

(B) develop appropriate summaries of such information for inclusion in adequate directions for use under section 502(f)(1) of the Federal Food, Drug, and Cosmetic Act and in summaries relating to side effects, contraindications, and effectiveness under section 502(n) of that Act.

(4) NIH INTERNET SITE.—The Director of the National Institutes of Health shall publish on the Institutes' Internet site and through other means that will facilitate access by practitioners, each report prepared under this subsection by the Director of the Agency for Healthcare Research and Quality.

(d) EVIDENCE.—In carrying out this section, the Director of the National Institutes of Health and the Agency for Healthcare Research and Quality shall consider only methodologically sound studies, giving preference to studies for which the Directors have access to sufficient underlying data and analysis to address any significant concerns about methodology or the reliability of data.

(e) AUTHORIZATIONS OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $75,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nominations on today's Executive Calendar: Calendar Nos. 160, 204, 205, 241, 243, 244, and

245. I further ask unanimous consent that the nominations be confirmed, the motions to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

The nominations considered and confirmed are as follows:

AIR FORCE

The following Air National Guard of the United States officers for appointment in the Reserve of the Air Force to the grades indicated under title 10, U.S.C., section 12203:

To be major general

BRIGADIER GENERAL JOHN B. HANDY, 8277
BRIGADIER GENERAL MARVIN S. MAYES, 9378
BRIGADIER GENERAL DOUGLAS R. MOORE, 5347
BRIGADIER GENERAL RICHARD L. TESTA, 1268

To be brigadier general

COLONEL JOSEPH G. BALSKUS, 7948
COLONEL BOBBY L. BRITTAN, 2797
COLONEL THOMAS J. DEARDORFF, 4064
COLONEL MICHAEL P. HICKEY, 3174
COLONEL CHARLES V. ICKES, II, 1323
COLONEL WILLIAM B. JERNIGAN, 8012
COLONEL HENRY C. MORROW, 7671
COLONEL DONALD J. QUENNEVILLE, 4967
COLONEL DANIEL R. SCACE, 6048
COLONEL TIMOTHY W. SCOTT, 4093
COLONEL EUGENE A. SEVI, 2584
COLONEL DARRYLL D.M. WONG, 0536

AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. JOHN W. ROSA, JR., 3351

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 8069:

To be major general

BRIG. GEN. BARBARA C. BRANNON, 0424

DEPARTMENT OF HOMELAND SECURITY

FRANK LIBUTTI, OF NEW YORK, TO BE UNDER SECRETARY FOR INFORMATION ANALYSIS AND INFRASTRUCTURE PROTECTION, DEPARTMENT OF HOMELAND SECURITY.

COAST GUARD

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES COAST GUARD RESERVE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be rear admiral

REAR ADM. (LH) DUNCAN C. SMITH, 4654

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES COAST GUARD TO THE GRADE INDICATED UNDER TITLE 14, U.S.C., SECTION 271:

To be rear admiral

REAR ADM. (LH) SALLY BRICE-O'HARA, 1553
REAR ADM. (LH) HARVEY E. JOHNSON, 4015
REAR ADM. (LH) DAVID W. KUNKEL, 0746
REAR ADM. (LH) DAVID B. PETERMAN, 8115

THE FOLLOWING NAMED INDIVIDUAL FOR APPOINTMENT AS PERMANENT COMMISSIONED REGULAR OFFICER IN THE UNITED STATES COAST GUARD IN THE GRADE INDICATED UNDER TITLE 14, U.S.C., SECTION 211:

To be lieutenant

MARY ANN C. GOSLING, 7976

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will now return to legislative session.

TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT ACT OF 2003

Mr. GRASSLEY. I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 123, S. 239.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 239) to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. GRASSLEY. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 239) was read the third time and passed, as follows:

S. 239

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Trauma Care Systems Planning and Development Act of 2003".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The Federal Government and State governments have established a history of cooperation in the development, implementation, and monitoring of integrated, comprehensive systems for the provision of emergency medical services.

(2) Trauma is the leading cause of death of Americans between the ages of 1 and 44 years and is the third leading cause of death in the general population of the United States.

(3) In 1995, the total direct and indirect cost of traumatic injury in the United States was estimated at $260,000,000,000.

(4) There are 40,000 fatalities and 5,000,000 nonfatal injuries each year from motor vehicle-related trauma, resulting in an aggregate annual cost of $230,000,000,000 in medical expenses, insurance, lost wages, and property damage.

(5) Barriers to the receipt of prompt and appropriate emergency medical services exist in many areas of the United States.

(6) The number of deaths from trauma can be reduced by improving the systems for the provision of emergency medical services in the United States.

(7) Trauma care systems are an important part of the emergency preparedness system needed for homeland defense.

SEC. 3. AMENDMENTS.

(a) ESTABLISHMENT.—Section 1201 of the Public Health Service Act (42 U.S.C. 300d) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1), by inserting ", acting through the Administrator of the Health Resources and Services Administration," after "Secretary";

(B) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively;

(C) by inserting after paragraph (2) the following:

"(3) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration to the unique needs of rural areas;";

(D) in paragraph (4), as redesignated by subparagraph (B)—

(i) by inserting "to enhance each State's capability to develop, implement, and sustain the trauma care component of each State's plan for the provision of emergency medical services" after "assistance"; and

(ii) by striking "and" after the semicolon;

(E) in paragraph (5), as redesignated by subparagraph (B), by striking the period at the end and inserting "; and"; and

(F) by adding at the end the following:

"(6) promote the collection and categorization of trauma data in a consistent and standardized manner.";

(2) in subsection (b), by inserting ", acting through the Administrator of the Health Resources and Services Administration," after "Secretary"; and

(3) by striking subsection (c).

(b) CLEARINGHOUSE ON TRAUMA CARE AND EMERGENCY MEDICAL SERVICES.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended—

(1) by striking section 1202; and

(2) by redesignating section 1203 as section 1202.

(c) ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.—Section 1202(a) of the Public Health Service Act, as such section was redesignated by subsection (b), is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting ", such as advanced trauma life support," after "model curricula";

(2) in paragraph (4), by striking "and" after the semicolon;

(3) in paragraph (5), by striking the period and inserting "; and"; and

(4) by adding at the end the following:

"(6) by increasing communication and coordination with State trauma systems.".

(d) REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.—Section 1212 of the Public Health Service Act (42 U.S.C. 300d–12) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (A), by striking "and" after the semicolon; and

(B) by striking subparagraph (B) and inserting the following:

"(B) for the third fiscal year of such payments to the State, not less than $1 for each $1 of Federal funds provided in such payments for such fiscal year;

"(C) for the fourth fiscal year of such payments to the State, not less than $2 for each $1 of Federal funds provided in such payments for such fiscal year; and

"(D) for the fifth fiscal year of such payments to the State, not less than $2 for each $1 of Federal funds provided in such payments for such fiscal year."; and

(2) in subsection (b)—

(A) in paragraph (1), by adding "and" after the semicolon;

(B) in paragraph (2), by striking "; and" and inserting a period; and

(C) by striking paragraph (3).

(e) REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.—Section 1213 of the Public Health Service Act (42 U.S.C. 300d–13) is amended—

(1) in subsection (a)—

(A) in paragraph (3), in the matter preceding subparagraph (A), by inserting "nationally recognized" after "contains";

(B) in paragraph (5), by inserting "nationally recognized" after "contains";

(C) in paragraph (6), by striking "specifies procedures for the evaluation of designated" and inserting "utilizes a program with procedures for the evaluation of";

(D) in paragraph (7)—

(i) in the matter preceding subparagraph (A), by inserting "in accordance with data collection requirements developed in consultation with surgical, medical, and nursing specialty groups, State and local emergency medical services directors, and other trained professionals in trauma care" after "collection of data";

(ii) in subparagraph (A), by inserting "and the number of deaths from trauma" after "trauma patients"; and

(iii) in subparagraph (F), by inserting "and the outcomes of such patients" after "for such transfer";

(E) by redesignating paragraphs (10) and (11) as paragraphs (11) and (12), respectively; and

(F) by inserting after paragraph (9) the following:

"(10) coordinates planning for trauma systems with State disaster emergency planning and bioterrorism hospital preparedness planning;";

(2) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "concerning such" and inserting "that outline resources for optimal care of the injured patient"; and

(ii) in subparagraph (D), by striking "1992" and inserting "2004"; and

(B) in paragraph (3)—

(i) in subparagraph (A), by striking "1991" and inserting "2004"; and

(ii) in subparagraph (B), by striking "1992" and inserting "2004"; and

(3) in subsection (c), by striking "1990, the Secretary shall develop a model plan" and inserting "2003, the Secretary shall update the model plan".

(f) Requirement of Submission to Secretary of Trauma Plan and Certain Information.—Section 1214(a) of the Public Health Service Act (42 U.S.C. 300d-14(a)) is amended—

(1) in paragraph (1)—

(A) by striking "1991" and inserting "2004"; and

(B) by inserting "that includes changes and improvements made and plans to address deficiencies identified" after "medical services"; and

(2) in paragraph (2), by striking "1991" and inserting "2004".

(g) Restrictions on Use of Payments.—Section 1215(a)(1) of the Public Health Service Act (42 U.S.C. 300d-15(a)(1)) is amended by striking the period at the end and inserting a semicolon.

(h) Requirements of Reports by States.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by striking section 1216 and inserting the following:

"SEC. 1216. [RESERVED].".

(i) Report by the Secretary.—Section 1222 of the Public Health Service Act (42 U.S.C. 300d-22) is amended by striking "1995" and inserting "2006".

(j) Funding.—Section 1232(a) of the Public Health Service Act (42 U.S.C. 300d-32(a)) is amended to read as follows:

"(a) Authorization of Appropriations.—For the purpose of carrying out parts A and B, there are authorized to be appropriated $12,000,000 for fiscal year 2004, and such sums as may be necessary for each of the fiscal years 2005 through 2008.".

(k) Conforming Amendment.—Section 1232(b)(2) of the Public Health Service Act (42 U.S.C. 300d-32(b)(2)) is amended by striking "1204" and inserting "1202".

(l) Institute of Medicine Study.—Part E of title XII of the Public Health Service Act (20 U.S.C. 300d-51 et seq.) is amended—

(1) by striking the part heading and inserting the following:

"Part E—Miscellaneous Programs"; and

(2) by adding at the end the following:

"SEC. 1254. INSTITUTE OF MEDICINE STUDY.

"(a) In General.—The Secretary shall enter into a contract with the Institute of Medicine of the National Academy of Sciences, or another appropriate entity, to conduct a study on the state of trauma care and trauma research.

"(b) Content.—The study conducted under subsection (a) shall—

"(1) examine and evaluate the state of trauma care and trauma systems research (including the role of Federal entities in trauma research) on the date of enactment of this section, and identify trauma research priorities;

"(2) examine and evaluate the clinical effectiveness of trauma care and the impact of trauma care on patient outcomes, with special attention to high-risk groups, such as children, the elderly, and individuals in rural areas;

"(3) examine and evaluate trauma systems development and identify obstacles that prevent or hinder the effectiveness of trauma systems and trauma systems development;

"(4) examine and evaluate alternative strategies for the organization, financing, and delivery of trauma care within an overall systems approach; and

"(5) examine and evaluate the role of trauma systems and trauma centers in preparedness for mass casualties.

"(c) Report.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to the appropriate committees of Congress a report containing the results of the study conducted under this section.

"(d) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $750,000 for each of fiscal years 2004 and 2005.".

(m) Residency Training Programs in Emergency Medicine.—Section 1251(c) of the Public Health Service Act (42 U.S.C. 300d-51(c)) is amended by striking "1993 through 1995" and inserting "2004 through 2008".

(n) State Grants for Projects Regarding Traumatic Brain Injury.—Section 1252 of the Public Health Service Act (42 U.S.C. 300d-52) is amended in the section heading by striking "**DEMONSTRATION**".

(o) Interagency Program for Trauma Research.—Section 1261 of the Public Health Service Act (42 U.S.C. 300d-61) is amended—

(1) in subsection (a), by striking "conducting basic" and all that follows through the period at the end of the second sentence and inserting "basic and clinical research on trauma (in this section referred to as the 'Program'), including the prevention, diagnosis, treatment, and rehabilitation of trauma-related injuries.";

(2) by striking subsection (b) and inserting the following:

"(b) Plan for Program.—The Director shall establish and implement a plan for carrying out the activities of the Program, taking into consideration the recommendations contained within the report of the NIH Trauma Research Task Force. The plan shall be periodically reviewed, and revised as appropriate.";

(3) in subsection (d)—

(A) in paragraph (4)(B), by striking "acute head injury" and inserting "traumatic brain injury"; and

(B) in subparagraph (D), by striking "head" and inserting "traumatic";

(4) by striking subsection (g);

(5) by redesignating subsections (h) and (i) as subsections (g) and (h), respectively; and

(6) in subsection (h), as redesignated by paragraph (5), by striking "2001 through 2005" and inserting "2004 through 2008".

NATIONAL MUSEUM OF AFRICAN AMERICAN HISTORY AND CULTURE ACT

Mr. GRASSLEY. I ask unanimous consent that the Rules Committee be discharged from further consideration of S. 1157 and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the bill by title.

The legislative clerk read as follows:

> A bill (S. 1157) to establish within the Smithsonian Institution the National Museum of African American History and Culture, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. KENNEDY. Mr. President, I strongly support S. 1157, the National Museum of African American History and Culture Act. The story of African Americans is a major part of the story of the United States. From the dark times of slavery, civil war, and reconstruction, to the extraordinary accomplishments of the civil rights movement of the past half century, it is essential for all Americans to know and understand that story in all its aspects, and this new museum in the Nation's Capital will be an especially valuable resource in achieving that goal. It will be a valuable cultural and educational experience for every visitor to Washington and for every student of American history in communities across the country.

Our Nation was founded on a promise of equality and opportunity for all, and for more than two centuries, we have struggled to fulfill that great promise. The struggle goes on today, on critical issues, such as guaranteeing that all our citizens are free from hate crimes and racial profiling, and are free to go to the polls and vote without intimidation or attempts to suppress their votes.

We know that civil rights is still the great unfinished business of America. As Robert Kennedy told the students at the University of Cape Town, at a time when the specter of apartheid hung heavily over South Africa:

> We must recognize the full human equality of all our people—before God, before the law, and in the councils of governments. We must do this, not because it is economically advantageous—although it is; not because the laws of God and man command it—although they do command it; not because people in other lands wish it to. We must do it for the single and fundamental reason that it is the right thing to do.

It is especially appropriate that this new museum dedicated to African-American history and culture will be part of the Smithsonian Institution in Washington. It is long overdue, and this legislation will help advance the cause.

This museum will be renowned as a source of African-American history throughout the United States. In cooperation with other museums, with historically black colleges, and with many other historical, cultural, and educational institutions, it will make this part of the Nation's history as widely available as possible. And millions of visitors who come here from throughout the world will be inspired by what they see and learn.

It is an honor to be a sponsor of this legislation, and I urge my colleagues to support it.

Mr. GRASSLEY. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to this matter be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 1157) was read the third time and passed, as follows:

S. 1157

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "National Museum of African American History and Culture Act".

SEC. 2. FINDINGS.

Congress finds that—

(1) since its founding, the United States has grown into a symbol of democracy and freedom around the world, and the legacy of African Americans is rooted in the very fabric of the democracy and freedom of the United States;

(2) there exists no national museum within the Smithsonian Institution located on the National Mall that—

(A) is devoted to the documentation of African American life, art, history, and culture; and

(B) encompasses, on a national level—

(i) the period of slavery;

(ii) the era of reconstruction;

(iii) the Harlem renaissance;

(iv) the civil rights movement; and

(v) other periods associated with African American life, art, history, and culture; and

(3) a National Museum of African American History and Culture would be dedicated to the collection, preservation, research, and exhibition of African American historical and cultural material reflecting the breadth and depth of the experiences of individuals of African descent living in the United States.

SEC. 3. DEFINITIONS.

In this Act:

(1) BOARD OF REGENTS.—The term "Board of Regents" means the Board of Regents of the Smithsonian Institution.

(2) COUNCIL.—The term "Council" means the National Museum of African American History and Culture Council established by section 5.

(3) MUSEUM.—The term "Museum" means the National Museum of African American History and Culture established by section 4.

(4) SECRETARY.—The term "Secretary" means the Secretary of the Smithsonian Institution.

SEC. 4. ESTABLISHMENT OF MUSEUM.

(a) ESTABLISHMENT.—There is established within the Smithsonian Institution a museum to be known as the "National Museum of African American History and Culture".

(b) PURPOSE.—The purpose of the Museum shall be to provide for—

(1) the collection, study, and establishment of programs relating to African American life, art, history, and culture that encompass—

(A) the period of slavery;

(B) the era of reconstruction;

(C) the Harlem renaissance;

(D) the civil rights movement; and

(E) other periods of the African American diaspora;

(2) the creation and maintenance of permanent and temporary exhibits documenting the history of slavery in America and African American life, art, history, and culture during the periods referred to in paragraph (1);

(3) the collection and study of artifacts and documents relating to African American life, art, history, and culture; and

(4) collaboration between the Museum and other museums, historically black colleges and universities, historical societies, educational institutions, and other organizations that promote the study or appreciation of African American life, art, history, or culture, including collaboration concerning—

(A) development of cooperative programs and exhibitions;

(B) identification, management, and care of collections; and

(C) training of museum professionals.

SEC. 5. COUNCIL.

(a) ESTABLISHMENT.—There is established within the Smithsonian Institution a council to be known as the "National Museum of African American History and Culture Council".

(b) DUTIES.—

(1) IN GENERAL.—The Council shall—

(A) make recommendations to the Board of Regents concerning the planning, design, and construction of the Museum;

(B) advise and assist the Board of Regents on all matters relating to the administration, operation, maintenance, and preservation of the Museum;

(C) recommend annual operating budgets for the Museum to the Board of Regents;

(D) report annually to the Board of Regents on the acquisition, disposition, and display of objects relating to African American life, art, history, and culture; and

(E) adopt bylaws for the operation of the Council.

(2) PRINCIPAL RESPONSIBILITIES.—The Council, subject to the general policies of the Board of Regents, shall have sole authority to—

(A) purchase, accept, borrow, and otherwise acquire artifacts and other property for addition to the collections of the Museum;

(B) loan, exchange, sell, and otherwise dispose of any part of the collections of the Museum, but only if the funds generated by that disposition are used for—

(i) additions to the collections of the Museum; or

(ii) programs carried out under section 7(a); and

(C) specify criteria with respect to the use of the collections and resources of the Museum, including policies on programming, education, exhibitions, and research with respect to—

(i) the life, art, history, and culture of African Americans;

(ii) the role of African Americans in the history of the United States from the period of slavery to the present; and

(iii) the contributions of African Americans to society.

(3) OTHER RESPONSIBILITIES.—The Council, subject to the general policies of the Board of Regents, shall have authority—

(A) to provide for preservation, restoration, and maintenance of the collections of the Museum; and

(B) to solicit, accept, use, and dispose of gifts, bequests, and devises of services and property, both real and personal, for the purpose of aiding and facilitating the work of the Museum.

(c) COMPOSITION AND APPOINTMENT.—

(1) IN GENERAL.—The Council shall be composed of 19 voting members as provided under paragraph (2).

(2) VOTING MEMBERS.—The Council shall include the following voting members:

(A) The Secretary of the Smithsonian Institution.

(B) 1 member of the Board of Regents, appointed by the Board of Regents.

(C) 17 individuals appointed by the Board of Regents—

(i) taking into consideration individuals recommended by organizations and entities that are committed to the advancement of knowledge of African American life, art, history, and culture; and

(ii) taking into consideration individuals recommended by the other members of the Council.

(3) INITIAL APPOINTMENTS.—The Board of Regents shall make initial appointments to the Council under paragraph (2) not later than 180 days after the date of enactment of this Act.

(4) SPECIAL RULE FOR CERTAIN MEMBERS.—Of the total number of members of the Council appointed under subparagraph (C) of paragraph (2), not fewer than 9 shall be of African-American descent.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in this subsection, each appointed member of the Council shall be appointed for a term of 6 years.

(2) INITIAL APPOINTEES.—As designated by the Board of Regents at the time of appointment, of the voting members first appointed under subparagraph (C) of subsection (c)(2)—

(A) 6 members shall be appointed for a term of 2 years;

(B) 6 members shall be appointed for a term of 4 years; and

(C) 5 members shall be appointed for a term of 6 years.

(3) REAPPOINTMENT.—A member of the Council may be reappointed, except that no individual may serve on the Council for a total of more than 2 terms.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the Council—

(i) shall not affect the powers of the Council; and

(ii) shall be filled in the same manner as the original appointment was made.

(B) TERM.—Any member of the Council appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of that term.

(e) COMPENSATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), a member of the Council shall serve without pay.

(2) TRAVEL EXPENSES.—A member of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, at

rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Council.

(f) Chairperson.—By a majority vote of its voting members, the Council shall elect a chairperson from its members.

(g) Meetings.—

(1) In general.—The Council shall meet at the call of the chairperson or on the written request of a majority of the voting members of the Council, but not fewer than twice each year.

(2) Initial meetings.—During the 1-year period beginning on the date of the first meeting of the Council, the Council shall meet not fewer than 4 times for the purpose of carrying out the duties of the Council under this Act.

(h) Quorum.—A majority of the voting members of the Council holding office shall constitute a quorum for the purpose of conducting business, but a lesser number may receive information on behalf of the Council.

(i) Voluntary Services.—Notwithstanding section 1342 of title 31, United States Code, the chairperson of the Council may accept for the Council voluntary services provided by a member of the Council.

SEC. 6. DIRECTOR AND STAFF OF THE MUSEUM.

(a) Director.—

(1) In general.—The Museum shall have a Director who shall be appointed by the Secretary, taking into consideration individuals recommended by the Council.

(2) Duties.—The Director shall manage the Museum subject to the policies of the Board of Regents.

(b) Staff.—The Secretary may appoint 2 additional employees to serve under the Director, except that such additional employees may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(c) Pay.—The employees appointed by the Secretary under subsection (b) may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates.

SEC. 7. OFFICE OF EDUCATION AND LIAISON PROGRAMS.

(a) In General.—

(1) Establishment.—There is established within the Museum the Office of Education and Liaison Programs.

(2) Functions.—The Office of Education and Liaison Programs shall—

(A) carry out educational programs relating to African American life, art, history, and culture, including—

(i) programs using digital, electronic, and interactive technologies; and

(ii) programs carried out in collaboration with elementary schools, secondary schools, and postsecondary schools; and

(B) consult with the Director of the Institute of Museum and Library Services concerning the grant and scholarship programs carried out under subsection (b).

(b) Grant and Scholarship Programs.—

(1) In general.—In consultation with the Council and the Office of Education and Liaison Programs, the Director of the Institute of Museum and Library Services shall establish—

(A) a grant program with the purpose of improving operations, care of collections, and development of professional management at African American museums;

(B) a grant program with the purpose of providing internship and fellowship opportunities at African American museums;

(C) a scholarship program with the purpose of assisting individuals who are pursuing careers or carrying out studies in the arts, humanities, and sciences in the study of African American life, art, history, and culture;

(D) in cooperation with other museums, historical societies, and educational institutions, a grant program with the purpose of promoting the understanding of modern-day practices of slavery throughout the world; and

(E) a grant program under which an African-American museum (including a nonprofit education organization the primary mission of which is to promote the study of African-American diaspora) may use the funds provided under the grant to increase an endowment fund established by the museum (or organization) as of May 1, 2003, for the purposes of—

(i) enhancing educational programming; and

(ii) maintaining and operating traveling educational exhibits.

(2) Authorization of appropriations.—There are authorized to be appropriated to the Director of the Institute of Museum and Library Services to carry out this subsection—

(A) $15,000,000 for fiscal year 2004; and

(B) such sums as are necessary for each fiscal year thereafter.

SEC. 8. BUILDING FOR THE NATIONAL MUSEUM OF AFRICAN AMERICAN HISTORY AND CULTURE.

(a) In General.—

(1) Location.—

(A) In general.—Not later than 18 months after the date of the enactment of this Act, the Board of Regents shall designate a site for the Museum.

(B) Sites for consideration.—In designating a site under subparagraph (A), the Board of Regents shall select from among the following sites in the District of Columbia:

(i) The area bounded by Constitution Avenue, Pennsylvania Avenue, and 1st and 3rd Streets, Northwest.

(ii) The Arts and Industries Building of the Smithsonian Institution, located on the National Mall at 900 Jefferson Drive, Southwest, Washington, District of Columbia.

(iii) The area bounded by Constitution Avenue, Madison Drive, and 14th and 15th Streets, Northwest.

(iv) The site known as the "Liberty Loan site", located on 14th Street Southwest at the foot of the 14th Street Bridge.

(C) Availability of site.—

(i) In general.—A site described in subparagraph (B) shall remain available until the date on which the Board of Regents designates a site for the Museum under subparagraph (A)(i).

(ii) Transfer to Smithsonian Institution.—Except with respect to a site described in clause (i) or (ii) of subparagraph (B), if the site designated for the Museum is in an area that is under the administrative jurisdiction of a Federal agency, as soon as practicable after the date on which the designation is made, the head of the Federal agency shall transfer to the Smithsonian Institution administrative jurisdiction over the area.

(D) Consultation.—The Board of Regents shall carry out its duties under this paragraph in consultation with—

(i) the Chair of the National Capital Planning Commission;

(ii) the Chair of the Commission on Fine Arts;

(iii) the Chair and Vice Chair of the Presidential Commission referred to in section 10;

(iv) the Chair of the Building and Site Subcommittee of the Presidential Commission referred to in section 10; and

(v) the Chairman and Ranking Member of each of—

(I) the Committee on Rules and Administration of the Senate;

(II) the Committee on House Administration of the House of Representatives;

(III) the Committee on Transportation and Infrastructure of the House of Representatives;

(IV) the Committee on Appropriations of the House of Representatives; and

(V) the Committee on Appropriations of the Senate.

(2) Consideration.—The Board of Regents shall take into consideration the recommendations of the Council concerning the planning, design, and construction of the Museum.

(3) Construction of building.—The Board of Regents, in consultation with the Council, may plan, design, and construct a building for the Museum, which shall be located at the site designated by the Board of Regents under this paragraph.

(b) Cost Sharing.—The Board of Regents shall pay—

(1) 50 percent of the costs of carrying out this section from Federal funds; and

(2) 50 percent of the costs of carrying out this section from non-Federal sources.

(c) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 9. CONGRESSIONAL BUDGET ACT COMPLIANCE.

Authority under this Act to enter into contracts or to make payments shall be effective in any fiscal year only to the extent provided in advance in an appropriations Act, except as provided under section 11(b).

SEC. 10. CONSIDERATION OF RECOMMENDATIONS OF PRESIDENTIAL COMMISSION.

In carrying out their duties under this Act, the Council and the Board of Regents shall take into consideration the reports and plans submitted by the National Museum of African American History and Culture Plan for Action Presidential Commission under the National Museum of African American History and Culture Plan for Action Presidential Commission Act of 2001 (Public Law 107–106).

SEC. 11. AUTHORIZATION OF APPROPRIATIONS.

(a) In General.—There are authorized to be appropriated to the Smithsonian Institution to carry out this Act, other than sections 7(b) and 8—

(1) $17,000,000 for fiscal year 2004; and

(2) such sums as are necessary for each fiscal year thereafter.

(b) Availability.—Amounts made available under subsection (a) shall remain available until expended.

TO AUTHORIZE TESTIMONY OF DONALD JOHNSON

Mr. GRASSLEY. Mr. President, I ask unanimous consent the Senate proceed to the immediate consideration of S. Res. 179, which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 179) to authorize testimony and legal representation in the State of New Hampshire vs. Donald Johnson.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. Mr. President, this resolution concerns a request for testimony in a criminal trespass action in the Concord District Court for the State of New Hampshire. In this action, a defendant has been charged with criminally trespassing on March 7, 2003, on the premises of Senator GREGG's concord office. The defendant refused repeated requests to leave Senator GREGG's office after it had closed for the night. The trial on this action is scheduled to be held on June 24, 2003. Pursuant to a subpoena issued on behalf of the State of New Hampshire, this resolution authorizes a staff member in Senator GREGG's office who witnessed the defendant's behavior concerning the relevant incident to testify in connection with this matter, with representation by the Senate legal counsel.

Mr. GRASSLEY. Mr. President, I ask unanimous consent the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table and that any statements relating to this matter be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 179) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 179

Whereas, in the case of State of New Hampshire v. Donald Johnson, pending in Concord District Court for the State of New Hampshire, testimony has been requested from Carol Carpenter, a staff member in the office of Senator Judd Gregg;

Whereas, pursuant to sections 703(a) and 704(a)(2) of the Ethics in Government Act of 1978, 2 U.S.C. §§288b(a) and 288 c(2), the Senate may direct its counsel to represent employees of the Senate with respect to any subpoena, order, or request for testimony relating to their official responsibilities;

Whereas, by the priyileges of the Senate of the United States and Rule XI of the Standing Rules of the Senate, no evidence under the control or in the possession of the Senate may, by the judicial or administrative process, be taken from such control or possession but by permission of the Senate;

Whereas, when it appears that evidence under the control or in the possession of the Senate may promote the administration of justice, the Senate will take such action as will promote the ends of justice consistently with the privileges of the Senate: Now, therefore, be it

Resolved That Carol Carpenter is authorized to provide testimony in the case of State of New Hampshire v. Donald Johnson, except concerning matters for which a privilege should be asserted.

SEC 2. The Senate Legal Counsel is authorized to represent Carol Carpenter in connection with any testimony authorized in section one of this resolution.

ORDERS FOR TUESDAY, JUNE 24, 2003

Mr. GRASSLEY. I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:30 a.m., Tuesday, June 24. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time of the two leaders be reserved for their use later in the day, and the Senate then resume consideration of S. 1, the prescription drugs benefit bill.

I further ask consent that the Senate recess from 12:30 p.m. until 2:15 p.m. for the weekly party lunches.

Mr. REID. Reserving the right to object, a lot of progress has been made on this Medicare bill in the past week. The two managers have done an excellent job of administering this piece of legislation. But the key part of this whole procedure is going to be the next few days. I hope the two managers who get along so well understand the difficulty on both sides. They are going to have to use maturity and skills and experience in working us through these next few days. I hope everyone understands this legislation, even though we have had some speeches talking about how good it is—since it is as good as everyone contemplated it was, I hope that no one would try to make any drastic changes to the underlying legislation. It would take away a lot of the good work and good will that has been built up.

I know the senior Senator from Iowa and the senior Senator from Montana both understand that.

Mr. GRASSLEY. Mr. President, for the benefit of the distinguished Democratic whip, I just came from a meeting with Senator BAUCUS discussing some of the issues the Senator has suggested. When I am done here serving as acting leader, I will return to that same meeting and we will try to get some of these things worked out tonight.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. GRASSLEY. For the information of all Senators, tomorrow the Senate will resume consideration of S. 1, the prescription drug benefit bill. We currently have approximately 33 amendments pending to the bill and several Senators have expressed interest in offering additional amendments during tomorrow's session. Under the order there will be two stacked votes beginning at 11 a.m. in relation to two of these amendments. In addition, there will be a vote in relation to the Dodd amendment following the policy luncheon recess. Therefore, I inform my colleagues that rollcall votes are expected to occur throughout the day tomorrow.

For the remainder of the week, the Senate continues consideration of the prescription drug benefits bill. The leader has stated on several occasions that the Senate will complete action on this historic legislation prior to adjourning for the July 4th recess. Therefore, Members should expect rollcall votes throughout the days and into the evenings throughout this entire week. Senators are asked to make the necessary scheduling arrangements.

ORDER FOR ADJOURNMENT

Mr. GRASSLEY. If there is no further business to come before the Senate, I ask that the Senate stand in adjournment under the previous order, following the remarks of Senator LAUTENBERG for up to 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNITED STATES POLICY TOWARD ISRAEL

Mr. LAUTENBERG. Mr. President, I thank the Republican manager in the Chamber and my colleague, the Democratic whip, for allowing me time to speak as in morning business.

What I want to do is call attention to some incidents that have occurred recently and that were highlighted, in my view, in the New York Times, on the front page, today. I will read from parts of these articles. I want to explain the reason I am so exercised by what I see.

I ask unanimous consent that the full text of these two articles be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the New York Times, June 23, 2003]

AFTER MISSILE RAID ON CONVOY, U.S. HUNTS FOR HUSSEIN'S DNA

(By Douglas Jehl with Eric Schmitt)

Washington, June 22.—An American Predator drone aircraft firing Hellfire missiles destroyed a convoy last week that was believed to be carrying fugitive Iraqi leaders, and experts are trying to determine whether those killed might have included Saddam Hussein or his sons, United States government officials said today.

The officials said they had obtained intelligence indicating that senior Iraqi leaders were traveling in the convoy. They suggested that the intelligence might have come from an intercepted telephone conversation or an informant. The attack took place Wednesday near the Syrian border in western Iraq.

There was no evidence so far, the officials said, to support the idea that Mr. Hussein or his sons might have been killed in the raid, and some officials were doubtful that they were. But they said intelligence teams, including DNA experts, were at the site to review the wreckage and assess the evidence.

Officials declined to say how many people, or vehicles, were in the convoy, but they said it had been completely destroyed. If DNA evidence was the only method of determining who had been killed, it could take days to get the results.

A British newspaper, The Observer, disclosed the attack in today's issue and said it had been an attempt to kill Mr. Hussein. The Pentagon and the United States Central Command declined today to discuss that report, and American officials who agreed to discuss it on the condition of anonymity said the United states had never been certain that Mr. Hussein or his sons were in the convoy.

Still, administration officials said the strike underscored a growing belief among American intelligence officials that Mr. Hussein and his sons were not killed during the war and have remained in Iraq. The attack on the convoy showed the pressure of a stepped-up manhunt after information provided by a Hussein confidant who was detained last week.

The aide, Abid Hamid Mahmoud al-Tikriti, 46, who had served as the Iraqi leader's secretary and bodyguard, told his American interrogators that Mr. Hussein and his sons, Uday and Qusay, survived the war, and that he himself traveled to Syria after the conflict with Mr. Hussein's sons before being expelled, according to Defense Department officials who have said they have not been able to corroborate those claims.

A senior administration official said tonight that President Bush had been aware of the strike before it occurred but did not have to approve it. The official said a team was moving in to try to recover the DNA of those in the convoy, but it was unclear if they had yet arrived at the scene.

Some American officials described the attack as having been in the same category as the March 19 and April 7 attacks on compounds where Mr. Hussein and his sons were believed to be hiding. American intelligence analysts now believe that Mr. Hussein and his sons probably survived both those attacks.

A senior administration official described the intelligence that led to the Wednesday attack as a good lead. But another administration official said, "I have no information that leads us to believe we got Saddam." A military officer said intelligence reports that Mr. Hussein or his sons might have been in the convoy might have been based more on hope than evidence.

"There might be people crossing their fingers, but it's just like a year ago, when they were crossing their fingers" in the hopes of capturing Osama bin Laden, one military official said. Mr. bin Laden, Al Qaeda's leader, is still believed to be alive after 21 months in which he has been the target of an intense manhunt.

In a television interview today, King Abdullah of Jordan said he had heard reports several days ago that Mr. Hussein and his sons were in Iraq's western desert region. But he said he had heard many reports of their whereabouts in recent weeks and months and did not know if this one was accurate.

"It's like Elvis," King Abdullah said on the ABC News program "this Week." "There's a lot of sightings of him all over the place."

Members of the Senate Intelligence Committee, including the chairman, Senator Pat Roberts, Republican of Kansas, said in television appearances today that they had not been informed of any new missile strike aimed at the Iraqi leader. Still, Senator Roberts, speaking on "Fox News Sunday," said, "I will not be surprised at any military action that would lead to the possibility that we have now finally killed Saddam Hussein."

Senator John D. Rockefeller IV of West Virginia, the ranking Democrat on the committee, said on the same program that any confirmation of the death of Mr. Hussein would serve to undercut the morale of fighters who are staging hit-and-run attacks on American soldiers and at the same time instill confidence among the broader Iraqi public.

The search for Mr. Hussein has been led by Task Force 20, a secret military organization that is working closely with American intelligence agencies and whose members include special Army and Navy counterterrorist teams.

The United States is flying U–2 spy planes and RC–135 electronic eavesdropping aircraft over Iraq on a regular basis. Both are able to scoop up electronic emissions and pinpointing locations for strike aircraft or Predator drones, which are piloted by remote control and can be either armed or unarmed; they are being flown from an air base in Iraq.

One senior administration official noted that Hellfire missile attacks on convoys by the Predators were rare and would not have been carried out except on the basis of good intelligence about an important target.

Other officials said that the United States had obtained good reconnaissance photos showing that the convoy had been destroyed, but that those photographs did not clarify who had been in the wreckage.

"Although we do have good intelligence, you don't know if you have someone until you've seen the analysis from the ground," said one senior American officer.

[From the New York Times, June 23, 2003]

Israelis and Palestinians Pressed to Compromise

(By Steven R. Weisman)

Shuneh, Jordan, June 22.—Secretary of State Colin L. Powell joined with top European, Arab and United Nations diplomats today to press for concessions in peace talks between Israel and the Palestinians, but their efforts were punctured by violence in the Gaza Strip that left four Palestinians dead.

In an illustration of the frustrations of the Middle East, diplomats here reported that before the latest deaths in Gaza, negotiators had made some progress in their talks over transferring security in most of the Gaza Strip from Israel to the Palestinian Authority. There was no telling tonight whether that progress would be set back.

The four Palestinians from the Aksa Martyrs Brigades were first said to have been killed today by Israeli tank fire, though other reports said they might have died when a bomb they were planting exploded prematurely.

The day's events lent a surreal cast to the scene here at the World Economic Forum in a resort on the Dead Sea, where more than 1,200 envoys, officials, business leaders and other conferees hailed recent progress in the Israeli-Palestinian situation even as the bitterness of that dispute coursed through countless conversations.

Coming to the end of one of his longest trips as secretary of state, Mr. Powell started in the morning by expressing mild but unmistakable criticism of Israel's killing of a top Hamas leader on Saturday night.

"I regret we had an incident that could be an impediment to progress," Mr. Powell said, referring to the killing of Abdullah Qawasmeh, a leading Hamas figure. "I would much rather on a Sunday morning wake up to find that we are moving forward, and it was not necessary to have this kind of activity on either side."

The secretary's terse reference to Israel's latest strike against suspected Palestinian terrorists marked the second time in two weeks that the United States felt compelled to criticize Israel, if only obliquely. The week before last, President Bush rebuked Israel for an attempt to kill a Hamas leader, saying it had undercut peace talks.

But the rebuke for Israel was mixed today with exhortations directed at the Palestinians by Mr. Powell and others to take action to stop attacks on Israeli soldiers and citizens so as to fortify Middle East peace efforts that have looked more promising recently than at any time in the past two and a half years.

Two diplomatic tracks were underway in Israel that were the focus of much of the discussion here on the Dead Sea. One was Israel's negotiation with the Palestinians on Gaza. The other was the Palestinian Authority's negotiations to achieve a cease-fire with Hamas.

A cease-fire with Hamas is supported by the Palestinians' leadership and by its main Arab backers, Saudi Arabia, Egypt and Jordan. All of them say they would prefer such an arrangement to a civil war between the militant groups and the shaky security forces under Mahmoud Abbas, the Palestinian prime minister.

American and Israeli officials say they are less impressed with the cease-fire talks, explaining that if there is a cease-fire, it almost certainly will have to be followed by aggressive actions by Palestinian security forces against Hamas, including arrests, forced disarmament and potential clashes.

For now, the negotiations on the Gaza Strip and the Hamas cease-fire talks, while not officially connected, appear to be intertwined, making progress on both even more difficult. Arab, European and American diplomats all say, for example, that Mr. Abbas may be waiting for a cease-fire before reaching an accord to take over the Gaza area.

On the other hand, Israel's prime minister, Ariel Sharon, may be holding up approval of a deal on the Gaza Strip until he sees how Mr. Abbas is going to handle Hamas. Some here speculate that Mr. Sharon may also be waiting to close the Gaza deal when Condoleezza Rice, President Bush's national security adviser, visits Israel late next week.

Arab diplomats attending the economic forum here assailed Israel for the killing of Mr. Qawasmeh and for its policy of pinpoint killings of militant leaders. Mr. Abbas's son said here that he thought Israel was deliberately trying to sabotage the cease-fire negotiations.

Mr. Powell, who left Washington a week ago for Cambodia and then traveled to Bangladesh before arriving here on Thursday night, made an emotional appeal for restraint by both Palestinians and Israelis at a news conference and in a speech this afternoon.

No less significant, Mr. Powell joined with Secretary General Kofi Annan of the United Nations and the foreign ministers of the European Union and Russia to sound the same theme. The four officials, sometimes referred to as the quartet, devised the staged peace plan for a Palestinian state known as the road map.

In a statement read by Mr. Annan, the four officials said they "deplore and condemn the brutal terror attacks against Israeli citizens" carried out by Palestinian militants, citing not only Hamas but Palestinian Islamic Jihad and Al Aksa Martyrs Brigades. "All Palestinian individuals and groups must end acts of terror against all Israelis, anywhere," the group said.

But there was also tough talk directed at Israel, including "deep concern over Israeli

> military actions that result in the killing of innocent Palestinians and other civilians."
>
> Mr. Annan, going beyond the statement, called on Israel "not to use disproportionate force in civilian areas," to stop demolitions of Palestinian homes and to stop engaging in "extra-judicial killings."
>
> The talk in the corridors here was about the Hamas and Gaza negotiations next door in Israel, however. A diplomat close to the negotiators said they seemed "pretty close" to resolving the Gaza dispute, which has centered on Israel's demand that it be allowed to maintain a security presence along the main road that runs the length of the Gaza Strip.
>
> Israel maintains that it must keep some forces on the road both to protect Israeli settlers in several pockets of Gaza and to make sure that Hamas and other groups do not regroup and arm themselves to carry out attacks in Israel itself.
>
> A source of surprise to many Arab and European diplomats here is the increasing evidence of the United States' willingness to make demands on Israel to take parallel actions—not only by giving up the Gaza Strip, but also by dismantling "outposts" of settlements and releasing prisoners.
>
> The American demands on Israel are thought to be based on the belief that without such actions, Mr. Abbas will not have the political support to act against Hamas, diplomats say. "The Americans are not really letting the Israelis off the hook on this," said a diplomat. "We all realize that time is running out."

Mr. LAUTENBERG. The first article from the New York Times is headlined "After Missile Raid on Convoy, U.S. Hunts for Hussein's DNA."

> An American Predator drone aircraft firing Hellfire missiles destroyed a convoy last week that was believed to be carrying fugitive Iraqi leaders, and experts are trying to determine whether those killed might have included Saddam Hussein or his sons, United States government officials said today.
>
> The officials said they had obtained intelligence indicating that senior Iraqi leaders were traveling in the convoy. They suggested that the intelligence might have come from an intercepted telephone conversation or an informant. The attack took place Wednesday near the Syrian border in western Iraq.
>
> There was no evidence so far, the officials said, to support the idea that Mr. Hussein or his sons might have been killed in the raid, and some officials were doubtful that they were. But they said intelligence teams, including DNA experts, were at the site to review the wreckage and assess the evidence.
>
> Officials declined to say how many people, or vehicles, were in the convoy, but they said it had been completely destroyed. If DNA evidence was the only method of determining who had been killed, it could take days to get the results.

The other article is printed almost side by side on the front page of the New York Times today. I read the first paragraph of the second article:

> Secretary of State Colin L. Powell joined with European, Arab and United Nations diplomats today to press for concessions in peace talks between Israel and the Palestinians, but their efforts were punctured by violence in the Gaza Strip that left four Palestinians dead.

Further on:

> Coming to the end of one of his longest trips as Secretary of State, Mr. Powell started in the morning by expressing mild but unmistakable criticism of Israel's killing of a top Hamas leader on Saturday night.
>
> "I regret that we had an incident that could be an impediment to progress," Mr. Powell said, referring to the killing of Abdullah Qawasmeh, a leading Hamas figure. "I would much rather on a Sunday morning wake up to find that we are moving forward, and it wasn't necessary to have this kind of activity on either side."

The Secretary's reference to Israel's latest strike against suspected Palestinian terrorists marked the second time in 2 weeks that the United States felt compelled to criticize Israel, if only obliquely. The week before last, President Bush rebuked Israel for an attempt to kill a Hamas leader, saying it undercut peace talks.

I call attention to the two stories that appeared side by side on the front page of today's New York Times with the headlines they were carrying. I was struck by the fact that officials are still trying to determine how many people were killed in the missile attack. The U.S. military struck the convoy that they believed carried wanted terrorists. And I support that, by the way. We are still waiting for CIA and Department of Defense corroboration that, indeed, regime members rather than civilians were hit in the attack.

The other story reports, as I mentioned before, how Secretary Powell expressed mild but unmistakable criticism of Israel's killing of a top Hamas official this past Saturday.

It just so happens that this past weekend, the Israeli Defense Forces targeted a Hamas leader by the name of Abdullah Qawasmeh who masterminded the death of 52 Israelis. If this number were converted to American lives on a proportionate basis, he would have killed more than 2,400 of our citizens. How would we react to that?

There is a curious inconsistency between how this administration is conducting its global war against terrorists—which, again, I support, including operations against remnants of the Iraqi regime—and how we expect our ally, Israel, to deal with its terrorist threats.

I support a roadmap to peace, and I am pleased to see the administration live up to its responsibilities by reentering as a mediator in one of the world's most intractable conflicts. But I also believe that no peace process or roadmap will ever work when terrorists are placated or appeased. The roadmap can only go forward when all parties uniformly denounce and resist Hamas, Jihad, and the other enemies of peace.

So I believe we must support Israel in its war against terrorists and act consistently in conducting our foreign policy.

Mr. President, with that, I yield the floor.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:30 a.m. tomorrow.

Thereupon, the Senate, at 7:42 p.m., adjourned until Tuesday, June 24, 2003, at 9:30 a.m.

CONFIRMATIONS

Executive nominations confirmed by the Senate June 23, 2003:

DEPARTMENT OF HOMELAND SECURITY

FRANK LIBUTTI, OF NEW YORK, TO BE UNDER SECRETARY FOR INFORMATION ANALYSIS AND INFRASTRUCTURE PROTECTION, DEPARTMENT OF HOMELAND SECURITY.

THE ABOVE NOMINATION WAS APPROVED SUBJECT TO THE NOMINEE'S COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

IN THE AIR FORCE

THE FOLLOWING AIR NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADES INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIGADIER GENERAL JOHN B. HANDY
BRIGADIER GENERAL MARVIN S. MAYES
BRIGADIER GENERAL DOUGLAS R. MOORE
BRIGADIER GENERAL RICHARD L. TESTA

To be brigadier general

COLONEL JOSEPH G. BALSKUS
COLONEL BOBBY L. BRITTAIN
COLONEL THOMAS J. DEARDORFF
COLONEL MICHAEL P. HICKEY
COLONEL CHARLES V. ICKES II
COLONEL WILLIAM B. JERNIGAN
COLONEL HENRY C. MORROW
COLONEL DONALD J. QUENNEVILLE
COLONEL DANIEL R. SCACE
COLONEL TIMOTHY W. SCOTT
COLONEL EUGENE A. SEVI
COLONEL DARRYLL D. M. WONG

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. JOHN W. ROSA, JR.

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 8069:

To be major general

BRIG. GEN. BARBARA C. BRANNON

IN THE COAST GUARD

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES COAST GUARD RESERVE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be rear admiral

REAR ADM. (LH) DUNCAN C. SMITH

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES COAST GUARD TO THE GRADE INDICATED UNDER TITLE 14, U.S.C., SECTION 271:

To be rear admiral

REAR ADM. (LH) SALLY BRICE-O'HARA
REAR ADM. (LH) HARVEY E. JOHNSON
REAR ADM. (LH) DAVID W. KUNKEL
REAR ADM. (LH) DAVID B. PETERMAN

COAST GUARD NOMINATION OF MARY ANN C. GOSLING.

HOUSE OF REPRESENTATIVES—*Monday, June 23, 2003*

The House met at 12:30 p.m. and was called to order by the Speaker pro tempore (Mr. BISHOP of Utah).

DESIGNATION OF SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
June 23, 2003.

I hereby appoint the Honorable ROB BISHOP to act as Speaker pro tempore on this day.

J. DENNIS HASTERT
Speaker of the House of Representatives.

MORNING HOUR DEBATES

The SPEAKER pro tempore. Pursuant to the order of the House of January 7, 2003, the Chair will now recognize Members from lists submitted by the majority and minority leaders for morning hour debates. The Chair will alternate recognition between the parties, with each party limited to not to exceed 30 minutes, and each Member, except the majority leader, the minority leader, or the minority whip, limited to not to exceed 5 minutes.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess until 2 p.m.

Accordingly (at 12 o'clock and 33 minutes p.m.), the House stood in recess until 2 p.m.

□ 1400

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. ADERHOLT) at 2 p.m.

PRAYER

The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

Lord God of covenant love, your servant Joshua said to the people: "Sanctify yourselves, for tomorrow the Lord will perform wonders among you."

In a Nation You have chosen to dwell, Your people look for signs of Your love and blessing.

But before we can see in ordinary events wonders of Your own making, we must embrace discipline and be purified; for only those clean of heart shall see God.

May the Members of Congress, believing in Your presence in their midst, prove to be leaders of the American people.

Purify their intent to serve You by providing what is best for Your people.

May this Nation be obedient to Your ordinances and thereby increase its expectations.

Lead us to see wondrous deeds accomplished in our own day, and come to know more deeply Your goodness so we proclaim You alone are the one true God now and forever. Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Wisconsin (Mr. GREEN) come forward and lead the House in the Pledge of Allegiance.

Mr. GREEN of Wisconsin led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed without amendment a bill and a Concurrent Resolution of the House of the following titles:

H.R. 2312. An act to amend the Communications Satellite of 1962 to provide for the orderly dilution of the ownership interest in Inmarsat by former signatories to the Inmarsat Operating Agreement.

H. Con. Res. 139. Concurrent resolution authorizing printing of the brochures entitled "How Our Laws Are Made" and "Our American Government", the publication entitled "Our Flag", the document-sized, annotated version of the United States Constitution, and the pocket version of the United States Constitution.

The message also announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 504. An act to establish academies for teachers and students of American history and civics and a national alliance of teachers of American history and civics, and for other purposes.

S. 686. An act to provide assistance for poison prevention and to stabilize the funding of regional poison control centers.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 20, 2003.

Hon. J. DENNIS HASTERT,
The Speaker, House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on June 20, 2003 at 10:25 a.m.:

That the Senate agreed to conference report S. 342.

That the Senate passed without amendment H.R. 658.

With best wishes, I am
Sincerely,

MARTHA C. MORRISON,
Deputy Clerk.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 20, 2003.

Hon. J. DENNIS HASTERT,
The Speaker, House of Representatives,
Washington, DC

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of rule II of the Rules of the U.S. House of Representatives, I have the honor to transmit sealed envelopes received from the White House on June 20, 2003, at 1:45 p.m. and said to contain messages from the President whereby he submits a copy of a notice filed earlier with the *Federal Register* continuing the emergency with respect to the Western Balkans first declared in Executive Order 13219 of June 26, 2001, and where by he submits a 6-month periodic report in accordance with 50 USC 1641 (c) and 50 USC 1703 (c) on the national emergency with respect to the Western Balkans.

With best wishes, I am
Sincerely,

MARTHA C. MORRISON,
Deputy Clerk.

□This symbol represents the time of day during the House proceedings, e.g., □1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

SIX-MONTH REPORT ON NATIONAL EMERGENCY WITH RESPECT TO WESTERN BALKANS—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 108–86)

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committee on International Relations and ordered to be printed:

To the Congress of the United States:

Consistent with section 401(c) of the National Emergencies Act, 50 U.S.C. 1641(c), and section 204(c) of the International Emergency Economic Powers Act, 50 U.S.C. 1703(c), I transmit herewith a 6-month report prepared by my Administration on the national emergency with respect to the Western Balkans that was declared in Executive Order 13219 of June 26, 2001.

GEORGE W. BUSH.
THE WHITE HOUSE, *June 20, 2003.*

CONTINUATION OF NATIONAL EMERGENCY WITH RESPECT TO WESTERN BALKANS—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 108–87)

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committee on International Relations and ordered to be printed:

To the Congress of the United States:

Section 202(d) of the National Emergencies Act (50 U.S.C. 1622(d)) provides for the automatic termination of a national emergency unless, prior to the anniversary date of its declaration, the President publishes in the *Federal Register* and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. Consistent with this provision, I have sent the enclosed notice, stating that the Western Balkans emergency is to continue in effect beyond June 26, 2003, to the *Federal Register* for publication. The most recent notice continuing this emergency was published in the *Federal Register* on June 25, 2002, 67 Fed. Reg. 42703.

The crisis constituted by the actions of persons engaged in, or assisting, sponsoring, or supporting, (i) extremist violence in the former Yugoslav Republic of Macedonia, and elsewhere in the Western Balkans region, or (ii) acts obstructing implementation of the Dayton Accords in Bosnia or United Nations Security Council Resolution 1244 of June 10, 1999, in Kosovo, that led to the declaration of a national emergency on June 26, 2001, has not been resolved. Subsequent to the declaration of the national emergency, acts obstructing implementation of the Ohrid Framework Agreemenet of 2001 in the former Yugoslav Republic of Macedonia, have also become a concern. All of these actions are hostile to U.S. interests and pose a continuing unusual and extraordinary threat to the national security and foreign policy of the United States. For these reasons, I have determined that it is necessary to continue the national emergency declared with respect to the Western Balkans and maintain in force the comprehensive sanctions to respond to this threat.

GEORGE W. BUSH.
THE WHITE HOUSE, *June 20, 2003.*

PRIVILEGED REPORT REQUESTING PRESIDENT TO TRANSMIT TO HOUSE DOCUMENTS RELATING TO IRAQ'S WEAPONS OF MASS DESTRUCTION

Mr. GREEN of Wisconsin, from the Committee on International Relations, submitted a privileged report (Rept. No. 168) on the resolution (H. Res. 260) requesting the President to transmit to the House of Representatives documents or other materials in the President's possession relating to Iraq's weapons of mass destruction, which was referred to the House Calendar and ordered to be printed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8, rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered or on which the vote is objected to under clause 6 of rule XX.

Record votes on postponed questions will be taken after 6:30 p.m. today.

EXPRESSING SYMPATHY FOR VICTIMS OF ALGERIAN EARTHQUAKE

Mr. GREEN of Wisconsin. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 264) expressing sympathy for the victims of the devastating earthquake that struck Algeria on May 21, 2003.

The Clerk read as follows:

H. RES. 264

Whereas, on the evening of May 21, 2003, a devastating and deadly earthquake of a magnitude of 6.8 on the Richter scale with a depth of 6 miles struck northern Algeria, killing more than 2,260 people, injuring more than 10,000, and leaving more than 200,000 homeless;

Whereas the earthquake of May 21, 2003, has left thousands of buildings in ruins and has severely disrupted health services, water supply lines, electricity, and telecommunications in Algeria and affected cities;

Whereas severe aftershocks with magnitudes greater than 4.0 have continued to terrify the people of Algeria and hamper rescue efforts;

Whereas the strength, courage, and determination of the Government and people of Algeria has been displayed since the earthquake;

Whereas the people of the United States and Algeria share strong friendship and mutual respect;

Whereas the United States airlifted to the earthquake-affected population 17,000 blankets, 1800 tents, electrical equipment, water purification kits, and 3 medical supply kits that will benefit 10,000 people over 3 months;

Whereas the United States has released $50,000 to the Algerian Red Crescent Society for emergency relief supplies; and

Whereas the United Nations Children's Fund (UNICEF) launched an emergency appeal for humanitarian and relief assistance to address the devastation caused by the powerful earthquake: Now, therefore, be it

Resolved, That the House of Representatives—

(1) expresses its deepest sympathies to the people of Algeria and particularly to the families of the victims and the survivors for the tragic losses suffered as a result of the earthquake of May 21, 2003;

(2) expresses its support for the people and to the Government of Algeria as they continue their efforts to rebuild their cities and their lives;

(3) expresses support for humanitarian assistance provided by the United States Agency for International Development and other American and international relief organizations;

(4) recognizes the important role that is being played by the United States and the international community in providing assistance to alleviate the suffering of the people of Algeria; and

(5) encourages a continued commitment by the United States and other countries and international organizations to the rebuilding of the earthquake-affected areas in Algeria.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Wisconsin (Mr. GREEN) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. GREEN).

GENERAL LEAVE

Mr. GREEN of Wisconsin. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H. Res. 264.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. GREEN of Wisconsin. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to thank the gentleman from California (Mr. LANTOS) for bringing H. Res. 264, expressing sympathy for the victims of the devastating earthquake that struck Algeria on May 21, 2003, before us today.

As many of you know, on May 21, an earthquake registering 6.8 on the Richter scale struck northern Algeria, 45 miles east of the capital of Algiers. This was followed with a series of aftershocks, five with magnitudes greater than 5.0, and at least 19 with magnitudes ranging between 4.0 and 4.9. These were the worst quakes to strike Algeria since 1980.

The impact was devastating. 2,268 Algerians were killed, making this deadlier than all of the other earthquakes in the world over the past 2 years combined, including the 2002 earthquake in Afghanistan which killed 1,000.

Thousands of buildings have been destroyed, and health services, water supplies, electricity and telecommunications have been severely disrupted. Confidence in the government has also been shaken as press reports link the high death toll with poor building construction and mismanagement of the housing sector.

The international response to this disaster has been vigorous. The U.S. contribution to the relief effort is currently valued at $1.6 million, including $827,107 in grants and relief supplies from the U.S. Agency for International Development Office of Foreign Disaster Assistance; $424,000 in relief supplies from the Department of Defense/Defense Security Cooperation Agency; and $368,000 in relief supplies from the Department of Defense/U.S. European Command. For other donors, the United Nations Office for Coordination of Humanitarian Affairs and the International Federation of the Red Cross and Red Crescent Societies are taking the lead.

Through this robust response, major catastrophes have been diverted, including cholera outbreaks. However, there is still a long way to go on the path towards recovery. Thousands of homes need to be rebuilt, and structures able to withstand earthquakes will need to be erected.

The great American educator, Catherine Beecher, said, "The delicate and infirm go for sympathy, not to the well and buoyant, but to those who have suffered like themselves." Unfortunately, we Americans are no strangers to tragedy and loss.

Mr. Speaker, the people of Algeria and their government stood with us after our own tragedy of September 11, 2001. They have been stalwart allies in our war on terrorism, and now it is our turn to aid our friends in a time of great need. It is with this in mind that we now express our solidarity with and our sympathy for those who have suffered in Algeria.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of this resolution, which I had the privilege of writing.

Mr. Speaker, I want to express at the outset my appreciation to my able assistant, Robin Roizman, for working on this resolution.

Mr. Speaker, I want to express my thanks to my colleagues, the gentleman from Wisconsin (Mr. GREEN); the distinguished chairman of our committee, the gentleman from Illinois (Mr. HYDE); the gentleman from Indiana (Mr. PENCE); and the gentleman from Pennsylvania (Mr. PITTS), for joining me in introducing this important resolution.

Mr. Speaker, H. Res. 264 expresses the deepest sympathy of the American people and of this Congress for the victims of the devastating earthquake that struck Algeria on May 21, 2003. This was the most tragic earthquake to hit that country in almost a quarter century. With a Richter scale reading of 6.8, the earthquake devastated the country, severely disrupted its health services, water supply, electricity and telecommunications.

The earthquake and its aftershocks have killed over 2,000 innocent people of Algeria, injured over 10,000, and left over 200,000 Algerian citizens homeless.

We immediately responded to this disaster by providing emergency humanitarian supplies. My resolution encourages our administration to continue providing assistance to the people of Algeria in this very difficult time.

The resolution expresses our sympathy for the Algerian people and calls on our administration to monitor conditions there and to continue providing all necessary assistance to the government and people of Algeria.

I want to note, Mr. Speaker, that we have in the gallery the distinguished Ambassador from Algeria, and I want to express to him personally our deep support and commitment to help in these difficult days for his country.

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I urge all of my colleagues to support H. Res. 264.

Mr. Speaker, I yield back the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. ADERHOLT). All Members are reminded not to introduce or refer to people in the balcony.

Mr. GREEN of Wisconsin. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. GREEN) that the House suspend the rules and agree to the resolution, H. Res. 264.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

COMMENDING PEOPLE OF THE REPUBLIC OF KENYA FOR CONDUCTING FREE AND FAIR ELECTIONS AND PEACEFUL AND ORDERLY TRANSFER OF POWER

Mr. GREEN of Wisconsin. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 177) commending the people of the Republic of Kenya for conducting free and fair elections, for the peaceful and orderly transfer of power in their government, and for the continued success of democracy in their nation since that transition, as amended.

The Clerk read as follows:

H. RES. 177

Whereas on December 27, 2002, the Republic of Kenya successfully held presidential, parliamentary, and local elections;

Whereas these elections were widely praised by objective international observers as free and fair;

Whereas the Department of State stated that with these elections the Kenyan people "have made a strong demonstration of their democratic commitment and established an important example for the region and for the world";

Whereas the European Union stated that "the overall conduct of the elections constitutes an example for other countries in the region";

Whereas these elections signal a major step forward for Kenyan democracy, particularly when compared with other elections held in Kenya since it became an independent state in 1963;

Whereas the transition of power put in motion by these elections culminated on December 30, 2002, when former President Daniel Toroitich arap Moi peaceably transferred the Kenyan presidency to President Mwai Kibaki; and

Whereas these elections and the subsequent transfer of power from leader to leader represent the birth of a successful new democracy in Kenya: Now, therefore, be it

Resolved, That the House of Representatives—

(1) commends the people of the Republic of Kenya for conducting free and fair elections, and the Government of Kenya for its successful completion of a peaceful and orderly transition of power;

(2) expresses its desire to see this new democracy in Kenya continue to thrive, as it has in the months following the 2002 elections;

(3) urges other African countries to look to Kenya as an example of a working democracy in action and to follow the example set by the people of Kenya during this recent election process;

(4) reaffirms the friendship that exists between the people of the United States and people of Kenya, as two nations bound together by the shared values of democracy;

(5) offers its commitment to working to ensure democracy is able to grow and flourish as Kenya moves into the challenging future that lies ahead; and

(6) commends the Government of Kenya for its commitment and concrete steps taken—

(A) to strengthen democracy, human rights and the rule of law;

(B) to combat corruption;

(C) to provide free and universal primary education;

(D) to fight against HIV/AIDS; and

(E) to support the United States in the war on terrorism.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Wisconsin (Mr. GREEN) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. GREEN).

Mr. GREEN of Wisconsin. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, there are many reasons for us to agree to this resolution and to commend the people and the Government of Kenya. First and foremost, just months ago Kenya conducted historic national elections. Historic because they were nonviolent and free and fair. People of Kenya rose up and rejected a trend of unfair antidemocratic elections that have marred not just Kenya but far too many countries and elections on that continent.

As a firsthand observer of those elections, I can testify to the determination that so many Kenyans and so many nongovernmental organizations showed in building a process for voter registration and voter education and ballot security that is commendable. Secondly, Mr. Speaker, we should commend Kenya for what those elections were all about. The now president, recently elected President Mwai Kibaki and his party won the presidency and the majority of the Kenya Parliament on a platform of rooting out corruption and reforming the government process and just as importantly offering the nation and the Kenyan people free primary school education. This platform was not only popular, obviously, but it was the right thing to do. It is a crucial part of a prescription for a brighter future for a country and a people of enormous potential. And while the new administration is young, it seems determined to follow through on its pledges.

The third reason, Kenya is a crucial ally and a good friend to America. We have a military access agreement with the government of Kenya. Kenya is a staunch ally and friend even though it is located in a troubled region; and as we all know vividly and tragically, Kenya has been the site of horrible and deadly acts of terrorism aimed at Western interests. Just last week we praised and thanked Kenya for its handling of the many refugees who have fled from Kenya's troubled neighbors.

Mr. Speaker, I ask that we commend Kenya for its successful elections and its announced plans to attack corruption and its plans to extend basic education. I ask that we thank Kenya for its commitment to fighting terrorism shoulder to shoulder with the United States, and I ask that we encourage Kenya to follow through in its promising first steps since the administration took over. The future can be right, it can be bright, and it can be uplifting if they follow through on what they have started.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of this resolution. First, I want to thank the gentleman from Wisconsin (Mr. GREEN), my good friend and colleague, a distinguished member of the Committee on International Relations who has brought special expertise on Africa to our committee, for introducing this resolution which draws attention to the highly successful elections held recently in Kenya.

Kenya, Mr. Speaker, has traveled a bumpy road as an emerging democracy and has struggled with corruption, ethnic politics and questionable elections. It sounds like some other countries we know. Yet throughout its 40 years of independence, the Kenyan people have kept the dream of democracy alive, strived to build strong civic institutions, and upheld the ideals of democracy; and now this has paid off.

Mr. Speaker, Kenya is one of our strongest allies in our global war against terrorism, and it has paid a very high price. Many civilian lives were taken in the attacks on our embassy in Nairobi and a major tourist hotel. May I mention parenthetically, Mr. Speaker, that just this past weekend we were again forced to close our embassy in Nairobi, our new embassy because of terrorist threats.

The Kenyan economy, which is so heavily based on tourism, has suffered enormously. Yet the government of Kenya remains a staunch ally in our global fight against terrorism, a democracy in the face of this vulnerability.

Mr. Speaker, our resolution puts the U.S. Congress on record, supporting the people and the leaders of Kenya as they strive to build their democracy. They are on the right track. I hope, Mr. Speaker, that congressional support does not end with this resolution. Kenya continues to need our assistance in consolidating its democracy. The country needs our help in preventing future terrorist attacks and in rebuilding their tourism industry. I urge all of our colleagues to support H. Res. 177.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H. Res. 177 which commends the people of the Republic of Kenya for conducting fair elections and maintaining a civil democracy.

Kenya, once a nation ripe with political corruption and intertribal conflict, has now established itself as an embodiment of democratic principle. Prior to the elections held in 2002, Kenya's system of government was used primarily as a means through which to achieve personal gain rather than the development of policies designed for the public good. The retirement of Daniel Arap Moi, after serving as president for two decades, ushered in a new beginning for Kenya's quest for political stability and overall sustainability. While intense power struggles and backroom deals among various political affiliations once permeated Kenya's government, the fair election of President Kibaki has given way to nation of openness and tolerance of different political ideologies within the scope of a diverse nation.

The peaceful transition of power has enabled Kenya to take on a more prominent position in the global community. Kenya has served an important role in fostering regional stability in the Horn of Africa. Kenya has invested a great deal of energy and resources in supporting the ongoing negotiations aimed at putting an end to the seemingly endless civil war being waged in Sudan. As the third largest economy in sub-Saharan Africa, Kenya has the potential to become one of the most influential countries in Africa.

Today Kenya remains a high priority for U.S. foreign policy interests. Kenya has remained a consistent supporter of U.S. efforts to combat terrorism on a global scale. However the U.S. should not simply reduce its partnership with Kenya to that of military and security concerns. Rather we should use this time of political calm to expand our range of interest to issues of human rights, democratization, and economic accountability. International donor agencies continue to fund a wide range of programs throughout the country as it is seen as nation of great possibility for economic growth and development. Research institutions, like the Center for Disease Control & Prevention, have made considerable investments in Kenya's public health system. Kenya's peaceful democratic transition has served as a humanitarian platform that other countries may be able to emulate. This point in time is a particularly critical juncture for Kenya. It will be important for Kenya to maintain its newfound sense of democracy as it attempts to sustain both its political as well as its economic stability.

Therefore I stand in solidarity with my colleagues in support of H. Res. 177 in hopes that Kenya continues along the path toward a peaceful democratic state.

Mr. LANTOS. Mr. Speaker, I yield back the balance of my time.

Mr. GREEN of Wisconsin. Mr. Speaker, first I would like to thank the gentleman from California (Mr. LANTOS) for his gracious and kind words.

Mr. Speaker, I have no further requests for time, and I yield back the balance my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. GREEN) that the House suspend the rules and agree to the resolution, H. Res. 177, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

COMMENDING THE SIGNING OF THE UNITED STATES-ADRIATIC CHARTER

Mr. GREEN of Wisconsin. Mr. Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 209) commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia, as amended.

The Clerk read as follows:

H. CON. RES. 209

Whereas the United States has an enduring interest in the independence, territorial integrity, and security of Albania, Croatia, and The Former Yugoslav Republic of Macedonia and supports their full integration in the community of democratic Euro-Atlantic states;

Whereas Albania, Croatia, and Macedonia have taken clear and positive steps to advance their integration into Europe by establishing close cooperative relations among themselves and with their neighbors, as well as their promotion of regional cooperation;

Whereas Albania, Croatia, and Macedonia have already contributed to European security and to the peace and security of southeast Europe through the resolution of conflicts in the region and their regional cooperation in the Southeast Europe Defense Ministerial;

Whereas on May 2, 2003, the United States-Adriatic Charter was signed in Tirana, Albania, by Secretary of State Colin Powell, Albanian Foreign Minister Ilir Meta, Croatian Foreign Minister Tonino Picula, and Macedonian Foreign Minister Ilinka Mitreva;

Whereas the Adriatic Charter affirms the commitment of Albania, Croatia, and Macedonia to the values and principles of the North Atlantic Treaty Organization (NATO) and to joining the Alliance at the earliest possible time;

Whereas Secretary of State Powell stated that the Adriatic Charter "reaffirms our partners' dedication to work individually, with each other, and with their neighbors to build a region of strong democracies powered by free market economies . . . [i]t underscores the importance we place on their eventual full integration into NATO and other European institutions . . . [a]nd most importantly, the Charter promises to strengthen the ties that bind the peoples of the region to the United States, to one another, and to a common future within the Euro-Atlantic family"; and

Whereas 75 Albanian special forces troops were sent to Iraq as part of the coalition forces during Operation Iraqi Freedom, 29 Macedonian special forces troops were sent to Iraq as part of the postwar stabilization force, and Albania, Croatia, and Macedonia all contributed to the stabilization forces in Afghanistan, as signs of their commitment to promote international freedom and security: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That Congress—

(1) strongly supports the United States-Adriatic Charter and commends Albania, Croatia, and Macedonia for their continued efforts to become full-fledged members of the North Atlantic Treaty Organization (NATO) and the European Union;

(2) urges NATO to invite Albania, Croatia, and Macedonia to join NATO as soon as each of these countries respectively demonstrates the ability to assume the responsibilities of NATO membership through the Membership Action Plan;

(3) welcomes and supports the aspirations of Albania, Croatia, and Macedonia to join the European Union at the earliest opportunity;

(4) recognizes that Albania, Croatia, and Macedonia are making important strides to bring their economic, military, and political institutions into conformance with the standards of NATO and other Euro-Atlantic institutions; and

(5) commends Secretary of State Powell for his personal support of the Adriatic Charter.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Wisconsin (Mr. GREEN) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. GREEN).

GENERAL LEAVE

Mr. GREEN of Wisconsin. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on the concurrent resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. GREEN of Wisconsin. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the concurrent resolution before us expresses the support of the Congress for the Adriatic Charter, as it was reported favorably by the Committee on International Relations on June 12.

The charter was signed on May 2 in the Albanian capital of Tirana by Secretary of State Powell and the foreign ministers of Albania, Croatia, and the former Yugoslav Republic of Macedonia, the three remaining NATO-aspirant nations.

The Adriatic Charter pledges the United States to support efforts by Albania, Croatia, and Macedonia to join Euro-Atlantic institutions like NATO and the European Union. In this agreement, the three aspirant nations commit themselves to accelerate their democratic reforms, protect human rights, implement market-oriented economic policies, and enhance their mutual cooperation. Under the Adriatic Charter, the United States and these three countries pledge to consult whenever the security of one of them is threatened. For their part, the aspirant countries promise to continue defense reforms and to undertake steps to enhance border security so they can contribute to regional stability.

Mr. Speaker, this Member urges the House to agree to this concurrent resolution.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of this resolution. First, I want to commend the gentleman from Nebraska (Mr. BEREUTER) and the gentleman from New York (Mr. ENGEL) and the gentleman from Florida (Mr. WEXLER) for their leadership on this important resolution, and the gentleman from Illinois (Mr. HYDE), our chairman, for moving it forward so expeditiously.

Our resolution celebrates cooperation and forward-thinking among the nations of the Balkans, a region that just a few years ago was engulfed in ethnic violence and strife. Our Nation, Mr. Speaker, has an enduring interest in the independence, territorial integrity, and security of Albania, Croatia, and Macedonia and supports their full integration in the community of democratic Euro-Atlantic states. The Adriatic Charter affirms the commitment of Albania, Croatia, and Macedonia to the values and principles of NATO and to their joining the Atlantic Alliance at the earliest practical time.

Albania, Croatia, and Macedonia have taken positive steps to advance their integration into Europe and have already contributed to European security and to the peace and security of southeast Europe through the resolution of severe conflicts in the region.

Mr. Speaker, I commend all of my colleagues who have worked on this concurrent resolution. I urge every Member of this House to support its passage.

Mr. Speaker, I yield back the balance of my time.

Mr. GREEN of Wisconsin. Mr. Speaker, I yield such time as he may consume to the gentleman from Nebraska (Mr. BEREUTER), the chairman of the Europe Subcommittee.

Mr. BEREUTER. Mr. Speaker, I thank the gentleman from Wisconsin (Mr. GREEN) for handling this concurrent resolution and for the support of the gentleman from California (Mr. LANTOS), as well, on this very important resolution.

I want to begin by of course expressing my strong support for the resolution and thanking the distinguished gentleman from New York (Mr. ENGEL), one of our colleagues on the Committee on International Relations, for authoring the legislation and for working with the staff of the subcommittee and the full committee. He has long been a champion of Albania in the House, and I am pleased to be a cosponsor of this resolution.

As mentioned by the gentleman from Wisconsin (Mr. GREEN), this is a pledge also on the part of Albania, Croatia, and Macedonia through what they did in Tirana for full continued support for moving towards NATO membership.

Under the Adriatic Charter, the United States and these three countries pledge to consult whenever the security of one of them is threatened. For their part, the aspirant countries promise to continue defense reforms and to undertake steps to enhance border security so that they can contribute to regional stability.

Some of the language in the Adriatic Charter might look familiar. Indeed, this document was based on the successful Baltic Charter, which was signed in 1998 between Estonia, Latvia, and Lithuania. Five years ago few observers would have been so bold as to predict that those three countries occupied for 50 years by the Soviet Union and then Russia-to-be would be poised to join NATO and the EU next year. The Baltic Charter signifies an American commitment to help those three countries in their successful efforts to join NATO and the EU. Today, the Adriatic Charter holds the potential for helping Albania, Croatia, and Macedonia to achieve the same goals.

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This Member, of course, recognizes and commends the efforts of Secretary of State Powell and those of our diplomats working the European and Eurasian Bureau of the State Department for their initiative in crafting the Adriatic Charter.

As NATO prepares to admit seven new countries next year, it is important that these three remaining candidate countries are not forgotten. NATO's door remains open to all who are willing and able to assume the responsibilities of membership, and it is important that the Congress assert that it is the achievements of Albania, Croatia, and Macedonia that will determine when their aspirations for accession will be realized. Each of them are working through membership action plans to meet NATO's standards, and each will be judged on their own accomplishments.

Mr. Speaker, already, these three nations have acted like allies. All three countries have sent troops to the International Security Assistance Force in Afghanistan. In addition, Albania sent 75 special operations troops to take part in Operation Iraqi Freedom, and Macedonia this month has sent 29 special forces troops to Iraq to take part in the stabilization operations there. We appreciate their contributions and look forward to the day when they are ready to take on the full responsibilities of NATO membership.

Mr. Speaker, the Adriatic Charter is also one more step towards President Bush's goal of a Europe whole and free from the Baltic to the Black Sea. This Member commends and congratulates the people of Albania, Croatia, and Macedonia for their initiative and progress, and this Member urges the House to pass this resolution.

Mr. ENGEL. Mr. Speaker, I rise in support of H. Con. Res. 209, which commends the signing of the U.S. Adriatic Charter. As the author of H. Con. Res. 209, I am honored that the House is now considering this important resolution.

On May 2, 2003, the U.S. Adriatic Charter was signed in Tirana, Albania by Secretary of State Colin Powell and the Foreign Ministers of Albania, Croatia, and the Former Yugoslav Republic of Macedonia. As Secretary Colin Powell noted when he signed the document, it is remarkable that the agreement was signed in Albania, a country once known only for its isolation and distance from Western principles. Today, Tirana is a capital filled with energy as it continues its opening to Europe. Macedonia and Croatia have seen similar changes.

As NATO has expanded through other countries of Europe, several former Yugoslav nations in South Central Europe were excluded. They just were not ready for membership. Today, three of those nations, Albania, Croatia, and Macedonia are now moving to make the needed changes and reforms so that they can join the North Atlantic structures.

The U.S. Adriatic Charter embodies a commitment by Alabania, Croatia, and Macedonia to the values and principles of NATO and a declaration of their intent to join NATO as soon as they meet Alliance standards. I strongly support their efforts to advance toward NATO membership and having Secretary Powell sign the Charter puts the United States firmly in support of their efforts to join NATO when they are ready.

By passing this resolution today, Congress will add its voice, by "urg[ing] NATO to invite Albania, Croatia, and Macedonia to join NATO as soon as these countries demonstrate the ability to assume the responsibilities of NATO membership."

H. Con. Res. 209 also welcomes and supports the aspirations of Albania, Croatia, and Macedonia to join the European Union at the earliest opportunity and recognizes that the three countries are making important strides to bring their economic, military, and political institutions into conformance with the standards of NATO and other Euro-Atlantic institutions. Finally, our resolution also commends Secretary Powell for his strong personal support of the resolution, as demonstrated by his travel to the region to sign the document.

Mr. Speaker, as the sponsor of H. Con. Res. 209, I think this is an appropriate forum to publicly thank Albania, for sending 75 commandos to Iraq to fight along side our troops. It is my hope that Albania, one of only three European countries to send ground troops to fight in the war, would be high on Defense Department's list when it considers the realignment of and new bases for American forces around the world.

Finally, I would like to thank the chairman of the Europe Subcommittee, Mr. BEREUTER, and his staff for their cooperation and support as we drafted this resolution, H. Con. Res. 209. I would also like to thank the ranking member of the subcommittee, Mr. WEXLER, for his support.

Again, I strongly support H. Con. Res. 209 and urge my colleagues to support its passage.

Mr. Speaker, I include letters from John Kraljic, President of the National Federation of Croatian Americans, His Excellency Nikola Dimitrov, Ambassador of the former Yugoslav Republic of Macedonia, and Martin Vulaj, Executive Director of the National Albanian American Council.

Embassy of the
Ambassador Republic of Macedonia,
Washington, DC, June 12, 2003.

Hon. Representative Eliot E. Engel,
House of Representatives, Washington, DC.

Dear Mr. Engel: Allow me to express my sincere gratitude for your initiative in adopting the resolution H. Con. Res. 209 by the Committee on Foreign Relations of the House of the Representatives regarding the signing of the United States-Adriatic Charter, charter of partnership among the United States, Albania, Croatia, and Macedonia.

Let me assure you one more time that Macedonia, along with Albania and Croatia is strongly committed to the values and principles of the NATO and is willing to joining the Alliance at the earliest possible time.

My country already contributes to European security and to the peace and security of southeast Europe through peaceful resolution of the conflicts and regional cooperation.

Macedonia strongly supports the endeavors of the Government of the United States to bring security, stability and democracy in Iraq and Afghanistan. My Government has sent troops to Iraq as part of the coalition forces to contribute the success of the operation Iraqi Freedom, and to Afghanistan.

Dear Mr. Engel, I look forward for future opportunity to exchange our views, and thank you again for your support to my country.

Sincerely,

Nikola Dimitrov.

National Federation of Croatian
Americans Cultural Foundation,
Washington, DC, June 19, 2003.

Hon. Eliot Engel,
Rayburn House Office Building, House of Representatives, Washington, DC.

Dear Congressman Engel: Thank you for the introduction of H. Con. Res. 209 and your important service in the U.S. Congress on the Europe Subcommittee of the House International Relations Committee.

The National Federation of Croatian Americans (NFCA) understands that your Concurrent Resolution commending the signing of the United States-Adriatic Charter—a charter of partnership among the United States, Albania, Croatia, and Macedonia—has been voted out of the Full Committee and awaits House Floor action. Please be aware that the NFCA fully supports the passage of this Resolution by both the House of Representatives and the Senate.

NFCA has long supported the Republic of Croatia's request for membership in the North Atlantic Treaty Organization (NATO). We believe it is a natural and important extension of Croatia's integration into important western security and related alliances since the Republic's reestablishment as a viable nation-state over ten years ago. Croatia is the most stable and economically developed country in southeastern Europe. Its democratic structure has been strongly established as evidenced by three national elections since 1990. Croatia has a wide range of political parties and a critical and independent press. Economically Croatia's Gross

Domestic Product is greater than that of most of its neighbors, some of whom have already joined NATO. Furthermore, since the time Croatia claimed its independence in the early 1990s, it has adopted American and NATO military techniques. Croatia currently participates as full partner in the U.S. and NATO war on international terrorism.

The NFCA is a Washington, DC-based national umbrella organization that represents over 20 Croatian American groups and 130,000 members. We have promoted the early admittance of Croatia into NATO and, indeed, believe that Croatia should be invited to join NATO as soon as it meets the criteria for membership. Our organization believes the passage of this Concurrent Resolution by the U.S. House of Representatives will further underline the need to bring Croatia into NATO at the earliest opportunity. The NFCA fully supports the passage of H. Con. Res. 209.

Thank you once again for your leadership on this important Resolution.

Sincerely,

JOHN KRALJIC,
President.

NATIONAL ALBANIAN
AMERICAN COUNCIL,
Washington, DC, June 23, 2003.

Hon. ELIOT ENGEL,
Co-Chairman of the Albanian Issues Caucus, Rayburn House Office Building, House of Representatives, Washington, DC.

DEAR CONGRESSMAN ENGEL: The National Albanian American Council wishes to express its grateful thanks to you for your initiative in introducing H. Con. Res. 209, which passed by the House International Relations Committee regarding the signing of the United States—Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia.

We believe that this is an important step in paving the way for Albania, Croatia, and Macedonia to become members of NATO in the future. It also reaffirms their determination to work individually and with each other to build a region of strong democracies powered by a free market economy.

We wish to thank you Congressman Engel for your outstanding work and your commitment to the development and democratization of the Balkans. The National Albania American Council wishes to recognize your outstanding contributions and your leadership in the Albania Issues Caucus on behalf of the Albania American Community.

Sincerely,

MARTIN VULAJ,
Executive Director.

Mr. RADANOVICH. Mr. Speaker, I rise today in support of H. Con. Res. 209. I am proud to support a resolution which commends the signing of the United States-Adriatic Charter and urges NATO to invite Croatia to become a member.

I have long supported the Republic of Croatia's request for membership in the NATO, and I believe it is a natural and important extension of Croatia's integration into important western security and related alliances since the Republic's reestablishment as a viable nation-state over 10 years ago.

Croatia is one of the most stable and economically developed countries in the southeastern Europe. Its democratic structure has been strongly established as evidence by three national elections since 1990.

Croatia has a wide range of political parties and a critical and independent press. Economically, Croatia's Gross Domestic Product is greater than that of most of its neighbors, some of whom have already joined NATO.

In addition, Croatia currently participates as a full partner in the United States and NATO war on international terrorism. Finally, I believe the passage of this concurrent resolution will further underline the need to bring Croatia into NATO at the earliest opportunity.

Mr. GREEN of Wisconsin. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. ADERHOLT). The question is on the motion offered by the gentleman from Wisconsin (Mr. GREEN) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 209, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

FAMILY FARMER BANKRUPTCY RELIEF ACT OF 2003

Mr. SENSENBRENNER. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2465) to extend for six months the period for which chapter 12 of title 11 of the United States Code is reenacted.

The Clerk read as follows:

H.R. 2465

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Family Farmer Bankruptcy Relief Act of 2003".

SEC. 2. SIX-MONTH EXTENSION OF PERIOD FOR WHICH CHAPTER 12 OF TITLE 11, UNITED STATES CODE, IS REENACTED.

(a) AMENDMENTS.—Section 149 of title I of division C of Public Law 105–277 (11 U.S.C. 1201 note) is amended—

(1) by striking "July 1, 2003" each place it appears and inserting "January 1, 2004"; and

(2) in subsection (a)—

(A) by striking "December 31, 2002" and inserting "June 30, 2003"; and

(B) by striking "January 1, 2003" and inserting "July 1, 2003".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on July 1, 2003.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Wisconsin (Mr. SENSENBRENNER) and the gentlewoman from Wisconsin (Ms. BALDWIN) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. SENSENBRENNER).

GENERAL LEAVE

Mr. SENSENBRENNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 2465.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 2465, the Family Farmers Bankruptcy Relief Act of 2003.

Earlier this year, the National Oceanic and Atmospheric Administration reported that certain parts of our Nation, particularly the western and Great Plains States, were experiencing "one of the worst droughts in 108 years." Other parts of the country, like the Northeast, are currently enduring seemingly unending days of rainy weather.

While bad weather may be merely an inconvenience for some of us, uncontrollable weather conditions represent just one of the many difficult challenges that confront family farmers. Like many small businesses, family farmers must also endure and react to rising energy costs, volatile marketplace conditions, and increasing competition from larger businesses. Unfortunately, these economic forces can negatively affect the financial stability of the family farmer.

In response to the particularized needs of family farmers in financial distress, chapter 12 of the Bankruptcy Code was enacted in 1986 as a part of the Bankruptcy Judges, United States Trustees, and Family Farmer Bankruptcy Act. Although originally enacted on a temporary basis to address the farming crisis of the 1980s, chapter 12 has been extended on nine occasions in recognition of the vital relief it offers to family farmers in financial distress. Unless further extended, chapter 12 will sunset at the end of this month.

It is crucial that this specialized form of bankruptcy relief for family farmers not be allowed to sunset for two fundamental reasons. First, family farmers, absent chapter 12, would be forced to file for bankruptcy relief under the Bankruptcy Code's other alternatives, none of which work as well for them as does chapter 12.

Chapter VII of the Bankruptcy Code, for instance, would require a farmer to liquidate; that is, sell the family farm to pay the claims of the farmer's creditors. Many farmers would be precluded from choosing bankruptcy relief under chapter 13 of the Bankruptcy Code because of its restrictive eligibility standards. Furthermore, Chapter XI, the Bankruptcy Code's business reorganization alternative, is not farmer-friendly in various respects, as it often entails an expensive and time-consuming process that does not readily accommodate the special needs of farmers.

Second, recent statistics demonstrate that there is not only a continuing need for chapter 12, but that this need is apparently increasing. According to the Administrative Office of the United States Courts, chapter 12 bankruptcy filings jumped by more than 62 percent over the past year. I introduced H.R. 2465 to extend chapter 12 for an additional 6 months through December 31, 2003, and thereby maintain the status quo while the Congress completes its consideration of comprehensive bankruptcy reform.

As my colleagues may recall, last March the House overwhelmingly passed H.R. 975, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2003, which is now awaiting consideration in the other body. H.R. 965 contains many farmer-friendly provisions that would make chapter 12 a permanent fixture of the Bankruptcy Code for family farmers and generally make it easier for farmers in financial distress to be eligible for this form of bankruptcy relief. In addition, H.R. 975 would raise the debt limit and lower the income threshold so that many more family farmers could avail themselves of chapter 12. Also, this bill, for the first time, would extend the benefits of this specialized form of bankruptcy relief to family fishermen.

It is my sincere hope that in the very near future, we will see comprehensive bankruptcy reform legislation finally enacted, together with the permanent extension of chapter 12. Thus, I urge my colleagues to vote for H.R. 2465.

Mr. Speaker, I reserve the balance of my time.

Ms. BALDWIN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, chapter 12 bankruptcy protection expires in 7 days. Once again, we are forced to approve a temporary extension of this vital protection.

Since I was first elected to Congress just 4½ years ago, we have passed seven temporary extensions of this bill. It is high time that we make this very noncontroversial program permanent. That is the bill we should be debating and passing today.

Mr. Speaker, chapter 12 provides an important backstop for our Nation's struggling family farmers by allowing them to reorganize their debts and keep their farms. What we do here in Washington directly affects the lives of real people facing real financial challenges.

I want to try to put a human face on this issue. In Wisconsin recently, a Columbus, Wisconsin farmer filed for chapter 12 bankruptcy. He works night and day to make his farm a success. Unfortunately, like many farmers, the weather and the market conspired to disrupt his cash flow. Filing chapter 12 gave his family time to negotiate with his creditors, while he switched from corn and soybean production to vegetable production, with local market sales. He sells his produce at farmers' markets in the Cities of Madison and Princeton. He is paying his debts. Under chapter 12, it was not only the Columbus farmer that benefited. His creditors got their money, and the people in my district can purchase his bounty.

Chapter 12 does not just provide a direct benefit to those using its protections. Many farmers who face possible bankruptcy never get to a court filing. The very existence of the option of filing for chapter 12 bankruptcy promotes negotiations between farmers and their creditors.

There is a great consensus that chapter 12 bankruptcy protections work well. It is for that reason that we have included a permanent authorization in the comprehensive bankruptcy reform bill for the past three sessions of Congress. In fact, it is considered so popular that it has been held hostage to the larger bill. Every time we come to the floor to extend chapter 12, we are told that permanent extension cannot be passed separately from the big bill because taking out a popular item might slow that bill's momentum. We were told we had to strip the permanent extension of chapter 12 from last year's farm bill because it would slow down the bankruptcy bill. Well, here we are again, passing yet another temporary extension, and still the permanent extension languishes with about as much momentum as the continental drift.

Mr. Speaker, the House should pass this bill today, and I urge my colleagues to do just that. But we should also be voting on making chapter 12 permanent. Let us end these uncertainties that the extension causes. Let us end this chapter 12 extension dance.

Since the current authorization will expire within a few days, farmers do need the immediate relief provided by this extension. With the current year's crops in the ground, farmers need to know that they can reorganize and keep their farming operations. This bill would provide the security that family farmers in financial crisis need to decide whether to stay in business for one more year.

I urge my colleagues to support this legislation.

Mr. Speaker, I yield back the balance of my time.

Mr. SENSENBRENNER. Mr. Speaker, I yield such time as he may consume to the gentleman from Nebraska (Mr. BEREUTER).

Mr. BEREUTER. Mr. Speaker, I rise in support of H.R. 2465.

Mr. Speaker, this Member rises today to express his support for H.R. 2465, which extends Chapter 12 bankruptcy for family farms and ranches to January 1, 2004. Chapter 12 bankruptcy once again is set to expire on July 1, 2003. This legislation is very important to the nation's agriculture sector.

This Member would express his appreciation to the distinguished gentleman from Wisconsin (Mr. SENSENBRENNER), the Chairman of the House Judiciary Committee, for introducing H.R. 2465. In addition, this Member would like to express his appreciation to the distinguished gentleman from Michigan (Mr. SMITH) for his efforts in getting this measure to the House Floor for consideration.

This extension of Chapter 12 bankruptcy is supported by this Member as it allows family farmers to reorganize their debts as compared to liquidating their assets. The use of the Chapter 12 bankruptcy provision has been an important and necessary option for family farmers throughout the nation. It has allowed family farmers to reorganize their assets in a manner which balances the interests of creditors and the future success of the involved farmer.

If Chapter 12 bankruptcy provisions are not extended for family farmers, it will be another very painful blow to an agricultural sector already reeling from low commodity prices. Not only will many family farmers have no viable option other than to end their operations, but it will also cause land values to likely plunge. Such a decrease in value of farmland will negatively affect the ability of family farmers to earn a living. In addition, the resulting decrease in farmland value will impact the manner in which banks conduct their agricultural lending activities. Furthermore, this Member has received many contacts from his constituents supporting the extension of Chapter 12 bankruptcy because of the situation now being faced by our nation's farm families—it is clear that the agricultural sector in hurting.

In closing, this Member urges his colleagues to support H.R. 2465.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself the balance of the time.

Mr. Speaker, no one is as frustrated as I am at the lack of progress on the overall bankruptcy reform bill, which is comprehensive and which will make this economy work better and more efficiently, particularly for those people who pay their bills and obligations on time. Without the overall bankruptcy reform bill being enacted into law, there will be those that use bankruptcy reform as a financial planning tool. That is absolutely wrong. Bankruptcy should exist for people and organizations that are genuinely down and out and who need to go through bankruptcy in order to get a fresh start, and the bill that is in the other body which this House passed by an overwhelming margin does just that.

I can understand the desire of people who are opposed to an overall bankruptcy reform bill to try to cherry-pick the popular items out of it and pass them piecemeal so that their opposition will end up sinking the overall bankruptcy reform bill once and for all. I do not go along with that, and I do not think the majority of this House will either.

The reason we have a temporary extension of chapter 12 here is to make sure that these protections for family farmers are maintained. But if chapter 12 and other issues are cherry-picked out, then the $44 billion a year of debt that is written off in bankruptcy will be passed on to those who pay their bills, including farmers who pay their bills in the form of higher goods and services.

That is why the overall bankruptcy reform bill ought to be enacted into law. And while the gentlewoman from Wisconsin might be prepared to give up on that issue, I am not, and that is why this bill is a temporary extension. We are going to do the job that needs to be done for the farmers today, and then, hopefully, later on this year, when the other body passes the overall bankruptcy reform bill, we will be able to do the job that needs to be done for people who pay their bills on time and, as agreed, to prevent this huge shift of costs from those who do not pay their bills to those who do.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. SENSENBRENNER) that the House suspend the rules and pass the bill, H.R. 2465.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. SENSENBRENNER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

□ 1445

VETERANS ENTREPRENEURSHIP AND BENEFITS IMPROVEMENT ACT OF 2003

Mr. SMITH of New Jersey. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1460) to amend title 38, United States Code, to permit the use of education benefits under such title for certain entrepreneurship courses, to permit veterans enrolled in a vocational rehabilitation program under chapter 31 of such title to have self-employment as a vocational goal, and for other purposes, as amended.

The Clerk read as follows:

H.R. 1460

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Entrepreneurship and Benefits Improvement Act of 2003".

SEC. 2. AUTHORIZATION FOR STATE APPROVING AGENCIES TO APPROVE CERTAIN ENTREPRENEURSHIP COURSES.

(a) APPROVAL OF ENTREPRENEURSHIP COURSES.—Section 3675 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(c)(1) A State approving agency may approve the entrepreneurship courses offered by a qualified provider of entrepreneurship courses.

"(2) For purposes of this subsection, the term 'entrepreneurship course' means a non-degree, non-credit course of business education that enables or assists a person to start or enhance a small business enterprise.

"(3) Subsection (a) and paragraphs (1) and (2) of subsection (b) do not apply to—

"(A) an entrepreneurship course offered by a qualified provider of entrepreneurship courses; and

"(B) a qualified provider of entrepreneurship courses by reason of such provider offering one or more entrepreneurship courses.".

(b) BUSINESS OWNERS NOT TREATED AS ALREADY QUALIFIED.—Section 3471 of such title is amended by inserting before the last sentence the following: "The Secretary shall not treat a person as already qualified for the objective of a program of education offered by a qualified provider of entrepreneurship courses solely because such person is the owner or operator of a business.".

(c) INCLUSION OF ENTREPRENEURSHIP COURSES IN DEFINITION OF PROGRAM OF EDUCATION.—Subsection (b) of section 3452 of such title is amended by adding at the end the following: "Such term also includes any course, or combination of courses, offered by a qualified provider of entrepreneurship courses."

(d) INCLUSION OF QUALIFIED PROVIDER OF ENTREPRENEURSHIP COURSES IN DEFINITION OF EDUCATIONAL INSTITUTION.—Subsection (c) of section 3452 of such title is amended by adding at the end the following: "Such term also includes any qualified provider of entrepreneurship courses.".

(e) DEFINITION OF QUALIFIED PROVIDER OF ENTREPRENEURSHIP COURSES.—Section 3452 of such title is further amended by adding at the end the following new subsection:

"(h) The term 'qualified provider of entrepreneurship courses' means—

"(1) a small business development center described in section 21 of the Small Business Act (15 U.S.C. 648), and

"(2) the National Veterans Business Development Corporation (established under section 33 of such Act (15 U.S.C. 657c)) insofar as the Corporation offers or sponsors an entrepreneurship course (as defined in section 3675(c)(2) of this title).".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to courses approved by State approving agencies after the date of the enactment of this Act.

SEC. 3. PROCUREMENT PROGRAM FOR CERTIFIED SMALL BUSINESS CONCERNS OWNED AND CONTROLLED BY QUALIFIED SERVICE-DISABLED VETERANS, ETC.

(a) ESTABLISHMENT OF PROGRAM.—The Small Business Act (15 U.S.C. 631 et seq.) is amended by redesignating section 36 as section 38 and by inserting after section 35 the following new sections:

"SEC. 36. PROCUREMENT PROGRAM FOR CERTIFIED SMALL BUSINESS CONCERNS OWNED AND CONTROLLED BY QUALIFIED SERVICE-DISABLED VETERANS.

"(a) SOLE SOURCE CONTRACTS.—In accordance with this section, a contracting officer may award a sole source contract to any certified small business concern owned and controlled by qualified service-disabled veterans if—

"(1) such concern is determined to be a responsible contractor with respect to performance of such contract opportunity and the contracting officer does not have a reasonable expectation that 2 or more certified small business concerns owned and controlled by qualified service-disabled veterans will submit offers for the contracting opportunity;

"(2) the anticipated award price of the contract (including options) will not exceed—

"(A) $5,000,000, in the case of a contract opportunity assigned a standard industrial classification code for manufacturing; or

"(B) $3,000,000, in the case of any other contract opportunity; and

"(3) in the estimation of the contracting officer, the contract award can be made at a fair and reasonable price.

"(b) RESTRICTED COMPETITION.—In accordance with this section, a contracting officer may award contracts on the basis of competition restricted to certified small business concerns owned and controlled by qualified service-disabled veterans if the contracting officer has a reasonable expectation that not less than 2 certified small business concerns owned and controlled by qualified service-disabled veterans will submit offers and that the award can be made at a fair market price.

"(c) ENFORCEMENT; PENALTIES.—Rules similar to the rules of section 31(c) shall apply for purposes of this section.

"(d) COLLECTION OF DATA REGARDING SMALL BUSINESS CONCERNS OWNED AND CONTROLLED BY SERVICE-DISABLED VETERANS.—

"(1) SURVEY.—Not later than 2 years after the date of the enactment of this section and each 3 years thereafter, the Administrator, in consultation with the Secretary of Veterans Affairs, shall complete a survey of service-disabled veterans receiving benefits under title 38, United States Code, to determine the number, identity, and primary industry classification of small business concerns owned and controlled by service-disabled veterans.

"(2) REPORT TO CONGRESS.—The Administrator, in consultation with the Secretary of Veterans Affairs, shall report to Congress on the results of each survey conducted under paragraph (1). Such report shall include the total number of small business concerns owned and controlled by service-disabled veterans.

"(e) CONTRACTING OFFICER.—For purposes of this section and section 37, the term 'contracting officer' has the meaning given such term in section 27(f)(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 423(f)(5)).

"SEC. 37. PRIORITY OF SMALL BUSINESS PROCUREMENT PREFERENCES.

"(a) IN GENERAL.—A contracting officer may not make a procurement from a source on the basis of a preference provided under any provision of this Act referred to in subsection (b) unless the contracting officer has determined that such procurement cannot be made on the basis of a preference provided under another provision of this Act with a higher priority under such subsection.

"(b) ORDER OF PRIORITY.—For purposes of this section, the following provisions of this Act are listed in order of priority from highest to lowest:

"(1) Section 8(a).

"(2) Section 36(b).

"(3) Section 36(a).

"(4) Section 31(b)(2)(B).

"(5) Section 31(b)(2)(A).

"(6) Section 8(m).

"(c) PRIORITY OF CERTAIN OTHER PROCUREMENT PREFERENCES.—A procurement may not be made from a source on the basis of a preference provided under any provision of this Act referred to in subsection (b) if the procurement would otherwise be made from a different source under section 4124 or 4125 of title 18, United States Code, or the Javits-Wagner-O'Day Act (41 U.S.C. 46 et seq.).".

(b) Certified Small Business Concern Owned and Controlled by Service-Disabled Veterans.—Subsection (q) of section 3 of the Small Business Act (15 U.S.C. 632) is amended by adding at the end the following new paragraph:

"(5) Certified small business concern owned and controlled by qualified service-disabled veterans.—

"(A) Qualified service-disabled veteran.—The term 'qualified service-disabled veteran' means any veteran who—

"(i) has one or more disabilities that are service-connected (as defined in section 101(16) of title 38, United States Code) and rated at 10 percent or more by the Secretary of Veterans Affairs; or

"(ii) is entitled to benefits under section 1151 of title 38, United States Code.

"(B) Small business concern owned and controlled by qualified service-disabled veterans.—The term 'small business concern owned and controlled by qualified service-disabled veterans' means a small business concern—

"(i) not less than 51 percent of which is owned by one or more qualified service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more qualified service-disabled veterans; and

"(ii) the management and daily business operations of which are controlled by one or more qualified service-disabled veterans or, in the case of a veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

"(C) Certified small business concern owned and controlled by qualified service-disabled veterans.—The term 'certified small business concern owned and controlled by qualified service-disabled veterans' means any small business concern owned and controlled by qualified service-disabled veterans that is certified by the Administrator as being such a concern.".

(c) Conforming Amendments.—Paragraph (2) of section 31(b) of the Small Business Act (15 U.S.C. 657a(b)) is amended—

(1) by striking "Notwithstanding any other provision of law" and inserting "In accordance with this section";

(2) in subparagraph (B)—

(A) by striking "a contract opportunity shall be awarded pursuant to this section" and inserting "a contracting officer may award contracts"; and

(B) by striking "; and" at the end and inserting a period; and

(3) by striking subparagraph (C).

(d) Department of Veterans Affairs Pilot Program.—

(1) In general.—In the case of a contracting officer of the Department of Veterans Affairs, the provisions of the Small Business Act referred to in paragraphs (1), (2), and (3) of section 37(b) of such Act shall be treated as being equal in priority for purposes of applying section 37 of such Act.

(2) Termination.—Paragraph (1) shall not apply with respect to procurements made after September 30, 2007.

SEC. 4. AUTHORIZATION TO PROVIDE ADAPTED HOUSING ASSISTANCE TO CERTAIN DISABLED MEMBERS OF THE ARMED FORCES WHO REMAIN ON ACTIVE DUTY.

Section 2101 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(c)(1) The Secretary may provide assistance under subsection (a) to a member of the Armed Forces serving on active duty who is suffering from a disability described in paragraph (1), (2), or (3) of that subsection if such disability is the result of an injury incurred or disease contracted in or aggravated in line of duty in the active military, naval, or air service. Such assistance shall be provided to the same extent as assistance is provided under that subsection to veterans eligible for assistance under that subsection and subject to the requirements of the second sentence of that subsection.

"(2) The Secretary may provide assistance under subsection (b) to a member of the Armed Forces serving on active duty who is suffering from a disability described in subparagraph (A) or (B) of paragraph (1) of that subsection if such disability is the result of an injury incurred or disease contracted in or aggravated in line of duty in the active military, naval, or air service. Such assistance shall be provided to the same extent as assistance is provided under such subsection to veterans eligible for assistance under that subsection and subject to the requirements of paragraph (2) of that subsection.".

SEC. 5. REINSTATEMENT OF MINIMUM REQUIREMENTS FOR SALE OF VENDEE LOANS.

(a) In General.—Section 3733(a) of title 38, United States Code, is amended—

(1) by striking paragraph (2) and redesignating paragraphs (3), (4), (5), and (6) as paragraphs (2), (3), (4), and (5), respectively; and

(2) in subparagraph (B)(i) of paragraph (3), as so redesignated, by striking "paragraph (5) of this subsection" and inserting "paragraph (4)".

(b) Increase in Maximum Percentage.—Section 3733(a)(1) of such title is amended—

(1) by striking "65 percent" in the first sentence and inserting "85 percent"; and

(2) by striking the second sentence.

(c) Stylistic Amendment.—Section 3733 of such title is amended by striking "paragraph (1) of this subsection" each place it appears and inserting "paragraph (1)".

SEC. 6. PAYMENT OF ACCRUED BENEFITS.

(a) Repeal of Limitation on Payment.—Subsection (a) of section 5121 of title 38, United States Code, is amended by striking "for a period not to exceed two years" in the matter preceding paragraph (1).

(b) Effective Date.—The amendment made by subsection (a) shall take effect with respect to deaths occurring on or after the date of the enactment of this Act.

The SPEAKER pro tempore (Mr. Aderholt). Pursuant to the rule, the gentleman from New Jersey (Mr. Smith) and the gentleman from Maine (Mr. Michaud) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. Smith).

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, before I begin discussing our bill, Mr. Speaker, I would like to note with great sadness the passing of the former chairman of the Committee on Veterans Affairs, Bob Stump. Bob was a great friend to all of those who served in the Armed Forces since his own Naval experience as a Navy corpsman serving in the South Pacific during World War II. Although you did not see Bob making the rounds on the Sunday morning talk shows, his words, and especially his actions and deeds, spoke volumes about his dedication to all those who serve and have served our country in the United States military.

Bob served in Congress for 26 years. He was chairman of the House Committee on Veterans Affairs from 1995 to 2000, and then chaired the House Committee on Armed Services until his retirement in December of 2002. He has left a lasting legacy of service to our country, and he will be dearly missed.

On behalf of the Committee on Veterans Affairs, I want to express our condolences to his wife, Nancy, his children, Karen, Hoot, and Bruce, and to his grandchildren as well.

Mr. Speaker, I rise today in strong support of H.R. 1460, as amended, the Veterans Entrepreneurial and Benefits Improvement Act of 2003. The Committee on Veterans Affairs reported H.R. 1460 unanimously on May 15 as a result of the initiative of the gentleman from Arizona (Mr. Renzi), who introduced the bill. This bill was introduced following a hearing on the state of veterans employment on February 5 at which the gentleman from Arizona (Mr. Renzi) highlighted the seriously inadequate performance of Federal agencies in reaching out to disabled veteran-owned businesses. Since then, the ranking member, the gentleman from Illinois (Mr. Evans), and I have worked closely with the chairman, the gentleman from Illinois (Mr. Manzullo), and the ranking member, the gentlewoman from New York (Ms. Velázquez), of the Committee on Small Business with respect to section 3 of the bill on which the Committee on Small Business had jurisdiction.

I am pleased that we have been able to formulate language agreeable to both committees, and I want to thank the gentleman from Illinois (Mr. Manzullo) and the gentlewoman from New York (Ms. Velázquez) for their cooperative efforts.

Mr. Speaker, disabled American veterans deserve a full opportunity to participate in the economic system that they fought so hard to defend. Section 2 of the bill would make improvements to the veteran and service-disabled veteran's small business opportunities by authorizing for the first time the use of VA education benefits to pay for nondegree/noncredit courses. These courses are offered by the Small Business Development Center and the National Veterans Business Development Corporation.

Section 3 of the bill has been, if you want to look at it one way, almost 23 years in the making. It contains a disabled veterans contracting preference provision derived from the 1980 White House Conference on Small Business convened by then-President Jimmy Carter.

The 1981 consultant report of the SBA Veterans Project and the 1999 report of the bipartisan Congressional Commission on Servicemembers and Veterans Transition Assistance made similar-type recommendations.

This provision for the first time would authorize Federal agencies to create sole-source contracts for disabled veteran-owned and -controlled small businesses. It would also furnish Federal agencies discretionary authority to restrict contracts to disabled veteran-owned and -controlled businesses if at least two such concerns were qualified to bid on the contract. This is the first time Federal contracting officers will have such authority.

Section 3 would also create a 4-year pilot in the Department of Veterans Affairs, service-disabled veterans-controlled businesses, and would have the same contracting priority as SBA's 8(a) program for socially and economically disadvantaged small business.

For all other Federal agencies, service-connected disabled-veteran-owned and -controlled businesses would be accorded priority to be awarded procurement contracts above the women-owned and HUBZone priorities, but just below 8(a) priorities.

In all cases, to be eligible for these procurement preferences, veterans who own and control small businesses would need to have at least a 10 percent service-connected disability.

The Federal Government, Mr. Speaker, contracts for about $235 billion in goods and services annually. America's sons and daughters who became disabled in their service to the Nation will now have some of the same types of contracting preferences accorded to other deserving groups.

Section 4 of the bill, Mr. Speaker, would extend VA's specially adapted housing grant to severely disabled service members prior to separation from active duty service. Under current law, an otherwise eligible servicemember may not apply for home modification assistance until he or she is actually separated from the military or placed on the temporary-disabled retirement list.

I want to commend the gentleman from Illinois (Mr. EVANS) for his leadership in putting together this important provision.

Section 5 would reinstate the Department of Veterans Affairs' vendee loan programs, which the VA administratively terminated last January. I want to thank the gentleman for joining me for authoring this provision.

When a purchaser agrees to buy a foreclosed VA home, VA often offers to finance the sale by establishing a vendee loan to encourage the prompt sale of a home. Vendee loans are made at market interest rates and often require a down payment. Borrowers are assessed a 2.25 percent funding fee that is paid in each case. The vendee loan program is based on sound business principles, and there is an ample body of empirical evidence to suggest that offering vendee financing is highly cost effective to the government. In March, for example, of 2002, a Booz, Allen, Hamilton study found that cost effectiveness of vendee loan financing, their report said that the government would save $16 million a year starting in 1999.

Finally, section 6 of the bill would repeal the existing 2-year limitation on accrued benefits so that a veteran survivor may receive the full amount of an award and of benefits and may not be penalized if VA does not process the claim in a timely manner. This section is derived from H.R. 241, legislation that I introduced earlier this year.

Finally, I want to thank especially the good leadership that the gentleman from Arizona (Mr. RENZI) has provided in shaping this legislation. As always, I wanted to thank my good friend and colleague, the gentleman from Illinois (Mr. EVANS), for his work on this, as well as the gentleman from Maine (Mr. MICHAUD) who is representing the minority in presenting this bill to the floor today and for his good work as ranking member of the subcommittee.

Mr. Speaker, I reserve the balance of my time.

Mr. MICHAUD. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today to express my strong support for H.R. 1460, the Veterans Entrepreneurship and Benefits Improvement Act of 2003, which I am a proud co-sponsor of. I also would like to thank the chairman of the committee, the gentleman from New Jersey (Mr. SMITH); the ranking member, the gentleman from Illinois (Mr. EVANS); and the chairman of the Subcommittee on Benefits, the gentleman from South Carolina (Mr. BROWN), for their work in bringing this important legislation to the floor.

This bill includes several provisions related to veterans who are owners of small businesses or who aspire to be.

I appreciate the efforts of the chairman, the gentleman from Illinois (Mr. MANZULLO); and the ranking member, the gentlewoman from New York (Ms. VELÁZQUEZ); as well as the staff of the Committee on Small Business for their assistance with those provisions.

H.R. 1460 would authorize the use of VA education assistance to pay for nondegree and noncredit business courses at approved institutions. This will enable veterans to obtain educational opportunities that meet their small business goals. This legislation would also improve the ability of service-disabled veterans who own small businesses to do business with the Federal Government.

As a member of both the Committee on Small Business and the Committee on Veterans Affairs, I am pleased that we are considering this legislation to help service-disabled veterans to obtain government contracts. These men and women who have sacrificed so much for this country, they are disabled as a result of their service to our Nation. The least that we can do is to say if you own a small business, then you should have the opportunity to obtain contracts from the Federal Government.

I am particularly disappointed about the number of service-disabled veterans who are obtaining Federal contracts. The number is already unacceptably small, and it has actually decreased over the past year. As Angela Styles of the Office of Management and Budget testified earlier this year, the Federal Government's record for contracts to service-disabled veterans is abysmal.

This bill will help improve that record. Section 4 of the bill includes provisions from H.R. 761, introduced by the ranking member, the gentleman from Illinois (Mr. EVANS), and by the chairman, the gentleman from New Jersey (Mr. SMITH). These provisions would allow servicemembers such as those seriously disabled during the Iraq War to obtain special adapted housing grants before being discharged from military service. These grants are available only to the most severely disabled veterans.

Under current law, servicemembers with severe disabilities may have their hospital discharge delayed if, for example, they do not have a wheelchair-accessible home available. But we can speed up the process by giving them their assistance immediately. Since they will meet the requirements as soon as they are discharged, there is no reason to delay providing them with assistance while their discharge is pending. This is a sensible, cost-effective and humane provision.

Section 5 of the bill would reinstate a particularly effective VA vendee home loan program, and I am puzzled as to what the reasons were for terminating such an effective, cost-saving program; and I am pleased that Congress is taking action to reinstate it.

H.R. 1460 also includes a provision of H.R. 241, which removes the time limitation on accrued benefits paid to the families of veterans who died while a claim for veterans benefits is pending. I have veterans in my district in Maine with claims which have been pending for many years. I hope none of them passes away while waiting for a decision. Should they do so, I want their families to see the full retroactive benefit to which the veteran is entitled.

I urge all Members to support this bill.

Finally, Mr. Speaker, I note with sadness the passing of a long-time friend of this Nation's veterans and former chair of our committee, Bob Stump. Although I did not have the opportunity to work with Mr. Stump, I appreciate the legacy of bipartisan cooperation he has left with the Committee on Veterans Affairs, similar to the gentleman from New Jersey (Chairman SMITH).

I would like to extend my sympathy and that of all members of this body to his wife and his children.

Mr. Speaker, I reserve the balance of my time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Arizona (Mr. RENZI), the author of the bill.

Mr. RENZI. Mr. Speaker, I too want to share the words and the memories of Congressman Bob Stump. I am privileged to serve a major portion of the district in Arizona that he served so greatly for many, many years and more so, to learn more about him through the experience of his staff members who now work for me here in Washington. In addition, what I have learned greatly with serving with the Committee on Veterans Affairs under his mentorship and leadership has been a great influence on me.

I thank the gentleman from New Jersey (Mr. SMITH) for those words, and to the gentleman from Maine (Mr. MICHAUD) I am also grateful. I will pass those on at the ceremony honoring Bob Stump this Wednesday in Arizona.

□ 1500

Mr. Speaker, I am pleased to stand here today in support of the thousands of service-disabled veteran small business owners across the Nation who want to do business with the Federal Government. The distinguished members of our community and the successful small businesses are an integral part of the backbone of our economy; the same economy they fought for so bravely; the same economy that they gave their personal sacrifice to preserve and protect.

I want to thank the gentleman from New Jersey (Mr. SMITH), the chairman, because it is he who saw this many years ago and helped pull together the various portions of this legislation to build a bill that the gentleman from Illinois (Mr. EVANS), the ranking member, has supported, the gentleman from Illinois (Mr. MANZULLO), the gentlewoman from New York (Ms. VELÁZQUEZ), and also our distinguished ranking member on the subcommittee, the gentleman from Maine (Mr. MICHAUD). I also want to thank the gentleman from South Carolina (Mr. BROWN) for allowing me to move forward this legislation, though it came under jurisdiction of his committee, and I especially want to thank the Committee on Veterans Affairs staff for their leadership and guidance in developing this legislation. They put a lot of hours into making this bill a reality.

This bill is a first step in improving our current practice of contracting opportunities, and I look forward to working with the Committee on Veterans Affairs in the future and with the Committee on Small Business to further extend these small business opportunities.

Our purpose in introducing this legislation was to give service-disabled business owners and Federal contractors the tools they need to meet the government-wide statutory goal of 3 percent established in Public Law 106–50. When the Committee on Veterans Affairs held an oversight hearing chaired by our committee chairman, the gentleman from New Jersey (Mr. SMITH), on February 5, the state of veterans entrepreneurship program was discouraging to hear. In many cases, there were only several agencies that had Federal contracts with any of our service-disabled veterans and many did not even reach 1 percent. This is unacceptable and our veterans deserve better.

This bill sets out to lift these barriers that have denied service-disabled veterans the opportunities to fully participate in Federal contracting, and we are morally bound to promote the successful employment of those who have borne the battle and bear the scars of freedom for all Americans.

For the first time, this legislation, H.R. 1460, will allow veterans to use the Montgomery GI bill to educate themselves and to take entrepreneurial courses from small business centers. The National Veterans Business Development Centers Corporation will also be included in their ability to teach many of our veterans. This gives veterans the business education and training they need to successfully operate small businesses, and it is a real investment towards improving our economy and our veterans' livelihood.

Secondly, we recognize certified small business owners as a source of Federal procurement programs. Service-disabled veterans have a tougher journey ahead of them when they return from duty with a disability, and these veterans are comprised of individuals of all races and both genders. Veterans have earned the right to compete for contracts on the same level as other classes of individuals.

We hope that in the future those who have served within the Department of Defense and have provided homeland security will also have a priority in contracting with DOD and the Department of Homeland Security.

Small business-contracting Federal officers will note that Public Law 106–50 directed the creation of a database of small businesses that have identified themselves as being owned by service-disabled American veterans. This has been a labor intensive task, and I commend the Department of Veterans Affairs for their progress in realizing this effort. It is critically important that our Federal contractors have access to this information and be able to identify veteran-owned businesses that qualify for prime and subcontractor awards.

This legislation is a beginning. This tool can be used by veteran contracting officers to find service-disabled veteran businesses and help them achieve the statutory goal of 3 percent.

I want to thank again the gentleman from New Jersey (Mr. SMITH) for his leadership and his kindness towards me and generosity. I thank everyone on the Committee on Veterans Affairs, and I hope disabled American veterans will find a way now to help grow their businesses and prosper.

Mr. MICHAUD. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself an additional minute.

I again want to thank my friends on the other side of the aisle for their good hard work on this legislation, and I especially want to thank the extraordinary work by the author of it, the gentleman from Arizona (Mr. RENZI). This is a bill that will help so many of our veterans who are service-connected disabled who are in the business realm to get the kind of government contracts that they are deserving of and hopefully will lead to greater wealth and a capability on their part to provide for their families and for their loved ones.

This is a good bill. It is pro-business, it is pro-veteran, and it deserves the support of everybody in this Chamber.

Mr. Speaker, again, I want to thank our subcommittee chairman, the gentleman from South Carolina (Mr. BROWN), and again, the gentleman from Maine (Mr. MICHAUD), who is the ranking member, for their work on this bill, for marking it up and bringing it forward to the full committee where we marked it up and passed it unanimously.

Mr. EVANS. Mr. Speaker, I support H.R. 1460, the Veterans' Entrepreneurship and Benefits Improvement Act of 2003 and urge passage by this Chamber. I would like to thank CHRIS SMITH, chairman of the full committee, the Benefits Subcommittee chairman, HENRY BROWN and ranking member, MICHAEL MICHAUD, for their hard work in bringing this legislation to the floor. I also want to acknowledge the contributions of DON MANZULLO and NYDIA VELÁZQUEZ, chairman and ranking member of the House Small Business Committee, along with their respective staffs for assisting us in crafting this legislation.

I am proud to be an original cosponsor of this bill as it provides increased opportunities for veterans to develop their entrepreneurial skills and become successful small business owners. Mr. Speaker, H.R. 1460 is a good bill and a step in the right direction with respect to its small business contracting provisions. The Federal Government engages in procurement contracts of up to $235 billion a year. Surely, service-disabled veteran small business owners deserve an opportunity to participate in this system.

Section 2 authorizes the use of VA education assistance to pay for nondegree and noncredit business courses at approved institutions. This provision should expand the educational and training opportunities for service-disabled veterans.

Section 3 authorizes Federal agency contracting officers to create sole source and restricted competition contracts for "certified" service-disabled veteran small business owners; requires the collection of relevant data and a report to Congress on service-disabled small business owners; and establishes a 4-year pilot program at the Department of Veterans Affairs through which service-disabled veteran small business owners would receive equal priority among all small business programs.

Section 4 is derived from a bill, H.R. 761, which I introduced. It would allow service members to apply for and receive a grant for specially adapted housing while still in military service. This legislation was prompted by reports of seriously disabled service members having to remain hospitalized until they were discharged from military services because they could not obtain a grant for specially adapted housing until after leaving military service. Without such a grant they were unable to obtain accessible housing. There is no question that these service members will be discharged from military service. In order to qualify for the specially adapted housing grant, severe disabilities incompatible with continued military service are required. I hope that the Senate will act quickly to pass this legislation. I do not want to see severely disabled servicemembers from the recent Iraq war unnecessarily hospitalized due to the lack of accessible housing.

Section 5 reinstates the VA's vendee loan program. The vendee loan program is a successful program that allows VA to finance loans to a new veteran or non-veteran purchaser when the prior loan has been foreclosed upon and VA has received the property. By allowing vendee loans, the VA is able to sell the property more quickly and at a higher cost than is possible with conventional financing. VA abruptly ended this program earlier this year. I strongly favor its reinstatement.

Finally, section 6 would allow a surviving spouse or dependent children to receive accrued benefits if the veteran dies while a claim for VA periodic monetary benefits is being processed. Currently there is a 2-year time limit on the retroactive period. I have introduced legislation to allow family members to continue the claims of veterans who die while a claim is pending. This provision is a good first step. The government should not be allowed to deny retroactive payments when the government's inaction is responsible for delayed adjudication of a claim.

Again, I thank my colleagues on the Veterans' Affairs Committee for their hard work and I urge my colleagues to vote to pass this legislation.

Mr. BROWN of South Carolina. Mr. Speaker, as an original sponsor of H.R. 1460, as amended, the "Veterans Entrepreneurship and Benefits Improvement Act of 2003. I encourage my colleagues to support this legislation. I commend representative RENZI, Chairman SMITH and Ranking Member EVANS of the Committee on Veterans Affairs, and Chairman MANZULLO and Ranking Member VELÁZQUEZ of the Small Business Committee for bringing this important legislation to the floor for consideration.

I especially want to comment on sections two and three of the bill.

Section two would allow veterans, disabled veterans, dependents of totally disabled or deceased veterans, and active-duty members of the Selected Reserve to use their VA benefits to pursue pre-entrepreneurship and entrepreneurship courses offered under the auspices of Small Business Development Centers and the National Veterans Business Development Corporation. Small businesses in the last decade accounted for about 70 percent of the new jobs created in our economy.

The men and women who have served in our military indeed are engaging and resourceful individuals. Indeed, the 1999 report of the bipartisan Congressional Commission on Servicemembers and Veterans Transition Assistance found the following: "a 5-year profile survey of veteran-owned businesses in Massachusetts conducted in the late 1980's and early 1990's showed that a pool of approximately 2,000 veterans engaged in micro businesses generated $74 million in taxable income for the Commonwealth of Massachusetts." And that is just in one state. With the availability of training under this bill, more veterans will be able to obtain the skills they need to start and grow their own small businesses. As Deputy Secretary of Veterans Affairs, Dr. Leo S. Mackay, Jr. testified at our April 30th hearing, "the potential for positive effects on the economy, with enhanced competition and creativity within the marketplace, is significant."

Section three of the bill would place disabled veteran-owned and controlled small businesses on a par with socially and economically disadvantaged veterans in the 8(a) contracting program for procurement contracts offered by the Department of Veterans Affairs for the next four years. This authority would apply to "setaside" and restricted competition contracts to be applied by contracting officers on a discretionary basis. For all Federal agencies, disabled veteran-owned and controlled small businesses would rank ahead of HUBZone and women-owned businesses in procurement preferences, but behind the 8(a) program. I find these types of preference as a needed 'first step' because of two additional findings of the Transition Commission: first, "Disabled-veteran entrepreneurs require additional assistance because these business owners encounter costs and impediments that are not factors for their non-disabled competitors. Second, as a matter of fundamental fairness, Congress should accord veterans a full opportunity to participate in the economic system that their service sustains."

Lastly, Mr. Speaker, I would note for the RECORD that the current independent Task Force for Veterans Entrepreneurship, the aforementioned Transition Commission, the 1981 expert report of the SBA Veterans Project, and the 1980 White House Conference on Small Business all recommended some type of federal "setaside" authority for disabled-veteran owned and controlled small businesses in the purchase of goods and services.

I encourage my colleagues to support this legislation.

Mr. REYES. Mr. Speaker, I rise in support of H.R. 1460. The provisions of this legislation remove barriers to small business ownership for veterans. H.R. 1460 allows veterans to use their education benefits to pay for non-degree or non-credit courses of entrepreneurship, enabling them to learn the skills that they will need when starting and running their own businesses. The bill additionally amends the Small Business Act to give small businesses owned by service disabled veterans the opportunity to secure sole source contracts from the Federal Government. By giving those participating in a veteran's rehabilitation program the chance to name self-employment as their vocational goal, H.R. 1460 makes entrepreneurship a viable career option for many for whom it was not before.

The passage of this legislation would mean a lot for those veterans who, like so many other Americans, dream of working for themselves. The opportunities that H.R. 1460 provides for self-employment are especially meaningful when salaried jobs can be so difficult to find. Large numbers of veterans live in my home district of El Paso, Texas where we unfortunately also have a high unemployment rate. A community like mine is a prime example of why we must provide veterans with the tools they need to become successful entrepreneurs. I urge my colleagues to join me in supporting this bipartisan legislation.

Mr. SMITH of New Jersey. Mr. Speaker, I have no further requests for time, and I yield back the balance of our time.

The SPEAKER pro tempore (Mr. ADERHOLT). The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and pass the bill, H.R. 1460, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. SMITH of New Jersey. Mr. Speaker, on that I demand the yeas-and-nays.

The yeas-and-nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

GENERAL LEAVE

Mr. SMITH of New Jersey. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 1460, as amended.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess until approximately 6:30 p.m. today.

Accordingly (at 3 o'clock and 6 minutes p.m.), the House stood in recess until approximately 6:30 p.m. today.

☐ 1830

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. CULBERSON) at 6 o'clock and 30 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on four motions to suspend the rules previously postponed.

Votes will be taken in the following order:

H. Res. 264, by the yeas and nays;

H. Res. 177, by the yeas and nays;

H. Con. Res. 209, by the yeas and nays; and

H.R. 2465, by the yeas and nays.

Proceedings on H.R. 1460 will resume tomorrow.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

EXPRESSING SYMPATHY FOR VICTIMS OF ALGERIAN EARTHQUAKE

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the resolution, H. Res. 264.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. GREEN) that the House suspend the rules and agree to the resolution, H. Res. 264, on which the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 382, nays 1, not voting 51, as follows:

[Roll No. 297]

YEAS—382

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Crane
Crenshaw
Cubin
Culberson
Cummings
Cunningham
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Flake
Foley
Forbes
Ford
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kind
King (IA)
King (NY)
Kingston
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Lantos
Larsen (WA)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Napolitano
Neal (MA)
Neugebauer
Ney
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pascrell
Pastor
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Price (NC)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (MI)
Rohrabacher
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Sherman
Sherwood
Shuster
Simmons
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiberi
Tierney
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—1

Paul

NOT VOTING—51

Berman
Brown, Corrine
Burton (IN)
Capuano
Conyers
Cramer
Crowley
Davis (AL)
Davis (CA)
Deal (GA)
DeMint
Feeney
Fletcher
Fossella
Gephardt
Houghton
Hulshof
Istook
Jefferson
Kilpatrick
Kirk
Kolbe
Langevin
Larson (CT)
Lipinski
Lofgren
Lowey
Lucas (OK)
Menendez
Mollohan
Nadler
Nethercutt
Northup
Pallone
Payne
Pomeroy
Pryce (OH)
Rogers (KY)
Ros-Lehtinen
Sanders
Shays
Shimkus
Simpson
Smith (WA)
Sullivan
Taylor (NC)
Tiahrt
Toomey
Velázquez
Weiner
Weldon (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. CULBERSON) (during the vote). The Chair would advise Members they have 2 minutes in which to record their vote.

☐ 1853

Mr. McINNIS and Mr. MOORE changed their vote from "nay" to "yea."

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

COMMENDING PEOPLE OF THE REPUBLIC OF KENYA FOR CONDUCTING FREE AND FAIR ELECTIONS AND PEACEFUL AND ORDERLY TRANSFER OF POWER

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the resolution, H. Res. 177, as amended.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. GREEN) that the House suspend the rules and agree to the resolution, H. Res. 177, as amended, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 380, nays 0, not voting 54, as follows:

[Roll No. 298]

YEAS—380

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Crane
Crenshaw
Cubin
Culberson
Cummings
Cunningham
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Flake
Foley
Forbes
Ford
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley (OR)
Hostettler
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kind
King (IA)
King (NY)
Kingston
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Napolitano
Neal (MA)
Neugebauer
Ney
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pascrell
Pastor
Paul
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Price (NC)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (MI)
Rohrabacher
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Sherman
Sherwood
Shuster
Simmons
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiberi
Tierney
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOT VOTING—54

Berman
Brown, Corrine
Burton (IN)
Capuano
Conyers
Cramer
Crowley
Davis (AL)
Davis (CA)
Deal (GA)
DeMint
Doolittle
Feeney
Fletcher
Fossella
Frank (MA)
Gephardt
Honda
Houghton
Hulshof
Istook
Jefferson
Kilpatrick
Kirk
Kolbe
Langevin
Lipinski
Lofgren
Lowey
Lucas (OK)
Meeks (NY)
Menendez
Mollohan
Nadler
Nethercutt
Northup
Pallone
Payne
Pomeroy
Pryce (OH)
Rogers (KY)
Ros-Lehtinen
Sanders
Shays
Shimkus
Simpson
Smith (WA)
Sullivan
Taylor (NC)
Tiahrt
Toomey
Velázquez
Weiner
Weldon (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised they have 2 minutes in which to record their votes.

□ 1900

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. HONDA. Mr. Speaker, on rollcall No. 298, had I been present, I would have voted "yea."

COMMENDING THE SIGNING OF THE UNITED STATES-ADRIATIC CHARTER

The SPEAKER pro tempore (Mr. CULBERSON). The pending business is the question of suspending the rules and agreeing to the resolution, H. Con. Res. 209, as amended.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. GREEN) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 209, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 381, nays 1, not voting 52, as follows:

[Roll No. 299]

YEAS—381

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Crane
Crenshaw
Cubin
Culberson
Cummings
Cunningham
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Flake
Foley
Forbes
Ford
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kind
King (IA)
King (NY)
Kingston
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Mica
Michaud
Millender-McDonald

Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Napolitano
Neal (MA)
Neugebauer
Ney
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pascrell
Pastor
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Price (NC)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (MI)
Rohrabacher
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Sherman
Sherwood
Shuster
Simmons
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiberi
Tierney
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (PA)
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—1

Paul

NOT VOTING—52

Berman
Brown, Corrine
Burton (IN)
Capuano
Conyers
Cramer
Crowley
Davis (AL)
Davis (CA)
Deal (GA)
DeMint
Feeney
Fletcher
Fossella
Gephardt
Houghton
Hulshof
Istook
Jefferson
Kilpatrick
Kirk
Kolbe
Langevin
Lipinski
Lofgren
Lowey
Lucas (OK)
McDermott
Menendez
Mollohan
Nadler
Nethercutt
Northup
Pallone
Payne
Pomeroy
Pryce (OH)
Rogers (KY)
Ros-Lehtinen
Sanders
Shays
Shimkus
Simpson
Smith (WA)
Sullivan
Taylor (NC)
Tiahrt
Toomey
Velázquez
Weiner
Weldon (FL)
Weller

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised they have 2 minutes in which to record their votes.

□ 1908

So (two-thirds having voted in favor thereof) the rules were suspended and the concurrent resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

FAMILY FARMER BANKRUPTCY ACT OF 2003

The SPEAKER pro tempore. The pending business is the question of suspending the rules and passing the bill, H.R. 2465.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. SENSENBRENNER) that the House suspend the rules and pass the bill, H.R. 2465, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 379, nays 3, not voting 52, as follows:

[Roll No. 300]

YEAS—379

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Crane
Crenshaw
Cubin
Culberson
Cummings
Cunningham
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Foley
Forbes
Ford
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kind
King (IA)
King (NY)
Kingston
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Napolitano
Neal (MA)
Neugebauer
Ney
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pascrell
Pastor
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Price (NC)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (MI)
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Sherman
Sherwood
Shuster
Simmons
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiberi
Tierney
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—3

Flake
Paul
Rohrabacher

NOT VOTING—52

Berman
Bradley (NH)
Brown, Corrine
Burton (IN)
Capuano
Conyers
Cramer
Crowley
Davis (AL)
Davis (CA)
Deal (GA)
DeMint
Feeney
Fletcher
Fossella
Gephardt
Houghton
Hulshof
Istook
Janklow
Jefferson
Kilpatrick
Kirk
Kolbe
Langevin
Lipinski
Lofgren
Lowey
Lucas (OK)
Menendez
Mollohan
Nadler
Nethercutt
Northup
Pallone
Payne
Pomeroy
Pryce (OH)
Rogers (KY)
Ros-Lehtinen
Sanders
Shays
Shimkus
Simpson
Smith (WA)
Sullivan
Taylor (NC)
Tiahrt
Toomey
Velázquez
Weiner
Weldon (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised they have 2 minutes in which to cast their vote.

□ 1914

So (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Ms. KILPATRICK. Mr. Speaker, I was unavoidably detained today. Had I been present for legislative business, I would have voted "yea" on the following measures under consideration of suspension of the rules: H. Res. 264, H. Res. 177, H. Con. Res. 209, and H.R. 2465.

PERSONAL EXPLANATION

Mr. DEMINT. Mr. Speaker, I was absent during rollcalls 297, 298, 299, and 300. Had I been present, I would have voted "yea" on each of those rollcalls.

PERSONAL EXPLANATION

Mr. FLETCHER. Mr. Speaker, on Monday, June 23, 2003, I was unavoidably detained due to commercial plane mechanical problems. Had I been present for rollcall vote Nos. 297, 298, 299, and 300 I would have voted the following way: Rollcall vote No. 297, H. Res. 264—"Yea"; rollcall vote No. 298, H. Res. 177—"yea"; rollcall vote No. 299, H. Con. Res. 209—"yea"; rollcall vote No. 300, H.R. 2465—"yea".

PERSONAL EXPLANATION

Mr. LANGEVIN. Mr. Speaker, this evening, I was unavoidably detained and unable to vote on the following measures: H. Res. 264 (rollcall vote 297); H. Res. 177 (rollcall vote 298); H. Con. Res. 209 (rollcall vote 299), and H.R. 2465 (rollcall vote 300).

Had I been present, I would have voted "yea" on rollcall vote 297, "yea" on rollcall vote 298, "yea" on rollcall vote 299, and "yea" on rollcall vote 300.

□ 1915

REPORT ON H.R. 2559, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2004

Mr. KNOLLENBERG, from the Committee on Appropriations, submitted a privileged report (Rept. No. 108–173) on the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, which was referred to the Union Calendar and ordered to be printed.

The SPEAKER pro tempore (Mr. CULBERSON). Pursuant to clause 1, rule XXI, all points of order are reserved on the bill.

MOURNING THE PASSING OF FORMER ATLANTA MAYOR MAYNARD H. JACKSON

(Mr. BISHOP of Georgia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BISHOP of Georgia. Mr. Speaker, it is with deep regret that I must announce that this morning Maynard Holbrook Jackson, former Mayor of the City of Atlanta, a very prominent American, passed away. He was a great Georgian, a great American, and we will mourn his loss. Shakespeare wrote, "All the world's a stage and all the men and women many players. Each has its entrance and its exit. One man in his time may play many parts."

So it is with Maynard Jackson. Born in Texas, spending most of his life in Georgia, a lawyer, a father, a mayor extraordinaire, founder of the Georgia Association of Black Elected Officials, a very, very important historic figure in political annals for African Americans and for Americans.

It is with deep regret that we mourn his passing. We will on tomorrow night have a special order so that we can pay due homage to a great American whom we loved so very much.

MOURNING THE PASSING OF HON. MAYNARD H. JACKSON

(Mr. SCOTT of Georgia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SCOTT of Georgia. Ladies and gentlemen of the House, this is indeed a sad day. Maynard Holbrook Jackson passed away with a severe heart attack that happened at Washington, D.C.'s Reagan National Airport this morning.

Maynard Jackson was a pioneer of soaring magnitude, not only in just the world of politics but in the world of business as well. It was his guiding influence that made the City of Atlanta a world class city. It was through his guidance that the Atlanta International Airport, which is now the world's busiest airport, was built. It was through his guidance and leadership that Atlanta became host to the 1996 Olympics, making it indeed a world class city.

We mourn his loss but indeed we celebrate an extraordinary life of significant and historic and legendary achievement. Not only was his mark on life for African Americans, for he was indeed a bridge-builder across racial lines at a time in Atlanta and in the South where we so desperately needed it.

Truly a giant in the forest has fallen this day. I know everybody in this House of Representatives, the Congress of the United States, joins with me in saying we thank God that he sent Maynard Holbrook Jackson our way. Truly a child of God and a sojourner of truth and righteousness and an extraordinarily great American, Maynard Holbrook Jackson.

MOURNING THE PASSING OF HON. MAYNARD H. JACKSON

(Ms. JACKSON-LEE of Texas asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. What a world of ironies. The day that the United States Supreme Court affirms the idea of race as a factor in equalizing opportunities for Americans and a warrior, a man of justice and equality, who stood fast in years before these contested issues came to the forefront, Maynard Holbrook Jackson, the former Mayor and Vice Mayor of the City of Atlanta, has lost his life.

Maynard Jackson was generous with his time. As a Representative from the State of Texas, might I acknowledge to my colleagues he was born in the great State of Texas. We sent him off to Atlanta, we bid him farewell, but he always remembered his roots and he never forgot his values, that of opportunity, that of fairness, that of the recognizing that business should be spread amongst those coming from all walks of life.

We lost him today but his legacy and enthusiasm that he shared with America, that yes, those individuals who come with a different background can engage in business, too. He created equal opportunity in Atlanta that was not offensive. He gathered the corporate community together and they joined him enthusiastically in promoting opportunities for women and minorities. And yes, as a young college student, I was privileged to visit with Vice Mayor Maynard Jackson when I was doing my thesis about coalition politics in the Deep South. He did not hesitate to sit down with me and give me a history not only of his life but the great heroes that inspired him.

He is a great soldier, a great warrior, and now I would say, lay your head down, my gentle warrior, lay down and rest that you will never be forgotten. Your words, your deeds will always be remembered that you are a great American hero. God bless you and God bless your family.

ON THE DEATH OF FORMER ATLANTA MAYOR MAYNARD JACKSON AND AFFIRMATIVE ACTION

(Ms. WATSON asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. WATSON. Mr. Speaker, I rise today to express my shock and sadness at the untimely passing of our dear friend, Maynard Jackson, former Mayor of Atlanta and one of our country's most charismatic political leaders. I also want to take this opportunity to remember Maynard's contribution to affirmative action on the day when the Supreme Court declared its support for the program.

Maynard was a giant of his time, a trailblazer and a dedicated public servant who became the inspiration for generations of African American politicians. His election in 1974 as the Mayor of Atlanta helped usher in a new movement of racial equality and a new process of interracial understanding and coexistence where the spirit of the civil rights movement was carried forward by victories at the ballot box.

Maynard will be remembered as the South's first big city African American mayor, but his legacy was much more than that. During his three terms as mayor, Maynard oversaw construction of the midfield terminal at Hartsfield Atlanta International Airport, established a cultural affairs department, brought the Olympics to Atlanta, and all the while gave voice to the city's in-town neighborhoods. Perhaps one of the most significant accomplishments of Maynard Jackson's tenure was his early support and leadership on affirmative action.

During his first term, Maynard instituted a groundbreaking affirmative action program that elevated the percentage of city contracts awarded to minorities in Atlanta from less than 1 percent in 1973 to 38.6 percent 5 years later.

One of the great success stories of Maynard's affirmative action program was the creation of a joint venture between white and minority-owned businesses during the construction of the Atlanta airport. Working from a vision of inclusion, Maynard was able to unite various groups and interests in building one of the most complex airport terminals in the world ahead of schedule and within the budget.

It is particularly ironic, then, that Maynard passed away on the day that the Supreme Court issued its landmark ruling. In two successive votes, the Justices recognized that the most effective way to cure society of its exclusionary practices is to make special efforts at inclusion, which is exactly what affirmative action does.

We will never forget him. He will have a legacy that will live on forever in the United States of America.

There has always been affirmative action in public policy—but for many years it operated to exclude, rather than include, people of color. Affirmative action was put in place to not only encourage diversity, but to be a minor step in the direction of justice after hundreds of years of institutional and social discrimination against women and people of color in the United States.

Much of the opposition to affirmative action is framed on the grounds of so-called "reverse discrimination and unwarranted preferences." In fact, less than 2 percent of the 91,000 employment discrimination cases pending before the Equal Employment Opportunities Commission are reverse discrimination cases. Under the law as written in Executive Orders and interpreted by the courts, anyone benefitting from affirmative action must have relevant and valid job or educational qualifications.

Opponents of affirmative action also claim it is discriminatory. The problem with this myth is that it uses the same word—discrimination—to describe two very different things. Job discrimination is grounded in prejudice and exclusion, whereas affirmative action is an effort to overcome prejudicial treatment through inclusion. The most effective way to cure society of exclusionary practices is to make special efforts at inclusion, which is exactly what affirmative action does. When thinking about affirmative action policy, it is important to keep this principle in mind.

In fact, despite the progress that has been made, the playing field today is still far from level. Women continue to earn 76 cents for every dollar earned by a male. Black people continue to have twice the unemployment rate of white people, and graduate from college at half the rate of white people. In fact, without affirmative action the percentage of Black students at many selective schools would drop to only 2% of the total student body.

While I applaud the Court's decision today, our society still suffers from racial discrimination. It is unfortunate that after all these years we are still fighting an uphill battle for full inclusion into our nation's society.

However, we are fortunate to have had the civil rights movement and leaders like Maynard Jackson. In remembering Maynard, we must carry on his legacy and his commitment to never waver from equality for all.

MOURNING THE PASSING OF HON. MAYNARD H. JACKSON

(Ms. CARSON of Indiana asked and was given permission to address the House for 1 minute.)

Ms. CARSON of Indiana. Mr. Speaker, I would like first to affirm what was said by the gentlewoman from California (Ms. WATSON), who so eloquently gave a very brief overview of the life and work of the Honorable Maynard Jackson. Maynard Jackson was perhaps one of the most profound individuals that I have met in a lifetime. He was very dedicated. He had a lot of energy. He had a lot of perseverance. He had a lot of vision. And indeed he was very spiritual.

As I sat there and heard the gentlewoman from California talk about him, I could not help but think about John the Revelator that sat on the lonely island of Patmos, looked at an old city but envisioned what was great for a new city, and then Maynard Jackson began to build a new city, Atlanta, Georgia, created millions of millionaires, did much to bring the city to the forefront. Maynard Jackson was a very unassuming individual, too. He followed scripture in terms of not boasting about himself but letting his light so shine by his good works.

He is an individual that I will never forget. He is a person that I know his family is in very great sorrow for. He was the son of a Baptist preacher, and so perhaps that explains some of the eloquence that Maynard Jackson had. But this country, not just Atlanta, not just his family but the whole country has indeed lost an incredible, a remarkable individual in that of the Honorable Maynard Jackson.

MOURNING THE PASSING OF HON. MAYNARD H. JACKSON

(Mr. KUCINICH asked and was given permission to address the House for 1 minute.)

Mr. KUCINICH. Mr. Speaker, I rise to mourn the passing of Maynard Jackson. When I had the great privilege of serving as Mayor of the City of Cleveland, Maynard Jackson and I were contemporaries in his service as Mayor of the City of Atlanta. In working with him through the years and learning his dedication, not only to the people of Atlanta but urban America, I was able to see that there was a real opportunity for people of good will to achieve a synthesis of that good will, of urban policy, because Maynard Jackson made the cause of cities his cause and he spoke to the needs of the people of urban America eloquently, with deep passion and with a concern about the potential of urban America that was being ignored. But he infused the City of Atlanta with his own potential, and with his passion and with his heart he helped raise Atlanta to greater and greater heights.

Maynard Jackson was not only a servant of Atlanta and the State of Georgia, but of America and the world because his life was about bringing people together and his life was about the potential of not only minorities but of every individual to make a dedication to community. So today, as Maynard Jackson passes, we can reflect on that wise Latin saying translated into English that says, "If you seek his monument, look around." And wherever you look, in urban America, where men and women are dedicated to building up cities, you are always going to remember and be reminded of Maynard Jackson.

□ 1930

SPECIAL ORDERS

The SPEAKER pro tempore (Mr. CULBERSON). Under the Speaker's announced policy of January 7, 2003, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

EXCHANGE OF SPECIAL ORDER TIME

Mr. KELLER. Mr. Speaker, I ask unanimous consent to take the Special Order time of the gentleman from Indiana (Mr. BURTON).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida (Mr. KELLER)?

There was no objection.

SALUTING SHERIFF KEVIN BEARY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida (Mr. KELLER) is recognized for 5 minutes.

Mr. KELLER. Mr. Speaker, I rise this afternoon to salute one of the leaders in my hometown of Orlando, Florida, who has just been recognized as America's top cop. It is my happy privilege to announce to this Chamber that Orange County, Florida, Sheriff Kevin Beary is the winner of the 2003 National Sheriff of the Year award. I was pleased to personally recommend my friend Sheriff Beary for this award, and I did not say nice things about him just because every time I see him he is packing heat.

Kevin is the fourth generation of the Beary family who have selflessly devoted themselves to protecting others. He commands one of the largest law enforcement agencies in the southeastern United States. He is not only responsible for the safety of 1 million people who live in the central Florida area but for the millions of tourists who visit places like Walt Disney World and Universal Studios in my district every year.

As a member of the House Crime, Terrorism and Homeland Security Subcommittee, I have relied heavily on his expert advice to help drive my law enforcement agenda. Sheriff Beary and I teamed up to protect the COPS program and put more police officers on the street. We have worked together to build a new Federal courthouse in downtown Orlando designed to embassy safety standards, and we have stood together shoulder to shoulder against casino gambling and the drug legalization movement in Florida. But I think most importantly we have worked together since the events of 9-11 to make sure that our first responders have the tools they need to protect the people of central Florida and the tourists who play in our backyard from those who would plot against our Nation.

Kevin Beary is everything a sheriff should be. He is a friend to our most vulnerable citizens. He is a tireless volunteer in our community, and frankly he scares the hell out of the bad guys who would prey on our neighborhoods. Love him or fear him, everyone in central Florida knows Kevin Beary means business; and in light of this prestigious award he has now received, everyone in America knows too.

When I have a question on an issue facing law enforcement before this Congress, the first thing I do is call my sheriff. I am pleased to have the 2003 National Sheriff of the Year Kevin Beary on my speed dial. I say to my colleagues they should all be so lucky.

IN MEMORY OF MAYNARD JACKSON

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia (Mr. LEWIS) is recognized for 5 minutes.

Mr. LEWIS of Georgia. Mr. Speaker, I rise today with a heavy heart to speak on the untimely passing of Maynard Hollbrook Jackson. I was blessed to know Maynard Jackson for almost 40 years. Maynard Jackson was a wonderful human being, a gifted, brilliant politician. He was the kind of individual who was not afraid to take risks. Maynard Jackson was always getting in the way for the common good.

In 1968, moved by the assassination of Dr. Martin Luther King, Jr., and Robert Kennedy, he ran for the United States Senate in the Democratic primary against incumbent Senator Herman Talmadge. He later made history by becoming the first African American mayor of a major southern city. His leadership as vice mayor of Atlanta and later as mayor of Atlanta for three terms transformed our city into the gateway to the New South. As mayor, Maynard Jackson emerged as a role model for other big-city mayors and younger elected officials. We often heard, if Maynard Jackson can do it, so can we. His accomplishments created a greater sense of possibility, a greater sense of hope, a greater sense of optimism.

Mr. Speaker, it is so ironic and almost eerie, really strange that Maynard Jackson's passing would happen at almost the same time as the Supreme Court's decision in support of affirmative action. He was one of the great champions for diversity, inclusion, and fairness, not just in government and business but in all areas of American life.

Perhaps Maynard Jackson's greatest accomplishment as mayor was the building of the Atlanta Hartsfield International Airport. Under Maynard Jackson's leadership, Atlanta Hartsfield became one of the largest and busiest airports in the world. At one time, Atlanta Hartsfield included more minority contractors than any other airport in the country. Maynard Jackson insisted that if majority contractors were to participate in construction of the airport, so would minority contractors.

Maynard Jackson must be remembered as one of the founding fathers, not just of the new Atlanta, not just of the New South, but of the new America. He will be missed by all of the good people of Atlanta, all of the good people of Georgia, and the Nation and around the world. As mayor, he established in a profound way the sister city program. Many of our cities around the world became sister cities of the city of Atlanta. He traveled far and broad to carry the message of hope.

Mr. Speaker, my prayers are with his wife, Valerie, his children, and all members of the Jackson family. We all mourn for the family. We mourn for the citizens of Atlanta, for the citizens of Georgia, and for all of his friends.

CONGRESSIONAL REDISTRICTING

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. CULBERSON) is recognized for 5 minutes.

Mr. CULBERSON. Mr. Speaker, I have joined the Congress after serving 14 years in the Texas House of Representatives, and in every one of those years the State of Texas operated under a Federal court order controlling our prison system. We have operated under Federal court orders controlling our mental health hospitals. We have operated under State court orders controlling our school finance system; and as a committed Jeffersonian, I fought strenuously to be sure that the people of Texas through their elected representatives would control our prisons, our mental health hospitals, and, above all, our school finance system which our legislature will deal with in a special session later this area.

One week from today, the Texas legislature will meet again in a special session to exercise the will of the people of Texas to control the way our congressional districts are drawn. That special session that will begin in 1 week has been the subject of much attention nationally in the preceding weeks; and of all the different analyses that I have seen done, the most eloquent, the most insightful analysis of what is taking place in the State of Texas in congressional redistricting was written by a young woman, Laura Childers, who expressed her opinion on the pages of the Houston Chronicle on May 15 of 2003. I would like to share her words with the Nation and with the Congress.

Laura Childers wrote: "I am not a Republican, and I am not a Democrat. I am a naive 17-year-old girl who has yet to cast her first vote. Maybe looking to the actions of my elders shall help to coach me in the manner that a ballot should be cast. This should be particularly useful in the presidential elections in November, upon which I, along with millions of my fellow young comrades, will have reached the powerful age of 18. So far I've learned a lot.

"It appears that the distinction of party and not of morality is what is supposed to define a politician in American legislatures today; am I correct? Take the recent Democrat walkout from the Texas House of Representatives. What I gather from this incident is that it does not necessarily matter to the defending exiles that Texas citizens voted the Republican majority into office for the explicit reason of passing Republican legislation. In fact, I've heard statements from Democrats and their supporters that going against the American public's will is a very patriotic thing to do. This leads me to believe that the old, apparently outdated, reasons for government institutions no longer stand. The hopes and dreams of Presidents George Washington and Abraham Lincoln for a voice in the government for every American, regardless of position or belief, have been shattered.

"The creation of the democratic experiment of the United States of America was designed to see if it was possible for men to rule themselves. For the first time in modern history, there existed a haven where there were no dictators, no kaisers, no kings and no queens. There were the people, the voters, the common man. The people were to rule themselves by imposing a type of controlled majority rule in the place of a tiny group of monarchial individuals. Representatives were to be elected by popular vote with the mission to represent and act upon the beliefs and wishes of their electors. Political parties naturally formed between groups of representatives who symbolized common wishes of their voters. In order to further promote these wishes, political parties unified with one another. The legislation proposed by the parties was made in the interest of the voter and was overturned or affirmed depending on the will of the majority. Thus bills were passed by population representatives in an effort to advocate for the bulk of all those represented.

"When people impede this delicate process, they encumber the right of every American voter to fair representation. By not allowing a majority rule but forcing a type of minority monarchy, the great voice of the American public has been silenced to a sickly whisper. In the place of a free democracy with freedom for all and dishonesty toward none, a type of legal party regime has been set up, and the rights of American individuals have vanished. If one party is allowed to manipulate government institutions on any level, State or national, as the group of Democrat representatives in leisure at an Oklahoma resort have, our rights as Americans have been breached. We have been denied the Government power granted to us upon the signing of our Constitution.

"If this is the way that the tumultuous ship of today's Government, the institutions of 2003, is intended to be steered, then this is not the America that I had thought it was, been taught it was and hoped it was.

"If the America I'd dreamed of and prayed for does not, in fact, exist and Thomas Jefferson's 'boisterous sea of liberty' has long since dried to a shadowy pit of political regimes and power-hungry abusers of our Mother Freedom, then I will fight for the hopes of Washington and I will battle for the lessons of Lincoln. If America is to be true to herself, if man still be just, then let our Lady Liberty's voice be heard to mend this crack entrenching on our precious, sacred, irreplaceable bell of liberty, our vote."

I am proud to say that Laura Childers is a constituent. She is a junior at Memorial High School in congressional district seven that I am so proud to represent, and I believe Laura Childers understands precisely what the American Constitution is about, what majority rule means, and what it means that the people of Texas have for the first time since 1876 voted in a new Republican majority in the Texas legislature, and Laura understands that it is the people of Texas and not the courts who should draw congressional districts.

□ 1945

THE CHILD TAX CREDIT

The SPEAKER pro tempore (Mr. GARRETT). Under a previous order of the House, the gentleman from Illinois (Mr. EMANUEL) is recognized for 5 minutes.

Mr. EMANUEL. Mr. Speaker, nearly a month ago, this body passed a $350 billion tax cut that benefited primarily the top 1 percent in the country. Warren Buffett and others, who although would benefit from it, spoke against that tax cut. Prior to that evening, the day before, Republicans out of the House and the Senate, with the Vice President, got together to work out an agreement. And we later found out, 2 days afterwards, nobody had known that 12 million children, 6.5 million working families, had been left out of that tax cut. It actually was in the Senate bill. Somehow, when the Vice President got in the room with the Republican House leadership here, the 12 million children of working families were left on the editing floor, because there was nobody outside of that conference room where the leadership met to represent the voice of 12 million children of working families.

Now, in about a week from now a good portion of the wealthiest 1 percent will begin to receive what people on average think is close to $100,000 worth of tax cuts. Now, we have passed in the other body and in the House a tax cut to ameliorate and address this shortcoming that both the President says he wants done, the other body leadership say they want done and leadership in this Chamber say they want done.

Now, we need to address this problem, because in one week we have a tax cut that is going into place that has left out 12 million children of working parents, 6.5 million families. These are the families that are rookie cops, first-year firefighters, first-year teachers, nurses, single mothers. We can provide a tax cut for these children.

Now, this is in contrast to in May, this body provided a $25 billion tax credit to the energy companies to do what? To drill for oil. Now, the last time I checked that is supposed to be in their business plan. They are supposed to be doing that as a purpose of their business. That is what they exist for. In the very week that we passed a $25 billion tax credit for the energy industry to do what, to drill, Exxon Mobil reported, and I want to read this absolutely correctly so nobody can get this wrong; Exxon reported that their net quarterly income had tripled and that it had $12.3 billion in cash on hand. Mr. Speaker, $12.3 billion cash on hand. Their net quarterly profits had tripled. We had passed them a $25 billion tax cut, so they could do what? Drill for oil. That is the main mission of what that energy company does.

Enron, in the 4 out of the last 5 years, had never paid any corporate income taxes, yet received subsidies to the tune of $200 million in tax subsidies, in grants through the Export-Import Bank, to do what? Provide an energy project in India. WorldCom, in 2 out of 3 years, paid no corporate income taxes and yet they reported $12.5 billion in corporate profits. In fact, last week in our Committee on Budget in a hearing on waste, fraud, and abuse, Robert McIntyre, as well as the comptroller of the country, spoke about many tax credits and tax incentives that are used for corporations to do what they are supposed to do, and a great deal of mismanagement of our dollars are spent for these corporate welfare programs. Yet 12 million children could be provided a tax cut as they go into summer camp, as their parents start planning for the next year to buy shoes and new clothes for the school year.

So myself and other Members are going to start marking off the day as we get closer and closer, as the wealthy in this country start to get their tax cut, we are going to mark off the days as we begin to forget our children. Today is June 23, and now we count down to the day in which the checks start to go out. Yet the conference has not met, there has been no leadership out of the White House; no leadership shown to bring together both parties around a common set of values.

Now, we can disagree about whether the first $350 billion tax cut should have been paid; we can disagree about whether corporate welfare should exist in the form of Enron not paying any corporate taxes; whether Exxon Mobil having $12.5 billion cash on hand deserved another $25 billion in tax credits to drill for oil. We can disagree on all of that, but surely we can come together around a common set of values, that if you work hard, if you are trying to do right by your children, raise them with the right set of values, that these families who make $12,000, $13,000, $14,000 a year, what a Congressman makes in a month, that they deserve a full $1,000 child tax credit.

We are going to count down the days every day to remind this body that until that day comes, that these families deserve a tax cut. They deserve to be rewarded for making the right choice of work over welfare. They deserve to get a tax cut like the wealthiest 1 percent in this country. Everybody seems to agree, yet nobody can come together into the same room to work out not only our economic interests, but our values and commonality.

So I would hope that as we mark this day that we would find the same interests that drove us so fast to give Exxon a tax credit to drill for oil, that we worked so fast and furious to give the wealthiest 1 percent in this country $100,000 in tax cuts, that we find the same moral courage, the same discipline, the same foresight to give the 12 million children, 6.5 million families who work every day, get up in the morning, do not come home until late at night, try to do right by their children, have chosen the voyage of work and raised their children with a common set of values that we all espouse to represent and to want to reward; that we should not put another speed bump in their way as they try to raise their family. We should give them the tax cut that says you have done right, your children deserve it, you deserve it, because this is their money, too.

So today we mark off that day as we count down to July 1, when the first set of checks go out to the wealthiest 1 percent, and yet we here in Washington representing these people have not found the time to come together to come to an agreement to give a voice to their values, to give a choice to our common sense of purpose here.

TRIBUTE TO A DEAR FRIEND, MAYNARD JACKSON

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WATERS) is recognized for 5 minutes.

Ms. WATERS. Mr. Speaker, I rise today to speak on behalf of my dear friend who passed this morning, Maynard Jackson. Maynard Jackson was a dear and treasured friend. He was a man that I worked very closely with. He was a man that I had the greatest respect for. I held him in high esteem because he was a learned individual who loved politics and who loved public policy, and demonstrated his ability to lead.

As my colleagues know, Maynard Jackson was a young man that graduated from Morehouse College when he was but 18 years old. He went on to get his law degree, and he was inspired by the death of Martin Luther King to enter politics, and enter politics he did.

He first ran against Mr. Talmadge, Herman Talmadge, and he lost that race. But he proved that there was a need for a new direction. He won the votes in Atlanta. He did that when outside of Atlanta, as a matter of fact, he lost by 3 to 1. But that really did launch his political career. Maynard Jackson went on to serve as Mayor for 3 terms in Atlanta.

I loved Maynard Jackson because he was a man of impeccable integrity. Not only did he provide a new kind of leadership for Atlanta, he opened up opportunities for African Americans and people of color. When Maynard Jackson, the first African American mayor to be elected in Atlanta, took office, African Americans were not really a part of the business community, and he actually alienated some of the white business community, because he insisted on opening up these opportunities. When I look at the airport there, I know the stories about how Maynard Jackson helped to implement affirmative action, and when we see some of the concessions that are there, they are there because Maynard Jackson led the way for much of that to take place.

Maynard Jackson loved the Democratic Party, and he served on the Democratic National Committee for many years. And as many folks know and understand, I encouraged him to run at our last winter meeting to be head of the DNC. Even though he started late, we created a conversation and discussion about what kind of leadership we needed for the DNC. Maynard Jackson certainly did not win that election. As a matter of fact, he bowed out and he supported Terry McAullife.

The debate that we created had to do with the direction of the party. Where are we going? Where is this party going? Maynard had a plan: the southern strategy plan. Maynard knew and understood that unless we increased the turnout and understand the importance of the South to the Democratic Party, then we could not win, and we will not win.

When we were in our struggle for Maynard to lead the Democratic National Committee, we finally agreed that Maynard would take over a new position that we created in the Democratic Party called the National Development Commission, of which he would be chairman. Under that, he would have the Voting Rights Institute. And Maynard set about with that designation to increase the awareness about what was wrong with the voting systems in this country.

We had just come out of Florida where votes had been stolen, where people had been turned away from the polls, where folks were identified as felons and put on lists who had never been to jail, and Maynard was convinced that we had to clean that up. And he begged the DNC to take this as their number one issue and their number one priority. Maynard identified people who were to serve with him as he tried to carry out his vision of this Voting Rights Institute. But, for whatever reasons, it did not happen. Maynard called me and he said, I am going to resign the position. I do not think that it is going to happen in the way that we thought it would happen. And I consider that one of the greatest losses for the Democratic Party. Maynard went on back to Atlanta, to Jackson Securities, a company that he had founded where he did tremendously well.

He was a fine businessman, and he worked well with so many elected officials around this country in order to achieve the kind of success that he was able to achieve in the bond business.

I am going to miss Maynard. He was a dear and close friend, and the Democratic Party and all of us who wish to see this party go in a new direction, understanding the significance of the South, are going to miss him, and unless his thoughts and his ideas are accepted by this party we are going to continue to lose.

REMEMBERING MAYNARD JACKSON

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WATSON) is recognized for 5 minutes.

Ms. WATSON. Mr. Speaker, I want to add my voice again to those who are lamenting the life well-lived, and the life just going into transition. It was Maynard Jackson, as my colleagues just heard, who had a vision of inclusion.

□ 2000

Maynard was able to unite various groups and interests in building one of the most complex airport terminals in the world ahead of schedule and within budget. And as I said before, it is particularly amazing that today was the day that Maynard Jackson transitioned and also the day the Supreme Court issued its landmark ruling.

In two successive votes, the Justices recognize that the most effective way to cure society of its exclusionary practices is to make special efforts to see that Americans are included, which is exactly what Maynard Jackson stood for when he mentioned the phrase "affirmative action." It was first used in President Lyndon Johnson's 1965 executive order. In 1967 Johnson expanded the executive order to include affirmative action requirements to benefit women. The policy was significantly expanded in 1969 by President Richard Nixon and then-Secretary of Labor George Schultz.

In 1973 Maynard Jackson began his leadership in implementing these policies, which enabled Atlanta to become a true world class city. There has always been affirmative action in public policy; but for many years it fought to exclude, rather than include, people of color. Affirmative action was put in place to not only encourage diversity but to be a minor step in the direction of justice after hundreds of years of institutional and social discrimination against women and people of color in the United States of America. Much of the opposition to affirmative action is framed on the grounds of so-called reverse discrimination and unwarranted preferences. In fact, less than 2 percent of the 91,000 employment discrimination cases pending before the Equal Opportunity Commission are reverse discrimination cases.

Under the law as written, in executive orders and interpreted by the courts, anyone benefiting from affirmative action must have relevant and valid job or educational qualifications. Opponents of affirmative action also claim it is discriminatory. The problem with this myth is that it uses the same word, discrimination, to describe two very different things. Job discrimination is grounded in prejudice and exclusion; whereas, affirmative action is an effort to overcome prejudicial treatment through exclusion and to provide inclusion. The most effective way to cure society of exclusionary practices is to make special efforts at inclusion, which is exactly what affirmative action does.

When thinking about affirmative action policy, it is important to keep this principle in mind. In fact, despite the progress that has been made, the playing field today is still far from level. Women continue to earn 76 cents for every dollar earned by a male. Black people continue to have twice the unemployment rate of white people and graduate from college at half the rate of white people. In fact, without affirmative action, the percentage of black students at many selective schools would drop to only 2 percent of the total student body.

While I applaud the Court's decision today, our society still suffers from racial discrimination. And in the name of Maynard Jackson, we must carry on his legacy and his commitment to never waiver from equality for all Americans.

Mr. Speaker, I rise today to express my shock and sadness at the untimely passing of my dear friend Maynard Jackson—former Mayor of Atlanta and one of our country's most charismatic political leaders. I also want to take this opportunity to remember Maynard's contribution to affirmative action on the day when the Supreme Court declared its support for the program.

Maynard was a giant of his time, a trailblazer and a dedicated public servant who became the inspiration for generations of African American politicians. His election in 1974 as the Mayor of Atlanta helped usher in a new movement of racial equality and a new process of interracial understanding and co-existence where the spirit of the civil rights movement was carried forward by victories at the ballot boxes.

Maynard will be remembered as the South's first big-city African-American mayor, but his legacy was much more than that. During his three terms as Mayor, Maynard oversaw construction of the midfield terminal at Hartsfield Atlanta International Airport, established a cultural affairs department, brought the Olympics to Atlanta, and all the while gave a voice to the city's in town neighborhoods.

Perhaps one of the most significant accomplishments of Maynard Jackson's tenure was his early support and leadership on affirmative action. During his first term, Maynard instituted a groundbreaking affirmative action program that elevated the percentage of city contracts awarded to minorities in Atlanta from less than 1 percent in 1973 to 38.6 percent five years later.

One of the great success stories of Maynard's affirmative action program was the creation of a "joint venture" between white and minority-owned businesses during the construction of the Atlanta airport. Working from a vision of inclusion, Maynard was able to unite various groups and interests in building one of the most complex airport terminals in the world ahead of schedule and within budget.

It is particularly ironic then that Maynard passed away on the day before the Supreme Court issued its landmark ruling. In two successive votes, the Justices recognized that the most effective way to cure society of exclusionary practices is to make special efforts at inclusion, which is exactly what affirmative action does.

The actual phrase "affirmative action" was first used in President Lyndon Johnson's 1965 Executive Order. In 1967, Johnson expanded the Executive Order to include affirmative action requirements to benefit women. The policy was significantly expanded in 1969 by President Richard Nixon and then Secretary of Labor George Schultz. In 1973, Maynard Jackson began his leadership in implementing these policies, which enabled Atlanta to become a world-class city.

There has always been affirmative action in public policy—but for many years it operated to exclude, rather than include, people of color. Affirmative action was put in place to not only encourage diversity, but to be a minor step in the direction of justice after hundreds of years of institutional and social discrimination against women and people of color in the United States.

Much of the opposition to affirmative action is framed on the grounds of so-called "reverse discrimination and unwarranted preferences." In fact, less than 2 percent of the 91,000 employment discrimination cases pending before the Equal Employment Opportunities Commission are reverse discrimination cases. Under the law as written in Executive Orders and interpreted by the courts, anyone benefitting from affirmative action must have relevant and valid job or educational qualifications.

Opponents of affirmative action also claim it is discriminatory. The problem with this myth is that it uses the same word—discrimination—to describe two very different things. Job discrimination is grounded in prejudice and exclusion, whereas affirmative action is an effort to overcome prejudicial treatment through inclusion. The most effective way to cure society of exclusionary practices is to make special efforts at inclusion, which is exactly what affirmative action does. When thinking about affirmative action policy, it is important to keep this principle in mind.

In fact, despite the progress that has been made, the playing field today is still far from level. Women continue to earn 76 cents for every dollar earned by a male. Black people continue to have twice the unemployment rate of white people, and graduate from college at half the rate of white people. In fact, without affirmative action the percentage of Black students at many selective schools would drop to only 2 percent of the total student body.

While I applaud the Court's decision today, our society stiff suffers from racial discrimination. It is unfortunate that after all these years we are still fighting an uphill battle for full inclusion into our Nation's society.

However, we are fortunate to have had the civil rights movement and leaders like Maynard Jackson. In remembering Maynard, we must carry on his legacy and his commitment to never waver from equality for all.

MAKING MEDICARE BETTER FOR ALL SENIORS

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under a previous order of the House, the gentlewoman from California (Ms. SOLIS) is recognized for 5 minutes.

Ms. SOLIS. Mr. Speaker, I am delighted to be here tonight to talk about a very important issue that is resonating across the country, and just recently on my return back from my district, more importantly, the issue of Medicare and prescription drug reform which is impacting largely low-income working families and especially many of the families that I represent in my district in California, Latino working families.

The facts are clear, 87 percent of uninsured Latinos come from working taxpaying families. However, nearly 60 percent of Latinos live in families with incomes below 200 percent of the poverty level. Many of these families, 37 percent, in fact, lack basic access to quality care. Low-income elderly Latinos face incomparable barriers to health care at just about every corner of their lives. Linguistic, cultural, financial burdens continually impede their health access that would otherwise be available to every American.

When President Johnson signed the Medicare bill back in 1965 he said, and I quote: "No longer will older Americans be denied the healing miracle of modern medicine."

Medicare was not created to exclude the elderly in exchange to enrich private insurance companies. The Republican proposal as I see it undermines the universal character of Medicare that ensures quality for all seniors. Instead, it provides different benefits to different seniors depending on your income. Figures estimate that the Medicare beneficiaries who spend $4,000 or more out of pocket on drugs are not individuals making less than 100 percent of poverty, not those between 100 and 200 percent of poverty, but those individuals who live with incomes greater than 200 percent of poverty. These are the people we are asking to pay the most for their prescription drugs.

The House Republican bill increases costs for seniors by $8 billion and does not offer meaningful benefits, nor does it make drugs affordable for our seniors. How can we even realistically say we are attempting to improve the lives of all Americans when the Latinos and low-income elderly population are the most susceptible for falling between the privatized cracks?

There are more than 214,000 Latino Medicare beneficiaries currently residing in the State where I come from, in California, and over 55 percent of those seniors report having little or no information. They do not even know about the bilingual toll-free Medicare phone number. Some do not even have telephones in their homes. Who will care for those beneficiaries when the Republicans impose unaffordable premiums, requiring spending up to $250 before they can receive any help at all? This even prohibits the HHS Secretary from negotiating better prices. I thought he was supposed to be working on our side on behalf of our consumers and our seniors.

With private and for-profit managed care plans competing to entice healthy seniors to enroll, traditional Medicare will be forced to raise out-of-pocket costs astronomically for the sickest and most disabled beneficiaries. The holes in the cracks are visible. We are just seeing what has occurred in the State of California where many beneficiaries were dumped and they were left without care.

I urge my colleagues on the other side of the aisle to think of the future of these populations, the low-income, taxpaying. Whether they are Latino or not, let us help all the elderly who deserve accessible and meaningful Medicare plans. Let us protect our Nation by caring for all American seniors, and let us begin by working with the program that we know works, that will make a difference for all of us.

HONORING MAYNARD JACKSON

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. PELOSI) is recognized for 5 minutes.

Ms. PELOSI. Mr. Speaker, I am sad to join my colleagues, the gentleman from Georgia (Mr. BISHOP), and the gentleman from Georgia (Mr. SCOTT), as well as the gentleman from Georgia (Mr. LEWIS) who was on the floor earlier, and I know the gentlewoman from Georgia (Ms. MAJETTE). I do not know if she has been here yet, and many other Members, the gentlewoman from California (Ms. WATERS) who was a very close friend of Maynard Jackson. I am saddened to add my personal thoughts and prayers to their wonderful comments about Maynard Jackson.

America has lost a great statesman today, and our hearts are saddened for his family and thousands of his colleagues and friends who loved him and worked with him on so many issues.

For his many friends at the United States Conference of Mayors where he served in key leadership roles, to those who worked with him in building the magnificent Atlanta airport in his tenure as mayor, to the many people that he touched as he worked tirelessly to bring the Olympics to Atlanta, the list goes on and on. Maynard Jackson, Jr., was larger than life, physically, politically and in every way.

Maynard Jackson was the essence of a public person. Being first elected the mayor of Atlanta and then reelected and term-limited for another term, Maynard found other venues in which to serve his beloved Atlanta. He was an entrepreneur, one who mentored many young people who had expressed an interest in starting their own businesses. Maynard Jackson can be best described as a facilitator of the people. A facilitator so much so that when he chose to return to elected office, Mr. Speaker, for a third term as mayor of Atlanta, he was elected overwhelmingly with 80 percent of the vote. People loved and trusted Maynard Jackson.

Maynard was a democrat with a small "d" and a capital D. He offered himself as the Chair of our party, as the gentlewoman from California (Ms. WATERS) said earlier. Even though he was not successful, Mayor Jackson continued to work on voter education and outreach within the party in a very significant way.

I was pleased to appoint Maynard Jackson to serve on the Election Assistance Commission Advisory Committee. I think it was an honor to all the Democratic members of the House that he accepted that position. This advisory committee would have had, and does have, the import of assisting 50 States to make sure that the American electoral system is accessible and fair. What greater American to oversee such a momentous task.

Mr. Speaker, this was a result of legislation passed by the House of Representatives, by the entire Congress, signed by the President to make sure that every vote in America counts, that the public knows that, that we do the outreach, that we have the education of the public, that we have the technical assistance and the financial assistance to States and to communities, to have a voting system that, again, is fair, understandable, accessible and in which every vote is counted.

Maynard Jackson devoted his life to the legitimacy of the process, to democracy in our country, to a commitment to enhance the voices of minorities in our country. We will miss him with his warm smile and his big heart. We all would say to Maynard, Well done. Well done.

I hope it is a comfort to his family that so many people mourn their loss and are praying for them at this sad time.

REMEMBERING MAYNARD JACKSON

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia (Mr. SCOTT) is recognized for 5 minutes.

Mr. SCOTT of Georgia. Mr. Speaker, I rise with a heavy heart, indeed, for Maynard Jackson was a very dear and close and personal friend of mine.

I say this with all sincerity and truthfulness, that had it not been for Maynard Jackson, I would not be here serving in the Congress of the United States. Maynard Jackson ushered in a whole era of black political participation unprecedented. He was a pioneer of soaring magnitude that touched so many people's lives.

In 1973 he gave opportunities and hope for so many of us when he ran and was elected to mayor. And to show the kind of person he was, one year later he encouraged me to run for the Georgia House of Representatives to start my career. I was elected as one of the youngest members of the House of Representatives of Georgia.

Maynard Jackson, one year after he was elected mayor, was in the street of Atlanta, on the Southside of Atlanta walking day to day and knocking on doors to help get me elected to the Georgia House of Representatives. So I hope you understand me when I say that I stand here with a deep and heavy heart.

☐ 2015

I have thought what could we say, what could we say in this hallowed Chamber of the Congress of the United States that would best epitomize Maynard Jackson?

To me, it is summed up in one word and that is great. Maynard Jackson was a great man. He was a great human being, not only great in size but great in his heart, great in his giving, extraordinarily great in his contributions, the guiding force to build the world's busiest airport Atlanta's International Airport, the guiding force to bring the 1996 Olympics to Atlanta Georgia, making us a world class city, opening door after door, not just in the world of politics, which has been mentioned, but in business, opening up doors of business opportunities for many of us who would not have those opportunities and those doors opened.

Greatness is his word. Greatness is its meaning, and maybe we ought to pause for a moment to ponder that word "greatness."

That question was put to the great Greek philosopher Aristotle, and Aristotle was asked, What does it take to make a great person? Aristotle replied, In order to be a great person, you must first of all know thyself. Maynard Jackson knew himself. He knew who he was and he knew whose he was, that he was foremost a child of God and he carried that with him.

His faith sustained him, gave him the courage to step out in 1969 as a young man and challenge the legendary Herman Talmadge for the United States Senate seat in Georgia in, 1969, one year after the assassination of Martin Luther King, Jr.

Later on, that word of greatness was asked of the great Roman general Marcus Aurelius. What does it take to be great, Marcus Aurelius was asked. Marcus Aurelius responded and said, In order to be great, you must first of all discipline yourself, and Maynard Jackson disciplined himself, carried himself.

Oh, he was a master politician. Nobody could work the room like Maynard Jackson, shaking hand after hand. I learned so much from him, how to shake somebody's hand and look them in the eye and make them feel like they are the most important person on Earth. That was Maynard Jackson.

The discipline of getting through Morehouse School at 18 years old, the discipline of becoming the first Vice Mayor of Atlanta, African American, and then becoming the first Mayor of Atlanta, African American; the discipline of Maynard Jackson.

Finally, that question was put to the great Messiah, Jesus Christ, and Jesus was asked, What does it take to make a great person? Jesus responded and said, In order to be great, you must first of all sacrifice yourself. Maynard Jackson sacrificed himself. He gave of his life. Indeed, he did.

We all knew he had some health problems, but he kept going, and I am sure as he was here in Washington, D.C., this morning, he was sacrificing himself to further expand opportunities.

When I last met with him, he said, It is a shame that we have 600,000 African Americans who are able to vote and are the age to vote in Georgia but are not registered to vote. David, we must do something about it. He was a man of action who knew himself, who disciplined himself, who sacrificed himself.

On this day, let it be known that a great oak fell in the forest of America and the world and we all need to thank God for sending Maynard Holbrook Jackson our way, not just the black folks' way, but not just the white folks' way, all of our way, for he was truly a bridge builder, and this Nation and this world is better because God sent Maynard Holbrook Jackson our way.

God bless Maynard Jackson.

HONORING MAYNARD HOLBROOK JACKSON

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under a previous order of the House, the gentleman from Georgia (Mr. BISHOP) is recognized for 5 minutes.

Mr. BISHOP of Georgia. Mr. Speaker, I stand again to address this House and to express my sorrow at the passing of my friend, a great man, Maynard Holbrook Jackson.

Longfellow wrote: "Lives of great men all remind us, We can make our lives sublime, And, departing, leave behind us, Footprints on the sands of time." Yes, Maynard has left great footprints. He left footprints as he left high school at 15 years of age to attend Morehouse College as an early admissions student, when he graduated from Morehouse College with a degree and went on to North Carolina Central University Law School, where he earned a law degree at a very early age. He had a deep baritone voice which he honed singing in the Morehouse College Glee Club. When he graduated from law school, he put that voice to work as a lawyer with the Emory Neighborhood Law Office practicing legal aid.

Maynard was a very, very astute and committed lawyer to the poor. He represented the poor in Atlanta when they were evicted, when they were hounded by debt collectors. He represented them when they had family problems, domestic problems. He handled divorce cases.

I followed him at the Emory Neighborhood Law Office, and I inherited a number of his cases as he moved on to leave even greater footprints.

When he went to the City of Atlanta and became Vice Mayor, inspiring all of us at what this young man could do in terms of leadership for his city, he left footprints there, and it was just a matter of time before he was drafted to make the run for Mayor, and Mayor he was, Mayor of the City of Atlanta where he transformed Atlanta into a world class, world renowned city.

He instituted affirmative action with city contracting. He proved that minorities and women could and would under his watch participate as partners in building Atlanta to greatness.

He developed a national demonstration project in his methods of implementing affirmative action in Atlanta which was followed across the country as other mayors and other cities began to follow the example and the road map that Maynard Jackson left, the footprints that he left there in the sands of time.

He was a leader in so many respects. He founded the Georgia Association of Black Elected Officials, which was an organization that helped to bring leadership and to strengthen all of the black elected officials in Georgia and, again, allowed Georgia to lead the Nation in growing a crop of African American elected officials so that he could put flesh and put life into the Voting Rights Act that was brought into being by the civil rights movements out of Atlanta and across the country.

He was one who could be said to have been born with a silver spoon in his mouth. He was from a well-to-do, upper middle class African American family. He was a son of a Baptist preacher, the grandson of one of the icons of Georgia history, John Wesley Dobbs, grand master of the Prince Hall Masons of Georgia, a leader in his own right in political undertakings throughout the State.

He was the nephew of Mattiwilda Dobbs, opera singer, one of the few African American opera singers in the 1950s.

He was a mentor, a bond attorney. He was a friend to so many, a helpful person. He helped young individuals who were interested in going into business or who were interested in running for office. He exemplified all that was good.

Yes, he was a great man, not because of the titles he carried, not because of the degrees that he had earned, the businesses that he started. He was great because he measured by the true standard of greatness set by Jesus, who said he who is great among you shall be your servant and who is the greatest shall be servant unto all.

Maynard Holbrook Jackson measured up. He was indeed great. We mourn his loss. We thank God and we thank his family that he came this way, that he helped make this world a little more of hope, a little less of fear and certainly much, much better because he traveled here.

CHILD TAX CREDIT

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Connecticut (Ms. DELAURO) is recognized for 5 minutes.

Ms. DELAURO. Mr. Speaker, it was exactly a month ago that the House passed a $350 billion tax cut, a tax cut that promised working families, those families who make between $10,500 and $26,600, it promised them a child tax credit, and these are our families who pay taxes, payroll taxes, sales taxes, property taxes, excise taxes.

Something happened on the way to the bill signing by the President of the United States. The Republican majority stole that child tax credit from 6.5 million families, 12 million children. Why? To make room for a $93,000 tax cut for millionaires; 183,000 millionaires will get that amount in a tax cut. So I say happy anniversary.

A week from today, 25 million families in this country will begin to receive their refunds in the mail, but not these six-and-a-half million families hardworking, tax paying families. These families are being held hostage, used as little more than a bargaining chip in the Republicans' never ending obsessive quest to cut taxes and cut them only for the wealthiest people.

Among these families who will not be receiving this tax credit are 200,000 military families, men and women who if we open the paper we can see are still fighting a war. We are losing almost every single day one GI. They are fighting this war in Iraq. They do not deserve to be held hostage by this majority, a majority that has made no bones about their complete and their utter indifference to these families' plight.

The people who have been excluded, these are some of the hardest working people in the country, people who earn minimum wage. They often work two or three jobs just to get by to help their families, and when we think about it for a moment, every minimum wage earning mother in this country paid more taxes than the Enron Corporation did. Enron Corporation paid no taxes in the last 4 out of 5 years. Every one of these families have paid more in taxes than a multibillion dollar corporation.

Make no mistake, this is an all out assault on millions of decent families in this country who work hard. They play by the rules, but this majority cannot put partisan politics aside and act simply and decisively to restore to these families the tax relief that they have rightfully earned, and it is an outrage but it also speaks volumes about their values and their priorities.

It has now been a month since this majority stole this child tax credit from these families. This calendar that is here tonight is here to remind this majority of those six-and-a-half million families that they hold hostage every day because they refuse to simply do what is right.

We will count down to July 1 when 25 million families are going to get the child tax credit, but these hardworking families are not. Every day this injustice is not corrected, every day they ignore the needs of honest, hardworking families in this country, is another day Democrats will be talking about this on the House floor. Every day the House takes up another bill that cuts taxes for the wealthiest people in this country is another day that we will be talking about this on the TV, on the radio and in the newspapers.

□ 2030

Every day will be another day that this will not go away, and it will not go away until this House has done something about it.

So I want to let my Republican colleagues know in no uncertain terms that the clock is ticking. We do not need to see a 2-month anniversary of this injustice. The time to act is now. Twelve million children are waiting.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under the Speaker's announced policy of January 7, 2003, the gentleman from Georgia (Mr. GINGREY) is recognized for 60 minutes as the designee of the majority leader.

Mr. GINGREY. Mr. Speaker, I rise tonight to talk about one of my favorite subjects, health care, and in particular to talk about the Medicare Prescription Drug and Modernization Act of 2003.

I am surely thankful this evening that I have this opportunity to talk about something which truly should be a bipartisan issue, the health of our Nation. I am particularly pleased that it is bipartisan on a day like today, when I learned before boarding a plane to come back to the Congress that a great man in Georgia had fallen. Former mayor, three-term Mayor Maynard Jackson has died. And I stand here tonight with a great deal of humility following some of the speakers who have already paid tribute to Mayor Jackson: the minority leader, the gentlewoman from California (Ms. PELOSI); the gentlewoman from California (Ms. WATSON); the gentlewoman from California (Ms. WATERS); and my colleagues and friends from the Georgia delegation, the gentleman from Georgia (Mr. LEWIS); the gentleman from Georgia (Mr. BISHOP); the gentleman from Georgia (Mr. SCOTT); and the gentlewoman from Georgia (Ms. MAJETTE).

Maynard Jackson was a great Georgian and a great American. For me to stand up here this evening and talk about the many things that he has accomplished would be a little bit redundant. I could talk about his efforts to bring the Olympics to the city of Atlanta in 1996, and he of course played a great part in that; but that is just a small thing that Mayor Jackson has done, and it would be not nearly enough just to point to that. My colleagues have done a wonderful job tonight in describing him and their deep friendship with him.

Let me just say that all Georgians mourn tonight the passing of Mayor Maynard Jackson, and we extend our heartfelt sympathy to his family. I would like to actually take just a few seconds of my time tonight for a moment of silence in tribute to Mayor Maynard Jackson.

I thank my colleagues.

Mr. Speaker, America has the world's best health care system because it relies on innovations of the private sector. A competitive free market system provides incentives to develop better drugs, better treatments, better care, and better forms of health care delivery. The President's framework for Medicare reform would apply the best practices of the private health care market to Medicare.

As successful as Medicare has been, it has not kept pace with dramatic improvements in health care because it is a government program, immune to many market forces. Medicare still does not provide seniors with an outpatient prescription drug benefit, full coverage for preventive care, or limits on high out-of-pocket expenses. As a result, our seniors lack many of the choices and benefits available to millions of Americans who have private health insurance.

Mr. Speaker, I would like to call on some of my doctor colleagues in this body who are with me tonight to talk about Medicare and the reform that we are going to pass in H.R. 1. So at this time I would yield to my colleague, the gentleman from Pennsylvania (Mr. MURPHY), to address this topic.

Mr. MURPHY. Mr. Speaker, I thank the gentleman from Georgia for yielding time. Mr. Speaker, I rise today to voice my support for the Medicare prescription drug bill that will be considered by the House later this week.

In the coming days, we are going to hear a lot of reasons why this bill is so important to our seniors. And, frankly, many of those reasons are correct. This is an important and long-overdue bill. I would like to say that prior to coming to Congress I was honored to serve as a State Senator in Pennsylvania, and there I served as chairman of the Committee on Aging and Youth, where we constantly worked to provide much-needed services for all seniors, but especially low-income seniors in Pennsylvania.

I should note that, in Pennsylvania, over 15 percent of our population is age 65 and older. Some of my colleagues might be surprised to learn that only Florida has a higher percentage of seniors age 65 or older. Access to prescription drugs means a lot to Pennsylvania seniors, as it does throughout the Nation; but in Pennsylvania we are fortunate to have a comprehensive State pharmaceutical assistance program that has been in existence since 1984. It is referred to as PACE and also PACENET.

For the last 19 years, low-income seniors in Pennsylvania have enjoyed access to affordable prescription drugs funded through the lottery program. Pennsylvania's PACE and PACENET programs currently serve about 220,000 seniors, spending about $500 million a year. It is the second largest program in the Nation. I have spoken to many of my constituents that have used PACE and PACENET over the years, and they have all told me one thing: it is a good program, they trust it, and it makes a huge difference in their lives.

Other seniors in Pennsylvania, as well as throughout the Nation, are asking, however, is there something else that can be done to assist them? Even in some small way, given the cost of prescription drugs for so many of them, very often over a thousand dollars a year, they need some assistance. And, Mr. Speaker, I want to point out that we are not just talking about quality-of-life issues. These drugs are often about life and death itself, and this is why this legislation is so incredibly important to our seniors.

When I won my election to this House of Representatives, one of my top priorities was to ensure that States with pharmaceutical assistance programs would be protected under this bill. That is extremely important because over a dozen States dedicate funds to provide some level of pharmaceutical assistance for the elderly. It is important for those citizens to know that Congress is working to protect those States that have invested so much. Some of the neighboring States to Pennsylvania, New York, New Jersey, nearby Connecticut, Florida, so many States have these programs and have invested so much. So seniors are asking us, will we still have some of these benefits, and the answer is yes.

I am pleased how closely Pennsylvania's delegation has worked together on this issue, and I particularly appreciate the Chair of the Subcommittee on Health of the Committee on Ways and Means, the gentlewoman from Connecticut (Mrs. JOHNSON), her guidance, support, and leadership on this issue. This legislation will fully integrate PACE and PACENET for Pennsylvania and other State pharmaceutical assistance programs into the new Medicare prescription drug benefit.

This means that for low-income seniors in Pennsylvania they will continue to enroll in and benefit from PACE and PACENET even if they have a choice of other plans to participate in. It gives PACE and PACENET the opportunity to continue to wrap around those programs and make sure that low-income seniors can continue to benefit from them. It also creates a commission so that PACE, PACENET, and Medicare are integrated into a single seamless benefit. Pennsylvania will have a seat on that commission, ensuring minimal disruption for PACE and PACENET beneficiaries.

Let us not forget that when people are in their 70s, 80s, and 90s, the last thing they need to juggle is how to deal with prescription drug benefits. They need a single seamless entity, whether it is a magnetic card they can swipe or whatever. The pharmacist and the physician will know what that senior's coverage is and will be able to help them in the simplest possible way to make sure they have access to that coverage.

For Pennsylvania, an integrated benefit means Medicare will share a significant portion of PACE and PACENET drug costs, and this freezes up additional funding for PACE and PACENET, possibly some $200 million a year. So the General Assembly can both shore up the financing of those programs in Pennsylvania as well as expand eligibility into higher-income levels, good news to many seniors, who up to this point have been paying out of pocket or trying to pay for other insurance policies.

But this bill is not just good for Pennsylvania citizens; it is good for all of our seniors. I would like to focus on another important aspect of this bill. Our seniors cannot afford to wait any longer. We in Congress must act to create a Medicare prescription drug benefit because seniors should never have to choose between food and drugs. The unfortunate truth is that seniors without drug coverage are more likely to skip doses or go without filling a prescription.

According to a 2002 study of seniors in eight States, among those with serious health problems, such as congestive heart failure and diabetes, one-third of those who lacked drug coverage reported skipping dosages in order to make their prescriptions last longer. What this means is that rather than controlling their diseases, they are more likely to end up in the hospital for expensive procedures.

In addition, access to newer prescription drugs has been shown to lower spending on other services, such as hospital care, due to fewer inpatient stays. Prescription drug coverage just makes sense. And if a senior does not take their medication, they are more likely to fall ill and end up in the hospital.

I fully expect over the next couple of days that, despite people calling for bipartisan cooperation, which sometimes, unfortunately, are just words in this town, people will try to poke holes in this bill. They will say it does not cover enough; it is not all things to all people. Mr. Speaker, I do not think there is a single piece of legislation that ever comes out of this assembly that everybody agrees on all portions of. But seniors have been asking for help, and it is important to them that we say help is on the way. It is time to dedicate our energies not just to rhetoric and partisan politics to use this as a mechanism to attack each other. Because seniors see right through this. One elderly gentleman told me, my eyes may be failing, but sometimes we are not as dumb as you think we are. We know what is going on, and we need help and we need it now. So it is important we pass this bill.

It is 2003, and seniors deserve comprehensive insurance coverage that includes prescription drugs. I urge my colleagues to join me in voting for this bill later this week. It is important, it is necessary, and it is critical we do it now. I thank my colleague.

Mr. GINGREY. I thank, Mr. Speaker, the gentleman from Pennsylvania (Mr. MURPHY), who, of course, talked a lot about the prescription drug benefit and how important a part of this Medicare reform that piece is, and indeed it is.

I want to call my colleagues' attention to this poster to my left in regard to, of course, strengthening Medicare. There are some other points that I want to make that I think are extremely important and that the President and the leadership of this Congress know all too well. Of course, my colleague from Pennsylvania was talking about the prescription drug benefit for our seniors, but this plan does so much more than that. So much more than that.

The Republican plan preserves Medicare for the future. We all know of the actuarial studies. We know of the bipartisan Commission on Medicare Reform. Everybody knows that if we do not do something in this legislation about preserving Medicare for the future that by the year 2030 the program, particularly the trust fund, the hospital trust fund, will be completely insolvent.

☐ 2045

Then the other thing about this reform is the very, very important point of giving seniors choices. What this bill will give to our seniors is a choice to remain if they want to remain in traditional Medicare, fee-for-service, something they are comfortable with. If they are not ready for a change, yes, they can remain in traditional Medicare and get the complete prescription drug benefit that the gentleman from Pennsylvania (Mr. MURPHY) was talking about. So this is very important. This is not a one-legged or two-legged stool; it is a three-legged approach, and we are going to have a good program for our seniors.

Of course the gentleman from Pennsylvania (Mr. MURPHY) was talking about sometimes a senior in his district could not see very well or hear very well or maybe their limbs are aching and they do not get around as well as they used to; but if Members come to my district and my town hall meetings, Members know they are thinking and are smart and understand this issue and want relief and want it now. That is what H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, is going to give to them.

Now, let us talk a little bit about some of these seniors. The gentleman from Pennsylvania (Mr. MURPHY) did a great job of touching on that and talking about some of the people in his district. Let me point out in this poster, providing for catastrophe, assistance for seniors in need, provisions in this legislation assist seniors facing catastrophic medical costs. Let me give an example of some folks in my district that are facing catastrophic medical costs.

Mr. And Mrs. Grady Jenkins are senior citizens who live in Rome, Georgia, in Floyd County, northwest Georgia, the heart of my district. Mr. Jenkins is 79. He is a World War II Navy veteran, and he worked at Georgia Craft, a paper mill. He and his wife have to pay $1,200 a month for their medicine. After they pay for their medicine and their living expenses, they can barely afford to eat. This could easily be a picture of Mr. And Mrs. Grady Jenkins. They are worried because the cost of fuel for heating and air keep rising. They do not know how they are going to make it.

Let me give another example, again in the 11th Congressional District of Georgia. George and Vera Rohr live in Buchanan in Haralson County. Mr. Rohr is a 72-year-old veteran and a Purple Heart recipient. He worked and retired from Lockheed. They are drawing Social Security, and they have a supplement. Unfortunately, he suffered an aneurysm last year: and with the doctor bills and the medicine they both have to take, they have depleted their savings, and now they are struggling to make ends meet. They go from paycheck to paycheck. She tries to pick up odd jobs when she can just to buy the groceries.

Horace Cline was a pharmacist for 49 years in Cave Springs, Georgia. He remembers a time when it only cost 50 cents to fill a prescription. Now he sees antibiotics that cost more than $10 a pill. He does not see how people can afford their medicine. Most of his elderly patients are on a fixed income, and most have three or four prescriptions a day to take. Many people have more than that. The average 75-year-old senior is taking 4½ prescription medications a day, and many of these do cost $10 a pill. This cannot stand.

In his little community, this pharmacist, he hears tragic stories every day of people sacrificing basic needs to buy the drugs they or their spouses need to stay alive. He remembers a little lady that only received $400 a month from her husband's retirement fund. Her prescriptions cost $300 a month, hardly leaving anything for food. He said it is not uncommon for people to ask for a stronger dose of the medicine so they can buy fewer pills and break them in half to be able to afford them.

Mr. Speaker, if you have ever tried to break apart one of these pills, let me say it is not easy. It is not easy for some of our weight-lifting friends, much less our senior citizens who are not so strong any more. People are improvising anywhere they can just to be able to afford the medicine and the doctor bills.

Mr. Speaker, it is a great honor to be in this 108th Congress, to be a freshman Member of a great group of men and women. I have great respect for Members on both sides of the aisle. I have a special deep respect for some of my physician colleagues who are Members of the 108th Congress, and one in particular, a freshman like myself who for many years practiced obstetrics and gynecology in Texas. He has only delivered fewer babies than I have because he has not been at it as long as I have.

Mr. Speaker, I yield to the gentleman from Texas (Mr. BURGESS) to speak on this very important issue.

Mr. BURGESS. Mr. Speaker, I thank the gentleman for yielding; and I would add to what the gentleman has just said, he is quite right, we do have a good class on both sides of the aisle and certainly a lot of people look to our freshman class for leadership on this and other issues.

I thank the gentleman from Georgia (Mr. GINGREY) for inviting me to talk about this important work that this House has undertaken to improve the Medicare program. The gentleman of course knows that Medicare is a 38-year-old government program, having been there at its inception. I came along a little later.

Mr. GINGREY. Mr. Speaker, I must say I absolutely deny being there at the inception of Medicare; maybe it was close, but not at the inception.

Mr. BURGESS. Mr. Speaker, I thank the gentleman for pointing that out. Medicare is a 38-year-old program, but unfortunately it has done little to adapt to the practice of medicine. There is no doubt that Americans have benefited from the development of new and innovative medications. These new drugs can improve and extend lives. It is a simple fact that fewer and fewer of us will die from acute illnesses, but more and more of us will be living with chronic conditions which mean the use of medications.

Drugs exist that can dramatically reduce cholesterol, fight cancer, and alleviate debilitating arthritis. Potent cancer-fighting drugs are reducing breast cancer mortality rates with great success. An entire new class of medicines, collectively known as selective estrogen receptor modulators, are reducing breast cancer mortality rates and one day may see an expanded role in the actual prevention of this disease.

Drugs that fight prostate cancer, diabetes and other life-threatening diseases are not available as a basic part of Medicare, forcing beneficiaries to often make difficult decisions related to their health. Medicare beneficiaries should have access to these drugs, just like so many of us have access to prescription drugs through our own health plans. Medicare was established to improve the health and well-being of America's seniors.

Because the current program does not provide prescription drugs as part of its basic benefit, it is hard to say that Medicare as-is lives up to that promise. With nearly 40 million people enrolled in Medicare and the number of Americans over 65 expected to increase substantially over the coming years, it is important that we approach this issue with clarity and foresight. We should be aware that if this Medicare change is not done right the first time, we could be leaving for our children and grandchildren a commitment that will be difficult, if not impossible, to meet.

This new entitlement, if not implemented properly, could threaten to imbalance future Federal budgets and displace other important priorities.

The bill that the Committee on Energy and Commerce and the Committee on Ways and Means approved last week tries to meet the needs of seniors today and on into the future and attempts to balance the future Federal spending commitments, but we must also be aware of ways that we can hold down the price of prescription drugs and further the taxpayer resources that will be devoted to a Medicare prescription drug benefit.

The United States, through our trade representatives, must work with foreign countries to dismantle their drug price control structures and embrace free market principles. No longer should our uninsured and our elderly bear the cost of pharmaceutical research and development for France, Germany, Canada, Japan and a multitude of other countries. By bringing the purchasing power of the Federal Government to bear, we should be able to positively impact the price of pharmaceuticals sold in this country through free market principles.

It is time to deal seriously with other countries that put our most vulnerable citizens at risk. We acknowledge our obligation to protect the American people from policies of foreign governments that can be described as predatory at best. And if we cannot hold down the price of drugs through market principles, the taxpayer will suffer. Because of the decisions made by this Congress, the beneficiary could bear more and more of their medical costs, and the health of all Americans could suffer because of less access to innovative drug therapies. This Congress stands at the threshold of improving the lives of America's seniors today and of course tomorrow's seniors as well.

Mr. Speaker, this is the first and possibly the only chance that we will have to get it right. We debate this Medicare bill largely through the lens of how we think our entire health care system should be reformed. We must implement commonsense, market-based reforms to hold down the cost of care and improve the doctor-patient relationship.

Bills such as H.R. 2114, the Health Access and Flexibility Act, would increase access to medical savings accounts for all Americans and grant States the flexibility to provide Medicaid and children's health insurance program recipients with health coverage under an MSA model by providing Americans with incentives to hold down medical spending through mechanisms such as a medical savings account and giving them more flexibility in how they spend their own money on medical costs. We can do a better job of containing the cost of health care and achieve better health outcomes.

And so it is with the current debate. We must all ask ourselves the question whether this legislation will meet the health needs of seniors and be accountable to taxpayers for the generations that will follow us. We are here debating this issue because of the absence of action, the absence of action by prior Congresses; but the failure of past Congresses and administrations must not hinder us from these two goals.

Mr. Speaker, we stand at the threshold of implementing important reforms that will impact the health of millions of Americans; but the gentleman from Georgia (Mr. GINGREY) is right, we need to do it now and we need to do it right.

Mr. GINGREY. Mr. Speaker, I thank the gentleman from Texas (Mr. BURGESS) and, of course, the gentleman brings up some very good points about other reforms that this Republican majority, this administration and this leadership are going to present to the American public.

The gentleman mentions the new and improved medical savings account. These are not for our seniors, and we are here tonight primarily talking about what we are doing to reform and improve Medicare, both the traditional fee-for-service and the Medicare advantage and the enhanced fee-for-service option; but also as the gentleman from Texas (Mr. BURGESS) points out, we are thinking much broader. We are thinking about what we can do for younger workers so they can plan for their future, so they can plan for the day that they become a senior. That is what the gentleman is talking about with regard to medical savings accounts which are so important because so much of the money that is spent on health care in this country today is going toward extended care and skilled nursing facilities as an example, many times after prolonged hospital stays.

The current Medicare program has no catastrophic coverage whatsoever. After an individual has spent 60 or 90 or at the very most 120 days in the hospital in any lone year, there is no coverage. Our seniors have no coverage; and whatever nest egg that mom or dad or grandparents have accumulated it is gone, it is exhausted. In many instances when they have to go to an extended nursing care facility for a prolonged stay those benefits are extremely limited and there is no money left to pay for it. The part paid for by Medicare is very limited.

□ 2100

So what happens to these individuals? They do not get thrown out on the street. Thank God, we are more compassionate in this country than that. We would never let that happen. But they become indigent. They literally become indigent. Then they are Medicaid eligible and so much of that Medicaid money which, of course, being a Federal-State cost sharing, in some instances 60–40, maybe 50–50, very expensive, and where are most of the dollars going? They are going to pay those bills in these extended care facilities.

The gentleman from Texas is so right. I am so appreciative, Mr. Speaker, to the gentleman from Texas for pointing that out to us. We are doing more than just reforming Medicare for the future and providing a prescription drug benefit for our seniors. We are going to make sure that those who will become our seniors in the future and ad infinitum will have a way to pay for things like extended care insurance. This is so very important and I am so appreciative of the gentleman from Texas for bringing that up.

Mr. BURGESS. If the gentleman will yield, of course this is a little bit off the subject but so terribly important that we make our constituents aware, especially those who are younger or middle-aged that the time to look into long-term care insurance, not a program that will be provided by the government but something that you should do as being a responsible member of society, the time to look into providing for long-term care for yourself and your spouse, the time to do that is now. I again recognize that that is a little bit off our subject tonight, but it does tie into the greater knowledge that at some point the Federal Government's ability to pay for everything that is going to be required possibly could be outstripped. By someone being responsible and providing for themselves and their families now with long-term care insurance, this is the time to do it for individuals our age and a little bit younger.

Mr. GINGREY. I thank the gentleman for bringing that to our attention because he is so right, and to have someone like the gentleman from Texas who has spent an entire career practicing medicine, being there every day and, of course, as an OB-GYN every night and every weekend as well, he understands the big picture. That is why it is so important to have Members like the gentleman from Texas bringing this information forward.

I see the gentlewoman from Florida (Ms. GINNY BROWN-WAITE) has joined us, the former Speaker pro tem of the Assembly in the great State of Florida. I yield to her on this very important subject. I thank the gentlewoman from Florida for being with us tonight.

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I would just like to correct the previous speaker. I was the President pro tem of the Florida Senate, not the Assembly or the House. It was the Florida Senate. When I was a Florida Senator, we had an option that we pushed for and actually achieved. That was, we offered prescription assistance to low-income seniors. When we were developing the bill, of course we had to live within a budget. We lived within the budget. I can just tell you that it is almost like I can predict what will happen. We will hear from the other side that it is not enough. For those people who are benefiting, something is better than nothing. The plan started out relatively small and it grew and it expanded. But we were helping the very low-income seniors in the State of Florida.

I rise today to remind my colleagues of the extreme importance of providing a prescription drug benefit for our seniors on Medicare. I cannot emphasize enough what a difference having a prescription drug benefit will make in the lives of our seniors, especially those low-income seniors, many of whom reside in Florida. I have a large number of seniors who are retired who regularly call my office, who regularly stop me in the grocery store and after church to tell me of the problems that they are having paying for their prescription drugs that equate to a quality of life. Seniors who rely on Medicare have nothing to help defray the cost of their prescription drugs, the majority of them. Some do have prescription drug programs, but the majority of them have only Social Security in my congressional district and they truly do need the help that a good prescription drug bill will provide. Seniors covered by Medicare right now are probably the select few who are paying retail prices for their prescription drugs. You and I might go to the pharmacy and pay either a small copay or a very small fraction of the cost of our drugs. We would go ballistic if a pharmacist told us that the prescription that we needed, quote, wasn't covered. Well, guess what? Seniors face this every single day.

A constituent called just as I was leaving the office this morning and told me how she has to pay $7.50 per pill for just one of her prescriptions. For people on a fixed income or anyone, for that matter, that is an enormously expensive drug. Yet this is a prescription drug, costly as it is, that my constituent needs to stay alive.

Mr. Speaker, I am new to this body. I have not been around for years of debate on this issue in this House. I was not here for the two previous sessions where there was a successful vote to bring a prescription drug benefit to our seniors. Maybe that makes me idealistic, maybe less jaded, whatever you want to call it. But I just cannot envision going home and telling my constituents, justifying to them, or trying to justify to them why Congress cannot give them a prescription drug benefit. I hope that I never have to try to justify that.

The previous occupant of the congressional seat from Florida's Fifth District voted against the prescription drug bill that was there in 2002. I made a commitment early on that I would vote for a prescription drug bill. The prescription drug bill that has been worked through two committees, both Ways and Means and Energy and Commerce, is coming along very well. It is a bill that I have some reservations about, but the reservations are mainly about the cost. But we should begin a program and we should actually probably tie that program to the $400 billion that we have appropriated to make sure that we stay within the budget guidelines.

Mr. Speaker, I again ask the Members of this House to join me in voting for the prescription drug bill that will be before us later on this week. It is important, I think, not just for a State like Florida where there are many senior citizens, I have the fourth highest senior population in this whole Congress, but it is important to every senior who struggles to meet those prescription drug costs.

Mr. GINGREY. I thank the gentlewoman from Florida. The gentlewoman from Florida brought up a couple of, I think, really, really good points, and that is the fact that our seniors who are not on a plan, and they are probably close to 30 percent, by anybody's estimate, probably 30 percent of our seniors have absolutely no coverage whatsoever. They do not have so-called MediGap or supplemental insurance. They are not getting a retirement health benefit that includes prescription medications from their employers. Thank goodness, many in that group are not poor enough to be dual eligible; that is, eligible for both Medicare and Medicaid. Those dual eligibles, of course, have a prescription benefit. And so we do have maybe 65, maybe 70 percent of our seniors do have a prescription drug benefit, but even those, Mr. Speaker, probably spend at least 50 percent out of pocket, what they have to pay. That 50 percent when you are talking about being on four or five or six pills a day and some of them costing $9 and $10, that mounts up in a hurry and that is where you get into these situations where people are having to choose between groceries and their medications. That is a very sad, dangerous situation.

I really appreciate the gentlewoman from Florida bringing up the fact that when these seniors go to their internist, to their primary care physician, indeed, yes, occasionally to their OB-GYN and get a prescription, but sometimes it is not just one prescription. They have these multi-system diseases. Sometimes there are two or three things that are failing at the same time. It takes these medications to keep our seniors healthy and well. So when they go to that pharmacist, as kind, as caring, as loving as the local corner druggist may be, they have got a handful of prescriptions, they do not have a plan to help them get a discount with volume purchasing and that sort of thing. There is no pharmacy benefit manager for them. They are paying sticker price. Our seniors know it. They are paying sticker price. It is pretty painful when they go back to that car and maybe they were only able to get half of that prescription filled or as we pointed out earlier, I think, one of the speakers mentioned that our seniors sometimes will ask for double the dose or maybe quadruple the dose so they can go home and get out that little pen knife and cut that pill in half or in quarters so they can stretch the budget, if you will. It is a very dangerous situation. Mistakes can be made, sometimes catastrophic, tragic mistakes.

The gentlewoman from Florida is bringing out a very important point, that these seniors are getting no breaks in the marketplace. We need to give it to them. That is what we are going to do in this prescription drug benefit under Medicare modernization.

Ms. GINNY BROWN-WAITE of Florida. If the gentleman will yield, actually in my district it is more like 50 percent of the seniors have no retirement prescription drug plan. I have many low-income seniors who have a little bit above their Social Security income, or just their Social Security income. My mother-in-law is a perfect example. She only has Social Security. If it were not for her children helping her, she would be one of those seniors making those very dangerous decisions. But not every family can help and not every family is willing to help. And so for the sake of the seniors who truly need assistance, this is the right thing to do and it is the right time to do it. I am sure that when we go home over the Fourth of July break that we will be hearing from our constituents throughout the Nation, thanking us for taking this step and keeping our fingers crossed that we come out with a great bill, between the Senate proposal and the House proposal that we truly will have a bill that will help seniors desperately in need of assistance.

Mr. GINGREY. I thank the gentlewoman. Mr. Speaker, no Member of this body understands this better than the gentlewoman from Florida. The Sunshine State is where all of us want to go to retire and live out a very, very healthy life there in that beautiful State of Florida. She has got probably a disproportionate number of her constituents who are our beloved senior citizens. She knows of what she speaks. I really appreciate her bringing that to us.

I would like to at this time recognize once again my physician colleague in the House, the gentleman from Texas.

Mr. BURGESS. I thank the gentleman for yielding. I would like to point out that when this Member retires, of course, he plans to go to the Lone Star State and make his retirement there, but his comments are well taken. The gentleman from Georgia knows this very well. He pointed out that an occasional senior will see their OB-GYN and, of course, they see their OB-GYN for monitoring and diagnosing conditions such as osteoporosis. Those medicines for osteoporosis, now fortunately a lot of those are administered on a weekly basis. But if a senior goes home with that prescription and finds it is too expensive to fill, the next time that doctor is going to be aware that the medicine has not been taken is when the follow-up bone density study is done 12 or 23 or 24 months later and no improvement or in fact a worsening of the condition has occurred because the medication could not be afforded by the patient, putting them at serious risk for hip fracture and all of the costs attendant with that. Of course as the gentleman knows, there is a 25 percent mortality within the year of that hip fracture for some groups of seniors.

This is a terribly important point. Although the gentlewoman from Florida is quite correct, there are some concerns about the cost of the bill, there are also concerns about the cost of doing nothing. Certainly the gentleman from Georgia and I both recognize that.

I also feel obligated to mention one other aspect, and we have talked about this before on the floor of this House, that is, of course, the bill H.R. 5 which we passed last March. Getting meaningful medical liability reform in this country will do so much to improve the affordability of not just Medicare but health care in general. The cost of defensive medicine in this country, according to one study that was done out at Stanford in 1996, is nothing short of staggering and it is really almost beyond my comprehension that we could expect to have any type of meaningful Medicare reform with cost containment without somehow getting our arms around the problem of the expense of medical liability in this country and the expense of the practice of defensive medicine.

Mr. GINGREY. I wanted to ask the gentleman, I am glad he brought that point up, about medical malpractice premiums and what it is doing and, of course, has resulted in a lot of defensive medicine practiced not just by our physicians like myself and the gentleman from Texas, Mr. Speaker, but also by the hospitals, by our facilities who are forced to protect themselves, to order in many instances a lot of tests that they really feel are not absolutely necessary but it is done in the interest of defending themselves against possibly a frivolous lawsuit that could be devastating to either that individual practitioner or to that little rural hospital in our small communities, and like my 17 counties in the 11th Congressional District of Georgia, many of these hospitals as an example, these rural hospitals, disproportionate-share hospitals that see so many Medicare and Medicaid patients, they are going to end up closing their doors.

□ 2115

And I really appreciate the gentleman from Texas, that Lone Star State mecca where actually, as he pointed out, every day is a good day to be in Texas, not just during retirement years. But I wanted to ask the gentleman from Texas about the cost and what kind of estimates, if any, do we have on the cost of defensive medicine without getting a good tort reform bill passed?

Mr. BURGESS. Mr. Speaker, I am going to apologize to the gentleman from Georgia. I do not have those figures at my fingertips. The last time I looked at that study by McKissick out of Stanford, for two diagnostic groups within the State of California, only that being chest pain and acute myocardial infarction, the cost was in the billions; and when we extrapolate that over hundreds of diagnostic codes over the 50 States, obviously that is a significant number of dollars.

Mr. GINGREY. Mr. Speaker, to the gentleman from Texas, I appreciate that. And that is exactly right, when we extrapolate that, and I have gotten verification of these numbers from the gentlewoman from Connecticut, the chairman of the Health Subcommittee under the Committee on Ways and Means who has done so much work on this bill, and I really commend her leadership. She has indicated to me that defensive medicine is costing the Federal Government and indeed the taxpayers of this country $14 billion estimated over the next 10 years. That would go a long way toward paying for this prescription benefit that we are going to be offering this year.

Mr. Speaker, the gentleman from Texas was talking earlier about the cost of prescription drugs and what we can do about that. Of course we are going to be providing a good prescription benefit for not just our neediest seniors. Of course the program is weighted toward them as well it should be, but we are providing a benefit for all of our seniors. But along with that, along with that, as the gentleman pointed out, it is very, very important that we address this issue of the cost of prescription medication. I think most people in this country, certainly the seniors that have to go and purchase those expensive drugs, know that it is just too much; and we need to continue to work very hard, as the gentleman from Texas points out, to get the market forces working to bring the price down, to make the pharmaceutical industry compete, as well they should and they are doing; and that is what we want.

We do not want government price controls. We want the market to determine, and we want of course these businesses, pharmaceutical businesses to have an opportunity to make a fair profit to recover, as the gentleman from Texas pointed out, the tremendous cost involved in research and development; and that of course is something that I think is extremely important. But we definitely feel that the competitive forces of the marketplace will bring prices down. And certainly, as we pointed out earlier, when a senior is part of a group, as we know, with the wonderful organization many of our seniors have memberships in AARP and they have a drug discount card.

In fact, I would like to just point out if I can get everyone's attention on one of the posters to my left, this is the typical medical prescription card which seniors will have, and they will be issued by a number of organizations. And with those cards if we did nothing else, and we are doing much more, as we pointed out earlier, but if we did nothing else, just the opportunity to buy as a group and the force of the marketplace, it is going to bring down the price of prescription drugs for all Americans but especially for our seniors.

Mr. Speaker, I wanted to spend a little bit of time talking about the Medicare program; and of course the gentleman from Texas mentioned a little earlier that the gentleman from Georgia, myself, was there from the inception of Medicare, and my wife told me to be sure to let the Members of this body know that of course I was there from the inception. I was just a very precocious first grader, but I do remember very well in 1965 when the Medicare bill was first passed, and the emphasis then in most health care was seeing one's physician, occasionally of course being admitted to the hospital for a needed surgical procedure. Nobody thought too much really in 1965 about the fact that here in 2003 that people would be on maybe four or five drugs. The average person 75 years old could be on that much medication. So there just really was not the emphasis in 1965, but things changed. Things have changed in many other aspects of our society. When I was in college, we used a slide rule. Nobody even knows what a slide rule is today. Our automakers gave us an Edsel, and now we have the new and improved and revised and beautiful Thunderbird. We need to do that with Medicare. We truly need to do that with Medicare.

I have been practicing long enough to see some significant changes; and I have seen managed care, health maintenance organizations with a great emphasis on preventative healthcare, preventative healthcare; and I applaud that because it is extremely important. If we wait to treat people when an episode of poor health or an accident has occurred, then it is so expensive, not to mention the tragedy and the suffering and the loss of life that occurs, but just the expense of waiting until a person is so sick and they show up in the emergency room, that paradigm has got to shift. That paradigm has got to shift.

I tell my colleagues in the House, Mr. Speaker, of my experience recently of going through so-called open heart surgery that I was faced with right after winning this election to the Congress, and now I am on five prescription medications every day. I am not a senior citizen yet. I am not Medicare-eligible. But I know they are very, very expensive, very expensive; and it just makes me think how important it would have been for me and how important it is for our seniors who maybe just turned 65 to be able to get the medications that they need to strengthen their bones, to prevent osteoporosis, to lower that blood pressure so they do not have a premature heart attack or a stroke and end up in a nursing home for the rest of their lives.

So things are changed. Society has changed. And now I do not think there are many physician colleagues of mine in this great United States who would not agree that a prescription benefit is every bit as important as a hospital benefit or a surgical benefit, and we have got to make that change. And that is what this President is doing. That is what this administration, that is what this leadership, what the gentleman from Illinois (Speaker HASTERT) and the gentleman from Texas (Mr. DELAY) and the chairmen of our committees of jurisdiction, the gentleman from California (Mr. THOMAS) of the Committee on Ways and Means and the gentleman from Louisiana (Mr. TAUZIN) of the Committee on Energy and Commerce, and their subcommittee Chairs are bringing to us. They are bringing not just this prescription benefit, but they are also bringing an option for change so that our seniors can get the same health care benefit that we, Members of Congress, have available to us and that all Federal employees have available to them, to be able to go to enhanced fee for service or a Medicare advantage plan where there is an emphasis on preventative health care, where they can get a routine physical done, where they can get their blood screened for lipid profile and cholesterol so that we will know early, early on, if they are at great risk for developing one of these serious illnesses. That is what it is all about. Colonoscopies, mammograms, things that will keep people healthy and prevent them from getting so far down the line with an illness that they cannot recover.

So that is what we call, Mr. Speaker, compassionate conservatism. That is what this President and this administration and this Republican majority and this leadership is all about, and that is what we are going to bring to the seniors of this country. We are going to bring a prescription benefit that is weighted toward the needy, that has a catastrophic cap; and, yes, that cap is going to vary depending on a person's income or net worth, as well it should. I think it is only appropriate that we take care of our neediest first, but all seniors need the same kind of benefit that I enjoy and other Members of Congress and Federal employees enjoy.

So that is a very, very big part of this program. It is not just providing a prescription benefit but also giving our seniors an opportunity and an option. Of course, they can remain in traditional Medicare, which we all know about a comfortable pair of shoes and we get used to something and change is difficult. I know change was difficult for me when I gave up a medical career to join the Congress and get on this rather steep learning curve. It is scary. It is scary, and maybe some of our seniors will decide to stay in traditional-fee-for-service Medicare, but they will have a prescription drug benefit. They will have the same prescription drug benefit.

What they will not have in that traditional paradigm is they will not have any catastrophic coverage. They will still have catastrophic coverage of course for the prescription benefit, but not for other costs involved like hospital stay or nursing home stay; and that is what we are trying to avoid by giving them an opportunity to join one of these other options where it is a competitive environment and an opportunity for these plans to compete against each other and lower the cost at the same time they are providing this preventative health care benefit like I mentioned, routine physicals, routine screening, and, yes, indeed, catastrophic coverage so that people who have worked all of their lives to build a little nest egg not become destitute and burdens on society in their senior years. That is not right. That destroys their dignity.

□ 2130

And if I do anything in this Congress, I am going to work hard to make sure that that does not happen to our seniors.

So in conclusion, Mr. Speaker, I want to thank my colleagues who are with me tonight to discuss this tremendously important issue. We do not have the perfect plan. Yes, bills can be improved, and that is what the committee process is all about. That is why we have two committees of jurisdiction and very intelligent people working on this bill to perfect it. This is so much better, Mr. Speaker, this is so much better than what we have currently. I am just very proud of our leadership, and I am very proud to be supportive of the Medicare Prescription Drug and Modernization Act of 2003.

REPORT ON RESOLUTION WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Mr. LINCOLN DIAZ-BALART of Florida (during Special Order of Mr. Gingrey), from the Committee on Rules, submitted a privileged report (Rept. No. 108–174) on the resolution (H. Res. 292) waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2555, DEPARTMENT OF HOMELAND SECURITY APPROPRIATIONS ACT, 2004

Mr. LINCOLN DIAZ-BALART of Florida (during Special Order of Mr. Gingrey), from the Committee on Rules, submitted a privileged report (Rept. No. 108–175) on the resolution (H. Res. 293) providing for consideration of the bill (H.R. 2555) making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPUBLICAN PRESCRIPTION DRUG BILL OUTLAWS BULK PURCHASING POWER TO NEGOTIATE LOWER DRUG PRICES

The SPEAKER pro tempore (Mr. Garrett of New Jersey). Under the Speaker's announced policy of January 7, 2003, the gentleman from Rhode Island (Mr. Langevin) is recognized for 60 minutes as the designee of the minority leader.

GENERAL LEAVE

Mr. LANGEVIN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include therein extraneous material on the subject of this Special Order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Rhode Island?

There was no objection.

Mr. LANGEVIN. Mr. Speaker, tonight I am pleased to be joined by many of my Democratic colleagues to discuss the lack of cost control provisions in the prescription drug bill before the United States House of Representatives, H.R. 2473. In particular, I feel that it is so essential that we call attention to the fact that this bill does nothing to use the country's bulk purchasing power on behalf of our seniors to lower the high cost of prescription drugs, the purchasing power we should be using to ensure the lowest cost of medications for our senior citizens. Quite the contrary, this bill expressly forbids it.

Like many of my colleagues, I held a sincere hope that the 108th Congress would overcome the inaction that has plagued this issue at the expense of America's senior citizens for so many years. I am extremely disappointed that the bill before the House this week not only fails to offer a structured and sound prescription drug benefit for Medicare beneficiaries, but also contains provisions that threaten the stability of the program that has provided health benefits for millions of elderly people and young adults with disabilities for the past 38 years.

While we all come to the floor with a range of grave concerns about this bill, my Democratic colleagues and I join together tonight with the united message that the House of Representatives must take action to address the rapidly rising costs of prescription drugs. H.R. 2473 not only fails to address this crisis, it actually contains a noninterference clause prohibiting the Secretary of Health and Human Services from using the bulk purchasing power of Medicare beneficiaries to negotiate for the lowest prices for senior citizens, a tactic that has proven effective in the State of Maine and is developing in Illinois and in other States.

Like many other places in the country, my home State of Rhode Island uses bulk purchasing power for seniors eligible for Medicaid to negotiate discounts for this population. America's seniors have made it clear that they want the government to assist them in obtaining their prescription drugs at a fair price.

Now, it infuriates me that in a situation where we have over 40 million people with a common and basic need, instead of taking advantage of that purchasing power to negotiate the lowest prices for the most rapidly increasing component of health care, the Federal Government is considering outlawing that practice. Amazing. The Federal Government is considering outlawing that practice.

An analysis of H.R. 2473 by the Consumers Union shows that spending on prescription drugs continues to grow. In fact, if we do not take action to curb the costs now, seniors will pay more out of pocket in 2007 with the prescription drug benefit as is currently proposed than they are paying in 2003 without it. Yet, just last week, the

Committee on Energy and Commerce defeated an amendment that would have repealed the noninterference provision and allowed the Secretary of Health and Human Services to negotiate with drug companies in a similar manner to that of the Secretary of Veterans Affairs and Medicaid programs. I think that is something that is worth noting. It is already being done successfully with the Veterans Administration in providing a drug benefit to our veterans at very low cost, and the government is able to buy these at obviously a reduced cost, in making sure that our veterans get the benefit that they need, these vital medications that are so important in keeping them healthy. Yet we are going to prevent the Secretary of Health and Human Services from doing the exact same thing for the rest of the seniors in this country who are struggling to get by in paying for their prescription medications. It is simply counterintuitive.

Studies show that seniors in other industrialized countries are paying significantly less for their prescriptions than America's seniors. And, in this case, the short answer really does sum it up. It is because their governments took action to protect their interests when it comes to pricing prescription drugs. In Canada where citizens pay, on average, 50 percent less than the seniors I represent in Rhode Island, for the five most commonly prescribed drugs, the government uses the bulk purchasing power of its people to help them, and that is the way it should be. My constituents are paying 292 percent more, for example, for Prilosec than they would be in Italy where again the government uses the bulk can purchasing power of people to help them. Prices in other countries are not the result of government contributions or subsidies to drug companies; they are the result of governments using purchasing power of significant blocks of people to negotiate better prices. It is very basic.

Let us also look at another area while we are on this subject of using mechanisms to reduce drug costs. Another place where we can take action to reduce the high cost of medications is generic drugs. Last week our colleagues in the Senate took substantive measures in their Medicare reform bill to address the rapidly escalating cost of prescription drugs by easing market entry of generic drugs. In fact, their vote to do so was nearly unanimous: 94 to 1. At the same time, the House leadership, though, in a quest to push through a mere pretense of a prescription drug benefit, has failed to acknowledge that without measures to control the cost of prescription drugs, any benefit will deteriorate in value over time. America's seniors deserve better than this.

Mr. Speaker, it is amazing. The Republican leadership is so eager to subsidize the insurance companies and allow drug manufacturers to continue to exploit America's seniors in the name of the free market system, but is apparently unwilling to use that same free market system to allow the natural market force of 40 million individuals, our struggling senior citizens, to come into play.

The noninterference clause, a small section on page 250 of a 321-page bill, must be brought to light. We must draw attention to the fact that any prescription drug benefit is rendered meaningless unless action is taken to curb the out-of-control costs of drugs that people need to stay alive.

I thank my colleagues who have joined me on the floor tonight to highlight the fact that at this very moment America's seniors are making choices between taking their medications as prescribed and putting food on their tables. Just this morning I joined Dr. Sarah Fessler and the Rhode Island Academy of Family Physicians in releasing a survey showing that a third of seniors in Rhode Island are relying on physician samples for their necessary medications, and 20 percent are failing to take them as prescribed because of costs, skipping prescriptions to make them last longer, and failing to refill them. The survey reiterates what we already know: that cost is the greatest barrier to seniors taking their prescriptions.

This situation, Mr. Speaker, will not fix itself. I urge my colleagues to pay careful attention to the details of H.R. 2473 and to think critically about the effect, or the lack thereof, it will have on the seniors in their districts.

Mr. Speaker, I am pleased to yield to the distinguished gentleman from Maine (Mr. MICHAUD), who in his first term has taken tremendous initiative by introducing the America Rx Act under which the Federal Government would act as a pharmacy benefits manager to negotiate low prescription prices for America's seniors, and it is very appropriate that he be the first speaker this evening, and I welcome him.

Mr. MICHAUD. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, this week we are prepared to debate a Medicare prescription drug package. We are focusing all of our energy on trying to pay for expensive prescription drugs. But one important aspect of this debate is missing; that is, finding a way to make drugs less expensive to begin with.

The fact is that drug prices continue to rise and are spiraling out of control, forcing more people to choose between medicine and food. Talking about paying for prescription drugs without talking about prices is like going to a grocery store telling them to fill up your cart and handing them a blank check. We are letting the company decide how much to charge and then we are proposing to have the government foot the bill.

Last month, I met with a group of seniors in my district in Bangor, Maine who were on a bus trip to Canada so they could buy the medicine they need at a price that they could afford. And guess what they saved? Out of 18 senior citizens, they saved over $19,000, just by crossing the border. That is a crying shame.

Like most Members of this House, I believe that expanding access to prescription drugs is one of the most important issues that we face. That is why I have taken the creative Maine Rx approach, which just received a favorable ruling from the United States Supreme Court, and brought it to this Congress.

Earlier this year, in an attempt to make prescriptions more affordable for all Americans, I introduced H.R. 1694, the America Rx Act of 2003. America Rx uses the power of the free market to negotiate lower prescription prices for all Americans who lack adequate coverage, similar to what they do in the Veterans Administration. We are the only industrialized Nation that does not negotiate lower cost for prescriptions, and it is time for a change.

Like Maine Rx, America Rx is a fresh approach that will not cost the taxpayers a single dime. This approach is simple, it is fair, and it works. It is time for America's seniors to gain access to affordable, lifesaving prescription drugs. We will be doing all Americans a disservice if we do not include ways to contain the cost in the upcoming debate.

Mr. LANGEVIN. Mr. Speaker, I thank the gentleman. Again, I share wholeheartedly in the statements that he has made, and I want to commend him for introducing H.R. 1694, the America Rx Act. Again, as the gentleman states, this bill establishes an America Rx program to establish fair pricing for prescription drugs for individuals without access to prescription drugs at discounted prices and, as the gentleman said, modeled after the Maine Rx program, by the Federal Government acting as a pharmacy benefits manager to negotiate the lowest prices. This approach uses the power of the free market to allow millions of American senior citizens, with no access to discount, to pool together and negotiate as one block. I cannot see what could be more basic than that. That is what certainly this Special Order is all about tonight.

I am now pleased Mr. Speaker, to yield to the gentleman from Maine (Mr. ALLEN), who has shown tremendous leadership on this issue by introducing the Prescription Drug Fairness for Seniors Act, which would require drug manufacturers to allow pharmacies to purchase drugs for resale to Medicare beneficiaries at the same price equivalent to the average foreign price based on the price consumers pay in six other industrialized nations.

□ 2145

Mr. ALLEN. Mr. Speaker, I thank the gentleman for yielding, and I thank him for his leadership in holding this Special Order tonight.

Many people across the country are really confused about what all these prescription drug plans mean for them. They are trying to sort out whether the Republican plan or the Democratic plan or whatever plan may be up, how it might possibly help them in the future. And, frankly, you cannot blame anyone for being confused out there because there are so many descriptions flying back and forth. But it is worth highlighting one that the gentleman from Rhode Island (Mr. LANGEVIN) highlighted before and my friend, the gentleman from Maine (Mr. MICHAUD) was mentioning as well and that is the way these two approaches treat the subject of price.

It seems that in every instance the Republican plans do everything they can to avoid trying to reduce prices; and, obviously, that is consistent with what the pharmaceutical industry wants. But the most remarkable thing about the prescription drug proposal made by the Republicans here in the House is actually like the Senate bill; it contains a provision essentially saying to the Secretary of Health and Human Services, you shall not negotiate lower prices for Medicare beneficiaries. And what are they afraid of? What are they afraid of?

Every private insurance company in the country tries to negotiate the lowest prices they can for themselves and for their beneficiaries. It really makes a huge difference. But here you have the Republicans in the House saying you cannot negotiate lower prices. They might as well say to the Federal Government, to Health and Human Services, we think you should pay higher prices to the pharmaceutical industry. Above all, we do not want the pharmaceutical industry to be paid less.

I did not bring them tonight, but I have some charts that go back in history; but they show that over the years every time there has been a major effort to improve the ability of seniors or anyone else to get their prescription drugs, they show that the pharmaceutical industry comes in and says, if you do this to us, if you make generics more widely available, if you have a rebate program under Medicaid, those are the two major developments over the last 15 years, if you do either one of these things, then we will have to cut back on research and develop.

And what happened in the aftermath of those acts? The 1988 Hatch-Waxman Act, which made it easier for generics to get into the market and in the mid-1990s a provision that basically capped Medicaid prices. In both cases, the industry said, we will have to cut back on research, and in both cases what the industry did was dramatically increase funding on research.

The truth is that all of this fear about what the pharmaceutical industry will do is misplaced. What our people need is very simple. They need lower prices.

Now, our seniors pay the highest prices in the world, the highest prices in the world for their prescription drugs. Here you have the biggest health care plan in the entire country, Medicare, 40 million beneficiaries, obviously some real ability to leverage lower prices; and the Republican bill in the House explicitly says we will not allow the Secretary to negotiate for lower prices. That is not where our home State of Maine is going. That is not where private insurance companies go. It really is completely off the wall. There is absolutely no reason to do that.

But when you look at the Republican plan in the House, you can also see that the benefit is not very good. It is really not very much. For example, if you pay, if you wind up with $4,900 of drug expenses in the course of a year, you are going to wind up paying about $3,600 of that all by yourself. For many Americans, for those whose drug expenses are less than $1,367 a year, all of those people, if they sign on to this plan will pay more in than they ever get out. It will not make any sense for them. And it is also true between about $2,400 and $4,900; those people with lose money as well. It is because the benefit is completely inadequate.

Now, we have our friends on the Republican side coming down here and saying what this country needs, what our seniors need is the same kind of prescription drug benefit that members of Congress have. Well, if that is what they need, why not provide it for them? Why not give them a prescription drug benefit more or less like we have, one with an 80/20 co-pay, for example? But they will not go there. And there is a reason why they will not go there. They cannot go there. They have given all the money back. They have basically got tax cuts: if all of their plans go into effect, they will have reduced tax revenues over 10 years by about $4 trillion. No wonder there is no money left for a real prescription drug benefit under Medicare. No wonder there is not enough money to fund Head Start or not enough money to fund special education or not enough money to even fund the President's initiative, No Child Left Behind. They have given the money back to people who earn over $370,000 a year.

Now, I suppose some people would say that is a very needy group; but it is hard to figure out, particularly when you have seniors all across the country who are choosing between food, rent and prescription drugs. I mean, there are so many stories; they cannot all be repeated. But I know one couple where he takes his medication one month, she takes her medication the next month because they cannot possibly pay for both of them. And that is why so many people in Maine and across the country now get their prescription drugs through Canada.

What does Canada do? Why is Canada so special? The bill I have introduced, H.R. 1400, the Prescription Drug Fairness for Seniors Act, basically says to the pharmaceutical companies, you cannot charge Americans more than you charge the Germans and the French and the British and the Italians and the Canadians and the Japanese, the other 6 countries in the G–7.

Just take the average foreign price, you cannot charge more to our people, our Americans, than you to do to those people in those other countries. It is that simple. And yet that is exactly what the Republicans will not do. They simply will not go there because their friends in the pharmaceutical industry cannot abide the thought of having the government do what the insurance companies do, which is negotiate lower prices.

We hope, in the State of Maine, and we hope across the country that people will finally understand that unless the government works to negotiate lower prices, our seniors will continue to pay the highest prices in the world. It is not right, and it needs to change. But it will not change in this House this week when the Republicans pass their prescription drug bill because they will talk about choice, but there is not much choice out there.

The President was out on the stump not so long ago and he said, we want seniors to have the kind of choices that members of Congress have, choices among many plans. Well, in my State and many States, guess how many choices I have? One. I have one plan in the State of Maine, one health care plan that I can choose. One. Not two, not three, not ten. One. And that is all there is. And this is what this bill promises. This bill promises, they say they are going to try to give the insurance companies enough money so there will be two plans in every district; but, in fact, this is a product that does not exist, this kind of insurance on prescription drugs. It looks and feel like another way to get past the next election, to have a plan. It does not take effect until 2006. What are we really talking about?

We need to reduce prices for our seniors. We ought to do it now. I thank the gentleman; I appreciate his time and leadership on this issue.

Mr. LANGEVIN. Mr. Speaker, I thank the gentleman for his words and for his leadership on this issue. He was very eloquent tonight, as he has been so many times in the past in addressing the prescription drug problem, in fighting for our seniors. I commend him for his service in this House and for his work on this issue.

I am now, Mr. Speaker, very pleased to yield to the gentleman from Illinois (Mr. EMANUEL), who has consistently worked to reduce prescription drug costs through targeted market reforms, a freshman Member of this House who has already shown his compassion for seniors and his leadership. I thank him for being here this evening.

Mr. EMANUEL. Mr. Speaker, I would like to thank my colleague from Rhode Island.

Tomorrow in a bipartisan fashion with about six Republicans and six-or-so Democrats, we will be introducing an amendment to the prescription drug bill that focuses on bringing competitive forces to the pricing of prescription drugs so we can make prescription drugs affordable to not only our elderly but our American families.

I think one of the things that is missing in this entire debate, in this entire strategy, is how to make drugs and prescription drugs more affordable and more accessible to people. How do you do that?

There are three parts to this bill. The first part would bring generic drugs to market quicker so name-brand drugs and pharmaceutical companies cannot employ frivolous lawsuits to keep generics off markets. If you had competition between generics versus prescription drugs, you would bring prices down from name-brand drugs.

The second portion of that bill, and that portion of the bill has been adopted by the Senate and also enjoys bipartisan support in this Chamber as it enjoys in the other Chamber. The second, as my good colleague from Minnesota, a Republican, a good colleague, enjoys overwhelming bipartisan support and also adopted in the Senate in bipartisan fashion, was the market access bill. It enables consumers, elderly as well as other families, to buy medications, Canada, Mexico, Israel, Italy, Germany, France, Netherlands, Great Britain and all of those countries, the same name-brand medications sold here in this country are sold in those countries at 50, 60, 70 percent reduced prices, but they are American-made medications.

Now, if we can import steel, we can import cars, we can import software, we can import wheat, food products and everybody always wants to espouse the virtues of globalization, well, let us allow them globalization to bring prices down here at home for prescription drugs.

Globalization is not supposed to be a one-way road just for corporations and their bottom line. Globalization is supposed to work for consumers. So allow globalization to work so if you can find that drug in the German market or the British market for cheaper, you could be allowed to buy it. It is called market access. So competition between generics versus name-brand. Allow us to buy products in West Germany or Canada or Mexico, wherever you can find them cheaper. Allow the global marketplace to determine the best price for the consumer.

The third portion of the bill is a bill that allows, take the family of drugs for cancer or AIDS. Every one of the medications on the market today was developed with government research, taxpayer money through the NIH. Allow the NIH to get a 10 percent royalty for that investment back to the taxpayers. You would do that, and in 10 years the NIH would be fully self-funded. It is one of the great venture capital arms in the entire world.

I worked in the private sector. We used to believe you look for a 30 percent IR, which is an investment return on your equity. Anything below a 30 percent return was considered "dumb money." And we have been treating the taxpayers like dumb money. Give the taxpayers a minimum of 10 or 15 percent return on their investment, and the NIH would be fully funded in 10 years through investment royalties.

In addition to that tax-funded research, whether it is in cancer, AIDS or any medication out there, today the taxpayers subsidize research through the R&D tax credit, research and development tax credit. And so not only are the taxpayers in this country paying on the tax credit on the upfront side through NIH funded research, but on the back side through research and development tax credit. We are paying for it twice. And the only benefit left to the American taxpayer is they get to pay the highest price for that drug when it comes on the market. They fund the research, and they get to pay the highest price.

□ 2200

The pharmaceutical industry in this country has been treating the seniors of this country and the American families with sick children as their profit guinea pig. They earn their profits off the back of Americans who have paid for the research.

It is my view what is missing is we need the market forces to bring the prices down so they are more affordable and more accessible to our elderly. If we are going to spend $400 billion on a prescription drug bill do my colleagues not think we want to get the most for our money? So in my view what is missing from this debate, what is missing from this discussion, what would make sure that we spend our $400 billion wisely is a market forces of competition from generic to name brand, prices overseas in Europe to American prices and then a return on our investment. That would bring real competition, and therefore, we would have the market forces working on behalf of the taxpayer rather than against them.

I am proud that we have a bipartisan bill, a lot of Republicans on it, a lot of Democrats. I think it represents our common values, but a number of people in this Chamber who will always be up here, we will hear them on every other debate, espouse the virtues of a free market. I am going to allow free market to reign. I came from the private sector. I think it is a wonderful thing.

I do not fault the pharmaceutical industry. They bought and paid themselves out of a free market when it comes to name brand versus generics. They have bought themselves out of a free market when it comes to preventing consumers from buying things in other marketplaces like they do any other product, and they have treated us like nothing but chumps when it comes to getting our tax dollars to fund the research. Yet they get the profit and we get the biggest payday with the highest prices.

So it is my view that if we bring the market forces to bear we will make drugs affordable, and most importantly, because the government will be funding the research as they do today, we will guarantee that those drugs continue to come to market and America stands as number one in the area of research for new drugs, new medications to cure other illnesses.

The Boston Globe did a story, and I will bring this back up. Thirty-two out of 35 of the drugs that they targeted were developed with NIH or FDA funding. We can make the whole NIH which is $26 billion fully self-funded. The last time in 1984 is when we passed a bill to get bring generics to market. Are we saying in close to 20 years our laws do not need an update, what it means to accelerating this research, that our laws allow pharmaceutical companies to keep generics off the market?

So we can do this, we can make the medication on our $400 billion we spend on a prescription drug benefit go farther, insure more people, get benefits and drugs cheaper to seniors, if we would allow the free market to reign when it comes to the pricing of drugs.

I know my fellows on the other side of the aisle believe in the free market. I am just going to give them a chance to put their money where their mouth is, and I look forward to the support of others in this area. I am pleased that my colleague organized this today because we focus the country on this. We are going to do I think what is right, get a prescription drug bill, but just because we do it does not mean it is right. It is how we do it that determines whether it is right.

I am pleased that we have support for all this. It is the right type of area. It makes sure that we have affordability. It makes sure, too, that we stay in the frontlines of having the best medications developed because we have been focusing on the taxpayers funding this research, now we are going to guarantee we get a return on our investment. As long as they want that tax R&D credit, which they should have, the pharmaceutical companies, we are going to make sure we get a 10 percent, 15 percent royalty on those dollars we invested.

Every cancer drug on the market today was funded by the taxpayers. Corporations got the profit and we got the biggest bill in America. Our brothers and sisters and fellow consumers in Germany and England and France are enjoying the benefits of taxpayer funded research. They are paying minimal prices at 50 percent, 60 percent less than we are. We are paying the highest price. They get the drugs for a cheaper price, and the corporations in America get the profits, and we get to pay the highest bill.

As we would say in Chicago, such a deal. That is what has happened.

So we need to take this three-step approach, all of it based on the principle of the free market. We bring the free market, we bring competition, it will drive prices down, spend $400 billion, reach more seniors with better affordable prescription drugs, and we will make the medications more accessible, more affordable because they will be cheaper in price.

Again, I want to thank my colleague from Rhode Island for organizing this and bringing the attention to this issue and allowing all the different perspectives to be brought to bear here in this Chamber.

Mr. LANGEVIN. Mr. Speaker, I thank the gentleman from Illinois for his very powerful words on this debate. I could only wish that every taxpayer in America could have heard those words tonight, along with our seniors, because it really crystallizes the debate itself, and I know we are going to be working on this together, both tomorrow, the rest of the week and until we bring this issue home. I thank the gentleman from Illinois for his comments.

That is an important aspect of this debate, the fact that taxpayer dollars have funded so much of this research, have developed these medications, and the only thanks that our taxpayers have received in return, our seniors have received in return, is high cost prescription medications that they cannot afford. That is outrageous and it is wrong.

We, as a compassionate Nation, as a determined people, have to do something about it. We have to change that and we have to make our prescription medications within reach for our seniors. No senior in America should have to make the choice between food and medication or paying their rent, not when it was their taxpayer dollars in the first place that helped develop those medications.

Mr. Speaker, I said earlier in my remarks, and each of the speakers tonight have again reiterated the argument, that we should let the free market system determine the cost of these medications, and by that, as I have said before, it means allowing our seniors to join together, use their bulk purchasing power to negotiate the lowest cost price for these medications. No prescription drug benefit should be passed by this House without that being a major component of that bill. No other insurance company, no other private insurance plan would have a prescription drug benefit without that component contained within it, and neither should one pass by this House.

Who does it benefit to pass a prescription drug benefit that does not include a component that uses the bulk purchasing power of this Nation without it being present in the bill? Is it the taxpayer? Well, certainly not because they are not getting the lowest negotiated price. Is it the seniors who are struggling to afford their medications? Well, certainly not.

It is the insurance companies, though. It is the pharmaceutical companies who do benefit: Let us keep the prescription drug prices high, let us keep the profits outrageously high, let us not be able to use bulk purchasing power that would negotiate a lowest cost price for our seniors, no, because that means that the pharmaceutical companies, the insurance companies, are out profits. That is simply wrong, Mr. Speaker, and I hope that my colleagues on both sides of the aisle will recognize this argument for what it is and do the right thing by our seniors.

Let us do what is done in Canada, in Great Britain, in Italy, in Japan, nations that for their seniors use their bulk purchasing power to bring down the high cost of medications that allows their people, their seniors to get the medications that they so readily need to stay healthy, which in many ways are wonder drugs and have become a replacement for surgery, but again, what good are they if our seniors cannot afford them? They have recognized that in Canada, in Great Britain, Italy, G–7 nations. We need to recognize that here in America.

Mr. Speaker, I thank my Democratic colleagues for joining me tonight to bring attention to this critical component of an issue that we all continue to debate throughout this week. In particular, I want to express my gratitude to the Members who have been persistent in supporting stand-alone legislation on the topic of rising prescription drug costs in recent years.

While it has yet to be brought to the floor, there is significant support in this Chamber for several pieces of legislation that would control prescription drug costs. We have heard about some of them. Tonight, we heard of the gentleman from Maine's (Mr. ALLEN) bill, H.R. 1400, the Prescription Drug Fairness for Seniors Act, which would significantly reduce prescription drug prices for all Medicare beneficiaries by requiring drug manufacturers to allow pharmacies to purchase medications for resale to Medicare beneficiaries at a price equivalent to the average foreign price based on the prices consumers pay in six other industrialized Nations. This legislation would provide up to a 40 percent savings on prescription drugs.

There is also bipartisan support for the Greater Access to Affordable Pharmaceuticals Act, which would speed the market entry of generic drugs by closing loopholes that are being used to lower priced competitors in the marketplace. We have heard about this this evening as well.

It is the right thing to do, to look at all of these options for controlling the high cost of prescription medications. We owe it to our seniors to look at this and do the right thing by them. We owe it to our seniors to fight for these cost controls.

Again, I ask the Republicans in this House to champion an issue that they have always championed and that is using the free market system, allowing the free market system to operate, to come to an equilibrium price. If we do that for our seniors, then everybody wins and we will have bipartisan support on that effort. It is the right thing to do. It is my sincere hope that the Republican leadership will see the light and allow Members to offer these bills and other amendments to the Prescription Drug and Medicare Modernization Act of 2003.

I will continue to work with my Democratic colleagues to promote legislation that will provide substantial medication savings for our seniors rather than the high profit margins for drug and insurance companies.

Mr. Speaker, I thank my colleagues who have joined with us tonight in speaking on this important issue.

ELIMINATION OF THE DEATH TAX

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under the Speaker's announced policy of January 7, 2003, the gentleman from Colorado (Mr. McINNIS) is recognized for half the time from now until midnight.

Mr. McINNIS. Mr. Speaker, I wanted to take a little time this evening to discuss an issue which I think is very basic but fundamental to American families, to the dream of American families in this Nation being able to pass on through their hard work, one business or a farm or a home or some type of asset from one generation to the next generation.

Unfortunately, in this country we have put into our tax code one of the most unfair, unjustified taxes that any tax code could have, and that tax is called, for short, the death tax. It has got a fancy word which they say the estate tax, but in fact, what it is is it is a tax upon a person's death. It is not a tax that is invoked for any other reason but for the fact that a person has died, and the moment they have died, the government, the State Government and the Federal Government, of course led by the Federal Government, shows up at the grave site and tries to get into that person's estate and invoke this death tax.

There is a little history to the death tax. The death tax, as I said, from any scholarly point of view, from any economic point of view, from any business point of view, if we take a look at the death tax, there truly is no justification for it.

□ 2215

On top of the fact that there is not a justification for the tax, under any economic sense, any economic study, on top of that, the tax is also at least a double taxation. Because the death tax is not a tax on property that has been accumulated during one's lifetime upon which no tax has been paid. When this property is accumulated by an individual, tax is paid either at the time of the accumulation or at the time of the sale. So this tax is not an attempt to collect some tax that for some reason or another has evaded the tax man's notice. That is not what this tax is about. This is a tax that is a tax on property that has already been taxed, and, in some cases, more than once. In some cases, two or three times.

Now, look, everybody agrees that we should carry our fair share of the burden. Nobody disagrees with that. We know that to operate a government, to operate a military, to operate the needs of the government that we have to have some revenue. But we determined a long time ago that that taxation ought to have at its fundamental core the word fairness. It ought to be fair. And time after time we have said, including in recent action by this body of the Congress, we have said time after time after time that double taxation hardly fits within the definition of fairness. It is not fair to tax somebody twice on the same property. And that is exactly what the death tax does.

Now, I believe that the death tax is a pretty good issue that shows a fundamental difference between the Republican Party and the Democrats. In my opinion, all of the Democratic candidates that are running for the Presidential office here in a couple of years support the death tax. Every Democrat, to the best of my knowledge, the Democrats that in this House or in the other body in the U.S. Congress that have a net worth of more than $1 million and that voted against elimination of the death tax have already done trust planning. So they do not have to pay the death tax.

We have people, for example, not just Democrats here in the House or on the other side, but we have other people out there, whose party affiliation I do not know, for example, Warren Buffett, and people like Bill Gates's father, and these are very, very wealthy individuals, and these are individuals who stand up and say that we ought to keep the death tax in this country. What is ironic about this, and frankly, in fact, a little hypocritical almost, and if it were not so serious it would be amusing, but I can remember several months ago where at one of these parties, and I think it was Bill Gates, Sr. who was doing an interview about how as a very wealthy individual, from a very wealthy family, that they supported the death tax. But where was he doing the interview from? He was doing it in the offices of their foundation. And what is the purpose of that foundation? The purpose of that foundation is to avoid the death tax.

So there are some very wealthy people in this country who, along with the liberal side of the Democratic Party, say we support the death tax, we think it is fair to have a death tax; but the reality of that is that if they have any money of their own, these individuals have already created foundations or have done trust work so that they largely avoid paying any kind of death tax. So that is not the kind of source we want to look to for some type of scholarly view as to whether or not a death tax is justified.

I do not look to the ivory towers of our universities to come up with some conclusion as to whether or not we should have a death tax. Where I look is, I go out into my district. I go out across this country; and I talk to the people who have worked hard, who have wanted to accomplish the American Dream. And one of the American dreams, and I think pretty much all my colleagues at some point or another in their life have had this dream, and that is to become successful, to be successful to the extent that they are able to help the generation behind them, their kids, their children; to be able to give them a start; to be able to maybe help them enjoy part of the life that they have enjoyed.

And for the sake of disclosure, Mr. Speaker, let me just mention that in my family, on my wife's side of the family, they have a family ranch. They have been in the ranching business since the 1860s or the 1870s out in Colorado. This is a beautiful ranch. It is beautiful not just in its physical characteristics, but it is beautiful in that the family, generation after generation after generation, has loved the land and has been able to stay on the land.

Now, in the past hundred years or so, or 50 years, ever since the death tax has been in place, one would think we live in a socialistic type of society where there is some kind of punishment for dying; it seems we want to make sure the family behind you does not have that opportunity to be able to live on that ranch and work the land like this family, the Smith family of Meeker, has done for generation after generation.

I can find example after example, Mr. Speaker. So one might ask, how did the death tax come about in the first place? Well, the death tax was designed to be a punishment against the wealthy, those very wealthy icons around the turn of the 19th century, the Ford family, the Carnegie family, the Rockefeller family, people like that. In society at that point in time there was such a large division between the very, very wealthiest and the population as a whole that somehow the politicians were persuaded that there should be a punishment in this country.

Here we are, in our classrooms, teaching that this is the greatest country in the history of the world, in part because we encourage innovation, and innovation has as its basic incentive reward. An individual is rewarded for innovation, that in our country if you invent a cure for cancer, you can become wealthy; in our country if you make a better seat belt, or as the old saying used to be, if you make a better mousetrap, there is incentive out there. We do not live in a socialistic society where no matter what you contribute, your share of the pie is always equal. That is not what we believe in. That is why socialism will never equal capitalism. But the reality of this tax is that somehow way back then the politicians decided to punish the wealthy people of this country, those few wealthy families.

What they never imagined was that it would not just punish the wealthy. In fact, it would not really punish those wealthy people at all, because most of those wealthy people throughout time, including today, including the Gates family, and I have respect for their accomplishments, although I disagree with them on the issue, but it does not really punish them because they are able to hire hundreds, or whatever numbers, of attorneys to get them out of it. Where it is punishing Americans is in the middle class of America.

You do not have to be wealthy to be hit by this thing. Prior to the Republican movement, led by our President, in which we at least begin to phase out the death tax through the year 2010, prior to that all a person really needed to own free and clear was, say a bulldozer, a dump truck, a pickup, and your office building for a little construction company. And guess what, your family was going to face the death tax upon your demise. This is a tax that is directed at the middle class of America, and it is a punishment tax so that the middle class of America, again because the wealthier class is able to plan around it, this is designed to take the middle class of America and make sure that instead of encouraging family businesses or family farms, instead of encouraging that to go from generation to generation, it serves as a punishment.

Now, let me just say that in the last 2 weeks this House once again said that we should take the elimination of the death tax, which is totally eliminated in 2010, but, unfortunately, comes back in full force in 2011, once again this House last week took action to permanently eliminate the death tax. And, frankly, I am stunned, not surprised, but I am stunned that we did have 44 Democrats, and I am not trying to get partisan on this issue, but let us call an ace an ace. The fact is this is one of the differences between the Democratic Party and the Republican Party, and that is the death tax; but I can say that 40 or 44 Democrats last week came across and voted with the Republicans to permanently eliminate the death tax. The rest of those Democrats did not come across. They support this tax. And it is a debilitating tax on the middle class of America.

Mr. Speaker, do you know what happens to some of these farms in my area that have to be sold for death taxes? They are not sold for ranches or farms. I live in the mountains of Colorado. That is my district. What happens when these farms or ranches are sold, they are turned into 35-acre ranchettes. They are turned into condominium projects. The open space that makes Colorado beautiful, that makes most of us in this room want to vacation in Colorado, gets turned into condominiums. Why? Not because of some greedy rancher that wants to make money. The Smith family could have made a lot of money a long time ago. But it is because our very own government forced this family to sell that ranch so that that ranch, the proceeds from the sale of that ranch could be used to pay the government.

Now, I have heard the argument, and I want to explore the argument a little, but I have heard the argument that, well, we need to spread the wealth. This is class warfare, and we saw it during the debate on the tax credit a couple of weeks ago; we saw it on the vote of the death tax. The Democratic philosophy, and let us lay it out here, the Democratic philosophy is more of a transfer system. If you get somebody that makes money over here and somebody does not quite make it over here, you ought to do some transfer to try to make them equal. But I can assure my colleagues that just works as a disincentive. We cannot have everybody be equal economically, or we would never have any incentive for someone to do better.

When we take a look at the arguments being used by the Democratic Party, by the liberal leadership over there, and I am talking about the minority leader, who is an ardent supporter of continuing this death tax, their argument is, well, gosh, what we do is we take from a wealthy family, and again let me remind everyone it is, in most cases, not a wealthy family, in fact this tax comes from middle-class families, so what they say, well, we get it from the people who have the money and we give it to people that are more in need of the money. Let me give an example of what happened to a family I know out in Colorado.

Mr. Speaker, I will not use the names of this family; but first of all, the father, the husband and wife started out with the wife as homemaker. He started out as a janitor in a construction company. Eventually, over 4 or 5 years, he became the bookkeeper of the construction company. Pretty soon, he was able to borrow enough money to buy the construction company. Pretty soon he had 5 or 10 people working for him. Then, 10, 20, 25 years later he was the largest investor in the local bank, he was the largest contributor to the local church, and he was the largest employer. Hundreds of people worked for him in the community. He was by far the largest contributor for everything from United Way to the Boy Scouts, to the Girl Scouts, to whatever. What happened, unfortunately, his wife got cancer and passed away. And then, unfortunately, my friend got terminal cancer as well.

Now, what happened is he sold the bank, the interest he had in the bank, and he got hit with capital gains taxation. Which again, fortunately, in the latest tax cut, we have reduced that to 15 percent. And I commend the President, the Speaker of the House, and I commend the majority leader in the Senate for leading the way on getting this capital gains reduced so that we can help bolster this economy.

□ 2230

But back to my story. In this town what happened was my friend sold the interest in the bank and got hit with capital gains. Shortly after selling the family interest in the bank, he was diagnosed with terminal cancer and died 3 months later. The estate tax when combined with the death tax on top of the capital gains tax, that family was taxed 71 cents on the dollar. That does not mean that the family was able to take 29 cents on the dollar, that is not what happened because they were not able to realize the true value of their assets because their assets were sold at a fire sale. They were forced to sell.

The family told me they thought they were able to keep a property that they had already paid taxes on in many cases more than once, on property that their father and mother had accumulated over a 65-year period of time, they were able to maybe keep that family for the next generation about 18 cents. How did they get the money, they had to sell the construction company. They had to stop contributing to the local charities, lay off employees, and sell transferable assets that were moved out of the community.

What happened to that money in this case? Did that money stay in that local community? It did not. It did not stay in that community. This is one of the bad things outside of the fact that the death tax is unfair. That money did not stay in that local community. That money was transferred to Washington, D.C. When it went to Washington, D.C., how many cents per dollar do you think ever went back to that tiny community in Colorado once it got back here to the bureaucracy? Probably nothing or some small fraction.

But what was the impact on that community when they took those properties and transferred it, simply because of the reason that the person, the two people that had earned it had died, that is the only reason this punitive tax was put in place, what happened, the church which he and his wife contributed 70 percent of their budget to, there were no more donations to the church. The employees lost their jobs. The construction company was forced to be sold. My understanding is that the construction company ownership, they then moved the construction company out of town. It hurt that community at different levels all throughout that community.

Mr. Speaker, it pokes a hole in the liberal argument. It is almost like a socialistic-type approach that we ought to tax these people that are wealthy or upper middle class that die, it is good for the community. It was not good for the community. It devastated that community. Let me remind my colleagues here, we are not talking about somebody who had not paid their taxes. They had paid taxes year after year after year. This was not untaxed property. The only reason that property was hit with the death tax was because of the fact that a death had occurred. That was the trigger event. That is what caused it.

Let me step back and tell Members, it is not just that community alone. I brought letters over. In the United States Congress, we get letters every day. I grabbed a few of them about the death tax. I want to read some of them.

Dear Congressman, We have operated a family partnership since the middle 1930s. My parents died 5 years apart in the 1980s, and the estate tax on each of their one-fifth interest was three to four times more than the total cost of the ranch which was purchased in 1946.

Mr. Speaker, this family bought a ranch in 1946 and the death tax when the husband and wife died was four to five times the original purchase price of the ranch. Tell me how one Democrat could vote to continue this tax. As

I said, 40 some of the Democrats voted to get rid of this tax, and I commend those 40. But for my other colleagues, and I say this respectfully, but for my other colleagues on the Democratic side who refuse to join the Republicans and the 40 conservative Democrats, how can you look at this family, how can you go to this family and justify this kind of tax on that property, on that family farm out there in middle America?

Let me go on. Here is another letter. I am a student at the University. I grew up in a family that has lived and thrived in agriculture for many years. My parents and grandparents are involved in a typical family farm, a farm that has been in the family for more than 125 years. Grandpa is 76, and in the last years of his life. My parents have been discussing this situation for the last several months. My parents worry about the death tax and about how they are going to be able to keep the farm running once grandpa passes away. The eventual loss of my grandpa will trigger this death tax on the family's farm. My parents hope that they will be able to pay the tax without having to sell part of the farm that my family has worked so hard over all these years just to keep the ranch together, just to make it so it can operate at a profit. The outcome does not good look good, however.

Mr. Speaker, farmers and ranchers are having enough trouble, and we are not just talking about farmers and ranchers, we are talking about small businesses, we are talking about the American dream. We are talking about a lot of families in America. Finally, through our leadership here, we were able to at least for a period of time begin to phase this tax out and eliminate it in 1 year. But unfortunately, because we could not get the votes on the other side, this tax comes back in full force.

Going back to the letter: Farmers and ranchers are having enough trouble keeping family operations running the way it is. My family has worked very hard to keep the family farm running this long. We feel like we are being penalized because one of our family members has died.

Here is another letter. This letter is not a plea for help, Mr. Congressman. Although I am not a victim of this tax, I appreciate the effort against it. I firmly believe that Congress and the government at large needs to recognize that America's future is and will always be firmly rooted in the success of small business. Many of these businesses are family owned, and they need the next generation to continue them into the future. I spent a few years working for a small, family-owned business. Not just myself, but several workers depended on the income that they derived from working for this small business. I fear for these workers when the tax man comes knocking. This tax has claws that rip at many people, and then the immediate family of the deceased has to worry about whether or not they can even continue the business, about the punishment that is being dealt to them by the government. It has a huge impact on the employees of the family business. I hope that people recognize this and will have an opportunity to eliminate it.

Here is another letter. As you know, farming and ranching is no slam dunk. If our farm is ultimately faced with the death tax burden, there is absolutely no way we could ever afford and justify holding onto this farm. This in turn will prevent us from: 1, keeping the farm for future generations; 2, keep it from becoming just one more development out in the middle of the country; 3, keep us from making it available to the deer and elk; 4, keeping it unavailable for other uses, for multiple use. You need to know, Congressman, we are only able to meet the daily operating cost of our farm under the present economic conditions of agriculture. Unless there is positive action taken by Congress on the death tax, we will start making the necessary plans to arrange our affairs so the family is the ultimate winner of the lifelong struggles of both my parents, Roberta and myself. There is no way we will allow the IRS and the government in Washington, D.C. to take it all away from us. They do not deserve it. But what does that mean, it means of course that we must begin the destruction and the development of one of the largest, most beautiful open spaces still left out in this part of the country. We do not want to do that, but we do not have any choice because of this death tax.

Here is another letter. Our 106-year-old mother passed away. Because we knew she was fearful of being placed in a nursing home, and we never considered it an option, my husband and I took care of her in our own home 2 days a week. She was alert, and we believe she would be living today if she had not injured herself. We are now faced with the unpleasant and unexpected task of selling our family home which was acquired by our parents in 1929 and where they raised six children. Prior to World War II, my parents had a greenhouse business on five acres of farm property. After World War II, the family returned from the relocation center where those of Japanese ancestry were incarcerated and signs that said "No Japs Wanted." My father died of a heart attack in 1953. My mother lost the business located on two acres, four greenhouses, the heating plant, the packing shed, which, by the way, had two bedrooms above which many of the children slept, to the State. The State took two acres of property for an on-ramp to the freeway, but my mother was able to keep our family home which she and my father built. Now I must say that because of the death tax, it will now be necessary to sell this property, this home, this family home, just to pay the taxes that are levied upon the family as a result and only as a result of the death of this family member.

Here is another letter. My family has ranched in northern Colorado for 125 years. My sons are the sixth generation to work this land. We want to continue, but the tax of the government is forcing almost all ranchers and many farmers out of business. The problem is called the death tax.

And again I want to say to my Democratic colleagues, how can you go and look at these families and justify the continuation of a death tax? How can you dare vote against the elimination of this tax? I just do not understand it. Are we so surrounded here in Washington, D.C. that some of my colleagues cannot see what is happening to the American family, the middle income family, the small business out there because of a tax on property that has already been taxed?

Do you not understand what a death tax does to these people? This should be a country that encourages generation after generation to continue the family foundation of running the business, whether it be a music store, whether it be a farm or a ranch. But believe it or not, some of my colleagues here continue to support taxing people upon the death of a member of their family, only triggered by the event of that death on property that has been taxed again and again.

People say you get awful excited when you talk about this issue, but I have seen what the devastation is to my constituents as a result of action taken out of this House many, many years ago. And even though it was initiated many years ago, it has continued because some Members do not have enough guts to stand up and vote it down.

We do not live in a world of socialism. We do not live in a world where class warfare ought to be instituted. We do not live in a world where we say to a family operation, you have been able to keep this land and now because the mother or father has died, we are going to redistribute the land. That is fundamentally unfair. Nobody is saying that someone should not carry their fair share. These people have carried their fair share, and I challenge any of my colleagues on the Democratic side that voted to continue the death tax, I challenge them to come out to Colorado, come out to a mountain family. And by the way, they will not let you go out of their house without you eating dinner, despite how you vote on this issue, but you look that family in the eye and tell them why you support putting a tax on their family when one of the members of their family dies on property that they have already paid the taxes upon.

□ 2245

It is not right. There is no way that you can justify the death tax. There is no way that the Gates family can justify supporting the death tax, other than the fact that they have a foundation that gets them around it. It is the same thing with some of these other very wealthy families that have come out in support of this death tax. Why? Because they have hired the lawyers. As I said, the Gates interview was being done out of the family foundation office. That foundation was built for the sole purpose of avoiding the death tax.

I worry about middle America. Get out to the heartland of America and tell me, especially my Democratic colleagues, I do not know what it takes to get them to realize how punishing this tax is. Go out to the heartland and talk to these people and see what you are doing to the families by simply casting a "yes" vote on this House floor to continue to tax people.

Let me show you. Here is what is going on. This is what the heartland of America looks like, just like that. It is family. Families have got to have something to eat. They have got to have a way to subsist. That is the way it is in my part of the country. Again, I live in the high mountains. We have a lot of agriculture out there. We do not have a lot of corporate agriculture. We may have families that incorporate for tax purposes but we do not have the Monsanto Copper Corporation. These are families that run these farms and ranches. The people that supply the wagons and supply the tractors, those are family-run small businesses. This death tax will destroy them. It threatens the American way of life. That is exactly what this death tax does. I cannot think of a better demonstration of what happens, and I want to show this picture to you. This is exactly what you are driving. I know that the more liberal side of the Democratic Party that supports the death tax, many of you also pat yourselves on the back, although I am not sure you are fully deserving of it, you still pat yourself on the back for being strong on the environment. We all need to be strong on the environment, but you take particular pride, the minority leader and some of the more liberal Members, the people of you that have voted to keep this death tax in place, you take particular pride in your record on protecting the environment. Let me show you what happens to the environment when you force these family farms to sell, when you force them out of business, because of this death tax that is what it looks like over here on the bottom. That is what it looks like before the death tax.

What is behind those cattle? Those are condominiums. This used to be open space. Look between the cattle and the trees on the mountain. What is between them? It is condominiums. That is exactly what your "yes" vote to continue to have a death tax, that is exactly what your vote has done. This land right here has to be sold to pay the death tax on this property, although all of the property had already paid its taxes year after year after year. Again, we are not talking about someone or some family that has not paid their taxes. We are talking about a family who has paid their taxes but the bureaucracy has not had enough of it. Frankly, and again I am not trying to be partisan, but let us call an apple an apple. The reality of it is the liberal wing back here, the left side, continually says, look, they have too much, this farm family that owns this land, they have too much. Let us approach it from a holistic point of view. Let us take it from them and give it to them. That is exactly what the death tax is envisioned to do, and it is wrong and you are hurting America. You are not only hurting the future of American families that want to continue small business or small farms or small ranches from one generation to the next, you are hurting the environment of America because just as this poster demonstrates, and look at it again, what used to be open space, what used to be open pasture, what used to be an unfettered view to the mountain is now a destroyed view because you have got condominiums right there being built to pay the death tax on that piece of property. Tell me where the equity in that is.

Let me read this:

My family has been on the ranch for 125 years. My sons are the sixth generation to work on this land. We want to continue, but the death tax is forcing almost all ranchers and farmers out of business. The demand for our land is very high and 35-acre ranchettes are selling in this area for a very high price. We want to keep our land as open space. We want to keep it as a ranch. But the government through its policy of death taxes is making it impossible for us because of what we will have to pay once a death event occurs. Ranchers are barely scraping by these days, anyway. If we were willing to develop home sites, we could stop worrying about the death tax but we want to save the ranch. And because we want to save the ranch and as a direct result of the death tax, we are in trouble. The family has been able to scrape up the estate taxes as each generation up to now dies, but I am telling you the time is out. I think we are done for. Our only other option is to give the ranch to a nonprofit organization. And they all want it but none of them will guarantee that they won't develop at least a part of it.

My dad is 90. We don't have much time to decide what to do. We are only one of two or three ranchers left around here. Most of the ranches have been subdivided. One of the last to go was a family that had been there as long as ours. When the old folks died, the kids borrowed money to pay taxes. Soon they had to start selling cattle to pay the interest. When they ran out of cattle, their ranch was foreclosed and is now being developed. That family which used to be a strong family, that had a gorgeous ranch, that survived generations and generations, that family now lives in a trailer near town and the father works as a highway flag man.

You can trace it all back to the votes that started on this House floor. You can trace it back to the most unjustified tax in our tax system. I do not care how you say it. I do not care how pretty my Democratic colleagues want to paint the picture. The fact is they need to come around and they need to join the Republicans and we need to eliminate the death tax on a permanent basis. You cannot justify it. In this upcoming presidential election, I think a litmus test that ought to be asked of every Democrat presidential candidate is, will you support total elimination of the death tax on America? My guess is that they will not look you in the eye, but my guess is none of them will do that. When you hear people and I say this to my colleagues, when you hear people out there talking in a very courageous tone about, look, I've made a lot of money and I think we should keep the death tax, take a look at what they have done, like the Gates, for example. They have put it into a foundation. Why? For the sole purpose to avoid the death taxes. That is why those foundations are created. I have a lot of respect for the Gates family. I am in awe of what they have done to make that. It has been an American dream. But the reality of it is they should not be considered an authority to speak on the death tax when in fact they have created a foundation in which to shelter that money. The better people to go and get an opinion from is, what I say, go out into the heartland of America. Go to Kansas. Go up into the Rockies and stop at some ranch house. Go in there and talk with those people. First of all, you are going to find that they are going to invite you in, they are going to feed you something. Ask them what the death tax will do to their family. Ask them how. Or better yet, to my liberal colleagues, you tell them how you can justify putting a death tax on a family. The fact is you cannot justify it. The fact is this tax is not justifiable from any economic argument. It certainly is not justifiable from a moral point of view. The only way that you could possibly justify a death tax is if you were a socialist and you believed in the concept that whatever is somebody's property ought to be everybody's property, that it ought to all go for the common good, that everything ought to be thrown into one pot and everybody shares equally. If you believe in the socialistic type of government, then you can justify a death tax. But if you believe in the democratic, capitalistic process which has made this country, by the way, the greatest country in the history of the world, there is no way under any circumstances that you could justify this tax.

As I said earlier, last week we voted, it is over on the other side now, we voted for permanent elimination of that tax, of that death tax. Unfortunately, most of the Democrats once again have chosen to support and to continue the death tax.

It is time for the American public, Mr. Speaker, to understand why there is a difference between Republicans and Democrats. There is one issue I feel very deeply about in my heart that separates our two parties. Granted, about 40 of the more conservative Democrats did vote to eliminate the death tax and for that they deserve credit. But when I am out there, I do not feel like I am getting in a partisan argument, I do not feel like I am taking any cheap spots when I point out that the death tax is primarily supported by the Democrats and the elimination of the death tax is driven by the Republicans. When you go out to the heartland of America, when you go out there into that countryside some time, see if you have got enough guts to look that farm family in the face and say to them, it is because of you that the next generation in that family will in all likelihood not be able to continue the farming or ranching operation.

I urge my colleagues and I urge especially my Democratic colleagues, it is time for you to surrender this issue, because it is the right thing to do. It is time for you Democrats to step up to the plate and support the American farmer and the American rancher and the American small business. The best way that you can do that is to vote to eliminate the death tax. Give these families, give these farms, give these small businesses, give these ranches an opportunity to go to the next generation. We all benefit. Our communities benefit. Our environment benefits. Push the socialistic temptation aside and adopt, rather, what I call the fairness doctrine. It is very simple, just be fair. If you could just be fair in your assessment of this horrible tax, you too next time will join the Republicans and vote against the continuation of the death tax.

IRAQ AND WEAPONS OF MASS DESTRUCTION

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under the Speaker's announced policy of January 7, 2003, the gentleman from Pennsylvania (Mr. HOEFFEL) is recognized for 60 minutes.

Mr. HOEFFEL. Mr. Speaker, I appreciate the opportunity to address the House with a number of my colleagues who will be joining me later, notably the gentleman from Massachusetts (Mr. DELAHUNT) and the gentleman from Hawaii (Mr. ABERCROMBIE), to talk about Iraq.

Mr. Speaker, we have had a great military victory in Iraq. Our young men and women performed with great courage and great effectiveness. We are all very proud of our military and the fact that the threat of the Saddam Hussein regime is no longer present to threaten regional and world peace. But we have two questions that we believe need to be addressed: First, is our military mission complete in Iraq? Secondly, having won the military victory, are we winning the peace?

Regarding the military mission, I would suggest to the House that our mission is not complete without a full accounting of the weapons of mass destruction. There is no question that the primary purpose for invading Iraq put forward by the administration last year and accepted by a majority of the Members of Congress, myself included, was for the purpose of disarming Saddam Hussein of weapons of mass destruction. There is no question that Hussein had such weapons in the past. The international United Nations inspectors were finding them in the mid and late 1990s. Hussein used weapons of mass destruction, notably chemical weapons, against his own citizens with devastating and brutal effects. No one has dreamt up or made up the motion that Hussein had in the past weapons of mass destruction. There is no doubt that he did. But we cannot find them now. We do not know where they are. Perhaps they are buried in the desert and we will find them next week. I hope that is the case. Perhaps he gave them to some other group or some other country. Perhaps he destroyed them. We do not know what happened, but many of us in the House believe that we must have a full accounting of what happened to the weapons of mass destruction before our military mission is complete, for two basic reasons. First off, we need to know where they are. If they are not in Iraq and have been given or taken someplace else, we need to secure them, to dismantle them. We need to know who has the custody of them.

□ 2300

If they are in Iraq, we have to find them. We have to make sure that the coalition forces gain custody of those weapons of mass destruction and not another group that might use them for evil purposes. If these weapons have been destroyed, all for the better; but we need to know why our intelligence did not know that fact. We frankly need to know what happened to them so that we could be sure that the world has been rid of that particular group of weapons of mass destruction and that, if they do exist, they are in safe custody.

The second reason that we need a full accounting of the weapons of mass destruction is to determine what has happened regarding our intelligence and the political use of that intelligence by the Bush administration in the arguments to support war in Iraq. There is no question that the Bush administration and the leading senior advisors to the President stated with complete certainty in the fall of 2002 that Saddam Hussein had weapons of mass destruction, was developing more weapons of mass destruction, and posed an imminent threat to the region and, in fact, to the world. In private briefings and in public statements, the President of the United States and his senior advisors assured Members of Congress and the American people that the weapons of mass destruction existed, that they were being developed in even greater numbers, and that they posed an imminent threat. And many of us, myself included, based our vote in favor of military action against Iraq for the primary purpose of disarming Saddam Hussein of weapons of mass destruction. Now we cannot find them.

More troubling, now stories are appearing in the press and intelligence analysts are stepping forward, only on the record if they have retired, off the record if they still are at work for the United States, saying, in fact, they were not giving such certain advice to the White House in the fall of 2002, that they were saying we cannot be sure what kinds of weapons of mass destruction Saddam Hussein had in the fall of 2002.

On September 26, 2002, the President made a speech in the Rose Garden stating with great certainty that Saddam Hussein had chemical and biological weapons of mass destruction and was developing additional chemical and biological weapons of mass destruction, and yet at the same time it now has become public. The Defense Intelligence Agency in September, 2002, was circulating a report through the White House in the highest levels of the administration saying "there was no credible evidence that Saddam Hussein currently had weapons of mass destruction or was developing more weapons of mass destruction." There was some evidence, but no credible evidence that that was a certainty. And that lack of certainty did not make its way into the public and private arguments made by the administration. So many of us feel that the Bush administration has a growing credibility gap regarding the weapons of mass destruction.

Why does this matter? It matters greatly for the President's new doctrine of preemption, of the preemptive use of military power to stop an enemy. I do believe in an age of terror when we are dealing with adversaries that do not always come from another country who do not always have a capital city to defend or a homeland to defend when we are dealing with terrorists who are not only faceless but stateless that it may be necessary to take preemptive military action if we are faced with an imminent threat to this country. But that presupposes that we have accurate intelligence. It is one thing to respond to an attack against us. That is the way America has always gone to war once we have been attacked, and it is easy, of course, in the traditional sense of warfare to see an armada massing in the bay or an army building on our borders to know that an attack is imminent.

In an age of terror, we will not always have that warning; so preemptive action may be wise and necessary in the future, but we must have accurate intelligence. We must be able to depend upon that intelligence. We must be able to depend upon the intelligence analysts bringing the information forward in a timely fashion, giving their best advice to the President and the White House, and then we have to depend upon the President and the White House using that information appropriately and wisely, using it to inform Congress and the American people, not to mislead Congress and the American people.

We do not know at this point what exactly happened regarding our intelligence. We do not know whether it was misused by anyone intentionally or unintentionally. We do not know whether the White House heard what it wanted to hear in these intelligence briefings. We do not know whether the intelligence briefings told the White House what the briefers thought the White House wanted to hear, nor do we know whether Congress was told what people only wanted us to know or perhaps what they thought they wanted us to know.

But these questions have to be answered because it goes to the very root of our democratic system, our checks and balances, the proper relationship between the executive and the legislative branches and whether or not we can have faith in the accuracy of our national intelligence agencies and in the proper use of that intelligence.

Before I go any further, we have been joined by the gentleman from Massachusetts (Mr. DELAHUNT), a senior member of the House Committee on International Relations and an eloquent spokesman on foreign policy and national security, my good friend; and I yield to him.

Mr. DELAHUNT. Mr. Speaker, I want to thank the gentleman from Pennsylvania (Mr. HOEFFEL) for again coming to the floor of this House to raise this issue to the American people because clearly our credibility is at risk; and as time passes, there is a growing crescendo of constituents of mine, of his, and of others of our colleagues inquiring as to what occurred in this particular case.

I think what I find particularly disturbing is that in the State of the Union Address by the President back on January 28, he referred to an African nation. That nation, it was subsequently revealed, is the nation of Niger and that there had been a series of letters exchanged between officials of that nation and the Saddam Hussein regime in Iraq relative to the desire of Saddam Hussein to purchase highly enriched uranium from that nation; and that was referenced in the State of the Union Address, as I indicated, by the President of the United States. In fact, it was one of the core ingredients in terms of the Administration's presentation to the American people for its rationale in launching military intervention into Iraq.

Now subsequently it has been revealed that that information was false and that those documents that were relied on by the President, by the White House were, in fact, false. They were forgeries. And that was known to our intelligence agencies, specifically the CIA. Now there appears to be disagreement between the CIA and the Administration as to the information that was brought to the White House by the CIA.

Mr. HOEFFEL. Mr. Speaker, is the gentleman aware that according to reports, the CIA informed the White House of the lack of accuracy of these reports in March of 2002, a full 10 months before the President's State of the Union Address this past January?

□ 2310

Mr. DELAHUNT. Yes, I am aware of that, and I am also aware of newspaper reports that indicated that there was nothing special, according to the National Security Adviser, about this particular information, and that they just simply did not inquire any further from the CIA as to the reliability of that particular information.

But what I find disturbing, I say to the gentleman, is that a week from that date, the Secretary of State, Colin Powell, presented the administration's case before the United Nations Security Council. And according, again, to newspaper reports, that information was omitted by the Secretary of State because he felt that that information was inaccurate.

Now, something is wrong. If, in the space of 7 days, through a vetting process at the Department of State by Secretary Powell, he made the decision to remove that key piece of evidence from his presentation to the Security Council, then something is remiss, something very, very serious.

Now, I know that the gentleman supported the resolution. I happened to vote against that resolution. We all had our own reasons. But even those who disagree on the issue as to whether there should have been military intervention in Iraq have an obligation, I would submit, to conduct a full and thorough review of what occurred and why this particular intelligence was referred to by the President of the United States as he addressed the American people, and clearly influenced the American people. And I would hope, and we understand that our intelligence committees on both the House and the Senate side, are conducting an investigation because of the concerns not only with this piece of information, but other pieces of information that were relied on or alluded to that supported the claim of the administration as to the intent and the position of weapons of mass destruction by Saddam Hussein.

But I would respectfully suggest that that is inadequate. I think we have to be candid that this is a political institution, the American people are represented by two major political parties, and I dare say that if there is disagreement within the intelligence committees of the House and the Senate, and if that disagreement should break along party lines, there will be accusations that the Republicans were stonewalling, or that the Democrats were seeking political advantage in an effort to embarrass the President. And I do not think the American people deserve that. I genuinely believe that this is a nonpartisan issue. This is an issue about America. This is an issue about democracy. This is an issue that has, I would suggest, consequences far into the future about America's image in the rest of the world.

I would hope that this body and that the President would consider convening an independent commission; take the politics out of this so there will not be any finger-pointing, and bring people on board that have reputations for probity, for integrity, and are eminently qualified to address these issues. We should take it away from this body, take it away from the Senate, so that it is not about politics.

Mr. Speaker, we have already had that experience. The Hart-Rudman Commission that none of us really knew about or thought about or gave special attention to until September 12, the day after. Because that particular commission was comprised of eminent Americans from different fields, all highly regarded, people whose integrity are not in question; people who had no political ax to grind, who did this country a great service and produced a document that predicted, that predicted September 11. They warned that the United States was at risk. That particular document was filed on February 25 of 2001. And tragically, tragically, it sat on a shelf and no one paid any attention to it. Mr. Speaker, I would think that given the work of that particular commission, some of those people might very well agree to serve their country again. Because we have this, as the gentleman describes it, growing credibility gap.

It is important to note that the CIA, again, according to newspaper reports, is in serious disagreement with the White House and the President. According to a Washington Post article that appeared on June 12, the story quoted a senior CIA analyst that this case, and it is referring to the evidence developed regarding the alleged, the alleged purchase of uranium from the country of Niger that proved to be false, a senior CIA analyst said that this case, and I am quoting his words now, "This case is indicative of larger problems involving the intelligence about Iraq's alleged chemical, biological, and nuclear weapons and its links to al Qaeda," which the administration cited, as we well know, as justification for war. Information not consistent, and this is a senior Central Intelligence Agency analyst who said this: "Information not consistent with the administration's agenda was discarded, and information that was consistent was not, was not seriously scrutinized."

We do not know what the proof is, and that is our obligation. That is why we are here. We have a responsibility to seek the truth, to answer questions. Not for political gain, not to embarrass anyone, but to reassure the American people that the integrity and the professionalism of their intelligence services is not questioned.

Mr. HOEFFEL. Mr. Speaker, let me ask the gentleman a question along this line of the growing credibility gap. I am sure the gentleman has heard about the two supposedly mobile labs that have been found in Iraq after the conflict. I wonder if the gentleman saw the news today about what appears to have been their actual use.

Mr. DELAHUNT. No, I have not, but I am eagerly awaiting to learn.

Mr. HOEFFEL. Mr. Speaker, the latest is that reports are now circulating that instead of being used for biological or chemical laboratories, these two trucks were used to make hydrogen for the purpose of filling up the Iraqi weather balloons needed by Iraqi artillery and used by all artilleries to gauge wind and currents and so forth to make their artillery shooting accurate. It appears that the loose canvas covering on these trucks would not be conducive to their use as chemical or biological laboratories and that the equipment there is probably designed for hydrogen production.

Mr. DELAHUNT. Mr. Speaker, if the gentleman would yield, I think it is important for us to be very clear and state that just recently, and I believe it was in Philadelphia, a city with which the gentleman is familiar, the President, once more, stated unequivocally that they will find the weapons of mass destruction. So I will accept the word of the President of the United States.

But this goes beyond just that question, because it is clear that up to this point in time, there have been no discoveries about weapons of mass destruction. It just has not happened.

But this is about integrity. This is about whether information was used in a way so that the American people were misled, or this was information that was given to the President of the United States, that was inaccurate and led him to come to the floor of this House, deliver the State of the Union address to the American people, and tell something and suggest to them something that in fact had not happened.

So again, I would hope that we would get the politics out of this process and seek to establish an independent commission, one of prominent Americans, that would take up this burden, and it is a burden, because it would be again calling on them to serve their country as they did so well when they told us: beware, America is at risk of an attack, a serious attack, that could cause a substantial loss of life by terrorists and no one was listening.

□ 2320

Mr. HOEFFEL. Mr. Speaker, I thank the gentleman for his comments and particularly for his suggestion. I think it is a very good one.

There is no doubt that we need an independent and nonpolitical review of the performance of our intelligence agencies and the use to which that intelligence was put. And I think an independent commission such as the gentleman describes is an excellent idea and one that I would certainly support.

We have been joined by our colleague, the gentleman from Hawaii (Mr. ABERCROMBIE), who was a passionate advocate on matters of national security and foreign policy; and I am happy to yield such time to the gentleman from Hawaii.

Mr. ABERCROMBIE. Mr. Speaker, I thank the gentleman very much.

In conjunction with the comments that the gentleman and the gentleman from Massachusetts (Mr. DELAHUNT) have been making, I want to preface my remarks with the observation that part of the complaint that is being made across the country with respect to this attack on Iraq and the subsequent war which is now unfolding is that where are people speaking out on it?

Well, we are here on Special Orders tonight. I think those who are observing our deliberations here on C-SPAN understand that the House is not formally meeting right now. I would think, I want to make it clear to those folks who are observing and listening to our deliberations here this evening, that we do not have the opportunity during the work day to be able to speak at length and in depth on this issue and the issues surrounding the attack on Iraq. We have the opportunities to ask questions and perhaps a followup or two in committee hearings, when we are able to get them, with respect to the defense budget or as we dealt with just recently having witnesses from the Department of Defense. Those are rather formal occasions, as they should be. Presentation is made by the Department of Defense or by the requisite executive agency, and so occasionally a dialogue back and forth.

If C-SPAN is not there, for all intents and purposes, it does not exist. When we go home to our districts and they say, where are the people who are opposed to this or have differing views or want to establish a different perspective, it is important to understand that the mass media in this country is owned by a small number of conglomerate interests, many of whom are associated with the kind of thing that is taking place just today.

I refer you to the Los Angeles Times, Monday, June 23, the business section: California firms lining up to capitalize on rebuilding of Iraq. Hundreds of millions if not billions of dollars involved in this opportunity. If you think for a moment that the national media is going to be covering the Special Orders, do you think we are going to appear even on "Nightline," which is probably the most objective and the most far-reaching of those who want to get the news out, I think we are dreaming.

Now, I look up right now and the galleries are right in front of us. For those of you who are across the country who are observing us and listening to us tonight, the galleries are empty. I suppose the news organizations might have to pay overtime, I am not sure, but there are no reporters volunteering their time because they are interested in what it is that we have to say.

Now, I have come back from a trip with a congressional delegation, the first congressional delegation to get into Iraq, to go to Bagdad, to go to Kirkuk in the north, a bipartisan delegation; and I am referring to the gentleman from Pennsylvania's (Mr. HOEFFEL) admonition and to the gentleman from Massachusetts' (Mr. DELAHUNT) suggestion about an independent commission to examine these issues, a nonpolitical review, if I remember what you said.

Mr. DELAHUNT. If my friend from Hawaii would yield, I think again one cannot overemphasize the need for the information to get out to the American people because it is important to know that the investigations that will be conducted in this House by the Permanent Select Committee on Intelligence in the other body will be conducted behind closed doors, and what we are looking for is to take the politics out of it.

Now, I hear some say that Democrats are raising these issues to embarrass the President. No one can gauge our sincerity, but I know that the gentleman from Pennsylvania (Mr. HOEFFEL) and many of us on both sides of the aisle, by the way, Republicans and Democrats, want a situation that does not lead to a political competition.

Here I just ran across a report from The New York Times dated June 18. And let me again quote: "Despite growing questions about whether the White House exaggerated the evidence about Saddam Hussein's chemical and biological weapons, President Bush and his aids believe that the relief that Americans feel about Mr. Hussein's fall in Iraq will overwhelm any questions about the case the administration built against him. Administration officials and Republican strategists say, 'I think we can ride this out,' said an official."

This is not a question of riding something out. This is a question of righting a wrong. A wrong, wherever the responsibility should fall, let the American people in an appropriate forum listen to the questions, listen to the evidence and form their own judgments. This is not about politics.

I do not know if either one of the gentleman had the opportunity to see the British Parliament in its inquiry into these issues. I found it extraordinary. It was carried on BBC. It was televised during the day. It received national attention there. And two former ministers of the Blair government who had resigned because they did not believe that the intelligence was accurate and was sufficient, they testified as to their observations. It was civil. It was respectful. It was a debate that I know has informed the British people.

□ 2330

We need that to happen here, but given the realities of our own political system, I think it is best if the President, the leadership of both branches, agree for an independent commission to have public hearings that are transparent, much like the Blair government has conducted in the United Kingdom.

Naturally, we are not going to expose sources, but I would like to know, for example, what happened between January 28 and February 5. On January 28, the President of the United States in his State of the Union address made this assertion, and on February 5, according to newspaper reports, the Secretary of State Colin Powell had that particular piece of evidence removed from his presentation to the United Nations Security Council. What happened during those 7 days?

The American people should have an answer.

Mr. ABERCROMBIE. Mr. Speaker, I think that that is what fits into the premise that I am establishing here, that we need to have the press in that gallery paying attention to what is going on here on the floor because this is the only place right now that such a commission is going to take place.

If someone wants to attribute partisan motives to what we are saying down here, they are going to do that anyway. I have to trust, as we all have to trust, that the people will make a decision as to whether what we are saying, why we are saying it, how we are saying it, where we are going, makes sense to them or not on the basis of ideology alone, as opposed to trying to get at what the truth of the situation is with respect to the national security interests of this Nation.

Mr. DELAHUNT. Mr. Speaker, I think what the American people have to understand is that we are not making allegations. We are not making assertions. We are asking for a process that will reassure the American people.

Others are making allegations, others like a gentleman who recently retired after 25 years in the State Department, the last four of which were in the Bureau of Intelligence, and his name is Greg Fieldman, 25-year veteran, and this is what he said, and I do not know what his political affiliation is. He could be a Republican for all I know. The al Qaeda connection and the nuclear weapons issues were the only ones that you could link Iraq to an imminent security threat to the United States, and the administration was grossly distorting the intelligence on both items.

That is his words. That is not my colleague's words, the gentleman from Pennsylvania's (Mr. HOEFFEL) words or my words or Democrat words in a partisan context. I want to hear from him, and the American people have a right to hear from him, and I am sure my colleagues on the other side of the aisle would expect to hear from him, also. I would hope that this idea is seriously considered by both sides.

Mr. ABERCROMBIE. Mr. Speaker, on that point, or on these series of points that are being made, for all intents and purposes, the only opportunity that the American people are going to have to have these questions explicated is on this floor during special orders, and I want to indicate, and I believe the three of us are agreed upon this, we are going to be back. Arnold Schwarzenegger is not the only one that is going to be back.

We are going to be back here on this floor. We are going to be asking the questions. We are going to be making the observations. We are going to be putting forward for the American people the opportunity to hear a perspective that is not necessarily or likely to be enunciated in the press, most particularly in the controlled press. We are not going to see this on the evening news. We are not going to see this in the so-called Sunday talk shows. They have the usual suspects on generally when that comes about.

So what I want to do this evening by way of establishing some of the premise is refer back again to the congressional delegation that we made May 23 through the 27 under the chairmanship of the gentleman from California (Mr. HUNTER), my good friend, our good friend, our able chairman, someone dedicated to the defense of this country by any standard of measure.

Of course, there are differences of opinion that we have in the Committee on Armed Services on which I am happy to be serving as to what the policies might or might not be with respect to the defense of the strategic interests of this Nation, but there is no difference between us on either our desire or our capabilities or our abilities to try to discern what the best course might be. That is precisely why we went. We did not go there to try and get into a contest with anybody on an ideological basis or party basis but rather to try to find out what was taking place.

Maybe tonight will be the first time people will be able to hear anything about what was known as the Organization for Reconstruction and Humanitarian Assistance, which has now become the Coalition Provisional Authority. These are important because we started out one way with a former general, Jay Garner, who has now been removed all of the sudden within almost days, weeks, in terms of workdays, just days, has been removed, and why? Not because General Garner was thought to be a bad person or an inadequate administrator or did not have the proper motivation or understanding, but because the mission to which he had been assigned and the mission which he expected to carry out, namely, a reconstruction effort, somewhat perhaps akin to the aftermath of a natural disaster, a dam bursting or a hurricane or typhoon or something of that nature, turned out to be a typhoon of entirely a different kind, namely, that there was chaos; that there was an inability to provide even the most elemental of protection for those who would be doing the reconstruction; that there was not an understanding and foundation in the population in which this reconstruction was supposed to take place that this was a mutually agreed-upon activity.

There were forces in the street that were, in fact, trying already to get the United States out of Iraq, and therefore, we had to have the intervention of a very competent and highly professional diplomat, Mr. Bremer, Mr. Paul Bremer, who came in and assumed the authority over what has become the Coalition Provisional Authority. What did he propose?

When we went to Baghdad to talk with him, he had put together what I called an outline. Some people would call this a plan, but I think Mr. Bremer is an honest and forthright person. I was very impressed with his desire to speak directly to us on the questions that we posed and the observations that we made. He did not try to finesse anything. He did not try to make anything into something other than what he thought it was. He gave that clear impression, and I think that was agreed upon by all Members there, Democrats and Republicans, who were there.

He came up with what could best be characterized as an outline, not a plan. A plan is something that we know how to implement, we know who is going to implement it, we know where it is going to be done. We did not know any of these things. We still do not know these things. We are making it up as we go along. This is not an accusation, as the gentleman indicates, against Mr. Bremer. On the contrary he is trying to put something together that was not planned for.

This is one of the key elements that we have to think about here when we are talking about we can have authority as General Shinseki said when he retired as Army Chief of Staff on June 11, you can be assigned command authority but you have to earn leadership.

The question here that has to be answered by the President, by the Department of Defense, by Mr. Rumsfeld and others is, are they really exercising the kind of leadership that we need in these circumstances? We cannot equate a political policy with patriotism. If you are trying to tell me, and this is where I draw the line here, if you are trying to tell me that I have to agree with somebody else's political policy or have my patriotism questioned or have my capacity to understand what the strategic interests of this Nation are, then you have crossed over the line, and what you are saying in effect is do not examine closely, do not analyze to any great degree the policies that I am putting forward because if you do then I will equate that with somehow being antipatriotic or against our troops.

If we are putting the lives of young men and women and the United States Armed Forces on the line, then we have to have policies that are worthy of the commitment and dedication and professionalism of those young people.

I got into electoral politics because we failed to do that in the Vietnam War because we decided then that we would equate military activity with political policy, and the military activity became the political policy. That is why we got to body counts in Vietnam to try and justify our insistence on being there militarily, and so we have to account for the key tasks to be completed here in the context of does this advance the interests of the United States at this juncture, pending some further inquiry as to how we got there in the first place.

□ 2340

And I will tell you that while these, in and of themselves, these 10 points of Ambassador Bremer to be completed, are worthy in and of themselves, they do not answer the question about what will be the role of the United States over the next 5 to 10 years, at least a decade.

And this is where General Shinseki's words become ringing in terms of his retirement and what he said at that retirement about command authority and earning leadership capacity. He said that there should be no confusion about the argument over what the military should be doing or not doing in this country and what its role is going to be in the post-attack phase in the context of the guerilla war that is now underway in Iraq. There should be no confusion as to the commitment of the United States military to civilian control. To raise these issues as to who was in charge is dysfunctional to the discussion. But he warned us, and these words are going to be prophetic, do not get involved in a 12-division policy with a 10-division army.

And what he was saying here is, were we adequately prepared ahead of time? Did we do the kind of planning that was necessary in order to accomplish this task? And was that mission that was outlined adequately underlined and a foundation established that would enable us to say with authority that the interests of the United States in terms of its strategic position in the world and whether or not we were facing imminent danger was in fact at stake? Absent that, then we are in for serious trouble. Because that means we will be engaged in essentially an ad hoc operation perhaps for over a decade to come in Iraq, and we will pay a fearful price for that in the lives and bloodshed of our American military and upon the taxpayers of this country and upon the credibility of the United States with regard to world opinion.

Mr. HOEFFEL. Mr. Speaker, if the gentleman would yield, his comments about Vietnam, I think, are very telling and warrant some consideration. One of my great concerns before the military involvement in Iraq started was not whether we would win that military confrontation. That was never in doubt. But how we would act afterwards and would we be perceived in perception or reality as a colonial power, an occupying power, or one that was there to liberate and help Iraqis gain control of their own lives.

Now, I have noticed that the United States asked the United Nations to name us and the British occupying powers, using that phrase in the U.N. resolution of a week or two ago, occupying powers, which seems to me to be sending the wrong signal to the rest of the world about what our role in Iraq should be. And the gentleman's comments about Vietnam, what I most recall about our quagmire in Vietnam was how poorly our Presidents explained the Vietnam policy to the American people.

Mr. ABERCROMBIE. Whether they were Democrat or Republican.

Mr. HOEFFEL. Absolutely right. And the great failing I see now is the inability of the current President to explain the costs, the challenges, and the time lines facing us as occupying powers, if you will, in Iraq.

The gentleman was there. I would be fascinated to hear his response based upon his firsthand observation.

Mr. ABERCROMBIE. Well, Mr. Speaker, if the gentleman will yield to me on that point, Ambassador Bremer was very, very direct in his characterization of us being an occupying power. And this was not said with any kind of bravado. It was simply an announcement of the realities that were involved and what his obligations were and what his responsibilities were in Iraq as the director of the coalition provisional authority.

And we ought to get something straight here about this. When we say coalition, we are talking about the United States of America. That is who is in charge here. When the Americans show up, then people mean business. I remember that from the Balkan situation before. And just by way of disclosure, on that I opposed President Clinton on that. So again I point out this has nothing to do with Democrats and Republicans, whether they are in the Presidency or not. This has to do with credibility in terms of whether or not the national interests are involved and to what degree they are involved. As a result, I think that we need to understand very clearly what Ambassador Bremer's dilemma is and what is he to do at this stage when contemplating how to advance civil society.

Now let us talk about the practical consequences of this. There is a reason that young men and women are being killed or wounded almost daily in Iraq today. We have no civil authority in place. When those who criticize those of us who were aware of this attack taking place under the terms and conditions and time that it took place, when they complain about, well, are you now ready to admit that you lost; that somehow we won and you thought we were going to lose. As my colleague from Pennsylvania pointed out, I do not know of anyone, certainly not any responsible person in the Congress, and I cannot think of anybody in the Committee on Armed Services that thought for a moment that the United States military would not succeed. We only have to observe them in action, as we have as recently on this trip at the end of May, to see that the professionalism, the capacity, the capabilities of the United States military is unparalleled.

That is not the question. The question is are the politicians and the politics behind the military activity up to the mark. That is what is at stake here. And that is why we have the situation in which these young people are being shot, are being wounded, are being put in harm's way every day. There is no civil authority there. We are trying to stand up a police force.

Does that sound familiar? It should, because we have been trying to do it since the late 1990s in the Balkans; and we are still, despite much more favorable circumstances in, at best, a very tentative dilemma with respect to whether or not with the NATO troops and United States troops leaving that area, whether or not chaos will descend once again. I will assure my colleagues if we leave any time soon, there will be chaos of a nature that the Secretary of Defense calls untidy.

Mr. HOEFFEL. Mr. Speaker, I thank the gentleman, and I would yield to my colleague from Massachusetts.

Mr. DELAHUNT. Mr. Speaker, I just wanted to add one observation. The gentleman mentioned the Balkans. What is transpiring today in Afghanistan is close to a disaster, and here again we have young Americans at risk every day. There has been an unfavorable review of what is occurring within Afghanistan. The warlords are still there. The Taliban are reconstituting themselves. The president, who had the support and continues to have the support of the United States, President Karzai, is fearful of leaving Kabul. Again, progress has not been measured, but rather the lack of progress is obvious; and we have been there 18 months.

Earlier, my colleague referred to General Shinseki. He had the courage to speak his mind. He had the courage to tell the American people. And by the way, I think we all agree, I think there is unanimity among us that Iraq and the world is better off without Saddam Hussein. That is not at issue here. We have had a changing policy in regard to Iraq dating back for years, including, by the way, in the 1980s, when this President's father, George Herbert Walker Bush, took Saddam Hussein off the terrorist list as Vice President in the early 1980s, in conjunction with, and, obviously, under the direction of President Reagan, installed an embassy in Baghdad, supplied agricultural credits in the amounts of billions of dollars to the Iraqis, and were providing intelligence from our military to the Iraqi military in terms of benefiting in their war with Iran.

I think we have to say it, they were fully aware that the Iraqis at that point in time were using chemical weapons. They knew. They knew what was happening in northern Iraq against the Kurds.

□ 2350

Mr. ABERCROMBIE. Mr. Speaker, if the gentleman would yield, that just goes to show that the interests of the United States at that time were deemed to be such that we could have that kind of diplomatic relationships with Saddam Hussein and the government in Iraq. The present Secretary of Defense was part of that, was in Iraq and trying to do business with Saddam Hussein.

The question is what caused that change? Was it really in the interest of the United States in terms of our defense and imminent danger to the United States to attack Iraq? That is a question that needs to be answered because it is going to inform us and instruct us where we are going from here, whether it is Iran, Syria, North Korea, whether it is the kind of policies that are going to come forward on Iraq itself. This is the kind of thing that needs not just an emphasis but needs explanation.

If we are going to have a policy worthy of the legacy of this Nation's triumph of democracy, we cannot simply assert it on behalf of other people, particularly in a place like Iraq which has never known it and whose entire history since World War I has been nothing but a division of the spoils among Western nations.

Mr. Speaker, I simply want to indicate to my colleagues, and I hope that we will have a dialogue in the future, particularly with those who have different views as to where we should be going and what we have accomplished to this point, or what we have failed to accomplish to this point, because it is the only place that the American people are going to get any kind of a dialogue like that. That is what this House is all about. This is the people's House. You cannot appear on this floor except by way of election. You can be appointed to the United States Senate; you cannot be appointed to the House of Representatives. This is the people's House. We come up for election, as my wife says, every other year, not every 2 years. You can have a driver's license longer than you can have a license to be on this floor, and that is as it should be because it was the intention of the Founders of this Nation that the people in this country have the opportunity to decide who will represent them here against the House of Lords on the other side of the building.

I would indicate that I will be coming back to the floor, and I hope to be joined by others because we do not intend to let this issue slide. We do not intend for anybody to get over this or get by it.

Mr. DELAHUNT. Or ride it out. Mr. Speaker, nobody is going to ride it out.

Mr. ABERCROMBIE. Not while we have the opportunity and obligation as Members of the House of Representatives to speak out on behalf of the people of this Nation.

Mr. HOEFFEL. Mr. Speaker, I have been here just 5 years. I have often heard of the gentleman's eloquence and passion, and he has proven it tonight with great glory.

Mr. DELAHUNT. Mr. Speaker, let me just close with an observation. It is my understanding that sometime this week we could very well be considering a proposal for prescription drug benefits. I juxtapose that with a headline that I noticed today, and I guess it must have been in the aftermath of Under Secretary Wolfowitz's testimony before the Committee on Armed Services where it was concluded that there was a probability that a substantial American presence would be required in Iraq for a decade and that the cost to the American people would be $54 billion a year.

I ask my colleagues and those that are watching us to reflect for a moment on the cost to the taxpayers and the reality of the deficit that we are facing far into the future and at the same time the needs of our seniors to have a genuine, significant, prescription drug benefit so they can live their lives with dignity and a sense that they are going to be treated as they should.

Mr. ABERCROMBIE. And that they are not under siege.

Mr. HOEFFEL. Mr. Speaker, the gentleman from Massachusetts (Mr. DELAHUNT) has framed the issue very well. There are many things we need to be talking about regarding the post-conflict situation in Iraq: how to secure it properly because security is a huge issue; and how to bring not just democracy to the people of Iraq but the institutions of democracy, free press, free speech, a noncorrupt judicial system.

The gentleman talks about the need for a full disclosure by the President of the costs of the commitment, the challenges and the time line that we face in Iraq.

As we close tonight, I cannot think of a better request we can make of the President, to tell the American people and the Congress what we will be facing in Iraq. If the people do not know, they will not support it. And if times get tough, and they have been, 17 people have died in Iraq since hostilities have supposedly ended.

Mr. DELAHUNT. The number I understand now is 43 young Americans have died since the end of the formal phase of combat.

Mr. HOEFFEL. It is staggering. We need a full description and a full setting-forth of the challenge by the President. I thank the gentleman from

Hawaii (Mr. ABERCROMBIE) and the gentleman from Massachusetts (Mr. DELAHUNT).

Mr. ABERCROMBIE. One closing remark. I do not think the parents and families of the young people who have died make any differentiation between formal and informal. I think those deaths are devastating regardless of the timing associated with it.

CORRECTION TO THE CONGRESSIONAL RECORD OF THURSDAY, JUNE 19, 2003, AT PAGE H5643

ELECTION OF MEMBERS TO CERTAIN STANDING COMMITTEES OF THE HOUSE

Mr. TERRY. Mr. Speaker, I offer a resolution (H. Res. 284) and ask unanimous consent for its immediate consideration in the House.

The SPEAKER pro tempore. The Clerk will report the resolution.

The Clerk read as follows:

H. RES. 284

Resolved, That the following Members be and are hereby elected to the following standing committees of the House of Representatives:

Committee on Agriculture: Mr. Neugebauer.

Committee on Resources: Mr. Neugebauer.

Committee on Science: Mr. Neugebauer.

Committee on Small Business: Mr. McCotter.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Nebraska?

There was no objection.

The resolution was agreed to.

A motion to reconsider was laid upon the table.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. JEFFERSON (at the request of Ms. PELOSI) for today on account of official business.

Ms. KILPATRICK (at the request of Ms. PELOSI) for today on account of personal reasons.

Mr. MENENDEZ (at the request of Ms. PELOSI) for today on account of his son's graduation.

Mr. LUCAS of Oklahoma (at the request of Mr. DELAY) for today on account of official business in his district.

Mr. TOOMEY (at the request of Mr. DELAY) for today on account of official business.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. LEWIS of Georgia) to revise and extend their remarks and include extraneous material:)

Mr. HINCHEY, for 5 minutes, today.

Ms. DELAURO, for 5 minutes, today.

Mr. LEWIS of Georgia, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. EMANUEL, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Ms. WATERS, for 5 minutes, today.

Ms. WATSON, for 5 minutes, today.

Ms. SOLIS, for 5 minutes, today.

Mr. SCOTT of Georgia, for 5 minutes, today.

Mr. BISHOP of Georgia, for 5 minutes, today.

(The following Members (at the request of Mr. KELLER) to revise and extend their remarks and include extraneous material:)

Mr. BURTON of Indiana, for 5 minutes, June 27.

Mr. SIMMONS, for 5 minutes, June 24.

Mr. GUTKNECHT, for 5 minutes, today and June 24, 25, and 26.

Mr. MORAN of Kansas, for 5 minutes, June 24.

Mr. KELLER, for 5 minutes, today.

Mr. CULBERSON, for 5 minutes, today.

Mr. SMITH of Michigan, for 5 minutes, today and June 24, 25 and 26.

Mr. ROHRABACHER, for 5 minutes, today.

Mr. PENCE, for 5 minutes, June 24.

Mr. FLAKE, for 5 minutes, June 24.

(The following Member (at her own request) to revise and extend her remarks and include extraneous material:)

Ms. PELOSI, for 5 minutes, today.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 504. An act to establish academics for teachers and students of American history and civics and a national alliance of teachers of American history and civics, and for other purposes; to the Committee on Education and the Workforce.

S. 686. An act to provide assistance for poison prevention and to stabilize the funding of regional poison control centers; to the Committee on Energy and Commerce.

ENROLLED BILLS SIGNED

Mr. Trandahl, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 658. An act to provide for the protection of investors, increase confidence in the capital markets system, and fully implemented the Sarbanes-Oxley Act of 2002 by streamlining the hiring process for certain employment positions in the Securities and Exchange Commission.

H.R. 2312. An act to amend the Communication Satellite Act of 1962 to provide for the orderly dilution of the ownership interest in Inmarsat by former signatories to the Inmarsat Operating Agreement.

SENATE ENROLLED BILLS SIGNED

The SPEAKER announced his signature to enrolled bills of the Senate of the following titles:

S. 342. An act to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act, and for other purposes.

S. 1276. An act to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

BILLS PRESENTED TO THE PRESIDENT

Jeff Trandahl, Clerk of the House, reports that on June 20, 2003 he presented to the President of the United States, for his approval, the following bills:

H.R. 389. To authorize the use of certain grant funds to establish an information clearinghouse that provides information to increase public access to defibrilation in schools.

H.R. 519. To authorize the Secretary of Interior to conduct a study of the San Gabriel River Watershed, and for other purposes.

H.R. 788. To revise the boundary of the Glen Canyon National Recreation Area in the States of Utah and Arizona.

ADJOURNMENT

Mr. HOEFFEL. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o'clock and 58 minutes p.m.), under its previous order, the House adjourned until tomorrow, Tuesday, June 24, 2003, at 9 a.m., for morning hour debates.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2754. A letter from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting the Department's final rule — Removal of Cold Treatment Requirement for Ya Pears Imported From Hebei Province in China [Docket No. 02-084-2] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2755. A letter from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting the Department's final rule — Exotic Newcastle Disease; Removal of Areas from Quarantine [Docket No. 02-117-8] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2756. A letter from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting the Department's final rule — Viruses, Serums, Toxins, and Analogous Products; Standard Requirements for Determination of Residual Free Formaldehyde Content of Biological Products [Docket No. 01-091-2] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2757. A letter from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting The Department's final rule — Tuberculosis Testing for Imported Cattle [Docket No. 00-102-2] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2758. A communication from the President of the United States, transmitting a report listing the aggregate number, locations, activities, and lengths of assignments for all temporary and permanent U.S. military and civilians involved in Plan Colombia, pursuant to Public Law 106—246, section 3204 (f) (114 Stat. 577); to the Committee on Armed Services.

2759. A letter from the Acting General Counsel, FEMA, Deparment of Homeland Security, transmitting the Department's final rule — Changes in Flood Elevation Determinations [Docket No. FEMA-D-7539] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2760. A letter from the Acting General Counsel, FEMA, Department of Homeland Security, transmitting the Department's final rule — Suspension of Community Eligibility [Docket No. FEMA-7809] received June 18, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2761. A letter from the Acting General Counsel, FEMA, Department of Homeland Security, transmitting the Department's final rule — Changes in Flood Elevation Determinations — received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2762. A letter from the Acting General Counsel, FEMA, Department of Homeland Security, transmitting the Department's final rule — Final Flood Elevation Determinations — received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2763. A letter from the Acting General Counsel, FEMA, Department of Homeland Security, transmitting the Department's final rule — Final Flood Elevation Determinations — received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2764. A letter from the Acting General Counsel, FEMA, Department of Homeland Security, transmitting The Department's final rule — Changes in Flood Elevation Determinations [Docket No. FEMA-B-7436] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2765. A letter from the President and Chairman, Export-Import Bank of the United States, transmitting a report involving U.S. exports to Australia, pursuant to 12 U.S.C. 635(b)(3)(i); to the Committee on Financial Services.

2766. A letter from the Assistant Secretary, Securities and Exchange Commission, transmitting the Commission's final rule — Certain Research and Development Companies [Release No. IC-26077; File No. S7-47-02] (RIN: 3235-AI57) received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2767. A letter from the Director, Office of Management and Budget, transmitting a report on the Cost Estimate For Pay-As-You-Go Calculations, pursuant to Public Law 108—18; to the Committee on the Budget.

2768. A letter from the Director, Office of Management and Budget, transmitting appropriations reports containing OMB cost estimates, pursuant to Public Law 108—11; to the Committee on the Budget.

2769. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human services, transmitting the Department's final rule — Amendment of Regulations on Aluminum in Large and Small Volume Parenterals Used in Total Parenteral Nutrition; Delay of Effective Date [Docket No. 02N-0241] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2770. A letter from the Regulations Coordinator, FDA, Department of Health and Human Services, transmitting the Department's final rule — Applications for FDA Approval to Market a New Drug: Patent Submission and Listing Requirements and Application of 30-Month Stays on Approval of Abbreviated New Drug Applications Certifying That a Patent Claiming a Drug Is Invalid or Will Not Be Infringed [Docket No. 02N-0417] (RIN: 0910-AC48) received June 18, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2771. A letter from the Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of Air Quality Implementation Plan; Washington [Docket No. WA-70-7148; FRL-7493-8] received June 5, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2772. A letter from the Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Appoval and Promulgation of Implementation Plans; State of Kansas [KS 179-1179a; FRL-7510-4] received June 5, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2773. A letter from the Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Control of Air Pollution From New Motor Vehicles and New Motor Vehicles Engines; Modification of Federal On-board Diagnostic Regulations for: Light-Duty Vehicles, Light-Duty Trucks, Medium Duty Passenger Vehicles, Complete Heavy Duty Vehicles and Engines Intended for Use in Heavy Duty Vehicles weighing 14,000 pounds GVWR or less; Extension of Acceptance of California OBD II Requirements [FRL-7492-6] (RIN: 2060-AJ77) received June 5, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2774. A letter from the Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Nebraska: Final Authorization of State Hazardous Waste Management Program Revision [FRL-7510-1] received June 7, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2775. A letter from the Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Control of Air Pollution From Motor Vehicles and New Motor Vehicle Engines; Revisions to Regulations Requiring Availability of Information for use of On-Board Diagnostic Systems and Emmission-Related Repairs on 1994 and Later Model Year Light-Duty Vehicles and Light-Duty Trucks and 2005 and Later Model Year Heavy-Duty Vehicles and Engines Weighing 14,000 Pounds Gross Vehicle Weight or Less [FRL-7509-8] (RIN: 2060-AG13) received June 5, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2776. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a report in accordance with Section 301 of the Diplomatic Security Act, pursuant to 22 U.S.C. 4831; to the Committee on International Relations.

2777. A letter from the Deputy Chief Counsel, Office of Foreign Assets Control, Department of the Treasury, transmitting the Department's final rule — Global Terrorism Sanctions Regulations — received June 4, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on International Relations.

2778. A letter from the Auditor, District of Columbia, transmitting a report entitled "The Department of Mental Health Failed to Implement a Vocational Rehabilitation Program for the District's Mental Health Consumers," pursuant to D.C. Code section 47—117(d); to the Committee on Government Reform.

2779. A letter from the Chair, Equal Employment Opportunity Commission, transmitting the semiannual report on the activities of the Inspector General and management's report for the period ending March 31, 2003, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 5(b); to the Committee on Government Reform.

2780. A letter from the Assistant Director, Executive and Political Personnel, Department of Defense, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Government Reform.

2781. A letter from the Inspector General, Equal Employment Opportunity Commission, transmitting the semiannual report of the Inspector General for the period October 1, 2002 through March 31, 2003, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 8G(h)(2); to the Committee on Government Reform.

2782. A letter from the Acting Chair, Federal Subsistence Board, Fish and Wildlife Service, Department of the Interior, transmitting the Department's final rule — Subsistence Management Regulations for Public Lands in Alaska, Subpart C and Subpart D —— 2003-2004 Subsistence Taking of Fish and Wildlife Regulations (RIN: 1018-AI62) received June 18, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2783. A letter from the King of Hawaiian Islands, Kindom of Hawaii, transmitting a report concerning S. 344, and jurisdiction regarding the Native Hawaiian and Na Kanaka Maoli People of Hawaii; to the Committee on Resources.

2784. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries off West Coast States and in the Western Pacific; Pacific Coast Groundfish Fishery; Annual Specifications and Managment Measures; Trip Limit Adjustments [Docket No. 021209300-3048-02 I.D. 052103A] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2785. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone: Annual Fireworks Events in the Captain of Port Portland Zone [CGD13-03-008] (RIN: 1625-AA00) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2786. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Security Zones; New York Marine Inspection Zone and Captain of the Port Zone [CGD01-03-060] (RIN: 1625-AA00) received May 29, 2003, pursuant to 5

U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2787. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Security Zone; Oyster Creek Generation Station, Forked River, Ocean County, New Jersey [COTP PHILADELPHIA 03-005] (RIN: 1625-AA00) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2788. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Vessel Movement Reporting System; Prince Williams Sound, Alaska [CGD17-03-001] (RIN: 1625-AA11) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2789. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Security Zone; Port of Anchorage, Knik Arm, Alaska [COTP Western Alaska 03-001] (RIN: 1625-AA00) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2790. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Drawbridge Operation Regulations; Corpus Christi — Port Aransas Channel — Tule Lake, Corpus Christi, TX [CGD08-03-021] received May 23, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2791. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Special Local Regulation: Harvard-Yale Regatta, Thames River, New London, CT [CGD01-03-030] received May 23, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2792. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Lake Michigan, Chicago, IL [CGD09-03-212] (RIN: 1625-AA00) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2793. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Security Zone; Protection of Alaska Marine Highway System (AMHS) vessel M/V Kennicott in Western Alaska waters received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2794. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Betsie Bay, Lake Michigan [CGD09-03-213] (RIN: 1625-AA00) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2795. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Security Zones; San Francisco Bay, California [COTP San Francisco Bay 03-002] (RIN: 1625-AA00) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2796. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Security Zone: Portland Rose Festival on Willamette River [CGD13-02-020] (RIN: 1625-AA00 (Formerly RIN: 2115-AA97)) received May 29, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2797. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Drawbridge Operation Regulations: Cape Cod Canal, MA [CGD01-03-040] received May 23, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2798. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Special Local Regulations for Marine Events; Severn River, College Creek, and Weems Creek, Annapolis, Maryland [CGD05-03-038] (RIN: 1625-AA08) received May 23, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2799. A communication from the President of the United States, transmitting the Annual Report to the Congress on Foreign Economic Collection and Industrial Espionage; to the Committee on Intelligence (Permanent Select).

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. HYDE: Committee on International Relations. House Resolution 260. Resolution requesting the President to transmit to the House of Representatives not later than 14 days after the date of the adoption of this resolution documents or other materials in the President's possession relating to Iraq's weapons of mass destruction, adversely; (Rept. 108–168). Referred to the House Calendar.

Mr. ROGERS of Kentucky: Committee on Appropriations. H.R. 2555. A bill making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes (Rept. 108–169). Referred to the Committee of the Whole House on the State of the Union.

Mr. YOUNG of Florida: Committee on Appropriations. Report on the Revised Suballocation of Budget Allocations for Fiscal Year 2003 (Rept. 108–170). Referred to the Committee of the Whole House on the State of the Union.

Mr. YOUNG of Florida: Committee on Appropriations. Report on the Suballocation of Budget Allocations for Fiscal Year 2004 (Rept. 108–171). Referred to the Committee of the Whole House on the State of the Union.

Mr. TOM DAVIS of Virginia: Committee on Government Reform. A Citizen's Guide on Using the Freedom of Information Act and the Privacy Act of 1974 to Request Government Records (Rept. 108–172). Referred to the Committee of the Whole House on the State of the Union.

Mr. KNOLLENBERG: Committee on Appropriations. H.R. 2559. A bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes (Rept. 108–173). Referred to the Committee of the Whole House on the State of the Union.

Mrs. MYRICK: Committee on Rules. House Resolution 292. Resolution waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules (Rept. 108–174). Referred to the House Calendar.

Mr. LINCOLN DIAZ-BALART of Florida. Committee on Rules. House Resolution 293. Resolution providing for consideration of the bill (H.R. 2555) making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes (Rept. 108–175). Referred to the House Calendar.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. TOM DAVIS of Virginia (for himself, Mr. BOEHNER, Mr. WELDON of Florida, Mr. LIPINSKI, Mr. SHAYS, Mr. CARTER, Mr. WILSON of South Carolina, Mr. EHLERS, and Mr. DEMINT):

H.R. 2556. A bill to provide low-income parents residing in the District of Columbia, particularly parents of students who attend elementary or secondary schools identified for improvement, corrective action, or restructuring under title I of the Elementary and Secondary Education Act of 1965, with expanded opportunities for enrolling their children in higher-performing schools in the District of Columbia, and for other purposes; to the Committee on Government Reform.

By Mr. YOUNG of Alaska (for himself and Mr. DUNCAN):

H.R. 2557. A bill to provide for the conservation and development of water and related resources, to authorize the Secretary of the Army to construct various projects for improvements to rivers and harbors of the United States, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. McINTYRE:

H.R. 2558. A bill to amend the Water Resources Development Act of 1976 to allow the Secretary of the Army to extend the period during which the Secretary may provide beach nourishment for a water resources development project; to the Committee on Transportation and Infrastructure.

By Mr. MANZULLO:

H.R. 2560. A bill to amend title XVIII of the Social Security Act to clarify the scope of chiropractic services that may be furnished under the Medicare Program and that chiropractors are the only health care professionals qualified under that program to furnish those services; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ANDREWS:

H.R. 2561. A bill to provide grants to States to establish, expand, or enhance prekindergarten programs for children who are not yet enrolled in kindergarten; to the Committee on Education and the Workforce.

By Mr. ANDREWS:

H.R. 2562. A bill to provide financial assistance to law school graduates who choose to accept employment in a public interest position; to the Committee on Education and the Workforce.

By Ms. BERKLEY:

H.R. 2563. A bill to amend the Head Start Act to provide additional funding for States with increased numbers of children eligible for participation in Head Start programs, and for other purposes; to the Committee on Education and the Workforce.

By Mr. CAPUANO (for himself, Mr. Delahunt, Mr. Neal of Massachusetts, Mr. Olver, Mr. Lynch, and Mr. Markey):

H.R. 2564. A bill to amend the Internal Revenue Code of 1986 to provide that the harbor maintenance tax is applied to certain ports that import cargo exceeding $100,000,000 in value per year; to the Committee on Ways and Means.

By Mr. FRANK of Massachusetts:

H.R. 2565. A bill to amend section 2119 of title 18, United States Code, to strengthen Federal carjacking law; to the Committee on the Judiciary.

By Mr. KIND (for himself, Mr. Gilchrest, Mr. Blumenauer, and Mrs. Tauscher):

H.R. 2566. A bill to reform the Army Corps of Engineers; to the Committee on Transportation and Infrastructure.

By Ms. McCOLLUM (for herself, Mr. Evans, Mr. Oberstar, Mr. Rodriguez, Mr. Ryan of Ohio, Mr. Filner, Ms. Corrine Brown of Florida, Ms. Waters, Mr. Gutierrez, Ms. DeLauro, Mr. Strickland, Mr. Snyder, and Mr. Michaud):

H.R. 2567. A bill to name the Department of Veterans Affairs Medical Center in Minneapolis, Minnesota, as the "Paul Wellstone Department of Veterans Affairs Medical Center"; to the Committee on Veterans' Affairs.

By Mr. OBERSTAR (for himself, Mr. Blumenauer, Mr. Hobson, Mr. Lipinski, Ms. Norton, Mr. Pascrell, Mr. Lampson, Mr. Honda, Mr. Frost, Mr. Serrano, Mr. Moran of Virginia, Mr. Sanders, Mr. Brown of Ohio, Ms. Woolsey, Mr. Doggett, Ms. Baldwin, Mr. Ballance, Mr. Case, and Mr. Scott of Georgia):

H.R. 2568. A bill to amend title 23, United States Code, to establish a transportation and active living program, a safe routes to school program, and a nonmotorized transportation pilot program; to the Committee on Transportation and Infrastructure.

By Mr. EVANS (for himself, Ms. Kaptur, Mr. Honda, Ms. Millender-McDonald, Ms. Lee, Mr. Grijalva, Mr. Abercrombie, Mr. Larson of Connecticut, Mr. Towns, Ms. Schakowsky, Mr. McDermott, Mr. Lantos, Mr. Wolf, Ms. Solis, Ms. Watson, Mr. Frank of Massachusetts, Mr. Schiff, Ms. Bordallo, Mr. Faleomavaega, Mr. Kucinich, Ms. Linda T. Sánchez of California, Mr. Davis of Illinois, Mr. Lampson, Ms. McCollum, Mr. Crowley, Mr. Sanders, and Mr. Lipinski):

H. Con. Res. 226. Concurrent resolution expressing the sense of Congress that the Government of Japan should formally issue a clear and unambiguous apology for the sexual enslavement of young women during colonial occupation of Asia and World War II, known to the world as "comfort women", and for other purposes; to the Committee on International Relations.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolution as follows:

H.R. 49: Mr. McInnis and Mr. Otter.

H.R. 196: Mr. Spratt.

H.R. 290: Mr. Holt, Mr. Taylor of Mississippi, Mr. Israel, Mr. Kirk, Mr. Sandlin, Mr. Lynch, Mr. Thompson of Mississippi, Mr. Wamp, Mr. Schiff, Mr. Pombo, Mr. Hayworth, Mr. Isakson, Mr. Bartlett of Maryland, Mr. Jones of North Carolina, Mr. Pickering, Mr. Sessions, Mr. Langevin, Mr. Ford, Mr. Weiner, Mr. Boehlert, Mrs. Jo Ann Davis of Virginia, Ms. Eshoo, Mr. McDermott, Ms. Slaughter, Mr. Platts, Mr. Lewis of Georgia, and Ms. Jackson-Lee of Texas.

H.R. 300: Mr. Burton of Indiana.

H.R. 303: Mr. Tom Davis of Virginia and Mr. Gephardt.

H.R. 328: Mrs. Northup, Mr. Filner, Ms. Granger, Mrs. McCarthy of New York, and Mr. Moran of Virginia.

H.R. 339: Mr. Herger.

H.R. 369: Ms. Kaptur.

H.R. 401: Mrs. Maloney and Mr. Lewis of Georgia.

H.R. 466: Mr. Wynn.

H.R. 487: Mr. Rohrabacher.

H.R. 531: Mr. Udall of New Mexico, Mr. Deal of Georgia, Mr. Clay, Mr. Chocola, and Ms. Linda T. Sánchez of California.

H.R. 548: Mr. Fletcher, Ms. Eshoo, and Mr. Collins.

H.R. 589: Mrs. Musgrave, Mr. Bilirakis, Mr. Gallegly, and Mr. Sullivan.

H.R. 594: Mr. Neugebauer, Mr. McCotter, and Mr. Etheridge.

H.R. 668: Mr. Sanders.

H.R. 713: Mr. Wexler.

H.R. 817: Mr. Becerra.

H.R. 898: Mr. Neal of Massachusetts.

H.R. 919: Mrs. Blackburn.

H.R. 935: Mr. Deutsch.

H.R. 941: Mr. Rush and Mr. Wynn.

H.R. 967: Mr. Michaud.

H.R. 1005: Mr. Pickering.

H.R. 1006: Mr. Van Hollen, Mr. Bradley of New Hampshire, Ms. Baldwin, and Mr. Doggett.

H.R. 1031: Mr. Wexler.

H.R. 1032: Mrs. Jo Ann Davis of Virginia and Mr. Stupak.

H.R. 1068: Mr. Delahunt, Mr. Spratt, Mr. Lucas of Oklahoma, and Mr. Clyburn.

H.R. 1105: Mr. Thompson of Mississippi.

H.R. 1117: Mrs. Musgrave.

H.R. 1167: Mr. Evans and Mr. Gutierrez.

H.R. 1173: Mr. Chocola.

H.R. 1191: Ms. Eshoo and Mr. Blumenauer.

H.R. 1196: Mr. Allen.

H.R. 1238: Ms. Dunn.

H.R. 1264: Mr. Bishop of Georgia.

H.R. 1268: Ms. Norton.

H.R. 1310: Mr. Goodlatte, Mr. Boehner, Mr. Shays, Mr. Kingston, Mr. Hastings of Washington, Mr. Simpson, Mr. Ballenger, Mr. Lucas of Kentucky, Mr. Wicker, Mr. Pickering, Mr. Rogers of Alabama, Mr. Price of North Carolina, and Mrs. Myrick.

H.R. 1394: Ms. Majette and Ms. Velázquez.

H.R. 1400: Mr. Lynch.

H.R. 1444: Ms. Slaughter.

H.R. 1470: Mr. McDermott.

H.R. 1472: Mr. Filner and Mr. Doggett.

H.R. 1473: Mr. Acevedo-Vilá and Mr. Sanders.

H.R. 1477: Mr. Moran of Virginia.

H.R. 1483: Mr. Grijalva and Ms. Linda T. Sánchez of California.

H.R. 1501: Mr. Grijalva.

H.R. 1513: Mr. Fletcher, Mr. Goodlatte, Mr. Gerlach, Mr. Lewis of Georgia, and Mr. Lucas of Kentucky.

H.R. 1606: Mr. DeMint.

H.R. 1622: Mr. Davis of Tennessee, Ms. Hart, Mr. Simmons, Mr. Stupak, Mr. Farr, Mr. DeFazio, and Mr. Weiner.

H.R. 1634: Mr. Boehlert.

H.R. 1647: Mr. Kind.

H.R. 1675: Ms. Baldwin.

H.R. 1694: Mr. Langevin.

H.R. 1707: Mr. Burgess and Mr. Green of Wisconsin.

H.R. 1709: Mr. Bell and Mr. Van Hollen.

H.R. 1760: Mr. Grijalva.

H.R. 1779: Mr. Calvert and Mr. Isakson.

H.R. 1828: Mr. Coble, Mrs. Bono, Mr. Burr, Ms. Jackson-Lee of Texas, and Mr. Payne.

H.R. 1838: Mr. Gutierrez, Mr. Rodriguez, Mr. Michaud, Mr. Strickland, and Mr. Holden.

H.R. 1839: Ms. Pryce of Ohio.

H.R. 1865: Mr. Renzi, Mr. Ross, and Mr. Davis of Alabama.

H.R. 1874: Mr. Sanders, Mr. McCotter, Mr. Abercrombie, Mr. Boehlert, Ms. Jackson-Lee of Texas, and Mr. Doyle.

H.R. 1886: Mr. Faleomavaega and Mr. Stark.

H.R. 1916: Mr. Nadler, Mr. Clyburn, Ms. Corrine Brown of Florida, Mr. Lantos, Mr. Rahall, and Mr. Goodlatte.

H.R. 2009: Ms. Slaughter, Mrs. Jones of Ohio, Mr. Farr, Ms. Norton, Mr. Rothman, Mr. Platts, and Mr. Van Hollen.

H.R. 2022: Mr. McInnis and Mr. Stark.

H.R. 2038: Ms. Slaughter.

H.R. 2042: Mr. Frost, Mr. Schiff, Mr. Wu, Mr. Neal of Massachusetts, Ms. Lofgren, Mr. Markey, Mr. Crowley, Mr. Stark, Mr. Kucinich, Mr. Smith of Washington, Ms. Harman, Ms. Berkley, Mr. Engel, and Mr. Sanders.

H.R. 2154: Mr. Gilchrest.

H.R. 2183: Mr. Rush, Ms. Hart, Mr. Rogers of Alabama, Mr. Hinojosa, Mr. Snyder, Mr. Alexander, and Mr. Filner.

H.R. 2193: Mr. Capuano, Mr. Hastings of Florida, Mr. Wynn, and Mr. Frost.

H.R. 2198: Ms. Linda T. Sánchez of California.

H.R. 2208: Mr. Flake and Mr. Neugebauer.

H.R. 2211: Mr. Isakson.

H.R. 2238: Ms. McCollum, Mr. Engel, Mr. Pallone, Mr. Emanuel, Mrs. McCarthy of New York, Ms. Corrine Brown of Florida, Mr. Deutsch, Mr. Rangel, Mr. Fattah, and Ms. DeLauro.

H.R. 2246: Mr. Gonzalez, Mr. Jenkins, Mr. Wamp, Mr. Frank of Massachusetts, Ms. Baldwin, Mr. Clyburn, Mr. Deal of Georgia, Mr. Kennedy of Rhode Island, Mr. Ehlers, Mr. Davis of Alabama, and Mr. Stupak.

H.R. 2247: Mrs. Jones of Ohio, Mr. Dingell, and Mrs. Christensen.

H.R. 2253: Mr. Cardoza, Mr. Gary G. Miller of California, Mr. Hayworth, and Mr. Ose.

H.R. 2262: Mr. Stupak and Mr. Davis of Alabama.

H.R. 2265: Mr. Boehlert.

H.R. 2291: Mr. Spratt.

H.R. 2295: Ms. Slaughter.

H.R. 2318: Mr. Lantos, Mr. Brown of Ohio, Mr. Davis of Illinois, Mr. Wynn, and Ms. Lee.

H.R. 2333: Ms. Baldwin.

H.R. 2351: Mr. Royce.

H.R. 2373: Ms. McCarthy of Missouri.

H.R. 2377: Mr. Wexler, Mr. Grijalva, and Ms. Jackson-Lee of Texas.

H.R. 2379: Mr. Wilson of South Carolina and Mr. Case.

H.R. 2414: Mr. Bradley of New Hampshire.

H.R. 2418: Mr. Frank of Massachusetts.

H.R. 2426: Mr. George Miller of California, Mr. Schiff, Mr. Towns, and Mr. Blumenauer.

H.R. 2429: Mr. Spratt.

H.R. 2433: Mr. Paul, Mr. Frost, and Mr. McGovern.

H.R. 2441: Mr. Bereuter.

H.R. 2482: Mr. Frank of Massachusetts.

H.R. 2498: Mrs. Christensen.

H.R. 2502: Mr. Shays.

H.R. 2505: Mr. Brown of Ohio, Mr. Scott of Georgia, Ms. Jackson-Lee of Texas, and Mr. McGovern.

H.R. 2512: Mr. Weiner.

H.R. 2513: Mr. Stenholm.

H.R. 2546: Mr. Grijalva, Mr. Gutierrez, Mr. George Miller of California, and Mrs. Tauscher.

H. J. Res. 38: Mr. Goode.

H. Con. Res. 194: Ms. Watson.

H. Con. Res. 213: Mr. Ballance, Mr. Larson of Connecticut, Mr. Capuano, Mr. Davis of Alabama, Mr. Levin, and Mr. DeFazio.

H. Con. Res. 217: Mr. Engel, Mrs. Jones of Ohio, Ms. Lee, Mr. Owens, Mr. Wynn, Mr. Smith of New Jersey, and Mr. Lewis of Georgia.

H. Con. Res. 224: Mr. Sanders.

H. Res. 103: Mr. Moran of Kansas and Ms. Hart.

H. Res. 136: Mr. Lucas of Kentucky.

H. Res. 234: Ms. Eshoo, Ms. Lofgren, Mr. Inslee, Mr. Sanders, Mrs. Jones of Ohio, and Mr. Scott of Georgia.

H. Res. 240: Mr. Scott of Virginia.

H. Res. 273: Mr. Bilirakis.

H. Res. 290: Mr. Larsen of Washington, Mr. Houghton, Mr. Levin, Mr. Dicks, Mr. Kildee, Mr. Manzullo, Mr. Oberstar, Mr. McDermott, Mr. English, and Mr. Souder.

AMENDMENTS

Under clause 8 of rule XVIII, proposed amendments were submitted as follows:

H.R. 2555

Offered By: Mr. Manzullo

Amendment No. 1: At the end of the bill (before the short title), insert the following:

Sec.   . None of the funds made available in this Act may be used by the Secretary of Homeland Security to enter into a contract for the procurement of manufactured articles, materials, or supplies unless section 2 of the Buy American Act (41 U.S.C. 10a) is applied to such procurement by substituting "at least 65 percent" for "substantially all".

H.R. 2555

Offered By: Mrs. Maloney

Amendment No. 2: In title II, in the item "OFFICE FOR DOMESTIC PREPAREDNESS—Domestic Preparedness", in paragraph (4) after the dollar amount insert "(increased by $300,000,000)".

In title III, in the item "Disaster Relief (including transfer of funds)", after the first dollar amount insert "(reduced by $300,000,000)".

H.R. 2555

Offered By: Mrs. Maloney

Amendment No. 3: In title II in the item "OFFICE FOR DOMESTIC PREPAREDNESS—Domestic Preparedness", in paragraph (4), after the dollar amount insert "(increased by $300,000,000)".

H.R. 2555

Offered By: Mr. Engel

Amendment No. 4: In title II, in the item "OFFICE FOR DOMESTIC PREPAREDNESS—Domestic Preparedness"—

(1) in paragraph (1), after the dollar amount insert "(reduced by $500,000,000)"; and

(2) in paragraph (4), after the dollar amount insert "(increased by $500,000,000)".

H.R. 2555

Offered By: Mr. Engel

Amendment No. 5: At the end of the bill (before the short title), insert the following:

Sec.   . None of the funds made available in this Act may be used to issue a certification of offsite emergency evacuation plans of nuclear power plants.

H.R. 2555

Offered By: Ms. Baldwin

Amendment No. 6: At the end of the bill (before the short title), insert the following:

Sec.   . None of the funds made available in this Act shall be used to enter into any contract to develop, lease, or procure Coast Guard vessels in the National Security Cutter class or Offshore Patrol Cutter class unless the main propulsion diesel engines are manufactured in the United States by a domestically operated entity. The Secretary of Homeland Security may waive the restriction in the preceding sentence on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that—

(1) adequate amounts of such components are not available from a domestically operated entity to meet requirements on a timely basis;

(2) such a contract is necessary to acquire capability for national security purposes; or

(3) there exists a significant cost or quality difference between components manufactured in the United States and components manufactured outside the United States.

H.R. 2555

Offered By: Mr. LoBiondo

Amendment No. 7: In title II, in the item "IMMIGRATION AND CUSTOMS ENFORCEMENT—Air and Marine Interdiction", after the dollar amount insert "(reduced by $5,000,000)".

In title II, in the item "TRANSPORTATION SECURITY ADMINISTRATION—Aviation Security"—

(1) after the first dollar amount insert "(reduced by $10,000,000)"; and

(2) after the fourth dollar amount insert "(reduced by $10,000,000)".

In title II, in the item "TRANSPORTATION SECURITY ADMINISTRATION—Administration", after the dollar amount insert "(reduced by $36,000,000)".

In title IV, in the item "CITIZENSHIP AND IMMIGRATION SERVICES—Operating Expenses", after the dollar amount insert "(reduced by $12,000,000)".

In title IV, in the item "UNITED STATES COAST GUARD—Operating Expenses", after the first dollar amount insert "(increased by $35,000,000)".

In title IV, in the item "UNITED STATES COAST GUARD—Acquisitions, Construction, and Improvements"—

(1) after the first dollar amount insert "(increased by $75,000,000)"; and

(2) after the sixth dollar amount insert "(increased by $75,000,000)".

In title IV, in the item "SCIENCE AND TECHNOLOGY—Research, Development, Acquisition, and Operations", after the dollar amount insert "(reduced by $47,000,000)".

EXTENSIONS OF REMARKS

TRIBUTE TO SACRAMENTO VALLEY UNION LABOR BULLETIN

HON. ROBERT T. MATSUI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. MATSUI. Mr. Speaker, I rise in tribute to the Sacramento Valley Union Labor Bulletin, one of the oldest labor newspapers on the west coast. On August 15, 2003, the Sacramento Valley Union Labor Bulletin will celebrate its 75th Anniversary with the publication of a Labor Day Special Issue. It is my honor to ask all of my colleagues to join me in saluting one of Sacramento's most trusted and important publications.

The Sacramento Central Labor Council and the Sacramento-Sierra's Building & Construction Trades Council, both AFL–CIO councils, own the Sacramento Valley Union Labor Bulletin. On September 3, 1928, under the leadership of editor Charles W. Lyons, the Sacramento Valley Union Labor Bulletin first went to press with a Labor Day issue. In the ensuing seventy-five years, the Sacramento Valley Union Labor Bulletin has enjoyed unparalleled success. It has published without interruption. Every issue of the Sacramento Valley Union Labor Bulletin is stored and available to the public at the California Room of the California State Library.

About 22 unions subscribe to the Sacramento Valley Union Labor Bulletin for their members. These unions range from service unions such as the Northern California Media Workers Guild, Bakers, Amalgamated Transit Union, Sacramento Area Fire Fighters to Building Trades Unions such as the Sheet Metal Workers, Glaziers, Plumbers, Painters, and IBEW. The great diversity in readership is a great reflection of the far-reaching importance of the Sacramento Valley Union Labor Bulletin in the Capital Region. Overall, there are 17,000 paid subscribers.

Throughout the course of its history, the Sacramento Valley Union Labor Bulletin has provided a vital forum for the expression of the messages and attitudes of the local labor community. In good times and bad, one can always look to the Sacramento Valley Union Labor Bulletin in order to discern the pulse of the labor community.

The Sacramento Valley Union Labor Bulletin has also provided Sacramento with some of its most distinguished community leaders. Former editor J.L.R. Marsh's stewardship of the bulletin was so admired that Mercy Hospital dedicated its Memorial Physical Therapy Unit in his honor. Another former editor, Richard Marriott, would go on to become one of the most beloved mayors in Sacramento history.

Mr. Speaker, as the Sacramento Valley Union Labor Bulletin celebrates its 75th Anniversary, I am honored to pay tribute to an invaluable resource to the Sacramento community. The Bulletin's commitment to the local labor community has been commendable. I ask all of my colleagues to join with me in wishing the Sacramento Valley Union Labor Bulletin continued success in all its future endeavors.

HAPPY 90TH BIRTHDAY MARGARET BUTCHER

HON. STEPHANIE TUBBS JONES

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mrs. JONES of Ohio. Mr. Speaker, I rise today to bring recognition to Margaret Butcher, in celebration of her 90th birthday on July 25. Mrs. Butcher has been a resident of the Glenville area of Cleveland for over 50 years.

The Butcher family has been a faithful member of St. James AME church for most of that time. She and her husband, Aljah Langston Butcher, raised five children, two of whom still reside in the Cleveland area. After having her 5th child, she went back to Kent State University and obtained a Bachelor's Degree in teaching. She received her Master's from Case Western University.

During her Cleveland residency, Mrs. Butcher has held jobs with the IRS, a small boat factory and a church-based school. She taught with Cleveland City schools for approximately 30 years. Currently, she tutors young students. Margaret has volunteered for several community activities over the years, most notably, the creation of a neighborhood oral history that was eventually transcribed and placed in the Western Reserve Historical Museum.

Mrs. Butcher resides at 12800 Fairhill Rd in Shaker Heights, OH. A reception is tentatively scheduled in her honor, Saturday, July 26.

Margaret Butcher was my good neighbor, but more than that, she is my good friend. It is truly an honor to know her and it gives me great pleasure, Mr. Speaker, to celebrate her today.

COMMENDING MEDGAR WILEY EVERS AND MYRLIE EVERS-WILLIAMS, FOR THEIR LIVES AND ACCOMPLISHMENTS

SPEECH OF

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 16, 2003

Mr. HASTINGS of Florida. Mr. Speaker, I rise today in strong support of this resolution, which commemorates and honors the lives of Medgar Evers and Myrlie Evers-Williams. These two outstanding Americans dedicated their lives to the struggle for civil rights, and Medgar Evers paid the ultimate price with his life. What makes Medgar and Myrlie even more remarkable is that they sought to change the situation, instead of letting the situation overcome them, they tried to overcome it.

The struggles that Medgar and Myrlie witnessed and endured as they attempted to integrate African-Americans into larger society are struggles that all minorities can identify and empathize with. As someone that has experienced racism, I empathize with Medgar and Myrlie's struggle, as do many Americans black, white and all colors in between.

Against extraordinary odds, they both received post-secondary educations in a racial climate that was filled with tension, and challenged a system that said that blacks were not good enough, not equal but, actually inferior to their white counterparts.

Medgar Evers, with his wife by his side, led the charge for civil rights in Mississippi for African-Americans. After the United States Supreme Court determined that segregation was unconstitutional, Medgar was the first African-American to apply to the University of Mississippi Law School but he was denied.

This denial did not deter Medgar and Myrlie from their pursuit of justice and equality. In 1954, Medgar accepted a position with the NAACP as their Mississippi Field Secretary and made Myrlie his secretary.

Together they aggressively attacked the racist societal barriers that continued to oppress African-Americans. They worked tirelessly to empower African-Americans by registering them to vote. They also organized rallies, built the NAACP's membership, and traveled around the country to educate the public, despite numerous threats.

Even though it's the 21st century, we have an obligation to remember and acknowledge the people who dedicated themselves to the fight for civil rights in our past. We owe them a debt of gratitude and a commitment to continue their efforts.

TRIBUTE TO CITY OF RANCHO CORDOVA, CALIFORNIA

HON. ROBERT T. MATSUI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. MATSUI. Mr. Speaker, I rise in tribute to the city of Rancho Cordova, California and its dedicated citizens. On July 1, 2003, Rancho Cordova will officially be incorporated and become California's newest municipality. I ask all my colleagues to join with me in wishing the city of Rancho Cordova the best of luck as it embarks on an exciting and promising future.

The modern history of Rancho Cordova began in 1846, when William Alexander

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

Leidesdorf settled in his newly acquired 35,500-acre domain, the Rancho Rio de los Americanos. Within a few years, the massive flow of gold seekers, the FortyNiners, en route to the gold fields, would come to identify the area as Hangtown Crossing. In the 1870s, the construction of gristmills brought a new wave of residents to the area. These residents would eventually abandon the name of Hangtown Crossing for the more prosaic name of Mills Station.

In the 1950s, postal officials and local vineyard owner, Ronald S. Federspiel, met to determine a new name for the area. In the years before, a great number of homebuyers related to the name, Rancho Cordova, since it was the name of their new neighborhood. When the postal officials and Mr. Federspiel discovered that the name fit perfectly on a stamp, the name Rancho Cordova was officially adopted.

In 1950, Aerojet General Corporation, developers of rocket fuels and space engines, choose Rancho Cordova as its home base. Subsequently, Mather Air Force Base, with the only navigation and electronic warfare training wing in the U.S.; McDonnell-Douglas Aircraft, missiles and space systems test center; PMI Manufacturers, Pittsburg Des Moines Steel Co., and many smaller industries would come to call Rancho Cordova home.

In many regards, Rancho Cordova already features some of the essential traits of a well-established city. By comparison, the city's population of approximately 57,000 is bigger than Santa Cruz, Fountain Valley, or San Rafael. In the Sacramento region, the only cities with greater populations are Sacramento, Davis, Roseville, Citrus Heights, and Elk Grove. Furthermore, Rancho Cordova is already the home to an impressive and growing list of businesses; Bank of America, Aerojet Industries, MCI, and Delta Dental, just to name a few. With another 55,000 jobs projected in the next decade, Rancho Cordova is well on its way to becoming one of the most important cities in the Sacramento region.

During the nearly two-decade drive to cityhood, the community leaders and citizens of Rancho Cordova displayed remarkable dedication, determination, and civic pride in ultimately achieving their goal. Judging from its citizens overwhelming commitment to promote and serve the best interest of the city, I have every confidence that Rancho Cordova will continue to achieve and realize greater goals and ambitions in the future.

Mr. Speaker, as the city of Rancho Cordova celebrates its cityhood; I am honored to welcome this vibrant community into our growing region. Rancho Cordova's future is bright and limitless. I ask all of my colleagues to join with me in wishing the city of Rancho Cordova continued success in all its future endeavors.

TAXPAYER PROTECTION AND IRS ACCOUNTABILITY ACT OF 2003

SPEECH OF

HON. EARL BLUMENAUER

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. BLUMENAUER. Mr. Speaker, this is another example of the Republican leadership taking a non-controversial, bipartisan bill and adding provisions to turn it into a divisive and bitter battle. The underlying bill contains technical changes and provisions that would make it easier for taxpayers to manage the tax system. We all support these changes and this bill would pass unanimously without the games the leadership insists on playing.

Unfortunately, the games they are playing pose terrible threats to many working men and women across the country. In this instance, Republican leadership has included a provision that strikes important health insurance standards protecting workers laid-off as a result of trade-related competition.

Trade Adjustment Assistance, TAA, enacted just last year, provides for a tax credit for 65 percent of the cost of health coverage for eligible individuals and qualified family members and establishes protections designed to ensure coverage for all participants. H.R. 1528 undermines the consumer protection provisions provided in the current TAA law and would essentially allow insurers to avoid covering workers 55 and older, who are the majority of TAA participants.

The timing of this could not be worse considering the President was only recently granted Trade Promotion Authority by Congress and we are moving quickly on free trade agreements with several countries and regions around the world.

Overall, these free trade agreements will benefit our economy, but there will be sectors that will lose out to foreign competition. Knowing this, Trade Adjustment Assistance programs and benefits have been set up to help those negatively impact by free trade.

I am appalled at the Republican leadership's ability to take a productive, bipartisan bill that benefits taxpayers across the country, which the underlying bill does, and risk it all by including a provision that hurts American workers.

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2003

SPEECH OF

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. GREEN of Texas. Madam Speaker, I rise in opposition to H.R. 660, the Small Business Health Fairness Act of 2003.

This legislation aims to make health insurance more affordable for small businesses by allowing them to band together to increase their purchasing power and negotiate lower rates for health insurance.

I know that our small businesses are struggling with their health insurance costs. With double-digit increases in premiums, Madam Speaker, many small businesses simply cannot afford to continue to provide coverage for their employees. And while I support measures to make health insurance more affordable, I have concerns that this legislation would not achieve that end. In fact, studies by both the Congressional Budget Office and RAND have indicated that existing AHPs have not reduced insurance costs for participants.

I also have concerns about this legislation because it would exempt AHPs from state insurance regulations that protect patients and families.

In Texas, health plans are required to cover maternity care, immunizations for children, mammography breast cancer screening, diabetes treatments and supplies, and certain mental health services. H.R. 660 would exempt AHPs from covering these vital services.

I don't think that small businesses and trade associations should have to sacrifice quality in order to afford their health insurance. By taking away these vital patient protections, the policies purchased under AHPs would be worth little more than the paper they are printed on.

The Kind/Andrews amendment, however, corrects many of these concerns by allowing small businesses to purchase insurance through a Small Employees Health Benefit Plan, similar to the FEHBP. This system would ensure that quality of health plans are protected, that low income employees have assistance to purchase policies, and that the smallest of small businesses get the additional assistance they need.

I urge my colleagues to support the Kind/Andrews alternative, and I yield back the balance of my time.

TRIBUTE TO NEWARK CENTRAL HIGH SCHOOL GIRLS VARSITY SOFTBALL TEAM

HON. JAMES T. WALSH

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. WALSH. Mr. Speaker, I rise today to honor the New York State Class B Champion Girls Varsity Softball Team from Newark Central High School. Their win was a great testament to the hard work and dedication of this team and its coaching staff.

Head Coach Mike Muscolino has a lot to be proud of, as his Lady Reds brought home not only the State title, but the Section V title and the Class B State Sportsmanship award as well. Newark High School athletic teams have always had a reputation for fair play and good sportsmanship, and this year's girls softball team was no exception. Their award adds an extra ounce of pride to their title, making their victory just that much sweeter.

On behalf of the people of the entire 25th District of New York State, I would like to congratulate the following champions on their outstanding triumph: Brandice Balschmiter, Amanda Baker, Jane Parcero, Holly Perry, Brittney Peters, Tab Pullen, Andrea Rommel, Sylina Santell, Christine Seppeler, Carrier Sheehe, Rachael Stowell, Sarah Wlodarczyk, Shelly Graham, Alex Hinckley, Karli Clingerman, Shannon Schulmerich, Corrie VanDemortel, Thaia Wheaton, as well as Head Coach Mike Muscolino and Assistant Coaches Lee Prong and Dan Pullen.

CONGRATULATING THE NCAA D–II BASEBALL CHAMPIONS

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. SKELTON. Mr. Speaker, let me take this means to congratulate the Central Missouri State University (CMSU) Baseball Team on their NCAA-Division II Baseball Championship.

With the leadership of Coach Brad Hill, "MIAA Coach of the Year," the CMSU Mules defeated Tampa 11 to 4 in the championship game to claim its second national title. The Mules ended the season 51–7, their fourth straight season with 50 or more wins.

The Mules also were led by the dedication of its six seniors: Rob Bergin, Boomer Berry, Eric Horner, Brandon Pugh, Brian Shewmaker, and Matt Whitney. Three members of the CMSU team made the NCAA-Division II All-Tournament Team: Zach Norman, Danny Guidry, and Danny Powers.

Mr. Speaker, this outstanding team has played a wonderful season of baseball and has made the people of Missouri proud. I know that the Members of the House will join me in congratulating them on their NCAA-Division II Baseball Championship.

CALLING ON JAPAN TO APOLOGIZE TO WOMEN FORCED INTO SEXUAL SLAVERY DURING AND PRIOR TO WORLD WAR II

HON. LANE EVANS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. EVANS. Mr. Speaker, today I introduce a resolution calling on Japan to issue an apology to the women and girls forced into sexual slavery during and prior to World War II.

During the war and the colonial occupation of South East Asia, Japan forced over 200,000 young women and girls, known euphemistically as "comfort women" by the Japanese, into military brothels. This sexual enslavement of mostly Korean and Chinese women was officially commissioned and orchestrated by the Government of Japan. Women throughout Southeast Asia were recruited by force, coercion, or deception, transported across national borders, and kept at the mercy of the Japanese military in subhuman conditions. They endured such horrific crimes as gang rape, forced abortions, sexual violence, and human trafficking.

However, the horror of this experience did not end with the cessation of hostilities. Many comfort women were killed by Japanese soldiers after Japan surrendered. In addition, some of these women had no family or homes to return to, and found themselves abandoned in hostile lands where they were viewed as collaborators. The few remaining survivors live daily with the painful memories of their enslavement, and many still suffer serious health effects as a result of violent physical and sexual abuse and sexually transmitted diseases contracted during their ordeal.

While the facts of these crimes are incontrovertible, Japan has not officially acknowledged guilt or assisted the victims. Japan has paid $1.3 billion in war reparations, yet none of it has gone to the victims of sexual enslavement and not one person has been tried for their crimes. Japan waited over 44 years to even acknowledge the use of comfort women and then only issued a very ambiguous apology. Japanese textbooks rarely mention this enslavement and extreme nationalists still deny Japan's involvement. A private fund set up to compensate comfort women is, according to the United Nations Special Rapporteur's reports, a complete denial of legal responsibility.

There are only a handful of these victims still alive. For too long, these women have had to live in silence and shame. My resolution calls for Japan to issue a clear and unambiguous apology, render state compensation to the victims, and provide historical accountability for these horrific crimes. The sexual enslavement of hundreds of thousands of women should not disappear into history without a full apology and compensation.

RECOGNITION OF MR. YASHVANT PATEL AND MATRI, INC.

HON. FRANK PALLONE, JR.

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. PALLONE. Mr. Speaker, I rise today to laud the accomplishments of Mr. Yashvant Patel, and the organization he created, Matri, Inc. Mr. Patel and Matri, Inc. have created a unique and important forum where Gujarati youth can uphold their traditional values while searching for a life partner using more modern methods. This forum has been the starting ground for many happy couples, and has provided a much-needed service to America's young Gujarati people.

Mr. Patel founded Matri, Inc. in 1995 with a specific vision of a forum where Gujarati youths could uphold their traditional values while searching for a life partner. The first Matri was hosted by Anand Pragati Mandal in Kearny, NJ, and it had less than 100 attendees. In the last nine years the event has grown drastically and become a professional non-profit organization, providing annual conventions with over 300 participants.

Matri serves an important role in the unique Gujarati youth culture. Although it is a matrimonial forum, it does not force ideas of marriage but instead encourages networking and meeting with people who share similar ideas and principles, who may become lifelong friends or even marriage partners in the future. It is their belief that similarities in dharma, poshaak and khorak (religion, dress and food) are necessary to create a successful marriage. Matri allows Gujarati parents to fulfill their duty to pave the way for their children and give them a prosperous and happy life by honoring Gujarati traditions.

Matri is actually the Sanskrit term for friendship, which is a key element in any successful marriage. Since the participants are allowed to meet without the pressure of parents, the event gives them the opportunity to meet other people and develop relationships. Matri estimates that approximately 15 percent of all participants meet with success each year.

Once again, Mr. Speaker, I would like to congratulate Mr. Patel and his organization for the fine and important work they have done over the past eight years. His organization is doing an enormously important service to an important group of our nation's citizens, and we thank him for it.

ON THE RETIREMENT OF CDC OFFICIAL FRANCIE DE PESYTER

HON. W.J. "BILLY" TAUZIN

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. TAUZIN. Mr. Speaker, it is with great sadness and great appreciation that I rise today to commemorate the retirement of someone who has been a treasure to the United States Congress for the last 28 years.

Ms. Francie de Peyster will be retiring from the Centers for Disease Control and Prevention (CDC) on June 30, 2003, after many years of distinguished leadership and of tireless dedication to improving our Nation's public health.

Ms. de Peyster's prestigious career in public service began right here in the House of Representatives for what is now my committee, the Energy and Commerce Committee. She worked for more than five years for Representative Tim Lee Carter on the staff of the Committee on Interstate and Foreign Commerce. Following her tenure in the House, Ms. de Peyster went to work for the CDC in its Washington office in 1980. Ms. de Peyster became Deputy Director of the CDC/Washington office in 1984. In June 2001, she received the Secretary of Health and Human Services' Award for Distinguished Service. And just last year, she worked closely with my Committee as we drafted and passed into law one of the most important public health and national security initiatives in recent history—the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

Ms. de Peyster's professionalism, civility, experience, and dedication will be greatly missed by her friends and colleagues in the Senate and the House, and we will remain eternally grateful for her outstanding contributions to this Nation. I know all my colleagues would want to join me in expressing our sincerest thanks and wishes of happiness to Francie as she enters retirement.

HONORING FUTURE FOOTBALL GREAT RYAN HOAG

HON. CHRISTOPHER COX

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. COX. Mr. Speaker, for the past 28 years, the Orange County community has given out its "Irrelevant Week" award to the last player selected in the National Football

League draft—an award premised on the "simple act of doing something nice for someone for no reason."

This year's award, Irrelevant Week XXVIII, honors Ryan Hoag, a wide receiver from Gustavus Adolphus College in St. Peter, MI, who was selected 262nd in the NFL draft by the Oakland Raiders. Ryan, who checks in at 6 feet 2 inches tall and 200 pounds, caught 56 passes in the 2002 season, racking up 808 yards and 10 touchdowns. This rock-solid performance earned Ryan his second straight first-team selection to the all-Minnesota Intercollegiate Athletic Conference team—and apparently also caught the eye of scouts for the Oakland Raiders, who hope that he can make a significant contribution to their team's future success. In addition to his football skills, Ryan is clearly a tremendous all-around athlete: he was a soccer and tennis star in high school, and he also competes on his college track team, where he recently placed third in the NCAA Division III national championships for the 100–meter race, with a cheetah-fast 10.51–second dash. And when his football playing days are over, Ryan says that he hopes to follow his true passion, teaching, by becoming a kindergarten teacher.

While Ryan will surely have a lot of hard work ahead of him if he is to earn his way onto the Oakland Raiders roster, long odds do not dampen the enthusiasm of Orange County community leaders like Paul Salata, who puts Irrelevant Week together. That is because we recognize that fame is fleeting, that humility is a virtue, and that even the last round NFL draft pick is a significantly better athlete than any member of Congress.

Today, I ask my colleagues to join with me in congratulating Ryan Hoag and everyone else who is involved in the Irrelevant Week celebration. In some ways, this celebration has outgrown its name, for I cannot think of anything more relevant to our spirit of community and our common humanity than doing nice things for other people. On behalf of the U.S. Congress and the people of Orange County whom it is my privilege to represent, congratulations to everyone associated with Irrelevant Week XXVIII, for being more relevant than you care to admit.

TRIBUTE HONORING 2003 LeGRAND SMITH SCHOLARSHIP FINALISTS

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. SMITH of Michigan. Mr. Speaker, It is a sincere pleasure to recognize the finalists of the 2003 LeGrand Smith Congressional Scholarship Program: Ashley Herlein of Spring Arbor, Michigan; Kristen Przybylski of Clinton, Michigan; Brian Jones of Battle Creek, Michigan; and Evelyn Levine of Albion, Michigan. This special honor is an appropriate tribute to the academic accomplishment, demonstration of leadership and responsibility, and commitment to social involvement displayed by these remarkable young adults. We all have reason to celebrate their success, for it is in their promising and capable hands that our future rests.

The finalists of the LeGrand Smith Congressional Scholarship Program are being honored for showing that same generosity of spirit, depth of intelligence, and capacity for human service that distinguished the late LeGrand Smith of Somerset, Michigan. They are young men and women of character, ambition, and initiative, who have already learned well the value of hard work, discipline, and commitment.

These exceptional students have consistently displayed their dedication, intelligence, and concern throughout their high school experience. They stand out among their peers due to their many achievements and the disciplined manner in which they meet challengers. While they have already accomplished a great deal, these young people possess unlimited potential, for they have learned the keys to success in any endeavor.

As a Member of Congress of the United States of America, I am proud to join their many admirers in extending our highest praise and congratulations to the finalist of the 2003 LeGrand Smith Congressional Scholarship program.

INTRODUCTION OF DC PARENTAL CHOICE INITIATIVE ACT OF 2003

HON. TOM DAVIS

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. TOM DAVIS of Virginia. Mr. Speaker, I rise today to introduce legislation, along with Education and Workforce Committee Chairman JOHN BOEHNER, that would provide relief to some of the long-standing challenges facing students in the District of Columbia public school system. The "DC Parental Choice Initiative Act of 2003," H.R. 2556, would authorize the appropriation of $15 million in new Federal funding to the District of Columbia to provide individual students up to $7,500 in scholarship money to be used at private schools of their own choosing in the District of Columbia.

One thing is clear: too many kids in our Nation's capital are not getting the education they need and fully deserve. Lower-income families concerned about the quality and safety of their children in District of Columbia public schools should not have to resign to sending their children to under-performing schools where students are not adequately motivated to perform.

At the same time, a school should not take for granted that it will automatically enroll every child that lives within a given radius of the school. Instead, that school should be striving everyday to ensure that it provides a learning environment that will attract new students and parents.

Over the past decade, Congress has spent considerable time and resources working with the District to reform its education system. Enacted laws, such as the "District of Columbia School Reform Act of 1995" and the "D.C. College Access Act of 1999," have provided an impetus to level the playing field and brighten the future for D.C. students.

However, the ability of D.C. schools to meet key performance goals has long been plagued by financial mismanagement as well as a host of other problems. Despite concerted efforts by local officials to improve the public school system, little evidence of progress in improving academic performance is available.

Poor academic achievement scores are unsettling to say the least: Only 6 percent of 4th graders in the District tested "proficient" or higher in math.

Standardized test scores remain stagnant for D.C. public schools: the average D.C. SAT score is 799 while the national average is 1020.

The National Assessment of Educational Process just released a "Reading 2000" Report Card: the District's school children were ranked as the worst readers in the country.

The disparity is too glaring to ignore. The drop out rate is about 40 percent. The current condition of schools is unacceptable.

I have traditionally opposed Federal dollars going to private schools because I think Federal dollars ought to be targeted to public schools. But, for the District, I think we have to ask this question: Wouldn't more choices funded by Federal dollars provide a needed alternative for low-income children attending low-performing schools?

As the United States Representative representing a district neighboring the District of Columbia, I have worked with the District on a number of initiatives to improve the standard of living in the District of Columbia, and along with it, the standard of living of the entire capital region. That is why I cannot ignore the grave challenges facing the District of Columbia public school system and that is why I am introducing the "DC Parental Choice Incentive Act of 2003."

The goal of school choice in the District of Columbia is to be an addition, not a subtraction. We all want the District's education system to improve, and this is at the very least a short-term effort to do something about it.

The bill I am introducing today, along with Chairman BOEHNER, would expand educational opportunities to D.C. students in under-performing elementary and secondary schools. The D.C. Choice Program would be established through a competitive process administered by the U.S. Department of Education to ensure that the public or private entity administering the initiative would be dedicated and capable of carrying out a top-notch program.

The D.C. Choice Program would provide scholarships of up to $7,500 to eligible students to cover the cost of tuition, fees, and transportation expenses, if any. The scholarship would be considered assistance to the students and not the schools. In order to ensure accountability, an evaluation would be conducted that would consider the impact and academic achievement attained by the program.

This legislation is the result of considerable negotiation and consultation with city officials, the Administration and the key committees of jurisdiction in Congress. And for the first time ever, the Mayor of the District of Columbia has come to the conclusion that ". . . if done effectively, this program would provide even more choices for primarily low income families who currently do not have the same freedom of choice enjoyed by their effluent counterparts."

I look forward to working with my colleagues on this important legislation.

HONORING THE DISTINGUISHED SERVICE OF LT. COL. STEVE GAY

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. GORDON. Mr. Speaker, I rise today to recognize the outstanding service of Lt. Col. Steve Gay, the U.S. Army Corps of Engineers Nashville district engineer and commander. His command at the Nashville district is coming to an end next month, as he will retire from the Corps.

Colonel Gay has been a tremendous asset to the Corps and its Nashville district, which covers parts of seven states and more than 59,000 square miles of the basins of the Cumberland and the Tennessee rivers. He is an invaluable leader who has performed his duties with great distinction and honor.

Colonel Gay's leadership at the Corps' Nashville district has helped make the region a better place to live through excellent management of water resources. Projects enhancing and protecting those resources have made Middle Tennessee a desirable location for many top-notch companies, which brought with them good jobs for our residents.

Colonel Gay has served the U.S. Army Corps of Engineers well and has garnered extensive awards and decorations in the process, including the Defense Meritorious Service Medal, the Meritorious Service Medal with two oak leaf clusters, the Army Commendation Medal, the Joint Service Achievement Medal, the Army Achievement Medal with one oak leaf cluster, the Air Assault Badge, the Parachutist Badge and the Ranger Tab.

I congratulate him for all the good work he has done with the Corps and for Middle Tennessee and wish him well in his retirement and his future endeavors.

TRIBUTE TO SCOTT GILES, DEPUTY CHIEF OF STAFF, SCIENCE COMMITTEE

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. SMITH of Michigan. Mr. Speaker, I rise today in recognition of the contribution and service of Mr. Scott Giles to the United States Congress. Scott is an outstanding public servant, truly committed to effecting positive change and improving the lives of all Americans.

I have had the pleasure of knowing Scott since January 2001, when he was appointed to serve as deputy chief of staff for the House Committee on Science. And as Chairman of the Subcommittee on Research, I have had the benefit of Scott's expert advice and diverse legislative talents on a wide range of issues.

Scott's expertise on Federal research and development and education policy has been key to our Subcommittee's legislative success, and to the Science Committee's growing influence in the House of Representatives. Scott was lead staff negotiator on several pieces of legislation we successfully shepherded through the Committee, to the House floor and eventually, onto the President's desk. Most notable of these pieces of legislation were the Cybersecurity Research and Development Act (Public Law 107–305) and the National Science Foundation Authorization Act of 2002 (Public Law 107–368), which included the National Math and Science Partnerships Act and the Tech Talent Act.

But Scott's impressive career began long before he came to the Science Committee. From 1982 to 1986, he served as legislative director for his Rochester, NY hometown Representative, the Honorable Frank Horton (R–NY). In 1986, he took a job as a senior associate and team leader at Cassidy & Associates. At Cassidy he provided government and public affairs services to colleges, universities, hospitals and non-profit organizations.

After 10 years at Cassidy, Scott and his wife, Kate headed to the University of Virginia, where Scott pursued a doctorate in ethics. In 1997 he felt the lure of Congress once again when he was asked to serve on the professional staff of the Senate Committee on Health, Education, Labor, and Pensions HELP. On the HELP Committee, Scott advised the Chairman on budget, education and research policy, served as the Committee's chief staff negotiator for budget and appropriations and was a principal staff member on the National Science Foundation Authorization Act of 1998, and the Higher Education Act Amendments of 1998.

Now, Scott, Kate and their three children, Abigail, Sam and Eliza, are embarking on a new adventure. They are moving north to Vermont, where Scott has been appointed Vice President of Policy, Research and Planning for the Vermont Student Assistance Corporation. Although the students and universities in Vermont are thrilled with this move, Congress is losing a valuable, incredibly talented staff member.

On behalf of Chairman BOEHLERT and all the members and staff of the Science Committee, thank you for your service to Congress. Scott, we wish you all the best in your future.

IN HONOR OF SOLOMON NEWBORN

HON. GARY L. ACKERMAN

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. ACKERMAN. Mr. Speaker, I rise today to pay tribute to a great American and a great New Yorker, Solomon Newborn, who passed away on June 16, 2003 at the age of 86, after a life dedicated to public service, his community of Plainview, the Town of Oyster Bay, his religion, and—most importantly—his family.

After growing up as the poor child of Austrian immigrants, Solomon worked his way through New York University, where he received both his Bachelor of Science in Accounting and his Master's Degree in Education.

During World War II, Sol decided to enlist in the Navy. But the Navy told him that it was no longer enlisting men, so Sol, determined to serve his country and his flag, enlisted in the Army Air Corps, the forerunner of the United States Air Force. Solomon Newborn became a decorated Captain who served valiantly in flight and in uniform fighting the Nazi regime.

Sol's dedication to the highest standards of his profession was always evident in his work. A Certified Public Accountant and recognized specialist in the fields of municipal auditing, Solomon was elected the Receiver of Taxes of the town of Oyster Bay in 1996, a position he held until 1983. He was also an author on taxation and municipal accounting, subjects he taught at Adelphi University and Queens College, my alma mater.

Sol also understood how important it was to be a part of a community. As soon as he and his wife, Rita, moved into their home in Plainview, New York, in 1953, they began to develop the idea for the Plainview Jewish Center. Sol was not only one of the founders, but the synagogue's first president. Today, The Plainview Jewish Center continues to thrive as one of the largest synagogues on Long Island. Ironically, Sol died a full half century to the day after the first planning meeting was held in the Newborn's own living room.

Solomon Newborn was the organizer of the Annual Brotherhood Conference of Plainview Service Clubs, served as Chairman of the Red Cross for Plainview and was the Senior Vice Commander of the Jewish War Veterans in Hicksville. His tireless efforts on behalf of his community and various groups have earned him the "Man of the Year" award from Yeshiva University and the "Masada" award from the United Jewish Federation.

Solomon is survived by Rita—his wife of 54 years, four children and one granddaughter: Ira, Evan, Jud, Kym and Stacey.

Solomon Newborn was the kind of man who led by his heart and always encouraged other public officials to be true to themselves. I ask my colleagues in the House of Representatives to please join me in honoring and thanking Solomon for his service to our nation and to extend to his family our deepest sympathies and condolences.

THANKING THE NATIONAL RESOURCES CONSERVATION SERVICE

HON. MARILYN N. MUSGRAVE

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mrs. MUSGRAVE. Mr. Speaker, I would like to thank the Natural Resources Conservation Service (NRCS), specifically Mary Miller and John Knapp of the La Junta, Co., NRCS Office for all of the wonderful work they do for rural Colorado and many of my constituents in Colorado's Fourth Congressional District.

NRCS has worked diligently to help farmers and ranchers in Eastern Colorado through this time of hardship and drought. Moreover, Mary and John have given special attention to briefing congressional staffers on many of the issues facing these farmers and ranchers.

Their service to the agricultural communities of Eastern Colorado is greatly appreciated by my staff and myself.

DR. WILLIE MANLEY: AMBASSADOR OF PEACE

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. FILNER. Mr. Speaker and colleagues, I am glad to have the opportunity to recognize and congratulate Dr. Willie E. Manley as a recipient of the Ambassador of Peace Award.

I am honored to be presenting this award to Dr. Manley on Tuesday, June 24, 2003. Dr. Manley is one of 100 recipients from around the world. As the award states, it is granted to individuals who have dedicated their lives to promoting "strong family life, interreligious cooperation, international harmony, renewal of the United Nations, a responsible public media, and the establishment of a culture of peace. Transcending racial, national and religious barriers, the Ambassadors for Peace contribute to the fulfillment of the hope of all ages; a unified world of peace wherein the spiritual and material dimensions of life are harmonized." Dr. Manley is certainly deserving of such an award.

Dr. Manley's life has exemplified those very values. At home, he is the loving husband of Vertis, and the dedicated father of seven children. In addition to his work at the Greater Life Baptist Church, he is a community activist: he has traveled as a missionary to South Africa and West Africa; been a Goodwill Ambassador to Korea; and served as a past President of the NAACP San Diego Chapter. Simply by reading his résumé, one realizes that Dr. Manley is a man who is dedicated in every way to his family, to his community, to his religion and to this world. He has worked at the local level, the national level and the international level; with the government, with non-governmental organizations, and at the grassroots.

His work has focused on peace and understanding among the people of the world. He has worked to improve race relations in the San Diego area. He has also worked to promote inter-denominational and inter-religious relations in San Diego and around the world. Indeed, I can think of no better candidate for the Ambassador of Peace Award than Dr. Willie E. Manley.

THE OCCASION OF THE RETIREMENT OF CHIEF MARK MEAKER

HON. DOUG OSE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. OSE. Mr. Speaker, I rise today to commend Mark Meaker for his many years of dedicated service to a number of Northern California fire departments, and also to congratulate him on the occasion of his upcoming retirement.

Mark Meaker began his fire service career in 1971 as a volunteer firefighter with the Arcade Fire District. After a year with Arcade, he went to work with the Citrus Heights Fire District in 1972 and worked his way up through the ranks. Chief Meaker spent eight years as a company officer, six as a battalion chief and five years as an Operations assistant chief for the Sacramento County Fire Protection District. In that period, he played a key role in the development of their ambulance program and was incident commander on many large-scale emergency operations

Mr. Meaker became Fire Chief of the Elk Grove Community Services District Fire Department in July of 1997. Since becoming Fire Chief, the department has completed construction of three new fire stations, and is scheduled to begin construction on a $2.7 million fire training facility this spring.

Under Chief Meaker's leadership the Elk Grove CSD Fire Department has dramatically improved upon the rate at which its crews respond to emergency situations. The department now executes an emergency response time of 5 minutes or less 75 percent of the time the crew is called into action. This is a 35 percent increase, up from 40 percent in the years prior to his service. Mr. Meaker supported the improved education and motivation of line personnel, implemented an aggressive move-up policy along with restrictions on units leaving their cover areas, and aided in the construction of additional fire stations. These improvements, along with Mr. Meaker's dedication and hard work, are responsible for the dramatic improvement in the Elk Grove CSD Fire Department's emergency response time.

After six years of serving as Fire Chief for the Elk Grove Community Service District Fire Department and more than 30 years of dedicated duty to California's fire service, Mark Meaker is retiring. It is my pleasure to honor him today; his hard work and dedication will be missed.

TRIBUTE TO IRONWOOD AARP CHAPTER #556 IN CELEBRATION OF ITS 35TH YEAR OF SERVICE

HON. BART STUPAK

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. STUPAK. Mr. Speaker, I rise today to congratulate a group of senior citizens who have kept their Ironwood American Association of Retired Persons Chapter #556 active and healthy for 35 years in Ironwood, Michigan.

Some of the charter members who were there when AARP Chapter #556 was first organized are still active members. Current Chapter President Ray Maurin presides over meetings the first Monday of every month at the Ironwood Senior Center.

Chapter #556 is involved every year in a workshop that brings Upper Peninsula AARP chapter presidents and others from Michigan AARP together, usually in the Ironwood area, to discuss legislative issues. These workshops are open to the public, are always informative and often lead to enthusiastic political discussions.

On an individual level, members of Chapter #556 this year joined forces with Lake Superior AARP Chapter #1791 to improve home safety for 52 homebound senior citizens by providing and installing home smoke detectors. This program was so popular that Grace Nurkkala, Michigan AARP Chapters Specialist, says she has a list of 25 additional seniors who have asked to be included.

Members of Chapters #556 and #1791 have also recently delivered cheerful, bright coffee mugs and live plants to brighten the lives of 52 seniors who receive home meal delivery through the Ironwood Senior Center.

As they stay active and engaged in political activity, reach out to their neighbors and join together for fellowship and action on issues important to senior citizens, the many members of Ironwood AARP Chapter #556 can be proud of their 35 year record of accomplishment on behalf of seniors.

Mr. Speaker, I hope that you and the other members of this body will join me in extending our heartiest congratulations to Ironwood AARP Chapter #556 on the 35th anniversary of its organization.

VETERANS LOSE ONE OF THEIR BEST FRIENDS

HON. LANE EVANS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. EVANS. Mr. Speaker, on June 20 the Nation lost a dedicated public servant and its veterans and Armed Forces personnel worldwide a loyal and steadfast champion. Our colleague, former Arizona Congressman Bob Stump, whose legacy is a remarkable record of programs that will benefit active duty service men and women, National Guard and Reserve personnel, and veterans for generations to come, passed away after a lengthy illness.

I consider it a privilege to have had the opportunity to serve in the House of Representatives with this gentleman from 1987 to the day of his departure—some 14 years, the full time for which we both served as members of the House Veterans' Affairs Committee. In that time, I never encountered a more generous, more courteous, more affable, nor more resolute individual in this body. I am proud to have served as Ranking Democrat under his very capable chairmanship of the Veterans' Affairs Committee and to have worked with someone who so clearly understood and practiced true bipartisanship.

Bob was one of those all-too-rare individuals in elected office—an unassuming, behind-the-scenes workhorse who eschewed self-promotion and who knew his way and how to get there. It didn't take long for one to understand that Bob's kindly manner sometimes belied the firm hand he kept on the helm of leadership in veterans' affairs and armed services, and in the cause of his constituents.

Those who have served in uniform, and those still serving, likely will never know the full measure of what this good man gave them, but they will feel it every day in a broad range of benefits and services that bear his mark. His near half-century of contributions to his country, beginning as a combat medic in the Pacific Theater of World War II, through service in both houses of the Arizona legislature, 26 years in the U.S. House of Representatives and chairmanship of two committees, will forever be held in the same high regard as the man we came to know and appreciate.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Tuesday, June 24, 2003 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

JUNE 25

9:30 a.m.

Armed Services

To hold hearings to examine the nomination of Lieutenant General John P. Abizaid, USA, for appointment to the grade of general and to be Commander, United States Central Command.

SH-216

Environment and Public Works

Fisheries, Wildlife, and Water Subcommittee

To hold oversight hearings to examine the consulting process required by Section 7 of the Endangered Species Act.

SD-406

Foreign Relations

To hold hearings to examine the implementation of the African Growth and Opportunity Act (P.L. 106-200).

SD-419

Appropriations

Labor, Health and Human Services, and Education Subcommittee

Business meeting to consider proposed legislation making appropriations for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 2004.

SD-124

10 a.m.

Energy and Natural Resources

Business meeting to consider pending calendar business.

SD-366

Governmental Affairs

To hold hearings to examine the nomination of Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.

SD-342

Health, Education, Labor, and Pensions

Business meeting to consider S. 1248, to reauthorize the Individuals with Disabilities Education Act, and pending nominations.

SD-106

Judiciary

To hold oversight hearings to examine the Department of Justice Inspector General's Report on the 9/11 detainees.

SD-226

2 p.m.

Banking, Housing, and Urban Affairs

Economic Policy Subcommittee

To hold oversight hearings to examine certain measures to strengthen the economic situation in rural America.

SD-538

Judiciary

To hold hearings to examine the nominations of Louise W. Flanagan, to be United States District Judge for the Eastern District of North Carolina, Allyson K. Duncan, of North Carolina, to be United States Circuit Judge for the Fourth Circuit, Samuel Der-Yeghiayan, to be United States District Judge for the Northern District of Illinois, Lonny R. Suko, to be United States District Judge for the Eastern District of Washington, Earl Leroy Yeakel III, to be United States District Judge for the Western District of Texas, and Karen P. Tandy, of Virginia, to be Administrator of Drug Enforcement, and Christopher A. Wray, of Georgia, to be an Assistant Attorney General, both of the Department of Justice, and Robert C. Brack, to be United States District Judge for the District of New Mexico.

SD-215

Foreign Relations

Near Eastern and South Asian Affairs Subcommittee

Judiciary Constitution, Civil Rights and Property Rights Subcommittee

To hold joint hearings to examine constitutionalism, human rights, and the Rule of Law in Iraq.

SD-226

2:30 p.m.

Foreign Relations

European Affairs Subcommittee

To hold hearings to examine the progress and challenges to the successor states to Pre-1991 Yugoslavia.

SD-419

Energy and Natural Resources

Public Lands and Forests Subcommittee

To hold oversight hearings to examine grazing programs of the Bureau of Land Management and the Forest Service, focusing on grazing permit renewal, BLM's potential changes to grazing regulations, range monitoring, drought, and other grazing issues.

SD-366

JUNE 26

Time to be announced

Governmental Affairs

Business meeting to consider the nominations of Judith Nan Macaluso, to be an Associate Judge of the Superior Court of the District of Columbia, Fern Flanagan Saddler, to be an Associate Judge of the Superior Court of the District of Columbia, and Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.

Room to be announced

9 a.m.

Agriculture, Nutrition, and Forestry

To hold hearings to examine H.R. 1904, to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape.

SR-328A

9:15 a.m.

Foreign Relations

Business meeting to consider S. Res. 90, expressing the sense of the Senate that the Senate strongly supports the nonproliferation programs of the United States, and the nominations of Marsha E. Barnes, of Maryland, to be Ambassador to the Republic of Suriname, Robert W. Fitts, of New Hampshire, to be Ambassador to Papua New Guinea, and to serve concurrently and without additional compensation as Ambassador to the Solomon Islands and Ambassador to the Republic of Vanuatu, John E. Herbst, of Virginia, to be Ambassador to Ukraine, Tracey Ann Jacobson, of the District of Columbia, to be Ambassador to Turkmenistan, George A. Krol, of New Jersey, to be Ambassador to the Republic of Belarus, John F. Maisto, of Pennsylvania, to be Permanent Representative of the United States to the Organization of American States, with the rank of Ambassador, Greta N. Morris, of California, to be Ambassador to the Republic of the Marshall Islands, Roger Francisco Noriega, of Kansas, to be an Assistant Secretary of State (Western Hemisphere Affairs), and William B. Wood, of New York, to be Ambassador to the Republic of Colombia.

SD-419

9:30 a.m.

Commerce, Science, and Transportation

Business meeting to consider S. 1264, to reauthorize the Federal Communications Commission, S. 1218, to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program, H.R. 1320, to amend the National Telecommunications and Information Administration Organization Act to facilitate the reallocation of spectrum from governmental to commercial users, S. 1262, to authorize appropriations for fiscal years 2004, 2005, and 2006 for certain maritime programs of the Department of Transportation, and S. 1106, to establish National Standards for Fishing Quota Systems, an original bill authorizing funds for TEA-21 programs, and pending nominations.

SR-253

Judiciary

Business meeting to consider pending calendar business.

SD-226

10 a.m.
Banking, Housing, and Urban Affairs
To hold hearings to examine affiliate sharing practices in relation to the Fair Credit Reporting Act.
SD–538

Finance
To hold hearings to examine the nominations of Josette Sheeran Shiner, of Virginia, to be a Deputy United States Trade Representative, with the rank of Ambassador, and James J. Jochum, of Virginia, to be an Assistant Secretary of Commerce.
SD–215

11 a.m.
Indian Affairs
Business meeting to consider pending calendar business.
SR–485

2 p.m.
Appropriations
Business meeting to consider proposed legislation making appropriations for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 2004, and proposed legislation making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004.
SD–192

Foreign Relations
To hold hearings to examine the Department of State's Office of Children's Issues, focusing on responding to international parental abduction.
SD–106

Judiciary
Terrorism, Technology and Homeland Security Subcommittee
To hold hearings to examine the growing Wahhabi influence of terrorism in the United States.
SD–226

2:30 p.m.
Intelligence
To hold closed hearings to examine certain intelligence matters.
SH–219

JULY 9

10 a.m.
Indian Affairs
To hold oversight hearings to examine the Indian Gaming Regulatory Act.
SD–106

JULY 16

10 a.m.
Indian Affairs
To hold hearings to examine S. 556, to amend the Indian Health Care Improvement Act to revise and extend that Act.
SR–485

JULY 23

10 a.m.
Indian Affairs
To hold hearings to examine S. 556, to amend the Indian Health Care Improvement Act to revise and extend that Act.
SR–485

Judiciary
To hold oversight hearings to examine certain pending matters.
SD–226

JULY 30

10 a.m.
Indian Affairs
To hold hearings to examine S. 578, to amend the Homeland Security Act of 2002 to include Indian tribes among the entities consulted with respect to activities carried out by the Secretary of Homeland Security.
SR–485

POSTPONEMENTS

JUNE 25

9:30 a.m.
Commerce, Science, and Transportation
To hold hearings to examine the nominations of Pamela Harbour, of New York, to be a Federal Trade Commissioner, and Nicole R. Nason, of Virginia, to be an Assistant Secretary of Transportation; to be followed by a hearing on Radio Ownership.
SR–253

HOUSE OF REPRESENTATIVES—*Tuesday, June 24, 2003*

The House met at 9 a.m. and was called to order by the Speaker pro tempore (Mr. BOOZMAN).

DESIGNATION OF SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
June 24, 2003.

I hereby appoint the Honorable JOHN BOOZMAN to act as Speaker pro tempore on this day.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

MORNING HOUR DEBATES

The SPEAKER pro tempore. Pursuant to the order of the House of January 7, 2003, the Chair will now recognize Members from lists submitted by the majority and minority leaders for morning hour debates. The Chair will alternate recognition between the parties, with each party limited to not to exceed 25 minutes, and each Member, except the majority leader, the minority leader, or the minority whip, limited to not to exceed 5 minutes, but in no event shall debate extend beyond 9:50 a.m.

The Chair recognizes the gentleman from Texas (Mr. DELAY).

FINISHING THE JOB FOR AMERICAN SENIORS

Mr. DELAY. Mr. Speaker, as we approach the 6 month mark for the 108th Congress, we can look back on our work with a great sense of accomplishment. Just in the last 3 weeks, the House has moved major legislation benefiting consumers, children, small businesses and working class parents. As important as these accomplishments have been, they are only part of a broader three-part agenda.

The Republican leadership of this Congress set three major objectives when we were sworn in.

We committed ourselves to do our part to support the war on terror, and through our work on the budget and the Operation Iraqi Freedom war supplemental, we have.

We committed ourselves to help get the economy started moving again, and since the House passed the President's Jobs and Growth Package, wealth has been created, losses recovered, consumer confidence has risen and jobless claims have fallen.

Finally, the Republican majority committed itself to work with the President to finally create a prescription drug benefit with Medicare.

American seniors have been waiting for Congress to act for years to finally make the Medicare program reflect 21st Century medical realities. We cannot wait on the sidelines while they are hurting financially and physically.

We must act, and this week we will. The House has twice before passed a prescription drug benefit, only to have it stalled along its way. But this time we are going to get it right and get a bill to the President's desk.

When we got here, our Nation faced three big problems: Terrorism, a sagging economy, and seniors being bankrupted by their prescription drug bills.

In response, we had three big ideas: Continuing our relentless war on terror, creating jobs and growing the economy, and adding a long overdue prescription drug benefit to Medicare.

This Republican Congress will not lose sight of the big picture, Mr. Speaker. For everything else we accomplish at the end of the day, we will be judged on how we meet these three challenges.

In the last 6 months, we have met the first two head on. It is time to do the same with the third. We have done a great deal so far, but it is time to finish the job.

MAKING AMERICA FISCALLY SECURE FOR FUTURE GENERATIONS

The SPEAKER pro tempore. Pursuant to the order of the House of January 7, 2003, the gentleman from Michigan (Mr. SMITH) is recognized during morning hour debates for 5 minutes.

Mr. SMITH of Michigan. Mr. Speaker, I rise today to talk about how much debt and how much of an increased tax there is going to be placed on my 10 grandchildren and everybody else's grandchildren and children. Let me just review what we have been doing on increased spending.

Discretionary increases have averaged 6.3 percent each year since 1996 and 7.7 percent each year since budget balance was reached in 1998. By this chart, you can see the red line where we have taken off on increased spending, not just keeping up with inflation, but 6.3 percent every year, which is two and three times the rate of inflation, and, in one year, four times the rate of inflation. How big can government get? How big do we want government to be?

This week we are considering a prescription drug program. The next chart, Mr. Speaker, shows what is going to happen to the total debt of this country. The blue line is the gross Federal debt. The debt held by the public is the green line.

Actually, we have two debts in this country. First, is the amount we borrow from Social Security. In 1983, we expanded the Social Security tax, increased the FICA tax, your payroll tax for Social Security, more than ever before in the history of the country and it is still going wrong. In fact, when we started Social Security, it was 1.5 percent of payroll, and now it is 12.4 percent of payroll. Seventy percent of American workers today pay more in their payroll tax than they do in the income tax. So we have been borrowing from Social Security right along, and this is the purple line coming up at the bottom and increasing to $10 trillion.

Already today we have a $9 trillion unfunded liability in Social Security. That means if we invested $9 trillion today, with interest it could keep Social Security solvent for 75 years. The alternative is we continue to increase taxes on somebody, someplace, to pay promised Social Security benefits, or we cut those benefits.

Now I want to talk about what we are about to approach this week, and that is having the largest increase in entitlement programs that has been passed by this Congress in 39 years.

What happened 39 years ago? We amended the Social Security bill in 1965 to include Medicare. The original estimates of the cost of Medicare as a percent of GDP is now just a small fraction of the actual costs of Medicare. In fact, Medicare is going bankrupt. It is going broke. There is going to be less money coming into Medicare and to Social Security than what is required to pay promised benefits. So we have been doing fiscal creative accounting, using general fund money trying to keep up. But now we are adding to the costs to Medicare by adding prescription drugs.

Dr. Thomas Sowell is a senior fellow at Hoover Institute. He says, "Why should seniors be singled out to be subsidized by taxpayers, except that their votes are being sought after by both parties?"

That was true in 1965. Both sides of the aisle decided they wanted to get more votes from seniors, so they amended Social Security to add the Medicare program. Now both sides of the aisle and the President are trying

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

to get more votes from seniors, so we are adding a prescription drug program.

I have 10 grandchildren, Mr. Speaker. They are going to be saddled with the largest debt in history. I see our Pages in this Chamber. They are the generation at risk. Why should they be asked to pay for a senior drug program? The retireing seniors today are probably the wealthiest seniors we are going to ever see in history.

We are losing our manufacturing base. We are spreading ourselves so thin with more government spending that we are mounting a massive debt for our kids and our economy.

Grandparents: as you look at prescription drugs, I think you have got to start thinking about what we are saddling our kids with.

I would like to pose a question: Why should my kids, who are trying to save enough money for their kids to go to college, pay for prescription drugs for seniors?

Let me ask another question, and that is about my 10 grandkids. Why should we pass this large increase in entitlement programs, which is going to mean a huge debt for all grandkids to deal with?

What we are doing is increasing the debt of this country more rapidly than ever before in history. It took the first 200 years of this Congress, of this Nation, to amass a $450 billion debt, the first 200 years. And now we are having a debt increase that we are passing on to our kids that amounts to about $450 billion per year.

RECESS

The SPEAKER pro tempore. There being no further requests for morning hour debates, pursuant to clause 12(a), rule I, the House will stand in recess until 10 a.m.

Accordingly (at 9 o'clock and 11 minutes a.m.), the House stood in recess until 10 a.m.

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AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. PETRI) at 10 a.m.

PRAYER

The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

Remember Your covenant with Your people, Lord; make us truly Your own. Instill in this Nation the promise once heard from Joshua: "Tomorrow, the Lord will perform wonders among you."

Strengthen the Members of the House of Representatives today as they address the problems, needs, and opportunities of tomorrow. With faith in You and in this Nation with its freedom, spontaneity, and resources, call us to move into the future.

Free us from the scenario of yesterday's fears and uncertainty. Fill us with vision and hope. Help us to build upon the solid rock of today's reality. With candor, civility, and creativity, guide the discussions that will reveal a plan for tomorrow.

By disposing ourselves, our energies, and our commitments to Your determinations, prepare us to be startled by wonders You alone can produce. From our feeble attempts, You piece together solutions to tomorrow's problems.

For in You, we place our trust, now and forever.

Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Ohio (Mr. KUCINICH) come forward and lead the House in the Pledge of Allegiance.

Mr. KUCINICH led the Pledge of Allegiance as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 239. An act to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes.

S. 1157. An act to establish the Smithsonian Institution the National Museum of African American History and Culture, and for other purposes.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION REFORM ACT

(Ms. DUNN asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. DUNN. Mr. Speaker, later this week, we will pass a prescription drug benefit for all seniors in Medicare that is affordable and voluntary. We will protect the poorest seniors by helping pay for their drug costs immediately. By using the same principles already used by private companies, we will lower drug costs for seniors by passing along to them bigger discounts from manufacturers.

We will also strengthen Medicare for future generations by providing preventive care such as cholesterol screening and initial physical exams, and chronic care management for seniors with serious and complicated illnesses.

We can only strengthen Medicare's future if we are able to ensure access to the services that seniors need today. In this Medicare bill, we increase payments to doctors and hospitals, especially in the rural communities, so that seniors can get better health services when they are needed.

For much too long, our parents and our grandparents have paid too much for their drugs. We have an opportunity now to change this, by passing a prescription drug bill for all seniors.

WAR IN IRAQ: MANUFACTURED CATASTROPHE

(Mr. KUCINICH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KUCINICH. Mr. Speaker, this administration deliberately took this Nation into a war against Iraq based on false premises. Iraq had nothing to do with 9-11, with al Qaeda's role in 9-11, with the anthrax attack on this Nation; did not represent an imminent threat to the United States, had no usable weapons of mass destruction. That is why the weapons of mass destruction cannot be found.

This deception made America less secure. It cut the United States off from the world community. It violated the U.S. Constitution, it violated the U.N. charter, it violated the Geneva Convention; and it continues to cost, because we are now losing our men and women in combat on a regular basis. We continue to lose them. It has cost the lives of countless innocent Iraqis. It has cost the taxpayers of this Nation over $100 billion, and it has cost tens of billions of dollars in damage to Iraq. It has strengthened religious fundamentalists in Iraq who now threaten the freedom of women in Iraq's society.

This manufactured catastrophe called "foreign policy" represents not only a failure of truth, a great credibility gap, but, more than that, America faces a crisis of legitimacy of this administration itself, which lied to the American people to get approval for a war.

ENSURE QUALITY OF CARE AND SOLVENCY OF MEDICARE

(Mr. BURNS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BURNS. Mr. Speaker, while the House is in the midst of debate that will improve Medicare for millions of seniors, we must ensure both the quality of care and the solvency of the Medicare system for all of our seniors.

Mr. Speaker, the prescription drug benefit we institute must be coupled with meaningful reforms within Medicare. We must provide meaningful prescription drug coverage and reforms to Medicare for seniors, both today and tomorrow.

APPLAUDING THE SUPREME COURT ON AFFIRMATIVE ACTION RULINGS

(Ms. LORETTA SANCHEZ of California asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I rise today to applaud the Supreme Court on its rulings on the University of Michigan affirmative action cases. The rulings indicate to the entire Nation that the Supreme Court believes in the basic premise behind affirmative action: to create opportunities for minorities and to eliminate discrimination.

Affirmative action programs have been successful in increasing the racial, ethnic, and gender diversity of many educational and workplace settings throughout the United States. Affirmative action has also been shown to provide a boost to the Nation's economy.

A recent study by the Educational Testing Service argued that diversity was one of the engines that drove the United States' economy. It showed that if African American and Hispanic workers were represented at colleges and universities in the same proportions as other 18- to 24-year-olds, the United States' wealth would increase by $231 billion a year, and annual tax revenues would increase by $80 billion. Why? Because it gives hope to blighted and forgotten areas of our Nation, and it improves trade and commerce worldwide.

This goes to show that by promoting adequate funding for kindergarten through twelfth grade education in underserved areas and promoting diversity in higher education in the workplace, our economy will improve.

TRIBUTE TO BOB STUMP

(Mr. SHADEGG asked and was given permission to address the House for 1 minute.)

Mr. SHADEGG. Mr. Speaker, last Friday the Nation lost a distinguished public servant. Bob Stump humbly and admirably served his country and represented Arizona for nearly 60 years.

His service began as a Navy medic during World War II and continued in Arizona in the State legislature and then here in the United States House of Representatives. From his Stetson hat down to his dusty leather boots, Bob personified the independence and western congeniality of Arizona. The soft-spoken conservative was true to his beliefs and always represented his constituents with integrity and determination.

Like so many courageous young men of his time, Bob enlisted in the Navy at the age of 16, too young to legally do so, in the midst of the second world war. He was elected to Congress in 1976 and, drawing on his military experience, Bob established himself as the preeminent champion for active military personnel and veterans.

His insight and knowledge on issues landed him the chairmanship of the House Committee on Veterans' Affairs in 1995, and then in 2000, the chairmanship of the House Committee on Armed Services. Even still, he never let the power go to his head. He was one of the few Congressman, indeed probably the only committee chairman, to personally answer his office telephone.

I looked to Bob Stump on so many issues. His advise was always thoughtful, solid, and consistent. He was the dean of our delegation, and I will sorely miss his leadership and friendship.

Mr. Speaker, for more than 25 years, he served this body with dignity and earned the admiration of not only myself, but of every Member of this House. He possessed the unwavering reliability and good judgment not commonly found in the politics of today.

Bob remains with us in spirit as a model of devoted service to Arizona and the Nation. He is and always will be missed.

HOUSE TO SPEND $400 BILLION FOR FLAWED PRESCRIPTION DRUG PLAN

(Mr. DEFAZIO asked and was given permission to address the House for 1 minute.)

Mr. DEFAZIO. Mr. Speaker, how can you spend $400 billion and not provide a decent Medicare prescription drug benefit? Well, it is an excellent question, but the Republicans have come up with a formula.

First, you underwrite the profits of the private insurance industry. Yes, there will be subsidies to the private insurance industry in this bill, trying to drive people out of Medicare; and you do that because they lost a bunch of money on crummy investments, and we have to help out their bottom line. Well, we can understand that; they are big campaign contributors.

Secondly, how else? Well, overall, number one, do nothing about the extortion it costs to prescription drugs in the United States. Do not allow the imports or the reimportation of American-manufactured drugs. Do not allow the people on Medicare to be organized into a group to drive down the price of these prescription drugs. No. Because actually, the pharmaceutical industry are bigger campaign contributors to the Republicans than the insurance industry. So we are going to spend $400 billion to provide a benefit nobody understands that is going to be pretty parsimonious.

We could do better. We could take on the pharmaceutical industry, and we can forget about giving a subsidy to the private insurance industry; and for $400 billion, we could provide a meaningful prescription drug benefit that seniors would enjoy and it would help with their health. But that is not where the majority is going in this House of Representatives.

PRESCRIPTION DRUG PLAN BURDENS FUTURE GENERATIONS

(Mr. SMITH of Michigan asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Michigan. Mr. Speaker, adding prescription drugs to Medicare is one of the most unfair burdens that Congress and the President have placed on future generations in a long, long time.

I have 10 grandkids and now, for a Medicare program that is already broke, insolvent Congress is adding benefits. We are reaching into the general fund to pay for Medicare. Medicare and Social Security are going to be insolvent within the next 10 to 14 years.

Yet we are adding a new prescription drug burden to Medicare, moving into socialized medicine, and making my kids and 10 grandkids and everybody else's responsible to pay for seniors' drug prescriptions.

Actually, today's retiring seniors are probably the most wealthy and better off than any generation of Americans. Yet we are placing a burden on our kids, and young workers who are trying to save money to send their kids to college. We are placing a huge burden on my grandkids to pay off the debt. We are actually borrowing the money, Mr. Speaker, to pay for this huge expansion in socialized medicine.

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PRESCRIPTION DRUG COVERAGE FOR SENIORS IN NEED

(Mr. KINGSTON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KINGSTON. Mr. Speaker, it is time to revise and reform Medicare. It is time to move us away from a government oriented, a Soviet model of socialism approach to health care for our senior citizens. We need a program that is light, a program that is solid, a program that is efficient, not one that is heavy with burdensome bureaucratic red tape.

We need to have a prescription drug benefit. We need to have one that does not just blanket us all with a brand new entitlement, one that does not necessarily worry about Ross Perots or some retiree from General Motors who already is getting it anyhow. But we need to help the widow out there who is choosing between tamoxifen for her breast cancer and rent for her home.

We want to help people stay independent. In 1965, when Medicare was conceived, the miracle drugs that are available to our seniors were not out there. They were not foreseen. Now we have drugs that enhance our life-style, that make us live longer and healthier and in less pain, and Medicare needs to adjust to this. That is what this bill is about that we will be voting on this week.

I am confident that we can take the best ideas of Democrat Party, the Republican Party, the Independents and move it out of this body, combine it with those in the other body and come up with a plan that is best for our seniors.

REMEMBERING ROBERT LEE STUMP

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Mr. Speaker, I rise today to pay tribute to Robert Lee Stump, former Congressman from Arizona and past chairman of the House Committee on Armed Services and Committee on Veterans' Affairs who died on Friday.

First elected to Congress as a Democrat, he became a Republican after Ronald Reagan assumed the presidency in 1981. It was truly an honor to serve as a member by me on the Committee on Armed Services under Chairman Stump's leadership. He was a man dedicated to the protection of the American people and peace in the world through a powerful military.

Bob Stump knew the only way to keep our forces strong was to take care of the soldier and his family both during service and retirement. He served in the Navy during World War II as a combat medic on Luzon, Iwo Jima, and Okinawa.

America has lost a great man and a true patriot, one of the finest statesman Arizona has ever produced. In conclusion, God bless our troops.

SENSIBLE MEDICARE REFORMS

(Mr. PENCE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PENCE. Mr. Speaker, as Congress this week considers the largest expansion of Medicare in 35 years, we should begin with the understanding that Medicare has actually cost the American taxpayers 7½ times in real dollars what it was projected to cost. And while the needs for some prescription drug for some seniors is very, very real, it is important also to recall that 76 percent of seniors in America today have prescription drug coverage.

I would offer that our reforms this week should be about focusing solutions at the point of the need. Let us help our seniors near the poverty level with urgent and sufficient prescription drug coverage. Let us reform Medicare so it will be there for the future without placing an undue burden on our children and grandchildren. Let us otherwise do no harm to the private sector foundation of the greatest health care system in the history of the world.

For all these reasons I will oppose a universal drug benefit in Medicare. By agreeing to a prescription drug benefit for all seniors rather than just those in need, Congress threatens our Nation's fiscal stability, our own private prescription plans, and the survival of our free market health care system.

One more massive Federal entitlement is, simply put, a prescription for disaster.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. PETRI). Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or yeas or nays are ordered, or on which the voted is objected to under clause 6 of rule XX.

Record votes on postponed questions will be taken later today.

SMALL BUSINESS ADVOCACY IMPROVEMENT ACT OF 2003

Mr. MANZULLO. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1772) to improve small business advocacy, and for other purposes, as amended.

The Clerk read as follows:

H. R. 1772

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Small Business Advocacy Improvement Act of 2003".

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) Excessive regulations continue to burden the Nation's small businesses.

(2) Federal agencies continue to propose regulations that impose disproportionate burdens on small businesses.

(3) An independent office of small business advocacy will help to ensure that Federal agencies are responsive to small businesses and that those agencies comply with their statutory obligations with respect to small businesses.

(4) The independence of an office that acts as an advocate for small businesses is essential to ensure that it can serve as an effective advocate without being restricted by the views or policies of the Small Business Administration or any other Federal executive branch agency.

(5) To be effective an office that acts as an advocate for small businesses needs sufficient resources to conduct creditable economic studies and research which are necessary for the maintenance of small business databases and for the accurate assessment of the impact of regulations on small businesses, the role of small business in the Nation's economy, and the barriers to the growth of small businesses.

(6) The research, information, and expertise provided by an independent office of small business advocacy will be a valuable source of information and advice for Congress and Federal agencies with which the office will work on behalf of small businesses.

(b) PURPOSES.—The purposes of this Act are—

(1) to ensure that there exists an entity that has the statutory independence and adequate financial resources to effectively advocate for and on behalf of small business;

(2) to require that such an entity report to the Chairmen and Ranking Members of the Committee on Small Business of the House of Representatives and the Committee on Small Business and Entrepreneurship of the Senate, and to the Administrator of the Small Business Administration in order to keep them fully and currently informed about issues and regulations affecting small business concerns and the necessity for corrective action by the regulatory agency or Congress;

(3) to provide a separate authorization for appropriations for such an entity; and

(4) to strengthen the role of the Small Business and Agriculture Regulatory Enforcement Ombudsman by ensuring continued cooperation between the Ombudsman and the Office of Advocacy of the Small Business Administration.

SEC. 3. APPOINTMENT OF CHIEF COUNSEL OF ADVOCACY.

(a) IN GENERAL.—Section 201 of Public Law 94–305 (15 U.S.C. 634a) is amended—

(1) by inserting "(a)" before "There is established";

(2) by striking the second sentence; and

(3) by adding at the end the following:

"(b) The management of the Office shall be vested in a Chief Counsel for Advocacy who shall be appointed from civilian life by the President, by and with the advice and consent of the Senate, and who should be appointed without regard to political affiliation and on the basis of fitness to perform the duties of the office.

"(c) No individual may be appointed under subsection (b) if such individual has served as an officer or employee of the Small Business Administration during the 5-year period preceding the date of such individual's appointment.

"(d) An individual serving as Chief Counsel on the date of the expiration of any term of the President may not continue to serve as Chief Counsel for more than 1 year after such date unless such individual is reappointed after such date by the President, by and with the advice and consent of the Senate. The preceding sentence shall not apply in the case of the expiration of a term of an individual holding the office of President if such individual is elected to the office of President for a term successive to such term.".

(b) INCUMBENT CHIEF COUNSEL FOR ADVOCACY.—The individual serving as the Chief Counsel for Advocacy of the Small Business Administration on the date of the enactment of this Act shall continue to serve in that position after such date in accordance with section 201 of Public Law 94–305 (15 U.S.C. 634a), as amended by this section.

SEC. 4. PRIMARY FUNCTIONS OF OFFICE OF ADVOCACY.

Section 202 of Public Law 94–305 (15 U.S.C. 634b) is amended—

(1) in paragraph (6) by striking "to minority enterprises" and inserting "to small business concerns owned and controlled by socially and economically disadvantaged individuals, to small business concerns owned and controlled by women, and to small business concerns owned and controlled by veterans";

(2) in paragraph (7) by striking "minority enterprises" and inserting "small business concerns owned and controlled by socially and economically disadvantaged individuals, small business concerns owned and controlled by women, and small business concerns owned and controlled by veterans";

(3) in paragraph (8) by striking "minority and other small business enterprises" and inserting "small business concerns owned and controlled by socially and economically disadvantaged individuals, small business concerns owned and controlled by women, small business concerns owned and controlled by veterans, and other small businesses";

(4) in paragraph (9) by striking "complete" and inserting "compete";

(5) by striking paragraph (11);

(6) by redesignating paragraph (12) as paragraph (11);

(7) in paragraph (11) (as so redesignated)—

(A) by striking "serviced-disabled" and inserting "service-disabled"; and

(B) by striking the period at the end and inserting "; and"; and

(8) by adding at the end the following:

"(12) make such recommendations and submit such reports as the Chief Counsel determines appropriate to the President, to the Chairmen and Ranking Members of the Committee on Small Business of the House of Representatives and the Committee on Small Business and Entrepreneurship of the Senate, and to the Administrator of the Small Business Administration, with respect to issues and regulations affecting small businesses and the necessity for corrective action by any Federal agency or by Congress.".

SEC. 5. ADDITIONAL FUNCTIONS.

(a) In General.—Section 203 of Public Law 94–305 (15 U.S.C. 634c) is amended—

(1) by inserting "(a)" before "The Office of Advocacy shall also perform"; and

(2) in subsection (a) (as so designated)—

(A) in paragraph (4) by striking "and" at the end;

(B) in paragraph (5) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

"(6) maintain economic databases and make the information contained therein available to the Administrator of the Small Business Administration and to Congress;

"(7) carry out the responsibilities of the Chief Counsel under chapter 6 of title 5, United States Code; and

"(8) maintain a memorandum of understanding with the Small Business and Agriculture Regulatory Enforcement Ombudsman regarding methods and procedures for cooperation between the Ombudsman and the Office of Advocacy and transmit a copy of such memorandum to the Committee on Small Business of the House of Representatives and the Committee on Small Business and Entrepreneurship of the Senate.".

(b) Appropriation Request.—Section 203 of Public Law 94–305 (15 U.S.C. 634c) is further amended by adding at the end the following:

"(b)(1) For each fiscal year, the Chief Counsel shall transmit the Office of Advocacy's appropriation estimate and request to the Office of Management and Budget, the Committee on Small Business of the House of Representatives, the Committee on Small Business and Entrepreneurship of the Senate, and the Committees on Appropriations of the House of Representatives and the Senate.

"(2) Each budget of the United States Government submitted by the President shall include a separate statement of the amount of appropriations requested for the Office of Advocacy.

"(3) Each such budget shall also include a statement indicating whether the proportion of the funds requested for the Office of Advocacy when compared to the funds requested for the Small Business Administration has increased, decreased, or stayed the same relative to the proportion of the amount appropriated for the Office of Advocacy for the previous fiscal year when compared to the amount appropriated for the Small Business Administration for the previous fiscal year.".

SEC. 6. PRINCIPAL DEPUTY CHIEF COUNSEL AND REGIONAL ADVOCATES.

Section 204 of Public Law 94–305 (15 U.S.C. 634d) is amended—

(1) by inserting "(a)" before "In carrying out"; and

(2) by adding at the end the following:

"(b)(1) The Chief Counsel may appoint 1 individual to serve as Principal Deputy Chief Counsel.

"(2) The Principal Deputy Chief Counsel shall be paid at an annual rate not less than the minimum rate, nor more than the maximum rate, for the Senior Executive Service under chapter 53 of title 5, United States Code.

"(3) An individual appointed to a position under this subsection shall not be counted toward the limitation contained in subsection (a)(1) regarding the number of individuals who may be compensated at a rate in excess of the lowest rate for GS–15 of the General Schedule.

"(c) The Chief Counsel may appoint regional advocates within each Standard Federal Region as appropriate. Such regional advocates shall—

"(1) assist in examining the role of small business in the economy of the United States by identifying academic and other research institutions that focus on small business concerns and linking these research resources to research activities conducted by the Office of Advocacy;

"(2) assist in representing the views and interests of small business concerns before Federal agencies whose policies and activities may affect small business;

"(3) assist the functioning of regional small business fairness boards in coordination with the Small Business and Agriculture Regulatory Enforcement Ombudsman;

"(4) assist in enlisting the cooperation and assistance of public and private agencies, businesses, and other organizations in disseminating information about the programs and services provided by the Federal Government that are of benefit to small business concerns and the means by which small business concerns can participate in or make use of such programs and services; and

"(5) carry out such duties pursuant to the mission of the Office of Advocacy as the Chief Counsel may assign.".

SEC. 7. OVERHEAD AND ADMINISTRATIVE SUPPORT.

Section 205 of Public Law 94–305 (15 U.S.C. 634e) is amended by inserting before "Each department" the following:

"(a) The Administrator of the Small Business Administration shall provide the Office of Advocacy with appropriate and adequate office space at central and field office locations of the Administration, together with such equipment, office supplies, communications facilities, and personnel and maintenance services as may be necessary for the operation of such offices.

"(b)".

SEC. 8. REPORTS.

Section 206 of Public Law 94–305 (15 U.S.C. 634f) is amended by striking "The Chief Counsel may" and all that follows through "on his activities." and inserting the following:

"(a) Not less than annually, the Chief Counsel shall submit to the President, the Committee on Small Business of the House of Representatives, the Committee on Small Business and Entrepreneurship of the Senate, the Committee on Government Affairs of the Senate, the Committee on Government Reform of the House of Representatives, and the Committees on the Judiciary of the Senate and the House of Representatives, and the Administrator of the Small Business Administration a report on agency compliance with chapter 6 of title 5, United States Code.

"(b) In addition to the reports required by this title, the Chief Counsel may prepare and publish such other reports as the Chief Counsel determines appropriate.

"(c)".

SEC. 9. AUTHORIZATION OF APPROPRIATIONS.

Section 207 of Public Law 94–305 (15 U.S.C. 634g) is amended by striking "not to exceed $1,000,000" and inserting "$10,000,000 for fiscal years 2003 and 2004, $12,000,000 for fiscal year 2005, and $14,000,000 for fiscal year 2006".

SEC. 10. CONFORMING AMENDMENTS.

(a) Rural Tourism Training Program.—Section 311 of the Small Business Administration Reauthorization and Amendments Act of 1990 (15 U.S.C. 653 note; 104 Stat. 2832) is amended by striking "Chief Counsel for Advocacy" and inserting "Administrator".

(b) Small Business and Agriculture Regulatory Enforcement Ombudsman.—Section 30(b)(2) of the Small Business Act (15 U.S.C. 657(b)(2)) is amended—

(1) in subparagraph (D), by striking "and" at the end;

(2) in subparagraph (E), by striking the period and inserting "; and"; and

(3) by adding at the end the following:

"(F) maintain a memorandum of understanding with the Office of Advocacy regarding methods and procedures for cooperation between the Ombudsman and the Office of Advocacy.".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Illinois (Mr. MANZULLO) and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) each will control 20 minutes.

The Chair recognizes the gentleman from Illinois (Mr. MANZULLO).

GENERAL LEAVE

Mr. MANZULLO. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 1772.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. MANZULLO. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Office of Advocacy of the Small Business Administration is unique within the executive branch. The main role of the Chief Counsel for Advocacy is to ensure that proposed regulations and policies do not unduly burden small businesses even if it means opposing part of the President's agenda. In the past, this independence has been put to the test.

The purpose of this legislation is to protect the Office of Advocacy from threats of funding cuts in order to enhance its independence. H.R. 1772 is nearly identical to legislation this House passed unanimously on May 21, 2002. In fact, H.R. 1772 is essentially a conference report agreed to with the other body last year, but unfortunately there was not enough time on the Senate floor to get this passed. The only differences between H.R. 1772 and the advocacy bill from last year is that there would be only one instead of two principal deputies at the Office of Advocacy and the rank of Chief Counsel is not elevated one level. However, the heart of this bill creating a separate budgetary line item for the Office of Advocacy is the same as last year.

To ensure that there are no games played with the Chief Counsel's budget, Congress will also get a sneak peek at the initial budget request he submits to the Office of Management and Budget before it becomes part of the President's official budget request. A separate budgetary line item is the top legislative priority for Tom Sullivan, the current Chief Counsel for the Office of Advocacy, and I am pleased to assist him in strengthening this office in moving this legislation.

I want to commend two of our subcommittee chairmen, the gentleman from Missouri (Mr. AKIN) and the gentleman from Virginia (Mr. SCHROCK) for championing this legislation on focus and other important priorities.

H.R. 1772 is one part of the overall solution to help reinvigorate our struggling small manufacturers battle unsound government regulations.

Mr. Speaker, I reserve the balance of my time.

Mrs. CHRISTENSEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Office of Advocacy serves a critical role to our Nation's entrepreneurs. It is a lone voice in the executive branch making sure that our Federal agencies take a step back and consider the needs of small businesses.

By raising awareness, Advocacy ensures that our Federal government accomplishes its intended goals without unfairly burdening small businesses. Too often the needs of small businesses are forgotten in Washington and the demands of corporate America come first.

Small businesses simply do not have the resources to keep up with the complex and burdensome Federal policies that take a one-size-fits-all approach. The need for a voice for small businesses in the Federal Government is why Congress created the Office of Advocacy. Congress made sure that Advocacy could produce reports and submit views without review by OMB, the only entity within the administration that can do this.

This allows the Chief Counsel to review legislation and regulations and truly call them as he sees them. However, too often the important work of Advocacy is compromised. The unique role of Advocacy has made it a target of entities such as the Small Business Administration and the Office of Management and Budget. Over the years the Chief Counsel has had to weather the stormy relationship with these two entities as they have attempted to limit the voice of Advocacy through budget shortfalls and other measures.

Mr. Speaker, for Advocacy to be effective, it must be truly independent to carry out its duties. The Chief Counsel must be able to critique an administration's agencies without concerns that the one holding the purse can silence them.

I wish to commend the gentleman from Missouri (Mr. AKIN) and the gentleman from Virginia (Mr. SCHROCK) for their efforts in taking this difficult issue on. It is an arduous task to balance the right combination of fiscal autonomy and flexibility necessary for Advocacy to do its job effectively.

H.R. 1774 gives Advocacy a separate line item so that it is no longer subject to a SBA Administrator who designates the Chief Counsel's fund as his personal slush fund. While this is a noble attempt to address the challenges facing Advocacy, H.R. 1774 falls short. While creating a line item may limit some of the Small Business Administrator's ability to control funding, the bill creates new problems and might actually increase the ways that SBA and OMB can influence the Office of Advocacy. The proposal is going to increase the scrutiny and profile of Advocacy but offers no protections from these problems.

Under H.R. 1774, an SBA Administrator will continue to have tools to exert pressure on a Chief Counsel. Because Advocacy will remain housed in the Small Business Administration and will rely on the resources of the Administrator, SBA will have control over the operations of the Chief Counsel. Nothing in this legislation prevents the SBA from charging for such services or prevents it from offering subpar services.

This legislation also exposes Advocacy to a greater threat from OMB. In the budget process, there will be no barriers for OMB to cut funding to a Chief Counsel that is viewed as being overly critical. Under H.R. 1772, Advocacy's budget will stand on its own, thus simplifying OMB's ability to underfund its budget.

One cannot underestimate the incentives of the Office of Management and Budget to limit the voice of Advocacy. I ask, how can Advocacy be independent if one day the Chief Counsel is criticizing a President's prescription drug plan, for example, and the next day he has to request funding from the body charged with carrying out the President's agenda?

An unintended consequence of this legislation is also the negative impact that Advocacy could have on other Small Business programs. If Congress is looking to restore dollars to an underfunded Advocacy, its first target for offsets could be critical SBA programs. We must make sure that the Chief Counsel will have a fully staffed office and know that such funding is not coming at the expense of other Small Business Administration programs.

H.R. 1772 should be viewed as a starting point. As this proposal works its way through the legislative process, proper safeguards must be in place if we are to approve the final version. H.R. 1772 in its current form does not address all of the issues surrounding the independence problem. In some ways, it exposes the Chief Counsel to even greater influence. However, because of the importance of an independent Advocacy we must get this legislation moving.

I wish to thank the gentleman from Missouri (Mr. AKIN) for getting this process going and look forward to working with him and our other colleagues to make sure that we can create a more independent Office of Advocacy. As an engine behind this Nation's economy, our small businesses deserve it.

Mr. Speaker, I reserve the balance of my time.

Mr. MANZULLO. Mr. Speaker, I yield 5 minutes to the distinguished gentleman from Missouri (Mr. AKIN), the chairman of the Subcommittee on Workforce, Empowerment and Government Programs.

Mr. AKIN. Mr. Speaker, I thank the gentleman from Illinois (Mr. MANZULLO) for allowing me to take up the Advocacy improvement bill, H.R. 1772. I would also like to thank my friend, the gentleman from Virginia (Mr. SCHROCK), for working with me on this important piece of legislation.

The Office of Advocacy is essential to the elimination of federally imposed regulations that just do not make sense. It is a government entity that exemplifies public service at its best and it is devoted to ensuring that small businesses are not encumbered by regulatory burdens that cost time and money and energy but achieve little, if anything.

The Office of Advocacy sometimes faces opposition from Federal regulatory entities that dislike having their regulations modified or questioned, and yet the office has been tireless and a key voice for small businessmen and women confronting these large agencies to prevent them from imposing unnecessary rules and regulations on small businesses and family owned companies.

The legislation before us today will give more power to the SBA's Office of Advocacy to do its vital work. H.R. 1772 will, among other things, give the Office of Advocacy its own source of funding through a line item in the Federal budget, thus giving the office a more permanent and autonomous role that makes it less susceptible to budgetary bullying from some of the folks in the executive branch that might have been offended.

Many colleagues of mine from both sides of the aisle frequently hear praises from constituents on the exemplary job of the Office of Advocacy. H.R. 1772 will ensure that that office is empowered and protected and given the tools that it needs to continue doing such a commendable job. As we strengthen the Office of Advocacy, the small business owners and entrepreneurs throughout the country will be better served. The real concerns of small business owners will be heard more clearly and addressed more readily as soon as this bill is signed into law.

Mr. Speaker, I thank the chairman for his leadership on this important issue.

Mrs. CHRISTENSEN. Mr. Speaker, I have no speaker at this time. I reserve the balance of my time.

□ 1030

Mr. MANZULLO. Mr. Speaker, I yield 5 minutes to the distinguished gentleman from Virginia (Mr. SCHROCK), the chairman of the Subcommittee on Regulatory Reform and Oversight.

Mr. SCHROCK. Mr. Speaker, I thank the gentleman from Illinois for yielding me the time.

Mr. Speaker, I rise in strong support of H.R. 1772, the Small Business Advisory Improvement Act.

The gentleman from Missouri (Mr. AKIN) and I cosponsored this legislation to strengthen an important office that supports our Nation's small businesses.

I want to start by reading a few statistics: $843 billion, that is a B, that is the annual cost of regulations to Americans; $6,975, that is the average cost per employee of regulations to small businesses; 8.2 billion hours, billion with a B, this is the annual time taken away from family and productive work to comply with Federal paperwork requirements.

I hope that everyone recognizes what a great drain on the creative resources of our entrepreneurs this burden has become. All that money and all those hours are spent on doing things that have nothing to do with creating jobs or making a better life for that citizen and his or her family. What a great waste of our natural resources.

I want to share with my colleagues another statistic: $21 billion, that is with a B, $21 billion, that is the amount of money the SBA's Office of Advocacy helped save the small businesses of this Nation last year. We should do all we can to support an office that acts as independent advocate for small business within the Federal Government, especially when this office also saves taxpayers time and money.

This savings is created by the good men and women of SBA's Office of Advocacy who work tirelessly to monitor the regulators in the other agencies of the Federal Government. They inject sensitivity to the needs and concerns of small business in every rule-making that will impact them, and they train their regulators in how to better comply with laws that Congress has put on the books, like the Regulatory Flexibility Act and the Small Business Regulatory Enforcement Fairness Act.

I know that without the Office of Advocacy and their good work, small businesses would be filling out more forms that have nothing to do with their business, paying more to comply with Federal regulations and requirements, and spending less times with their families.

I have only been the chairman of the Subcommittee on Regulatory Reform and Oversight for a short time, but in that short time I have heard from a great many small business industries. They all believe that the Office of Advocacy is doing a tremendous job in helping to save small businesses money and save them from unnecessary regulatory burdens.

From the home builders to the florists, from microbusinesses to small manufacturers, they all seem to agree that the Office of Advocacy is a necessary safeguard for small businesses; and they strongly support making the office more independent.

Unfortunately, there have been times in the Office of Advocacy's history when its independence was threatened. Since its views are completely independent of the administration which it serves, it is often at odds with that administration. One example would be the previous administration's ergonomic rules, rules that would have caused small businesses endless amounts of money. That rule-making put the Office of Advocacy squarely in opposition to a rule that was being proposed by another agency and one that the residents of the last White House supported.

It is for circumstances like that that the office must have some degree of budgetary independence from the Small Business Administration to be able to remain independent.

Additional concepts in the bill like continued cooperation with the Office of National Ombudsman and greater oversight of agency compliance with regulatory flexibility statutes are more reasons to support H.R. 1772.

Mr. Speaker, I urge my colleagues to protect the private sector of our economy from unnecessary governmental burdens by passing this bill.

Mrs. CHRISTENSEN. Mr. Speaker, I yield myself the balance of my time.

No one disputes the accomplishments and the importance of the Office of Advocacy. Just as the role of small business is more critical during an economic downturn, so is the need for an independent Office of Advocacy. To achieve the goal of independence, it needs a delicate balancing act.

As a voice of small business, the chief counsel is often in a difficult situation because his office is a part of the same Federal Government it has been charged with monitoring, and many of these bodies within the Federal Government have incentives to limit the chief counsel's effectiveness.

In our efforts to increase independence, we need to make sure that an SBA administrator can no longer meddle in the affairs of the Office of Advocacy. The chief counsel should be able to perform his or her role without having to look over their shoulder.

Legislation must strengthen the ability of advocates to speak out against all agencies, including the Office of Management and Budget. OMB must not be able to hold funding over the head of the chief counsel as a threat to fall in line with an administration.

Finally, in our efforts to solve this problem, we must not create new ones. We do not want a situation where we are robbing Peter to pay Paul. Advocacy funding must not come at the expense of Small Business Administration programs designed to help our Nation's small businesses. To do so would be a step backward for this Nation's small business.

I am confident that because of the bipartisan nature of this debate it will allow us to fashion a solution that gives advocacy the necessary freedom to operate. Today we have started that process, and I look forward to working with our colleagues to increase the voice of small business.

Mr. Speaker, I yield back the balance of my time.

Mr. MANZULLO. Mr. Speaker, I yield myself such time as I may consume.

This is a good bill. It advances the cause of an independent Office of Advocacy. It enhances the budget. It makes the administration, whether Republican or Democratic, more responsive to the person who occupies the Office of Advocacy; and I would urge my colleagues for a "yes" vote.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. PETRI). The question is on the motion offered by the gentleman from Illinois (Mr. MANZULLO) that the House suspend the rules and pass the bill, H.R. 1772, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

PREMIER CERTIFIED LENDERS PROGRAM IMPROVEMENT ACT OF 2003

Mr. MANZULLO. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 923) to amend the Small Business Investment Act of 1958 to allow certain premier certified lenders to elect to maintain an alternative loss reserve, as amended.

The Clerk read as follows:

H.R. 923

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Premier Certified Lenders Program Improvement Act of 2003".

SEC. 2. LOSS RESERVES OF PREMIER CERTIFIED LENDERS TEMPORARILY DETERMINED ON THE BASIS OF OUTSTANDING BALANCE OF DEBENTURES.

Paragraph (6) of section 508(c) of the Small Business Investment Act of 1958 (15 U.S.C. 697e(c)) is amended—

(1) by striking "The Administration" and inserting the following:

"(A) IN GENERAL.—The Administration"; and

(2) by adding at the end the following new subparagraph:

"(B) TEMPORARY REDUCTION BASED ON OUTSTANDING BALANCE.—Notwithstanding subparagraph (A), during the 2-year period beginning on the date that is 90 days after the date of the enactment of this subparagraph, the Administration shall allow the certified development company to withdraw from the loss reserve such amounts as are in excess of 1 percent of the aggregate outstanding balances of debentures to which such loss reserve relates. The preceding sentence shall not apply with respect to any debenture before 100 percent of the contribution described in paragraph (4) with respect to such debenture has been made.".

SEC. 3. ALTERNATIVE LOSS RESERVE PILOT PROGRAM FOR CERTAIN PREMIER CERTIFIED LENDERS.

(a) IN GENERAL.—Subsection (c) of section 508 of the Small Business Investment Act of 1958 (15 U.S.C. 697e) is amended by adding at the end the following new paragraphs:

"(7) ALTERNATIVE LOSS RESERVE.—

"(A) ELECTION.—With respect to any eligible calendar quarter, any qualified high loss reserve PCL may elect to have the requirements of this paragraph apply in lieu of the requirements of paragraphs (2) and (4) for such quarter.

"(B) CONTRIBUTIONS.—

"(i) ORDINARY RULES INAPPLICABLE.—Except as provided under clause (ii) and paragraph (5), a qualified high loss reserve PCL that makes the election described in subparagraph (A) with respect to a calendar quarter shall not be required to make contributions to its loss reserve during such quarter.

"(ii) BASED ON LOSS.—A qualified high loss reserve PCL that makes the election described in subparagraph (A) with respect to any calendar quarter shall, before the last day of such quarter, make such contributions to its loss reserve as are necessary to ensure that the amount of the loss reserve of the PCL is—

"(I) not less than $100,000; and

"(II) sufficient, as determined by a qualified independent auditor, for the PCL to meet its obligations to protect the Federal Government from risk of loss.

"(iii) CERTIFICATION.—Before the end of any calendar quarter for which an election is in effect under subparagraph (A), the head of the PCL shall submit to the Administrator a certification that the loss reserve of the PCL is sufficient to meet such PCL's obligation to protect the Federal Government from risk of loss. Such certification shall be in such form and submitted in such manner as the Administrator may require and shall be signed by the head of such PCL and the auditor making the determination under clause (ii)(II).

"(C) DISBURSEMENTS.—

"(i) ORDINARY RULE INAPPLICABLE.—Paragraph (6) shall not apply with respect to any qualified high loss reserve PCL for any calendar quarter for which an election is in effect under subparagraph (A).

"(ii) EXCESS FUNDS.—At the end of each calendar quarter for which an election is in effect under subparagraph (A), the Administration shall allow the qualified high loss reserve PCL to withdraw from its loss reserve the excess of—

"(I) the amount of the loss reserve, over

"(II) the greater of $100,000 or the amount which is determined under subparagraph (B)(ii) to be sufficient to meet the PCL's obligation to protect the Federal Government from risk of loss.

"(D) RECONTRIBUTION.—If the requirements of this paragraph apply to a qualified high loss reserve PCL for any calendar quarter and cease to apply to such PCL for any subsequent calendar quarter, such PCL shall make a contribution to its loss reserve in such amount as the Administrator may determine provided that such amount does not exceed the amount which would result in the total amount in the loss reserve being equal to the amount which would have been in such loss reserve had this paragraph never applied to such PCL. The Administrator may require that such payment be made as a single payment or as a series of payments.

"(E) RISK MANAGEMENT.—If a qualified high loss reserve PCL fails to meet the requirement of subparagraph (F)(iii) during any period for which an election is in effect under subparagraph (A) and such failure continues for 180 days, the requirements of paragraphs (2), (4), and (6) shall apply to such PCL as of the end of such 180-day period and such PCL shall make the contribution to its loss reserve described in subparagraph (D). The Administrator may waive the requirements of this subparagraph.

"(F) QUALIFIED HIGH LOSS RESERVE PCL.—The term 'qualified high loss reserve PCL' means, with respect to any calendar year, any premier certified lender designated by the Administrator as a qualified high loss reserve PCL for such year. The Administrator shall not designate a company under the preceding sentence unless the Administrator determines that—

"(i) the amount of the loss reserve of the company is not less than $100,000;

"(ii) the company has established and is utilizing an appropriate and effective process for analyzing the risk of loss associated with its portfolio of PCLP loans and for grading each PCLP loan made by the company on the basis of the risk of loss associated with such loan; and

"(iii) the company meets or exceeds 4 or more of the specified risk management benchmarks as of the most recent assessment by the Administration or the Administration has issued a waiver with respect to the requirement of this clause.

"(G) SPECIFIED RISK MANAGEMENT BENCHMARKS.—For purposes of this paragraph, the term 'specified risk management benchmarks' means the following rates, as determined by the Administrator:

"(i) Currency rate.

"(ii) Delinquency rate.

"(iii) Default rate.

"(iv) Liquidation rate.

"(v) Loss rate.

"(H) QUALIFIED INDEPENDENT AUDITOR.—For purpose of this paragraph, the term 'qualified independent auditor' means any auditor who—

"(i) is compensated by the qualified high loss reserve PCL;

"(ii) is independent of such PCL; and

"(iii) has been approved by the Administrator during the preceding year.

"(I) PCLP LOAN.—For purposes of this paragraph, the term 'PCLP loan' means any loan guaranteed under this section.

"(J) ELIGIBLE CALENDAR QUARTER.—For purposes of this paragraph, the term 'eligible calendar quarter' means—

"(i) the first calendar quarter that begins after the end of the 90-day period beginning with the date of the enactment of this paragraph; and

"(ii) the 7 succeeding calendar quarters.

"(K) CALENDAR QUARTER.—For purposes of this paragraph, the term 'calendar quarter' means—

"(i) the period which begins on January 1 and ends on March 31 of each year;

"(ii) the period which begins on April 1 and ends on June 30 of each year;

"(iii) the period which begins on July 1 and ends on September 30 of each year; and

"(iv) the period which begins on October 1 and ends on December 31 of each year.

"(L) REGULATIONS.—Not later than 45 days after the date of the enactment of this paragraph, the Administrator shall publish in the Federal Register and transmit to the Congress regulations to carry out this paragraph. Such regulations shall include provisions relating to—

"(i) the approval of auditors under subparagraph (H); and

"(ii) the designation of qualified high loss reserve PCLs under subparagraph (F), including the determination of whether a process for analyzing risk of loss is appropriate and effective for purposes of subparagraph (F)(ii).

"(8) BUREAU OF PCLP OVERSIGHT.—

"(A) ESTABLISHMENT.—There is hereby established in the Small Business Administration a bureau to be known as the Bureau of PCLP Oversight.

"(B) PURPOSE.—The Bureau of PCLP Oversight shall carry out such functions of the Administration under this subsection as the Administrator may designate.

"(C) DEADLINE.—Not later than 90 days after the date of the enactment of this Act—

"(i) the Administrator shall ensure that the Bureau of PCLP Oversight is prepared to carry out any functions designated under subparagraph (B), and

"(ii) the Office of the Inspector General of the Administration shall report to the Congress on the preparedness of the Bureau of PCLP Oversight to carry out such functions.".

(b) INCREASED REIMBURSEMENT FOR LOSSES RELATED TO DEBENTURES ISSUED DURING ELECTION PERIOD.—Subparagraph (C) of section 508(b)(2) of the Small Business Investment Act of 1958 (15 U.S.C. 697e(b)(2)) is amended by inserting "(15 percent in the case of any such loss attributable to a debenture issued by the company during any period for which an election is

in effect under subsection (c)(7) for such company)" before "; and".

(c) CONFORMING AMENDMENTS.—

(1) Subparagraph (D) of section 508(b)(2) of the Small Business Investment Act of 1958 (15 U.S.C. 697e(b)(2)) is amended by striking "subsection (c)(2)" and inserting "subsection (c)".

(2) Paragraph (5) of section 508(c) of the Small Business Investment Act of 1958 (15 U.S.C. 697e(c)) is amended by striking "10 percent".

(d) STUDY AND REPORT.—

(1) IN GENERAL.—The Administrator shall enter into a contract with a Federal agency experienced in community development lending and financial regulation or with a member of the Federal Financial Institutions Examinations Council to study and prepare a report regarding—

(A) the extent to which statutory requirements have caused overcapitalization in the loss reserves maintained by certified development companies participating in the Premier Certified Lenders Program established under section 508 of the Small Business Investment Act of 1958 (15 U.S.C. 697e); and

(B) alternatives for establishing and maintaining loss reserves that are sufficient to protect the Federal Government from the risk of loss associated with loans guaranteed under such Program.

(2) TRANSMISSION OF REPORT.—The report described in paragraph (1) shall be transmitted to the Committee on Small Business of the House of Representatives and the Committee on Small Business and Entrepreneurship of the Senate not later than 90 days after the date of the enactment of this Act.

(3) LIMITATION.—The amount of the contract described in paragraph (1) shall not exceed $75,000.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Illinois (Mr. MANZULLO) and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) each will control 20 minutes.

The Chair recognizes the gentleman from Illinois (Mr. MANZULLO).

GENERAL LEAVE

Mr. MANZULLO. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on this legislation.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. MANZULLO. Mr. Speaker, I yield myself such time as I may consume.

The SBA's 504 Certified Development Company program provides small businesses with long-term, fixed-rate financing for the purchase of fixed assets such as land, buildings and equipment for business expansion purposes. The loans are made by CDCs, usually nonprofit corporations organized to contribute to the economic development of a particular community or region. The entire 504 program runs totally on user fees charged to small business borrowers. It does not receive an annual appropriation.

SBA has a Premier Certified Lender program that gives discretion to certain qualified CDCs to approve 504 loans subject to the borrower being eligible and the available loan authority. In return for this lower regulatory oversight, these premier CDCs must set aside more money in order to cover potentially bad loans than regular CDCs. Some premier CDCs believe that this amount of reserve is well beyond what is prudently required.

My good friend and colleague, the gentleman from California (Mr. DOOLITTLE), introduced H.R. 923 for the purpose of allowing premier CDCs to take a cue from the private sector by using a risk-based management approach to calculate the loan loss reserve requirements. I agree with this approach subject to certain conditions to protect the taxpayer and to ensure that no unintended consequences result from this change in policy such as higher loan fees. Our staffs have met to develop an acceptable compromise which unanimously passed the committee last month. I am pleased to present it to my colleagues before the full House today.

This bipartisan compromise creates a 2-year pilot program that permits qualified premier CDCs to use a risk-based approach to calculate their loan loss reserve requirements. In order to ensure that premier CDCs' loan loss reserves are sufficient to protect the taxpayer, the compromise establishes a Bureau of PCLP oversight within the Office of Lender Oversight at SBA. For those premier CDCs not in the new pilot program, they can withdraw from their loss such amounts that are in excess of 1 percent of their total outstanding loan balances. Finally, this compromise provides for a study to evaluate alternative loan loss reserve approaches.

H.R. 923 is about providing more liquidity and capital into the hands of small businesses without any additional cost to the taxpayer. I urge my colleagues to support H.R. 923.

Mr. Speaker, I reserve the balance of my time.

Mrs. CHRISTENSEN. Mr. Speaker, I yield myself such time as I might consume.

Mr. Speaker, today I rise in strong support of H.R. 923. This legislation is among the first steps that Congress will take this year to ensure that the Small Business Administration continues to serve the needs of our country's small businesses. I would like to thank the gentleman from California (Mr. DOOLITTLE) for bringing this important bill to the Committee on Small Business's attention.

This legislation will allow certified development companies to make more loans to small businesses while safeguarding the interests of our taxpayers. This is good for the government and good for small business, the driver of this Nation's economy.

Even though access to capital is access to opportunity for small businesses, many find it difficult to get funding, especially given the current lending environment. The SBA's lending program addresses this by providing a vital stream of funding to small businesses. Last year, these programs supplied $21 billion in capital, accounting for 40 percent of all long-term small business lending to this country's entrepreneurs.

Among SBA's loan programs, the 504 program provides the best value to taxpayers because it is completely self-funded. While the 504 program requires no funding, it contributes substantially to the economic growth of our communities. Given the weak state of our economy, the 504 program is especially important now because it promotes investment where we need it most, in the small business sector.

Yet capital remained elusive to many small businesses because the SBA, in many cases, took too long to make these loans and the process was too complicated. Since the SBA processing time for 504 applications can frequently approach 30 days, borrowers and lenders were deterred from participating.

In response to this, Congress created the Premier Certified Lender program. Through this public-private partnership, certified development companies are permitted to process their 504 loans without SBA approval. In exchange for this autonomy, SBA requires the certified development companies to assume responsibility for some of the losses associated with the loans they make.

While the Premier Certified Lender program addresses one problem, it created another by requiring the certified development companies to hold loan loss reserves in excess of amounts necessary to protect the government. These excess funds could serve a much better purpose, like being used to make loans for small business, the number one job creator in the United States, instead of sitting in a ledger helping no one at all.

To address these issues, today we are creating a pilot program that will permit the certified development companies to maintain loan loss reserves sufficient to protect the government and to draw out those amounts that are held in excess of such purposes. In order to oversee this new program, we are creating a new bureau within SBA.

By creating a system that frees up these funds, certified development companies will then be able to make more loans to small businesses, which is exactly what this Nation needs in a time of such economic uncertainty. Economic recovery is only within reach if small businesses are able to start up and grow, and this is impossible without capital.

H.R. 923 takes the important first steps to modernize the 504 program and, in doing so, increases small businesses' ability to secure much-needed capital.

Mr. Speaker, I urge the adoption of this legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. MANZULLO. Mr. Speaker, I yield 5 minutes to the gentleman from California (Mr. DOOLITTLE), my good friend and colleague, the author of the bill.

Mr. DOOLITTLE. Mr. Speaker, I thank the gentleman from Illinois (Mr. MANZULLO) and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) for their remarks. I very much appreciate the support that they have given me on this bill and the cooperation that we have had from their staffs. I would like to acknowledge the gentlewoman from New York (Ms. VELÁZQUEZ), the ranking member, as well.

Indeed, the explanation for what this bill does has been clearly articulated by both our previous speakers and so I will choose not to repeat that, Mr. Speaker; but I have a statement which I will submit for the RECORD.

□ 1045

I feel that this bill, as was explained by our previous speakers, will actually do something to help stimulate the economy. The Premier Certified Lenders Program is an excellent program. It has been unnecessarily tied down by the problem with the requirements about the loan loss reserves. This bill, as was explained, creates a risk-based approach to loan loss reserves with sufficient safeguards and monitoring to make sure that everything is going along as we would wish it to.

In the process, however, a tremendous amount of funds will be freed up that will be used to make loans to small businesses, and as we know, as this process unfolds, that will result in the employment of more people and the generation of more capital and will trigger, indeed, the very process that we need to have happen in order to make this a more vibrant and stronger economy.

Mr. Speaker, I rise today in support of H.R. 923, the Premier Certified Lenders Program Improvement Act, legislation I introduced in February.

Over the past few years, I have had an opportunity to learn of the outstanding work that certified development companies are doing across the county and in my district, in particular. CDCs participating in the Premier Certified Lenders Program are providing thousands of loans to small businesses and helping these businesses to create jobs and wealth.

As my colleagues know, small businesses are the economic backbone of our Nation. Nearly one in four American households are either starting a business, presently owning a a business, or investing in someone else's business. Our economy depends on entrepreneurs whose spirit result in the creation of both new businesses and new jobs.

I think the best policy our government can pursue to help small businesses in this country is to get out of their way. Unshackle the American spirit from high taxes and burdensome regulations, Mr. Speaker, and we shall witness tremendous job creation and economic growth. If the government seeks to help small businesses, it should remove regulatory hurdles and provide incentives for entrepreneurs.

One successful example of government encouragement of small business expansion is the Premier Certified Lenders Program PCLP. This program was established in 1997 and allows a participating Certified Development Company, CDC, the expanded authority to review and approve SBA 504 Loan requests and to foreclose, litigate, and liquidate SBA 504 Loans made under the Program. By taking on this authority, the private sector is able to stretch limited Federal resources in order to help more small businesses.

Unfortunately, current law requires premier certified lenders to deposit and maintain 1 percent of each debenture issued in a loan loss reserve fund, from which they are to reimburse the Small Business Administration, SBA, for 10 percent of any loss. Premier certified lenders must maintain that deposit throughout the life of the loan, even as the loan matures, the debenture is paid down, and the risk is reduced.

This requirement has resulted in the accumulation of unnecessarily high loan loss reserve funds for some premier lenders. In addition, it has deterred additional premier certified lenders from participating in the program at all.

Mr. Speaker, my bill simply allows these premier lenders the option of creating risk-based loan loss reserves. It includes several safeguards to ensure that these companies do not make bad loans and put Federal taxpayers at risk. Specifically, premier certified lenders must maintain no less than $100,000 in their loan loss reserve funds; they must employ 3rd-party auditors to review their reserve funds on a quarterly basis; their auditors must be approved by the SBA; and the PCL must meet SBA performance benchmarks to retain their eligibility to hold risk-based loan loss reserve funds.

Mr. Speaker, I want to sincerely thank Mr. MANZULLO, my friend and the Chairman of the Small Business Committee, for working with me to get the bill to this point. I also want to thank the Ranking Member, Ms. VELÁZQUEZ for her valuable input, and Mrs. CHRISTENSEN for representing Ms. VELÁZQUEZ on the floor today. Finally, I want to express my gratitude to the Chairman's and Ranking Member's staff, as well as my staff, for putting in so much time and energy into this effort.

I encourage my colleagues to support our Nation's small businesses by supporting this important legislation.

Mr. Speaker, I very much appreciate the bipartisan cooperation we have had on this, and I urge the passage of the bill.

Mrs. CHRISTENSEN. Mr. Speaker, I yield such time as he may consume to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Speaker, let me first of all thank the gentlewoman from the Virgin Islands for yielding me this time. I also want to commend the chairman, the gentleman from Illinois (Mr. MANZULLO), and the ranking member, the gentlewoman from New York (Ms. VELÁZQUEZ), for bringing this legislation to the floor and getting us to this point.

When we talk about small businesses and we talk about the development of small business, one of the primary problems that people face is finding enough money to actually get a business off the ground, keep it going, keep it moving, have enough capital to actually carry the business on until they reach the point where they have the kind of cash flow and they have the kind of returns that they know they need in order to be stable and keep being successful. This PCLP Improvement Act helps to do all of that. It helps to make capital available and it gives people assistance to acquire what they actually need.

While it is true, Mr. Speaker, that some of the best things in life are free, I remember the song that says "But you can give it to the birds and bees, what I need is money." And what small businesses need is capital to help them grow, develop and flourish. This legislation helps to do that.

Again I commend Chairman MANZULLO, my colleague from Illinois, and the ranking member for bringing this to the floor.

Mr. MANZULLO. Mr. Speaker, I reserve the balance of my time.

Mrs. CHRISTENSEN. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker; small businesses today face many barriers to achieving their success. Today's legislation helps address one of the most significant barriers faced by small businesses: Access to capital. The bill before us today will make more capital available to small businesses, spurring economic development in our Nation's communities.

While today's legislation fixes a problem with the 504 program, it is only a stopgap measure. Even after we pass this legislation, small businesses will still have to endure SBA's inconsistent and bureaucratic 504 loan processing procedures. As such, today's legislation is the first of several near-term steps to centralize, streamline, and modernize the 504 program so that it is better able to meet the needs of our small businesses. First among these steps is this year's SBA reauthorization, in which we will address many of these deficiencies in order to help our country's small businesses access capital more readily.

Mr. Speaker, I would like to take this moment to thank Adam Minehardt, a Democratic staff member of the Committee on Small Business, and Greg Orlando, a staff member for the gentleman from California (Mr. DOOLITTLE), for their work on this important legislation. I also wish to thank the gentleman from California

(Mr. DOOLITTLE) once again for bringing it to the committee, and our chairman and ranking member for their leadership on this bill and all the others we have worked on this year. This bill is truly a bipartisan product and the work reflects that spirit.

Mr. Speaker, I again urge the adoption of this legislation.

Ms. MILLENDER-McDONALD. Mr. Speaker, I rise today to offer my support for H.R. 923, the Premier Certified Lenders Program Act of 2003.

Mr. Speaker, small business owners all over this nation have long been faced with a number of hurdles that limit their ability to be successful. Health care costs have risen at an astronomical rate, Federal regulations are being issued that establish competitive advantages for large firms, and, perhaps most importantly, access to capital is extremely limited.

In an attempt to address concerns about small business financing issues, 3 years ago Congress established the Premier Certified Lenders Program (PCLP) as a permanent Small Business Administration program.

The PCLP delegates substantial authority and autonomy to selected Certified Development Companies (CDCs) participating in the Small Business Administration's 504 Loan Program to offer long-term, fixed-rate financing for major fixed assets such as land and buildings.

My district is home to a CDC, the Long Beach Area Certified Development Corporation, and it serves the Cities of Long Beach, Signal Hill and Southern Los Angeles County. Ms. Regina Grant Peterson does an excellent job in reaching out to my constituents, doing all she can to promote economic development in the community.

Currently, because of antiquated laws, CDCs participating in the PCLP must keep financial reserves in excess of what is actually necessary to safeguard against potential losses, and are not allowed to withdraw from these reserves until loans are paid in full.

This severely limits the lending potential of these entities, costing small businesses nationwide millions of dollars in unused capital.

H.R. 923 addresses this issue by allowing participating lenders to withdraw from their loan loss reserves attributable to the payment of principal on outstanding loans.

In addition, the legislation would also create a Bureau of Lender Oversight within SBA that will oversee the calculation of loan loss reserves, thereby insuring that government monies are used appropriately.

Mr. Speaker, as a Ranking Member of the Small Business Committee, I enthusiastically support this measure, and I support its swift passage.

Mrs. CHRISTENSEN. Mr. Speaker, I yield back the balance of my time.

Mr. MANZULLO. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. PETRI). The question is on the motion offered by the gentleman from Illinois (Mr. MANZULLO) that the House suspend the rules and pass the bill, H.R. 923, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. MANZULLO. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

HOMELAND SECURITY TECHNICAL CORRECTIONS ACT OF 2003

Mr. COX. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1416) to make technical corrections to the Homeland Security Act of 2002, as amended.

The Clerk read as follows:

H.R. 1416

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Homeland Security Technical Corrections Act of 2003".

SEC. 2. TECHNICAL CORRECTIONS RELATING TO CRITICAL INFRASTRUCTURE INFORMATION.

Section 212(3) of the Homeland Security Act of 2002 (Public Law 107-296; 6 U.S.C. 131(3)) is amended by striking "systems—" and inserting "systems insofar as such information pertains to—".

SEC. 3. VISA ISSUANCE.

Section 428(a) of the Homeland Security Act of 2002 (Public Law 107-296; 6 U.S.C. 236(a)) is amended—

(1) by striking "subsection," and inserting "section,"; and

(2) by striking "office" and inserting "officer".

SEC. 4. RESPONSIBILITIES OF UNDER SECRETARY FOR EMERGENCY PREPAREDNESS AND RESPONSE.

Section 502 of the Homeland Security Act of 2002 (Public Law 107-296; 6 U.S.C. 312) is amended by striking "shall include—" and inserting "shall be responsible for—".

SEC. 5. MILITARY ACTIVITIES OF THE COAST GUARD.

Section 876 of the Homeland Security Act of 2002 (Public Law 107-296; 6 U.S.C. 456) is amended to read as follows:

"SEC. 876. MILITARY ACTIVITIES.

"Nothing in this Act confers on the Secretary any authority over warfighting, the military defense of the United States, or other military activities that are authorized to be directed by the Secretary of Defense. This Act shall not be construed to limit the existing authority of the Secretary of Defense over warfighting, the military defense of the United States, or other military activities, including such activities of the Coast Guard when it is operating as a service in the Navy under section 3 of title 14, United States Code.".

SEC. 6. ANNUAL INDEPENDENT EVALUATION OF INFORMATION SECURITY PROGRAM AND PRACTICES OF AGENCIES.

Section 3535(b)(1) of title 44, United States Code, is amended by inserting "or any other law" after "the Inspector General Act of 1978".

SEC. 7. IMMIGRATION-RELATED POWERS AND DUTIES OF THE SECRETARY AND THE ATTORNEY GENERAL.

(a) IN GENERAL.—Section 1102 of the Homeland Security Act of 2002 (Public Law 107-296; 116 Stat. 2273) is amended—

(1) in the matter preceding paragraph (1), by striking "as amended by this Act, is further amended by—" and inserting "is amended—";

(2) by amending paragraph (1) to read as follows:

"(1) by amending the section heading to read as follows:

"'POWERS AND DUTIES OF THE SECRETARY OF HOMELAND SECURITY AND THE ATTORNEY GENERAL'";

(3) by amending paragraph (2)(D) to read as follows:

"(D) by redesignating the paragraph (8) added by section 372(3) of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, and the paragraph (9) added by section 373 of such Act, as paragraphs (10) and (11), respectively; and"; and

(4) in the matter added by paragraph (3)—

(A) by striking "the Immigration Reform, Accountability and Security Enhancement Act of 2002." and inserting "the Homeland Security Act of 2002."; and

(B) by striking "this section" and inserting "this subsection".

(b) CONFORMING AMENDMENTS TO IMMIGRATION AND NATIONALITY ACT.—

(1) SECTION 103.—Section 103 of the Immigration and Nationality Act (8 U.S.C. 1103) is amended—

(A) in subsection (a)—

(i) in paragraph (2)—

(I) by striking "He" and inserting "The Secretary of Homeland Security"; and

(II) by striking "of the Service." and inserting "of the Department of Homeland Security relating to the powers, functions, and duties conferred upon the Secretary by this Act and all other laws relating to the immigration and naturalization of aliens.";

(ii) in paragraph (3)—

(I) by striking "He" and inserting "The Secretary of Homeland Security";

(II) by striking "he deems" and inserting "the Secretary deems"; and

(III) by striking "his authority" and inserting "the Secretary's authority";

(iii) in paragraph (4)—

(I) by striking "He" and inserting "Except as otherwise provided by law, the Secretary of Homeland Security";

(II) by striking "the Service or the Department of Justice" and inserting "the Department of Homeland Security"; and

(III) by striking "employee of the Service." and inserting "employee of the Department.";

(iv) in paragraph (5)—

(I) by striking "He" and inserting "Except as otherwise provided by law, the Secretary of Homeland Security";

(II) by striking "in his discretion," and inserting "in the Secretary's discretion,"; and

(III) by striking "such number of employees of the Service as to him shall appear necessary and proper." and inserting "such number of employees of the Department of Homeland Security as shall appear necessary and proper to the Secretary.";

(v) in paragraph (6)—

(I) by striking "He" and inserting "The Secretary of Homeland Security"; and

(II) by striking "of the Service." and inserting "of the Department of Homeland Security.";

(vi) in paragraph (7)—

(I) by striking "He" and inserting "The Secretary of Homeland Security";

(II) by striking "of the Service" each place such term appears and inserting "of the Department of Homeland Security";

(III) by striking "he may," and inserting "the Secretary of Homeland Security may,"; and

(IV) by striking "in his judgment" and inserting "in the Secretary's judgment";

(vii) in paragraph (8), by striking "Attorney General" and inserting "Secretary of Homeland Security";

(viii) in paragraph (10) (as redesignated by section 1102 of the Homeland Security Act of 2002)—

(I) by striking "Attorney General" each place such term appears and inserting "Secretary of Homeland Security"; and

(II) by striking "of the Service." and inserting "of the Department."; and

(ix) in paragraph (11) (as so redesignated)—

(I) by striking "Attorney General" and inserting "Secretary of Homeland Security"; and

(II) by striking "by the Service" each place such term appears and inserting "by the Department";

(B) in subsection (b), by striking "Attorney General" each place such term appears and inserting "Secretary of Homeland Security";

(C) by amending subsection (c) to read as follows:

"(c) The Secretary of Homeland Security may enter into cooperative agreements with State and local law enforcement agencies for the purpose of assisting in the enforcement of the immigration laws.";

(D) in subsection (d), by striking "The Commissioner," and inserting "The Secretary of Homeland Security,";

(E) in subsection (e)—

(i) by striking "The Commissioner" and inserting "The Secretary of Homeland Security"; and

(ii) by striking "district office of the Service" and inserting "field office of the Department of Homeland Security"; and

(F) in subsection (f)—

(i) by striking "Attorney General" and inserting "Secretary of Homeland Security";

(ii) by striking "of the Immigration and Naturalization Service" and inserting "of the Directorate of Border and Transportation Security of the Department of Homeland Security"; and

(iii) by striking "the functions of the Service," and inserting "the functions of the Directorate,".

(2) SECTION 287(g).—Section 287(g) of the Immigration and Nationality Act (8 U.S.C. 1357(g)) is amended by striking "Attorney General" each place such term appears and inserting "Secretary of Homeland Security".

(c) CLERICAL AMENDMENTS.—

(1) HOMELAND SECURITY ACT.—The table of contents in section 1(b) of the Homeland Security Act of 2002 (Public Law 107-296; 116 Stat. 2135) is amended by inserting after the item relating to section 1103 the following:

"Sec. 1104. Effective date.".

(2) IMMIGRATION AND NATIONALITY ACT.—The table of contents of the Immigration and Nationality Act is amended by amending the item relating to section 103 to read as follows:

"Sec. 103. Powers and duties of the Secretary of Homeland Security and the Attorney General.".

(d) CONSTRUCTION.—The amendments made by this section shall not be construed to repeal, or limit the applicability of, section 456, 462(e), 1512(d), or 1517 of the Homeland Security Act of 2002, or any other similar provision pertaining to the treatment of references in law, with respect to any provision of law that is not amended by this section.

SEC. 8. EFFECTIVE DATE OF MODIFICATIONS TO REORGANIZATION PLAN.

Section 1502(d) of the Homeland Security Act of 2002 (Public Law 107-296; 6 U.S.C. 542(d)) is amended by striking "subsection (d)" each place it appears and inserting "subsection (c)".

SEC. 9. REPORT ON WAR RISK INSURANCE FOR AIR CARRIERS.

Section 1204 of the Homeland Security Act of 2002 (116 Stat. 2287) is amended—

(1) by redesignating subparagraphs (A) through (C) as paragraphs (1) through (3), respectively, and by moving the text of such paragraphs 2 ems to the left;

(2) in the matter preceding paragraph (1) (as so redesignated) by striking "Secretary" and inserting "Secretary of Transportation"; and

(3) in paragraph (3) (as so redesignated) by striking "Department" and inserting "Department of Transportation".

SEC. 10. AUTHORITY TO ARM FLIGHT DECK CREW WITH LESS-THAN-LETHAL WEAPONS.

Section 1405(a) of the Homeland Security Act of 2002 (116 Stat. 2307) is amended by striking "section 6 of this Act" and inserting "section 1406 of this Act".

SEC. 11. REQUIREMENT TO SUBMIT REPORTS AND NOTIFICATIONS TO SELECT COMMITTEE.

(a) REQUIREMENT.—The Homeland Security Act of 2002 (Public Law 107-296) is amended by inserting after section 4 the following:

"SEC. 5. REQUIREMENT TO SUBMIT REPORTS AND NOTIFICATIONS TO SELECT COMMITTEE ON HOMELAND SECURITY.

"In any case in which a report or notification is required by this Act or an amendment made by this Act to be submitted to the Congress or to a Committee of the Congress, such report shall also be submitted to the Select Committee on Homeland Security of the House of Representatives.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1(b) of the Homeland Security Act of 2002 (Public Law 107-296) is amended by inserting after the item relating to section 4 the following:

"Sec. 5. Requirement to submit reports and notifications to Select Committee on Homeland Security.".

SEC. 12. CLARIFICATION OF REPORTING REQUIREMENT CONCERNING ELECTRONIC COMMUNICATIONS PRIVACY ACT EMERGENCY DISCLOSURE EXCEPTION.

Section 225(d)(2) of the Homeland Security Act of 2002 (Public Law 107-296; 116 Stat. 2157) is amended by striking "2702(b) of title 18, United States Code," and inserting "2702(b)(7) of title 18, United States Code (as added by paragraph (1)(D)),".

SEC. 13. EFFECTIVE DATE.

The amendments made by this Act shall take effect as if included in the enactment of the Homeland Security Act of 2002 (Public Law 107-296).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. COX) and the gentleman from Texas (Mr. TURNER) each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. COX).

Mr. COX. Mr. Speaker, I yield myself 5 minutes.

Mr. Speaker, I want to thank my friend, the gentleman from Texas (Mr. TURNER), the ranking minority member of the Select Committee on Homeland Security, and the rest of the committee members for devoting their time and energy to the important work of this committee. I rise today in support of H.R. 1416, which amends the Homeland Security Act.

Mr. Speaker, the broad bipartisan support given to this bill exemplifies the collaborative nature of our committee. This committee is united in its mission to provide aggressive oversight of the Department of Homeland Security and to ensure the full implementation of the Homeland Security Act. When President Bush called on Congress to create the Department of Homeland Security last year, the goal was to create a more secure America. By putting one department in charge of scores of agencies and programs, we can better protect our country, we can protect our critical infrastructure, and, most importantly, we can protect the American people.

Congress proved it was up to the challenge. In a display of bipartisan cooperation, in only 5 months Congress delivered to the President's desk for signature the 187-page Homeland Security Act of 2002. This law authorized the most comprehensive reorganization of the Federal executive branch since the creation of the Department of Defense in 1947. The act clearly laid out goals of the Department of Homeland Security: The prevention of another terrorist attack, the protection of our critical national infrastructure, and preparedness in the event we cannot prevent attacks on our domestic territory.

Key to this is our ability to collect, analyze and use timely and accurate intelligence information. This lies at the heart of the primary mission of preventing another terrorist attack. What we do not know empowers our enemies, but what we do know will help defeat them. By properly understanding the threats that confront us, we can better allocate our resources, and we can focus our security efforts where they are most needed, where the risks and potential consequences of attacks are greatest.

The Department of Homeland Security must analyze information quickly and reliably so that it can marshal its own resources as needed and, more importantly, it must also transmit that information to those on the front lines, our State and local law enforcement and first responders, who protect us and our critical infrastructure.

The Homeland Security Committee has been overseeing the Department's early efforts to achieve this critical intelligence capability mandated by the Homeland Security Act and we will continue to do so. This committee and the Department of Homeland Security are also working together to ensure that a comprehensive security plan is in place to make the best use of intelligence. Critical elements of this security plan include a layered defense, effective border security, thorough passenger and baggage screening at America's airports, and a rigorous inspection process to keep would-be terrorists and their weapons out of the country.

Our first responders must also have the best information about pending threats as well as the training and the tools to respond to any disasters if they were to occur. The Homeland Security Act laid out a vision of a more secure America, which is now being realized through the efforts of the Department of Homeland Security working in concert with other Federal agencies, State and local governments, private industry, charitable organizations, community centers, and private citizens. Secretary Ridge and his staff are working diligently to coordinate these efforts and to complete this mission, a mission that is as difficult as it is important. I thank Secretary Ridge for his leadership and for being willing to work very closely with the Homeland Security Committee in the House during the act's implementation.

The legislation we are considering today is in itself an important aspect of the act's implementation. Congress' desire to expedite the creation of this important department meant that minor errors were made and certain details were omitted from the Homeland Security Act. As a result, my fellow Members and I felt that one of the first orders of business of the Homeland Security Committee in the current Congress should be to honor the original intentions of the drafters by making certain corrections to the act so that it can be properly implemented. Today's legislation successfully fills in the cracks created by the speedy construction of the Homeland Security Act and strengthens the legislation which is already helping the United States win the war on terror.

Mr. Speaker, I reserve the balance of my time.

Mr. TURNER of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 1416, the Homeland Security Technical Corrections Act, and I first want to thank the chairman, the gentleman from California (Mr. COX), for his leadership of our new Select Committee on Homeland Security.

The legislation before us is a product of the bipartisan cooperation that we have on that committee. It has been a pleasure to work with the chairman. I know that all of our members who serve on that important select committee feel the same dedication that the chairman and I do to accomplishing the task of protecting America and to do it in a way that moves us forward in a more rapid and stronger way.

The select committee, of course, has been in business for just a few months, and no business is more important than the work of the House Select Committee on Homeland Security. We have quickly discovered that when it comes to doing all we can to protect America, our needs are indeed very great.

Mr. Speaker, we are, as we all know, involved in a great struggle: The war against international terrorism. It is not a war we sought, it is not a war we started, but it is a war that we must and we will finish. Mr. Speaker, we must move faster in some very critical areas. We must do a better job in determining how to meet the threat posed by international terrorism.

The testimony before our committee from some high officials in the Department of Homeland Security revealed to us that there are only 21 analysts matching intelligence on threats with our vulnerabilities and then recommending protective action. This critical area of the Department of Homeland Security, the responsibility which is housed within the Office of Information Analysis, has been the subject of scrutiny by our select committee, and both sides of the aisle have expressed concern about the lack of full functioning of that particular entity, which in many ways is the nerve center of the Department of Homeland Security.

It is perhaps the most important new addition that this Congress provided in the Homeland Security Act of 2002, to place within that department the responsibility for gathering the threat information and matching it against our vulnerabilities, and then using that information to direct the entire activities of the 22 agencies that were merged into that new department, and to further take that information, of matching threat against vulnerability, and providing it to our States and our local entities so that they will know how to protect their communities against the threat of terrorism.

We also learned in our committee, during a hearing on Project BioShield, that this very same Office of Information Analysis has to date only one, only one person dedicated to responding to the bioterrorist threat. Our committee, in a bipartisan hearing, shared our mutual concern for the failure to get that particular activity within that Office of Information Analysis functioning in a way that it must function in order to carry out the purpose and intent of the Project BioShield legislation that we will be considering on this floor in just a few days.

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Mr. Speaker, I believe it is clear that all of us understand that we must move faster to ensure that this critical function of this Department is in place, up and running as soon as possible. It has become very clear that we as a Nation need to make the same commitment to the protection of our homeland as we made to securing victory in Afghanistan and Iraq. This Congress made sure that our 220,000 troops that fought in Operation Iraqi Freedom were supported by the best equipment and training in the world; and the cost of that battle, according to the appropriations made by this body, will approach $65 billion.

Today, to secure America from the threat of terrorism, the Coast Guard has plans to review security for 4,400 port facilities and over 10,000 ships that enter our waters, and yet this Congress has yet to make the commitment to make sure that the funds are there to get the threat assessments done that are required to carry out that important responsibility. We must move faster.

Today we have only one person on guard for every 16 miles on our northern border. The PATRIOT Act called for the tripling of our forces on our northern border to close the gaps on our northern frontier. The resources have not yet been committed to deploy the 1,800 border personnel needed to enhance our security. We must do better, and we must move faster.

Today, we know that half of the firefighters' shifts across our Nation that will be the first called upon to respond to a terrorist attack lack the necessary communications equipment to deploy in the field so as to be able to talk to one another and to the other agencies that would be responding in the event of a terrorist attack. We must do better, and we must move faster.

Mr. Speaker, we have many challenges ahead of us, but I am confident that this legislation is but a first step in moving us forward as a Nation to be sure that we do everything necessary to be sure that every American can know that they will be safe and secure in their communities.

Mr. Speaker, I reserve the balance of my time.

Mr. COX. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. CAMP), the chairman of the Subcommittee on Borders and Infrastructure.

Mr. CAMP. Mr. Speaker, I rise in support of H.R. 1416, the Homeland Security Technical Corrections Act of 2003. This bipartisan bill makes grammatical and technical changes to the Homeland Security Act of 2002.

The Department of Homeland Security, the product of the Homeland Security Act, has existed for a little more than 100 days. The Homeland Security Act brought together a number of Federal agencies with homeland security functions into one collaborative effort, joining resources, information and missions to defend our Nation.

Protecting our Nation from attack requires strengthening our border defenses. We must know who and what is passing through our country. The American people deserve this level of security. Utilizing technology advancements, we can monitor individuals and intelligently screen cargo without delaying legitimate trade and travel. Cross-border commerce is critical to the American economy. Trade with Canada and Mexico, our country's top trading partners, is growing at a rapid pace with almost $1.4 billion crossing the northern border every day; and with more than $250 billion in trade per year with Mexico, our Nation cannot lose sight of the vital importance of the uninterrupted flow of trade as new policies for border security are pursued. Security and commerce are not mutually exclusive goals.

Since the Department of Homeland Security was officially created, coordination between border security agencies has definitely improved. Twenty-four hours a day, American citizens are patrolling our borders, searching cargo, and checking individual travelers. This is not new since September 11, 2001; however, we are now acutely aware of the threat to our Nation and people and have stepped up our response by uniting our security functions. As the new Department continues integrating and organizing, there are certain areas that the Federal Government needs to address.

As chairman of the Subcommittee on Border and Infrastructure of the Select Committee on Homeland Security, I look forward to working with the gentleman from California (Mr. COX) and the Department of Homeland Security to address security along our Nation's borders, over 300 ports of entry, and to better protect our critical infrastructure. As Congress continues to assist the new Department in meeting obligations in the act, I would like to thank the gentleman from California (Mr. COX) for bringing this technical corrections bill to the floor and for his leadership, and reiterate my support for H.R. 1416.

Mr. TURNER of Texas. Mr. Speaker, I yield 5 minutes to the gentlewoman from California (Ms. LORETTA SANCHEZ), who is the ranking member of the Subcommittee on Borders and Critical Infrastructure.

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I rise today to talk about H.R. 1416, the Homeland Security Technical Corrections Act. I would like to commend our chairman, the gentleman from California (Mr. COX), for his leadership and stewardship, and also, of course, the gentleman from Texas (Mr. TURNER) for the stewardship that they have on this new Select Committee on Homeland Security and for their efforts to push this bill and to get it included on the suspension calendar.

H.R. 1416 is a historic bill because it is the first bill that our committee, the Select Committee on Homeland Security, will do. I trust that it is going to be the first of many bills that this committee will work on in a very bipartisan manner as we continue to tackle the many difficult issues surrounding homeland security.

Over the last month, members of our committee worked very diligently to look at the oversight function through a number of informative hearings and briefings. Unfortunately, however, the message is all too often the same: the Department of Homeland Security is not moving fast enough to fill the gaps that exist in so many areas of homeland security.

H.R. 1416 comes to the floor on the heels of a select committee delegation trip and field hearing in Southern California just this past weekend. The hearing focus was on one specific aspect of homeland security, port security. Our ports are one of the most vulnerable threat risks in our Nation, and we need to provide the means and resources for adequate security.

Every year, more than 4 million cargo containers accounting for 35 percent of all the U.S. international trade passes through the ports of Los Angeles and Long Beach. Over the weekend we saw for ourselves just how important this port is to economic and trade commerce issues for the United States and the global economy. And the message that we received from Southern California witnesses involved in port security was familiar to all of us because we had heard it from other witnesses in other areas of homeland security: they are understaffed, they are underequipped, and they are underfunded.

Members of the Coast Guard told us they have not received the funding that they need for basic security upgrades. The United States Customs Inspector Program is understaffed, and employees that are there do not have the equipment that they need to adequately secure and check the containers, and resources needed are just the beginning of the problem that we saw at our ports. We heard from the sheriffs from both Los Angeles and Orange counties who are in desperate need of funding, especially Orange County, because unlike Los Angeles, we are not considered a high threat urban area and because funding of one of our most costly expenditures, personnel costs, simply does not exist at this point. They told us they have not seen any of the money that they were promised to cover personnel and other costs. The funds simply are not getting through the pipeline down to the local level.

In my community, the city of Anaheim where Disneyland is located, our police department spends over $20,000 every day that we go from yellow to orange alert just on our police department. If we go to red alert, it is double that, almost $40,000 additional money every day; and yet we have not helped at the Federal level to get that money down to them. It does not include equipment that they need, supplies, the fire department personnel or personnel at the emergency operations center, and then there are other costs to consider also.

For instance, the Joint Terrorism Task Force that has been set up and is very effective in sharing intelligence and information between FBI and CIA and the local law enforcement agencies, the State of California, they want to participate in that and they do, but at their own costs. The city of Anaheim, at its own cost; the city of Santa Ana, at their own cost; the County of Orange, at their own cost.

Our first responders do not have the necessary resources to allow them to dedicate a few of their personnel to these effective anti-terrorism programs. This is a striking example of good solutions that exist where there are no resources to adequately implement them. The Department of Homeland Security has done a decent job in outlining what its mission is. However, we need to move quickly and forcefully to achieve that mission. The Department has a number of programs in place to improve homeland security. But so far the first responders, the people right at street level, handling information, trying to understand what is happening, trying to stop things from happening, and God forbid having to react to what happens, they have not seen the information they need nor the resources they need; and I hope that this is not just the first piece of legislation that our committee does, but that we continue our oversight function and our program function to get this done.

Mr. COX. Mr. Speaker, I yield 3 minutes to the gentlewoman from Washington (Ms. DUNN), the vice chairman of the Select Committee on Homeland Security.

Ms. DUNN. Mr. Speaker, every morning 180,000 of our fellow citizens go to work with one main thing on their mind, to prepare, to prevent and to respond to a potential terrorist attack in the United States. These people work for one of the 22 agencies that have been brought together under the umbrella of the Department of Homeland Security.

Homeland security has new meaning since September 11. We can no longer assume that we will be protected from terrorist acts. We now live in a world where we must prepare for possible attacks. For this reason, I was proud to support the President's request for the creation of a Department of Homeland Security that is solely focused, with a very laser-like focus, on the prevention and protection from terrorist attacks in this country.

Since its inception on January 24, 2003, the Department of Homeland Security has made significant strides in protecting the country from terrorist attacks. Let me give a few examples. In March 2003, the Department opened its door and then it launched Operation Liberty Shield, the first comprehensive national plan to increase protections of American citizens and national infrastructure. Homeland security funding has increased over 1,000 percent from fiscal year 2001 to fiscal year 2004, and this has allowed States and localities to purchase new technologies and tools for first responders.

Recently the Department ran TOPOFF II, a simulated exercise in Seattle and Chicago using large-scale weapons of mass destruction. Exercises like this are very important to provide first responders the experience needed to know when the decisions are going to be made, who is going to make these decisions, and how to handle our resources.

While the Department of Homeland Security has had great success over the last 5 months, there are still many issues to be resolved. The House of Representatives took the appropriate steps at the beginning of the 108th Congress in establishing a Select Committee on Homeland Security to help Secretary Ridge in guiding and overseeing the newly created Department. As with all Federal agencies, it is very important to hold this large Department accountable to the people we represent. The Select Committee on Homeland Security will act as the people's voice to focus attention toward our security. It will listen to the first responders, it will find a better way to get the millions of dollars that have already been allocated and should have been already received by first responders, such as $45 million in grants allocated to the State of California, but not received by their first responders. We need to help solve this problem.

It will be a focal point between Congress and the administration to coordinate the necessary resources to best defend our Nation. I look forward to continuing to work with the gentleman from California (Mr. COX) and other members of our committee to develop legislation and provide oversight that will aid the Department of Homeland Security in their mission to prepare, prevent, and respond to a terrorist attack to protect our constituents all over the country.

Mr. TURNER of Texas. Mr. Speaker, I yield 5 minutes to the gentleman from New Jersey (Mr. ANDREWS), a member of the Select Committee on Homeland Security.

□ 1115

Mr. ANDREWS. Mr. Speaker, I thank my friend from Texas for yielding me this time. I would like to congratulate and thank the gentleman from California (Mr. COX) and the gentleman from Texas (Mr. TURNER) for their leadership in bringing the first of what I hope is a series of bipartisan bills to the floor that will improve our country's homeland security. There is much work to be done. In each area that comprises homeland security, the work of this committee thus far has uncovered significant weaknesses and deficiencies that our country must resolve.

Homeland security first is the matter of knowing who is outside the fence of our home who is trying to do us harm, and that principally is a matter of diplomacy and intelligence. I frankly was dismayed to hear in recent weeks the testimony about the chaotic and dysfunctional relationship between the Department of Homeland Security and the various intelligence agencies. You cannot stop someone from attacking America if you do not know that they are trying to do it. This is an urgent problem that needs our attention.

The second aspect of homeland security is building the highest and strongest wall that we can build around our country. There is significant progress that has been made here. I especially commend the gentleman from Texas (Mr. THORNBERRY), chairman of the Subcommittee on Cybersecurity, and the gentlewoman from California (Ms. LOFGREN), who I think have very correctly focused on the risk to the country in the cybersecurity area.

But there are many more areas that need to be pursued. I would echo what the gentlewoman from California (Ms. LORETTA SANCHEZ) said a few minutes ago. The front line soldiers in making that wall as high and strong as possible are America's first responders, our police, our fire, our emergency services personnel. Later today, the House will consider a homeland security appropriations bill that does more for those first responders than has ever been done before in the history of the Federal Government. It is not nearly enough. It is not happening nearly soon enough. I know there will be some discussion under the appropriations bill about the wisdom of trading off over $2 trillion worth of tax cuts for more urgent and necessary help for these first responders. I think we should have chosen to help the first responders, and I think that is an area of debate that should be explored as the committee goes forward.

The third area of homeland security is the question of chain of command and allocation of responsibility when we have a terrorist attack that is imminent or ongoing. There is chaos and dysfunction in this area as well. Because everyone is in charge of an ongoing attack, no one is in charge of defending against an ongoing attack. The Select Committee on Homeland Security, working together with the Committee on Armed Services and other relevant committees, needs to think about who would be in charge in America this morning if, God forbid, our President received word that a terrorist attack was happening right now, who reports to whom, who is in charge of whom, and who is responsible for what. This is an area that is unexplored and dysfunctional at the present time.

Finally, homeland security is a matter of response. It is a matter of the immediate aftermath of an attack. One of the most impressive things about September 11 was how the first responders and other responders reacted to the tragedies in New York and in Virginia and Pennsylvania, because in many ways they were making it up as they went along. They did not have the contingency plans, they did not have the equipment, they did not have the training. They did a heroic and spectacular job. One of the least impressive things about our country's preparations in homeland security is how still relatively unprepared we are for that immediate aftermath. Questions about taxing the public health system, questions about evacuation plans, questions of coordination and joint services agreements among municipalities, counties and States still need to be worked out.

This is a bipartisan mission of national urgency. I am encouraged that the committee has worked together on this technical corrections bill. I fully support it. But if this is all we do and if this is as far as we go, then the deficiencies that I pointed out this morning will come back to haunt us. That benefits no one; that jeopardizes everyone. I hope that we will work together in the months and years to come to strengthen ourselves so we never again live another nightmare like this country did on the 11th of September, 2001.

Mr. TURNER of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. DICKS).

Mr. DICKS. Mr. Speaker, I thank the gentleman from Texas for yielding me this time. I want to commend the chairman and Mr. TURNER for the work that has gone on on this particular legislation; and I want to rise, too, to raise my concerns about this whole homeland security effort. I have had several meetings with Tim Lowenberg, the head of the National Guard in Washington State and Governor Locke's coordinator for homeland security. We have discussed on two or three occasions our mutual concerns about the resources getting back to those first responders in the State of Washington. In fact, I have contacted my fire department and police department in Tacoma and in Bremerton, the two biggest cities in my district. I have convened a meeting of the officials, and very little of the money that Congress has authorized and appropriated has actually gotten back to those first responders. I think this is something we have got to get straightened out. The Congress has to get this straightened out. I also have been out to

Northern Command. I regret that I could not be with the chairman on their recent trip twice now to talk to General Eberhart about the role that the military of the United States is going to play.

As strange as it may seem, for many, many years we did not have a CINC that was in charge of protecting the United States. We took it for granted that somehow we were secure from an attack. That is one thing that 9–11 certainly did change. We now recognize the vulnerability of our country and the vulnerability of our infrastructure. I agree with the comments that I have heard here this morning. We need to continue to do more. We have got to get the private sector to protect its critical assets. We have got to work with them to make certain that they are doing it. The chemical industries, our nuclear reactors, our energy plants, the transmission lines for our power grids and facilities, all of these things have to have a plan for protection. The States have to have, I believe, an individual plan for their protection. So there is a lot of work that has to be done. I want to make the same plea.

I worked with the gentleman from California (Mr. COX) on a select committee on transfer of technology to China. I have great confidence in his leadership and in his willingness to take on a tough issue. But we have to have the courage in this body, this institution, to tell the administration when they are doing a good job, but also tell them when they are not doing enough. I worry that when you have the Council on Foreign Relations and the Brookings Institution taking independent looks at what has happened in the last 2 years since 9–11 and the conclusion is that not much has really changed, then we in this body have a responsibility to make certain that the job, in fact, is getting done. Let us continue to work on a bipartisan basis, but let us make sure the job is getting done.

Mr. COX. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. THORNBERRY), the chairman of the select committee's Subcommittee on Cybersecurity, Science, and Research and Development.

Mr. THORNBERRY. Mr. Speaker, I appreciate the chairman yielding me this time, and I rise in support of this technical corrections bill. I also want to acknowledge that there is a lot of work left to be done. We will not make our country as secure as it needs to be in just a few short weeks, months or possibly even years. It is tempting for us in the Congress to think that if we can just pass a bill or we can spend more money, then we will have solved the problem. That is probably not true with most problems. It is particularly not true here. In fact, I have said that if we spend the whole Federal budget on something called homeland security, we will still not have eliminated the terrorist threat to the United States.

Instead, we have to do it the harder way. We have to really understand the problems, we have to set priorities, and we have to have the sense of urgency that is required coupled with a thoughtfulness that indicates that we are really doing the right thing. There is a tension there that I think a lot of us on both sides of the aisle feel.

In our Subcommittee on Cybersecurity, Science, and Research and Development, we are focusing partly on technologies, so that we can identify technologies that have been developed and encourage them to be fielded quickly so that we can be safer quickly. And then in addition, we can research those areas where technologies have not yet been developed where there is a need. We will focus on the cyber threat. We are having a hearing, for example, this week to try to understand the nature of the threat, also our vulnerabilities and the appropriate role of the Federal Government. We are interested in the information technology of the Department itself, because whether we are focused on the borders or in many other aspects of guarding our homeland, having good information technology, where the databases communicate with each other, that are user friendly but also secure is a key part of the challenge that faces this Department.

Mr. Speaker, to be successful there has to be partnerships involved, partnerships across the aisle, partnerships with the administration, partnerships with the private sector. I look forward to working with all my colleagues to develop those partnerships and to be successful.

Mr. COX. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. SHADEGG), the chairman of the Subcommittee on Emergency Preparedness and Response.

Mr. SHADEGG. Mr. Speaker, I thank the gentleman for yielding me this time. I rise in strong support of H.R. 1416, the Homeland Security Technical Corrections Act. Today's bill represents our committee's first adjustment of the Homeland Security Act. As we have been examining some of the issues pertinent to homeland security, it will be necessary to make other changes to the act in order to provide clearer counsel to the Department as it undertakes its massive new responsibilities. For example, on my Subcommittee on Emergency Preparedness and Response, we have discovered that while the Department's main mission is to prevent terrorist attacks against the United States, the law fails to rest the specific responsibility for preventing such attacks with any one of the four directorates; and therefore it is unclear which of those directorates is in charge of this most critical mission. Other examples of how and where fine tuning of the statute is needed will arise as we do our work, and we will act to improve the law.

Mr. Speaker, the Department of Homeland Security became a reality just in March. It represents the largest reorganization of the Federal Government since World War II. This is truly a herculean task, but the Department has taken some important steps to assist our Nation's readiness for emergencies. $566 million has been made available to the States and the cities from the fiscal year 2003 budget to assist first responders in the form of funding for equipment, training, planning and exercises. $750 million has been made available for firefighter assistance grants from the fiscal year 2003 budget to help rural, urban and suburban fire departments better train, prepare and equip themselves. On April 30, $1.5 billion was made available to States and localities from the fiscal year 2003 supplemental budget to help State and local law enforcement personnel pay for equipment, training and exercises and to offset the costs associated with enhanced security measures deployed during heightened periods of threat. On May 14, $700 million was allocated from the fiscal year 2003 supplemental budget as part of the urban area security initiative for 30 cities and their contiguous counties and mutual aid partners to enhance the security of urban areas with high-density populations.

I rise in strong support of this legislation. I thank the chairman for bringing it forward. I look forward to working to make our Nation more secure.

Mr. COX. Mr. Speaker, I yield 2 minutes to the gentleman from Nevada (Mr. GIBBONS), the chairman of the Subcommittee on Intelligence and Counterterrorism.

Mr. GIBBONS. Mr. Speaker, I thank the gentleman from California for yielding me this time. I rise in support of H.R. 1416, the technical corrections bill for the Homeland Security Act. Mr. Speaker, following the events of September 11, 2001, our Nation began the most significant reorganization of the Federal Government since 1947, all in an effort to better protect America from terrorist attacks. The Department of Homeland Security was founded in an effort to create a centralized authority capable of streamlining and harmonizing our country's domestic security.

One of the clearest lessons learned from the tragic events of September 11 was the need for our intelligence and security agencies to share information and unify their efforts to the most feasible extent possible. Tasked with meeting this challenge is the Department of Homeland Security's directorate of information analysis and infrastructure protection, commonly known as the IAIP. H.R. 1416 will help the directorate achieve the goal of information-sharing.

The Homeland Security Act established the IAIP as a critical component in providing comprehensive threat analysis and management capacity to our Nation and will serve as the primary focal point for intelligence-sharing and analysis related to domestic security.

□ 1130

IAIP will provide vertical as well as the horizontal information flow that will allow our security forces, including our local community first responders, to respond as quickly and effectively as possible in executing their mission. As the Department of Homeland Security moves forward in accomplishing its mandate to make America safer, the Director of Information Analysis and Infrastructure Protection will have to play an integral role in assuring our intelligence agencies share information with each other as well as with the State and local law enforcement agencies and first responders.

I would like to thank Secretary Ridge and his department staff for their assistance and cooperation with our efforts in Congress to assure the Department of Homeland Security accomplishes this dual task of protecting against future terrorist attacks and preparing our Nation for our Nation's emergency response should an attack unfortunately occur. As Secretary Ridge and the Department of Homeland Security continue their work in this unchartered area, I look forward to a continued successful and productive relationship and urge support for H.R. 1416.

Mr. COX. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. LINCOLN DIAZ-BALART), the vice chairman of the Subcommittee on Legislative and Budget Process under the Committee on Rules.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, the Homeland Security Act of 2002 represented a monumental undertaking to reorganize multiple Federal agencies with various jurisdictions. This legislation, as amended by the Select Committee on Homeland Security, is an important step in the committee's oversight of the newly created department. Among other things, the technical corrections in H.R. 1416 further clarify the powers and duties of the Secretary of Homeland Security and the Attorney General.

Further, the gentleman from California's (Chairman COX) mark addressed concerns raised about the original bill's language that would have potentially placed jurisdiction of the Bureau of Citizenship and Immigration Services under the Under Secretary of Border and Transportation. These corrections provide guidance and more accountability by creating a clearer chain of command.

By abolishing the INS and reorganizing its functions, the Homeland Security Act I think made tremendous strides toward achieving a delicate balance between protecting our country from those who might do it harm and those properly seeking admission into the United States.

I look forward to continuing to work through the select committee under the leadership of the gentleman from California (Chairman COX) and also with the gentleman from Texas (Mr. TURNER) and all of our colleagues to continue to strike an important balance that we did in the example mentioned of Immigration and Border Control. Under the leadership of the gentleman from California (Chairman COX), we are taking the first of many steps to ensure that the Department of Homeland Security is appropriately organized to not only help prevent terrorist attacks through heightened security and preparedness but also to respond effectively in times of need.

Our successes, Mr. Speaker, will depend much on the foundation which we have laid in the framework for this new department, and we will continue to work to ensure that we do so as effectively as possible.

Mr. TURNER of Texas. Mr. Speaker, I yield myself such time as I consume.

Let me thank the gentleman from California (Chairman COX) for his leadership on this bill and his continued effort to try to mold our committee into one that will accomplish the goal that we all have of building a secure America. I know that when we look at where we are now there are many deficiencies, and we must recognize that the oversight responsibility of our committee is perhaps the most challenging of any committee in the Congress. The reorganization of 22 agencies molded into one Department of Homeland Security is a landmark change designed to be sure that the focus of those agencies is on protecting America, and so I am pleased that the chairman and I and members of our committee have worked closely together to take on the responsibility of oversight which is so critical, ensuring that we mutually achieve the goal that we have in mind.

We all know that we must set the priorities. The priorities for homeland security can never be set unless the Department of Homeland Security carries out that vital function of determining the threats and matching them against the vulnerabilities, and I am pleased that the chairman has provided the leadership that we need to move forward in that area.

There is much to be done, Mr. Speaker, and we must move faster and we must be stronger than we are today if we are going to ensure a secure America. This legislation is but a small step in that direction, and I am pleased to join with my colleagues in support of H.R. 1416.

Mr. Speaker, I yield back the balance of my time.

Mr. COX. Mr. Speaker, I yield myself the balance of the time.

I want to return the thanks and congratulations to the gentleman from Texas (Mr. TURNER), the ranking member, for his leadership and work on this important legislation.

The bill that we are bringing before the House today represents the extraordinary scope of responsibilities of the Department of Homeland Security. Although this is a technical corrections bill, it amends portions of the Homeland Security Act concerning the breadth of the responsibilities of the department, including critical infrastructure protection, visa issuance, first responders, the military activities of the Coast Guard, information security, training for first responders to enforce border controls within the country, war risk insurance, arming flight deck crew on commercial airliners, and enforcing the Privacy Act. Each of these subjects is touched upon in the bill, H.R. 1416, that is now before us.

This committee is going to continue its aggressive oversight. We are going to continue legislating and improving the Homeland Security Act itself, and we are going to continue authorizing ever more resources, both financial and information, as we fight the war against terrorism.

Between last year and the current appropriations cycle, the Congress has authorized and enacted over $17 billion in funding for homeland security. We have increased funding for first responders over 1,400 percent. Just this year, a few months ago, we added $3.5 billion additional in a supplemental spending bill for first responders, and later today on the floor we will make appropriations for the next year with an additional $4.4 billion for first responders.

Beyond money we need to provide information, as the ranking member and I have both stressed here on the floor, we need to share that intelligence information between the Intelligence Community and law enforcement in Washington, and we need to share between Washington and our State and local law enforcers.

Mr. Speaker, I am confident that we can win the war on terrorism. I know we are in this for the long haul, but the preparations that this Congress is making today will stand this country in good stead for years to come. I urge support for H.R. 1416.

Mrs. CHRISTENSEN. Mr. Speaker, I rise in support of H.R. 1416, the Homeland Security Technical Corrections Act of 2003. This is the first bill from our new but very important Select Committee on Homeland Security and I want to thank our chairman and ranking member for their leadership through the difficult waters of protecting our homeland.

The establishment of the Homeland Security Department on March 1 was only the beginning of an ongoing process in defending our homeland against terrorism, as is this technical corrections bill, which we are debating today.

There are still areas where lines of responsibility need to be clarified and cemented, and certain processes need to be streamlined and made more first responder friendly.

The Homeland Security Act is one which treats the Territories fairly, but there is one issue involving the need to ensure that Indian tribal governments are included amongst the governmental entities that are consulted with respect to activities carried out by the Secretary of the Department of Homeland Security that still needs to be corrected.

I sought unsuccessfully to address this problem during markup of H.R. 1416 in our committee but I expect that it will be resolved successfully when the bill gets over to the other body.

I urge my colleagues to support passage of H.R. 1416.

Mr. LANGEVIN. Mr. Speaker, I rise this morning in support of H.R. 1416. The bill makes various technical corrections to the Homeland Security Act of 2002, which we passed in the wake of the September 11 terrorist attacks to better equip our Nation to prepare for and respond to future disasters, whether natural or man-made.

Since passage of that bill last year, we have come a long way, but there is much work to be done. We now have a Department of Homeland Security, employing close to 200,000 people and assuming the responsibilities of dozens of former Federal agencies. We have sharpened the Nation's focus on the crucial issue of homeland security and given Federal, state, and local officials and first responders the tools to better meet our pressing security needs.

But as the ranking member of the Select Committee on Homeland Security, Mr. TURNER, has said, we must move faster, and we must be stronger. When it comes to protecting our citizens, making progress is simply not enough.

One of the most critical shortcomings facing us is the failure of the Department of Homeland Security's Intelligence Directorate to fulfill its role as the nerve center of the new agency. The intelligence unit was intended to be the very heart of DHS, and its effective operation is indispensable to the success of every other division of the department. This directorate is tasked with collecting and analyzing intelligence information from our nation's intelligence community, and then mapping the perceived threats against our vulnerabilities.

It is this process that should be creating the information on which all of our homeland security decisions are based. Instead, decisions are being made, resources are being allocated and priorities are being set without the benefit of this all-important analysis. Meanwhile, the Intelligence Directorate is woefully unprepared to undertake its responsibilities. We must correct this state of affairs immediately if DHS is ever to operate as intended.

So, Mr. Speaker, while I rise in support of this technical corrections bill, I also want to stress how many more significant issues remain to be addressed. I hope the administration and this Congress will turn their attention to them without delay.

The SPEAKER pro tempore (Mr. PETRI). The question is on the motion offered by the gentleman from California (Mr. COX) that the House suspend the rules and pass the bill, H.R. 1416, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. COX. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

PROVIDING FOR CONSIDERATION OF H.R. 2555, DEPARTMENT OF HOMELAND SECURITY APPROPRIATIONS ACT, 2004

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 293 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 293

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2555) making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations. After general debate the bill shall be considered for amendment under the five-minute rule. Points of order against provisions in the bill for failure to comply with section 501 of House Concurrent Resolution 95 and clause 2 of rule XXI are waived except as follows: sections 514, 521, and 522. During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentleman from Florida (Mr. LINCOLN DIAZ-BALART) is recognized for 1 hour.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the distinguished gentleman from Texas (Mr. FROST), ranking member, pending which I yield myself such time as I may consume. During consideration of this resolution, all time is yielded for the purposes of debate only.

Mr. Speaker, House Resolution 293 is an open rule that provides for the consideration of H.R. 2555, the Fiscal Year 2004 Department of Homeland Security Appropriations Act. The rule provides 1 hour of general debate evenly divided and controlled by the chairman and ranking minority member of the Committee on Appropriations.

As we begin the cycle, the 2004 appropriations cycle, I think it is fitting that the first bill that the House considers will be the Department of Homeland Security Appropriations Act. It has been now approaching 2 years since the Nation was severely hurt by the cowardly attacks of September 11, 2001. Appropriate decisive and necessary steps in our defense and our foreign policy have been evident under the leadership of President Bush through successful efforts to rid Afghanistan of al Qaeda and the oppressive Taliban regime and recently to remove a ruthless dictator from power in Iraq. The United States military has performed and succeeded with extraordinary distinction each and every time that it has been called upon.

Now I look forward to the fair debate that is provided under this rule and the eventual passage of this legislation so that we can continue to act as well on local, State and Federal levels to reinforce the security of the United States of America. Funding from this Congress to protect the homeland in this legislation, the underlying legislation, is $29.4 billion, $1 billion over President Bush's request, and this legislation will provide $4.4 billion to the Office of Domestic Preparedness.

I have seen firsthand the work of Federal dollars when supplemented with State and local funding to make our communities safer. In south Florida the local governments and municipalities have taken extensive steps to secure the safety of airports and seaports, utilities and water supplies, but they certainly need the supplemental funding and grants that this bill makes available. With over 7,500 miles of land border and 361 seaports, the local authorities obviously, Mr. Speaker, will always be the front line of defense. First responders are the key to the effective protection of our communities. The Office of Domestic Preparedness has seen an increase in grants and aid of 1,400 percent since September 11, 2001. Through fiscal year 2004, this Congress has enacted or proposed over $17 billion in funding for local emergency work. Although much of the funding goes through State governments for distribution, of those funds 80 percent must be sent, passed on to the local municipalities by the States within 45 days.

□ 1145

To further ensure the safety of the American people, we have instituted very clear guidelines for grant eligibility. Local and State officials must create a multiyear Homeland Security Plan. This will ensure that Congress is not just throwing money at the problem, but working to find a forum in which State and local governments can find comprehensive, long-term solutions.

The Department of Homeland Security is also working diligently to protect our ports of entry. There is $61.7 million in this bill for the Container Security Initiative known as CSI. It is our belief that security at the ports of the United States should really be the last line of defense, if possible, and not the first.

Through the Container Security Initiative, the Bureau of Customs and Border Protection is working with the world's largest ports to secure and screen cargo before it leaves for the United States. We now require 24-hour advanced notice for manifests of cargo ships heading to the United States. This allows the Department of Homeland Security to see what is on a ship before it gets near the coasts of the United States. Through a sophisticated database screening system and ground personnel working with other countries, the Department of Homeland Security is creating a frontline of defense hundreds, and, in many instances, thousands of miles from the United States.

H.R. 2555 also continues funding for the Transportation Security Administration at over $5 billion, $5.172 billion to be exact, $360 million over the President's request, as we continue to work to ensure that airplane travel is as safe as possible.

Finally, Mr. Speaker, this bill addresses the creation of Project Bioshield. In a speech to the Bio 2003 Convention Center and Exhibition yesterday, President George W. Bush stated, "Project Bioshield will give our scientific leaders greater authority and more flexibility in decisions that may affect our national security. Our labs will be able to hire the right experts, to buy the right equipment, and to speed the construction of the right facilities to accelerate urgently needed discoveries."

Mr. Speaker, I believe that Project Bioshield is truly one of the most important programs created as a direct result of the threats to the homeland of the United States. Similar to the space race during the decade of the 1960s, the Nation faces a time when it must rely on the great innovations of science and research, in this instance, to keep our communities safe. I am confident that this legislation addresses those needs by providing Project Bioshield with nearly $6 billion over the next 10 years.

H.R. 2555, Mr. Speaker, is very important legislation. It is important that we bring it forth today. I am proud to be able to do so. It is essential to the continued commitment by this Congress for the security and safety of all citizens and residents of the United States and, in fact, to the well-being of our homeland. We bring it forth under a fair and open rule. The legislation was reported out of the Committee on Appropriations by a voice vote. I think it is very appropriate to thank, and I do so, the gentleman from Florida (Chairman YOUNG) and the gentleman from Kentucky (Chairman ROGERS) for their leadership on this important issue; and I urge my colleagues to support both the rule and the underlying legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I supported the Department of Homeland Security back when most Republicans still opposed it, and I served on the Select Committee that created the new Department last year, so I expect to vote for this bill to fund the Department on final passage.

But before we get to that point, Members will have the chance to address several serious weaknesses in America's homeland defense system.

First, we need to pass the amendment of the gentleman from Wisconsin (Mr. OBEY), the ranking member of the committee, to increase security at our ports, our airports, and our northern border, and to meet other vital security needs identified by the Bush administration. As it stands, the base bill does not address major holes in homeland defense, and the Obey amendment would plug some of those. And to do it, all we have to do is ask millionaires to take slightly smaller tax breaks than they are already getting next year. It is a reasonable trade: about 200,000 millionaires would give up just $5,000 of the over-$88,000 in tax breaks they are getting next year, and all Americans would get critical homeland security investments.

Unfortunately, the Republican leadership is not willing to ask millionaires to accept an $83,000 tax break next year rather than an $88,000 tax break, so they blocked the Obey amendment.

Fortunately, Mr. Speaker, addressing the second issue does not cost a dime, but it is fundamental to the success of the new Department of Homeland Security. As my colleagues will recall, when the Congress created this powerful new domestic security agency last year, several Members, Republicans as well as Democrats, expressed concern that its powers could be abused and turned against law-abiding American citizens. The former House majority leader, Dick Armey of Texas, was particularly outspoken on this issue.

Unfortunately, we have already seen an example of the danger that concerned Mr. Armey.

And that is why it is absolutely critical that the House act to protect the Department of Homeland Security from ever again being used as the Department of Political Security, as happened just last month.

Mr. Speaker, the Department of Homeland Security became involved in a partisan political dispute last month when it helped Texas Republicans hunt down law-abiding Democratic State legislators. Specifically, the Homeland Security agency charged with tracking terrorists was enlisted to help Texas Republicans trying to track Democratic lawmakers who had stood up to the Republican leadership in Austin. These Democratic legislators violated neither State nor Federal law. They simply used a legal parliamentary tactic, breaking a quorum, in a legislative battle to stop an unprecedented bill to unnecessarily redraw Texas's congressional districts. They employed a legitimate parliamentary tactic that Republicans have used at other times and in other places.

But when Abraham Lincoln broke a quorum in the Illinois legislature in 1839, his political opponents did not have the option of using the Department of Homeland Security to track him down. Neither did the officers of the U.S. Senate in 1988 when Senate Republicans tried to break a quorum.

Today, however, the Department of Homeland Security has enormous domestic intelligence powers. And somehow, on May 12, 2003, America's homeland security resources were employed to help Texas Republicans against their political rivals.

There is really no disputing this, Mr. Speaker. According to a report by the Department's own Inspector General, the Homeland Security Department's Air and Marine Interdiction Coordination Center spent its resources helping the Texas State police and the Texas Republican leaders directing the manhunt trying to find the plane of former Texas Speaker Pete Laney, a Democratic legislature who had flown to Oklahoma, to break the quorum. Many of my colleagues will remember Mr. Laney as the Democrat who introduced George W. Bush to the Nation on the night that he was declared President by the Supreme Court.

If my colleagues can believe it, Mr. Speaker, Homeland Security officials maintain that the 40 minutes they spent assisting in the Texas Republican's manhunt was only a "minimal" amount of work. That is a troubling excuse.

If the Department of Homeland Security spent just 1 minute in a domestic political dispute, then it was 1 minute too long. But they spent 40 minutes, which is longer than it took for terrorists to carry out their September 11 attack on the World Trade Center.

Even the office of a Republican Member, Representative KEN CALVERT, who represents the Riverside area where the AMICC is based, called to express shock at their involvement, at the Homeland Security Department's involvement in this political matter.

Mr. Speaker, Homeland Security officials also contend that they were tricked into getting involved. The report issued by the Department's Inspector General indicates that "several individuals" were instructing the Texas State police officer who got homeland security involved in the manhunt. According to a partial and heavily blacked-out transcript released by the Homeland Security officials, the officer was taking direct orders from a "State representative."

The Texas State police refused to identify who was directing them, and they quickly destroyed most of the documents relating to the episode. As a result, Homeland Security referred this case to the Federal Bureau of Investigation, but the FBI says it has no interest in investigating.

Fortunately, some Texas State police field notes survived the document purge and they indicate that Texas Republicans, Governor Rick Perry, State House Speaker Tom Craddick and others, personally instructed the State police during much of the manhunt which was run out of Speaker Craddick's office.

So as my colleagues can see, Mr. Speaker, a lot of disturbing questions remain unanswered about how homeland security resources were used to help the Texas Republicans track their political rivals.

Mr. Speaker, let me be clear: my goal here today is to protect the Department of Homeland Security. Its mission, safeguarding Americans against the threat of terrorism, is too important to risk undermining its credibility with the public.

But even if homeland security officials were misled, and the available facts do not clearly support that excuse, the entire episode still reveals the Department of Homeland Security's dangerous vulnerability to abuse.

Unfortunately, Homeland Security officials have refused to even acknowledge the Department's vulnerability or the threat it poses to their mission. Secretary Ridge has refused to release the complete tapes of the Department's communications with Texas officials or anyone else involved in this episode, despite legitimate requests from numerous Members of Congress, including the ranking members of the House and Senate committees that oversee the Department.

And the Department's Inspector General declared that its own agency's actions were "appropriate."

Mr. Speaker, that is so wrong that it is frightening. It is never appropriate to use homeland resources for partisan purposes, no matter how many minutes Homeland Security officials spend helping one political party, or which party they help. On the contrary, it is a dangerous abuse of power, one that threatens the liberties of all Americans, and one that risks public support for the Department of Homeland Security.

That is why the gentleman from Texas (Mr. EDWARDS), a member of the Committee on Appropriations, and the gentlewoman from Texas (Ms. JACKSON-LEE), a member of the Select Committee on Homeland Security, submitted amendments to the Committee on Rules last night to ensure that the Department of Homeland Security never again finds itself being used for partisan purposes.

Republicans on the Committee on Rules, however, seem not to understand the seriousness of the Department's vulnerability or the importance of closing this loophole immediately, because they blocked both amendments.

As a result, there is only one way to protect the Department of Homeland Security against political abuse: by opposing the important procedural vote known as the previous question. If we defeat the previous question, I will amend the rule to allow the House to consider these two amendments to restore public trust in America's homeland security officials.

Mr. Speaker, this should not be a partisan issue. I urge my colleagues to put politics aside and oppose the previous question.

Mr. Speaker, I yield 3 minutes to the gentleman from Minnesota (Mr. SABO), the ranking member of the Subcommittee on Homeland Security of the Committee on Appropriations.

Mr. SABO. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise in opposition to the rule for the fiscal year 2004 Homeland Security appropriations bill. The rule should be opposed for several reasons. I will raise two of them.

First, the rule does not protect an amendment I offered that was adopted in committee which concerns the Transportation Security Administration's new computerized airline passenger profile system called CAPPS2.

As proposed, CAPPS2 potentially represents the largest-ever intrusion of the Federal Government into our personal lives. Under it, a Federal agency would mine sensitive personnel data on millions of people for the routine event of flying on an airplane. The privacy and due process concerns are immense. The administration has been working on CAPPS2 since late last year.

□ 1200

But there remains many unanswered questions about it. It deserves far more scrutiny than has been paid so far. I am concerned that TSA may not currently possess the expertise to design a fair and effective passenger screening system, one that catches the people who mean us harm, while protecting those who do not.

I am concerned for law abiding people, especially those with common names and those who move residences often or who do not have well-established credit histories like college students and older Americans. I worry that these honest people will be singled out for further TSA screening, not based on risk but simply because the system is not well designed.

I am concerned that while TSA may set up a mediator to deal with passenger problems, it may be a mediator in name only. There may be no adequate process for passengers to get problems fully resolved because TSA will not control all the data bases it plans to use. If so, once red flagged, will law abiding people be needlessly hassled every time they fly? And to make matters worse, would such mistaken red flags of people who pose no risk cause the passenger and baggage screening systems to become overburdened, thereby raising the risk of lowering it?

My amendment, the CAPPS2 provision in the bill, requires the GAO to review CAPPS2 as it exists today before funding can be obligated on a planned pilot program.

GAO's review would mirror the recommendations put forth by the Secretary of Defense and the Attorney General in the report they submitted on May 20 on DOD's Terrorism Information Awareness Program. It is unclear how many of these recommendations, if any, have been filed by the TSA or by the Department of Homeland Security. I suspect none.

The CAPPS2 provisions in the bill are reasonable and should have been protected in the rule from points of order.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield 4 minutes to the gentleman from Indiana (Mr. PENCE), truly one of the most thoughtful and really an extraordinary leader in this House.

Mr. PENCE. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I was here, as you were, and as most of us in this institution were on the day September 11, 2001. It was a sunny day, just really very much like today. All of us were busy about our business, breakfast meetings of that Tuesday, when we received word of what happened in New York and then happened again and then happened within a proximity of these buildings that is still jarring to the memory of most Americans, the causality and the horrific tragedy at the Pentagon.

So this business of homeland security is a very serious and near-to-the-heart business for me. While I am not a member of the Committee on Appropriations that crafted the critical legislation upon which this rule is based, I am a member of the House Committee on the Judiciary's Subcommittee on Crime, Terrorism and Homeland Security; and I was compelled to come to the floor today, Mr. Speaker, and speak about what it is that we are doing in the majority for homeland security. And because there is much in the national debate and much in the debate on this blue and gold carpet that suggests that we are not doing our part. And I am duty-bound to come here today and say that I believe we are. In fact, I helped to draft the legislation that created the new Department of Homeland Security.

And the first priority of that new department, the first of its kind in decades, is to protect our Nation against further terrorist attack. Our first priority, Mr. Speaker, is to ensure the Department is properly funded to fulfill its mission. And I believe the gentleman from Kentucky (Mr. ROGERS) and the members of the subcommittee who prepared this critical appropriations legislation in the area of homeland security have crafted a balanced bill that will keep our homeland safer in an age of growing terrorist threats, will meet those needs of first providers.

The bill recognizes the need for coordination at every level of homeland security. Here are a few examples: We do support State and local first responders, $1.9 billion for an Office of Domestic Preparedness basic formula grants; $500 million for State and local law enforcement terrorism prevention grants; $750 million for firefighters grants; $168 million for emergency management performance grants.

Also, this legislation today will do much to strengthen and protect our borders, porous as they have been, threatening our national security. This bill will provide $9 billion for border protection and related activities, including $129 million for inspection technologies for vehicles and cargo; $61.7 million for container security, and $12.1 million for Customs Trade Partnership Against Terrorism.

We also are enhancing the transportation security, $1.6 billion for passenger screening, $1.2 billion for baggage screening efforts, and the list goes on and on and on.

Mr. Speaker, much will be said today as we proceed through this rule, debate, and through general debate that the majority has not done enough. But there are literally billions and billions of dollars carefully crafted in the area of first responders, protecting our borders, transportation security that argue eloquently and forcefully otherwise.

I urge my colleagues to support the Homeland Security Appropriations Act and this rule. I believe it strikes a balance perfectly between the missions previously under the umbrella of other agencies that now find themselves under this new department.

Mr. FROST. Mr. Speaker, I yield 5 minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, Austin, Texas is the proud capital of the Lone Star State. And we say rather modestly there that we are the live music capital of the world. We do so because of an immense amount of talent and a great interest in music in our community. But of late there has been music of a different type.

We have had the Republican majority leader, the gentleman from Texas (Mr. DELAY) trying to call the tune and forcing the leaders of our State to dance to his tune. Indeed, he has spent so much time in Austin arm twisting and cajoling State legislators, huddling a week ago today with the Governor, Lieutenant Governor, and Speaker of Texas House, that just this past Friday he was named by Texas Monthly as one of the 10 worst members of the Texas legislature, not of the United States Congress. It is difficult to determine for which body he is devoting the most time.

Against that backdrop, we consider this legislation. The problem that we face today is that no matter how much we appropriate for homeland security to protect us against terrorism, if its resources are being diverted to political purposes, such as fulfilling the desires of the gentleman from Texas (Mr. DELAY), then we will not have the protections that the American people deserve. We know that the Department allocated some of its resources to searching for Texas legislators who were involved in legitimate opposition to the DeLay Redistricting Plan.

The Department first assigned a former Republican Congressional candidate from Texas as the Inspector General to conduct an "independent" investigation to decide whether the resources had been misallocated. When that gentleman, after his biased and partisan background on this matter was exposed, recused himself, and then another person was appointed, we were assured that she, as an Inspector General at the Department of Homeland Security, would get to the bottom of this.

She assured us she would explore all aspects of the misuse of the Department of Homeland Security, but then produced a report that only looked at the sole issue of the Department's inability to find a cotton farmer from Plainview and where his plane had gone. I hope they are able to do a better job with terrorism than they did in locating an airplane of a former Democratic Speaker of the Texas House. She did not, as promised, conduct a broad examination of misuse of any resources in any part of the Department. Though she told us she would get to the bottom of who required that this investigation be undertaken, she did not do that and her report is silent on whether any federal office holders or their employees were involved.

As with the Department of Justice, the Federal Bureau of Investigation, the United States Attorneys Office, the U.S. Marshals Service, we have received no information in response to repeated requests about how they may have been misused by the gentleman from Texas (Mr. DELAY) or others in this investigation in the State of Texas. In fact, we have a stone wall and we have asked the gentleman from Texas (Mr. DELAY), well known as "the hammer" to tear down that stone wall. To date we have nothing but silence and excuses and stonewalling with reference to these matters.

What relevance does that have to today's appropriations request? All the relevance in the world. If the Department of Homeland Security, the U.S. Marshals Service or the Department of Justice can be used for partisan political purposes like this and all it takes is a call from someone with a badge, what is there to prevent a sheriff somewhere in America who wants the Department of Homeland Security to help with a divorce investigation to involve them in this? If there is a local police chief who wants to do some opposition research on the opponent of a local mayor who is up for reelection, who will prevent the Department of Homeland Security from getting involved in that? If you have a local police officer who is suspicious of a political or religious group, what is there to prevent the Department of Homeland Security from responding to his request.

Well, from what we have learned in "Texasgate" so far, one would say there is very little and that this episode only reinforces the concerns of many Americans that this Department, well intentioned as it may be, would bring us a new America in which the watchword is "spy on our neighbors." There is very real concern about government resources that should be dedicated to protecting American families and instead could be misused for personal or political gain.

Until we get a full and complete disclosure from all the participants in this scandal, we will not have a complete answer as to whether Americans are adequately protected, and that is the purpose of defeating this motion for the previous question on this rule. In this way, we can attempt to get to the bottom of this and to ensure that the resources are not diverted from where they should be to protect our families, into protecting some political partisan who is trying to reshape America in his image.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 10 minutes to the gentleman from Wisconsin (Mr. OBEY), the ranking member on the full Committee on Appropriations.

Mr. OBEY. Mr. Speaker, will the Chair notify me when I have used 5 minutes?

The SPEAKER pro tempore (Mr. SIMPSON). The Chair will.

Mr. OBEY. Mr. Speaker, this bill should not even be here at this time. The Committee on Appropriations chairman, the gentleman from Kentucky (Mr. ROGERS), knows his stuff. And he demonstrated that last year when he did very heavy oversight of the Transportation Security Administration, which was totally screwed up at the time.

The problem we have with this bill being before us today is that this new agency was extremely reluctant to provide useful information to this Congress so that we could make intelligent judgments about how to allocate money to this new agency. And we have a specific problem, because the reorganization bill that passed with much ballyhoo last year is not what it is cracked up to be. Before the passage of that legislation we had 133 agencies that had something to do with homeland security. And what the bill finally did was to take 22 of those agencies, not including the FBI and the CIA, the two gut agencies in our fight against terrorism, so they took 22 agencies, put them in the department that they called "Homeland Security," and we are supposed to stand up and sing Hosannas. The problem is that left 111 other agencies uncoordinated, outside the tent.

So we had that basic confusion to begin with, and now we have even more confusion at the agency. This new agency, for instance, we are told still has not prepared a telephone directory for its employees so people can reach who they are supposed to reach if they have a problem.

Now, there is nothing wrong with this bill if you think it is perfectly okay to proceed on the status quo, because this bill provides a meager 1.8 percent increase over last year's budget for the agencies meant to protect us against terrorism. But because of inflation that means there will be on a per capita basis less security provided to each and every citizen of this country this year than was the case last year. And yet we hear many stories about deficiencies in securing this country.

□ 1215

Example, we had over 60 uncleared aircraft that flew from Canada into the United States last year. We have no assurance about what was in those planes or who was in those planes. We have $4 billion that the Coast Guard has told us that we need to provide over time to our port facilities for security purposes. We are only inspecting 2 percent of all of the cargoes that come into our national ports; and we have what was supposed to be the brain of the agency, the information analysis division, having a terrible time getting off the ground after the reorganization.

So I want to put the House on notice now. I intend to offer an amendment that would add $1 billion to key security functions. I would add $400 million for port security grants. The Coast Guard has told us that we need $4.4 billion, and this will speed up that timetable a bit. My amendment would also bring to 25 percent the Federal contribution of port facility security needs. That leaves a huge percentage of the bill still in local hands. If we do not do this, it will take close to 20 years before we are providing half the cost of meeting that security. That is a little bit too long to wait, I think.

Thirdly, we would add $100 million to the Coast Guard to effectively implement the Maritime Security Administration Act, which was created in order to improve our ability to analyze vessel threat information. And my amendment would also provide $100 million to increase the number of Customs inspectors now inspecting container ships into the United States. This would allow 1,300 additional Customs inspectors to be brought on. That is still a drop in the bucket in comparison to what they need.

We would also provide $200 million to improve security on the northern borders, some 5,500 miles long; and we have virtually no capacity to cover large sections of it. During Operation Liberty Shield, there were 10 aircraft that came across that border without a clearance, even though that border was being patrolled by air for 30 straight days. I would say that is a problem.

People will say how do we intend to pay for this amendment. We would intend to pay for the amendment by reducing the size of the tax cut that this Congress just provided for people who make over $1 million a year. We would reduce that average tax cut from $88,300 to $83,300. That is hardly crippling the most well-off people in this country, but that tiny adjustment in their windfall would enable us to significantly enhance the security of the United States. It would inure to their benefit as well as citizens who do not get that fat a tax cut. I think it is perfectly rational.

I know some people will say, "Oh my goodness, you must not do that because you will be invading the jurisdiction of another committee." I would point out that if you go back just a few months ago on the omnibus appropriation bill, we had a whole slew of proposals that the House leadership insisted that we put into that appropriation bill. Most of those items were under the jurisdiction of the Committee on Ways and Means. So all we are doing is what the leadership of this House itself did last year, and it seems to me that we ought to put the welfare of the country, ahead of what Dick Bolling, my mentor from Missouri, described years ago as being jurisdictional dung hill politics. We should not worry about jurisdiction. We should worry about what kind of a job we do on the substantive level.

So basically, Mr. Speaker, the Committee on Rules did not allow my amendment to be made in order. What is happening is this: when the budget resolution process was first established by the Congress, the purpose was to make Congress face up to choices and to recognize what the trade-offs would be when you made those choices; but the way the House leadership is running the budget process today, they are guaranteeing that there is never any linkage between actions and consequences.

What this House did on the budget resolution, what this House did on the tax bill has now dictated to this committee the limitations under which we bring this bill to the floor, and that is why this bill is woefully inadequate in terms of meeting the security interests and needs of the United States.

So I make no apology for trying to do something a little different in order to try to get more resources into this area. I think any American concerned with our security would understand why we do it; and I think it is about time that we demonstrate that there are costs, there are costs to the tax action that was just taken in Congress. Those costs mean that we have less money available to make the crucial investments we need in homeland security and, for that matter, also health care, education, science, you name it.

What I am trying to do is to demonstrate what those real trade-offs are, even though it is apparent that the majority leadership in the House wants to hide those trade-offs from the American people. I think the public has a right to know what services they are going to be denied on the security front because of that tax action.

I thank the gentleman for his time.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield 5 minutes to my good friend, the gentleman from Texas (Mr. BARTON).

Mr. BARTON of Texas. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I really did not plan to speak on this bill, but some of my good friends on the minority side from Texas have been up talking about alleged abuse of funding or power in terms of homeland security officials attempting to find some missing State legislators who went down to Austin and then left Austin and went up to Ardmore, Oklahoma, hung out at the Holiday Inn for a couple of days while the Texas legislature was considering a redistricting bill for Congress.

The Inspector General of the homeland security has done an investigation of this allegation and found no substance to it, no merit. As it turns out, the information in terms of the tail number and things like that are available to any citizen in this country who wishes to call the FAA. If they have a tail number, and if that airplane is in the air, FAA will tell a person where that particular airplane is. That is public information unless they have changed the protocol in the last 2 or 3 weeks, and is available to anybody who wishes to try to track where somebody is, that is, if they have the tail number.

What happened down in Austin was that the Texas House was going to move a bill to rectify past gerrymanders of the congressional lines that go back over 30 years, and some of the Democratic State legislators decided that they did not want to be part of it; and under the Texas Constitution, it requires a two-thirds vote to have a quorum. Enough legislators left town on an organized basis, went up to Oklahoma and hung out until the legislature session had ended. Well, that is according to the rules and may be good press, but it is not going to work in the long term because the Governor called a special session that is going to start in a couple of weeks, and the lines are going to be redrawn to verify the voting wishes of the people of Texas, not of some of the political polls in the minority party.

So I just wanted to come over and set the record straight. There has been no abuse of power. There has been no illegal use of funds. There has been nothing like that.

Mr. DOGGETT. Mr. Speaker, will the gentleman yield?

Mr. BARTON of Texas. I yield to the gentleman from Austin, briefly.

Mr. DOGGETT. Mr. Speaker, is the gentleman aware that the Inspector General of the Department of Homeland Security has not reported on any aspect of whether homeland security resources were used other than the aircraft and has specifically declined to report on which individuals may have asked that homeland security resources be diverted for this purpose? In other words, the investigation is incomplete.

Mr. BARTON of Texas. Mr. Speaker, I appreciate my good friend from Austin raising that question.

My information is that the Inspector General has done an investigation. There is not an issue there. I think some State officials when this, what I would call a "bug out" to Ardmore, the gentleman may have a different term for it, he might call it something differently, but when that happened, the Governor and the Speaker of the House, as is their authority under the Texas law, sought to bring the recalcitrant lawmakers back to the legislature so there would be a quorum; and they touched bases with a number of State and Federal officials, and some of the Federal officials made a couple of phone calls, but there was no abuse of power and nothing illegal that has happened, and this is what the investigation has said.

Again, I am here as a Republican, a Member of the majority party. I have got no problem if in Austin certain legislators do not want to report for a quorum. That is something that we have the authority to do here; and as my colleague knows, the Texas constitution requires a two-thirds membership present if there is a question of the quorum. So we do not have a problem with that, but I think the State officials in Austin had every right to try to find where those legislators went and try to get them back if they could get them back so there would be a quorum, and there is nothing illegal about that, and there is nothing unethical about that, and there is nothing improper about that.

So I just kind of wanted to set the record straight. It may be good political theater, but there is no illegality that has gone on and the Inspector General said that.

Mr. FROST. Mr. Speaker, how much time is remaining on each side?

The SPEAKER pro tempore (Mr. SIMPSON). The gentleman from Texas (Mr. FROST) has 6 minutes remaining. The gentleman from Florida (Mr. LINCOLN DIAZ-BALART) has 13 minutes remaining.

Mr. FROST. Mr. Speaker, I yield 15 seconds to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, just to complete the record, it is very clear that the office of Inspector General did not explore anything other than one aircraft. They did not explore the other misuse of the response of the Department of Homeland Security; and, second, it is clear that they failed to provide or even pursue evidence on the question of which Federal officials may have asked for this misappropriation of resources. Finally, to complete the record, history shows that it was Abraham Lincoln who was among the first to use this tactic of defeating a quorum.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield 4 minutes to the gentleman from Arizona (Mr. HAYWORTH), my good friend.

Mr. HAYWORTH. Mr. Speaker, I thank my friend from Florida for yielding me this time, and I would rise in support of this rule.

It has been interesting to hear the debate, if we could characterize it as that, thus far. We hear about an internal redistricting dispute within the State of Texas. We have the other friends predictably come to this well and somehow try to trot out the shopworn thesis that the people's economic security at home should be invalidated by command and control spending here in Washington; and undergirding all this, Mr. Speaker, is this simple proposition for the left: it is never enough.

Indeed, if we take the debate and the dispute as it is here and in so many different areas, our same friends who come to us time and again on different issues and would have the American people believe that they are the champions of eliminating the deficit, that they are for fiscal responsibility, when it comes to spending programs, and perhaps this one especially, they begin from the thesis that there is never enough spending, not that the considerable resources that we will bring to bear in this appropriation, billions of dollars, can be utilized in judicious, concentrated fashion to bring about the desired ends. No, no.

Mr. Speaker, the resounding chorus from the left is, it is never enough, with an interesting variation. If one succeeds in America, they are to be singled out for punishment for succeeding, for paying their taxes; we want to reinstitute taxes on them because their economic security or the economic security they provide to workers they hire in small business should be invalidated for the class warfare scenario that states somehow they are unworthy because they succeed.

So my friends will offer an amendment, I suppose, later when we move this on to raise taxes; and I would suggest, Mr. Speaker, to this House and to my colleagues, in so doing, they are denying what is obvious and that is that there is a link between economic security for all Americans and homeland security for all Americans.

Just as we understand the best social program on Earth is a job, we get there not from the command and control of the left who believe the answer is always in bureaucratically driven jobs. We get there by allowing people to use their money to save, spend and invest to create new jobs in the private sector; and yes, we maintain a judicious and concentrated use of funds to protect our homeland and to protect the American people.

□ 1230

But again, Mr. Speaker, remember what the resounding chorus will be from the left: It is never enough. And there are myriad uses for your money over and beyond the saving, spending and investing of same in your family's economic security.

You see, I do not believe, Mr. Speaker, these two goals are mutually exclusive. I believe the American people need to keep more of their hard-earned money to save, spend, and invest, because I believe it will lead to higher employment and economic gains. But I also believe the bill we will consider today stands up for national security, makes a difference for this American Nation, and so I would ask my colleagues to join with me in voting in the affirmative.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I wish that this debate was simply about making sure that the homeland is secure. I rise in opposition to this rule and associate myself with the words of the ranking member of this committee, the gentleman from Wisconsin (Mr. OBEY).

This is not about stealing hard-earned dollars from taxpayers, it is about providing for the safety of Americans and taking a few thousand dollars from the million-dollar earners that the big tax bust this Republican administration has given, where those making $1 million will get a whopping $90,000 check almost, merely taking a few thousand from that paycheck and providing Americans with the kind of security they deserve.

Frankly, Mr. Speaker, while we speak on this floor with two or three Members, Rome burns, terrorists are planning, cells that terrorists have are in the United States, terrorists are walking across the border, and terrorism is much rampant around the United States and around the world. Why? Because this administration is doing nothing about it.

So I come to the floor today to talk about making sure that Homeland Security protects neighborhoods and communities and ports and cities and school districts.

This is not a joke. This is not about a mere political question in the State of Texas where those who did not want to be struck up and hung by the Republican Party used their constitutional rights and left the floor of the House. This is about an OIG report that comes to the United States Congress with all these black marks in it. There is no truth in these reports. They are not telling us the truth. They are hiding the truth. And yet the people on this floor and the people who run these committees refuse to have an investigation to find out what the truth is.

Mr. Speaker, we need an amendment that has been rejected, that simply tells us to make sure that no homeland security funds can be used for the surveillance powers of the Department of Homeland Security for purposes not related to protecting homeland security. That is all we are asking. I would say that this is a rule that should be rejected.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Texas (Mr. CULBERSON).

Mr. CULBERSON. Mr. Speaker, with some personal experience, having served 14 years in the Texas Legislature, and having many friends who serve in the Texas House, and having just been elected in the 2000 election, I felt compelled to come to the floor and offer some personal perspective on the, I think, highly improper and blatant partisan attacks that the Democrats are making that have absolutely nothing to do with homeland security.

The Inspector General has already made a report on whatever allegations the Democrats are making. The Inspector General has already determined that everything that was done was properly done. The majority leader's office has said repeatedly, and this is confirmed by the Inspector General's report, that there was no contact between the majority leader's office and the Department of Homeland Security. This is an irrelevant distraction from the core important work that this Congress and the Nation must do in protecting our borders, in preventing people from coming across the border who might pose a threat to the security of this Nation.

The Democrats in Texas who walked off the job in the regular session of the legislature did so in a way that the public in Texas, the people of Texas recognized was improper; that it was wrong for them to walk off. And in fact it is incredible to me that the Democrats who walked off the job did so in a way that completely defied the majority will of the people of Texas.

Since Reconstruction, since 1876, the Democrats have controlled the State of Texas. We just elected a new Republican majority to the Texas House. The Texas Senate is now Republican. Our Governor is Republican. The Federal courts have controlled our prisons for up to 25 years. I led the effort to regain control over our Texas prison system from Federal Judge William Wayne Justice. Our State courts control our school finance system. Federal courts control our mental health hospitals in Texas. And it is entirely proper, in fact it is essential under our constitutional republican form of government that the people control their institutions, that the people control the way their congressional districts are drawn, and a majority of the people of Texas elected a Republican Legislature to pass Republican legislation.

Now, I can attest, as the Republican whip in the Texas House, that I still have tread marks on my back from being run over every day by Ann Richards and Speaker Pete Laney. I always got right back up and dove into the fighting, fighting the tax increases the Democrats passed repeatedly in Texas, fighting Ann Richards and the Democrats' creation of the first income tax on businesses in Texas. I got right back up after they passed those new tax increases, and I did not give up and walk out. It is a part of the process that you make your best argument in the legislative body, and if you lose, that is majority rule.

I think it is also very instructive that the Democrats chose to walk out to protect their own political hides. They did not walk out to protect some minority group or some special interest group they are so fond of. They walked out to protect their own political hide. It is very revealing for the people of the United States to see that the Democrats choose to pick up this kind of dust, to make this sort of distraction, to walk out and shut down the entire legislative process to protect their own political power, to protect their own political hides rather than to go and walk out or make this big statement in defense of some group or some budget cut that they might have disagreed with.

I think it is entirely appropriate that the Inspector General's report has shown that everything that was done was done so properly. And also, the Speaker of the House has authority in Texas, as the Speaker does here, to place a call in the House and use the law enforcement authority at his disposal to find members, to locate them and bring them back on the job. This House Chamber has been locked down before to keep Members in the Chamber so they would do their job, and it has been done several times in Texas.

In fact, while I was there, the Democrats did walk out once in protest over failure of the legislature to create a pre-kindergarten program, I think in 1991. But again, here they walked out to protect their own political skins. I urge the House to vote against this amendment.

Mr. FROST. I would inquire as to how much time remains, Mr. Speaker.

The SPEAKER pro tempore (Mr. SIMPSON). The gentleman from Texas (Mr. FROST) has 3¾ minutes remaining and the gentleman from Florida (Mr. LINCOLN DIAZ-BALART) has 5 minutes remaining.

Mr. FROST. Mr. Speaker, I reserve the balance of my time.

Mr. DIAZ-BALART. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. SWEENEY).

Mr. SWEENEY. Mr. Speaker, I thank the gentleman for yielding me this time, and I had no intention of coming to the floor and speaking on this rule. I am a member of the Select Committee on Homeland Security, and I assume there will be plenty of time this afternoon for me to give my appropriate comments. But I have to just say to my colleagues that I am quite frustrated. I am a New Yorker, I am an American, and I lost friends in the World Trade Center on September 11. What I would like to say to my friends on the other side is, let us move on. Let us not use any more distractions in this process.

We waited a year, a year, to create the Department of Homeland Security because the other body, in its leadership from the Democratic Party, decided a year ago that they would rather play politics than go to the business of the people and go to the business of creating this Department of Homeland Security.

I listened to the esteemed ranking member of the Committee on Appropriations, the gentleman from Wisconsin (Mr. OBEY), on the floor a little while ago. And I have to say that I have great disagreement on policy, but I appreciate and respect the fact that he is coming to this floor and talking about the substance of this bill and the issue facing the American people on this most critical issue.

Mr. Speaker, I would ask my friends, and implore upon my friends to allow us to move on and let us do the business of the people. That is what leadership is about, and that is what they expect of us.

Mr. FROST. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, it is unfortunate that Members on the other side of the aisle and their colleagues in Texas sought to misuse Federal resources. Now, the Inspector General said, oh, but it was only 40 minutes, so it is no big deal. I would remind the gentleman on the other side of the aisle that the attack on the World Trade Center occurred in less than 40 minutes, and so Republicans in Texas sought to divert homeland security resources for 40 minutes.

What did they also seek to do? They also contacted the Department of Justice, tried to involve the FBI, tried to involve the U.S. Marshals Service, tried to involve the U.S. Attorney's Office in Texas. This was a blatant misuse of Federal resources, even if it were one minute. But it was not just one minute, and it was not just the Department of Homeland Security. It was other agencies of the Federal Government. They know it. It should never have happened and, hopefully, it will never happen again.

I urge Members to vote "no" on the previous question. If the previous question is defeated, I will offer an amendment to the rule that will make in order two very important amendments that were submitted to the Committee on Rules last night and rejected by the Republican majority. Both of these amendments seek to protect the Department of Homeland Security against the type of political abuse it suffered when it ended up helping Texas Republicans hunt down their political rivals in a legislative dispute.

The first amendment, by the gentleman from Texas (Mr. EDWARDS), a member of the Committee on Appropriations, would require the Secretary of the Department of Homeland Security to implement written procedures for the use of personnel and resources for any nonemergency use of homeland security services; and would prohibit the Office of Air and Marine Interdiction of the Bureau of Immigration and Customs Enforcement from supporting Federal, State or local law enforcement or humanitarian efforts until that is done.

The second amendment, by the gentlewoman from Texas (Ms. JACKSON-LEE), a member of the Department of Homeland Security, would prohibit the Department from using funds for political purposes or for any other purpose not relating to protecting homeland security.

I am confident that all Americans and all Members of this House support this sentiment expressed in these two amendments. So I urge Members on both sides of the aisle to vote "no" on the previous question. Let me emphasize a "no" vote will not stop the House from taking up the Homeland Security appropriations bill. It will not prevent other amendments from being offered under the open rule. However a "yes" vote will preclude the House from considering these two very important amendments that are critical to protecting the Department of Homeland Security's ability to protect Americans against terrorism.

Also, assuming that the previous question passes, there will then be a vote on the rule, and I would urge Members at that point to vote against the rule so that the gentleman from Wisconsin (Mr. OBEY) will have the opportunity to offer his amendment to put money back in this legislation to do the things that should have been done originally.

Mr. Speaker, I ask unanimous consent to insert the text of the amendment and extraneous materials immediately prior to the vote on the previous question.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. FROST. Again, Mr. Speaker, let me emphasize that to protect the Department of Homeland Security against political abuse, vote "no" on the previous question.

Mr. Speaker, I yield back the balance of my time.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we are very proud of the legislation being brought forth today by the Committee on Appropriations. I know that the chairman, the gentleman from Kentucky (Mr. ROGERS), worked long and hard on this bill and deserves commendation by all of us as well as all the other Members that have worked so hard on this legislation.

Mr. Speaker, there are $29.4 billion in this underlying legislation for the Department of Homeland Security. That includes $4.4 billion for the Office of Domestic Preparedness. Now, the resources that the Congress is appropriating for the Office of Domestic Preparedness constitutes an increase of 1,400 percent for that critically important issue since September 11, 2001. The Congress is doing its job.

□ 1245

I think all of us should and I am sure do praise the work of the Subcommittee on Infrastructure and Border Security, that has permitted them to bring forth this legislation. There is a very important initiative of the many new initiatives to protect the Nation that is being funded by this legislation, the Container Security Initiative, so that commerce, trade that we see in all the ports of America, those containers sent from abroad, that they be inspected before they leave the ports that they come from so that the security of the Nation is significantly augmented in that fashion. That Container Security Initiative is funded in this bill.

There are many other reasons why we should pass this legislation. I feel very proud of the underlying legislation and the fact that we are moving forward to increase the security of the American people. I urge support for the underlying legislation and this totally fair, open rule.

The material previously referred to by Mr. FROST is as follows:

PREVIOUS QUESTION FOR H. RES. 293 RULE ON H.R. 2555: FISCAL YEAR 2004 HOMELAND SECURITY APPROPRIATIONS

At the end of the resolution, add the following:

"SEC. 2. Notwithstanding any other provision of this resolution, the amendments printed in section 3 shall be in order without intervention of any point of order and before any other amendment if offered by the Member designated. Each amendment may be offered only in the order specified in section 3. The amendments are not subject to amendment except for pro forma amendments or to a demand for a division of the question in the committee of the whole or in the House.

SEC. 3. The amendments referred to in section 2 are as follows:

(1) Amendment by Representative Edward of Texas or a designee:

At the end of the bill (before the short title), insert the following:

LIMITATION ON USE OF PERSONNEL AND RESOURCES OF THE OFFICE OF AIR AND MARINE INTERDICTION

SEC. . (a) Congress finds that in May 2003 personnel and resources of the Office of Air and Marine Interdiction of the Bureau of Immigration and Customs Enforcement were utilized in an improper manner to locate legislators of the State of Texas who were not in violation of any Federal, State, or local law, or in need of any emergency humanitarian assistance.

(b) None of the funds made available in this Act may be used to provide personnel or resources of the Office of Air and Marine Interdiction of the Bureau of Immigration and Customs Enforcement to support Federal, State, or local law enforcement or humanitarian efforts until the Secretary of Homeland Security implements written procedures to provide such personnel or resources for such purposes. The limitation of the preceding sentence shall not apply with respect to the use of funds for a bona fide emergency situation.

(2) Amendment by Representative JACKSON-LEE of Texas or a designee:

At the end of the bill (preceding the short title) insert the following:

SEC.   . None of the funds made available in this Act may be used for political purposes or any other purpose not related to protecting homeland security, including for—

(1) use of the surveillance powers of the Department of Homeland Security, for a purpose not related to protecting homeland security, to—

(A) tap personal or business telephones; or

(B) otherwise monitor or record conversations or activity in any home, office, or other location; or

(2) use of the investigative powers of the Department of Homeland Security, for a purpose not related to protecting homeland security, to track automobiles, airplanes, or other modes of transportation.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. SIMPSON). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. FROST. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clauses 8 and 9 of rule XX, this 15-minute vote on ordering the previous question will be followed by 5-minute votes on adopting the resolution, if ordered, and on the motions to suspend the rules relating to H.R. 923 and H.R. 1460.

The vote on H.R. 1416 will be taken later today.

The vote was taken by electronic device, and there were—yeas 221, nays 196, not voting 17, as follows:

[Roll No. 301]

YEAS—221

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—196

Abercrombie
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boyd
Brady (PA)
Brown (OH)
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—17

Ackerman
Boucher
Brown, Corrine
Brown-Waite, Ginny
Cannon
Cardoza
Conyers
Cramer
Cubin
Feeney
Gephardt
Hulshof
Matsui
Ryun (KS)
Smith (WA)
Waters
Wicker

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SIMPSON) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1306

Mrs. McCARTHY of New York and Mrs. CAPPS changed their vote from "yea" to "nay."

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. FROST. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this vote and the remainder in this series will be conducted as 5-minute votes.

The vote was taken by electronic device, and there were—ayes 220, noes 197, not voting 17, as follows:

[Roll No. 302]

AYES—220

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Dunn
Ehlers
Emerson
English
Everett
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly

Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—197

Abercrombie
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boyd
Brady (PA)
Brown (OH)
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—17

Ackerman
Boucher
Brown, Corrine
Brown-Waite, Ginny
Carter
Conyers
Cramer
Cubin
Duncan
Feeney
Gephardt
Hulshof
Ryun (KS)
Smith (WA)
Visclosky
Waters
Wicker

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

☐ 1313

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. WICKER. Mr. Speaker, on rollcall Nos. 301 and 302 I was inadvertently detained. Had I been present, I would have voted "yea."

PREMIER CERTIFIED LENDERS PROGRAM IMPROVEMENT ACT OF 2003

The SPEAKER pro tempore. The pending business is the question of suspending the rules and passing the bill, H.R. 923, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Illinois (Mr. MANZULLO) that the House suspend the rules and pass the bill, H.R. 923, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 416, nays 3, not voting 15, as follows:

[Roll No. 303]

YEAS—416

Abercrombie
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Burgess
Burns
Burr
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel

Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (FL)

NAYS—3

Duncan
Flake
Paul

NOT VOTING—15

Ackerman
Brown, Corrine
Brown-Waite, Ginny
Burton (IN)
Conyers
Cramer
Cubin
Feeney
Gephardt
Hulshof
Larson (CT)
Ryun (KS)
Smith (WA)
Weller
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SIMPSON) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1319

Mr. UDALL of New Mexico changed his vote from "nay" to "yea."

So (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

VETERANS ENTREPRENEURSHIP AND BENEFITS IMPROVEMENT ACT OF 2003

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and passing the bill, H.R. 1460, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and pass the bill, H.R. 1460, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 421, nays 0, not voting 13, as follows:

[Roll No. 304]

YEAS—421

Abercrombie
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOT VOTING—13

Ackerman
Brown, Corrine
Brown-Waite, Ginny
Conyers
Cramer
Cubin
Feeney
Gephardt
Granger
Hulshof
Radanovich
Ryun (KS)
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1331

So (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

The title of the bill was amended so as to read: "A bill to amend title 38, United States Code, to improve education and entrepreneurship benefits, housing benefits, and certain other benefits for veterans, and for other purposes.".

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. RYUN of Kansas. Mr. Speaker, unfortunately, I missed four votes in the House of Representatives on June 24, 2003. Had I been in attendance I would have made the following votes:

The Previous Question on H.R. 293, the Rule for H.R. 2555, Homeland Security Appropriations Act for FY04. Had I been in attendance, I would have voted "yea."

Passage of H. Res, 293, Rule for H.R. 2555, Homeland Security Appropriations Act for FY04. Had I been in attendance, I would have voted "yea."

Passage of H.R. 923, Premier Certified Lenders Program Improvement Act of 2003. Had I been in attendance, I would have voted "yea."

Passage of H.R. 1460, Veterans Entrepreneurship Act of 2003. Had I been in attendance, I would have voted "yea."

GENERAL LEAVE

Mr. ROGERS of Kentucky. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and that I may include tabular and extraneous material on H.R. 2555.

The SPEAKER pro tempore (Mr. SIMPSON). Is there objection to the request of the gentleman from Kentucky?

There was no objection.

DEPARTMENT OF HOMELAND SECURITY APPROPRIATIONS ACT, 2004

The SPEAKER pro tempore. Pursuant to House Resolution 293 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2555.

□ 1334

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2555) making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes, with Mr. GILLMOR in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Kentucky (Mr. ROGERS) and the gentleman from Minnesota (Mr. SABO) each will control 30 minutes.

The Chair recognizes the gentleman from Kentucky (Mr. ROGERS).

Mr. ROGERS of Kentucky. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this is a historic day. Only 4 months after the Department of Homeland Security was stood up, we now consider in the Congress the very first ever Homeland Security appropriations bill on the House floor.

The creation of the Department is by far the largest reorganization of the Federal Government in its history. Mr. Chairman, 180,000 employees, 22 security-related agencies merged into a single unit, agencies as diverse as the new Transportation Security Administration, FEMA, the Customs Service, the Secret Service, the Coast Guard, and some 18 other agencies throughout the government.

But, Mr. Chairman, I want to spend a couple of minutes talking about the breadth of the problem that we face.

On our borders, we have to protect ourselves: 2,000 miles of border with Mexico; 5,500 miles of border with Canada. There are 9,500 miles of shoreline. We have 157 ports of entry, 361 seaports. There are 440 million visitors who arrive in our country by land, sea, and air each year. There are 118 million vehicles that come here, 11 million of them trucks; 2.5 million railcars; and 17 million cargo containers that cross through our ports every year.

In transportation, there are some 768,000 commercial flights that enter the U.S. at 429 commercial airports, carrying some 635 million passengers a year. We have 18,000 general aviation airports. We have 143,000 miles of freight railways, 3.9 million miles of highways, and 550 major public transportation systems throughout our country. There are 590,000 bridges. There are 526,000 interstate trucking companies, 43,000 of them certified to carry hazardous materials.

We have 150 oil refineries, 86,000 miles of crude oil pipelines, 278,000 miles of natural gas pipelines. There are 66,000 chemical and hazardous materials plants. There are 1,800 Federal reservoirs. There are 9,300 power plants, including 104 nuclear, in our country.

And then there are all sorts of high-target, high-risk symbols of our Nation. We are speaking from one even as I talk now: the Capitol. We have the White House, the Washington Monument, the Lincoln Memorial, the Statue of Liberty, the St. Louis Arch, the Golden Gate Bridge, and on and on and on, including some 463 skyscrapers in our land.

I mention those facts, Mr. Chairman, to highlight the enormous challenge that we face as we begin to tackle our homeland security needs. Protecting American citizens from harm is the first and foremost duty of the Federal Government, and this awesome task largely falls upon the shoulders of the Department of Homeland Security.

This bill, Mr. Chairman, provides $29.4 billion for the Department. That is an increase of just over $1 billion above what we were asked by the President, and $535 million more than the current-year levels.

The bill recognizes that while the Department of Homeland Security has the lead in developing our national Homeland Security strategy, implementation of that strategy requires the active participation of State and local governments and the private sector.

When it comes down to it, homeland security, Mr. Chairman, is essentially hometown security; and it requires the active engagement of all Americans and all branches of government.

The bill before us today recognizes the role each stakeholder must play in this big mission. It funds not only the Department's first full year of operations, but also anticipated efforts of State and local governments and the private sector.

As we debate this bill today, I urge my colleagues to remember everything that has been accomplished since September 11. While some might suggest that we are not doing enough, I would say we are making tremendous progress in our war on terror. The glass is not half empty; it is half full.

Since September 11, we have provided $75.8 billion for homeland security funding across the entire government. For these 22 agencies that now make up the new Department of Homeland Security, we have provided $43.9 billion through fiscal year 2003; and in this bill, we add an additional $29.4 billion, bringing the total provided to the Department to $73.3 billion for fiscal years 2002 through 2004.

Protecting the Nation's borders is our first line of defense against terrorism. We include in the bill a total of $9 billion for border protection and related activities. That is an increase of $400 million over the current enacted levels, including $2 billion for the U.S. Coast Guard homeland security activities. This bill makes innovative technology and capital investments a priority, recognizing that our borders will only be secure when we use a combination of people and technology.

Since September 11, 5,400 inspectors, special agents, and Border Patrol agents have been added to our borders, increasing coverage at ports by 25 percent. An additional 4,100 Coast Guard personnel have been hired to protect our ports and our waterways, increasing the intensity and number of inspections at ports of entry. We will continue to inspect 100 percent of all high-threat cargo and high-threat vessels coming into our waters.

We include $388 million for port security grants. The $100 million included in this bill is another down payment to secure critical port facilities, bringing the total funding since 9–11 to $488 million.

Since September 11, we have provided $263 million for technology, including radiation detectors for our ports and nonintrusive inspection technologies for cargo screening. These technologies have been deployed at our busiest land and sea ports, including Miami, Los Angeles, and Newark; and in this bill we add another $129 million for those technologies, bringing the total since 9–11 to $392 million.

We provide $60 million for the Customs Container Security Initiative, fully funding that effort since its inception. We include $62 million for that program, bringing the total funding to $122 million to support the participation of nearly all of the 20 foreign megaports from which we receive practically all of our cargo. This initiative targets high-threat cargo before it comes into our ports.

We also place in the bill a high priority on funding our State and local first responders. I believe it is essential that our State and local governments have the resources to address the needs of our hometowns. We include $4.4 billion for our first responders, law enforcement officers, firefighters, and emergency response personnel. And since September 11, Mr. Chairman, I want all of my colleagues to hear this: since September 11, the Congress has appropriated $20.8 billion in assistance to our State and local governments for terrorism prevention and preparedness.

□ 1345

That, Mr. Chairman, is an increase of 1,000 percent before 9/11. Despite that significant investment, there are concerns about how and when this money gets to both State and local organizations. I agree in some instances it is taking too long for those funds to get there and the complex process is complicated and cumbersome. We tried to address that in this bill. I am optimistic that this issue will be addressed as part of the final bill that is sent to the President for his signature.

Enhancing transportation security is a continuing concern. Since 9/11 we have provided a total of $10.38 billion for passenger safety through the Transportation Security Administration. Passenger screening, baggage screening, cargo screening, an additional $5.172 billion is included in this bill. Since September 11, $1.5 billion has been spent on explosive and trace detection systems, including the development, procurement and installation in our airports. We include in this bill an additional $335 million for the purchase and installation of these systems, as well as $50 million for air cargo safety and $40 million for research on next generation technologies at our airports.

Science and technology are critical to improving security, increasing efficiency and reducing costs. We include $900 million for science and technology, including $60 million, Mr. Chairman, to design develop and test any missile devices for our commercial aircraft. Other funds are targeted at research, development and rapid deployment of innovative technologies that our universities and other public and private organizations are already developing.

Lastly, the bill includes $5.6 billion over 10 years to encourage commercial development and production of medical countermeasures against bioterrorism, the so-called BioShield program. Funding in fiscal year 2004 is limited to $890 million. These funds will remove the barriers to develop next generation treatment for potential bioterror agents and will encourage the private sector to conduct the necessary research to counter bioterror threats.

Mr. Chairman, the bill before us today is the first Department of Homeland Security appropriations bill ever considered by these bodies. I believe it presents a well-balanced approach to tackling the job ahead. It invests in people. We invest in technology. We invest in partnerships. It funds efforts to assess our vulnerabilities and capitalize on our assets.

A lot of people would want us to spend tons and tons of more money, and believe me, if we thought it was useful to do so we would have no compunction against doing that. But there has got to be somewhere where we sensibly allocate our funds to our vulnerabilities and spend those dollars, but we should not spend money just for throwing it away.

I believe this bill is responsible, and I urge my colleagues to support this historic measure.

Mr. Chairman, I reserve the balance of my time.

Mr. SABO. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, first let me congratulate the gentleman from Kentucky (Chairman ROGERS) on the first homeland security bill and congratulate him on a job well done and also add my thanks to the staff, both minority and majority, for their hard work in putting this bill together. We really do appreciate their efforts.

Mr. Chairman, I rise in support of the fiscal year 2004 Homeland Security appropriations bill. But I must say that in many ways I think it is premature for this bill to be the first appropriations measure brought to the floor. The Department is in serious disarray, and the committee received very little support from the Department in putting together this bill and report. In fact, many of the agencies transferred to the Department were prevented by the Department from providing responsive information to the subcommittee.

Hearings could not even be arranged for four of the largest and most important of the Department's 11 major agencies. Those four agencies constitutes $9 billion, or 31 percent, of the Department's total budget. And I must say that that is an additional reason for thanking the staff, both minority and majority of this committee, for putting a bill together with the lack of information coming from the Department.

In some ways the current state of the Department of Homeland Security reminds me of the situation we faced 1 year ago and still face today with TSA. The management failures of TSA are well known, and I fear that the Department of Homeland Security is going down the same path. The Department so far has failed to develop a useful road map of its security goals for the Nation. If anyone at the Department has a strategy for basic objectives, such as securing the northern border, tracking all vessels entering American waters, or ensuring that airline cargo is effectively screened, no one has been willing to share that information with us. I find that disturbing.

If the Department will not define its goals, it is up to the Congress to do them. This bill provides $29.4 billion in discretionary budget authority for the Department of Homeland Security. This is only $536 million, or 1.8 percent, above fiscal 2003 funding. The gentleman from Kentucky (Chairman ROGERS) has managed to fill some of the most glaring funding gaps contained in President Bush's 2004 budget, specifically funding for first responder programs contained in this bill. However, the tightness in the budget resolution restricts this bill from doing more to protect our borders, secure our ports and other critical infrastructure. This does not serve our Nation well.

In conclusion, while I support the bill overall, I have many concerns with the current abilities, or rather inabilities of the Department of Homeland Security to adequately address obvious homeland security gaps.

Mr. Chairman, I reserve the balance of my time.

The CHAIRMAN. Does the gentleman from Tennessee (Mr. WAMP) seek unanimous consent to control the time of the gentleman from Kentucky (Mr. ROGERS)?

Mr. WAMP. Yes, Mr. Chairman.

The CHAIRMAN. Is there objection to the request of the gentleman from Tennessee?

There was no objection.

Mr. WAMP. Mr. Chairman, I yield 3 minutes to the gentleman from Florida (Mr. YOUNG), the distinguished chairman of the full Committee on Appropriations.

Mr. YOUNG of Florida. Mr. Chairman, I appreciate the gentleman yielding time.

I rise in strong support of the bill. Mr. Chairman, as you know, when we made the recommendation to reorganize the Committee on Appropriations, it was a major reorganization, the biggest reorganization in many, many years, and it was the right thing to do. When I selected the gentleman from Kentucky (Chairman ROGERS) to chair this subcommittee, it was the right choice. He has done a tremendous job in understanding the issues and in bringing together all of the various agencies that are involved in homeland security.

This is a good bill. There are some who will say that it is too much spending, and others who will say that it is not enough. You are going to hear that on all 13 appropriations bills. I tend to think we are just about in the right place on all of the bills.

Today we are focused on homeland security. On Friday we will consider the Military Construction appropriations bill. We have already marked up in addition to Homeland Security and Military Construction, after about a 4-week delay in getting approval on the budgetary levels, the Interior, Agriculture, Labor-HHS, Legislative and Defense appropriations bills in subcommittee.

Tomorrow we will mark up the Labor-HHS bill, the Interior bill, and the Agriculture appropriations bill in the full committee.

On Thursday we will mark up the Defense appropriations bill and the Legislative Branch appropriations bill in full committee. So for the Members' interested in having some idea of our schedule, we plan to have those bills through the House before the August recess.

The committee, once we were freed up from the hold that we had due to budgetary issues, has moved quickly and in a very responsible way, and I am happy to report, Mr. Chairman, that in addition to this good bill we are considering today, the Military Construction bill, which is also a good bill, will be considered on Friday and the Committee on Appropriations is well underway with the eleven other bills and has a very aggressive schedule.

Mr. SABO. Mr. Chairman, I yield 5 minutes to the gentleman from Wisconsin (Mr. OBEY), the distinguished ranking member of the committee.

Mr. OBEY. Mr. Chairman, I thank the gentleman for yielding me time.

Mr. Chairman, it is difficult to know how to handle the money in this bill because in my view the reorganization which took place leaves us with still a very discombobulated set of agencies, and it also I think has confused people about what our priorities are.

I am proud of the fact that on four separate occasions this Committee on Appropriations on a bipartisan basis tried to add additional funding for key homeland security items even though on each of those four occasions the White House opposed our efforts. But I want to tell you that today I think the chairman has produced a perfectly reasonable bill provided that we think that the status quo is all right given everything that has happened.

My problem is that I and my staff and the chairman of the full committee and his staff, have had extensive conversations with virtually every one of the national securities agencies in this country. And we got from them a year ago, a year and a half ago, and we have gotten from them as recently as a few weeks ago, their honest best estimates about where we need additional support in order to increase security of people on the home front.

The problem we have today is that we cannot put the resources in this bill that we ought to be putting in because the Congress, the majority party in the Congress, has decided that instead their number one and virtually only priority is tax cuts. And those are skewed mightily to the most well-off people in this country.

And the problem is that when you decide that you are going to put a trillion dollars into tax cuts, then that means that money is not available, not even a portion of it, to use to deal with our high priority needs at home, be they education or health care or, in this case, homeland security. And so what happens is that because of the way the budget process is handled, the public never gets to understand what the linkage is between the tax cut decisions that were made by this Congress and the linkage with these funding limitations for high priority security items.

So very simply, I will be trying to offer an amendment that does a number of things. We will add about $400 million to the Coast Guard for port security grants. The Coast Guard estimates that their long-term needs are for $4.4 billion. We think we ought to do more than just add $100 million to it under those circumstances.

We would increase our share of funding, the share of the Federal contribution for port facility security needs. The problem is, if we stay with the $100 million contained in this bill, it will take about 20 years to close the need in the estimate of the Coast Guard.

We also provide $100 million to implement the Maritime Transportation Security Act to improve and analyze vessel threat information.

We also add $100 million to the Customs inspectors so we can have 1,300 additional people inspecting containers shipped into the United States. Right now only 2 percent of those containers are checked. We think that is a needlessly reckless vulnerability. We are trying to increase by 6 percent the total number of inspector personnel. I think that is hardly out of line.

Then we add $200 million to try to improve northern border security. As I pointed out in the Committee on Rules, during Operation Liberty Shield, 10 aircraft came across the border without clearance even while we were patrolling that northern border by air. We have no idea who or what would have been in those planes.

We proposed to pay for this funding by reducing the size of the tax cut that will go to those with incomes of more than a million dollars next year. We proposed to reduce the size of their tax cut by 6 percent so that instead of getting $88,000 on average, they will get $83,000 per average. That is hardly putting them in the poor house. But it would enable us to reestablish additional support for these crucial investments.

I would urge the House to allow us to consider that amendment because the public has a right to know which of us are for it and which of us are against it. They have a right to know whether we put tax cuts for wealthy people ahead of the security of this Nation.

□ 1400

Mr. WAMP. Mr. Chairman, I yield 2 minutes to the gentleman from New Jersey (Mr. FRELINGHUYSEN), the chairman of the Subcommittee on the District of Columbia.

Mr. FRELINGHUYSEN. Mr. Chairman, today I rise in strong support of the fiscal year 2004 Homeland Security appropriations bill. This bill is a first of its kind but, more important, in the history that is being created with this first-ever homeland bill is the fact that this bill, simply put, makes America and my home State of New Jersey a safer place.

We in New Jersey and New York and the New York metropolitan area know better than most how vulnerable an open and free society can be. We put a very human face on the homeland security issue, as 700 New Jersey citizens went into Lower Manhattan that terrible morning on September 11, 2001, and never came home again, and many more people in New York City as well and residents from over 80 countries. This is all very personal.

These appropriations if spent and managed wisely may well prevent another catastrophic attack on American soil. While we can never really totally eliminate our vulnerabilities, this bill takes important steps to better protect our people and the infrastructure that carries them into and around New York City and over and under the Hudson River each and every day and protects people in other communities and cities around the Nation as well.

Notably, this historic bill recognizes that, while the Department of Homeland Security has the lead in developing our national homeland security strategy, implementation of the strategy requires the active collaboration and contributions of all States and municipal governments, and the private sector as well. It also recognizes that many of the agencies merged into the Department of Homeland Security in March have traditional missions.

For these and other reasons, Mr. Chairman, I support the passage of this appropriations bill.

Mr. SABO. Mr. Chairman, I yield 5 minutes to the distinguished gentleman from North Carolina (Mr. PRICE).

Mr. PRICE of North Carolina. Mr. Chairman, I am pleased to participate in this first-ever debate on the Homeland Security appropriations bill. I want to commend the gentleman from Kentucky (Mr. ROGERS), the chairman; and the gentleman from Minnesota (Mr. SABO), the ranking member, for their leadership of our subcommittee and the fine staff, majority and minority, for their good work.

Our task was to develop a budget where none had previously existed for a

Department that is struggling to master its mission. Hearings could not even be arranged for many of the largest and most important of the Department's 11 major agencies. As a result, we did not have the benefit of questioning important agencies such as Immigration and Customs Enforcement, Citizenship and Immigration Services, Information Analysis and Infrastructure Protection, and Office of Domestic Programs. Those four agencies alone constitute 31 percent of the Department's total budget.

The bill before us today provides over $35 billion for the new Department, which is $1 billion over the administration's request. In addition to providing for big-ticket items such as $5.6 billion for Project Bioshield, it provides $4.4 billion in grants to our first responders, which is 25 percent more than the President requested, and $900 million for the science and technology directorate to promote the research and development of security-related technologies.

I am also pleased with the attention paid to the equally important non-homeland security traditional missions of the many agencies now incorporated in this new Department. For example, the bill before us today rejects the administration's proposal to discontinue the section 404 postdisaster hazard mitigation program and combines it with $200 million for predisaster mitigation activities to both learn from the past and prepare for the future.

I am also encouraged that the bill recognizes the potential of our Nation's institutions of higher learning: $80 million is included for the rapid development of promising homeland security technologies by universities, national laboratories, nonprofit institutions and private companies, as well as $35 million for university and fellowship programs, including $25 million for the creation of university-based centers of excellence.

There are, however, Mr. Chairman, ample grounds for concern: for example, the security of our Nation's ports. Despite no request from the administration, the subcommittee has appropriated $100 million for port security grants to shore up our significant vulnerabilities there. Unfortunately, our Republican friends rejected a Democratic amendment that would have added $500 million toward the $4.4 billion the Coast Guard estimates is needed for port facility security improvements. We would have paid for that by a small reduction in the tax cut going to people making over $1 million a year.

Still, the subcommittee has been assured and must continue to demand the completion of port vulnerability assessments at the Nation's 55 largest ports by the end of 2004.

I remain concerned, Mr. Chairman, with overall fiscal year 2004 appropriations for law enforcement and emergency services. Given the importance of our Nation's first responders to the security of our communities, I want to ensure that the overall funding levels for the Office of Justice Programs, Community Oriented Policing Services, (COPS), the Byrne grant programs, and related accounts remain at or above fiscal 2003 levels.

I support this Homeland Security appropriations bill with the expectation that other appropriations bills, unlike the President's budget request, will provide adequately for first responders. We cannot allow those on the front lines to fall victim to an appropriations shell game, giving with one hand, taking away with the other, to the detriment of our local communities.

Mr. Chairman, it has been over a year and a half since September 11. Much has been accomplished; yet many, many challenges remain. I rise today in support of this appropriations bill, while recognizing the progress we have yet to make in providing for the security of our homeland.

Mr. ROGERS of Kentucky. Mr. Chairman, I yield 1½ minutes to the gentleman from Tennessee (Mr. WAMP), a very valuable member of our subcommittee, who has contributed much to this bill.

Mr. WAMP. Mr. Chairman, I want to make two points: one, if my colleagues like what they see with our Armed Forces and what they have seen in the last several months around the world in terms of our men and women in uniform, I want them to know that what we are trying to do with homeland security is essentially the same kind of bipartisan cooperation here in the Congress so that we adequately resource and establish the priorities for homeland security that mirror what we have done in the Congress to support national security throughout the years, so that the technology that is deployed and the efficiencies that are created, the accountability that is instilled in the Department of Homeland Security is the same as the Department of Defense, and it is difficult. We can always spend more money, but I want my colleagues to know that this bill adequately and effectively resources the needs that we have today.

I also want to point out that a lot is going to be said about tax cuts as we debate all of the appropriations bills, it already has been, but this is not a tax bill. We cannot cut taxes or raise taxes in an appropriation bill. We are charged with spending the money within the budget agreement, and that debate was in April. It obviously lingers here, but that debate was in April. Now we have the responsibility within the budget agreement to spend the money and set the priorities; and in doing so at homeland security, we have had extraordinary cooperation.

I salute the professional staff, I think one of the best staffs that has ever been assembled here; and it was important that we put the best people on the field that we could possibly find, on both sides of the aisle. Our committee work and our chairman and our ranking member, the leadership has been extraordinary; but this is such an important issue. It needs to be the best possible.

So we are off to a good start. Let us stay focused.

Mr. SABO. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from New York (Mr. SERRANO), a member of our subcommittee.

Mr. SERRANO. Mr. Chairman, let me first simply say on a comment that we just heard on the House floor that it is related to taxes, because it is a simple mathematical equation. If we have less money to spend because we give it away to the rich, then we have less money for education, for housing, for senior citizens, and for homeland security; and this is a fact of life.

However, having said that, I want to take this opportunity, first, to thank the gentleman from Kentucky (Mr. ROGERS), the chairman, and the gentleman from Minnesota (Mr. SABO) for this historic moment in putting together this bill. This bill, in my opinion, has some deficiencies; but on the other hand, it is a historic bill. It is the first time we have attempted to put together a bill like this and to take care of a need. Therefore, Mr. Chairman, I rise in reluctant support of H.R. 2555.

On September 11, everything changed in this country. The savage attacks on New York and Washington brought home to America that the threat of terrorism at home was terribly real. Among the responses by Congress were the creation of the Department of Homeland Security and the reorganization of the Committee on Appropriations to oversee and fund the new Department. The gentleman from Kentucky (Mr. ROGERS) has ably taken up the challenge of chairing the new House Subcommittee on Homeland Security. However, the leadership of this House has failed to give him or our ranking member the resources they need to do the job. The bill would not even provide enough funding to keep up with inflation, never mind step up the pace of improvements to our security.

As has been amply covered in other statements and is thoroughly demonstrated by the Obey amendment, which the Republican leadership through the Committee on Rules refused to make in order, there are gaping holes in our security, and at the rate we are going it will be many years before they can be filled. From ports to airport perimeters to our borders, we continue to face risk to our security that must be addressed, but cannot be, under this bill.

On a somewhat more parochial level, I am disappointed that we were unable to do more for grants to high-density urban and high-threat areas. Secretary Ridge just yesterday stated that he believed $750 million would be "a nice place to start," not the $500 million now in the bill.

If I sound somewhat negative in my support of this bill, one needs to understand that I was there in New York on September 11. I saw the tragedy that took place. I saw the crime committed on our country, and the scene of the crime was New York; and so New York has had a tendency to know what it is that we need to deal with this issue because we saw it firsthand. That does not take away our respect for our chairman, our ranking member, the work of the committee.

Mr. Chairman, once again, I reiterate my support for the bill in the hope that as it continues to go through the Senate, it becomes the bill it should be.

Mr. ROGERS of Kentucky. Mr. Chairman, I yield 1 minute to the gentleman from Iowa (Mr. LATHAM), a very distinguished and very helpful member of our subcommittee who contributed greatly to this bill.

Mr. LATHAM. Mr. Chairman, I thank the chairman for yielding to me.

Mr. Chairman, first of all, I want to commend the gentleman for the great job that he has done on this bill. It is the first Homeland Security appropriation bill in history. We are charting new waters here, and I also want to strongly compliment the great staff that we have on the subcommittee. They have done just an outstanding job to bring this very difficult bill together with all the ramifications that we have.

All Members here should be keenly aware of how difficult this task is and how broad the jurisdiction is, trying to combine 22 different Federal agencies into one Department, have them communicate with each other, have them function together, have them understand their role is to cooperate with States and local governments to ensure our homeland security.

This is a bill unlike any other that we have; and as the Chairman has said so many times, we are successful when nothing happens. As we are spending all this money, if the final outcome is that everything remains quiet, we have been successful, and it is very difficult to judge exactly how many dollars need to go exactly where to complete our role, but I think the chairman and the subcommittee have done an outstanding job.

Mr. Chairman, I rise in support of this bill, and commend Chairman ROGERS for his attention to the many difficult issues we have discussed in our hearings on homeland security.

He has been given the tough job of putting together a spending bill for this new Department and this bill is a testament to his good work and the good work of the Subcommittee staff—they have done an excellent job under difficult circumstances.

Mr. Chairman, the approach the Subcommittee has taken with this bill has been one of strong support for the mission of this new Department and a scrutiny of the many requests and ideas put forth by Members and others.

I believe this has been the best approach because we are moving through uncharted territory. One of my concerns has been that—going forward with this new bill—we would put forth too much money in a way that would paint us into a corner before all of the most pressing homeland security needs became clear.

I believed early on—and still believe—the members of this Committee deserve to know the most efficient methods in which to deploy our Homeland Security resources.

We cannot appropriately fund programs that do not have understandable goals or clear justifications. Every State and Member of Congress should be aware of the pitfalls of adding monies to specific accounts because they feel they have the best answer to our Homeland Security problems.

Let me remind you. We are witnessing the infancy of a Department. There are few of us in this body who have been faced with the enormous and important task of funding a new Department of this size.

I am certain nearly every one of you has been asked to request funding for a specific appropriation for a specific homeland security project. I'm betting that most of you have been overwhelmed by the number of "potential targets" in your district.

Those of us on the Subcommittee share your concern. But, this bill is not about Congress making local security decisions—it is about making sure our local responders have a functional Federal agency to work with to solve those problems.

That said—as we move deeper into the process of providing for our Homeland Security, we are going to get a clearer picture of what our needs are. We will be in a better position to prioritize those needs.

Congress is not in a position to mess around with local funding matters. Until the Congress, the administration and our local providers have confidence in the long-term needs, I think the approach we are taking today—in this first year of funding for this new Department—is the correct one.

Again, I want to commend the Chairman for his work on this bill and I urge all of the Members of this body to support this bill.

□ 1415

Mr. SABO. How much time is remaining on both sides, Mr. Chairman?

The CHAIRMAN. The gentleman from Minnesota (Mr. SABO) has 14½ minutes remaining and the gentleman from Kentucky (Mr. ROGERS) has 9 minutes remaining.

Mr. SABO. Mr. Chairman, I reserve the balance of my time.

Mr. ROGERS of Kentucky. Mr. Chairman, I yield 1 minute to the distinguished gentleman from New York (Mr. SWEENEY), who has been a member of the subcommittee who has been extremely helpful to us in this bill.

Mr. SWEENEY. Mr. Chairman, I want to especially thank the chairman of the subcommittee for all his great work.

This is not just about the merging of 22 Federal agencies into one. This is not just about responding to the needs of first responders. This is not just about establishing a system that not only helps first responders but creates a system of first preventers. This has really been a monumental task undertaken to give direction to an entity, a notion, a thought about protecting the American people here at the homeland, something prior to September 11, 2001 we did not give a lot of time to and that goes well beyond anything this government has ever done. This is about first responders, this is about border security, this is about aviation and port security, it is about a BioShield program, and it is about the four corners of defense.

I want to take my 1 minute to especially tell the chairman of the subcommittee, the gentleman from Kentucky (Mr. ROGERS), how thankful I am as a New Yorker, as an American citizen, as someone who lost friends and neighbors in the attack of September 11, for the commitment that he is honoring that we all made on September 11, 2001, for the great work that he has put into this, and for the fact that I feel greatly confident that as we go forward and need to make adjustments as this process evolves, that we have the right person in place at the subcommittee level.

Mr. SABO. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Chairman, I thank the gentleman for yielding me this time, and I rise in support of H.R. 2555, the first annual appropriations measure for the Department of Homeland Security. This bill will help us equip our Nation to prepare for and respond to future disasters. But it is not enough. When it comes to protecting our citizens, we must move faster and we must be stronger.

One critical shortcoming facing us is the failure of the DHS Intelligence Director to fulfill its role as the agency's new nerve center. The effective operation of this unit is indispensable to the success of the rest of the Department. Instead, resources are being allocated and priorities are being set without a reliable threat assessment that can be mapped against existing vulnerabilities.

We also continue to fall short of meeting our responsibility to first responders. Firefighters, police, health care workers and others on the front lines need our support to keep America safe. With dozens of States experiencing grave budget crises, first responders are more desperate than ever for Federal assistance.

In countless other areas, from port security to air cargo screening to computer interoperability, we are not moving fast enough and we have not become strong enough. We simply must make homeland security our top priority and devote the necessary resources to it.

Even at a time of mounting deficits, though, the administration and Republican leaders in Congress have found trillions of dollars for tax cuts for the wealthiest of Americans. I only wish the same determination were at evidence in this bill.

Mr. ROGERS of Kentucky. Mr. Chairman, I yield 1 minute to the gentlewoman from Missouri (Mrs. EMERSON), the hard working member of our subcommittee.

Mrs. EMERSON. Mr. Chairman, I wish to thank the chairman, the gentleman from Kentucky (Mr. ROGERS), for the tremendous job that he and his staff have done in putting together the inaugural Homeland Security appropriations bill and also for the honor of allowing me to serve on that subcommittee as well.

This bill does make a large investment in our Nation's first responders. We have added $888 million above the President's request for the Office of Domestic Preparedness, Firefighters and Emergency Management. This also includes another $750 million in firefighter grants, which has greatly been appreciated in Missouri and, in my judgment, is one of the most successful programs that FEMA and DHS have undertaken.

The bill also makes another important investment in intercity bus security by adding $10 million for this critical initiative. We also include over $5 billion for various transportation security initiatives to ensure that not only our airports continue to run smoothly but also our ports and our highways.

We make a large investment in the future by investing $900 million for science and technology. The funds will target research, development and deployment of innovative technologies that will help us protect the Nation well into the future.

So, Mr. Chairman, I want to thank the chairman again and also Michelle, Stephanie, Jeannie, Jeff, Brian, Tammy, and Tom for the great work they have done.

Mr. SABO. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, one of the disappointments I had in this rule was it did not waive a point of order on what I thought was a very reasonable limitation on the development of CAPPS2. The gentleman from Kentucky graciously accepted that amendment in committee. I would hope that the folks who are objecting would not raise a point of order when we get to that in the regular bill.

The provision is a moderate attempt to make sure that this very, very large system of compiling information on the American public receives the closest of scrutiny and the closest of examination by GAO and others before it is implemented.

Our amendment left in place the money for the program, left in place the capacity of the Department to proceed with work on how they want to put the program together, but requires it be scrutinized by GAO and the Academy of Science to look at the privacy issues and also to look at its effectiveness. It has the potential to be the largest intrusion of the American government into the private lives of American people that has ever occurred. It also, on the other hand, has the ability to be a system that totally complicates our screening process if it is not done well. Rather than simplify, it may make our whole screening process more cumbersome and more costly and less effective.

If a point of order is raised, the only alternative we will have is to seek a pure limitation without the language. I would hope the House would adopt such a limitation, if that is the situation we find ourselves in, but I much prefer we preserve the language which is for new activity of the Department, one not specifically authorized with guidelines by Congress. It is a new activity that the Department is pursuing and we simply want to put some regulations in place as they move forward to make sure this whole new large complicated program is put in place in a fashion that would work.

I might remind people this is an agency that has had trouble figuring out whether their own workforce has had criminal involvement in the past. They are struggling to make sure that their personnel do not have criminal backgrounds. They have not succeeded doing that yet. So we should be a little cautious before we give them a blank check to move forward with a huge new complicated screening process of the American public.

Mr. Chairman, I reserve the balance of my time.

Mr. ROGERS of Kentucky. Mr. Chairman, I yield 1 minute to the gentlewoman from Texas (Ms. GRANGER), another hard-working member of our subcommittee.

Ms. GRANGER. Mr. Chairman, one of our greatest strengths as a Nation has always been our ability to move people and products more safely and efficiently than anywhere else in the world. Unfortunately, as we saw on 9/11, this strength makes our transportation infrastructure a tempting target for terrorists.

Those hijackers that turned four planes into missiles were not just trying to kill thousands, they were also trying to restrict our freedom of movement, our way of life. As people travel more and more, and further and further for business and pleasure, the potential for a large-scale loss of life and an attack involving an airplane, boat, train or truck grows.

While protecting innocent lives is our top priority in homeland security, we all know that serious economic consequences can result after a terrorist attack when it disrupts the flow of goods and people in America's transportation network. These disruptions do not just cost money for big corporations with stranded products, they raise grocery prices for families, cut the earnings of farmers, and cause small businesses to close their doors.

In recognizing the importance and vulnerability of America's transportation infrastructure, Congress has moved quickly to strengthen transportation security. Since 9/11, we have provided more than $10 billion to safeguard and will add $5 million more in this legislation.

Mr. SABO. How much time do I have left, Mr. Chairman?

The CHAIRMAN. The gentleman from Minnesota (Mr. SABO) has 10 minutes remaining and the gentleman from Kentucky (Mr. ROGERS) has 6 minutes remaining.

Mr. SABO. Mr. Chairman, I yield 4 minutes to the gentlewoman from New York (Mrs. LOWEY).

Mrs. LOWEY. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. SWEENEY. Mr. Chairman, will the gentlewoman yield?

Mrs. LOWEY. I yield to the gentleman from New York, my good friend, for a colloquy, who will then yield back to me.

Mr. SWEENEY. Mr. Chairman, I intend to do just that, and I thank the gentlewoman for yielding to me.

Mr. Chairman, I rise to enter into a colloquy as well with the gentleman from Kentucky, the chairman of the Subcommittee on Homeland Security. The chairman, who I have had the pleasure of working with, has done a great job, as I said before on this bill, and I thank the gentleman for the inclusion of high threat funds in this particular bill and actually for having created the fund in the first instance. But I wish to highlight some concerns I have with the current distribution formula.

The City of New York spends $13.5 million a week, $700 million a year on extra police protection during its current state of alert. That amounts to more than $1 billion since September 11. And I am not talking about money that the city would spend anyway for police protection. I am talking about the net additional amount New York spends to protect against terrorist attacks.

New York's needs were highlighted as recently as last week when news of an al-Qaeda operative was arrested for plotting to sever the cables on the Brooklyn Bridge. The operative said one of the main foils to his plan was the added security around the bridge which prevented him from acting.

One of the reasons terrorist prevention needs are not met by some cities is because of the formula the Department uses to distribute funds. I know this is an authorizing issue more than an appropriations issue, but no first responder discussion is complete without recognizing the current formulas, which do not provide enough emphasis on the threat information.

The President and the administration at times have said they support a threat-based distribution of first responder funds in this national strategy for homeland security, and it is my hope this Congress moves quickly to enact a new threat-based formula to apply to first responders.

I recently introduced a bill to reform the first responder formula to reflect today's realities, and that bill would lessen the impact of allocating funds based on geography in favor of a quantitative assessment of threat information, vulnerability and consequences. We are dealing with serious people and we need a serious formula.

I know the war in Iraq is over, to whatever degree, and the national threat level has decreased since then, but last week's news stories prove we must remain vigilant in our fight against terrorism, particularly in New York, and I cannot stress strongly enough the need for focusing first responder funds on high-threat areas. It is no secret where the terrorists are focusing their resources, and I would ask the gentleman from Kentucky how he can address the concerns I outlined if the gentlewoman from New York will yield time to the gentleman from Kentucky.

Mrs. LOWEY. Mr. Chairman, reclaiming my time, I thank the gentleman from Kentucky (Mr. ROGERS) for agreeing to enter into this colloquy, and I wish to associate myself with the remarks of my colleague from New York.

We in New York have been bracing for another terrorist blow since September 11, and all of America has experienced that anxiety. I know the chairman is totally committed to doing everything possible to protect our communities against any potential attack.

☐ 1430

It is my understanding from both Federal and local intelligence briefings that New York is still acknowledged to be the top target for terrorism. I believe that New York City and other cities across our country, including Yonkers, New York, in my district, need dedicated resources to protect sites of national significance and critical infrastructure.

I agree with Secretary Ridge that we must distribute Federal funds on the basis of threat of terrorist attack and need, as well as population. That is not to say that States without high-density urban areas do not have important security needs. Our resources are limited, our responsibilities enormous, so we must be strategic; and I hope that the number of us who represent high-threat, high-density urban areas can work with the gentleman to examine this issue.

I appreciate the leadership of our chairman, and I thank the gentleman from New York (Mr. SWEENEY) for his hard work.

Mr. ROGERS of Kentucky. Mr. Chairman, will the gentlewoman yield?

Mrs. LOWEY. I yield to the gentleman from Kentucky.

Mr. ROGERS of Kentucky. Mr. Chairman, I thank the gentleman and gentlewoman for this colloquy and applaud the fight they have led for New York, which is one of the reasons we enacted a total of $800 million for high-threat, high-density urban areas in fiscal year 2003.

Of that $800 million, New York received $186 million to assist first responders with the increased security costs associated with the war in Iraq and Operation Liberty Shield. I am aware of the concerns the formula has generated. I assure my colleagues I appreciate the degree to which New York is a target and the expenses New York faces. I am also aware of those rural areas that rely on the basic formula grants to fulfill their first responder requirements. I believe any reform to the formula must ensure that these rural areas are not abandoned. I will work closely with the gentlewoman and the gentleman as the bill progresses to conference on these and other matters.

Mr. SABO. Mr. Chairman, I yield myself such time as I may consume.

In relationship to our latest colloquy, I understand the concern of people over the situation in New York. They clearly have unusual problems. Would the chairman agree with me that we do not know precisely how the agency sets criteria for the balance of funds in this particular discretionary program?

Mr. ROGERS of Kentucky. Mr. Chairman, will the gentleman yield?

Mr. SABO. I yield to the gentleman from Kentucky.

Mr. ROGERS of Kentucky. Only in a general sense. The presence of high-risk infrastructure, the urban intensity of the region, we leave it to the discretion of the Secretary, as I think we should, rather than some formula. As the gentleman knows, we have been working together.

Mr. SABO. Mr. Chairman, we have a little trouble getting a precise understanding of what criteria are used.

Mr. ROGERS of Kentucky. Mr. Chairman, if the gentleman will continue to yield, the gentleman is correct, but I think in due course of time, perhaps before the bill finally reaches the President, we will have found out more.

Mr. SABO. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. TURNER).

Mr. TURNER of Texas. Mr. Chairman, we consider today, of course, for the first time the appropriations for the new Department of Homeland Security. Just as the new Department is taking its first steps to make America safer, we are also embarking on an effort to try to secure the resources that we need for the longer term to ensure victory in the war against terrorism. This bill is a good start, and I support dedicating resources above the President's request to prepare our communities by training and equipping first responders and securing our ports and our transportation systems.

However, as we have been finding in the hearings before the Select Committee on Homeland Security, serious deficiencies remain in the Department's ability to carry out its mission of protecting all Americans from those harms that could come our way through terrorism. Testimony before our Select Committee on Homeland Security revealed that there is one, precisely one, person in the Department of Homeland Security assessing the bioterror threat to America and determining how to match that threat against our vulnerabilities and then make plans to protect America from bioterrorism.

It is clear we must move faster and we must be stronger to protect America. We have learned that, while over 4,000 port facilities and 10,000 ships that enter our ports are required to undergo security reviews, there is no funding to fulfill that mission. We must move faster and be stronger. We have learned that there are serious gaps in coverage on our northern border. There is on average only one person guarding every 16 miles of our Canadian border. The PATRIOT Act called for tripling the forces to protect our northern border, and the 2002 Border Security Act goes even further, but gaps still remain. We must move faster, and our forces must be stronger.

Mr. Chairman, just a few months ago this Congress voted to spend $65 billion to prosecute the war in Iraq. We spent those funds to make sure that our forces had the best training and the best equipment possible. We need to make the same commitment to those who fight on behalf of homeland security today.

Mr. ROGERS of Kentucky. Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. COX), the chairman of the Select Committee on Homeland Security.

Mr. COX. Mr. Chairman, the gentleman from Kentucky (Mr. ROGERS) and the gentleman from Florida (Mr. YOUNG) have done an extraordinary job in bringing to the floor a bill that has as its object the most important function of the Federal Government, protecting these United States from attack. Nothing that we do is more important.

The $29 billion in this legislation for the coming year is nearly 4 percent more than the President requested. It is $250 for every single taxpayer in America. It is an extraordinary amount of money to meet the new challenges of the post-September 11 world.

The $4.4 billion in this bill for first responders is nearly $1 billion more than the President requested. We have in fact in this Congress increased funding for first responders by more than 1,000 percent since September 11.

The Select Committee on Homeland Security, of which the gentleman from Kentucky (Mr. ROGERS) and the gentleman from Florida (Mr. YOUNG) are valued members, have had hearings and field investigations of the problems of getting these monies to our first responders on the front lines. The pipeline is the problem. That money is not getting to where it belongs.

That is why, in addition to the work that we can do in this bill as we go forward in conference, the Select Committee on Homeland Security will also be bringing to this floor legislation to unclog the pipeline and better distribute these monies on a threat basis, the way we have always done it for national security. We will streamline the grant process and base it on the principle of threat analysis.

I commend the chairman for the resources and direction provided in this legislation to ensure an intelligence analytical capacity within the Department of Homeland Security to meet not only the biothreat, but all of the threats to our homeland security that we face. This is an enormous amount of money. We now face the task of making sure that it is wisely spent. In the exercise of our oversight function, we will do just that. Our Nation's freedoms and our way of life depend upon it.

Mr. SABO. Mr. Chairman, I yield 1 minute to the gentleman from Maryland (Mr. HOYER), a distinguished member of the Committee on Appropriations.

Mr. HOYER. Mr. Chairman, I rise to talk about the Obey amendment which will be offered shortly. The Obey amendment puts before the Congress of the United States, before our Republican colleagues and before our Democrat colleagues, the question of what options do we want to pursue. The gentleman from California (Mr. COX) has said that the most important objective is keeping our homeland secure, keeping America and Americans safe.

The Obey amendment says do you care more about giving tax cuts to those at the very upper ranks of taxpayers, or do you care about keeping ports, airports, bridges and roads secure? It is a very simple question. It is a question, though, all of us must answer; and we must answer them with the responsibility to the American public that we have uppermost in our minds.

Mr. Chairman, I urge my colleagues, I urge this House to allow the gentleman from Wisconsin (Mr. OBEY) to offer this amendment and to support this amendment and to say to America, we are prepared to protect you.

Mr. SABO. Mr. Chairman, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE) and congratulate the gentlewoman on Rice's victory in the NCAA baseball tournament last night.

Ms. JACKSON-LEE of Texas. Mr. Chairman, I thank the gentleman for his vision and knowledge of that great sport of baseball, and let me congratulate the Rice Owls. We are excited and delighted that we have such national respect.

I rise to be able to add my support for the Obey amendment. Having just come back from field hearings in Long Beach and Los Angeles with the Committee on Homeland Security, I assure Members it is crucial to get funds in the hands of our local responders; and I use that terminology because I believe it means not only the first responders of firefighters and law enforcement, but nurses, doctors and hospitals, school districts and local government, city and county. That is why I have asked for amendments that I have offered to be made in order that in fact we expedite and simplify the regulatory maze that is required of these entities to get funding right on the ground.

It was amazing from a helicopter overview to be able to see how close residential communities are to sites of potential terrorist acts. We must act now to ensure that our first responders are the first ones that are taken care of to protect our neighborhoods. We need to move forward.

Ms. MILLENDER-McDONALD. Mr. Chairman, I rise to offer an amendment to the Homeland Security Appropriations Act.

This germane amendment would direct the Secretary of Homeland Security, in conjunction with the appropriate federal agencies, such as the Federal Transit Administration, to determine the percentage of frontline transit employees who have received training in emergency preparedness and response training.

This amendment would have also directed the Secretary of Homeland Security is to Report to Congress no later than 90 days after enactment of this legislation the percentage of "frontline transit employees" who have received emergency preparedness and response training.

In addition, the Secretary of Homeland Security would coordinate with the appropriate federal agencies such as the Federal Transit Administration and provide recommendations on what training on emergency preparedness and response training shall be provided to "frontline transit employees."

Mr. Chairman this amendment would have provided this new agency with guidance for years to come.

Understandably, we are all grappling with setting priorities and funding levels for new security programs and emerging threats.

By establishing a baseline of what security training our transit workforce needs, it will assist us in establishing priorities and funding levels in future years.

But make no mistake about the importance of establishing a comprehensive transit security-training program for our nation's frontline transit employee workforce.

We need to start now in order to properly plan for the future.

For years, governments around the world have recognized that public transportation is a major terrorist target.

Until 9/11 the United States has been largely spared the kinds of terrorist campaigns waged against public surface transportation.

However, we cannot wait for a tragedy to happen to prompt us to address our vulnerabilities. We must act now!

An October 2001 study released by the Mineta Institute, Protecting Public Surface Transportation Against Terrorism and Serious Crime: An Executive Overview cites that between 1920 and 2000 there have been approximately 900 terrorist attacks and other significant criminal incidents involving public surface transportation systems.

However, all but 14 of these attacks occurred after 1970, the year that marks the beginning of modern terrorism.

Attacks against transportation and transportation infrastructures accounted for 42 percent of all international terrorist attacks, according to the most recent statistics provided by the USDOT Office of Intelligence and Security in 1998.

Again, Mr. Chairman, I offer my statement for the RECORD.

Mr. BLUMENAUER. Mr. Chairman, hometown security should be our number one priority to ensure the American public is safe from terrorism—both domestic and foreign.

The federal government has made significant commitments, but unfortunately these have been more show than substance. The most recent example is the budget for the homeland security appropriations. I know from my own experience that there are vast unmet needs in every community around the country, and Oregon is no exception. The federal government should be helping communities to pay for the costly precautions that local governments must take to respond to high level security alerts, the effects of which ripple through crippled local budgets. We have yet to make local governments whole from the federal government imposed shut down of airports following September 11th. There are vast and clear needs for the Coast Guard which this budget virtually ignores.

We are lavishing hundreds of billions in tax relief for those who need it the least when we are investing billions of dollars in questionable military expenditures, like theater missile defense or Star Wars. It inexcusable that we do not do a better job of listening to and meeting the needs of our local communities around the country. I, in good conscience, find it very hard to vote for this appropriation and hope that we will send the message that Congress should step up and make its action match its rhetoric and the need.

Mr. TOM DAVIS of Virginia. Mr. Chairman, I rise in strong support of H.R. 2555, the Fiscal Year 2004 Department of Homeland Security Appropriations Act.

This important legislation provides $30.4 billion in funding for the upcoming year, $1 billion over the Administration's request, including $4.4 billion for grants to the police, firefighter and emergency medical personnel that are on the front lines of our nation's homeland preparedness and emergency response. In addition, I am pleased to see in this legislation a timeline to expedite the allocation of these resources within 120 days of passage of this Act.

We have heard today, Mr. Chairman, and will continue to hear that there are simply not enough funds included in this bill to achieve our goal of making our homeland secure. The fact, however, is that to date the federal government has spent $20.8 billion for our nation's first responders, and we will continue to fund what is necessary to ensure they have the training, equipment and resources necessary to do their job.

We in this House know full well that money spent does not simply translate into increased preparedness. This in only a start, and we must continue to be vigilant in not only appropriating adequate funds, but ensuring that these funds are administered strategically as part of a comprehensive plan to address our nation's vulnerabilities and needs. We must remember that while the Department of Homeland Security develops our national homeland security strategy, the implementation and the ultimate success of that strategy rests with our state and local governments.

In closing, Mr. Chairman, the protection of the American citizens is the first and foremost duty of the federal government, and this Congress will continue to work with the Administration, and our states and localities to this end. This bill is a solid next step for our nation's emergency preparedness and response capabilities and I urge my colleagues to support it.

Mrs. CHRISTENSEN. Mr. Chairman, I rise in support of the Obey amendment to add an additional $1 billion to H.R. 2555 to help fill critical homeland security deficiencies and urge my colleagues to support its adoption.

Mr. Speaker, the bill before us would provide $30.4 billion for operations and activities of the Department of Homeland Security in Fiscal Year 2004 and permit the Department to use an additional $4.8 billion in Immigration and air passenger fees.

Whether these amounts are sufficient for the Department to successfully carryout its mission is difficult to know because the Department has provided the subcommittee and my own Select Committee on Homeland Security with very little information about their mission and overall plan of operations. In fact, budget justifications for many important activities within the Department were not submitted for months after the President's budget was released and hearings could not even be arranged for four of the largest and most important of the Department's eleven major agencies.

This is very troubling, Mr. Speaker, particularly in light of the enormity of the Department's mission to protect the country from terrorist attacks.

Equally troubling is the denial by the rules committee of an amendment which was offered by our colleague the Ranking Democrat of the Appropriations committee, DAVE OBEY, to provide an addiitonal $1 billion to help fill critical homeland security deficiencies. The Obey amendment would have added an additional $400 million to the bill for additional port security grants. The Coast Guard has reported that it needs approximately $4 billion more than the $463 million that has been appropriated since September 11th for port security improvements.

In my district, the highest priority for securing our territory against attacks has been and continues to be the establishment of a "Border Patrol" unit for the Virgin Islands.

Working in coordination with our U.S. Attorney's Office, the U.S. Customs' Service, the F.B.I., the Transportation Security Administration, and the U.S. Coast Guard, the Government of the Virgin Islands is in the final stages of developing a strategic anti-terrorism and Homeland Security plan for the territory. A critical component of any such plan will require additional resources for our federal agencies, especially the Coast Guard which has to oversee what may be the busiest cruise ship port in the Caribbean—the port of Charlotte Amalie, St. Thomas. Additionally, the Coast Guard is also called upon to inspect the several ships that visit our waters daily, as well as, the pipes that lead from the ships to the tanks on land. Their search procedure for all ships follow international law and regulations differ for each different type of ship.

In addition to being the location of the busiest cruise ship ports in the Caribbean, the U.S. Virgin Islands is also home to HVENSA, the largest oil refinery in the Western Hemisphere, which regularly receives a number of very large tankers.

The Coast Guard has requested the establishment of a Border Patrol Unit for the Virgin Islands to better enable them to meet their several mandates for protection of our coast, which includes 175 miles of unprotected open borders and is the gateway to the United States as its southern most border.

Enactment of the Obey amendment would have significantly increased the likelihood that the Virgin Islands would receive a critically need border patrol unit.

Mr. Chairman, the Democratic members of the Select Committee on Homeland Security have been seeking answers to a number of fundamental questions about the Department, since the committee's inception. We have been trying to find out whether the Department is fulfilling its responsibility to better coordinate and access threat information and ensure that in the event of a terrorist attack, federal, state, local and private entities are prepared to respond to the event. These questions and others remain unanswered and the bill we are debating today unfortunately does very little to help us receive them.

I urge my colleagues to adopt the Obey amendment.

Ms. ROYBAL-ALLARD. Mr. Chairman, I rise in support of H.R. 2555, the Homeland Security Appropriations Act of 2004. As a member of the Homeland Security Subcommittee, it has been an honor to take part in the formulation of the new Homeland Security Department. I would like to commend our Chairman, HAL ROGERS, and our Ranking Member, MARTIN SABO, who under tight fiscal restraints did the best job possible putting together this first appropriations bill for the new Department of Homeland Security.

The Department of Homeland Security has had both success and failures. It has been successful in unifying principal border and transportation security agencies, coordinating a network of disaster response capabilities, and creating a central point for the analysis and dissemination of intelligence pertaining to terrorist threats. Beyond that however, the Department has failed to develop a useful roadmap of security goals the Department seems critical to protecting the homeland, such as securing the northern border, tracking all vessels entering American waters or insuring that airline cargo is effectively screened.

As a result, many of the windows of opportunity for terrorist organizations such as al Qaeda are nearly as wide open today as they were on September 11th. Of equal concern, is the fact that the Department seems to be stalled in its ability to put in place a program to close those windows open to terrorist attacks.

Overall this bill provides $29.4 billion in discretionary funding for fiscal 2004. That is only about 1.8 percent above the overall funding level allocated to agencies within the Department for fiscal year 2003. The Congressional Budget Office however, forecasts that prices will increase during the current fiscal year by 2.3 percent. As a result, the bill actually provides funding for the coming year that in terms of real dollars is about $150 million below current levels.

Mr. Chairman, cities such as my hometown of Los Angeles are the ones who must bear the brunt of this inadequate funding. Los Angeles is one of the largest cities and metropolitan areas in the country, and is considered to be one of the most "at risk" areas for terrorist attacks. With one of the world's largest port complexes and a major international airport, Los Angeles has heightened vulnerability to potential terrorist attacks.

Without adequate federal support, protecting our cities and towns is extremely costly and causes tremendous hardship on local governments. For example, Los Angeles officials have reported to me that during the days of the three Orange threat levels, the city registered $7.2 million in additional security costs. This figure includes additional costs for areas such as our city airports, our port, our public utility centers, our convention center and our police department. Although I am pleased that today's bill provides $500 million for "high threat urban areas" like Los Angeles, clearly this does not provide the funds needed to address the security needs of Los Angeles and other highly vulnerable urban areas.

In addition to representing the downtown portions of the City of Los Angeles, I also represent nine smaller municipalities including Downey, Commerce, Bell Flower, Huntington Park, and Vernon. Like other small cities and rural communities across the nation, these smaller cities are often overlooked in the urgent rush to protect the homeland and to establish emergency preparedness plans. These smaller cities, have increased security needs since September 11, 2001, and have also had to incur additional costs in response to our nation's heightened security alerts. Protecting our small cities is just as important as protecting our large cities, and national landmarks. To highlight this fact, I successfully included language in the bill's report which establishes a process that ensures local governments will be included in the development and review process of each state's emergency preparedness and security response plan.

Mr. Chairman, another areas of concern is the fact that the funding for our nation's commercial seaports continues to be dangerously inadequate. Our ports are one of our nation's most vulnerable assets. Yet this administration, and the leadership of this Congress continue to underfund our ports. While critics focus on the cost of providing this security, I want to highlight the cost of not providing this security. The labor shutout at the port complex of Los Angeles and Long Beach last fall is estimated to have cost $1 billion per day nationwide. This was only one port complex and yet the daily cost was staggering. If our ports experience a terrorist attack, international commerce would grind to a standstill. The Coast Guard has estimated that the infrastructure security needs at our ports will cost $1 billion in the first year and some $4 billion over a ten year period. Yes, this bill provides only $100 million in port security grants.

Congress was swift about providing funding to secure our nation's airways following the events of September 11, 2001. We must not wait for a similar tragedy at one of our ports to finally provide the necessary security funds.

Mr. Chairman, I must also express my displeasure that the Homeland Security Subcommittee was unable to hold a budget hearing with the Bureau of Citizenship and Immigration Services. This bureau was created under the Department of Homeland Security. Its responsibility is to build and maintain a service system that provides immigration information and benefits to the more than seven million annual applicants in a timely, accurate, consistent, courteous, and professional manner.

Having never met with Mr. Aguirre, the Acting Director, this committee has no way of knowing if this bureau is fulfilling its stated mission. Consequently, I am fearful that without adequate oversight and funding this new bureau will fall into the same bureaucratic trap that made the INS inadequate to meet the needs of this nation's immigrant community. I am hopeful that the subcommittee will have a hearing and receive a full budget justification from the Bureau of Citizenship and Immigration Services before this bill comes to the floor for a vote next year. I am also hopeful that next year the President's budget will request enough funds to realistically address the thousands of cases in backlog at this bureau. Although the committee increased the President's budget request by $14 million, the amount is still fifteen percent less than what was provided in Fiscal Year 2003 for immigration services.

Mr. Chairman, I am also concerned about the ongoing difficulties regarding airport security screeners at Los Angeles International Airport (LAX). These difficulties stem from the poor quality of the Transportation Security Administration's (TSA) security background checks. Despite assurances from TSA that their airport security workforce had been screened, authorized at LAX and other airports discovered that some members of their security screener workforce had criminal convictions. These airports petitioned TSA for the authority to conduct their own background check of the screeners at their own expense. TSA officials at first rejected the request before finally granting approval. The ongoing background checks by these airports are continuing to identify employees with disqualifying convictions. Hopefully, this issue will be resolved once and for all when the Office of Personnel Management (OPM) completes the last of its outstanding background checks on the TSA airport screeners.

Until such time, I am pleased that the bill includes language I offered that urges the TSA to work cooperatively with airport authorities that wish to conduct their own background checks of their TSA screener workforce.

I am also pleased that the bill includes report language that provides guidance to the Department of Homeland Security on two issues critical to the immigrant community. The report language expresses concern about the pattern of harassment, excessive use of force, and racial profiling by private vigilante groups that conduct paramilitary-like operations along our Southwestern border. In San Antonio for example, the sheriff recently arrested vigilantes who were charged with assault for their illegal arrest of two migrants from El Salvador. Vigilantes taking immigration law into their own hands is illegal, and their activity can lead to serious violations of fundamental rights. It can also interfere with the legal activities of protecting our homeland. For that reason, I am pleased that the report includes language I offered expressing concern that vigilante operations against migrants along the Southwestern border should not be tolerated, and may interfere with the work of the Department of Homeland Security.

Mr. Chairman, I am also pleased that the report contains language I requested directing the Department of Homeland Security to improve the processing and resettlement of refugees. Since the Sept. 11, 2001 attacks, increased security checks on individual refugee cases, combined with greater limits on the travel of refugee and immigration officers, have resulted in a slowdown of interviews necessary for U.S. resettlement. Many of these precautions are understandable, but as the Department of Homeland Security begins to shape its policy and procedures, we need to find a safe and acceptable method to quickly process legitimate refugee claims.

The world is looking to the United States for continued leadership in providing a safe environment free of abuse and persecution for many of the world's refugees. I am pleased that the report requests a plan from the Department of Homeland Security, in conjunction with the State Department, to overcome the hurdles encountered during the processing of refugee claims.

Mr. Chairman, while I am disappointed in this bill's inability to fully fund many of our countries initial national security needs, I support the efforts of the Chair and the Ranking Member to best allocate these limited resources. We have much more work ahead of us. I urge the conferees to address this issue of limited funds. In closing, I want to reiterate that I have enjoyed working with Chairman ROGERS who I know did his best given the limited resources the subcommittee was provided.

Mr. NUSSLE. Mr. Chairman, I rise to speak on the unfolding of the appropriations process for fiscal year 2004 and the Homeland Security appropriations bill in particular. The actual appropriations process commenced on April 10 when, five days before the statutory deadline, the U.S. Congress agreed to a budget resolution that established an overall limit or allocation on appropriations for fiscal year 2004.

THE BUDGET RESOLUTION

The budget resolution provided a total allocation for discretionary appropriations of $785.6 billion in fiscal year 2004, including the amounts held in reserve for the Bioshield initiative. This represents a 2.6 percent increase over the current year, which is slightly higher than the rate of inflation. Additionally, the budget resolution allowed an additional $23.2 billion to be appropriated in advance for fiscal year 2005.

The Congress agreed on this number after considerable deliberations involving the Leadership, the Budget and Appropriations Committees, and rank and file Members. We started with CBO's reestimate of the President budget request of $786.6 billion. We added $890 million for biological and chemical threats and another $215 million for the Iraq supplemental. At the same time, it was reduced by $2.2 billion to reflect advance appropriations that were not part of the President's original budget submission.

302(b) ALLOCATIONS

Last week the House Appropriations Committee finally decided how to divide that allocation across its 13 appropriations subcommittees. Under these allocations, total appropriations for defense and military construction will have climbed by 7.1 percent a year between fiscal years 2000 and 2004. Somewhat surprisingly, all other non-defense discretionary spending will have increased over the same period by a robust 8.2 percent.

The Appropriations Committee appropriately exercised its prerogative to allocate funding based on Congressional priorities. The Appropriations Committee comes in under the Administration request's by $3.2 billion for defense and $1.8 billion for Foreign Affairs. At the same time, it would exceed the President's request by $448 million for Labor, HHS and Education, $400 million for VA–HUD, $279 million for Energy & Water, $221 million for Agriculture, and $241 million for Commerce, State & Justice.

HOMELAND SECURITY APPROPRIATIONS

Today we consider the first of these appropriations bills, H.R. 2555, the Homeland Security Appropriations Act of 2004. This is a landmark occasion: the first separate appropriation bill for the Department of Homeland Security, which consolidates 22 Federal agencies and is expected to reach 180,000 employees.

The spending levels in this important measure are consistent with the limits for fiscal year 2004. The bill provides $29.4 billion in appropriations for fiscal year 2004, an increase of

$8.1 billion or 38 percent above last year's level. Much of this increase is for Border and Transportation, Emergency Preparedness, Informational Analysis and the Coast Guard. With total fiscal year 2004 appropriations equal to the allocation for the Homeland Security Subcommittee, the bill complies with the Congressional Budget Act.

The bill does provide an advance appropriation for Bioshield in fiscal year 2005, however, that is not permitted under the terms of the budget resolution.

H.R. 2555 does not contain any emergency-designated BA, which are exempt from budget limits. Nor does it rescind any previously appropriated BA.

This bill demonstrates Congress' unflinching commitment to win the war against terrorism. Consistent with the Budget Resolution, the bill provides resources above the President's request in areas like Border and Transportation Security, Emergency Preparedness and Response, and Science and Technology. This bill will enhance the Nation's ability to secure our borders, protect lives and property, and disrupt terrorist financing.

The bill also provides appropriations for the acquisition of various countermeasures against nuclear, radiological and biological threats. The authorization for these countermeasures has been reported by the Energy and Commerce and Government Reform Committees and will be acted upon by the Homeland Security Committee later this week.

BIOSHIELD

I am pleased the Appropriations and authorizing committees were able to meet a critical need in the fiscally responsible manner outlined in the budget resolution. Rather than create another entitlement program, the program was kept fully within the oversight of the Appropriations Committees. In order to give the administration the assurance of adequate funding in the outyears, the bill provides advance appropriations for fiscal years 2005 through 2013.

My only concern with this approach is that some might be tempted to exploit the fact that much of the advance of appropriations are scored in fiscal year 2005 on the expectation they will spend out over time by reducing that amount in 2005 to achieve spurious savings. I take it in good faith that the Appropriations Committee will leave these funds untouched in fiscal year 2005 so they will be available as the need arises in subsequent years.

CLOSING

As we enter the appropriations season, I wish Chairman YOUNG and all our colleagues on the Appropriations Committee the best as we strive to meet the needs of the American public within the framework established by the budget resolution.

Mr. ROGERS of Kentucky. Mr. Chairman, I yield back the balance of my time.

Mr. SABO. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the bill shall be considered for amendment under the 5-minute rule. During consideration of the bill for amendment, the Chair may accord priority in recognition to a Member offering an amendment that he has printed in the designated place in the CONGRESSIONAL RECORD. Those amendments will be considered read.

The Clerk will read.

The Clerk read as follows:

H.R. 2555

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes, namely:

TITLE I—DEPARTMENTAL MANAGEMENT AND OPERATIONS

DEPARTMENTAL ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses for management and operations of the Department of Homeland Security $221,493,000; of which not to exceed $78,975,000 shall be for the Office of the Secretary and Executive Management; of which not to exceed $116,139,000 shall be for the Office of the Under Secretary for Management; of which not to exceed $8,106,000 shall be for the Immediate Office of the Under Secretary for Border and Transportation Security; of which not to exceed $10,044,000 shall be for the Immediate Office of the Under Secretary for Information Analysis and Infrastructure Protection and the Command Center; of which not to exceed $3,293,000 shall be for the Immediate Office of the Under Secretary for Emergency Preparedness and Response; and of which not to exceed $4,936,000 shall be for the Immediate Office of the Under Secretary for Science and Technology: *Provided*, That not to exceed $2,000,000 may be used for unforeseen emergencies of a confidential nature, to be allocated and expended under the direction of the Secretary of Homeland Security: *Provided further*, That not to exceed $40,000 shall be for allocation within the Department for official reception and representation expenses as the Secretary may determine.

AMENDMENT OFFERED BY MR. FILNER

Mr. FILNER. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. FILNER:

In the item relating to "DEPARTMENTAL ADMINISTRATION—SALARIES AND EXPENSES" after the first dollar amount, insert "(reduced by $5,000,000)".

In the item relating to "BUREAU OF CUSTOMS AND BORDER PROTECTION-SALARIES AND EXPENSES (INCLUDING TRANSFER OF FUNDS)" after the dollar amount, insert "(increased by $5,000,000)".

Mr. FILNER. Mr. Chairman, I thank the gentleman from Kentucky (Mr. ROGERS) and the gentleman from Minnesota (Mr. SABO) for bringing us this bill on such an urgent matter.

I come with a small amendment that has rather big ramifications on our southern border with Mexico. I represent all of the California-Mexico border. As the President of the United States and his Secretary of Homeland Security agreed with the President of Mexico, we need a smart border, a smart border meaning security, yes, tight security, but efficiency also.

□ 1445

We need a blending at our borders of security and efficiency. In my district, I have got about a quarter of a million, that is over 250,000, legal crossings every day through the six or seven border crossings in my district. That is a lot of traffic. That traffic is very legal. It is for important purposes, important for our economy, important for our families, jobs, housing, culture, education, all that is going on in this exchange across the U.S.-Mexico border. We have shown that we can have the security we want with efficiency. We started a new program several years ago called SENTRI, meaning Secure Electric Network for Travelers Rapid Inspections. What that means in English is that we give people who have legitimate business across the border to travel, and they do it frequently, we give them as extensive a background check as is necessary to guarantee they are secure. We also give their vehicle a background check, and that vehicle and that person is matched when they cross the border by a smart card and a transponder. That is the SENTRI system. The Customs and INS now and under Department of Homeland Security set aside certain lanes of the border crossings for that purpose, for the SENTRI crossings.

Unfortunately, the demand for those smart cards way exceeds the ability right now of the Department of Homeland Security to meet. There is a backlog of 6, 7, 8 months. The Subcommittee on Homeland Security, and I thank the gentleman from Kentucky for this, in their report said what a great program SENTRI is. They complimented the fact that it exists. What we at the border need, though, is some assurance from this Department that money will go to this incredibly important use. We are not sure given some of the problems in the organization of this new Department that people are looking at the border and will think about it. We need some accountability that the money will go into that program.

We now have 42,000 motorists using SENTRI. As I said, there are three or four times that who are waiting to participate. The backlog is over 6 months. There is no assurance that that backlog will decrease unless there is some dedication of funds to this program.

I know that there is on the part of the committee a rightful concern with, "earmarks." I just ask that the chairman think about accountability not only in the Department but for the stakeholders at the border. We have people on both sides of the border, people who are doing legal business that are so important to our economies. Mexico is now our largest trading partner. A big part of that trade goes on trucks through California, the other part through Texas. We need to move that quickly with security guaranteed.

That is what my amendment will do. The folks who are doing this at the border need to know that the money is going to be there. They need to know that their business can be carried on. They need to know that they can expand their business because they know that crossing the border will be enhanced in a positive fashion. I say to the gentleman from Kentucky and the gentleman from Minnesota, I know that there is some reluctance to specify programs in their bill. I would just hope that such an amendment with such ramifications for our whole economy, and not just in Texas and New Mexico and Arizona and California where the border crossings are, but in Kentucky where there are people waiting for just on-time delivery. They need to know that SENTRI is working. I would ask for approval of $5 million for the SENTRI program.

Mr. ROGERS of Kentucky. Mr. Chairman, I rise in opposition to the amendment.

Mr. Chairman, I rise in reluctant opposition to this amendment by the gentleman who has been working very hard on the issue. Originally, this program permitted those certified as low-risk travelers to cross the Mexican border on an expedited basis for 1 year. However, in order to accommodate the unexpected increases in enrollment in that program following 9-11, Customs and Border Protection in February 2003 extended the enrollment period to 2 years. That had the effect of benefiting both participants in the program and the government by reducing paperwork and made the annual enrollment fee a biennial fee. But current enrollees had their eligibility automatically extended for 2 years from the date of their last enrollment and the applications backlog that was being blamed for increased waits at the border has been greatly reduced. So I do not think the problem is as bad as it perhaps was at the outset.

Number two, we took $333 million in the 2003 wartime supplemental and gave that to the Bureau of Customs and Border Protection. We have not received their spend plans on how they intend to use those funds. The Department, however, could, I would remind the gentleman, could use a portion of the supplemental to support the SENTRI expansion. They do have some discretion.

Number three, and the gentleman alluded to this. We have already cut the funds for the Department's administration by 25 percent. The moneys he would take with this amendment would come out of administration. We have already cut them past the bone almost. Additional reductions could reduce the basic departmental administration programs and impair their ability to fulfill management of the entire agency.

For all those reasons, Mr. Chairman, I reluctantly oppose the amendment and would urge Members to reject it.

Mrs. DAVIS of California. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I rise today in support of the Filner amendment to the Homeland Security appropriations bill. This amendment would provide the Bureau of Customs and Border Protection with critical funding to reduce the backlog of applications for the SENTRI program. I acknowledge the words that were just spoken about the need to use administrative funding; but, Mr. Chairman, we use less than 1 percent of that budget for this program. I want to tell you how important it is. The gentleman from California (Mr. FILNER) and I are well acquainted with the merits of the SENTRI program. I thank him for his work on this amendment and for his continued support on border management issues. The gentleman from California is a cosponsor of the SAFE Border Act, legislation that I introduced to modernize SENTRI. I would also like to thank Chairman ROGERS and Ranking Member SABO for the inclusion of report language regarding SENTRI.

So what does SENTRI do? It prescreens applicants. The program accepts only low-risk travelers who pass a background and a vehicle check, and it focuses enforcement efforts on those travelers who are not prescreened. Moving low-risk travelers into SENTRI lanes permits border agents to concentrate on other border crossers. It allows the entry of thousands of San Diego and Tijuana residents who cross the border every day and play a vital role in the area's economic and social life as commuters, shoppers, or visitors. Unfortunately, our border infrastructure has not kept pace with the booming traffic volume, and travelers frequently encounter delays and congestion at the border. SENTRI is an innovative program. It integrates security with efficiency. In this program we have a model of best practices that enhance national security and facilitate legitimate traffic. Why would we not direct resources to this program? Why would we not take every advantage, every opportunity to increase security?

To some extent SENTRI has become a victim of its own success. Enrollment increased, as we know, by more than 100 percent after September 11 and currently prospective applicants must wait several months. Next March, SENTRI will certainly need funding to handle the heavy processing demands caused by both renewals and new enrollees. Our agents at the border shoulder an enormous responsibility every single day. We owe them the appropriate resources and support they need to carry out their duties. We must also think about the technology and equipment needs of a program like SENTRI. This type of investment in our ports of entry results in greater border security and better trade flow.

Supporting this amendment, Mr. Chairman, would not only allow agents to reduce the SENTRI application backlog but means that the Bureau of Customs and Border Protection could do more background checks and improve national security. The ability to control our border is national security. It is trade and it is commerce for our region. It is an investment in the future of our ports of entry. It is communities seeking solutions to address our border management issues.

I hope my colleagues will join me in supporting the Filner amendment.

Mr. FILNER. Mr. Chairman, will the gentlewoman yield?

Mrs. DAVIS of California. I yield to the gentleman from California.

Mr. FILNER. I just would like to point out in furtherance of both our arguments and before the gentleman from Texas speaks, that there may be a rather slow hiring at the Department and thus carryover funding may be more than anticipated. With this really small amount of money from that account, it should not influence in a negative fashion anything about the hiring for this Homeland Security Department. I would again reinforce what she was saying, that the money is there, it is just a question of saying that it is going to be available and thus everybody at the border knows what is going on and we will have a more efficient border.

Mrs. DAVIS of California. I thank the Member for pointing out the fact that this is a phased-in process, and it is true that we will be doing it in a gradual way. But it gives people a sense of hope, a sense of knowledge, a sense of commitment that they and their businesses will be cared for as they move forward and as they try and increase commerce along the border, the good commerce that we all look forward to.

Mr. REYES. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, the vast majority of border crossings are made for legitimate purposes. As we seek to secure our borders, we cannot afford to strangle them. With 22 percent of our Nation's exports and imports crossing our land borders, we need to have adequate systems in place to ensure that legitimate trade and travel are not unduly impaired. SENTRI is one such system that has been used successfully in my district of El Paso, Texas, in putting together dedicated commuter lanes. These lanes reduce waiting times at the border for prescreened, low-risk, frequent border crossers.

The Filner amendment would provide needed funds to reduce the backlog of people applying to enroll in the SENTRI program. In my own district, we need some of these very same funds to replace equipment in our enrollment centers that often break down and other legitimate purposes to increase the legitimate flow of traffic back and forth between our borders. The sooner we can screen people out who pose no threat to our security, the more we will be able to concentrate our limited resources on those that may pose a threat to our national security.

Therefore, Mr. Chairman, I rise this morning to urge my colleagues to join me in voting "yes" on the Filner amendment.

Mr. HINCHEY. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I want to express my appreciation to the gentleman from Kentucky as well as the gentleman from Minnesota for the hard work that they have done on this bill under very difficult circumstances. Part of the problem is that there does not seem to be enough money to deal with the problems of domestic security at a time when this Nation appears to be under threat. At least that is what the administration would lead us to believe. Every other week we are going up to the orange alert code. Local governments around the Nation are responding to that. So if we are under threat, we need to be providing for the people at the local level who have to deal with that threat. This bill for all the care that has been put into fashioning it does not deal with that problem adequately. The problem seems to be that there is not enough money. I have heard people come to the floor here, even today, and talk about the fact that this is the appropriations process, it is not the budget process. But nothing here happens in isolation. This is all of a piece. If you are going to cut taxes, if you are going to take money out of the Treasury, do not be surprised if a little while later you do not have enough money to pay for your domestic security programs. That is the situation that we are confronting in the context of this bill.

Let me be even a bit more specific. Last year, we appropriated $2.9 billion of grants to State and local governments to help them prepare for and defend against terrorist attacks.

□ 1500

Eight hundred million dollars or about 30 percent of that was directed to high-threat areas. Some people would argue that 30 percent is not enough to be directed toward high-threat areas. They ought to have more than that. But we are getting even less in this particular bill. Seventy percent in last year's appropriation went to other places across the country. That number under this piece of legislation goes up to 83 percent, and the effective cut for areas under high threat goes from $800 million to $500 million, and that has to be spread all across the country in areas that constitute areas of high threat. Secretary Ridge himself has said that the $800 million is not enough. Certainly the $500 million is not enough.

We are not providing for the kind of national security that the administration talks about and Members of this Congress take this floor to talk about. It is one thing to express one's understanding of the need to deal with the problems of domestic threat. It is another to face up to those domestic threats and provide the resources so that the people out there on the firing line, the local government officials, the police, the firemen, emergency medical services personnel and others are able to contend with the problem when they express themselves and almost certainly they will.

So for all the care that the chairman and the ranking member have put into this bill, it remains deficient overall in the amount of money that we are spending on national security. No fault of theirs. They have been restricted in the amount of money they have to work with. There is not enough money allocated by this Congress or by the administration to deal with this problem. There is a lot of money for tax cuts. There is $80 billion to fight the war in Iraq, but there is not enough money to provide for domestic security. And on top of that in the context of this bill, we are cutting back on the amount of money that is allocated to high-threat areas specifically. That is foolish and we need to correct it.

We are beginning a process with this appropriation bill here today, and it is my hope that we will all work together constructively so that in the final analysis when we pass the final appropriation measure, we will have a bill that adequately provides funding for our domestic security needs and also takes into consideration those additional specific security needs that exist in areas of high threat across the country.

Mr. ROGERS of Kentucky. Mr. Chairman, I move to strike the requisite number of words, and I rise in opposition to the amendment.

Mr. Chairman, the gentleman that just spoke made some comments that I feel must be responded to. It is not really relevant to this amendment, but I will try to make it so, and that is whether or not we are providing enough funding for our State and local responders. I hear it every day. We hear it every day. Most people are uninformed or misinformed about how much money is going out there. In this bill we provide over $4 billion, and added to the moneys that we put in the 2002 bill and the 2003 bill, we will have appropriated some $20.8 billion just for State and local first responders. The money is going out in different sorts of grants. There are eight or 10 different sorts of grants, one of which goes to the high-threat urban areas such as New York, Washington, L.A., other places, and those go out at the discretion and in the decision of the Secretary.

Last year, the current year 2003, we provided $800 million for just the high-threat/high-density urban areas. The administration in the 2004 request did not request any funds in that account. We put $500 million back in that account, and that is in the bill as we speak. However, in the other grant accounts we have increased the grants for State and local first responders by over $1 billion. We do not hear that talked about, but it is there. There is over $1 billion more in those grant programs this year and next year than this year, $203 million above what we gave this year and $1 billion over what the President requested.

So I want to ask where is the beef? Where is the beef?

Those moneys are going out under competitive and discretionary grant programs to our States. Under this bill our States are required by law to give that money, 80 percent of it, to the locals within 60 days. The States have got to set up their own machinery for processing these applications. They have not done that yet. New York's application was almost tardy. We are just now getting the applications. And yet then we are saying you are not giving us the money. The money is there when you qualify and will be there during this year, but we have increased the amounts of money that go to State and local first responders $203 million above what they have now and $1 billion more than was requested by the President.

If the administration wants to submit a change in their budget request that changes these grants in some fashion, I am sure they will send us the supplement to their budget and we will give it due consideration. But, Mr. Chairman, I want to be sure that Members understand the State and local first responder grant moneys are there more than last year, $1 billion more than the President requested. If the States will get their committees together and do their paperwork and apply for these moneys, they will be there, and if there are any delays in the pipeline, it is mainly because the States and localities have not applied for the money.

So Mr. Chairman, I rest my case.

The CHAIRMAN. The question is on the amendment offered by the gentleman from California (Mr. FILNER).

The question was taken; and the Chairman announced that the noes appeared to have it.

Mr. FILNER. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from California (Mr. FILNER) will be postponed.

The Clerk will read.

The Clerk read as follows:

COUNTERTERRORISM FUND

For necessary expenses, as determined by the Secretary of Homeland Security, $20,000,000, to remain available until expended, to reimburse any Federal agency for the costs of providing support to counter, investigate, or prosecute unexpected threats or acts of terrorism, including payment of rewards in connection with these activities: *Provided*, That the Secretary shall notify the Committees on Appropriations 15 days prior to the obligation of any amount of these funds in accordance with section 503 of this Act.

Department-Wide Technology Investments

For development and acquisition of information technology equipment, software, services, and related activities for the Department of Homeland Security, and for the costs of conversion to narrowband communications, including the cost for operation of the Land Mobile Radio legacy systems, $206,000,000, to remain available until expended: *Provided*, That none of the funds appropriated shall be used to support or supplement the appropriations provided for the United States Visitor and Immigrant Status Indicator Technology system and the Automated Commercial Environment.

Office of the Inspector General

SALARIES AND EXPENSES

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses for the Office of the Inspector General in carrying out the provisions of the Inspector General Act of 1978 (5 U.S.C. App.), $58,118,000; of which not to exceed $1,000,000 may be used for unforeseen emergencies of a confidential nature, to be allocated under the direction of the Inspector General of the Department of Homeland Security: *Provided*, That in addition, $22,000,000 shall be derived by transfer from the Emergency Preparedness and Response Disaster Relief Fund.

TITLE II—BORDER AND TRANSPORTATION SECURITY

CUSTOMS AND BORDER PROTECTION

Bureau of Customs and Border Protection

SALARIES AND EXPENSES

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses of the Bureau of Customs and Border Protection for enforcement of laws relating to border security, immigration, customs, and agricultural inspections and regulatory activities related to plant and animal imports, including planning, construction, and necessary related activities of buildings and facilities, $4,584,600,000; of which not to exceed $25,000 shall be for official reception and representation expenses; of which not to exceed $129,000,000 to remain available until September 30, 2005, shall be for inspection technology; of which such sums as become available in the Customs User Fee Account, except sums subject to section 13021(f)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(f)(3)), shall be derived from that account; and of which not to exceed $5,000,000 shall be for payments or advances arising out of contractual or reimbursable agreements with State and local law enforcement agencies while engaged in cooperative activities related to immigration: *Provided*, That none of the funds available to the Directorate of Border and Transportation Security may be used to pay any employee overtime pay in an amount in excess of $30,000 during the calendar year beginning January 1, 2004, except that the Commissioner of Customs and Border Protection may exceed such limitation as necessary for national security purposes and in cases of immigration emergencies: *Provided further*, That uniforms may be purchased without regard to the general purchase price limitation for the current fiscal year: *Provided further*, That no funds shall be available for the site acquisition, design, or construction of any Border Patrol checkpoint in the Tucson sector: *Provided further*, That the Border Patrol shall relocate its checkpoints in the Tucson sector at least once every 7 days in a manner designed to prevent persons subject to inspection from predicting the location of any such checkpoint.

AMENDMENT OFFERED BY MR. OBEY

Mr. OBEY. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. Obey:

In title II, in the item relating to "Bureau of Customs and Border Protection—salaries and expenses", after the aggregate dollar amount, insert "(increased by $100,000,000)".

In title II, in the item relating to "Bureau of Immigration and Customs Enforcement—salaries and expenses", after the aggregate dollar amount, insert "(increased by $200,000,000)".

In title II, in the item relating to "TRANSPORTATION SECURITY ADMINISTRATION—Aviation Security"—

(1) after the aggregate dollar amount, insert "(increased by $150,000,000)"; and

(2) insert before the period at the end the following:

: *Provided further*, That of the total amount provided under this heading, $75,000,000 shall be available only for grants to airports for perimeter security improvements, $50,000,000 shall be available only to screen cargo carried on passenger aircraft, and $25,000,000 shall be available only to ensure that overseas aircraft maintenance facilities that service United States aircraft comply with United States security standards

In title II, in the item relating to "TRANSPORTATION SECURITY ADMINISTRATION—Maritime and Land Security", after each of the dollar amounts, insert "(increased by $400,000,000)".

In title IV, in the item relating to "UNITED STATES COAST GUARD—Operating Expenses"—

(1) after the aggregate dollar amount, insert "(increased by $100,000,000)"; and

(2) insert before the period at the end the following:

: *Provided further*, That of the total amount provided under this heading, $100,000,000 shall be for implementation of all of the requirements of the Maritime Transportation Security Act of 2002 (Pub. L. 107–295)

In title IV, in the item relating to "INFORMATION ANALYSIS AND INFRASTRUCTURE PROTECTION—Operating Expenses", after the aggregate dollar amount, insert "(increased by $50,000,000)".

At the end of the bill (before the short title), insert the following:

Sec.   . In the case of taxpayers with adjusted gross income in excess of $1,000,000 for the tax year beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Pub. L. 108–27) shall be reduced by 5.66 percent.

Mr. OBEY (during the reading). Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the Record.

The CHAIRMAN. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. ROGERS of Kentucky. Mr. Chairman, I reserve a point of order.

Mr. OBEY. Mr. Chairman, this amendment attempts to do six things. It would add $400 million for port facility security grants. The Coast Guard says that we need more than $4.5 billion over time to secure those operations. At the committee rate of only an additional $100 million per year, it would take 20 years for us to get halfway to the task that is defined for us by the Coast Guard. I do not think that is fast enough. We would also add $100 million for the Coast Guard to implement the Maritime Transportation Security Act, which passed this Congress last November, which is aimed at strengthening our ability to analyze vessel threat information.

We need simply look at the newspaper headlines yesterday about explosives bound for Sudan that were picked up by the Greek government, 680 tons of explosives and 8,000 detonators in the ship Baltic Sky, which the inspectors described as being tantamount to the power of an atomic bomb. I think that makes eminently clear why we need to protect our own ports to a greater extent.

Thirdly, we would add $100 million to increase the inspections of containers that are being shipped to this country. Right now we inspect only 2 percent. We would add 1,300 more inspectors. We are just scratching the surface in terms of what we need.

Fourth, we would add $200 million to improve northern border security. That border is 5,500 miles long. It is highly vulnerable. I referred earlier to the some 60 aircraft that flew across that border unannounced and unflagged over the past year.

We would then add $150 million for aviation security to secure airport perimeters and to strengthen our ability to screen cargo on passenger planes. It is kind of strange to provide screening for passengers if we do not provide it for cargo.

Lastly, we would add $50 million for the Information Analysis and Infrastructure Protection Division in the new agency that is supposed to be the nerve center, the brain, of that agency in targeting what our biggest vulnerabilities are. We would pay for that by reducing the size of the tax cut that was passed by this Congress. We would reduce the size of the tax cut for taxpayers who earn more than $1 million a year. They are scheduled to get an $88,000 tax cut. We would reduce that tax cut to $83,000. So instead of getting $17.7 billion next year, they would only get $16.6 billion in tax reduction. I hardly think that is laying a scratch on them.

Mr. Chairman, the purpose of the Budget Act was to try to force the Congress to recognize the choices and the trade-offs that are attendant to any budget. The problem is that the way the budget process has been used, we have a situation in which we have a huge disconnect between actions on the tax bill and the consequences that flow in terms of reduced services and reduced security for the country. So I would simply ask that we recognize that this amendment meets essential services. It provides essential services, and it also has the added feature of demonstrating that there is a price to pay for tax cuts primarily aimed at such high-income people, especially when it means and requires that by the time we finish our action on the tax side of the ledger, we have only table scraps left to provide needed services not just for homeland security for that matter but for education, health care, and a number of other crucial items.

For those who say we are invading the jurisdiction of another committee, we did that at the expressed request of the House leadership just a few months ago on the omnibus appropriations bill. So this is nothing new, and I would urge support for the amendment, Mr. Chairman.

POINT OF ORDER

The CHAIRMAN. Does the gentleman from Kentucky (Mr. ROGERS) insist on his point of order?

Mr. ROGERS of Kentucky. Mr. Chairman, I make a point of order against the amendment because it proposes to change existing law and constitutes legislation in an appropriations bill and therefore violates clause 2 of rule XXI, which states, in part, an amendment to a general appropriations bill shall not be in order if changing existing law, and I ask for a ruling from the Chair.

The CHAIRMAN. Does any other Member desire to be heard on the point of order? The gentleman from Wisconsin.

PARLIAMENTARY INQUIRIES

Mr. OBEY. Mr. Chairman, I do and I would first raise a parliamentary inquiry. Could the Chair tell us what rules were waived by the Committee on Rules for consideration of the majority committee bill and its provisions?

The CHAIRMAN. The Chair will read the pertinent portion of House Resolution 293, the rule providing for consideration of this bill in Committee of the Whole, and that portion is: "Points of order against provisions in the bill for failure to comply with section 501 of House Concurrent Resolution 95 and clause 2 of rule XXI are waived except as follows: sections 514, 521, and 522."

□ 1515

Mr. OBEY. Mr. Chairman, I have a further parliamentary inquiry.

The CHAIRMAN. The gentleman will state it.

Mr. OBEY. Is it not true that the selective waiving of the rules as cited by the Chair make clear that the DeLauro amendment and the Sabo amendment, which were offered in committee, were not protected by the rule? That is the practical effect of that language, as I understand it.

The CHAIRMAN. The sections specified in the rule, 514, 521, and 522, are not protected.

Mr. OBEY. So my understanding is that that means that the DeLauro language on corporate expatriates and the Sabo amendment with respect to CAPPS were both precluded from being considered by the House.

Would the Chair answer one other parliamentary inquiry, please. What rules are waived to enable my amendment to be offered on behalf of the minority?

The CHAIRMAN. The rule does not speak to amendments to the bill.

Mr. OBEY. Mr. Chairman, then let me simply raise a further parliamentary inquiry.

The CHAIRMAN. The gentleman may state it.

Mr. OBEY. Because what I think the Chair just said is that the Committee on Rules, in contrast to the way it handled majority provisions, that the Committee on Rules did not make in order a waiver for our side of the aisle.

But let me ask the Chair as a parliamentary inquiry, is it not correct that on the omnibus appropriations bill just a few months ago that we amended the Medicare Act not once, but in two separate areas, to provide a 6 percent increase in funding for providers under the Medicare Act, even though that was considered invading another committee's jurisdiction?

Is it also not true that on that omnibus legislation the committee was allowed to increase payments under division N, section 401(b) of the Medicare Act for rural hospitals? Is it not true that we waived the rules to allow the U.S. Customs Service to conduct vehicle inspections on the Canadian side of the U.S.-Canada border? And is it not also true that during the tumultuous debate about what to do about the dilemma of the airlines, that we waived rules again to allow the committee to include in its appropriation bill the bailout for the airlines as well as the extension of unemployment benefits to those in that industry?

The CHAIRMAN. As the Chair stated on June 26, 2002, the Chair cannot place issues into historical context; and, therefore, the gentleman has not stated a proper parliamentary inquiry.

Mr. OBEY. Well then, Mr. Chairman, I would simply say that I would urge the Chair to uphold my right to offer this amendment, because I cannot believe that the majority leadership would want to be so unfair as to waive provisions of our rules for the majority party's bill, but to not extend the same opportunity to those of us on the minority side, and to point out that I have just recited four instances where, just a few months ago, the majority leadership insisted that we provide these waivers for these non-appropriated purposes.

The CHAIRMAN. Do further Members wish to speak on the point of order?

If not, the Chair is prepared to rule.

The gentleman from Kentucky makes a point of order that the amendment proposes to change existing law in violation of clause 2(c) of rule XXI.

The amendment, in pertinent part, proposes to increase budget authority to be offset by a change in certain tax statutes under the Internal Revenue Code.

As the Chair previously ruled on September 8, 1999, and July 26, 2001, an amendment to a general appropriation bill addressing tax-rate reduction under the Internal Revenue Code constitutes legislation in violation of clause 2(c) of rule XXI; and, therefore, the point of order is sustained.

Mr. OBEY. Mr. Chairman, on that I most reluctantly and respectfully move to appeal the ruling of the Chair.

The CHAIRMAN. The question is, Shall the decision of the Chair stand as the judgment of the committee?

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. ROGERS of Kentucky. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 222, noes 200, not voting 12, as follows:

[Roll No. 305]

AYES—222

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Gerlach
Gibbons
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney

Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (FL)

NOES—200

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—12

Baird
Brown-Waite, Ginny
Camp
Conyers
Cubin
Garrett (NJ)
Gephardt
Gilchrest
Gutierrez
Paul
Smith (WA)
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN (during the vote). Members are advised that there are less than 2 minutes remaining in this vote.

☐ 1541

Mr. PASCRELL changed his vote from "aye" to "no".

Mr. HEFLEY changed his vote from "no" to "aye".

So the decision of the Chair stands as the judgment of the Committee.

The result of the vote was announced as above recorded.

The CHAIRMAN. Are there further amendments to this paragraph? If not, the Clerk will read.

The Clerk read as follows:

In addition, for administrative expenses related to the collection of the Harbor Maintenance Fee, pursuant to Public Law 103–182, and notwithstanding section 1511(e)(1) of Public Law 107–296, $3,000,000 to be derived from the Harbor Maintenance Trust Fund and to be transferred to and merged with this account.

Automation Modernization

For expenses not otherwise provided for Bureau of Customs and Border Protection automated systems, $493,727,000, to remain available until expended, of which not less than $318,690,000 shall be for the development of the Automated Commercial Environment: *Provided*, That none of the funds appropriated under this heading may be obligated for the Automated Commercial Environment until the Bureau of Customs and Border Protection prepares and submits to the Committees on Appropriations a plan for expenditure that (1) meets the capital planning and investment control review requirements established by the Office of Management and Budget, including OMB Circular A–11, part 3; (2) complies with the Bureau of Customs and Border Protection's Enterprise Information Systems Architecture; (3) complies with the acquisition rules, requirements, guidelines, and systems acquisition management practices of the Federal Government; (4) is reviewed and approved by the Bureau of Customs and Border Protection Investment Review Board, the Department of Homeland Security, and the Office of Management and Budget; and (5) is reviewed by the General Accounting Office: *Provided further*, That none of the funds appropriated under this heading may be obligated for the Automated Commercial Environment until such expenditure plan has been approved by the Committees on Appropriations.

IMMIGRATION AND CUSTOMS ENFORCEMENT

Bureau of Immigration and Customs Enforcement

SALARIES AND EXPENSES

For necessary expenses of the Bureau of Immigration and Customs Enforcement for enforcement of immigration and customs laws, detention and removals, investigations, including planning, construction, and necessary related activities of buildings and facilities, $2,030,000,000; of which not to exceed $5,000,000, to remain available until expended, shall be for conducting special operations pursuant to Public Law 99–570 (19 U.S.C. 2081); of which not to exceed $15,000 shall be for official reception and representation expenses; of which not less than $100,000 shall be for promotion of public awareness of the child pornography tipline; and of which not less than $200,000 shall be for Project Alert: *Provided*, That none of the funds available to the Bureau of Immigration and Customs Enforcement may be used to pay any employee overtime pay in an amount in excess of $30,000 during the calendar year beginning January 1, 2004, except that the Assistant Secretary of the Bureau of Immigration and Customs Enforcement may exceed such limitation as necessary for national security purposes and in cases of immigration emergencies: *Provided further*, That of the total amount of funds made available for activities to enforce laws against forced child labor in fiscal year 2004, not to exceed $5,000,000 shall remain available until expended for support of such activities: *Provided further*, That uniforms may be purchased without regard to the general purchase price limitation for the current fiscal year.

Federal Protective Service

(INCLUDING TRANSFER OF FUNDS)

For expenses, not otherwise provided for, necessary for the operations of the Federal Protective Service, $424,211,000 shall be transferred from the revenues and collections in the General Services Administration, Federal Buildings Fund.

Automation and Infrastructure Modernization

For expenses not otherwise provided for Bureau of Immigration and Customs Enforcement automated systems, $367,605,000, to remain available until expended, of which not less than $350,000,000 shall be for the development of the United States Visitor and Immigrant Status Indicator Technology system (US VISIT): *Provided*, That none of the funds appropriated under this heading may be obligated for US VISIT until the Bureau of Immigration and Customs Enforcement prepares and submits to the Committees on Appropriations a plan for expenditure that (1) meets the capital planning and investment control review requirements established by the Office of Management and Budget, including OMB Circular A–11, part 3; (2) complies with the Bureau of Immigration and Customs Enforcement Enterprise Information Systems Architecture; (3) complies with the acquisition rules, requirements, guidelines, and systems acquisition management practices of the Federal Government; (4) is reviewed and approved by the Bureau of Immigration and Customs Enforcement Investment Review Board, the Department of Homeland Security, and the Office of Management and Budget; and (5) is reviewed by the General Accounting Office: *Provided further*, That none of the funds appropriated under this heading may be obligated for US VISIT until such expenditure plan has been approved by the Committees on Appropriations.

Air and Marine Interdiction

For expenses, not otherwise provided for, necessary for the operation, maintenance and procurement of marine vessels, aircraft, and other related equipment of the Office of Air and Marine Interdiction of the Bureau of

Immigration and Customs Enforcement, including operational training and mission-related travel, and rental payments for facilities occupied by the air or marine interdiction and demand reduction programs, the operations of which include the following: conducting homeland security operations; interdiction of narcotics and other illegal substances or items; the provision of support to Department of Homeland Security and other Federal, State, and local agencies in the enforcement or administration of laws enforced by the Bureau of Immigration and Customs Enforcement; and, at the discretion of the Under Secretary for Border and Transportation Security, the provision of assistance to Federal, State, and local agencies in other law enforcement and emergency humanitarian efforts, $175,000,000, which shall remain available until expended: *Provided*, That no aircraft or other related equipment, with the exception of aircraft that are one of a kind and have been identified as excess to Bureau of Immigration and Customs Enforcement requirements and aircraft that have been damaged beyond repair, shall be transferred to any other Federal agency, department, or office outside of the Department of Homeland Security, during fiscal year 2004 without the prior approval of the Committees on Appropriations.

AMENDMENT NO. 7 OFFERED BY MR. LOBIONDO

Mr. LoBIONDO. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 7 offered by Mr. LoBiondo:

In title II, in the item “IMMIGRATION AND CUSTOMS ENFORCEMENT—Air and Marine Interdiction”, after the dollar amount insert “(reduced by $5,000,000)”.

In title II, in the item “TRANSPORTATION SECURITY ADMINISTRATION—Aviation Security”—

(1) after the first dollar amount insert “(reduced by $10,000,000)”; and

(2) after the fourth dollar mount insert “(reduced by $10,000,000)”.

In title II, in the item “TRANSPORTATION SECURITY ADMINISTRATION—Administration”, after the dollar amount insert “(reduced by $36,000,000)”.

In title IV, in the item “CITIZENSHIP AND IMMIGRATION SERVICES—Operating Expenses”, after the dollar amount insert “(reduced by $12,000,000)”.

In title IV, in the item “UNITED STATES COAST GUARD—Operating Expenses”, after the first dollar amount insert “(increased by $35,000,000)”.

In title IV, in the item “UNITED STATES COAST GUARD—Acquisitions, Construction, and Improvements”—

(1) after the first dollar amount insert “(increased by $75,000,000)”; and

(2) after the sixth dollar amount insert “(increased by $75,000,000)”.

In title IV, in the item “SCIENCE AND TECHNOLOGY—Research, Development, Acquisition, and Operations”, after the dollar amount insert “(reduced by $47,000,000)”.

Mr. LoBIONDO. Mr. Chairman, I rise today to offer an amendment that continues my campaign and the campaign of many others to ensure that our maritime security efforts have as much resources available to defend against the potential disaster of an attack at one or more of our ports. My amendment would increase funding for the Coast Guard by $110 million; $35 million would go to fund the congressionally mandated review and approval of approximately 10,000 facilities and vessel security plans that owners and operators must submit to the Coast Guard next year; and $75 million to help get the critically needed Deep Water Acquisition Program back on track.

My amendment would provide roughly half of what has been requested for support by the Coast Guard for these programs.

□ 1545

Tomorrow in the full Committee on Transportation and Infrastructure session, we will be marking up the 2004 Coast Guard Authorization Act, which provides the funding for these important programs at the level requested and supported by the Coast Guard.

I would add that over 85 Members of the House have sent the appropriators a letter in support of our authorized level of funding.

At a May 22 hearing before my subcommittee, the commandant of the Coast Guard explained that the Coast Guard would need an additional $70 million to fund 150 full-time personnel to review and approve of the Vessel and Facility Security Plans mandated by the MTSA. If these plans are not reviewed and approved by the Coast Guard within a year of its submission, the owners will not be allowed to operate their vessels in U.S. waters, and noncompliant port facilities would be shut down.

With 95 percent of our Nation's trade entering and leaving our ports, this will have a chilling effect on our economy. Moreover, without additional funding to meet this congressionally imposed mandate, the Coast Guard will have to divert precious resources and personnel from other traditional missions, including search and rescue, drug interdiction, and fisheries enforcement. My amendment would provide $35 million for this purpose, half of what is needed.

At a June 3 hearing before my subcommittee, the commandant announced his support for the $702 million in funding for Deepwater. This level of funding represents what is needed to counteract 3 years of underfunding and would get the program back on track.

The Coast Guard operates the second oldest naval fleet in the world, and some assets have been commissioned since World War II. Nearly half of the 110-foot Patrol Boat Fleet is in immediate need of repair for structural deterioration and has cost over 6 months of lost patrol days on the west coast. On average, the High Endurance Cutter Fleet is having a fire in their main engineering spaces on every patrol, and the fleet's main search and rescue helicopter is equipped with radar designed and installed nearly 20 years ago. Therefore, the successful and timely implementation of Deepwater would ensure that the Coast Guard would have the modern assets necessary to respond to any threats necessary.

Mr. Chairman, I understand the very difficult decision-making process that confronted the appropriators in drafting this bill. I commend the gentleman from Florida (Mr. YOUNG) and the gentleman from Kentucky (Mr. ROGERS) for their work, and at this point I would indicate my willingness to withdraw my amendment if the gentleman from Kentucky (Mr. ROGERS) would be willing to enter into a colloquy with me.

Mr. ROGERS of Kentucky. Mr. Chairman, I rise to oppose the amendment.

Mr. LoBIONDO. Mr. Chairman, will the gentleman yield?

Mr. ROGERS of Kentucky. I yield to the gentleman from New Jersey.

Mr. LoBIONDO. Mr. Chairman, will the chairman enter into a colloquy with me on this subject?

Mr. ROGERS of Kentucky. I certainly will.

Mr. LoBIONDO. Mr. Chairman, as I have said, I am willing to withdraw my amendment if the gentleman agrees to work with me as the bill moves forward to increase funding for the Deepwater program and provide additional funding for the review and approval of the Vessel and Facility Security Plans.

Mr. ROGERS of Kentucky. I thank the gentleman for his advocacy on behalf of the Coast Guard, and he has been a champion at that for his entire career in the Congress.

While I cannot support his amendment, I do recognize the need to provide additional funding for Deepwater and for the administrative costs associated with the review and approval of the congressionally mandated facility and vessels security plans. I look forward to continuing to work with the gentleman from New Jersey to ensure adequate resources are made for these priorities in fiscal 2004.

Mr. LoBIONDO. Mr. Chairman, I thank the gentleman for his leadership on this issue and recognize the very difficult decision-making process he was confronted with in development of this bill.

Mr. Chairman, I ask unanimous consent to withdraw my amendment.

The CHAIRMAN. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

The CHAIRMAN. The amendment is withdrawn.

Ms. PELOSI. Mr. Chairman, I move to strike the last word.

Mr. Chairman, as Members of Congress, our first responsibility set forth in the preamble to the Constitution is to provide for the common defense. In our time, the common defense means protecting our homeland from terrorists, as well as from traditional military threats to our interests at home and abroad.

The consideration of the first-ever appropriations bill for the Department of Homeland Security could have been a historic opportunity to demonstrate our commitment to the common defense by addressing some of the most glaring deficiencies in our Nation's security. Sadly, it is yet another missed opportunity.

The Republican's Homeland Security bill does not provide the resources necessary to do the job. The Republican bill does not meet the broad needs of our ports, our borders, our air transportation system, and other critical parts of our infrastructure.

In determining the Nation's priorities, the Republican majority has chosen to cut taxes for those who need it least, while shortchanging the homeland security needs of everyday Americans. The gentleman from Wisconsin (Mr. OBEY), the Committee on Appropriations ranking member, showed great leadership with an amendment to provide for America's security, to provide for the common defense, to protect the homeland.

The amendment would have provided an additional $1 billion to improve homeland security by adding $500 million to port security, everyone recognizes that is the minimum figure that is needed to protect our ports; $100 million to assist in the development of an automated vessel tracking system; $200 million to pay either for a year-round air and marine interdiction program at our northern border or to increase to 6,900 the number of agents patrolling the northern border by the end of fiscal year 2004; $150 million in security grants to airports and overseas maintenance facilities; and, finally, $50 million for vulnerable assessments at critical infrastructure locations.

Where would this $1 billion come from? The Obey amendment would be paid for by rolling back the tax cut for millionaires, that is, people making $1 million per year. People making $1 million a year or more would have their tax cut cut from $88,326 to $83,326. For that $5,000, for the 200,000 people making over $1 million a year, by reducing their tax cut from $88,000 to $83,000, America can be much safer.

What would my colleagues choose, to protect the American people or to give $5,000 more to people making $1 million a year or more?

Mr. Chairman, success in both the war on terrorism and the effort to better protect our Nation and its people will require a sustained effort and a resolve lasting many years. This bill should have been a testament to that resolve; but sadly, it is not. We need to act now to protect the American people.

Recent history suggests that our security could be tested anytime and any place. We know what our exposure is, what our vulnerabilities are. The gentleman from Wisconsin (Mr. OBEY) addressed them in his amendment. We must take every step to be ready. We have that responsibility.

Providing for the common defense is enshrined in our Constitution as one of our highest responsibilities. Its importance as a national priority is not reflected in this bill.

I want to commend the gentleman from Wisconsin (Mr. OBEY) for his leadership, the gentleman from Minnesota (Mr. SABO) for his as well, and it is with the highest regard for the chairman of the subcommittee who has served in this House with great dignity that I regret opposing what has been put forth by the Republican leadership on the floor today. It again misses an opportunity for the American people.

Mr. REGULA. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I would like to enter into a colloquy with the distinguished gentleman from Kentucky. I would like to address the issue of how our national emergency preparedness and response plan addresses older Americans, the disabled, and others with special needs.

Our experience with the horrible attacks of September 11, 2001, exposed gaps in our response plan as many elderly and disabled people living near the World Trade Center were trapped for days before receiving assistance. Successive evaluations have identified particular problems, including lack of coordination in city-wide community services, lack of a system to identify and locate older and disabled people, and lack of access to necessary public information both before and after an emergency.

I believe this issue is of great importance in the event of a future terrorist attack and I look forward to working with the gentleman in addressing this great need.

Mr. ROGERS of Kentucky. Mr. Chairman, will the gentleman yield?

Mr. REGULA. I yield to the gentleman from Kentucky.

Mr. ROGERS of Kentucky. Mr. Chairman, I want to thank the distinguished gentleman for his very thoughtful comments and agree that the needs of older Americans and those with special needs should be addressed. I look forward to working with the gentleman on this important issue.

Mr. REGULA. Mr. Chairman, I thank the gentleman for his comments.

Ms. MCCARTHY of Missouri. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I want to commend both the majority and the minority members and the appropriations staff for their hard work on this first homeland security appropriations bill. I realize that this has been a formidable task.

Never the less, I am concerned that we have not given enough debate to issues raised by our state and local government officials and our local first responders.

For instance, fire fighters in Kansas City have told me that we must develop and fund an infrastructure to communicate effectively with agencies in the same community as well as surrounding communities during times of crisis.

Moreover, our local public health officials must have the necessary resources to be adequately prepared to cope with emergencies, particularly bioterroist attacks.

As the ranking member of the subcommittee on intelligence and counterterrorism of the select committee on homeland security, I question the Department of Homeland Security's ability to provide accurate and timely intelligence assessments, including bioterrorism threats to this country with the limited resources provided in H.R. 2555.

I thank the chair for the opportunity to address these important issues, and hope that in conference the additional funds called for by the ranking member, Mr. OBEY (the gentleman from Wisconsin) will be included.

The American people deserve such protection. Our first responders deserve such resources to assure the protection of the people they serve.

The CHAIRMAN. The Clerk will read.

The Clerk read as follows:

TRANSPORTATION SECURITY ADMINISTRATION

AVIATION SECURITY

For necessary expenses of the Transportation Security Administration related to providing civil aviation security services pursuant to Public Law 107–71, $3,679,200,000, to remain available until expended, of which not to exceed $3,000 shall be for official reception and representation expenses: *Provided*, That of such total amount, not to exceed $1,672,700,000 shall be for passenger screening activities; not to exceed $1,284,800,000 shall be for baggage screening activities; and not to exceed $721,700,000 shall be for airport support and enforcement presence: *Provided further*, That security service fees authorized under section 44940 of title 49, United States Code, shall be credited to this appropriation as offsetting collections and used for providing civil aviation security services authorized by that section: *Provided further*, That the sum herein appropriated from the General Fund shall be reduced on a dollar-for-dollar basis as such offsetting collections are received during fiscal year 2004, so as to result in a final fiscal year appropriation from the General Fund estimated at not more than $1,609,200,000: *Provided further*, That any security service fees collected in excess of the amount appropriated under this heading shall be treated as offsetting collections in fiscal year 2005: *Provided further*, That none of the funds in this Act shall be used to recruit or hire personnel into the Transportation Security Administration which would cause the agency to exceed a staffing level of 45,000 full-time equivalent screeners: *Provided further*, That of the total amount provided herein, $235,000,000 shall be available only for physical modification of commercial service airports for the purpose of installing checked baggage explosive detection systems and $100,000,000 shall be available only for procurement of checked baggage explosive detection systems.

AMENDMENT OFFERED BY MR. TERRY

Mr. TERRY. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. TERRY:

Page 11, line 12, insert after the dollar amount the following: "(reduced by $20,000,000)".

Page 16, line 23, insert after the dollar amount the following: "(increased by $10,000,000)".

Page 17, line 3, insert after the dollar amount the following: "(increased by $10,000,000)".

Page 22, line 1, insert after the dollar amount the following: "(increased by $10,000,000)".

Mr. TERRY. Mr. Chairman, this amendment is simple in the sense that what it does is it provides 20 million additional dollars for our first responders, and it takes it from a flush, although well-improved, Transportation Security Agency.

I want to start off by complimenting the gentleman from Kentucky (Mr. ROGERS), the chairman of the subcommittee. Most of the time when an amendment is offered, it is because that person has disagreed philosophically with the direction of that particular appropriation. I am here to compliment the chairman and say that I agree with his priorities, Mr. Chairman, and two of those priorities that he has provided are an extra $1 billion of funding for our first responders above the President's request. He has also decreased to bring down the number of TSA agents in our airports, and I greatly appreciate both of those.

My goal here today is to improve on what the gentleman has already done, Mr. Chairman. I would like us to take an even bigger step in helping our first responders.

When we look at our homeland security today, we rely a great deal on our fire, police and emergency services; and while we talk about a new Homeland Security Department and funding that Department, most of the people receive a vision of a top-down system that comes from Washington, D.C., down to the local levels. But the reality is when an emergency occurs, when a terrorist attack occurs, whether it is in Oklahoma City or Omaha or New York City or Washington, D.C., the first people on the scene, to take control of the scene, to rescue those that have been injured or killed in the security area are our first responders.

□ 1600

I do not think we can do enough to provide them the proper training and the proper equipment. I have talked to our police officers, who call themselves blue canaries, because they know that when an emergency occurs, when they run into those buildings to secure the areas, they say they know it is biological or chemical or deadly when they keel over. Well, I think when we have a national security policy, a homeland security policy that relies on them, I would like to provide them additional dollars.

Now, why the TSA? I think most of us that go through airports can tell of personal examples with what appears to be a very flush budget in the respect of seeing the number of white shirts with patches standing around. In fact, at my airport in Eppley, just a few months ago, there was an extremely long line, as there was on Monday morning, but they only had one of the stations open. And I asked the person why there was only one security station open when there were as many as 10 twelve white shirts standing around, and I was told, quote-unquote, they are on break. I called our new security administrator for Eppley and he told me it was broken down. Now, the people on the scene had a different opinion. But that is just one example.

Unfortunately, over the last few months what we have also seen is not only the vast number of employees standing around but the vast number of passengers standing in extremely long passenger lines. Last week, at Reagan National, it literally went out the door. It literally went out the door, yet there were many employees there working. How does that happen, when there is more employees than there were before and the lines are two or three times longer? We are having record numbers of people standing in lines and a number of complaints coming into our office about our own airport.

Now, I go through a lot of airports, and I have talked, Mr. Chairman, to several people in charge of these airports. I get really extremely harsh critique of TSA from airport administrators. In fact, one told me that he wanted to find out the background of the security administrator appointed to their airport to see if this person had any experience with civil airports. TSA denied the request, so a Freedom of Information Act was filed and that was denied on PATRIOT Act grounds. So we do not even know if the people being appointed have any experience in providing security.

At least in Omaha, Nebraska, I know there were two or three people that would have been grade-A-plus in security, yet they were denied for someone we do not even know the background of. And how many of us have similar experiences to tell?

So, Mr. Chairman, I understand your position and I respect it, but I stand by my amendment to help our first responders.

Mr. ROGERS of Kentucky. Mr. Chairman, I rise in opposition to the amendment.

Let me say, Mr. Chairman, I reluctantly, very reluctantly rise to oppose this amendment. The gentleman is a good Member, and he has expressed heartfelt thoughts here. And, goodness knows, I have expressed very serious and long-standing reservations about the number of screeners that TSA has deployed in airports throughout the country. But in the bill before us we already reduce the number of screeners by another 4,600 in fiscal 2004, and that is on top of the 6,000 screeners that will be laid off between now and September of this year. That would be a reduction from current levels, roughly, of some 10,600 less than we have now.

In the 2002 bill, when it was in Transportation, we capped the number of screeners at 45,000. This cut the gentleman would make would take us well below that cap. This further reduction of $20 million from the screener fund would require them to lay off another 500 to 1,000 screeners on top of what I just mentioned. That would take us well below the 45,000 level that we had set now for the 2 or 3 years in the Congress as the maximum level at TSA.

The monies the gentleman would take from TSA he would give to the first responders, and heavens knows we want to give them all we can, but in this bill, as the gentleman mentioned, we are already $1 billion for first responders above what the President requested, and some $200 million plus above what the current level of spending for first responders is. So I just think that it would be unwise to adopt this amendment, as much as I sympathize with the gentleman's philosophy in offering it.

Mr. SABO. Mr. Chairman, will the gentleman yield?

Mr. ROGERS of Kentucky. I yield to the gentleman from Minnesota.

Mr. SABO. Mr. Chairman, I would join the chairman in opposing the amendment. The committee and the chairman have been very tough task masters of TSA when it comes to the number of screeners. We have been urging them for a long time to use more part-time people and to make more efficient use of their personnel. On the other hand, if we get too harsh, there may be imbalance around the country in terms of where there are vacancies and where there are an overabundance. So if we get too tough, we can be very counterproductive.

I agree with the chairman that first responder money is important, but the committee has been very disciplined in dealing with TSA, and I would join the chairman in opposing this additional cut.

Mr. ROGERS of Kentucky. Reclaiming my time, Mr. Chairman. I thank the gentleman. I would rather that we let the TSA absorb these cuts that we already have in place, which will cut 10,600 screeners by the end of 2004. Let us do that before we take further steps. We can assess it at that time. If we still have a problem, I would be supportive of the gentleman's amendment. But for the moment, I think we have done just about enough.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Nebraska (Mr. TERRY).

The amendment was agreed to.

Mr. NADLER. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I was intending to offer an amendment to this title of the bill, but the amendment is to increase the appropriation in the bill by $5 billion for the purpose of stationing American inspectors in every foreign port from where ships leave for the United States in order to inspect every container before it is put on a ship bound for the United States. Unfortunately, I could not find a $5 billion offset in this bill. What I wanted to do, obviously, was to reduce the tax cuts, the hundreds and hundreds of billions of dollars of tax cuts, by $5 billion to offset this. But the rules of the House do not permit that, so my hands are tied.

Let me address for a moment the necessity of this amendment, if not in this bill then elsewhere. The greatest danger this Nation faces, which we are not addressing in any real shape or form, is that some foreign terrorist group, al-Qaeda, whoever, or some rogue nation, will get hold of a nuclear bomb and attack the United States. We are spending about $100 billion on an anti-ballistic missile system ostensibly to meet that threat. But think about it a minute. The leader of any rogue nation who had a few atomic bombs and wanted to attack the United States would not put them on a missile, because a missile has a return address. We would know from where the missile came, if God forbid someone attacked American cities. That leader would know that if he launched nuclear-tipped missiles at American cities, his country would cease to exist, along with his regime and him, would cease to exist a half-hour later. So he would not put the atomic bombs on a missile, he would put them in a ship.

Mr. Chairman, six million shipping containers come into this country per year. We inspect less than 2 percent of them. Ninety-eight percent of those six million containers, for all we know, have atomic bombs in them. It does not do any good to inspect them in Newark or New York or Los Angeles where they night explode. I know Secretary Ridge and others are saying we are going to set aside a few hundred million dollars and send some inspectors to foreign ports to look at some high-risk containers. High risk? Well, if we look at the high-risk containers, the bombs will be in the low-risk containers, or at least those that used to be low risk.

Mr. Chairman, the catastrophe that could be caused from one atomic bomb in an American city would make 9/11 look like child's play. That catastrophe would cost half a million lives immediately, probably trillions, trillions in economic damage. We cannot afford to risk one nuclear explosion in an American city. President Bush said, when he was trying to motivate a war with Iraq, that we could not wait for the mushroom cloud. Well, I am not so sure the facts justified that reference with respect to Iraq, but they most certainly justify that reference with respect to six million shipping containers coming into this country with God knows what inside.

So, Mr. Chairman, my amendment that I would have offered, if the majority did not prevent me from offering this amendment, would have appropriated $5 billion, which is little enough for this purpose, and would have sufficed to enable an American inspection team to see to it that no container, not one container, is put on any ship bound for the United States in a foreign port until that container is searched and sealed and certified by an American inspection team in the foreign port to say there is no weapon of mass destruction on board that.

Mr. Chairman, if we do not do this, during the war that we are engaged in now and maybe for the next 10, 20, 30, or 40 years with the terrorists, then we ought to have our collective heads examined. Any American city could be destroyed, millions of lives lost by one atomic bomb in any container in any ship. We cannot afford not to spend the money to search and inspect every single container, whether our intelligence people think it is a high-risk or a low-risk container, every container in a foreign port with an American inspection team to make sure there is no weapon of mass destruction on board that container.

For $5 billion, Mr. Chairman, we could do that. Five billion dollars a year. Compare that to trillions of dollars in tax cuts that we have passed in these last 2 years. Where does the risk lie for the American people? I would urge, and I would challenge the Bush administration to make the $5 billion a year available and to institute this and to say to foreign countries that no container gets put on a ship in their port without being inspected first by an American inspection team.

And, by the way, if they did not want an American inspection team in their ports, that is fine, they are sovereign, but they cannot ship anything to the United States. We must hermetically seal this country from nuclear bombs possibly contained in ships, and this is the only way to do it. The failure of this Congress and of the administration to deal with this subject seriously is one that I hope will not result in cataclysmic catastrophe for the American people.

Mr. ROGERS of Kentucky. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I could not let the gentleman's statement go unanswered. We cannot talk in this forum about all that we are doing at our ports in searching container freight and other freight. I would be happy to talk to any Member privately about it, but we cannot talk about all that we are doing in a public forum because it is sensitive information.

However, the Customs and Border Protection Agency tells me that they are inspecting 100 percent of all high-risk cargo based on collecting advanced information such as manifests, intelligence, and targeting systems. I have had the experience of going to some of those ports myself and watching the operation. Watching as we use the equipment on these containers that we do search and then the ones that we physically search.

The 2003 spending bill had monies in it for a thing called the Container Security Initiative, essentially operating at about 20 megaports and several smaller ports all over the world. The idea is to push the perimeter of defense off of our shores. We all know if a bad container gets to us, it is too late. If you catch it only when it comes to your port, it is too late. So we have moved offshore to 20 megaports now, places like Rotterdam, Singapore, and the like, and inspecting and searching and securing containers before they ever sail for America.

☐ 1615

Mr. Chairman, the bill provides $62 million to expand that to 30 megaports around the world and especially those in very sensitive parts of the world.

Now we already have in place $165 million from the wartime supplemental that we passed for additional inspectors, agents, technology and $129 million for additional inspection technology in this bill. Those monies will be used to push the border out to these 30 foreign seaports through the Container Security Initiative, but there is also $12 million for government-private partnerships to tighten security in private facilities and $3 million to continue what is called the Operation Safe Commerce to make smart containers and our supply chain even more secure.

I want Members to know that we are focusing exactly on what the gentleman has talked about, and that is container freight. There are more than 17 million containers a year, there is 17 million a year; 7 million comes by sea, 12 million by land across our borders with Mexico and Canada. It is a huge problem to deal with.

However, if we stop and search physically every single container regardless of whether or not it looks to be suspicious for some reason, we would absolutely shut down commerce in the world. So much of our commerce depends on the container freight business. I think we are going about it the sensible way. I am convinced after having visited several ports, spending a lot of time with the folks that are doing this, looking at the machinery and the results and how they go about doing it, that we are doing as good as we can in the span of time that we have had. Obviously it is going to get better. We are going to keep pushing at it. That is the reason we have loaded this bill down with money for that very purpose. I thank the gentleman for bringing this issue to us so we can discuss it.

Mr. GEORGE MILLER of California. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I wanted to pick up where the last two speakers spoke, and that is the question of port security and what we know or do not know about the 20 million containers that come across America's borders every year, come by truck and train traffic, and the rest through ports.

I have to say that I appreciate that the committee is doing a lot. The question is when will the committee be done doing its work, and when will the Nation say that it knows enough about the containers coming into its ports. I am not sure that we can inspect every port, but what is very clear is the amount of information that we have to have about these containers from the point of origin to the time that they embark for the United States is incomplete. Even the effort to go into the megaports, which I think is important since some 80 percent of the commerce is shipped through those ports, that does not tell us, that does not give us the kind of information about the containers even coming to the megaports. That is what has to be established. A system, a credible system has to be established so those individuals responsible for the security of this Nation and the movement of those containers across the borders of this Nation are able to make an assessment as to the security of this Nation posed by those individual containers.

We are not going to be able to inspect every one of them because commerce is not going to allow us to do that. It would break down the system. But we can require a great deal more information about the contents of that container, the sealing of that container, the movement of that container, through electronic locks, through GPS systems, so we can start to trace that. Then we can make our decision upon risk. But by the time that container gets into the port of Hamburg or Hong Kong or Long Beach or Oakland, California, it is too late. If one of these container goes up with a dirty bomb, you will shut down the globalized container system in this world because we then will have to inspect every container. That is too late. That is far too late.

The terrorist does not just have to strike. As we saw, terrorists now understand that beyond the initial act are the economic consequences. They now see what that means. But if they are going to come to the United States and they want to do our people harm, they put in a nuclear device, they put in a dirty bomb, inspecting it in the Port of New York, the Port of Long Beach or the Port of Oakland is far too late. It does not matter if it goes up on the ship once it comes through the Golden Gate, if it goes up on the port property, or if it goes up on the railroad train, that is too late. Of those, we are inspecting 2–4 percent of the containers.

At some point we have to establish a deadline so that people will know, as the gentleman from New York (Mr. NADLER) said, if they want to engage in commerce in the United States, an inspection system has to be in place going back to the point of origin to follow that container all of the way.

We did this in the oil spill liability provisions after the Exxon Valdez. We said in 25 years if you want to continue to have access and ship petroleum products to the United States, you will do it in double-hulled ships. We should be saying to the shippers, to international commerce, by 2004 or 2005 if you want to continue to have access, you have to provide for this monitoring of cargo, for the transparency of the system and the monitoring of the ships.

We have some 40,000 ships roaming around the world with containers on them. This is the kind of system that the American public is entitled to, and why so. As the gentleman from New York (Mr. NADLER) pointed out, many of the experts which have been briefing Congress since September 11, 2001, have been telling us we are more likely to have a dirty bomb come into this country by way of container than we will ever have the risk of it coming in by way of missile. That is the threat to the home front. That is the major threat.

What we see here, while we are taking these incremental steps and I applaud many of them, we do not have a plan for deciding at what point this is going to be a secure system. We have to start putting deadlines on the transparency of this system, on the security of this system, and access to the American markets. That is how we are going to get unified system.

The gentleman from New York is right. The Container Security Initiative, the Operation Safe Commerce, the Customs Trade Partnership Against Terrorism are all important initiatives, but they are taking too long. They are taking too long. What is the price of security? What is the price of the home front? What is the price of a secure port system and a secure transportation system? Those are the questions we have to start asking ourselves, not whether we have put in another $100 million or $200 million; is the system secure. Right now we cannot tell the American public that in the foreseeable future that our system is secure.

The CHAIRMAN. Are there any further amendments to this paragraph?

If not, the Clerk will read.

The Clerk read as follows:

Federal Air Marshals

For necessary expenses of the Federal air marshals, $634,600,000, to remain available until expended.

Maritime and Land Security

For necessary expenses of the Transportation Security Administration related to maritime and land transportation security grants and services pursuant to Public Law 107–71, $231,700,000, to remain available until expended: *Provided*, That of such amount, $100,000,000 shall be available only to make port security grants, which shall be distributed under the same terms and conditions as provided for under Public Law 107–117.

Intelligence

For necessary expenses of the Transportation Security Administration related to transportation security intelligence activities, $13,700,000, to remain available until expended.

Research and Development

For necessary expenses of the Transportation Security Administration for research and development related to transportation security, $125,700,000, to remain available until expended.

Administration

For necessary expenses of the Transportation Security Administration for administrative activities, including headquarters and field support, training, and information technology, $487,100,000, to remain available until September 30, 2005.

FEDERAL LAW ENFORCEMENT TRAINING CENTER

Salaries and Expenses

For the necessary expenses of the Federal Law Enforcement Training Center, $136,629,000, of which $26,635,000 shall be for material and support costs of Federal law enforcement basic training and shall remain available until September 30, 2006, and of which not to exceed $12,000 shall be for official reception and representation expenses: *Provided*, That notwithstanding any other provision of law, the Center is authorized to expend appropriations for the purchase of police-type pursuit vehicles without regard to the general purchase price limitation; student athletic and related recreational activities; conducting and participating in firearms matches and the presentation of awards for such matches; public awareness and enhancing community support of law enforcement training, including the advertisement and marketing of available law enforcement training programs; room and board for student interns; short-term medical services for students undergoing training at Center training facilities; travel expenses of non-Federal personnel attending course development meetings; services authorized by section 3109 of title 5, United States Code; support of Federal law enforcement accreditation; and a flat monthly reimbursement to employees authorized to use personal cell phones for official duties: *Provided further*, That (1) funds appropriated to this account may be used at the discretion of the Center's Director to train United States Postal Service law enforcement personnel, State and local law enforcement personnel, foreign law enforcement personnel, and private security personnel; (2) with the exception of private security personnel, the Center's Director is authorized to fully fund the cost of this training, including the cost of non-Federal travel, or to seek full or partial reimbursement for this training; and (3) such reimbursements shall be deposited in this appropriation: *Provided further*, That the Center is authorized to obligate funds in anticipation of reimbursements from agencies receiving training at the Center, except that total obligations at the end of the fiscal year shall not exceed total budgetary resources available at the end of the fiscal year: *Provided further*, That the Center is authorized to accept and use gifts of property, real and personnel, and to accept services, for authorized purposes: *Provided further*, That the Center is authorized to harvest timber and use the proceeds from timber sales to supplement the Center's forest management and environmental programs: *Provided further*, That notwithstanding any other provision of law, students attending training at any Center site shall reside in on-center or center-provided housing, to the extent available and in accordance with Center policy.

Acquisition, Construction, Improvements, and Related Expenses

For expansion of the Federal Law Enforcement Training Center, for acquisition of necessary additional real property and facilities, and for ongoing maintenance, facility improvements, and related expenses, $32,323,000, to remain available until expended: *Provided*, That the Federal Law Enforcement Training Center is authorized to accept reimbursement to this appropriation from government agencies requesting the construction of special use facilities on training centers operated by the Federal Law Enforcement Training Center: *Provided further*, That notwithstanding any other provision of law, all facilities shall remain under the control of the Federal Law Enforcement Training Center, which shall be responsible for scheduling, use, maintenance, and support.

OFFICE FOR DOMESTIC PREPAREDNESS

Domestic Preparedness

For grants, contracts, cooperative agreements, and other activities of the Office for Domestic Preparedness, as authorized by the Homeland Security Act of 2002 (Public Law 107–296) and the USA PATRIOT Act of 2001 (Public Law 107–56), $3,503,000,000, to remain available until expended: *Provided*, That of the amount provided under this heading—

(1) $1,900,000,000 shall be for basic formula grants;

(2) $500,000,000 shall be for grants to State and local law enforcement for terrorism prevention activities;

(3) $200,000,000 shall be for critical infrastructure grants;

(4) $500,000,000 shall be for discretionary grants for use in high-density urban areas and high-threat areas; and

(5) $35,000,000 shall be for grants for Centers for Emergency Preparedness:

Provided further, That the application for grants appropriated in subsections (1), (2), and (3) under this heading shall be made available to States within 30 days of enactment of this Act; States shall submit applications within 30 days of the grant announcement; and the Office for Domestic Preparedness shall act on each application within 15 days of receipt: *Provided further*, That 80 percent of the funds appropriated in subsections (1), (2), (3), and (4) under this heading to any State shall be allocated by the State to units of local governments and shall be distributed by the State within 60 days of the receipt of funds: *Provided further*, That section 1014(c)(3) of Public Law 107–56 shall not apply to funds appropriated in subsections (4) and (5) under this heading: *Provided further*, That none of the funds appropriated under this heading shall be used for construction or renovation of facilities: *Provided further*, That funds appropriated in subsections (3) and (4) under this heading shall be available for operational costs, including personnel overtime as needed.

AMENDMENT NO. 2 OFFERED BY MRS. MALONEY

Mrs. **MALONEY**. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment No. 2 offered by Mrs. Maloney:

In title II, in the item "OFFICE FOR DOMESTIC PREPAREDNESS—Domestic Preparedness", in paragraph (4) after the dollar amount insert "(increased by $300,000,000)".

In title III, in the item "Disaster Relief (including transfer of funds)", after the first dollar amount insert "(reduced by $300,000,000)".

Mrs. **MALONEY** (during the reading). Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the Record.

The **CHAIRMAN**. Is there objection to the request of the gentlewoman from New York?

There was no objection.

Mr. **ROGERS** of Kentucky. Mr. Chairman, I reserve a point of order.

The **CHAIRMAN**. The gentleman from Kentucky (Mr. Rogers) reserves a point of order.

Mrs. **MALONEY**. Mr. Chairman, the al Qaeda has not gone away, and we know al Qaeda does not choose its targets at random, it chooses targets to inflict the greatest numbers of casualties, to do the greatest damage economically, and to get the most publicity. Just last week, we were reminded that New York is still a target when the Attorney General announced that an al Qaeda terrorist was targeting the Brooklyn Bridge. He was deterred from attacking the bridge by the efforts of the New York Police Department.

This is just one example of how since 9/11 a large share of the burden of providing for the national defense has fallen on our cities. In Congress we have provided some funds to help. We even sent part of the money to where the need is. In fiscal year 2003, we provided $2.9 billion for grants to State and local governments to help them prepare for and defend against terrorist attacks. We even said that $800 million of that should be directed to where the threat is greatest. That is about 30 percent. The rest of the fund went out under a formula that is entirely unrelated to where the terror threat is.

Under this bill as it is currently drafted for the next fiscal year, that 70 percent will increase to nearly 83 percent. Our effort to protect the most likely targets of terrorism is moving backwards. We are cutting the funds to the Nation's most threatened cities by almost 40 percent, by $300 million, from $800 million to $500 million, and we are increasing the percentage that will go under the formula that is unrelated to potential threat, a formula that Secretary Ridge has repeatedly said is inappropriate and must be changed.

This formula sends the money where the threat is not. Just yesterday Secretary Ridge himself said of the high threat money and I quote, "I would like to see the number significantly higher than $500 million." He went on to say, "At the end of the day, I do believe that there are some communities and regions that need more money."

My amendment will simply follow Secretary Ridge's advice and restore funding for high-threat cities. I understand that this approach is subject to a point of order. I originally had wanted to shift money from another account, but the fact is this bill severely underfunds our security needs. Resources are too scarce to shift between accounts, but our cities need more funding. New York City spent more than $200 million over the last year on counterterrorism. The grants so far amount to $220 million for New York, but very little of that can offset the personnel costs that the city has identified at more than $900 million.

The assistance provided after the September 11 attacks paid for cleanup and replacement of equipment. It did not cover the security costs. This is not just an issue for New York and Washington, but it is a high-priority issue for many cities, including L.A., Chicago, San Francisco, New Orleans, Kansas City, Cincinnati, Houston and any city with a port or a mass transit system.

Mr. Chairman, it is our responsibility to appropriate the funds needed to protect the American people and this bill falls dangerously short. Respecting the request of the gentleman from New York (Mr. Sweeney), who has worked very hard in a bipartisan way for New York City and State, I am withdrawing my amendment, also at the request of the gentleman from Kentucky (Mr. Rogers), and I appreciate the commitment from the New York delegation, the gentleman from New York (Mr. Hinchey), the gentlewoman from New York (Mrs. Lowey), and the gentleman from New York (Mr. Serrano) along with help from the gentleman from Minnesota (Mr. Sabo) and the gentleman from Wisconsin (Mr. Obey) to restore this in conference.

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I appreciate very much the leadership of the gentleman from Minnesota (Mr. Sabo) and the gentleman from Kentucky (Mr. Rogers).

Mr. Chairman, I withdraw my amendment.

The **CHAIRMAN**. Without objection, the amendment is withdrawn.

There was no objection.

Mr. **ENGEL**. Mr. Chairman, I move to strike the last word.

Mr. Chairman, first of all I want to quote Secretary of Homeland Security Ridge from an Associated Press article yesterday. This is what he said:

"At the end of the day, ladies and gentlemen, if you take a look at the population, the density of population, the critical infrastructure and the threat, there's one city that no matter how you move those factors around or weigh those factors, there's one city at the top of the list and it's New York City."

I want to associate myself with the gentlewoman from New York (Mrs. MALONEY), the things that she said. We will have other people from the New York delegation speaking about this as well, because we feel very, very strongly about getting the money for homeland security for New York City which is obviously, as Secretary Ridge said, the number one threat.

In fiscal year 2003, we provided $2.9 billion for grants to State and local governments to help them prepare for and defend against terrorist attacks. $800 million, or about 30 percent of that, was directed to high-threat areas. The rest of the fund went out under a formula that is entirely unrelated to where the terror threat is. Under this bill, as it is currently drafted for the next fiscal year, the 70 percent that is not related to high-threat areas will increase to nearly 83 percent. I believe that that is wrong.

Just last week a plot was uncovered, as my colleague said, to blow up the Brooklyn Bridge. Our intelligence agencies continue to say that New York remains a top target for terrorists and common sense would tell anybody the same thing. New York has been hit twice by radical terrorists. Thousands have died. We continue to rebuild; but to better ensure our safety and the safety of the world's financial capital, we need to better spend Federal tax dollars. When New York is hit by attacks, all Americans are hurt. The economic impact is all over the country. People in Montana, Oklahoma and Oregon, it affects everyone in this country when New York is hit by attacks.

I also had intended to offer an amendment to move $500 million from the State grant program to the high-threat program. I will not do that because I understand that there are needs across the country for assistance. Thus, it is obvious that this bill is not adequate to our needs as a Nation. I hope that we can somehow get around to the fact that we desperately need more money for high-threat areas. I would hope that in the negotiations between us and the other body that we would rectify this.

Why is this bill underfunded in my opinion? The answer is simple math. We have cut our revenues by trillions of dollars to pay for tax cuts. There is a trade-off, I believe, tax cuts or security. We believe that security is more important. My friend from Wisconsin wants to add an amendment to limit the tax cut for millionaires to just over $83,000 this year instead of the $88,000 they are set to get. I do not think it is too much to ask that people who have benefited the most in this great Nation pay $4,000 more for the security of all of us.

Mr. Chairman, I again hope that when we have our negotiations, when we have our conferences that we will be able to put more money where it belongs to protect high-threat areas like New York City.

Mr. ROGERS of Kentucky. Mr. Chairman, I move to strike the last word.

I am compelled again to talk about New York. All of us here are sympathetic, understanding, we want to help; but I feel compelled to lay out some facts that have not been laid out here. The fiscal year 2003 bill, we gave $800 million in that bill for the high-threat, high-density urban area grants and the discretion of the Secretary. $100 million of that was in the omnibus; $700 million was in the supplemental. However, that money has not been spent. There is $800 million laying there. Why? Because the grant application deadline for that first $100 million just ended on June 16, a couple of weeks ago, and has not been processed. The application deadline for the $700 million that was in the supplemental is not up until July 7. We have not processed the applications yet. Those moneys will be going out there, to New York and the other cities.

In addition to that, what I am saying is, I guess, have a little patience. Number two, when the President's request came up to us for fiscal year 2004, there was no request for high threat, high-density urban grant moneys. Zero. The subcommittee worked on it, and we put in $500 million. Now people call that a cut. Boy, that is a strange use of the word. We increased it $500 million. If the Secretary thinks we ought to change that, then he needs to send us a budget supplemental and amend his request and we will consider it.

However, all of the other grant programs, and there are six or seven of them, there are basic formula grants, there are law enforcement terrorism prevention grants, there are critical infrastructure grants, there are firefighter assistance grants, there are emergency management performance grants, there are emergency operations centers grants, all of which New York is eligible to apply for. We increased those funds over what the President wanted us to by $1 billion. So that now there is $4.04 billion available in those grant programs immediately. I would guess just by the odds and by the importance of New York that when you apply for those grants with the increased numbers there, all of these grants, you are probably going to wind up with more money than you got this year. But, please, have patience and understand that the rest of the country is interested in this as well. We want to help you, but I ask for your patience and understanding.

Mrs. DAVIS of California. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I rise in support of the amendments offered by the Members from New York. While it is true that we do not know where the next attack may be and that the entire Nation is vulnerable, I believe that it is important to recognize those areas considered as high-threat and high-density. The gentleman mentioned that there are other cities involved and, of course, we know that. Take my own city of San Diego as an example. San Diego is home to nearly 3 million residents and hosts millions of tourists annually. It is one of the regions that I believe Secretary Ridge has spoken about. In fact, he voiced those concerns when he visited San Diego recently. We have an international border and ports of entry, a coastline, a seaport, a busy airport, several major highways, a mass transit system, large public venues such as SeaWorld and Qualcomm Stadium, site of the Super Bowl. We have numerous military bases and military housing areas, and even a nuclear power plant. Protecting such an extensive list of vulnerable areas requires significant resources. Yes, we are applying for a lot of that money. We are trying. We are doing our best.

Like all of my colleagues, I have heard from my first responders, from the sheriff's department, the police department, the fire department, the Coast Guard, the port authority, the Navy, the Marines and others about their struggle to protect our critical infrastructure. I believe that they are doing a fabulous job. But they need more, and they need our help. This is an important amendment. I urge my colleagues to support it.

AMENDMENT OFFERED BY MR. BRADY OF TEXAS

Mr. BRADY of Texas. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. BRADY of Texas:

In title II in the item "OFFICE FOR DOMESTIC PREPAREDNESS—DOMESTIC PREPAREDNESS"—

(1) in paragraph (1), after the dollar amount insert "(reduced $200,000,000)"; and

(2) in paragraph (4), after the dollar amount insert "(increased by $200,000,000)".

Mr. BRADY of Texas (during the reading). Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BRADY of Texas. Mr. Chairman, I would first like to commend the gentleman from Kentucky (Mr. ROGERS) and the gentleman from Florida (Mr. YOUNG) for their leadership and hard work on homeland security. I rise today in support of the Weiner-Brady-

Fossella amendment to make our homeland security budget smarter and more targeted to high-threat areas. We are at war in this war on terrorism. In war, there are likely targets and there are less likely targets. You protect them both. I know that Chairman ROGERS and Chairman YOUNG have fought hard to make sure we do exactly right, protect both likely targets and less likely targets.

What this amendment does is focus on those communities, on those States that will likely be and have been identified as high-threat, high-density urban areas. The States that have these high-threat communities include much of our country, New York and California, Texas and Illinois, Arizona and Colorado, Florida, Hawaii and Georgia, Massachusetts and Maryland, Michigan and Missouri, New Jersey, Ohio and Pennsylvania, South Carolina, Tennessee, Washington and the District of Columbia, all States that are host to urban areas that are at high risk and high threat of a terrorist attack. This amendment targets $200 million and shifts it to the high-threat, high-density urban area funding. Part of the community that I represent, Houston, Texas, is on that list of top 10 communities. It is, I would imagine, as a result of both communications from al Qaeda terrorists, from information received from interviews with al Qaeda operatives and Houston is, of course, the energy capital of the world. It is home to more than 50 percent of the oil and gas refining in this country. If you chose to target America's energy supplies, if you chose to bring this country down by taking down our energy pipelines or our oil and gas facilities, this is where you would start. But we are not the only community at high risk and high threat of a terrorist attack. There are many throughout this country.

What we seek from this amendment is making sure that these communities have a pool of money with that threat. More importantly, we make sure that when other communities are added to this list, when they suddenly become at high threat and a high-risk community, that when they come to the Federal Government for help, they are not told, we're sorry, we sent this money to other regions, less likely, less at risk, but that was the money we had. Unfortunately for all our efforts, and I know our government moves so slowly, even with the best intentions, I am afraid our communities do not understand our grant application process. I do not think they understand our time line. I think our communities are at risk today. We offer this amendment in good faith, recognizing just how diligent our chairman is in trying to protect communities of all size and all risk.

Mr. WEINER. Mr. Chairman, I move to strike the last word. I want to thank the gentleman from Texas, the gentleman from New York (Mr. FOSSELLA), the gentleman from New York (Mr. NADLER), and others with whom we have consulted on trying to come up with a way to answer some of the fundamental questions. First of all, I think that we can be of agreement because, frankly, every Member, including the distinguished chairman and ranking member, have said that yes, the total number of dollars is probably not enough and this is going to be an ongoing process to see to it that we do allocate enough money to this because, frankly, we have no choice.

I want to thank the gentleman from Kentucky, the gentleman from Minnesota, the gentleman from Wisconsin, and others who have worked so hard to get that number as high as we can get it. There also, I believe, can be no other answer but yes to the question, do some areas have greater costs than others? Are there greater costs in ports of California, in States like New York? I will give Members an example. It is costing New York City $13 million a week to deal with the needs of homeland security. A week. If you drive over the Brooklyn Bridge at 3 o'clock in the morning on a weekday morning, you will find both lanes inside closest to the stanchion with a fixed patrol car sitting there all day, all night, because of the national security threat that exists. That is more police man-hours than many police departments, and that is something that New York is absorbing because of these risks.

Another question that is a little tougher to answer, but I know how I would answer it, is who should decide how homeland security funds get divided? Should it be my distinguished colleagues on the Committee on Appropriations and those of us in this body, or should it be Secretary Ridge and the administration? I vote for the gentleman from Kentucky and the gentleman from Minnesota and others here in this body, but I think we should keep in mind what Secretary Ridge has said.

□ 1645

Secretary Ridge has said very clearly, in fact, just within the last 24 hours, that he believes that the present way we are distributing the money should be changed. He said "distributing those dollars according to the old formula, I don't believe we get maximum security for the dollars that are expended at the national level."

This is continuing the quote: "I'd like to see the numbers significantly higher than $500 million."

He goes on to say, "I think every State should be given a certain amount of money," a sentiment that I agree with, "but at the end of the day, I do believe that there are some communities and regions that need more money."

Continuing the quote: "I have concerns about the distribution formula, [where] We just basically send out dollars to States and localities on a formula that doesn't consider infrastructure, doesn't consider anything other than population." I do not believe that is where are we at this House, and frankly I do have great confidence in my colleagues deciding how to distribute the money, but we do have to recognize that this is not just a New York City issue, as the chairman alluded to previously. This is an issue that affects about 30 different States and localities all around the country. The gentleman from Texas articulated the needs of his district. Others have come to this floor and talked about their cities and States. The fact remains that there are certain places that unfortunately are more likely today to be targets of terrorist attack than others and have to take steps that cannot be avoided. If for no other reason, many of the trials that are being held of those that are accused of terrorism are being held in New York City. Just the enforcement costs in Washington, D.C. and suburban Virginia, in New York City, in Chicago, Illinois in one case, just those costs are much higher than they are elsewhere. There has been a large increase in the overall basic formula grant, and I think the committee deserves great credit for this. What this amendment seeks to do is take the $700 million that was allocated last year, increase the $500 million to that $700 million. That still provides a $700 million increase in the basic formula grant, and I believe that that is a healthy step.

I, however, want to say in closing, I want to close the way I began. I do believe that the chairman in his colloquy that he entered into earlier has clearly articulated his desire to get the money where it needs to go. I do believe that this is an amendment that gets the chairman and gets our House to that place.

Mr. SABO. Mr. Chairman, I move to strike the requisite number of words, and I rise in opposition to the amendment.

I would like to ask the gentleman from Kentucky (Mr. ROGERS) a question.

Mr. ROGERS of Kentucky. Mr. Chairman, will the gentleman yield?

Mr. SABO. I yield to the gentleman from Kentucky.

Mr. ROGERS of Kentucky. Mr. Chairman, I would be happy to answer a question.

Mr. SABO. Mr. Chairman, did I just hear correctly a little while ago that the Secretary's request of our committee for the high-threat urban grant was zero?

Mr. ROGERS of Kentucky. That is correct.

Mr. SABO. And our committee has recommended what?

Mr. ROGERS of Kentucky. Five hundred million.

Mr. SABO. Five hundred million. And this goes to a limited number of communities in the country?

Mr. ROGERS of Kentucky. It goes to the so-called high-threat/high-density urban areas of the country, and I think they are talking probably of 20 cities or less, in the complete discretion of the Secretary.

Mr. SABO. Which criteria that many of us have trouble understanding yet. The balance of the money flows by formula to the States, including the States that are eligible for this additional $500 million?

Mr. ROGERS of Kentucky. That is correct.

Mr. SABO. Reclaiming my time, for those of us who come from the heartland of the country, we are having discussion over how much money should go to ports. We have allocated a significant amount, and others would like to allocate more. My assumption is most of that goes along the coast.

Mr. ROGERS of Kentucky. I would guess so. But there are not many ocean ports in Minneapolis, I do not think.

Mr. SABO. No. We do have a river one but fairly small. So I think it would be fair to say we made a special effort to try to allocate more money to ports, that that will go to a limited part of the country.

Mr. ROGERS of Kentucky. That is correct.

Mr. SABO. But we find that when we raise threat levels in this country, the law enforcement and local responders are expected to respond throughout the country and they have the same problem over time, training, teaching people how to use new equipment, wondering what it means, increasing pressure on local law enforcement. What I hear from all of them is that their expenditures exceed whatever revenue they are getting from the Federal Government. I expect the gentleman hears the same thing.

Mr. ROGERS of Kentucky. I hear the same thing every day.

Mr. SABO. And this amendment, as I understand it, would take some of this little money that we distribute throughout the country and say we are going to cut that from everyone. Where they are working, trying to coordinate expenditures to make most efficient use of it, take it from that and give them to a few areas where we have already increased the administration's budget by $500 million; am I right?

Mr. ROGERS of Kentucky. That is the way I understand the amendment. It would take $200 million away from all the States in order to beef up this cap from $500 million to $700 million just for the high-density/high-urban area grants.

Mr. SABO. Reclaiming my time, and this is money that local responders can use for buying new equipment in a coordinated fashion, in a State plan or for training to have them become equipped to meet the threats that may occur in this country?

Mr. ROGERS of Kentucky. The gentleman is correct. In addition to that, as we have previously said, the subcommittee increased the amount of money for all of the grant programs of which there are seven, for firefighter grants and for infrastructure grants, emergency management grants, formula grants to States and cities and the like. All those grant programs, we increased by $1 billion above what the President wanted and $203 million more than the 2003 levels. So all of the States that have these high-density urban areas that would be eligible for the high-density grants will also be eligible for very larger pots of money that everyone else is trying to share with, and yet this amendment would take from that moneys and put it into the high-density/high-urban areas. We have gone through this in our subcommittee and in our full committee and we have labored with it and wrestled with it with the gentleman and in a bipartisan fashion from big cities and small, big States and small, and this was the best we could do. We think it is a fair way to do it. And to take the moneys from one area now and give it to another would open us up to an ugliness that I do not think we need to see in this battle.

Mr. SABO. Mr. Chairman, I thank the gentleman for his comments, and I think he has given good advice to the body.

Mr. FOSSELLA. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, in spite of the wonderful exchange, I rise in support of the amendment, and I have great respect for the Members here on both sides and what they go through in this process. It is a difficult one to question and constantly evaluating and balancing priorities.

My number one priority, as far as I am concerned, is to protect the American people. I think everybody in this Chamber supports that proposition. The question is how you would do that the best way? We could do it in a lot of different ways. We can root out the terrorists overseas as our great brave men and women are doing in Iraq and Afghanistan and around the globe. That is one way. We have great local police departments and Federal law enforcement officials, intelligence officials who try to root out evil before it pops its head, and we can allocate funding to the places that need it the most. And I know there may be a fundamental difference as to where that money should go, and that is okay. But if the Members asked me how I stand up here and proclaim that not just New York City but those areas that we have defined as high-threat areas should get a disproportionate amount of this money, Exhibit A is September 11. Exhibit A demonstrates that the terrorists sought out places like New York City. Why? Because it is the capital of finance, the capital of the world in some people's minds, and, indeed, as we hope and pray they are not, but, indeed, they are out there trying to do the same thing right now. So if the Members ask me why we are here to try to shift the money to what we think is a priority, I think I would say I do not ever want to see something like September 11 happen again. And with all due respect to the towns and villages around the country that wrestle with this problem every day, I think it is common sense to suggest that some areas could be more targeted than others. I do not think there is an American who would not say every town is equal in that respect. So I would hope, and I take the chairman at his word because I have immense respect for him, for the people who he has around him, to work with us to ensure that not just New York City, but those urban areas full of American citizens get that funding they need.

It has been brought up before what Secretary Ridge says. I am not going to rehash it. I will submit it for the RECORD. New York City, counterterrorism, intelligence and public safety, $200 million; training for first responders, police, fire, $99 million; security enhancement for facilities, $187 million; emergency preparation response equipment, $189 million; communications and information technology, $223 million. Total loan, $900 million.

The gentleman from New York (Mr. WEINER) and the gentleman from Texas (Mr. BRADY), who offered this, the gentleman from New York (Mr. NADLER), and I know the gentleman from New York (Mr. SWEENEY) has worked hard. He mentioned the Brooklyn Bridge. Go to any bridge in New York City, any tunnel, 24 hours a day, people scanning cars, checking cars, checking trucks. Why? So that anybody coming into the city can feel more free and secure. That is what this debate is about. And I am hopeful that the good chairman once again, and I believe him, will follow through and use all existing systems to ensure that these cities and urban areas get what they deserve and get what they need.

TOM RIDGE. Well first of all, I share both the Governor's and the Mayor's concern to reduce distributing those dollars. According to the old formula, I don't believe we would be at maximum security with the dollars that are being expended at the federal level. We are going to work to get that number as high as possible. Having been a member of Congress for twelve years, that's the beginning of the process. The House has had a number in mind. They've passed that and we'll be working with the Senate. There's still a long way to go, but I would like to see the number risen, significantly higher than the $500 million.

REPORTER. Mr. Secretary, have you given the Governor and the Mayor a specific limit, a specific amount of money?

TOM RIDGE. No, I think we are all in agreement that it would have been a nice place to start with the 750. If we can get the Congress to restore that quarter of a billion dollars, that would be a great place to start. To finish there, that would be at least preserving the status quo. As for the supplemental, we got about $700 million and I think at least preserving what we are able to distribute before. At the end of the day ladies and gentlemen, if you take a look at the population, the density of the population, the equivocal infrastructure and the threat, there is one city that no matter how you move those factors around and weigh those factors it ends up at the top of the list and its New York City. I think every state should be given a certain amount of money and they build up a capacity to protect the infrastructure, and the capacity to respond, and the capacity to prevent a terrorist attack. But at the end of the day, I do believe there are some communities and regions that need more money because of the multitude of factors, not just population.

Mr. NADLER. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I appreciate, as do other speakers, the hard work of the members of the Committee on Appropriations and of the chairman and ranking member of the Appropriations subcommittee. The bill before us provides $500 million for 47 high-threat/high-density areas, 47 cities. People are talking about New York. We are talking about 47 cities that are high-risk areas, $500 million. The bill also provides, as I understand it, $1.9 billion for the rest of the country. Low risk or less than high-risk areas. The amendment would change that somewhat to make it $700 million for the 47 high-risk areas, $700 million for all 47 high-risk areas combined, and $1.7 billion the low-risk areas or less-than-high-risk areas in the rest of the country. By way of comparison, just keeping police officers on duty costs the City of New York, one high-risk area, $676 million a year. This amendment would make $700 million available to all 47 high-risk areas. So we are talking about a small fraction of what any of these high-risk areas are spending.

There is not enough being allocated, there is not enough that we could allocate, for all the high-risk areas and the rest of the areas. All some of us are saying here for New York, for Pennsylvania, for Illinois, for Houston, for Texas, for other high-risk areas is that we should be a little more rational in allocating the funds a little more on the basis of where the heavier expenditures are necessary because of where the risks are and how much it costs to guard against those risks and a little less on the uniform geographic basis which is the other half of this allocation.

□ 1700

Now, I understand, of course, that in the end the committee and the conference committee are going to make this allocation. What we are saying now is we want to bring to the attention of the body some of the considerations that say that there should be a little more rationale, rationality, to put a little more of the money for high-risk areas where so much more is necessary.

I appreciate the work that has been done by the committee and the work that will be done. I hope the committee will see its way clear to balancing this a little better, not for New York alone, but for the other 46 high-risk areas which have billions of dollars that have to be spent on this, not hundreds of millions.

Mr. OBEY. Mr. Chairman, I move to strike the requisite number of words.

I would simply like to observe one fact, Mr. Chairman. I understand that one of the reasons why so many members of the New York delegation are exercised on this issue today is because Mr. Ridge, who is the head of the Homeland Security agency, was quoted in the newspapers saying that, yes, it was absolutely true, there ought to be more money for high-threat areas. That is very nice to hear him say that.

The problem is, his budget, the budget presented by the President on behalf of his agency, had not one dime in for that purpose, and this committee put in $500 million. It was $700 million that was put in in the omnibus just a few months ago.

So I appreciate the sentiments being voiced here today, but I would point out that since this House passed a tax package which has taken away this committee's ability to provide funding that we ought to be providing for this and other high-priority areas in this bill, it seems to me that at this point, rather than asking this committee to get a double hernia trying to do something which is fiscally impossible, given the budget caps that we have been provided, it seems to me what he ought to do is march down to the White House and tell the President to amend his budget and his tax bill so we can afford his legitimate request. Without that, to me, at this point, we are just flap-jawing and we are not going to have any real opportunity to help the areas of the country you are talking about, except by hurting other areas of the country.

The Republican tax package which my colleagues voted for on that side of the aisle has put us in this position where, if we are going to deal with problems in one section of the country, we have to beggar thy neighbor. I am not very enthused about that. I think New York and other high-impact areas deserve this money, but I think the rural areas do too; and I would simply say that short as this bill is on this item, it does a whole lot better by that part of the country than the President's recommendation.

So the first thing I would say to Mr. Ridge is, go back to Washington and lobby your President, to ask him to put in the money that you told the New York folks was necessary.

Mr. SWEENEY. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I am going to probably not take the full 5 minutes because, in part, I am going to reiterate some things that have already been said here on the floor: in part, the colloquy that the chairman of the subcommittee engaged in and, in part, in reflection of the last two amendments in particular, which I think point out the real difficult task this subcommittee, this chairman, and the ranking member faced in the course of putting together this plan.

In stating the obvious, I will agree with the ranking member of the overall committee. It is quite clear that there apparently has been a change at the administration; that the current plan or the current structure of the plan that was sent forward has changed significantly, certainly overnight, and it is somewhat reflective in the fact that my colleagues in the New York delegation have come to the floor and have argued vehemently. But they are not new to that argument. We have all been making the case that we are not quite sure whether there is enough money in high-risk, high-density funding in this particular program. But I can tell my colleagues that not anyone, Mr. Chairman, in this Chamber, in this House, and in this Nation can tell us whether we have appropriated enough at this point in time. That is exactly the point, exactly the point that I think the chairman of the subcommittee has been making.

Given the information we have now, given the money that has been appropriated and flowed out, given what we know in terms of the expenses, and we talked about it in that colloquy earlier, we are trying to meet those needs, that this House has recognized that needs exist in specific areas that rise to a certain level above what the rest of the community is, and that it is somewhat grossly unfair for us to have to make those determinations on where exactly all of this goes, taking possibly from one area unequally and giving to another area.

But it is absurd to make the point or argue that there is not enough money there. We have appropriated billions and billions of dollars, and what we see here in place is a work in progress.

I would say to my friends from New York especially, but to those from other parts of the country who have introduced the last couple of amendments who would like to see us take from one fund to the other, that that is not the appropriate course at this time, given the information that we have. I actually trust the notion that when we go to conference, the very people who created the high-risk, high-density fund, the gentleman from Kentucky (Chairman ROGERS), this subcommittee, are in the best place to determine what that appropriate funding is going to be; and I have every bit of confidence that we are going to be able to meet that need.

There has been an acknowledgment on this floor by the chairman, by this committee, that the work is incomplete; that there are needs that are going to be met. It is not just here in high-risk; it is in a lot of other places. But given the opportunity to examine that, I hear the call from the chairman, and I have every bit of confidence that we are going to be able to do that, equally covering the needs of the rest of the communities in our Nation to ensure the safety of the American people.

Mr. BRADY of Texas. Mr. Chairman, will the gentleman yield?

Mr. SWEENEY. I yield to the gentleman from Texas.

Mr. BRADY of Texas. Mr. Chairman, based upon the gentleman's comments, the hard work that the gentleman has done, and I know that this is a key issue and I appreciate the gentleman from New York (Mr. WEINER) and the gentleman from New York (Mr. FOSSELLA) and others who are involved in this, and I also appreciate the strong leadership of our chairman, the gentleman from Kentucky (Mr. ROGERS); and based upon this discussion today, based upon the hard work, because we all try to raise the level of funding for our communities, I ask unanimous consent to withdraw my amendment.

The CHAIRMAN. Is there objection to the request of the gentleman from Texas?

There was no objection.

The CHAIRMAN. The Clerk will read.

The Clerk read as follows:

TITLE III—EMERGENCY PREPAREDNESS AND RESPONSE

Administrative and Regional Operations

For necessary expenses for administrative and regional operations of the Emergency Preparedness and Response Directorate, $168,589,000, including activities authorized by the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.), the Flood Disaster Protection Act of 1973 (42 U.S.C. 4001 et seq.), the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.), the Earthquake Hazards Reduction Act of 1977 (42 U.S.C. 7701 et seq.), the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2201 et seq.), the Defense Production Act of 1950 (50 U.S.C. App. 2061 et seq.), sections 107 and 303 of the National Security Act of 1947 (50 U.S.C. 404–405), Reorganization Plan No. 3 of 1978, and the Homeland Security Act of 2002; of which not to exceed $3,000 shall be for official reception and representation expenses.

Preparedness, Mitigation, Response, and Recovery

For necessary expenses for preparedness, mitigation, response, and recovery activities of the Emergency Preparedness and Response Directorate, $363,339,000, including activities authorized by the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.), the Flood Disaster Protection Act of 1973 (42 U.S.C. 4001 et seq.), the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.), the Earthquake Hazards Reduction Act of 1977 (42 U.S.C. 7701 et seq.), the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2201 et seq.), the Defense Production Act of 1950 (50 U.S.C. App. 2061 et seq.), sections 107 and 303 of the National Security Act of 1947 (50 U.S.C. 404–405), Reorganization Plan No. 3 of 1978, and the Homeland Security Act of 2002; of which $25,000,000 shall be for emergency operations centers grants: *Provided*, That the aggregate charges assessed during fiscal year 2004, as authorized by Public Law 106–377, shall not be less than 100 percent of the amounts anticipated by the Department of Homeland Security necessary for its radiological emergency preparedness program for the next fiscal year: *Provided further*, That the methodology for assessment and collection of fees shall be fair and equitable, and shall reflect costs of providing such services, including administrative costs of collecting such fees: *Provided further*, That fees received pursuant to this section shall be deposited in this account as offsetting collections, shall become available for authorized purposes on October 1, 2004, and shall remain available until expended.

Public Health Programs

For necessary expenses for countering potential biological, disease, and chemical threats to civilian populations, $484,000,000, including $400,000,000, to remain available until expended, for the Strategic National Stockpile.

Biodefense Countermeasures

For necessary expenses for securing medical countermeasures against biological terror attacks, $5,593,000,000, to remain available until September 30, 2013: *Provided*, That not to exceed $3,418,000,000 may be obligated during fiscal years 2004 through 2008, of which not to exceed $890,000,000 may be obligated during fiscal year 2004.

Grant Programs

For activities designed to reduce the risk of flood damage to structures pursuant to the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.), notwithstanding sections 1366(b)(3) (B)–(C) and 1366(f) of such Act, and for a pre-disaster mitigation grant program pursuant to title II of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5131 et seq.), $200,000,000, to remain available until expended, of which $20,000,000 shall be derived from the National Flood Insurance Fund, and shall remain available until September 30, 2005: *Provided*, That grants made for pre-disaster mitigation shall be awarded on a competitive basis subject to the criteria in section 203(g) of such title II (42 U.S.C. 5133(g)): *Provided further*, That notwithstanding section 203(f) of such title II (42 U.S.C. 5133(f)), grant awards shall be made without reference to State allocations, quotas, or other formula-based allocation of funds.

Emergency Food and Shelter

To carry out an emergency food and shelter program pursuant to title III of Public Law 100–77 (42 U.S.C. 11331 et seq.), $153,000,000, to remain available until expended: *Provided*, That total administrative costs shall not exceed 3½ percent of the total appropriation.

Mr. WELDON of Pennsylvania. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I want to, first of all, before I enter into a colloquy with the distinguished chairman, thank the chairman of the subcommittee. Even before it was created, the leaders on this subcommittee were instrumental in helping our first responders.

There has been a lot of rhetoric about this Congress not doing enough for the first responders. Let me say to my colleagues in this body that before 9–11 occurred there was no program to assist our first responders nationwide, nothing. And Congress has, over the past years, had plenty of opportunities, but never saw fit. And disasters were not new. We had them all during the history of this country.

It was this Congress in 2000, with the leadership of the distinguished chairman of the full committee and the distinguished chairman of this subcommittee, who saw fit to create a grant program for our 32,000 fire and EMS departments in America. That was created in 2000, the year before 9–11. Initially, it was funded at $100 million. It went to $300 million, and this year, because of the leadership of the distinguished chairman from Kentucky and the support of the ranking member, the support for our firefighter grant program is at $715 million.

Many of our colleagues have said it is the most popular and most successful program that Congress has created. We are doing good work on behalf of the Nation's first responders. I want to applaud this subcommittee for their outstanding efforts and let them know, as the founder and chairman of the Fire Caucus and a former fire chief myself, they have done outstanding work; and it is paying dividends all over the country.

So, Mr. Chairman and Mr. Ranking Member, thank you for your strong support of the Nation's first responders.

Mr. Chairman, I rise today to engage in a colloquy with my colleague, the gentleman from Kentucky (Mr. ROGERS), the distinguished chairman of this subcommittee, regarding a very important program called FIRESAT.

Mr. Chairman, one need not look further than the news reports of the destructive and violent wildfires in Arizona. In 2000, over 8 million acres of pristine wilderness burned, and Federal agencies expended more than $1.3 billion in fire suppression costs. Last year, in 2002, wildfires scorched over 7 million acres. Hundreds of homes were destroyed and firefighters gave their lives.

FIRESAT is a satellite system that is able to detect wildfires in their early stages while they are still less than 1 acre in size. While the tools are at our disposal to save lives and billions of dollars, the equipment for this program remains boxed in offices in Reston, Virginia. This project can be fully activated with the necessary security upgrades and software upgrades in time for the fire season this year for $7.5 million. In relation to the billions of dollars lost in these wild land fires every year, this is truly a smart investment. Finally, Mr. Chairman, we have the technology and the means to do something about this.

FIRESAT was originally labeled the Hazard Support System and developed by Ratheon with funds which I obtained from the Department of Defense in 1997. The system was subsequently transferred to the U.S. Geological Survey and NOAA who, for unknown reasons, did not request funds for the program in their budget. At the request last year of Joe Albaugh, the director of FEMA, we successfully transferred the system, now named FIRESAT, within the Homeland Security Act to the Department of Homeland Security's Directorate for Emergency Preparedness and Response.

Today is our opportunity to install a commonsense solution to the annual wildfires that wreak havoc to communities and forests all over America and place countless firefighters in danger. I hope that under the leadership of the gentleman from Kentucky (Mr. ROGERS) an opportunity will present itself to fund this economical and much-needed program.

Mr. ROGERS of Kentucky. Mr. Chairman, will the gentleman yield?

Mr. WELDON of Pennsylvania. I yield to the gentleman from Kentucky.

Mr. ROGERS of Kentucky. Mr. Chairman, I thank the gentleman for yielding.

Let me return the thanks. The gentleman from Pennsylvania has been our leader in the Congress for first responders, not just firefighters, but first responders in general; and he brings an expertise to this job not just from an educational point of view, but he is back there with them. So I want to thank the gentleman for his leadership on these issues and for bringing this very timely subject to our attention.

Considering the devastation that wildfires cause our Nation each year, I look forward to working with the gentleman during conference so that we can address this important matter.

Mr. BELL. Mr. Chairman, I move to strike the last word.

Mr. Chairman, the House is set to pass a Homeland Security appropriations bill that falls well short of where our country needs to be to effectively combat our greatest vulnerability: the threat to our Nation's port facilities.

Today, in the Democratic Caucus Task Force on Homeland Security, we had the opportunity to hear from Rand Beers, who recently resigned from President Bush's National Security Council because he said that "the administration wasn't matching its deeds to its words in the war on terrorism. They are making us less secure, not more secure."

He told us that our Nation's port facilities are crying out for protection and that the administration's neglect of the issue was a cause of great concern and puzzlement for him.

The Coast Guard says that the cost of infrastructure improvements to secure our ports for fiscal year 2004 would run around $963 million. This bill only appropriates $100 million. Welcome funding, yes, but far short of where we need to be.

The Coast Guard also says that it will need $70 million to evaluate the security plans for ports across America by the July 2004 deadline mandated by the Maritime Transportation and Security Act. This bill does not provide any of the $70 million the Coast Guard says it needs.

The Obey amendment would address these and many others needs, yet we cannot consider the Obey amendment here today.

Why is it that we continue to neglect port security funding when the CIA tells us we are more likely to be attacked by a weapon of mass destruction smuggled aboard a ship than we are by an intercontinental ballistic missile? The fact that our ports are threatened might come as a surprise to millions of Americans who watched as Secretary Ridge announced that the Department of Homeland Security was releasing millions of dollars in port security grants.

☐ 1715

But it does not come as a surprise to those of us in Congress who listened as administration officials told us that those scant few dollars appropriated for port security grant programs and Operation Safe Commerce would probably be rerouted to aviation security.

Mr. Chairman, in light of recent world events, this is simply unacceptable. We are not giving port security the funding it needs just weeks after an Egyptian sailor attempted to smuggle anthrax aboard a ship bound for North America. We are not giving port security the funding it needs the day after 600 tons of explosives were discovered aboard a ship bound for a fictitious company in Sudan. And we are not funding port security the same day my hometown paper, the Houston Chronicle, says that al Qaeda might be targeting oil and port facilities in Houston during the Fourth of July holiday.

We cannot afford to ignore the Obey amendment. Like Rand Beers said, "America's ports are crying out for protection."

Mr. Chairman, it is about time we start listening.

The CHAIRMAN. Are there further amendments?

If not, the Clerk will read.

The Clerk read as follows:

Firefighter Assistance Grants

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses, not otherwise provided for, for programs as authorized by section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2201 et seq.), $750,000,000 to remain available through September 30, 2005: *Provided*, That up to 5 percent of this amount shall be transferred to "Preparedness, Mitigation, Response, and Recovery" for program administration.

Disaster Relief

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses in carrying out the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.), $1,800,000,000 and, notwithstanding 42 U.S.C. 5203, to remain available until expended, of which not to exceed $22,000,000 may be transferred to the Office of Inspector General for audits and investigations.

Flood Map Modernization Fund

For necessary expenses pursuant to section 1360 of the National Flood Insurance Act of 1968, $200,000,000, and such additional sums as may be provided by State and local governments or other political subdivisions for cost-shared mapping activities under section 1360(f)(2) of such Act; to remain available until expended.

National Flood Insurance Fund

(INCLUDING TRANSFER OF FUNDS)

For activities under the National Flood Insurance Act of 1968, and the Flood Disaster Protection Act of 1973, not to exceed $32,761,000 for salaries and expenses associated with flood mitigation and flood insurance operations, and not to exceed $77,809,000 for flood mitigation, to remain available until September 30, 2005, including up to $20,000,000 for expenses under section 1366 of such Act of 1968, which amount shall be available for transfer to Grant Programs until September 30, 2005, and which amounts shall be derived from offsetting collections assessed and collected pursuant to 42 U.S.C. 4014, and shall be retained and used for necessary expenses under this heading: *Provided*, That no funds, in excess of $55,000,000 for operating expenses; $565,897,000 for agents' commissions and taxes; and $40,000,000 for interest on Treasury borrowings, shall be available from the National Flood Insurance Fund without prior notice to the Committees on Appropriations.

Disaster Assistance Direct Loan Program Account

For direct loans, as authorized by section 319 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act: *Provided*, That these funds are available to subsidize gross obligations for the principal amount of direct loans not to exceed $25,000,000: *Provided further*, That the cost of modifying such loans shall be as defined in section 502 of the Congressional Budget Act of 1974. In addition, for administrative expenses to carry out the direct loan program, $558,000.

TITLE IV—OTHER DEPARTMENTAL ACTIVITIES

CITIZENSHIP AND IMMIGRATION SERVICES

Operating Expenses

For necessary expenses for citizenship and immigration services, including international services, $248,500,000.

UNITED STATES COAST GUARD

Operating Expenses

For necessary expenses for the operation and maintenance of the Coast Guard, not otherwise provided for; payments pursuant to section 156 of Public Law 97–377 (42 U.S.C. 402 note); and recreation and welfare; $4,703,530,000, of which $1,300,000,000 shall be for defense-related activities; of which

$25,000,000 shall be derived from the Oil Spill Liability Trust Fund; and of which not to exceed $3,000 shall be for official reception and representation expenses: *Provided*, That none of the funds appropriated in this or any other Act shall be available for pay of administrative expenses in connection with shipping commissioners in the United States: *Provided further*, That none of the funds provided in this Act shall be available for expenses incurred for yacht documentation under section 12109 of title 46, United States Code, except to the extent fees are collected from yacht owners and credited to this appropriation.

Environmental Compliance and Restoration

For necessary expenses to carry out the Coast Guard's environmental compliance and restoration functions under chapter 19 of title 14, United States Code, $17,000,000, to remain available until expended.

Reserve Training

For all necessary expenses of the Coast Guard Reserve, as authorized by law; maintenance and operation of facilities; and supplies, equipment, and services; $94,051,000.

Acquisitions, Construction, and Improvements

For necessary expenses of acquisition, construction, renovation, and improvement of aids to navigation, shore facilities, vessels, and aircraft, including equipment related thereto, $805,000,000, of which $23,500,000 shall be derived from the Oil Spill Liability Trust Fund; of which $66,500,000 shall be available until September 30, 2008 to acquire, repair, renovate, or improve vessels, small boats, and related equipment; $138,500,000 shall be available until September 30, 2006 for other equipment; $70,000,000 shall be available until September 30, 2005 for personnel compensation and benefits and related costs; and $530,000,000 shall be available until September 30, 2008 for the Integrated Deepwater Systems program: *Provided*, That the Commandant of the Coast Guard is authorized to dispose of surplus real property, by sale or lease, and the proceeds shall be credited to this appropriation as offsetting collections and shall be available until September 30, 2006 only for Rescue 21 (the National Distress and Response System Modernization program): *Provided further*, That upon initial submission to the Congress of the fiscal year 2005 President's budget, the Secretary of Homeland Security shall transmit to the Congress a comprehensive capital investment plan for the United States Coast Guard that includes funding for each budget line item for fiscal years 2005 through 2009, with total funding for each year of the plan constrained to the funding targets for those years as estimated and approved by the Office of Management and Budget.

Alteration of Bridges

For necessary expenses for alteration or removal of obstructive bridges, $19,500,000, to remain available until expended.

Research, Development, Test, and Evaluation

For necessary expenses, not otherwise provided for, for applied scientific research, development, test, and evaluation; and maintenance, rehabilitation, lease and operation of facilities and equipment, as authorized by law; $22,000,000, to remain available until expended, of which $3,500,000 shall be derived from the Oil Spill Liability Trust Fund: *Provided*, That there may be credited to and used for the purposes of this appropriation funds received from State and local governments, other public authorities, private sources, and foreign countries, for expenses incurred for research, development, testing, and evaluation.

Retired Pay

For retired pay, including the payment of obligations therefor otherwise chargeable to lapsed appropriations for this purpose, payments under the Retired Serviceman's Family Protection and Survivor Benefits Plans, payment for career status bonuses under the National Defense Authorization Act, and for payments for medical care of retired personnel and their dependents under the Dependents Medical Care Act (10 U.S.C. ch. 55), $1,020,000,000.

INFORMATION ANALYSIS AND INFRASTRUCTURE PROTECTION

Operating Expenses

For necessary expenses of the Directorate of Information Analysis and Infrastructure Protection of the Department of Homeland Security as authorized by law, $776,000,000, to remain available until September 30, 2005.

SCIENCE AND TECHNOLOGY

Research, Development, Acquisition, and Operations

For necessary expenses of activities of the Department of Homeland Security in carrying out the purposes of title III of the Homeland Security Act of 2002 (Public Law 107–296), for basic and applied research, development, test and evaluation, construction, procurement, production, modification and modernization of systems, subsystems, spare parts, accessories, training devices, operation of the Science and Technology Directorate and its organizations and activities, including the Homeland Security Advanced Research Projects Agency, for cooperative programs with States and local governments to enable the detection, destruction, disposal, or mitigation of the effects of weapons of mass destruction and other terrorist weapons, and for the construction, maintenance, rehabilitation, lease, and operation of buildings and other facilities, and equipment, necessary for the activities of the Directorate, $900,360,000, to remain available until September 30, 2006.

UNITED STATES SECRET SERVICE

Salaries and Expenses

For necessary expenses of the United States Secret Service, $1,148,700,000, including purchase of American-made side-car compatible motorcycles; hire of aircraft; services of expert witnesses at such rates as may be determined by the Director; rental of buildings in the District of Columbia, and fencing, lighting, guard booths, and other facilities on private or other property not in Government ownership or control, as may be necessary to perform protective functions; for payment of per diem and subsistence allowances to employees where a protective assignment during the actual day or days of the visit of a protectee require an employee to work 16 hours per day or to remain overnight at his or her post of duty; the conducting of and participating in firearms matches; presentation of awards; for travel of Secret Service employees on protective missions without regard to the limitation on such expenditures in this or any other Act; for research and development; for making grants to conduct behavioral research in support of protective research and operations; not to exceed $25,000 for official reception and representation expenses; not to exceed $100,000 to provide technical assistance and equipment to foreign law enforcement organizations in counterfeit investigations; for payment in advance for commercial accommodations as may be necessary to perform protective functions; and for uniforms without regard to the general purchase limitation for the current fiscal year: *Provided*, That $1,633,000 shall be available for forensic and related support of investigations of missing and exploited children: *Provided further*, That $4,783,000 shall be available as a grant for activities related to the investigations of exploited children and shall remain available until expended: *Provided further*, That up to $18,000,000 for protective travel shall remain available until September 30, 2005: *Provided further*, That subject to the reimbursement of actual costs to this account, funds appropriated in this account shall be available, at the discretion of the Director, for the following: training United States Postal Service law enforcement personnel and Postal police officers, training Federal law enforcement officers, training State and local government law enforcement officers on a space-available basis, and training private sector security officials on a space-available basis: *Provided further*, That the United States Secret Service is authorized to obligate funds in anticipation of reimbursements from agencies and entities, as defined in section 105 of title 5, United States Code, receiving training sponsored by the James J. Rowley Training Center, except that total obligations at the end of the fiscal year shall not exceed total budgetary resources available under this heading at the end of the fiscal year: *Provided further*, That the James J. Rowley Training Center is authorized to provide short-term medical services for students undergoing training at the Center.

Mr. LATHAM (during the reading). Mr. Chairman, I ask unanimous consent that the remainder of the bill through page 37, line 13 be considered as read, printed in the RECORD and open to amendment at any point.

The CHAIRMAN. Is there objection to the request of the gentleman from Iowa?

There was no objection.

The text of the bill from page 31, line 6, through page 37, line 13, is as follows:

Acquisition, Construction, Improvements, and Related Expenses

For necessary expenses of construction, repair, alteration, and improvement of facilities, $3,579,000, to remain available until expended.

TITLE V—GENERAL PROVISIONS

Sec. 501. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

(TRANSFERS OF UNEXPENDED BALANCES)

Sec. 502. Subject to the requirements of section 503 of this Act, the unexpended balances of prior appropriations provided for activities in this Act may be transferred to appropriation accounts for such activities established pursuant to this Act. Balances so transferred may be merged with funds in the applicable established accounts and thereafter may be accounted for as one fund for the same time period as originally enacted.

(INCLUDING TRANSFER OF FUNDS)

Sec. 503. (a) None of the funds provided by this Act, provided by previous appropriation Acts to the agencies in or transferred to the Department of Homeland Security that remain available for obligation or expenditure in fiscal year 2004, or provided from any accounts in the Treasury of the United States derived by the collection of fees available to the agencies funded by this Act, shall be available for obligation or expenditure through a reprogramming of funds that: (1) creates a new program; (2) eliminates a program, project, or activity; (3) increases funds for any program, project, or activity for which funds have been denied or restricted by the Congress; or (4) proposes to use funds directed for a specific activity by either the House or Senate Committees on Appropriations for a different purpose, unless both Committees on Appropriations are notified 15 days in advance of such reprogramming of funds.

(b) None of the funds provided by this Act, provided by previous appropriation Acts to the agencies in or transferred to the Department of Homeland Security that remain available for obligation or expenditure in fiscal year 2004, or provided from any accounts in the Treasury of the United States derived by the collection of fees available to the agencies funded by this Act, shall be available for obligation or expenditure for programs, projects, or activities through a reprogramming of funds in excess of $5,000,000 or 10 percent, whichever is less, that (1) augments existing programs, projects, or activities; (2) reduces by 10 percent funding for any existing program, project, or activity, or numbers of personnel by 10 percent as approved by the Congress; or (3) results from any general savings from a reduction in personnel that would result in a change in existing programs, projects, or activities, as approved by the Congress; unless the Committees on Appropriations are notified 15 days in advance of such reprogramming of funds.

(c) Not to exceed 5 percent of any appropriation made available for the current fiscal year for the Department of Homeland Security in this Act or provided in previous appropriation Acts may be transferred between such appropriations, but no such appropriation, except as otherwise specifically provided, shall be increased by more than 10 percent by such transfers: *Provided*, That any transfer pursuant to this section shall be treated as a reprogramming of funds and shall not be available for obligation unless the Committees on Appropriations are notified 15 days in advance of such transfer.

SEC. 504. Except as otherwise specifically provided by law, not to exceed 50 percent of unobligated balances remaining available at the end of fiscal year 2004 from appropriations made available for salaries and expenses for fiscal year 2004 in this Act, shall remain available through September 30, 2005, for each such account for the purposes authorized: *Provided*, That a request shall be submitted to the Committees on Appropriations for approval prior to the expenditure of such funds: *Provided further*, That these requests shall be made in compliance with reprogramming guidelines.

SEC. 505. Except as otherwise provided in this Act, funds may be used for hire and purchase of motor vehicles as authorized by section 1343 of title 31, United States Code: *Provided*, That purchase for police-type use of passenger vehicles may be made without regard to the general purchase price limitation for the current fiscal year.

SEC. 506. The Federal Emergency Management Agency "Working Capital Fund" shall be available to the Department of Homeland Security, as authorized by sections 503 and 1517 of the Homeland Security Act of 2002, for expenses and equipment necessary for maintenance and operations of such administrative services as the Secretary of Homeland Security determines may be performed more advantageously as central services. Such fund shall hereafter be known as the "Department of Homeland Security Working Capital Fund".

SEC. 507. The Federal Emergency Management Agency "Bequests and Gifts" account shall be available to the Department of Homeland Security, as authorized by sections 503 and 1517 of the Homeland Security Act of 2002, for the Secretary of Homeland Security to accept, hold, administer, and utilize gifts and bequests, including property, to facilitate the work of the Department of Homeland Security: *Provided*, That such fund shall hereafter be known as "Department of Homeland Security, Gifts and Donations": *Provided further*, That any gift or bequest shall be used in accordance with the terms of that gift or bequest to the greatest extent practicable.

SEC. 508. Funds made available by this Act for intelligence activities are deemed to be specifically authorized by the Congress for purposes of section 504 of the National Security Act of 1947 (50 U.S.C. 414) during fiscal year 2004 until the enactment of the Intelligence Authorization Act for fiscal year 2004.

SEC. 509. The Federal Law Enforcement Training Center is directed to establish an accrediting body that will include representatives from the Federal law enforcement community, as well as non-Federal accreditation experts involved in law enforcement training. The purpose of this body will be to establish standards for measuring and assessing the quality and effectiveness of Federal law enforcement training programs, facilities, and instructors.

SEC. 510. None of the funds in this Act shall be available to plan, finalize, or implement regulations that would establish a vessel traffic safety fairway less than 5 miles wide between the Santa Barbara Traffic Separation Scheme and the San Francisco Traffic Separation Scheme.

SEC. 511. None of the funds in this Act may be used to make a grant unless the Secretary of Homeland Security notifies the Committees on Appropriations not less than 3 full business days before any grant allocation, discretionary grant award, or letter of intent totaling $1,000,000 or more is announced by the department or its directorates from (1) any discretionary or formula-based grant program of the Office of Domestic Preparedness; (2) any letter of intent from the Transportation Security Administration; or (3) any port security grant: *Provided*, That no notification shall involve funds that are not available for obligation.

SEC. 512. Notwithstanding any other provision of law, no agency shall purchase, construct, and/or lease any additional facilities, except within or contiguous to existing locations, to be used for the purpose of conducting Federal law enforcement training without the advance approval of the Committees on Appropriations, except that the Federal Law Enforcement Training Center is authorized to obtain the temporary use of additional facilities by lease, contract, or other agreement for training which cannot be accommodated in existing Center facilities.

SEC. 513. The Federal Law Enforcement Training Center is directed to ensure that all of the training centers under its control are operated at their highest potential capacity efficiency throughout the fiscal year. In order to facilitate this direction, the Director is authorized to schedule basic and advanced law enforcement training at any site the Federal Law Enforcement Training Center determines is warranted in the interests of the Government to ensure the best utilization of the Center's total capacity for training, notwithstanding legislative prohibitions.

The CHAIRMAN. The Clerk will read.

The Clerk read as follows:

SEC. 514. Section 114 of title 49, United States Code, is amended by adding at the end the following:

"(t) FEE AUTHORITY FOR TRANSPORTATION CREDENTIALS.—

"(1) Subject to the provisions of this subsection, the Secretary of Homeland Security may impose reasonable fees and charges on an individual or an individual's employer, where such an individual requires a credential or background records check under Federal law for an activity in the field of transportation, to cover the costs of providing the credential or performing the backgrounds records check, including—

"(A) conducting or obtaining a criminal history records check and a review of available law enforcement databases and records of other governmental and international agencies;

"(B) review and adjudication of requests for waiver and appeals of agency decisions with respect to providing the credential, performing the background records check, and denials of requests for waiver and appeals; and

"(C) any other costs of the Transportation Security Administration related to providing the credential or performing the backgrounds records check.

"(2) The Secretary shall ensure that the fees are reasonably related to the costs of the Transportation Security Administration for providing services rendered. The amount of costs imposed under this subsection shall be determined by the Secretary and shall not be subject to judicial review.

"(3) Notwithstanding section 9701 of title 31 and the procedural requirements of section 553 of title 5, the Secretary may impose a fee under this subsection through the publication of notice in the Federal Register.

"(4) Notwithstanding section 3302 of title 31, any fee collected under this section—

"(A) shall be credited as an offsetting collection to the account in the Treasury from which the expenses were incurred and are available to the Secretary for these expenses; and

"(B) shall remain available until expended.".

POINT OF ORDER

Mr. MICA. Mr. Chairman, I make a point of order against section 514.

The CHAIRMAN. The gentleman will state his point of order.

Mr. MICA. Mr. Chairman, I raise a point of order against section 514 on page 37, line 14 through page 39, line 10. This particular section violates clause 2 of rule XXI. It changes existing law and therefore constitutes legislating on an appropriations bill in violation of the House rules.

The CHAIRMAN. Are there other Members desiring to be heard on the point of order?

If not, the Chair is prepared to rule.

The Chair finds that section 514 proposes directly to change existing law, to wit: section 114 of title 49, United States Code, and as such it constitutes legislation in violation of clause 2(b) of rule 21, and the point of order is sustained. Section 514 is stricken from the bill.

The Clerk will read.

The Clerk read as follows:

SEC. 515. None of the funds made available by this Act may be used for the production of customs declarations that do not inquire whether the passenger has been in the proximity of livestock.

SEC. 516. None of the funds made available by this Act shall be available for any activity or for paying the salary of any Government employee where funding an activity or paying a salary to a Government employee would result in a determination, regulation, or policy that would prohibit the enforcement of section 307 of the Tariff Act of 1930.

SEC. 517. None of the funds made available in this Act may be used to allow—

(1) the importation into the United States of any good, ware, article, or merchandise mined, produced, or manufactured by forced or indentured child labor, as determined pursuant to section 307 of the Tariff Act of 1930 (19 U.S.C. 1307); or

(2) the release into the United States of any good, ware, article, or merchandise on which there is in effect a detention order, pursuant to such section 307, on the basis that the good, ware, article, or merchandise may have been mined, produced, or manufactured by forced or indentured child labor.

SEC. 518. Appropriations to the Department of Homeland Security in this Act shall be available for purchase of insurance for official motor vehicles operated in foreign countries; purchase of motor vehicles without regard to the general purchase price limitations for vehicles purchased and used overseas for the current fiscal year; entering into contracts with the Department of State for the furnishing of health and medical services to employees and their dependents serving in foreign countries; and services authorized by section 3109 of title 5, United States Code.

SEC. 519. None of the funds appropriated in this Act may be used for expenses of any construction, repair, alteration, and acquisition project for which a prospectus, if required by the Public Buildings Act of 1959, has not been approved, except that necessary funds may be expended for each project for required expenses for the development of a proposed prospectus.

SEC. 520. None of the funds in this Act shall be used to pursue or adopt guidelines or regulations requiring airport sponsors to provide to the Transportation Security Administration without cost building construction, maintenance, utilities and expenses, or space in airport sponsor-owned buildings for services relating to aviation security: *Provided*, That the prohibition of funds in this section does not apply to—

(1) negotiations between the agency and airport sponsors to achieve agreement on "below-market" rates for these items, or

(2) space for necessary security checkpoints.

SEC. 521. Section 835 of the Homeland Security Act of 2002 (Public Law 107-296; 6 U.S.C. 395) is amended—

(1) in subsection (a), by inserting before the period ", or any subsidiary of such an entity";

(2) in subsection (b)(1), by inserting "before, on, or" after the "completes";

(3) in subsection (e)(1)(B), by striking "which is after the date of enactment of this Act and"; and

(4) in subsection (d) by striking all after "in the interest of" and inserting "national security.".

POINT OF ORDER

Mr. MICA. Mr. Chairman, I make a point of order.

The CHAIRMAN. The gentleman will state his point of order.

Mr. MICA. Mr. Chairman, I raise a point of order against section 521 on page 41, line 15 through line 25, of H.R. 2555 on the grounds that this provision changes existing law in violation of clause 2(b) of the House rule 21 and therefore is legislation included in a general appropriations bill.

The CHAIRMAN. Do further Members desire to be heard on the point of order?

The gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Chairman, I wish to be heard on the point of order.

The CHAIRMAN. The gentlewoman from Connecticut may proceed.

Ms. DELAURO. Mr. Chairman, I want to express my serious opposition to this point of order and point out the hypocrisy of what my friends on the other side of the aisle are doing here.

I offered this amendment during the Committee on Appropriations consideration of this bill. It was accepted by the chairman and it was passed on a voice vote. Yet, today they use a technical excuse to justify stripping it from the bill. Just another gimmick.

This amendment would do nothing more than restore the law to the form it held when 318 Members of this House voted for a motion to recommit that I offered to prohibit the Department of Homeland Security from contracting with corporate expatriates on July 26, 2002. But before that bill became law, loopholes were added that exempted most of the expatriate companies from the provision.

Expatriate companies are those that go offshore solely for the purposes of not paying taxes in the United States. At the time the majority leadership said publicly that those loopholes would be closed. Last November 19 the former leader of the other body told reporters that he had received a commitment from the Speaker and the majority leader that this would be fixed. Unfortunately, we have yet to do that.

We have an obligation to address this issue. American companies, particularly those contracting with our government, ought to be paying American taxes just like every citizen and corporation in this country. By this action, the Republican majority is demonstrating that they do not hold those same values. Since the majority leadership has failed to act, I offered an amendment in the Committee on Appropriations to close those loopholes added to the law last summer. Let me stress again that this amendment was accepted by the chairman of the subcommittee and passed on a voice vote.

The amendment would simply prohibit Federal agencies from contracting with a domestic subsidiary of any company that has moved overseas. This will prevent corporations from setting up a shell company overseas but then continue to exploit the tax loophole by obtaining government contracts here at home.

One high ranking Republican member of the Committee on Ways and Means said about closing this loophole that "business does not like that."

Is that how we decide how to solve our problem? This amendment would further make the contract ban retroactive so it applies to existing corporate expatriates.

Finally, the amendment includes a waiver solely for the purposes of national security, which is what was included in the original ban passed on the floor. That waiver was unnecessarily expanded last year for all intents and purposes, making the entire provision meaningless.

Evidence shows that corporate expatriates cost our government about $4 billion in revenue, funds that we sorely need. Yet they continue to receive $2.7 billion in government contracts after they have abdicated their most basic responsibility as citizens. We should not reward these companies with contracts from the very department that is charged with safeguarding our homeland security.

We should not use procedural sleight of hands to disguise the fact that some in this body want to condone that very practice. I am not calling for a vote at this time, but I would hope that the House leadership will seriously revisit this issue. It is wrong. It is un-American, and it is a travesty to think about these companies who refuse to pay taxes to this country and yet want to be the beneficiaries of the dollars and the contracts in order to deal with homeland security. Let us live up to the commitment that 318 of us made last year.

The CHAIRMAN. Are there further Members desiring to be heard on the point of order?

Mr. MICA. Mr. Chairman, the DeLauro amendment adopted by the Committee on Appropriations as part of the Homeland Security Appropriations Bill is in fact a significant change in the procurement policy of the United States, a subject clearly within the jurisdiction of the Committee on Government Reform under House Rule 10.

The DeLauro amendment calls for a broad sweeping contracting ban for so-called inverted domestic corporations and is clearly a change in existing law. As such, this section is in clear violation of clause 2(b) of House Rule 21, providing that no provision changing existing law shall be reported in any general appropriations bill.

The CHAIRMAN. Are there Members wishing to be heard on the point of order?

The Chair is prepared to rule and will so rule.

The Chair finds that section 521 proposes directly to change existing law, to wit: section 835 of the Homeland Security Act of 2002, and as such it constitutes legislation in violation of clause 2(b) of rule 21, and the point of order is sustained. Section 521 is stricken from the bill.

Mr. NEAL of Massachusetts. Mr. Chairman, I move to strike the last word.

Mr. Chairman, for the better part of 2 years now we have been promised a vote on closing the Bermuda loophole, an effort to amend this process on the floor where the Republican leadership has accepted by a margin so lopsided that it rivals any vote that we will take in any given legislative year. I believe 318 members of this House voted to do something about these corporate expatriates who not only leave the United States to avoid paying taxes but then have the unmitigated gall to bid on defense work in homeland security legislation. Ingersoll Rand, TYCO, these companies are avoiding billions of dollars in taxes, joint taxes estimated that we would garner, an additional $5 billion if we would simply close the Bermuda tax loophole.

Now, I know what the talking points of the Republican Party are on this. It is the corporate tax structure that is at fault. Well, if that is the case after 9 years why have not we done something about it? It is unbelievable where we had a chairman of the Committee on Ways and Means who used to say he was going to pull the Tax Code up by its roots. Well, America tonight knows that that tax system is more complicated and more unfair than ever.

We were going to drive a stake through the heart of the Tax Code. We were going to have tax simplicity. You know what we have had? We have had the rewarding of rich friends by our failure to address this issue.

For the Americans that are viewing this evening, I would ask you what would happen if you moved to Bermuda and declared that by renting a post office box you had taken citizenship on that island nation.

□ 1730

The IRS would be after you the next day. There would be no avenue of retreat, no opportunity to do what these corporations are doing. We have got 150,000 troops in Iraq tonight; and we talk about patriotism, while these guys renounce their citizenship and everybody knows that they continue to do substantial business and have their real corporate addresses here in the United States? And yet we cannot get a vote in this House of Representatives on that matter.

Two years ago, David Rogers in the Wall Street Journal was promised by the leadership of this House "there would have to be a vote on the Bermuda tax loophole." We are no closer to doing that this evening than we were 2 years ago; and that argument, again it galls everybody. It is the corporate tax structure that is at fault, not these folks moving offshore to avoid their responsibilities to live in this great Nation. That is patriotic, to pay our taxes and the $82 billion that Iraq is costing and $42 billion for homeland security.

We define patriotism by allowing these guys to move their corporate address to Bermuda for one exclusive purpose, to avoid taxes. What does that say about this great Nation and our principles? Yet the intransigence of the leadership on the majority side month after month after month is to do nothing about it. Put that question on the floor here about whether or not these folks should pay their taxes and I tell my colleagues what we would get, 350 votes for it and everybody knows it.

Mr. HAYES. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I rise today with my friend, the gentleman from Tennessee (Mr. WAMP), in support of providing domestic sourcing preferences for the Department of Homeland Security. As we take steps to protect our homeland security, an integral part of the process is strengthening our national and economic security. Through applying provisions that support the American industrial defense base to the Department of Homeland Security we can help ensure that American companies are able to provide the crucial goods needed by the agency to promote homeland security.

The American taxpayer provides the dollars which Congress then appropriates. It is only right that those same dollars are reinvested back into our economy. These dollars are reinvested back into our companies and workers and not those of a foreign country who could be an opponent or, at worst, a non-ally.

It is wise to provide for the livelihood of American citizens while funding government agencies. Homeland security starts at home, just as the name implies, in the homes and paychecks of American families. One of the most frequent questions I am asked by constituents is how they can sell their products or goods to the U.S. Government.

Today we have the ability to ensure that U.S. companies will be able to pursue and win contracts with the Federal Government. We have the opportunity to safeguard our economic security and keep America strong while providing necessary funds for America's homeland security.

My top two priorities are economic security and national security. Strengthening our homeland security is something that we are all working hard to do. There is no reason that the Department of Homeland Security should not do everything they can within reason to buy American goods.

A few years back we had an unfortunate episode where the U.S. Army purchased over 1 million black berets for U.S. soldiers. The problem was that a majority of those berets were made in China, and I think we all can agree that is ridiculous.

We need to take steps to ensure that government agencies not only improve our homeland security, but we have also got to take advantage of every opportunity we can to strengthen and promote jobs here at home.

I urge adoption of this crucial provision and would like to thank the gentleman from Kentucky (Mr. ROGERS) and his staff for working with me to provide American companies every opportunity to contract with the Department of Homeland Security and keep America strong.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I move to strike the last word.

Mr. Chairman, it is obvious that the ranking member of the full committee and the chairman of the full committee, as well as the gentleman from Kentucky (Mr. ROGERS) and the gentleman from Minnesota (Mr. SABO), respectively the chairman and ranking member of the Subcommittee on Homeland Security, are making every effort to work as diligently as they can on addressing the question of homeland security.

Mr. Chairman, I think it is important to address the question of neighborhood security, and I believe that in the course of the debate on the floor of the House many Members have come to debate questions and offer amendments not to be frivolous, but to ensure that our duty and responsibility to the American people are carried out.

I rise in support of an amendment, recognizing that the offerers have withdrawn it, but I rise to explain to my colleagues the importance of the concept offered by the gentleman from Texas (Mr. BRADY) and the gentleman from New York (Mr. WEINER). I came back from field hearings not in my district but in Long Beach, California, and Los Angeles, California; and I think it is important to note that there is no attempt here to diminish anyone's need for security in any part of the country. In fact, I am a very strong advocate for focusing on urban and rural areas because no one ever knows where a terrorist will attack, but I think this concept of delivering moneys only on the basis of population and not having a formula that responds to the high-targeted areas, let me share with my colleagues from the Houston Chronicle a comment noted that, with Texas as the target, officials are especially concerned about oil or gas facilities and pipelines because al Qaeda terrorists in the past have talked about attacking the energy sector as a way of damaging America's economy, officials said.

Mr. Chairman, even on 9-11 as we were trying to find out what was happening, rumors abounded that Houston was one of the cities because of its oil interests and its oil facilities that might be on the list of the terrorists that were now in the United States and tragically and horribly had struck the World Towers. It is important to recognize reality, and this idea of the formula is to make sense out of a simple process that gives moneys on the basis of population.

I believe, for example, we would take one State that might get $33 a person because of its population that is less than the State of Texas with its high density and its problems with oil refineries and other oil interests, and they would only get $3 or $4 a person. I know as we visited Long Beach and Los Angeles, and I use them only as an example, that the issue that was being made by those first responders was the need for resources in their hands.

Another point that was made was the need for resources to utilize the personnel, Mr. Chairman, not just for equipment, and this is one of the things that I believe we should openly discuss, that the formula that is presently utilized gives money only for equipment to our first responders. They need money for personnel. One can have the highest degree of equipment; but if they do not have personnel in the law enforcement, police departments, if they do not have personnel in the fire department, specifically the hazardous materials unit, that usually four people or five people or six people, it is key, Mr. Chairman, that we look at this not from the position of indictment, that we are accusatory or that we are not in sync with the mission that we are going forward on, but at the same time we should look for it in improvement.

Let me share with my colleagues the words of Secretary Ridge and paraphrase him, that generally speaking, the way that we have been distributing funds of old does not help the present situation. The very fact that each State should get the same amount of money does not help us fight terrorism. Some States should get more money than others because they have been elevated to a higher risk of terrorism.

So the reason why I believe it was worthy to have the debate that provided us the opportunity to discuss a different formula change is because, Mr. Chairman, it is crucial that this body does the right thing in securing the American people, and changing the formula would help us do the right thing. Getting the moneys in the hands of those first responders and others helps us do the right thing; and I would hope as our colleagues see this bill move forward, giving us more money, as the gentleman from Wisconsin (Mr. OBEY) has suggested that we do, in the right and fair way would help do the right thing.

I ask my colleagues to consider these elements as we move forward.

The CHAIRMAN pro tempore (Mr. McHUGH). The Clerk will read.

The Clerk read as follows:

SEC. 522. (a) None of the funds provided in this or previous appropriation Acts may be obligated for testing (other than simulations), deployment, or implementation of CAPPS2, the Computer Assisted Passenger Pre-screening System that the Transportation Security Administration ("TSA") plans to utilize to screen aviation passengers, until the General Accounting Office has reported to the Committees on Appropriations that—

(1) a system of due process exists whereby aviation passengers determined to pose a threat and either delayed or prohibited from boarding their scheduled flights by the TSA may appeal such decision and correct incorrect information contained in CAPPS2;

(2) the underlying error rate of the government and private data bases that will be used both to establish identity and assign a risk level to a passenger will not produce a large number of false positives that will result in a significant number of passengers being treated mistakenly or security resources being diverted;

(3) the TSA has stress-tested and demonstrated the efficacy and accuracy of all search tools in CAPPS2 and has demonstrated that CAPPS2 can make an accurate predictive assessment of those passengers who would constitute a threat to aviation;

(4) the Secretary of Homeland Security has established an internal oversight board to oversee and monitor the manner in which CAPPS2 is being developed and prepared;

(5) the TSA has built in sufficient operational safeguards to reduce the opportunities for abuse;

(6) substantial security measures are in place to protect CAPPS2 from unauthorized access by hackers or other intruders;

(7) the TSA has adopted policies establishing effective oversight of the use and operation of the system; and

(8) there are no specific privacy concerns with the technological architecture of the system.

(b) Not later than December 31, 2003, the National Academy of Sciences shall submit a report to the Committees on Appropriations that assesses the likely impact of the CAPPS2 system on privacy and civil liberties and includes recommendations for practices, procedures, regulations, or legislation to eliminate or minimize adverse effect of such system on privacy, discrimination, and other civil liberties.

POINT OF ORDER

Mr. MICA. Mr. Chairman, I have a point of order against section 522.

The CHAIRMAN pro tempore. The gentleman will state his point of order.

Mr. MICA. Mr. Chairman, I raise a point of order against section 522 on page 42, line 1, through page 43, line 24. This section violates clause 2 of rule XXI. It, in fact, changes existing law and, therefore, constitutes legislating on an appropriations bill in violation of the House rules.

Furthermore, Mr. Chairman, I have assured the sponsor of this original provision, the gentleman from Minnesota (Mr. SABO), that the House Committee on Transportation and Infrastructure will be adding a similar provision to our aviation security bill, H.R. 2144, during full committee markup tomorrow, Wednesday, and we will have similar language, and we do have the authority to authorize this language.

Unfortunately, his language is authorizing on an appropriations measure; and therefore I raise that point of order.

The CHAIRMAN pro tempore. Does any Member wish to be heard on the point of order?

Mr. SABO. Mr. Chairman, I do.

The CHAIRMAN pro tempore. The gentleman from Minnesota is recognized.

Mr. SABO. It is sort of strange. Would the gentleman from Florida yield?

Mr. MICA. Mr. Chairman, I would be glad to yield.

Mr. SABO. In discussion of his point of order, we are trying to figure out how——

The CHAIRMAN pro tempore. The Chair notes to the gentleman from Minnesota that under the rules of the House, debate on a point of order must be directed to the Chair, who hears each Member separately.

Mr. SABO. Okay. Let me see if I figure out how we do this, Mr. Chairman.

The CHAIRMAN pro tempore. I would note, just to help the gentleman with his dilemma, that others may be heard on it on their own time.

Mr. SABO. Mr. Chairman, I think I understand what the gentleman from Florida is saying is that he is raising a point of order against this provision because it is legislation on an appropriation bill. However, he is also telling me that the authorizing committee is meeting tomorrow and it is their intent to adopt provisions that are similar in substance to what is contained in the language of the appropriations bill, which will then be amended in another bill.

The gentleman from Minnesota would observe that, as he has read what is intended to be offered tomorrow, that in many ways it is similar and if that bill were before us we would not be subject to a point of order. However, the gentleman from Minnesota has also observed that some of the enforcement techniques within the proposed language are significantly weaker.

I would observe that the proposal that the committee will be considering tomorrow leaves the responsibility for reviewing CAPPS2 proposal internally in the Department while the language in question, which is subject to a point of order now, gives that responsibility to the GAO; and I would hope the gentleman from Florida would consider such language because frankly one of my concerns is the Department may not be equipped to make a good judgment.

We, frankly, have watched an agency that has had a problem trying to figure out which of their own employees do or do not have criminal backgrounds, and we think it might be a significant advantage to have the GAO look at their proposed plans before they are implemented rather than waiting until a year after deployment and development of these plans to have a GAO study.

□ 1745

So I would urge the gentleman from Florida, as he ponders whether he should continue to press this point of order, that they might well consider expanding at an earlier stage the review of GAO of the pending plans of the agency.

The CHAIRMAN pro tempore (Mr. McHugh). Does any other Member wish to be heard?

Mr. MICA. Mr. Chairman, again, I think that the point of order that I raised clearly does demonstrate, in fact if we look at the language before us, that there is authorization language contained by the gentleman from Minnesota (Mr. Sabo), which is excellent language and directive language but it does authorize on an appropriations measure, which is not allowed under the rules of the House.

The gentleman has raised issues about the substance of what is proposed in the full committee markup, and we will address some of those, but we do have a provision and we clearly have under our charter the responsibility for legislating the procedure which is followed. We will have the Under Secretary directed to not implement, other than on a test basis, the CAPPS2 program until the Under Secretary provides to Congress a certification that certain steps are taken. And later on we will have, of course, a GAO review required under our measure.

So we have the authority to the point of order clearly under the charter within the Committee on Transportation and Infrastructure. This is going to be considered under the FAA AIR-21 reauthorization. The security measure which is being considered, H.R. 2144, will be marked up tomorrow and blended into legislation which has already passed the House and, again, clearly under our authority as authorizers.

The CHAIRMAN pro tempore. If no other Member wishes to be heard on the point of order, the Chair is prepared to rule.

The Chair finds that section 522 proposes explicitly to supersede existing law, most immediately by proposing to restrict funds that were appropriated in other acts. As such, it constitutes legislation in violation of clause 2(b) of rule XXI, and the point of order is sustained. Section 522 is stricken from the bill.

AMENDMENT OFFERED BY MR. HAYES

Mr. HAYES. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. Hayes:

At the end of the bill (before the short title), insert the following:

Sec. . None of the funds made available in this Act may be used in contravention of the applicable provisions of the Buy American Act (41 U.S.C. 10a–10c).

Mr. HAYES. Mr. Chairman, I have spoken as to my support for this amendment, and if he so desires I would yield to my friend and cosponsor, the gentleman from Tennessee (Mr. Wamp).

Mr. WAMP. Mr. Chairman, will the gentleman yield?

Mr. HAYES. I yield to the gentleman from Tennessee.

Mr. WAMP. Mr. Chairman, I thank the gentleman for yielding to me, and I certainly appreciate the privilege of having my name associated with anything that the gentleman from North Carolina (Mr. Hayes) does here.

The Buy American provisions that we have talked about a lot in the past on this floor are very germane to this debate. I appreciate the fact that we can offer this amendment, hopefully without anyone raising a point of order against it, because it is essential that in this appropriations bill, as we prioritize the homeland security needs of the future, that we put all the language we can in the bill to encourage United States business and enterprise to produce and provide the goods and services that we need to secure our homeland.

Let me give an example, one very large example. In this bill we actually fund into the future a program called BioShield, where the administration leads and we scrub and fund and hold the hearings on an effort to provide the stockpiles for vaccines and immunizations in the event that we are attacked. Companies all around the world make these products. But when we are talking about chelating agents that would actually provide relief and support to those people affected that we may stockpile in a dozen locations around the country in very large quantities, I want a United States manufacturer, if at all possible, to make those products, and I want those products stockpiled here in the United States, if at all possible.

That is all that this language says, is that wherever we can we buy American for these products and services. And on this BioShield initiative in this bill, it is $5.6 billion over the next 10 years, including a 2004 appropriation, the coming year appropriation of $890 million. That is a lot of money. It is a lot of procurement. It is very important that wherever we can we look to United States companies.

Mr. Chairman, there are countries around the world that have not been particularly supportive of us in recent years that have the advanced capabilities of providing these products and services and goods from time to time. And we do not want to respond in a punitive way whatsoever. If they have the products, and we need them, and we have good relations, that is great. But what we want to say is there are businesses and workers and interests in this country that support our country with their taxes. We want to support them wherever we possibly can.

That is the intent. That is the reality of this legislation. Many have come before us and attached Buy American amendments to a host of legislative matters, some big, some small, but I have to say, as we begin this new Department of Homeland Security, as we properly resource it, I cannot think of a more important issue that we attach Buy American provisions to than securing our homeland, to make sure that we actually control as much as possible what these products actually are, to make sure that they are what they say they are, and that we know what we are getting if an event happens once again.

So, Mr. Chairman, I applaud the author; he and I are going in the same direction, and we have teamed up on this amendment.

Mr. HAYES. Mr. Chairman, reclaiming my time, I thank the gentleman for his remarks, I thank the chairman, the gentleman from Kentucky (Mr. Rogers), and I urge the support of others to keep America strong and to support our industrial defense base.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from North Carolina (Mr. Hayes).

The amendment was agreed to.

AMENDMENT OFFERED BY MR. MARKEY

Mr. MARKEY. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. Markey:

At the end of the bill (before the short title), insert the following:

Sec. . None of the funds made available in this Act may be used to approve, renew, or implement any aviation cargo security plan that permits the transporting of unscreened or uninspected cargo on passenger planes.

Mr. MARKEY. Mr. Chairman, I bring a very important subject to the attention of the Members of the House. Each one of us, justifiably so, and every American, more than 100 million, who get onto planes in our country every year are now required to take their shoes off as they go through a process in an airport to ensure that no danger will befall the other passengers on that plane. Now, that is completely justifiable, and I think all Americans, well, almost all Americans, accept that now as part of the process of getting on any airplane in America since September 11.

We in Boston, at Logan Airport, know the consequences, because two of the planes that were hijacked came from Boston, came from Logan Airport, and came from within five miles of my home. So my amendment today deals with the reality that after everyone's shoes have been inspected, bags have gone through security, and this is what the Transportation Security Administration now requires, after the booties of babies are taken off and inspected, underneath, on the same plane, on the same day, with the same passengers on board, with their shoes now back on after having been screened underneath the cargo, the cargo has not been screened.

My amendment would require that the cargo that goes on the passenger planes that more than 100 million Americans each year fly is screened as well as the passengers themselves, as well as grandma, as well as the babies with their booties, because it is unfair to every American who gets on a plane to be put in danger that the cargo on that plane has not been screened.

Now, what do we mean by screening? We mean the same level of physical inspection of passenger plane cargo as is applied to passenger plane luggage and to the passengers themselves. What do we not mean? We do not mean the Known Shipper Program, which is the current excuse for allowing commercial cargo to be carried on passenger planes without physical screening. And which technology will we use? We will use the same technology that American air carriers use to screen cargo in international airports every single day of the week all day long. Who will do the screening? The same screeners who are now being laid off, 3,000 of them, 6,000 of them who are trained to do this job. We cannot allow this to go on any longer.

Mr. SHAYS. Mr. Chairman, will the gentleman yield?

Mr. MARKEY. I yield to the gentleman from Connecticut.

Mr. SHAYS. Mr. Chairman, may I ask how much time the gentleman has left?

The CHAIRMAN pro tempore. The gentleman has 1½ minutes remaining.

Mr. SHAYS. Mr. Chairman, I rise in strong support of this amendment, which will require the Transportation Security Administration, TSA, to develop a plan to screen or inspect all cargo that is carried on passenger planes.

To me, it blows me away that we would allow any freight to go in the belly of an aircraft that has not been inspected. And at the very least the public has the right to know that basically 20 percent of the cargo in the belly of an aircraft is totally unscreened. Its cargo is unscreened. We could have not one, not two, not three, but we could have a number of planes knocked out of the sky at any one time simply because we are not inspecting the freight cargo that is in the belly of an aircraft.

Mr. Chairman, with that, I will yield back to my colleague and thank him for his amendment. I cannot think of a stronger and more important amendment.

Mr. MARKEY. Mr. Chairman, reclaiming my time, I thank the gentleman and I urge support of the full House on as important an amendment as we are going to be called on to vote on this year in Congress.

Mr. ROGERS of Kentucky. Mr. Chairman, I rise in opposition. TSA currently screens cargo based on the Known Shipper Program and identifies potentially troublesome cargo by additional screening. By law, they are required to ensure adequate cargo security measures, but not 100 percent screening of air cargo. In essence, this amendment would stop airlines from loading cargo onto passenger aircraft until TSA can screen or inspect each individual piece.

Now, in the bill, we already provide $50 million for the security of air cargo. This funding will do the following: It will develop an air cargo security program for domestic and foreign air cargo carriers. It will promote the development and implementation of a risk-based freight screening system that will identify pieces of cargo that require closer scrutiny and participation in the Known Shipper Program, including linkages with other databases to verify shipper information that is provided. We provide for development of state-of-the-art detection technologies that will screen cargo and also research and test devices that exist now and procedures to be applied to air cargo.

□ 1800

Right now, Mr. Chairman, it is not humanly possible to inspect every piece of cargo that goes onto the aircraft. TSA does not have the staff or technologies in place to do that. For example, airport screeners screen passengers and baggage using explosive detection and trace machines. These machines are not certified to screen cargo, nor can they handle the large pallets that cargo is typically shipped in. In these cases, the pallets would need to be broken apart and screened by hand. That is very time-consuming and labor intensive.

In addition, in many cases cargo is sorted and prepared onto pallets at airport warehouses nowhere near the airports; and to implement this amendment, the cargo would need to be screened at these off-site locations. According to an analysis prepared by Battelle just prior to 9–11, 100 percent screening of all cargo on passenger carriers would require at least $500 million in the first year alone. That includes procurement of equipment, installation, training, and staffing. It would require 7,800 employees, which would include 6,600 screeners and 1,100 supervisors. If we adopt this amendment, TSA would need to hire a substantial number of new staff to inspect cargo and install new technologies at all of these warehouses.

Even if there was sufficient funding in the bill, which there is not, it is not logistically possible to have all of these screeners and technologies in place by the beginning of the fiscal year. TSA is currently in compliance with the Transportation Security Act, which requires TSA to provide adequate security measures for air cargo. The law does not require every piece to be screened or inspected, as this amendment would. We do not require every piece of cargo that goes onto a ship be screened when it is loaded onto a ship or before it is off-loaded. Instead, DHS targets what cargo pieces need to be more closely inspected based on intelligence and innovations such as the advanced manifests that we now require.

By adopting this amendment, TSA would have to refuse to allow airlines to transport any cargo until all of it can be screened, and I would point out that the money-strapped airlines would be sorely tried trying to do this, and it would greatly impact their bottom line.

Currently, the only cargo airlines can ship on passenger planes is from a known shipper. They cannot, for example, ship any mail above 16 ounces because the shippers may not be known.

So, Mr. Chairman, I understand the obvious meaning of the amendment. I appreciate the concern the gentleman has. We have tried to address that in the bill with $50 million to begin to address the problem. To adopt this kind of a drop-dead provision would mean chaos in the airlines. It would not substantially increase the security that is now ongoing in loading cargo onto planes. The Known Shipper Program is reliable. It is working, and while we spend the $50 million this coming year to begin to try to get the machines and technology in place to be able to screen, as we do, container freight in most cases, this money should be sufficient for that purpose. So I would urge defeat of the amendment.

Mr. SCHIFF. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I rise to speak on the Markey amendment, and that issue is the glaring hole that remains in our airline security. It is a shocking realization for most Americans to learn that almost fully half of the cargo that is in the hold of an air passenger plane when they get on a plane to go on vacation or work travel, that almost half of that cargo is commercial cargo that is never screened by anyone for explosives.

That is a massive failure in our airline security. Some months ago I introduced the Airline Cargo Security Act modeled after legislation by Senators

FEINSTEIN and HUTCHISON which would require the TSA to adopt comprehensive measures to inspect airline cargo. It gives the TSA flexibility to use a variety of different methods to accomplish this, from new technologies to blast-proof containers, to a database of known shippers; but it requires that the job get done. The airline industry is hanging by a slender thread. Terrorists do not have to hijack our airplanes any more to wreak chaos on this industry and wreak devastation on this country and our economy. They just have to blow a plane out of the sky. Given the fact that so much of the cargo is not screened for anything, this is tragically too easy to accomplish. This has to change. This has to change.

It is hard to overstate the significance and the disparity of this security problem. All of us have had the experience of going through the airport now and having to take our belt and shoes off and remove the toenail clippers from our carry-on luggage, but imagine the fact that in the hold of that plane are huge containers which have not been inspected by anyone. And when we consider the security lapses in shipping that cargo, the opportunities when that freight is forwarded to include explosive or other dangerous materials in that cargo, it is extraordinary.

Indeed, I think most Americans would find it baffling that we go through these personally intrusive measures when we go to the airport, but our cargo goes through nothing. We cannot fight the last battle; we cannot simply predict that terrorists are going to use the same technique they used before. We have to be forward-thinking and recognize that there are wholesale gaps in what we are doing to protect the American people. I applaud my colleague for raising this issue in this legislation. I want to urge my colleagues both here today and in the future to address the issue of cargo security. Let us not wait for a tragedy to awaken us to this problem.

Mr. OBEY. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I simply want to note in the Obey amendment, which the House was not allowed to vote on today, we would have added $150 million for airline security, including an additional $50 million for this very project, doubling what the committee has in its bill.

The problem that we have is that the known-shipper system is simply a trust-the-luck system based on what we know about shippers and the people who work for them. Our concern is about what we do not know. We have just seen that TSA had a very difficult time in doing the background screening for criminal activity before they hired a number of people, and those people had to be let go. We really do not have any way of knowing what is happening within the businesses of the people who are shipping. It just seems to me that this amendment is eminently prudent and should be adopted.

Mr. SHAYS. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, first let me say, and I do not say this out of formality but because I believe it deeply, that the chairman of the subcommittee has crafted a good bill, and this is the first bill on homeland security, and I applaud the gentleman for his tremendous efforts and work; but he has given us an opportunity to discuss something which has troubled me deeply.

I chair the Subcommittee on National Security of the Committee on Government Reform. We learned clearly before September 11 of the terrorist threat. We knew it was a new threat, and we knew that we needed to develop a strategy to confront it and to reorganize our government; and we are in that process. But what blew me away when we debated the Aviation Security Act was the fact that I had always thought that we screened all of the luggage put in the belly of the airplane by passengers.

We put an amendment on the bill in 2001 that said by the end of 2003 we would have to search all baggage. We finally got it included in the bill, even though the Inslee amendment was not made in order. It was put in as a manager's amendment, but people said we could not do it by the end of 2003. Then when the bill came back from the Senate and we had our conference bill, it said by the end of 2002.

I thought, "If we could not do it then by 2003, how can we do it by the end of 2002?" And what I was told was that we really do not want people to know that we cannot secure the aircraft from explosives, so that is what they did. We had to amend the bill eventually and say we would have adequate security measures.

Mr. Chairman, the definition of adequate security measures includes machinery we do not have yet, dogs that we are using, swabs on the outside of luggage, and then hand searches. The bottom line is even the passenger baggage on aircraft is not fully checked for explosives. And then we learn to compound that, we have the cargo holds. Cargo that is put in the belly of a passenger aircraft is not checked, and it is just wrong.

We cannot say that we have adequate security measures to inspect cargo. We do not. It is a fraud. Maybe the chairman is right that this is an amendment that is going to be a problem, and maybe when we get to conference we will have to find a better way to deal with it, but we have to send a message.

Mr. MARKEY. Mr. Chairman, will the gentleman yield?

Mr. SHAYS. I yield to the gentleman from Massachusetts.

Mr. MARKEY. Mr. Chairman, I respect the gentleman from Kentucky (Mr. ROGERS), and I know it is a difficult job that he has; but there are two programs in America. One is the known-tripper program. We are all part of the known-tripper program. Every American that gets on a plane is part of a known-tripper program. They want to know who you are. You have to show your ID. They are going to check you if you are suspicious. They are going to go through your bags. They do now care who you are, baby or grandmother.

The known-shipper program for cargo, on the other hand, going onto the very same place, only requires a piece of paper. They do not know what warehouse it really came from.

That al Qaeda operative that just got arrested last week ran a cargo firm. When he was interviewed, he said he was working with other people. He said the name of the firm was Kashmir, Kashmir Service. It was his own trucking company, a cargo firm. That is something we cannot run the risk of happening in this country. They have to go through the same screening for biological, chemical, and nuclear material that would go on a plane as every one of us on a known-tripper program has to go through. The gentleman from Connecticut (Mr. SHAYS) is right, we cannot afford not to pay the price. It might cost us some money, but America cannot afford not to pay it. It cannot be allowed to occur.

Mr. SHAYS. Mr. Chairman, the bottom line is a plane could be blown out of the sky from explosives in the belly of an aircraft because someone shipping cargo is simply able to get it on the airplane. We have learned from the terrorists there is no line they will not cross. I hope this amendment is passed; and then if we have to change the amendment, we can do that in conference.

Mr. Chairman, I rise in strong support of this amendment, which will require the Transportation Security Administration (TSA) to develop a plan to screen or inspect all cargo that is carried on passenger planes.

Since September 11, our nation's homeland defenses have undergone tremendous improvements. I truly believe we are safer today than we were prior to these heinous attacks, but we don't feel safer because we had a false sense of security that was cruelly lifted.

In 2001, when Congress was considering the Aviation Security Act, I was shocked to learn that less than 10 percent of checked baggage on domestic flights was being screened. I worked with Congressman Jay Inslee to add a provision to the bill requiring all checked baggage to be screened for explosives.

During a recent hearing of the Select Committee on Homeland Security, I was equally surprised to learn that air, which accounts for approximately 22 percent of all baggage on passenger flights, is not being screened for explosives. If we are not screening all the baggage and cargo on passenger planes, then we are once again giving the American people a false sense of security.

The bottom line is as long as cargo and baggage screening is incomplete, there are gaps in aviation security that are unacceptable. TSA must come to grips with this challenge, which continues to leave too many air travelers at risk.

Mr. Chairman, I urge my colleagues to vote in favor of this common-sense amendment.

Ms. JACKSON-LEE of Texas. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I think all of us have made it very clear that our efforts are to support the work of this appropriations subcommittee. But, Mr. Chairman, I rise in tribute, in remembrance of the many lives that have been lost through terrorist acts in the United States. It precedes the horrific tragedy of 9-11. I am particularly cognizant of the 1988 Pan Am 103 plane crash where an interline bag was the cause of that horrific tragedy where so many families lost their loved ones.

We know that we have come a long way from that tragedy. Our bags are in fact screened and unaccompanied bags are screened. But when we began this journey and we began to tell our airports and our airlines that they were going to have to haul in this enormous equipment and make sure that every bag was screened, what an uproar. Nobody thought it could happen. Nobody thought we would be successful. It would take too long. There would be backlogs.

□ 1815

Yes, it is an inconvenience; but we have done it, and every airport to a certain extent is working toward that goal. At our large airports we have these huge machines that our bags must go through. Why, then, Mr. Chairman, can we do any less or should we do any less for cargo, because as we have determined in our field visits, the same kind of activity is occurring in our ports, where in many instances we are checking paperwork and we are looking at paperwork given to us by foreign entities. Oh, yes, we do have criteria. Our intelligence gathering has improved. We are looking at different marks that staff and personnel can check off. When one mark does not come up, they say, this is suspicious and they put them in a different category. We are doing a better job. But I think this amendment of the gentleman from Massachusetts (Mr. MARKEY) and the gentleman from Connecticut (Mr. SHAYS) is a sensible, reasonable approach that may be inconvenient, may seem like a high mountain to climb; but in the long run we will be able to not only pay tribute and mourn the loss of those who over the years have died in terrorist attacks and in particular the Pan Am 103, which in my community we lost an endeared family member, we will be able to assure that we have done as much as we could do in that area.

That is why I think this is an important amendment, recognizing the hard work of this committee and the efforts that have already been made, but I clearly believe that our work is not complete. We mourn the loss of the Pan Am 103 and other tragic acts. Pan Am 103 was a suitcase that was unaccompanied, before our knowledge reached the sophistication of terrorists. Now we cannot speculate what cargo might contribute to some unfortunate and tragic act. Let us be proactive and get in front of this question and help the committee in the way that we could and can help it, and, that is, to look favorably on the amendment offered by the gentleman from Massachusetts.

Mr. STRICKLAND. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise to support this amendment. But what I want to say more than anything else is that I think that those of us who serve in this Chamber deserve to tell the American people the truth. I believe that most moms and dads who get on an airplane and this summer when they take their families on vacations and they get on an airplane, they believe that those of us who serve in this Chamber have taken the necessary steps to see that they are not blown out of the sky as a result of a bomb being placed in cargo that is on that plane. I think most Americans think we are already doing this.

We want the airlines to succeed. We have given billions of dollars in aid to the airline industry. Can you imagine what will happen to passenger travel in this country if an airplane is blown out of our sky this summer with vacationers, travelers, businesspeople on it? This is something that we have got to face up to.

The gentleman from Washington (Mr. INSLEE) and I and others stood on this floor months ago when we argued night after night after night that there needed to be complete screening and inspection of everything that went onto an airplane. The American people heard that, and I think most of them agreed with us. But for us to say we cannot do it because we do not have the money is a hollow argument. We find money around here for everything we think is important. Everything that we truly believe is important, that is of value to us, we fund. It ought to be a value to make sure that those who travel on our aircraft can do so with the confidence that we have done everything humanly possible to protect them.

It is beyond me why we would not embrace this amendment. It is just beyond me. I hope we do not have to stand here in this Chamber at some time in the future and talk in somber tones about those who have lost their lives to a terrorist act when we could have taken an action that prevented that terrible tragedy from happening.

Mr. YOUNG of Alaska. Mr. Chairman, this amendment prohibits any funds from the Homeland Security appropriation from being used to approve a security plan that permits the transporting of unscreened or uninspected cargo on passenger planes.

Air cargo is a potential area of vulnerability in our aviation security system.

In the Aviation and Transportation Security Act, Congress moved to ensure that all checked baggage was screened for explosives. But carry-on baggage and air cargo is still not screened for bombs, at least not the plastic explosives that terrorists tend to use. However, carry-on baggage is screened by x-ray, and air cargo is screened by the "known shipper program." In both areas, we could do better and I appreciate the efforts of the gentleman from Massachusetts to do so.

I am concerned that this amendment could be misinterpreted as requiring that all air cargo be put through an explosive detection system or be opened and physically inspected. If the plain language of the amendment required that, I would oppose it. That is clearly impractical, if not impossible. Currently, there are no machines large enough and quick enough to screen all air cargo in this way. And physical inspection is so cumbersome that it would grind our economy to a halt. This would be a particular problem in my State of Alaska, where the people are especially dependent on air cargo for obtaining necessary goods and service.

However, the amendment simply prohibits any funds from being spent to approve an airline security plan unless that plan provides that air cargo will be screened. Such screening is currently being done through the known shipper program and I would expect that to continue. Over time, new technology may enable us to improve air cargo screening and I would support the use of such technology as long as it would not impede the flow of air commerce.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Massachusetts (Mr. MARKEY).

The question was taken; and the Chairman announced that the noes appeared to have it.

Mr. MARKEY. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from Massachusetts (Mr. MARKEY) will be postponed.

AMENDMENT NO. 1 OFFERED BY MR. MANZULLO

Mr. MANZULLO. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Mr. MANZULLO:

At the end of the bill (before the short title), insert the following:

SEC. . None of the funds made available in this Act may be used by the Secretary of Homeland Security to enter into a contract for the procurement of manufactured articles, materials, or supplies unless section 2 of the Buy American Act (41 U.S.C. 10a) is applied to such procurement by substituting "at least 65 percent" for "substantially all".

Mr. TOM DAVIS of Virginia. Mr. Chairman, I raise a point of order against the gentleman's amendment because it proposes to impose new duties and constitutes legislation on an appropriations bill and therefore violates clause 2(c) of House rule XXI.

The CHAIRMAN. The gentleman from Virginia raises a point of order. Is there further discussion on the point of order?

Mr. MANZULLO. My understanding is that the gentleman was going to reserve a point of order so I could get my point across.

Mr. TOM DAVIS of Virginia. I reserve the point of order.

The CHAIRMAN. The gentleman from Virginia reserves the point of order.

Mr. OBEY. Mr. Chairman, I would also reserve a point of order on the amendment.

The CHAIRMAN. The gentleman from Wisconsin also reserves a point of order.

Mr. MANZULLO. Mr. Chairman, the American economy is in the midst of a manufacturing crisis. Over the past 3 years, we have lost 2.6 million manufacturing jobs. In the past 12 months, 53,000 manufacturing jobs each month have been lost in this country. These are good-paying jobs. Small business manufacturers pay on average 20 percent more to their employees than other small businesses and provide a vast majority of the basic products such as tools, dies and molds that are essential to our national security and essential to our defense industrial base.

In 1981, Rockford, Illinois, my district's largest city, had an unemployment rate of 24.9 percent, the highest in the Nation. Today it is around 11 percent. I do not want to see a recurrence of what happened in 1981. But we are losing our industrial base in this country. Unlike the past when factories were closed during an economic downturn but reopened when times improved, today a too-frequent outcome is the permanent closure of the factory. The jobs leave forever. Young people entering the workforce do not have a manufacturing career choice left open to them as they did in the past.

Since 1933, the Buy American Act has safeguarded the interests of American manufacturers by requiring the Federal Government to purchase domestically produced products. But that only means 50.001 percent has to be American goods. The Department of Labor's May employment report showed again the 34th consecutive month of loss of manufacturing jobs.

Let me tell my colleagues what happened in Rockford, Illinois. After 112 years in business, Ingersoll Milling ceased operations. The Rockford machine tool maker was one of only two companies to make machines to shape radar absorbent composites into the skin of stealthy warplanes. In bankruptcy, a Chinese state-owned enterprise is trying to buy Ingersoll. The only plant that is left in the United States is in Kentucky and that is Cincinnati Machine. They have just downsized from 750 people to 350 people. We are losing the ability to have manufacturing facilities to defend the United States. The purpose of this amendment is to build that manufacturing core to say, wake up, Washington, wake up, America, the manufacturing jobs are gone, the security of our Nation is being imperiled.

This amendment simply increases the Buy American content from 50 percent to 65 percent. It is so simple. The money that is being used to protect America, we are only asking 65 cents of that be used to buy American products. This is a very simple amendment. We would ask that this body take its part in restoring American manufacturing in this country. I would urge my colleagues, urge them, beg them, beseech them, to adopt this amendment to help the restoration of our manufacturing base.

Mr. TOM DAVIS of Virginia. Mr. Chairman, I move to strike the last word.

Actually, this amendment would radically change the current application of the Buy American Act from 50 percent to include products made in America even if most of the cost of the components, up to 65 percent, are produced domestically. This substantially increases the 50 percent test as provided in the current regulations.

Some companies have responded to the current Buy American Act restrictions by establishing costly, labor-intensive product-tracking systems that are not needed in the commercial business to ensure that the products are being sold to government. In a few cases, companies have simply stopped selling certain products in the Federal marketplace. This denies our government access to some of the latest, most cost-effective products in our fight against terrorism and preserving homeland security. This radical Buy American Act if it were allowed to be part of this legislation would impose financial and legal burdens on taxpayers and the commercial companies that sell to the Department.

I would, therefore, insist on my point of order.

POINT OF ORDER

The CHAIRMAN. Do the gentleman from Virginia and the gentleman from Wisconsin insist upon their points of order?

Mr. OBEY. Mr. Chairman, I would simply agree with the point of order lodged by the gentleman. I do not happen to have much of a problem with the substance; but it seems to me that if the rules are to be applied around here, they ought to be applied to everybody on both sides of the aisle.

The CHAIRMAN. Are there any other Members desiring recognition?

Mr. BALLENGER. Mr. Chairman, I would like to speak to the point of order.

The CHAIRMAN. The gentleman may proceed for five minutes. The point of order is reserved.

Mr. BALLENGER. Mr. Chairman, the Raleigh News & Observer headline this past Sunday said, "North Carolina's Trade Deficit Soars: Manufacturing Slide Continues Despite Decline in Dollar." One in four North Carolinians employed in manufacturing have lost their jobs during the past 5 years. Plants across the State are closing their doors entirely, and other firms are moving jobs offshore, truthfully mostly to China.

North Carolina's 10th Congressional District has a disproportionately large percentage of local economies built on manufacturing. So the communities I represent are struggling even more due to this manufacturing recession. The National Association of Manufacturers reports that job losses will continue as long as U.S. imports from China are six times as large as exports to China. These statistics highlight why I have become a strong proponent of the newly formed Defense Industrial Base Caucus.

The U.S. cannot be reliant on foreign manufacturers of military or homeland security systems and equipment. We have got to invest in critical industries where we do not have the capacity for self-sufficiency and purchase goods from those United States sectors that are the best in the world. A recent admission from the Pentagon underscores the need for the U.S. to regain its manufacturing self-sufficiency. The Swiss Government's refusal to provide crucial bomb components during Operation Iraqi Freedom could have hampered our efforts in the fight effectively if the war had lasted a little longer. We cannot afford to be hamstrung by countries that disagree with our intentions and our goals as we defend the homeland.

The U.S. makes the best products in the world. We have got to provide jobs for the American people. There is no better place to demonstrate that commitment than providing our first responders with American-made products, procured with taxpayers' dollars.

The CHAIRMAN. Are there any other Members seeking recognition?

Mr. McCOTTER. Mr. Chairman, I rise to address the point of order.

The CHAIRMAN. The gentleman's point of order is reserved. The gentleman is recognized for five minutes.

Mr. McCOTTER. Mr. Chairman, I rise to address the point of order and in support of the amendment. My concern is that the American Government be as concerned about homeland security as we should be about household security. When tax dollars are taken from the American people, from the entrepreneurs and the people who create wealth in this country, those tax dollars should not be used by their government to put them out of work or to decimate our manufacturing base. I believe that this is a reasonable amendment, and I wholeheartedly support it.

The CHAIRMAN. Will the gentleman from Virginia advise if he insists upon his point of order and state the grounds for his point of order?

Mr. TOM DAVIS of Virginia. I do, Mr. Chairman.

Again, I make the point of order because it proposes to impose new duties and constitutes legislation on an appropriations bill and violates clause 2(c) of House rule XXI.

☐ 1830

The CHAIRMAN. The Chair is prepared to rule. The Chair finds that this amendment explicitly supersedes existing law and the amendment therefore constitutes legislation in violation of clause 2 of rule XXI. Therefore, the point of order is sustained and the amendment is not in order.

Mr. FILNER. Mr. Chairman, I would challenge the ruling of the Chair.

Mr. TOM DAVIS of Virginia. Mr. Chairman, I move to table.

The CHAIRMAN. The motion to table is not available in the Committee of the Whole.

The question is, Shall the decision of the Chair stand as the judgment of the Committee?

PARLIAMENTARY INQUIRY

Mr. OBEY. Mr. Chairman, parliamentary inquiry.

The CHAIRMAN. The gentleman may state his parliamentary inquiry.

Mr. OBEY. Mr. Chairman, is this motion debatable?

The CHAIRMAN. The question is debatable under the five-minute rule.

Mr. OBEY. Then could I move to strike the last word?

The CHAIRMAN. The gentleman is recognized for 5 minutes.

Mr. OBEY. Mr. Chairman, I would simply urge the gentleman to withdraw his motion. I know of no one who disagrees with the ruling of the Chair, and I do not see why we should impose on the House when we already have seen another amendment dealt with on the subject in a proper manner. This amendment clearly was not. Everyone knew it was not in order, and there is no doubt in my mind the Chair's ruling is correct.

The CHAIRMAN. The question is, Shall the decision of the Chair stand as the judgment of the Committee?

The question was taken; and the Chairman announced that the ayes appeared to have it.

RECORDED VOTE

Mr. FILNER. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 385, noes 28, not voting 21, as follows:

[Roll No. 306]

AYES—385

Abercrombie
Ackerman
Aderholt
Akin
Allen
Andrews
Bachus
Baker
Baldwin
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonner
Bono
Boozman
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doggett
Doolittle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
Eshoo
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Obey
Olver
Ortiz
Osborne
Ose
Otter
Oxley
Pallone
Pascrell
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tauscher
Tauzin
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Turner (OH)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (AK)
Young (FL)

NOES—28

Alexander
Baca
Baird
Ballance
Boswell
Costello
Etheridge
Filner
Green (TX)
Hinchey
Hinojosa
Jackson-Lee (TX)
Kucinich
McDermott
Menendez
Nadler
Oberstar
Owens
Pastor
Sanders
Scott (VA)
Tanner
Taylor (MS)
Towns
Turner (TX)
Velázquez
Waters
Woolsey

NOT VOTING—21

Bonilla
Brown-Waite, Ginny
Burr
Conyers
Cox
Cubin
Dingell
Dooley (CA)
Doyle
English
Gephardt
Hunter
Hyde
Keller
Kleczka
Moran (KS)
Paul
Reyes
Skelton
Smith (WA)
Wynn

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN (during the vote). There are 2 minutes remaining on this vote.

☐ 1858

Messrs. SANDERS, BACA, TOWNS, and GREEN of Texas changed their vote from "aye" to "no."

Ms. HART, Ms. HARMAN, Ms. MILLENDER-McDONALD, and Messrs. INSLEE, ACKERMAN and HAYES changed their vote from "no" to "aye."

So the decision of the Chair stands as the judgment of the Committee.

The result of the vote was announced as above recorded.

☐ 1900

AMENDMENT OFFERED BY MS. JACKSON-LEE OF TEXAS

Ms. JACKSON-LEE of Texas. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Ms. JACKSON-LEE of Texas:

At the end of the bill (preceding the short title), insert the following:

SEC. . The Secretary of Homeland Security shall develop measures to simplify and expedite the grant allocation process of the Department of Homeland Security so that a percentage of funds is provided directly to fire departments in urban and rural areas, police departments, law enforcement agencies, hazardous materials teams, emergency medical staff, and other first responders, hospital districts, school districts, city and county governments, non-profit organizations, port and airport security, and citizen corps groups in the 10 cities most vulnerable to terrorist attacks, without the funds being first allocated to State government agencies.

Ms. JACKSON-LEE of Texas (during the reading). Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Mr. ROGERS of Kentucky. Mr. Chairman, I reserve a point of order on the amendment.

The CHAIRMAN. The gentleman reserves a point of order.

The gentlewoman from Texas is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Chairman, as we have been proceeding with this debate, I think we have been on common ground that the security of America's homeland has to be our first priority. Many of us have agreed with the leadership of the gentleman from Wisconsin (Mr. OBEY), that a billion dollars needed to be added to the Homeland Security appropriations to be able to give and free the hands of the appropriators on the many, many needs that are facing our Nation. But there is another issue, Mr. Chairman, that I think is crucial for us to be able to address directly: The needs of our neighborhoods, and let me share them with you.

Mr. Chairman, my amendment specifically and particularly isolates the crux of the problems that I have heard from many, many local communities. In fact, Mr. Chairman, in a hearing with Secretary Brown, an Assistant Secretary under the Homeland Security Department, in his energetic testimony he acknowledged the importance of involving the local community in their own security.

I do not know if many of my colleagues are aware that in the Homeland Security authorizing legislation there are the concepts called citizen corps. These are organizations that are resident in our respective communities, engaging neighborhoods, towns, cities and rural areas in their own security. But yet there is no funding for those particular entities. This amendment simplifies or asks that the process of getting funds to our local entities be expedited so that a percentage of funds be provided directly to fire departments in urban and rural areas, police departments, law enforcement agencies, hazardous material teams, emergency medical staff, and other first responders, hospital districts, school districts, city and county governments, nonprofit organizations, port and airport security and citizen corps groups in the 10 cities most vulnerable to terrorist acts.

Let me share with you, Mr. Chairman, testimony from Noel Cunningham in our field hearing just this past weekend, the Chief of the Port Police of the Port of Los Angeles. His words can apply to ports all over the Nation, but also to communities all over the Nation.

Since 9/11 we have spent approximately $6 million of our own funds to enhance port security. We have added staffing and equipment resources for our port police. What they actually need, Mr. Chairman, is they need resources to help us, if you will, for their personnel. That is one of the things that we heard, that buying equipment, which is some of the limiting requirements of grants, is not their only need. They need it for personnel and we have not been able to provide monies for personnel.

As a central component to the Nation's economic engine, we need to receive a reasonable and appropriate share of the Federal port security funding. That is another comment from Chief Cunningham. So my amendment would simply provide an expedited way to get monies into homeland security.

I had another amendment, Mr. Chairman, that I had discussed in the rules, and that is to make sure that no monies are spent as an abuse of power at the Homeland Security Department. That is, of course, whether you think it is humorous that 55 Democrats in Texas ran away to avoid a quorum, they used their constitutional rights. I am sorry that that amendment could not be brought up today, and that is an amendment that says we limit the use of the Homeland Security funds for any surveillance or tracking of individuals not related to homeland security. I am going to continue to work on that issue because it is a crucial issue.

But on this matter I would like to pose a question to the chairman of the committee, the gentleman from Kentucky (Mr. ROGERS), as it relates to the question of working with local communities to get resources directly in their hands, first responders, port and airport security, the citizen corps group, though we know that they are not necessarily funded but working with civic clubs on getting resources, when I say civic clubs, civic communities, county and city governments to get funds directly in their hands so that neighborhoods and communities can be safe.

Mr. Chairman, I yield to the gentleman from Kentucky.

Mr. ROGERS of Kentucky. Mr. Chairman, I thank the gentlewoman for yielding.

We have provisions in this bill that requires that the State to whom we give the money must send the money on to the localities within 30 days, and then 80 percent of the monies that we give to those States must be passed on to local units of government within 60 days. Those are provisions in our bill that we added in an attempt to force the money quickly to the community.

Ms. JACKSON-LEE of Texas. Reclaiming my time, I appreciate the gentleman's response.

What I would like to be able to say to this body is that even as we give those instructions to the State, what I am finding out by our local responders, and I use that term broadly, but our community, local community interests who have the responsibility for securing the neighborhoods, the neighborhoods that are around ports, the neighborhoods that are around refineries, the neighborhoods that are in dangerous high terrorist vulnerable areas is that the processes are so difficult.

I hope that this body can work through the process that we will be able to provide a less complicated process and expedite the application process so that our local communities, civic clubs and all will be able to have the resources they need.

Mr. Chairman, I propose this amendment to H.R. 2555, the Department of Homeland Security appropriations bill and I urge my colleagues to support my amendment.

The purpose of this amendment is to expedite and simplify the grant application process so that needed homeland security funds go directly to first responders, local districts, and local government agencies, without first going to the States.

The efforts to secure our homeland will occur at the local level. City and county fire departments, police departments, hazardous materials teams, and other first responders will need to be well-equipped to protect American citizens from terrorist attacks. In our efforts to fund our local first responders, Congress has authorized and appropriated hundreds of millions of dollars. However, few of those dollars have made it to the hands of local first responders.

I participated in two hearings last week with representatives of government agencies who confirmed that funds are not getting to America's local first responders. First, at a hearing of the full Select Committee on Homeland Security, Undersecretary Mike Brown of the Federal Emergency Management Agency and the Department of Homeland Security said that delays getting funds to local first responders and civic groups persist. During on-site reviews last weekend, Chief Cunningham of the Los Angeles Port Authority confirmed that few, if any, Federal homeland security dollars are reaching first responders.

One reason for the delay is that often funds appropriated to city and county agencies for homeland security initiatives, through a lengthy application process, must first be disbursed to the States. State governments then have their own grant application process for funds disbursed by the Department of Homeland Security. This unnecessary application process is preventing local communities from finalizing the preparations for dealing with terrorist attacks and is endangering our citizens.

I propose this amendment to the Department of Homeland Security appropriations bill to disburse a percentage of the funds directly to local homeland security organizations in those cities, including Houston, that were deemed more vulnerable to a terrorist attack by Secretary Tom Ridge. This amendment will allow local organizations engaged in homeland security to get funds now.

Mr. Chairman, this amendment will enable many communities to prepare for terrorist attack without further unnecessary delay. This amendment protects America's citizens and I urge my colleagues to support this amendment.

AMENDMENT TO HOMELAND SECURITY APPROPRIATIONS BILL, 2004 OFFERED BY MS. JACKSON-LEE OF TEXAS

At the end of the bill (preceding the short title) insert the following:

SEC. . None of the funds made available in this Act may be used for political purposes or any other purpose not related to protecting homeland security, including for—

(1) use of the surveillance powers of the Department of Homeland Security, for a purpose not related to protecting homeland security, to—

(A) tap personal or business telephones; or

(B) otherwise monitor or record conversations or activity in any home, office, or other location; or

(2) use of the investigative powers of the Department of Homeland Security, for a purpose not related to protecting homeland security, to track automobiles, airplanes, or other modes of transportation.

Mr. Chairman, I propose this amendment to H.R. 2555, The Department of Homeland Security appropriations bill and I urge my colleagues to support my amendment.

This amendment prohibits the use of funds made available to the Department of Homeland Security through this act from being used for political purposes, or other purposes not related to protecting homeland security.

In the course of the recent redistricting controversy in Texas, several allegations of misuse of resources of the Department of Homeland Security surfaced. Specifically, there were reports that the Air and Marine Interdiction Coordination Center, which is staffed by employees of the Department of Homeland Security, received a telephone call asking the Coordination Center to locate a particular aircraft that belonged to former Texas House Speaker Pete Laney. There were also allegations that surveillance was conducted on private and business phones, and that the Department of Homeland Security was involved with the Texas Department of Public Safety in the destruction of documents related to the redistricting controversy.

The use of Department of Homeland Security resources for political purposes endangers the lives of American citizens. While hundreds of millions of dollars are authorized and appropriated to protect our homeland, every one of those dollars is needed if America is to be protected from terrorist attacks. The police departments, fire departments, emergency medical staffs, hazardous materials teams, and other first responders across the country are in dire need of equipment and operational funds. Every available dollar appropriated for Homeland Security should be used for homeland security initiatives.

My amendment to the Department of Homeland Security Appropriations bill will ensure that funds are not misused for political purposes or other purposes not related to homeland security. My amendment will also ensure that the wasteful, political use of funds that occurred in Texas last month does not occur in other cities.

Mr. Chairman, my amendment is a non-partisan proposal that will protect the constituents of every member of this committee, and every Member of the House of Representatives. I urge my colleagues to support my amendment.

The CHAIRMAN. Does the gentleman insist upon his point of order?

Mr. ROGERS of Kentucky. I do, Mr. Chairman.

The CHAIRMAN. Will the gentleman state his point of order?

Mr. ROGERS of Kentucky. Does the gentlewoman have a statement she would care to make in regard to the amendment?

The CHAIRMAN. Are there any Members wishing to be heard on the point of order?

Ms. JACKSON-LEE of Texas. Mr. Chairman, I will withdraw this amendment, but let me just simply say very briefly that our responsibility is to ensure the homeland, and I, in my advocacy, believe that is the neighborhood.

I would like to work with the chairman in respect of this point of order on getting rid of the red tape that is also bogging down the State system so that monies can get, as I said, to the hazardous material teams, the emergency medical staff, the first responders, hospital districts, school districts in a fast and efficient way.

Finally, Mr. Chairman, that we can manage to unstrap these local communities from using these funds for equipment only but can use it for personnel. I hope that we can work together to ensure that.

Mr. Chairman, I am going to withdraw this particular amendment as it is subject to a point of order at this time.

The CHAIRMAN. The gentlewoman asks to withdraw her amendment.

Is there objection to the request of the gentlewoman from Texas?

There was no objection.

AMENDMENT NO. 6 OFFERED BY MS. BALDWIN

Ms. BALDWIN. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 6 offered by Ms. BALDWIN:

At the end of the bill (before the short title), insert the following:

SEC. . None of the funds made available in this Act shall be used to enter into any contract to develop, lease, or procure Coast Guard vessels in the National Security Cutter class or Offshore Patrol Cutter class unless the main propulsion diesel engines are manufactured in the United States by a domestically operated entity. The Secretary of Homeland Security may waive the restriction in the preceding sentence on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that—

(1) adequate amounts of such components are not available from a domestically operated entity to meet requirements on a timely basis;

(2) such a contract is necessary to acquire capability for national security purposes; or

(3) there exists a significant cost or quality difference between components manufactured in the United States and components manufactured outside the United States.

Mr. ROGERS of Kentucky. Mr. Chairman, I reserve a point of order against the amendment.

The CHAIRMAN. The gentleman reserves a point of order against the amendment.

The gentlewoman from Wisconsin (Ms. BALDWIN) is recognized for 5 minutes on her amendment.

Ms. BALDWIN. Mr. Chairman, my amendment is simple. It would prohibit funds from being used to enter into any contract to develop, lease or procure Coast Guard vessels in the National Security Cutter Class or Offshore Patrol Cutter Class of ships unless the main diesel engines are manufactured in the United States.

The Coast Guard's Deepwater program is a large acquisition effort to replace and modernize the aging fleet of the Coast Guard ships. I fully support this program. However, when procuring the most critical components of these ships, the main propulsion engines, I believe the Coast Guard should contract with American firms that make the engines here in the United States.

The Department of Defense in many instances already must contract with firms that produce their components here in America. Because the Coast Guard was previously under the Department of Transportation and is now under the Department of Homeland Security, it has not been subject to these domestic manufactured provisions for components. I believe our government should contract with American firms whenever possible. The Federal Government is one of the largest customers in the world. Using American labor can help get our economy back on track. But in particular, in matters of national security, we should ensure that American workers build what we need to keep America safe.

After September 11, we tragically learned that Americans were not as safe, even on our own soil, as we had once thought. The Coast Guard's mission has increased exponentially since that awful day. In this uncertain time and as we have experienced shifting global alliance, it makes no sense to allow foreign nations to build critical component for large Coast Guard vessels. After all, the Coast Guard is now in the Department of Homeland Security, and is not keeping capable, hard working Americans working the essence of homeland security?

I have a firm in my district that produces these engines. They were ready to start filling orders tomorrow. They competed in the first round of Deepwater engine contracts awarded earlier this year. Even though they can prove that their engines would cost less in total operating costs, the Coast Guard gave the contract to a German firm that will now build engines in their homeland. And so that Members understand that this is not strictly a local issue for me, there are several other firms in the United States that stand ready to compete for these contracts and are perfectly capable of producing quality American-made engines for the Coast Guard.

I have often visited the employees of the plant in my district. They are confused and frustrated. They do not understand why a branch of the Armed Services would choose to give a major contract to a foreign competitor. Although their plant is operational, there are many workers who are currently laid off. The workers that I talk to are not only worried for themselves and their families, they are desperately worried about their buddies who are waiting, waiting for the call that tells them to come back to work so they will be able to support their families once again.

Mr. Chairman, we are bleeding good-paying, family-supporting manufacturing jobs in this country. When manufacturing jobs go away, our history shows us that it is very hard to get them back. My amendment is a small but needed change to the current Coast Guard procurement process.

The gentleman from Kentucky (Mr. ROGERS), the chairman of the subcommittee, has reserved a point of order against this amendment. The gentleman has a choice. He can insist and press on with his point of order and continue funneling good paying jobs overseas or he can allow this amendment to go forward as we just did a short while ago with the amendment presented by the gentleman from North Carolina (Mr. HAYES). I hope that he has the best interest of America's working families at heart.

The CHAIRMAN. The gentlewoman has yielded back.

Does the gentleman from Kentucky (Mr. ROGERS) insist upon his point of order?

Mr. ROGERS of Kentucky. Mr. Chairman, I reserve the point of order.

Mr. KNOLLENBERG. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I speak in opposition to the amendment which I believe is nothing more than a blatant attempt to use the legislative process to give one American company an unfair competitive advantage over another American company. It is wrong and should be defeated.

The amendment seems innocent enough. No funds should be used to procure Coast Guard vessels in the National Security Cutter Class or Offshore Patrol Cutter Class unless the main propulsion diesel engines are manufactured in the U.S. by a domestically operated entity.

Now, that sounds just like a restatement of the Buy American Act, but it is not. The Buy American Act does not consider the nationality of the contractor when determining if a product is of domestic origin. Manufactured articles are considered domestic if they have been manufactured in the U.S. from components "substantially all," quote, of which have been mined, produced or manufactured in the U.S.

□ 1915

"Substantially all" means that the cost of foreign components does not exceed 50 percent of the cost of components.

Now, when the Coast Guard wants to purchase diesel engines for its ships, it has two options, Detroit Diesel in Michigan, Utah, Kansas and I believe Ohio, and Fairbanks Morse Engine in Wisconsin. Both are fine companies that manufacture their engines in the U.S. with components, substantially all of which come from the U.S. as well. They both comply with the Buy American Act, creating a healthy competition for the Coast Guard's contracts, which I think we would all agree is a good thing; but it seems that some people do not want competition.

Detroit Diesel is a subsidiary of that German company Daimler Chrysler, which is based in Germany, while Fairbanks Morse Engine is based in the U.S. and notably I believe only in Wisconsin.

The current procurement program for the Coast Guard Deepwater program, for which these engines will be built, is already under way. If this amendment were to be signed into law, Detroit Diesel will no longer be eligible for Coast Guard contracts because it is not a domestically operated entity.

Fairbanks Morse Engine will corner the market, not because it builds better diesel engines than Detroit Diesel, but because it found a way to shut out the competition; and it will have done so by changing the rules in the middle of the game.

There are 5,000 Americans working in those four States for Detroit Diesel. They build diesel engines that the current law says are American products. These Americans should not be penalized because their parent company is based in another country. Congress should not even be involved in this issue.

This amendment is frankly outrageous. It is not our job to give one American company a competitive advantage over another, and I obviously implore my colleagues to not be fooled by what seems to be an innocuous amendment, but there are 5,000 Americans who work for Detroit Diesel who are waiting and depending on us and the Members of this body.

Mr. TOM DAVIS of Virginia. Mr. Chairman, I move to strike the last word.

I rise in support of the gentleman's point of order. This amendment would apply a radical domestic source restriction to the acquisition of main propulsion diesel engines for use in Coast Guard vessels, and my friend from Michigan just said, in the middle of the game. It could delay this procurement.

This could have a devastating effect on the Coast Guard's ability to buy the best propulsion engines at reasonable cost to support its critical antiterror missions because it takes competition out of the picture. Restrictive provisions such as these run counter to efforts to create an open, flexible, responsive, and impartial competitive acquisition system that will enable all government agencies, including the Coast Guard, to acquire from the world market the best products available at fair and reasonable prices. Indeed, we owe our taxpayers nothing less than to get the best value for the taxpayer dollar as we buy these, and this amendment abrogates that Buy America Act provisions apply here.

It has been reiterated here by the gentleman from North Carolina (Mr. HAYES) that this amendment would impose substantially new duties on the Department, and because of that I believe it also violates House rule XXI; and I want to applaud the gentleman for raising the point of order and support it.

POINT OF ORDER

Mr. ROGERS of Kentucky. Mr. Chairman, I make a point of order against the amendment because it proposes to change existing law and constitutes legislation in an appropriations bill and, therefore, violates clause 2 of rule XXI which states in pertinent part, an amendment to a general appropriations bill shall not be in order if changing existing law. The amendment gives affirmative direction in effect.

I ask for a ruling from the Chair.

The CHAIRMAN. Does any other Member wish to be heard on the point of order against the Baldwin amendment? If not, the Chair is prepared to rule.

The Chair finds that this amendment does include language conferring authority; and, therefore, the amendment constitutes legislation in violation of clause 2 of rule XXI, and the point of order is sustained, and the amendment is not in order.

AMENDMENT OFFERED BY MS. WATERS

Ms. WATERS. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Ms. WATERS:

At the end of the bill (before the short title), insert the following:

SEC. . (a) The Secretary of Homeland Security shall conduct a review of the proposed project for construction of a remote passenger check-in facility at Los Angeles International Airport to determine whether the project as designed will protect the safety of air passengers and the general public.

(b) Upon completion of the review and not later than the end of fiscal year 2004, the Secretary shall transmit to Congress and the Administrator of the Federal Aviation Administration a report containing the results of the review.

Ms. WATERS (during the reading). Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentlewoman from California?

There was no objection.

Mr. ROGERS of Kentucky. Mr. Chairman, I reserve a point of order on the amendment.

The CHAIRMAN. The gentlewoman from California (Ms. WATERS) is recognized for 5 minutes.

Ms. WATERS. Mr. Chairman, if the gentleman from Wisconsin's (Mr. OBEY) amendment had been accepted, there would be no need for my amendment. His amendment did what I think needed to be done in order to make our Homeland Security Department real.

The gentleman from Wisconsin's (Mr. OBEY) amendment would have shored up what we say we want to do by appropriating $1 billion to improve aviation security, maritime security, infrastructure security, and border security and port security.

Now, it seems to me if this administration was serious about homeland security, we would not hear these weak arguments that we are hearing on the floor tonight. It is absolutely amazing that the people on the other side of the aisle, my colleagues on the other side of the aisle can get up and defend against needing more money to make our homeland secure. It is really not to be understood how they can defend contracts going to foreign companies when we have Members on this floor begging for the opportunity to have these contracts in their districts to do something about this unemployment that was created by this administration.

Mr. Chairman, the day is over for flashlights and duct tape and plastic material. This is about some serious business. Some of us really do take this seriously. We want to fight terrorism. We want to spend the money on it. We want to have real homeland security, and I am absolutely amazed that my friends on the other side of the aisle do not understand that.

I come because I have got a problem in Los Angeles. The Los Angeles International Airport, which is located in my congressional district, is the third largest airport in the United States with a capacity to serve 78 million air passengers per year. On July 2, 2002, Los Angeles Mayor Jim Hahn proposed a plan to expand LAX by constructing a remote passenger check-in facility. The mayor estimated that this project would cost 9 to $10 billion. The environmental impact report on this project is due to be released in the near future.

Supporters of this proposed project to construct a remote passenger check-in facility claim that the facility is necessary to improve the safety and security of LAX and prevent terrorist attacks at LAX. However, it is even more likely that the concentration of passengers in a remote passenger check-in facility could actually reduce the safety and security of LAX.

The Rand Corporation conducted a security study of the proposed remote passenger check-in facility, which was released on May 14, 2003. The study concluded that the proposed project would not improve the security of LAX. The study also concluded that concentrating passengers in the proposed remote passenger check-in facility would make the check-in facility the likely target of a terrorist attack. The study even suggested that concentrating passengers in the remote passenger check-in facility could exacerbate the effects of an attack on airport operations.

The Rand study did conclude that limiting the capacity of the airport could reduce the overall vulnerability of LAX to terrorist attacks. However, this could be accomplished by maintaining LAX at its existing capacity, with no additional airport construction projects.

My amendment would require the Secretary of Homeland Security to review the proposed project to construct a remote passenger check-in facility at LAX to determine whether the project will protect the safety of air passengers and the general public. The Secretary will be required to transmit to Congress and the Federal Aviation Administration a report containing the results of the review.

Mr. Chairman, I am simply saying homeland security, look at this, review it, give us an assessment. If we are about the business of securing the homeland, this is a very simple request. If, in fact, my airport, which is already identified as one of the highest security risks in the United States, is attacked because we are concentrating passengers, I have been to the Committee on Rules twice. I am on this floor, and if I cannot get support for a simple review to talk about whether or not this would be safe, then something's wrong with those who purport to want homeland security.

Mr. Chairman, I am here today to say that again the gentleman from Wisconsin's (Mr. OBEY) amendment should have been accepted because this amendment will ensure that we have a real emphasis on homeland security in fighting this terrorism. Without it, we are just joking; we are playing games. We do not really mean that we want to support terrorism.

POINT OF ORDER

Mr. ROGERS of Kentucky. Mr. Chairman, I make a point of order against the amendment because it proposes to change existing law and constitutes legislation in an appropriations bill and, therefore, violates clause 2 of rule XXI which states in part, an amendment to a general appropriations bill shall not be in order if changing existing law. The amendment imposes additional duties and, therefore, violates the rule.

I ask for a ruling from the Chair.

The CHAIRMAN. Are there further Members desiring to be heard on the point of order? If not, the Chair is prepared to rule.

The Chair finds that this amendment does include language imparting direction. The amendment, therefore, constitutes legislation in violation of clause 2 of rule XXI, and the point of order is sustained and the amendment is not in order.

AMENDMENT OFFERED BY MR. TANCREDO

Mr. TANCREDO. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. TANCREDO:

At the end of the bill (before the short title), insert the following:

SEC. . None of the funds made available in this Act may be used to provide assistance to any State or local government entity or official that restricts any government entity or official from sending to, or receiving from, the Department of Homeland Security information regarding an individual's citizenship or immigration status, as prohibited under section 642(a) of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1373(a)).

Mr. OBEY. Mr. Chairman, I reserve a point of order on the amendment.

The CHAIRMAN. The gentleman from Colorado (Mr. TANCREDO) is recognized for 5 minutes on his amendment.

Mr. TANCREDO. Mr. Chairman, as was indicated in 1996, this body did, in fact, pass the Illegal Immigration Reform and Immigration Responsibility Act. One provision of that act states notwithstanding any other provision of Federal, State or local law, a Federal, State or local government entity or official may not prohibit or in any other way restrict any government entity or official from sending to or receiving from the Immigration and Naturalization Service information regarding the citizenship or immigration status, lawful or unlawful, of any individual.

It is a good provision of law. I am glad that we passed it. One problem with it is that there are no provisions for any sort of sanction should a State, local, or any other agency choose to violate the law.

It was indicated earlier there was some degree of indignation that was identified as appropriate by some of my colleagues on the other side when we have corporations, they say, who have fled from the United States, sought some sort of tax haven off the coasts of America, yet would make application for funds under this act. They were indignant and outraged; and I, by the way, share that feeling of indignation.

It is also, I think, somewhat outrageous to have cities apply for funds under this act when they pass legislation, which has been done in several cities around the country, that actually prevents the law enforcement agencies in those cities from sharing information or obtaining information from the Immigration and Naturalization Service, or the Bureau of Immigration and Customs as it is now known.

So this is a very simple amendment. It just says a person cannot obtain funds under this act if they are, in fact, one of those cities that have done as I have just described.

□ 1930

Mr. SABO. Mr. Chairman, I rise in opposition to the amendment.

Mr. Chairman, I was trying to listen to the gentleman from Colorado as he explained his amendment. I have read the amendment several times and I, frankly, have to admit I do not understand it.

Mr. TANCREDO. Mr. Chairman, will the gentleman yield?

Mr. SABO. I yield to the gentleman from Colorado.

Mr. TANCREDO. Mr. Chairman, I would be happy to explain it again. The purpose of the amendment is to restrict the ability of cities, counties, and local entities that have violated provisions of the 1996 act which are word for word what we have described in this amendment.

Mr. SABO. Mr. Chairman, reclaiming my time, we now have a new department. It could not have existed in 1996.

Mr. TANCREDO. Mr. Chairman, if the gentleman will continue to yield, I would note that the law, and as I understand the law subsequent to that time, has indicated the term INS can be used interchangeably with Homeland Security, or the Bureau of Immigration and Customs.

Mr. SABO. So it applied to the INS, the existing law?

Mr. TANCREDO. If the gentleman will continue yielding, the original law in 1996, yes, it did.

Mr. SABO. Would it now apply to all parts of the Department of Homeland Security, so it would also apply to TSA?

Mr. TANCREDO. The law applies as it applied before. It does not change the application of the law, it simply provides some enforcement mechanism.

Mr. SABO. But does it expand who the law applies to?

Mr. TANCREDO. If the gentleman is continuing to yield, it does not. It is exactly the same wording of the 1996 act. The only thing we are doing is adding some sort of sanction for its violation.

Mr. SABO. Are there new and different grants that could be restricted?

Mr. TANCREDO. Grants under the provisions of this act.

Mr. SABO. I am trying to understand, again, Mr. Chairman. Can the gentleman tell me who the original law applied to, in what form?

Mr. TANCREDO. Shall I read the law again? Does the gentleman wish me to read the law?

Mr. SABO. Yes.

Mr. TANCREDO. Notwithstanding any other provision of Federal, State or local law, a Federal, State, or local government entity or official may not prohibit or in any other way restrict any government entity or official from sending to or receiving from the Immigration and Naturalization Service information regarding the citizenship or immigration status, lawful or unlawful, of any individual.

As I say, this amendment does not change anything except it adds a sanction for any one of those entities that in fact violate the law.

Mr. SABO. But, Mr. Chairman, what I am trying to get at, I guess, is my understanding that you are saying that the old law applied to the INS; this law now applies to the Department of Homeland Security, which is 22 agencies rather than one agency.

Mr. TANCREDO. The gentleman is correct that this act, the act that we are amending, does in fact include TSA, Coast Guard, Secret Service, and First Responders, and the amendment would apply to all of those agencies also.

Mr. SABO. So it would be a significant expansion in the scope of what the current law is?

Mr. TANCREDO. I suppose under that interpretation that is true.

Mr. SABO. I thank the gentleman.

POINT OF ORDER

The CHAIRMAN pro tempore. Does the gentleman from Wisconsin insist on his point of order?

Mr. OBEY. Yes, I do. I think the gentleman's last words indicate the validity of the point of order.

As I understand it, under the gentleman's amendment, if States prohibit information from going to the Homeland Security agency, then the State can get no dollars under this act. My understanding of current law is that it only prohibits States from providing information to the INS. But Homeland Security, as the gentleman from Minnesota has indicated, includes TSA, it includes the Coast Guard, it includes Secret Service, FEMA, and a number of other agencies.

To me, this amendment substantially expands the scope of the coverage and, therefore, I think is legislation on an appropriations bill and not in order under the House rules.

The CHAIRMAN. Do any other Members desire to be heard on the point of order? If not, the Chair is prepared to rule.

The Chair notes that the limitation addresses a broader segment of the Executive than is addressed by the cited statute. As such, the amendment is susceptible to the construction that it attempts to apply the cited statute in cases where it is not otherwise applicable.

Because the proponent of the amendment has not carried the burden of persuading the Chair that the amendment is solely a negative restriction on funds in the bill without changing the application of existing law, the Chair is constrained to sustain the point of order. The amendment is not in order.

AMENDMENT OFFERED BY MS. JACKSON-LEE OF TEXAS

Ms. JACKSON-LEE of Texas. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Ms. JACKSON-LEE of Texas:

At the end of the bill (preceding the short title), insert the following:

SEC. . In addition to the amounts provided elsewhere in this Act, the amount of $3,000,000 is hereby appropriated to the Secretary of Homeland Security for a grant to the University of Texas Center for Biosecurity to establish a homeland security training capacity in Houston, Texas, with strong academic and community partners.

Mr. ROGERS of Kentucky. Mr. Chairman, I reserve a point of order on the amendment.

The CHAIRMAN. The gentleman from Kentucky reserves a point of order on the amendment; and the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes on her amendment.

Ms. JACKSON-LEE of Texas. Mr. Chairman, I recognize that this amendment that I intend to discuss would be considered an earmark. I would like to think that the reason I am bringing this amendment to the floor goes to the earlier debate that we had on the question of expediting funds to those who are in the fight against terrorism.

Mr. Chairman, there is a desperation out there, Mr. Chairman, and, frankly, this particular program is a program that has a very important mission. In a few days the Select Committee on Homeland Security will be marking up the BioShield legislation that is to provide, in essence, a shield around the United States against bioterrorism. The mission of this center is to educate the front line public health work force, medical and emergency responders, key leaders, and other professionals to respond to threats such as bioterrorism and other emergencies that affect our communities. The center responds to the unique challenges in Texas to which regional campuses, including three sites along the critical U.S.-Mexican border, and through its urban campuses located in San Antonio, Dallas, and Houston.

Mr. Chairman, this is not a request because it happens to be in my area, but it is a request because Texas is listed as one of the most vulnerable areas for terrorism. This center will work nationally. The center works with academic institutions, governmental agencies, and relief organizations to promote our health security programs.

This amendment I am offering is representative of a number of amendments that I have offered on the basis that there is desperation out there. Another amendment that is not part of this but I want to make mention of, Mr. Chairman, is an amendment for $1 million to the University of Texas Health Science Center and Charity Productions to develop community-based homeland security preparedness. This, I hope, will educate my colleagues, along with other Members interested, to the fact that we must ensure the protection of the neighborhoods.

This particular proposal coming from the University of Texas Health Science Center and Charity Productions is to provide for an emergency preparedness education program for community residents. Charity Productions is also developing an emergency preparedness education program in conjunction with the University of Texas. The civic organization collaborates with human service organizations, such as the Red Cross and the NAACP. To date, this civic coalition has held several emergency and disaster citizen workshops.

The goals of the partnership between the University of Texas Health Science Center and Charity Productions is to train neighborhood stakeholders, provide a comprehensive rage of opportunities to ensure neighborhood safety, and to facilitate full participation for all community residents, whether or not their active language is English, to increase community partnerships and to work with governmental programs to provide the support and training necessary at the grass roots level. The value of these collaborative efforts in the event of a terrorist attack is immeasurable.

The question always has to be that when we try to secure the homeland we have to secure the neighborhoods. These earmarks that I am suggesting are clearly to bring to the attention of this floor that we must expedite the funds to these local communities.

My other amendment, that again I will simply discuss, has to do with resources to the Houston Bureau of Immigration Customs Enforcement, and the grounds are basically the same; that in fighting terrorism there are some places that have a higher ranking. Houston was ranked number seven on the list of cities most vulnerable to a terrorist attack by Secretary Tom Ridge of the Department of Homeland Security. Certainly we need effective immigration controls necessary to add to the safety of the region.

Mr. Chairman, it is crucial as we move through this process that we realize that all of this cannot be done in Washington. It has to be done on the homefront. Again, I remind my colleagues of the overview that many of us took this past weekend when we could clearly see neighborhoods within yards, within blocks of very dangerous or potentially dangerous areas, meaning they were vulnerable to terrorist attacks. While I was in California, there was a train derailment that wound up going into a local crowded residential area.

Mr. Chairman, desperation causes us to want to move the Department faster, to want to move the funds faster, to want to simplify the process to ensure that monies are gotten directly to those who are doing research.

I also want to add, Mr. Chairman, the importance of including Hispanic serving institutions in research, which is what this BioShield effort will do and these monies will do, historically black colleges, Native American institutions, Asian Pacific so we can expand the reach to culturally diverse communities. So though we may not be able to move forward today, we clearly should be moving forward to be of greater assistance to those who are securing the homeland.

Mr. Chairman, I propose this amendment to H.R. 2555, the Department of Homeland Security appropriations bill, and I urge my colleagues to support my amendment.

The purpose of this amendment is to appropriate funds to the University of Texas—Center for Biosecurity, in conjunction with academic and community partners, to establish training programs for dealing with biological terrorist attacks in the Houston area.

Protecting America's homeland will be accomplished at the local level. To adequately prepare local police departments, fire departments, hazardous materials teams and other first responders will require expert training and education. Additionally, preparing community-based nonprofit organizations and civic corps will require guidance on how members of the community can help government agencies in the event of a terrorist attack. The University of Texas—Center for Biosecurity's training initiative will not only prepare the Houston area to deal with a terrorist attack, it will provide a training model for other cities across the country.

The University of Texas—Center for Biosecurity is located within the School of Public Health of The University of Texas Health Science Center at Houston. The mission of this center is to educate the frontline public health workforce, medical and emergency responders, key leaders, and other professionals to respond to threats such as bioterrorism, and other emergencies that affect our communities. The center responds to the unique challenges in Texas through its regional campuses, including three sites along the critical United States-Mexico border and through its urban campuses located in San Antonio, Dallas, and Houston. Nationally, the center works with academic institutions, governmental agencies, and relief organizations to promote our health security program objectives. The Center for Biosecurity is organized into four main homeland security cores to conduct its programs: training and education, research, integrated response, and community service.

The Training and Education component provides an integrated forum to bring critical community responders together under the philosophy of "training together to respond together." This endeavor includes both short-term targeted programs of instruction, as well as longer term opportunities for more specialized education culminating in master's and doctoral degrees.

The research component focuses on emerging public health and safety issues to provide analysis, evaluation, and technology solutions for homeland security health threats that endanger the community and those who must respond to preserve their health. The center also strives to translate new ideas into effective solutions that address State-based health security needs.

The Integrated Response component works with public health, medical, and affiliated first responders to identify training needs to improve our Nation's health security. In addition, we strive to provide the tools for preparedness and response where active collaboration between vital emergency response sectors will be critical to achieve the best health outcomes for the population. Lessons from the military are integrated into civilian practice.

The Community Service component provides expertise for planning, training exercises, executive leadership, public health, and hospital preparedness in both domestic and international settings. Partners in vulnerable communities are critical to this preparedness effort. Local partners integral to this center include Texas Southern University on issues related to providing mass medical prophylaxis to underserved populations, and Prairie View A&M on issues related to public health outreach and nursing.

Mr. Chairman, the University of Texas—Center for Biosecurity is a critical program for preparing the Houston area for a terrorist attack. My amendment will provide needed funding for this pilot program. I urge my colleagues to support my amendment.

AMENDMENT TO H.R. 2555, AS REPORTED
OFFERED BY MS. JACKSON-LEE OF TEXAS

At the end of the bill (preceding the short title), insert the following:

SEC.   . In addition to the amounts provided elsewhere in this Act, the amount of $3,000,000 is hereby appropriated to the Secretary of Homeland Security for a grant to the University of Texas Center for Biosecurity to establish a homeland security training capacity in Houston, Texas, with strong academic and community partners.

Mr. Chairman, I propose this amendment to H.R. 2555, the Department of Homeland Security Appropriations bill and I urge my colleagues to support my amendment.

This amendment requests that $1,000,000 in Department of Homeland Security funds be appropriated for the University of Texas Health

Science Center and Charity Productions to develop community-based homeland security preparedness measures.

Securing America's homeland must be accomplished at the local level. It is imperative that community-based organizations work in conjunction with state and local government officials, first responders, and medical personnel to ensure that needed services are provided to the community in the event of a terrorist attack, and needed information only available to members of the community gets to public officials. The partnership between University of Texas Health Science Center and Charity Productions seeks to develop and implement programs to assist local community officials in their homeland security preparedness efforts.

The University of Texas Health Science Center at Houston embraces a mission to advance the health of the people of the State of Texas, the Nation, and our global community through educating compassionate health care professionals and innovative scientists. The University of Texas Health Science Center at Houston supports its mission by working with the community organizations to meet the needs of local residents. Charity Productions is a nonprofit organization dedicated to providing innovative programs and workshops for community groups, school districts, parents, youths, law enforcement agencies, and various other service providers.

Charity Productions has developed a prototype community activism initiative designed to reach underserved communities and get them active in homeland security efforts through civic clubs. The local focus of the charity allows members of the community to work directly with health care, fire, and police officials to prepare for terrorist attacks. The University of Texas Health Science Center brings technical, medical and emergency expertise to the partnership. One of the goals of MNP is to develop and implement an Emergency Preparedness Education Program (EPEP) for community residents. Charity Productions is also developing EPEP in conjunction with the University of Texas. The Civic Organization Collaborates with human service organizations such as the Red Cross, and NAACP. To date the Civic Coalition has held several Emergency and Disaster Citizens Workshops.

The goals of the partnership between University of Texas Health Science Center and Charity Productions are: to train neighborhood stakeholders; provide a comprehensive range of opportunities to insure neighborhood safety; to facilitate full participation for all community residents whether or not their active language is English; to increase community partnerships; and to work with governmental programs to provide the support and training necessary at the grassroots level. The value of these collaborative efforts in the event of a terrorist attack is immeasurable.

Mr. Chairman, this amendment requests funds to implement a program that will provide safety to the citizens of the Houston area, and will provide a model for local communities across the country in their homeland security preparedness efforts. I urge my colleagues to support my amendment.

AMENDMENT TO H.R. 2555, AS REPORTED OFFERED BY MS. JACKSON-LEE OF TEXAS

At the end of the bill (preceding the short title), insert the following:

SEC.   . In addition to the amounts provided elsewhere in this Act, the amount of $1,000,000 is hereby appropriated to the Secretary of Homeland Security for a grant to the University of Texas Health Science Center and Charity Productions to develop community-based homeland security preparedness initiatives in the Houston area.

Mr. Chairman, I propose this amendment to H.R. 2555, the Department of Homeland Security Appropriations bill and I urge my colleagues to support my amendment.

My amendment seeks a $1,000,000 appropriation for the Houston Bureau of Immigration and Customs Enforcement for homeland security related immigration and customs enforcement measures.

The events of September 11 have illustrated the importance of strict enforcement of immigration laws and regulations. Likewise, the events in the aftermath of September 11, from terrorism profiling to illegal detentions, have illustrated that our immigration efforts related to fighting terrorism must be refined. My amendment allocates funds to the Houston Bureau of Immigration and Customs Enforcement to make the necessary changes to immigration enforcement procedures in regards to fighting terrorism.

Houston was ranked number seven on the list of cities most vulnerable to a terrorist attack by Tom Ridge, the Secretary of the Department of Homeland Security. As such, effective immigration controls are necessary to protect Houston from terrorist attacks. The homeland security/immigration enforcement component of Houston's Bureau of Immigration and Customs Enforcement will promote public safety and local security by deterring illegal migration, preventing immigration-related crimes regarding terrorism, and removing individuals, especially criminals, who are unlawfully present in the Houston area. This mandate is carried out by the Immigration Investigations, Detention and Removal, and Intelligence Departments.

The Immigration Investigation Department, and their staff of field agents, investigates violations of the criminal and administrative provisions of the Immigration and Nationality Act. The Detention and Removal Department is responsible for the supervision, detention, and removal of aliens who are in the Houston area and United States unlawfully or who are found to be deportable or inadmissible. Finally, the Intelligence Department analyzes and implements intelligence received from the National Office, and collects and analyzes immigration intelligence for the Houston area.

The funds will be used to finance existing immigration enforcement programs, and to develop new programs to improve immigration enforcement and reduce the likelihood of terrorist attacks in the Houston area.

Mr. Chairman, if terrorists are unable to breach the borders of the United States their ability to perform terrorist acts will be all but eliminated. I propose my amendment to fund the immigration control efforts in the city of Houston. I urge my colleagues to support my amendment.

AMENDMENT TO H.R. 2555, AS REPORTED OFFERED BY MS. JACKSON-LEE OF TEXAS

At the end of the bill (preceding the short title), insert the following:

SEC.   . In addition to the amounts provided elsewhere in this Act, the amount of $1,000,000 is hereby appropriated to the Secretary of Homeland Security for use by the Houston, Texas, Office of the Bureau of Immigration and Customs Enforcement for homeland security related immigration and customs enforcement in the Houston area.

POINT OF ORDER

The CHAIRMAN. Does the gentleman from Kentucky insist upon his point of order?

Mr. ROGERS of Kentucky. I do, Mr. Chairman. I make a point of order against the amendment because it provides an appropriation for an unauthorized program, therefore it violates clause 2 of rule XXI which states, in pertinent part, an appropriation may not be in order as an amendment for an expenditure not previously authorized by law.

Mr. Chairman, the authorization for this program has not been signed into law. The amendment, therefore, violates clause 2 of rule XXI, and I respectfully ask for a ruling.

The CHAIRMAN. Do other Members desire to be heard on the point of order?

Ms. JACKSON-LEE of Texas. Mr. Chairman, I said this earlier today. We are working as best we can, but I would argue that while Rome is burning we are standing on this issue of waiving points of order and, therefore, those who are in great need of resources to protect America and to protect neighborhoods are without those resources.

This amendment was offered in desperation, the need to move forward on funding the opportunities for neighborhoods to secure themselves, that school districts can provide safe places in the community for our neighbors, to educate our neighbors about homeland security, to provide personnel, to provide resources and to provide equipment.

What I would say, Mr. Chairman, is that in light of the point of order, the point has been made, and I hope to work with the authorizing committee as we move through the appropriations process to douse this fire that Rome now is engulfed in and to be able to say to our communities that we are expediting those funds and providing the necessary resources.

Mr. Chairman, I ask unanimous consent to withdraw the amendment.

The CHAIRMAN. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

The CHAIRMAN. The amendment is withdrawn.

Mr. STRICKLAND. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I rise to discuss the funding of the Federal Emergency Management Agency. The bill before us includes $1.8 billion in disaster assistance for FEMA to use in fiscal year

2004 to assist the many communities across the country that will encounter natural disasters such as ice storms, tornadoes, and forest fires.

Mr. Chairman, I planned to offer an amendment today that would have given FEMA an additional $1.6 billion that it needs just to cover a shortfall in disaster assistance for the 2003 year.

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But the communities that are waiting for this money cannot wait any longer. They cannot wait for the new fiscal year to begin in October when FEMA's coffers will be replenished. The administration has an obligation to ask Congress immediately to provide FEMA with the money it needs to help the communities that were promised assistance by the President when he declared those cities and towns disaster areas. FEMA is running so low on money right now that I understand the agency is only fulfilling a part of its mission under the Stafford Act, parts A and B for debris removal and emergency protection measures.

While I believe it is very important for FEMA to provide funds for these important categories of assistance, relief under categories C through G of the Public Assistance Program are also vitally important. Unfortunately, I have been informed that FEMA has frozen funding for the Public Assistance Programs that help communities rebuild roads and bridges as well as public buildings and utilities. This is unacceptable.

I know that the communities in the 29 counties in Ohio that the President declared disaster areas this winter have already expended money to rebuild the local infrastructure required to get these towns back on their feet. In one of my counties, Monroe County, Ohio, the county engineer has already spent so much money and has failed to be reimbursed for it that he has had to lay off five county employees. Five workers in Monroe County, Ohio, are unemployed tonight because FEMA has not met its obligations.

In southern Ohio, FEMA approved 1,363 projects across 29 counties to be funded following this winter's ice storms that occurred in my district and districts of many other Members throughout the region, both Republican and Democratic Members. Because of FEMA's funding shortfall, however, 293 reconstruction projects remain to be funded. Only 80 percent of approved projects in Ohio have been completed since last winter's ice storm. The State is still waiting for $11 million from FEMA to finish up the remaining 293 projects, but across this country the situation is the same.

The National Emergency Management Association has indicated in a letter to the gentleman from Illinois (Mr. HASTERT) and the gentlewoman from California (Ms. PELOSI) that thousands of applications will go unanswered if supplemental appropriations in the range of $1.6 billion are not passed immediately. More than 35 States and Territories have experienced disasters just this year and thousands of projects in those States will go unfunded unless the administration asks Congress for supplemental appropriations.

I am circulating a letter to Secretary Ridge today, and I ask all of my colleagues to join me. We should ask Secretary Ridge to work with the administration to ensure that a request for supplemental appropriations is made immediately so that the appropriations committees in the House and Senate can begin work on a bill to provide FEMA with the money the agency needs to continue disaster payments to the States. The States cannot wait for the fiscal year 2004 appropriations process to run its course. They need assistance now, as do the thousands of communities across the country that are waiting to be reimbursed for the important rebuilding projects that they have already begun or for the funds that they need to begin these projects.

Mr. Chairman, I just call this issue to the attention of my colleagues and to this House. This is a critical matter. It needs to be addressed. As I said, I am calling upon Secretary Ridge and I hope all of my colleagues in the House will be willing to sign a letter to the Secretary asking that this request for supplemental funds be coming forthwith.

Mr. YOUNG of Florida. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I suggest to the gentleman that his comments are very well taken and when the administration makes the request, which we do anticipate, for FEMA and other issues, that the Committee on Appropriations will move on it quickly and very likely apply it to the very next appropriations bill that is in the process and ready to be considered by the House.

Mr. STRICKLAND. Mr. Chairman, will the gentleman yield?

Mr. YOUNG of Florida. I yield to the gentleman from Ohio.

Mr. STRICKLAND. Mr. Chairman, the gentleman has made me very happy. I appreciate the gentleman's concern and personal commitment, and we look forward to getting this done so these communities can get the help they so desperately need.

Mr. ENGEL. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I also want to talk about FEMA. FEMA is now under the jurisdiction of the Department of Homeland Security. FEMA and the Nuclear Regulatory Commission have a memorandum of understanding that FEMA is in charge of certifying offsite emergency evacuation plans of nuclear power plants. The process is still underway for the Indian Point plant in New York in Westchester County.

I originally was going to put forth an amendment which would prevent Federal funds from being spent by FEMA to certify any offsite emergency evacuation plans for nuclear power plants, but I will not offer this amendment. However, I feel it is critical that I speak about a matter of homeland security to my constituents and the 20 million people living near the Indian Point Nuclear Power Plant in New York.

While I am not against nuclear power, I believe it is in our Nation's vital interest to shut down the Indian Point Nuclear Power Plant in Buchanan, New York, right near my district of Bronx, Westchester, and Rockland Counties. Indian Point is located 35 miles north of midtown Manhattan. The planes that flew into the World Trade Center passed directly over the nuclear power plant and blueprints for American nuclear power plants were found in al Qaeda caves in Afghanistan.

The problems with Indian Point are not new. Indian Point is located in a densely populated area, in fact the most densely populated area in all of the United States. In fact, it is the nuclear power plant that is the closest to any densely populated metropolitan area of the United States, and it happens to be the major metropolitan area of the United States.

Approximately 20 million people are located within the 50-mile emergency planning zone. The road system in the area is woefully inadequate to meet the needs of those people living in the area making an evacuation in the event of an emergency at Indian Point impossible.

No matter what the cause of radioactive release at Indian Point, terrorists or accidental, the result would be the same. The 20 million people living in the emergency planning zone would be in grave danger. Now the emergency evacuation plan that FEMA is now considering is fatally flawed and will not protect the public. An independent investigation of emergency preparedness at the plant conducted by former FEMA Director James Lee Witt and commissioned by Governor Pataki found that "the current radiological response system and capabilities were not adequate to overcome their combined weight and protect the people from an unacceptable dose of radiation in the event of a release from Indian Point."

Following the release of the report in early January of this year, Governor Pataki and the four county executives from both parties within the 10-mile emergency planning zone refused to certify the evacuation plans. The report concluded there was no way to improve the existing emergency plan to sufficiently meet the current security threat.

If we are to truly protect the citizens of the tri-State area of New York, New Jersey and Connecticut, we must shut Indian Point down. Again, I want to say I am not anti-nuclear power, but I am against risking the lives of 20 million American people.

FEMA, despite refusing to certify the emergency evacuation plans on February 21, saying it could not provide reasonable assurance that the public would be protected in the event of a radioactive release from the plant, has still not issued a final determination. As a result, Indian Point is still operating despite the fact that no Federal agency is protecting the safety and security of my constituents.

We all know that if built today, Indian Point would never be sited anywhere near the New York Metropolitan Area. Furthermore, September 11 changed the equation. While I may not have been worried about the fact that a nuclear power plant was located in my backyard before September 11, now we all know it is a potential terrorist target. We should not allow a nuclear plant to continue to operate just simply because it exists. FEMA must be forced to take the post-9/11 world into account when it evaluates the offsite emergency evacuation plan.

In that case, I cannot imagine how FEMA could then provide reasonable assurance that the public would be protected should something go wrong at the plant. I know the gentlewoman from New York (Mrs. LOWEY) shares these sentiments. I think it is very important that we understand that the Indian Point Nuclear Power Plant should be shut down.

The CHAIRMAN. Are there further amendments to the bill?

If not, the Clerk will read.

The Clerk read as follows:

> This Act may be cited as the "Department of Homeland Security Appropriations Act, 2004".

SEQUENTIAL VOTES POSTPONED IN COMMITTEE OF THE WHOLE

The CHAIRMAN. Pursuant to clause 6 of rule XVIII, proceedings will now resume on those amendments on which further proceedings were postponed in the following order: The amendment offered by the gentleman from California (Mr. FILNER), and the amendment offered by the gentleman from Massachusetts (Mr. MARKEY).

The first electronic vote will be conducted as a 15-minute vote. The second electronic vote will be conducted as a 5-minute vote.

AMENDMENT OFFERED BY MR. FILNER

The CHAIRMAN. The pending business is the demand for a recorded vote on the amendment offered by the gentleman from California (Mr. FILNER) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will designate the amendment.

The Clerk designated the amendment.

RECORDED VOTE

The CHAIRMAN. A recorded vote has been demanded.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 149, noes 274, not voting 11, as follows:

[Roll No. 307]

AYES—149

Ackerman
Alexander
Baca
Baird
Ballance
Becerra
Berkley
Berman
Bishop (NY)
Blumenauer
Boehlert
Boswell
Boyd
Brown (OH)
Brown, Corrine
Capps
Cardin
Cardoza
Carson (IN)
Case
Clay
Clyburn
Costello
Crowley
Cummings
Cunningham
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
Dingell
Doggett
Dooley (CA)
Doolittle
Engel
Eshoo
Etheridge
Evans
Farr
Filner
Ford
Fossella
Frank (MA)
Gonzalez
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hefley
Hinchey
Hinojosa
Hoekstra
Holt
Honda
Hostettler
Houghton
Hunter
Inslee
Issa
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (CT)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kaptur
Kennedy (RI)
Kildee
Kind
Kleczka
Kolbe
Kucinich
Langevin
Lantos
Larsen (WA)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Majette
Maloney
Matsui
McDermott
McGovern
McHugh
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Olver
Ortiz
Owens
Pastor
Paul
Payne
Pelosi
Quinn
Renzi
Reyes
Rodriguez
Roybal-Allard
Rush
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Schakowsky
Schiff
Scott (VA)
Sherman
Shimkus
Slaughter
Solis
Spratt
Stark
Stenholm
Tancredo
Tauscher
Thompson (CA)
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Walsh
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wynn

NOES—274

Abercrombie
Aderholt
Akin
Allen
Andrews
Bachus
Baker
Baldwin
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bell
Bereuter
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehner
Bonilla
Bonner
Bono
Boozman
Boucher
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capuano
Carson (OK)
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cooper
Cox
Cramer
Crane
Crenshaw
Culberson
Davis (AL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
English
Everett
Fattah
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hill
Hoeffel
Holden
Hooley (OR)
Hoyer
Hulshof
Hyde
Isakson
Israel
Istook
Janklow
Jenkins
John
Johnson (IL)
Kanjorski
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
LaHood
Lampson
Larson (CT)
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Lynch
Manzullo
Markey
Marshall
Matheson
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McInnis
McIntyre
McKeon
McNulty
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mollohan
Moore
Moran (KS)
Murphy
Murtha
Musgrave
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Obey
Osborne
Ose
Otter
Oxley
Pallone
Pascrell
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Royce
Ruppersberger
Ryan (WI)
Ryun (KS)
Sabo
Sandlin
Saxton
Schrock
Scott (GA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Souder
Stearns
Strickland
Stupak
Sullivan
Sweeney
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Turner (TX)
Upton
Visclosky
Vitter
Walden (OR)
Wamp
Waters
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (FL)

NOT VOTING—11

Brown-Waite, Ginny
Conyers
Cubin
Gephardt
Hobson
Johnson, Sam
Kilpatrick
Myrick
Skelton
Smith (WA)
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN (during the vote). Members are advised that 2 minutes remain in this vote.

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Messrs. BROWN of South Carolina, BEAUPREZ, MILLER of Florida, TAYLOR of Mississippi, BRADY of Texas, and ISRAEL, and Mrs. JO ANN DAVIS of Virginia and Ms. McCARTHY of Missouri changed their vote from "aye" to "no."

Messrs. TANCREDO, QUINN, JONES of North Carolina, BOEHLERT, HEFLEY, WALSH, EVANS, HOLT, MATSUI, SCHIFF, FOSSELLA, SHIMKUS, RENZI, SHERMAN, and Ms.

ESHOO changed their vote from "no" to "aye."

So the amendment was rejected.

The result of the vote was announced as above recorded.

AMENDMENT OFFERED BY MR. MARKEY

The CHAIRMAN. The pending business is the demand for a recorded vote on the amendment offered by the gentleman from Massachusetts (Mr. MARKEY) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will designate the amendment.

The Clerk designated the amendment.

RECORDED VOTE

The CHAIRMAN. A recorded vote has been demanded.

A recorded vote was ordered.

The CHAIRMAN. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 278, noes 146, not voting 10, as follows:

[Roll No. 308]

AYES—278

Abercrombie
Ackerman
Aderholt
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bilirakis
Bishop (GA)
Bishop (NY)
Blumenauer
Boehlert
Bono
Boswell
Boucher
Boyd
Brady (PA)
Brady (TX)
Brown (OH)
Brown, Corrine
Burr
Burton (IN)
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Castle
Chabot
Clay
Clyburn
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Frelinghuysen
Frost
Gerlach
Gilchrest
Gonzalez
Goodlatte
Gordon
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Hart
Hastings (FL)
Hayworth
Hefley
Hensarling
Hill
Hinchey
Hinojosa
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Houghton
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (IL)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kelly
Kennedy (RI)
Kildee
Kind
King (NY)
Kirk
Kleczka
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
LaTourette
Leach
Lee
Levin
Lewis (GA)
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Nadler
Napolitano
Neal (MA)
Ney
Nussle
Oberstar
Obey
Olver
Ortiz
Ose
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pickering
Platts
Pomeroy
Price (NC)
Quinn
Rahall
Ramstad
Rangel
Reyes
Rodriguez
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Shadegg
Shays
Sherman
Shimkus
Simmons
Simpson
Slaughter
Smith (NJ)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Wexler
Whitfield
Woolsey
Wu
Wynn

NOES—146

Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bishop (UT)
Blackburn
Blunt
Boehner
Bonilla
Bonner
Boozman
Bradley (NH)
Brown (SC)
Burgess
Burns
Buyer
Calvert
Camp
Cannon
Cantor
Carter
Chocola
Coble
Cole
Collins
Crane
Crenshaw
Culberson
Cunningham
Deal (GA)
DeLay
DeMint
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Flake
Franks (AZ)
Gallegly
Garrett (NJ)
Gibbons
Gillmor
Gingrey
Goode
Goss
Granger
Graves
Harris
Hastings (WA)
Hayes
Herger
Hobson
Hostettler
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Johnson (CT)
Johnson, Sam
Keller
Kennedy (MN)
King (IA)
Kingston
Kline
Knollenberg
Kolbe
Latham
Lewis (CA)
Lewis (KY)
Linder
Lucas (OK)
McCrery
McHugh
McInnis
McKeon
Mica
Miller, Gary
Musgrave
Myrick
Nethercutt
Neugebauer
Northup
Norwood
Nunes
Osborne
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pitts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Radanovich
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Ryun (KS)
Schrock
Sessions
Shaw
Sherwood
Shuster
Smith (MI)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Walsh
Wamp
Weller
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (FL)

NOT VOTING—10

Brown-Waite, Ginny
Conyers
Cox
Cubin
Gephardt
Kilpatrick
McDermott
Skelton
Smith (WA)
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 2028

Messrs. ROHRABACHER, LINCOLN DIAZ-BALART of Florida, KIRK, and ROYCE, Mrs. KELLY, Ms. ROS-LEHTINEN, and Ms. HART changed their vote from "no" to "aye."

So the amendment was agreed to.

The result of the vote was announced as above recorded.

AMENDMENT OFFERED BY MR. TANCREDO

Mr. TANCREDO. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. TANCREDO:

At the end of the bill (before the short title), insert the following:

SEC.   . None of the funds made available in this Act may be used to provide assistance to any State or local government entity or official that restricts any government entity or official from sending to, or receiving from, the Bureau of Immigration and Customs (assuming the responsibility of the Immigration and Naturalization Service) information regarding an individual's citizenship or immigration status, as prohibited under section 642(a) of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1373(a)).

□ 2030

Mr. TANCREDO. Mr. Chairman, in 1996, the House passed the Illegal Immigration Reform and Immigration Responsibility Act, a provision of which I have restated in this amendment. It simply says that notwithstanding other provisions of Federal, State, or local law, that a Federal, State, or local government entity or official may not prohibit or in any way restrict any government entity or official from sending to or receiving from the Immigration and Naturalization Service information regarding the citizenship or immigration status, lawful or unlawful, of any individual.

That is current law. We passed that in 1996.

There was just one tiny problem with it. There are no sanctions, there are no provisions for a penalty if localities, in fact, violate the law. Unfortunately, there are cities in the United States that have disregarded the law. Recently, as a matter of fact, the City of New York rescinded an ordinance that for 20 years had prohibited police officers from not communicating——

Mr. SABO. Mr. Chairman, if the gentleman will yield, I am having trouble following what this amendment does or does not do. It may be of significant relevance to some people.

Mr. TANCREDO. Mr. Chairman, there are several cities in the United States that have chosen to pass legislation, pass laws that, in fact, restrict the ability of their own police forces, in many cases, from sharing information with the now Bureau of Immigration and Customs. That is a violation of the law. It is a violation of the present law. Unfortunately, there are no sanctions for that violation.

All this amendment does is to impose such sanctions by saying that no funds made available in this act and under the provisions of specifically the Immigration and Naturalization Service, which has now become the Bureau of Immigration and Customs, can be forwarded to such a city that has, in fact, violated the law. It is as simple as that. There is nothing else to it. It was the original amendment that I made during the discussion earlier. I have changed the language to reflect the concerns of the Parliamentarian and the reason it was ruled out of order.

That is the entire scope of the amendment, Mr. Chairman.

Mr. SABO. Mr. Chairman, I reserve a point of order.

The CHAIRMAN. If a Member wants to reserve a point of order, it must be done before the amendment is presented.

Mr. SABO. Mr. Chairman, I move to strike the last word.

I want to ask the gentleman a question. What cities would this apply to?

Mr. TANCREDO. Mr. Chairman, will the gentleman yield?

Mr. SABO. I yield to the gentleman from Colorado.

Mr. TANCREDO. Well, there are several cities that have passed laws in the nature I have just described, including Los Angeles; Portland, Maine; Houston; Seattle; San Francisco; San Jose; Portland, Oregon; San Diego; and Chicago, to name a few. I think there are others.

Mr. SABO. Houston. And do I understand correctly, because I have tried to read this language. I am sorry, there was so much noise I could not clearly hear what the gentleman was saying.

Under old law, under the INS, there were certain restrictions that we passed that in some fashion applied to the transfer of funds from the INS if a city did certain things; is that what it states?

Mr. TANCREDO. No. Mr. Chairman, if the gentleman will yield, the original law did not apply to the transfer of any funds. It was simply a law making it illegal for any city to restrict the flow of information to or from the Department of the Immigration and Naturalization Service, actually.

Mr. SABO. Mr. Chairman, reclaiming my time, as I read this amendment, this says, none of the funds can be used to provide assistance to any State or local government, entity, or official that does certain things. I do not quite understand the end of this, what they are or are not doing.

My assumption is that now this would apply to FEMA funds, emergency funds; it would apply to airports that are receiving funds under the Transportation Security Act.

Mr. TANCREDO. Mr. Chairman, if the gentleman would yield, no, that is not correct. That was the original concern the gentleman raised. The Parliamentarian at that time ruled that because the original amendment had the words "Homeland Security," that the gentleman was correct in his point of order. I have changed it so that it does not refer to the Department of Homeland Security. It refers specifically to the Bureau of Immigration and Customs, which meets the Parliamentarian's concern; and I have reintroduced the amendment.

Mr. SABO. Mr. Chairman, reclaiming my time, I am sorry, I am having trouble again. But as I read this, none of the funds made available in this act may be used to provide assistance to any State or local government or official that restricts any government entity or official from sending or receiving funds, and I am not sure what agency the gentleman is referring to. But "none of the funds that are used to provide assistance" would now include all of the funds flowing to airports from the TSA; and it would apply to FEMA funds, I would assume. It would apply to all of the first responder funds that are in this bill. I would assume it would apply to all the port funds that are in this bill.

Mr. TANCREDO. Mr. Chairman, will the gentleman yield?

Mr. SABO. I yield to the gentleman from Colorado.

Mr. TANCREDO. Mr. Chairman, once again, the law that I am amending, the provision of the law that I am addressing here is current law. The provision of the law that we are dealing with is the part of the 1996 act.

All this amendment does is say that no funds can be provided through the Bureau of Immigration and Customs to cities that have violated this law. That is it. We are simply putting teeth into the original law. That is all there is to it. Nothing more. It is as simple as that. And it is through the Bureau of Immigration and Customs. It is not TSA in particular, by the way, the one that the gentleman keeps referring to.

Mr. SABO. Mr. Chairman, I will let someone else maybe try and figure it out. I remain confused. It just seems to go farther to me than what the gentleman has indicated.

Mr. FRANK of Massachusetts. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise to strike the last word in an effort to understand the first few words.

The gentleman from Colorado said to the gentleman from Minnesota that the only funds involved were funds under the Illegal Immigration Reform and Immigrant Responsibility Act, but that is not what it says. The amendment says "none of the funds made available in this act." The reference to the Immigration Responsibility jawbreaker does not come until the bottom. What it says is that if you violate the Illegal Immigration Reform and Immigrant Responsibility Act, then you get no funds under this act.

I know we debated what "is" is, but I thought we were pretty clear on what "this" is. This is this. This is the act. It says "none of the funds made available in this act."

So the question is, in line 2 of the gentleman's amendment, when it says "none of the funds made available in this act," what act is he talking about? And it would appear to be the act that we are now about to enact.

I wanted to ask the question precisely. I would ask the gentleman when it says in line 1, none of the funds made available, and in line 2, this act, in line 2, what do the words "this act" refer to?

I yield to the gentleman from Colorado.

Mr. TANCREDO. Mr. Chairman, the amendment goes on to further define it, and it is defined: through the money that is provided to the Bureau of Immigration and Customs.

Mr. FRANK of Massachusetts. Mr. Chairman, reclaiming my time, no, it does not. The gentleman has not read his own amendment, much less written it.

What this says is, you do not get any funds under this act if you violate the Illegal Immigration Act. It does not say that the funds come under the act; it is a 2-part amendment. It says, first, you do not get any funds under this act. It does not define this act later on; it defines what forfeits money under this act. What causes you to forfeit money under this act is a violation of the Immigration Act. It does not say in here that you lose money under the Immigration Act; it says you lose money under this appropriation if you violate that act.

I will yield again.

Mr. TANCREDO. Mr. Chairman, I must admit I do not believe that the gentleman is really confused about the purpose of the amendment or the words that are printed here. It is, in fact, quite clear.

We have run it around the horn here several times, including with the Parliamentarians. The issue that the gentleman brought up earlier dealing with an expansion of the original law has been dealt with by this new amendment. We are speaking specifically of the Bureau of Immigration and Customs.

Mr. FRANK of Massachusetts. Mr. Chairman, reclaiming my time, I would say to the gentleman, I understand his concern with making clear, and I have heard him say this in other contexts, that English is the official language, and I would urge him to work on that, because English is what it states here, and it says, in English, this is in English now, the only language I speak being a typical American; it says in English, "none of the funds made available in this act may be used to provide assistance to any State that violates the Illegal Immigration Reform and Immigrant Act.''

So it is very clear. It is this act to which the funds refer. The act that was passed in 1996 triggers the loss of funds under this act. And it seems to me it is a far harsher penalty for the violation and the very fact that the gentleman offers the amendment in one form and then explains it in another is, I think, an indication of its weakness.

☐ 2045

Mr. OBEY. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, the gentleman who is offering this amendment has just said that what he is doing is to apply to existing law with respect to the Immigration Act as a new set of sanctions. And what that means is that none of the funds provided in this bill can go to any locality that is violating that law which means they get no fire grants, they get no port security money, they get no money for their Office of Domestic Preparedness.

It applies to FEMA. How many of you want to have a disaster and find out because of some technicality your State is not eligible for any money? How would you like that if it happened to fire funds, for instance?

So I would say that it is very clear, you are making a very big change in what localities can receive under this bill. Now, State and localities are already being short-changed and should have received far more than they did in the tax bill because of their budget crunch. This will simply add to their woes and will do so inadvertently if they were simply in violation because of a technicality.

It is obvious to me that we are going to have a vote on this bill. As far as I am concerned, we might as well get on with the vote and get out of here.

Mr. NADLER. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I am not going to speak for 5 minutes. I just want to say what this amendment does, to be blunt, is it says that if any city in the country, and according to the gentleman who read a list of most of the large cities in the country, if they are in violation of a particular provision of the Immigration Act which now has no sanction, this will put a sanction on the city, on all the large cities, and the sanction will be that we will leave them open and naked to the terrorists. That is what it says.

No funds can go to those cities to protect their ports, no funds made available in this act. This act makes available funds for fire, for police, for emergency responses, for protection against terrorists. Now, I know we want to get to a vote but this is about as important an amendment as we have taken up here in a long time. Because whether the people understand it or not, what this amendment will do, and maybe we should do something about non-enforcement about the immigration provision, maybe the Committee on the Judiciary should hold hearings on that, but in fact what this amendment does is say most of the large cities in the country because they are not in compliance with a specific provision of the immigration law will get no funds to use to protect themselves against the terrorists. No funds for port security, no funds for airport security, no funds for fire and emergency response. That, I submit, makes no sense.

It says to all the citizens in all those large cities, we will hold you hostage so that the terrorists have a free hand at you if your city violates the immigration law. That is not the way to enforce the immigration law. I urge a no vote.

Mr. ROHRABACHER. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I hope the public is paying attention to this debate. If we had major cities throughout this country, they are refusing to cooperate with the INS and other people who are trying to protect us from illegal aliens that may be coming in to do terrorist acts, they should not be getting funds from this government. We are trying to ask them to comply to protect our citizens when we are given that type of a description.

Mr. Chairman, I yield to the gentleman from Colorado (Mr. TANCREDO) to give him a chance to answer some of these absurd charges.

Mr. TANCREDO. Mr. Chairman, at least the gentleman from the other side who spoke a minute ago did reflect accurately, I think, the purpose of the amendment. It is to do exactly that. It is to restrict funds to those cities which have decided to restrict their police or other agencies from sharing information with the Bureau of Immigration and Customs. That is accurate and that is the first time it was described accurately by anybody on the other side. That is exactly what I want to do. Because, Mr. Chairman, there are in fact cities that are violating that law. We passed it in 1996. There has got to be some way for us to impose some sort of sanction or repeal the law with or if it is on the books, let us have some teeth in that.

Mr. ROHRABACHER. Reclaiming my time, the purpose of this amendment is clear. We are trying to have cooperation throughout the country in a matter that is vital to our national security and the safety of our people. If there are people in those governments, in those cities that are refusing to cooperate with us, refusing to permit those who are responsible for protecting our borders to get assistance, they should not be getting funds. This is how we will encourage them to get involved and to help protect America.

Mr. MENENDEZ. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, three quick points.

Number one is this says none of the funds, no funds will go to any municipality, any State entity, any governmental entity for any homeland security purpose if they have chosen in a totally legitimate way not to give information about someone's citizenship like mine or anyone else's because that is what the gentleman's amendment reads.

This is a coercive action against any State, municipal or other entity to say to that State, municipality or other entity, you must do a series of things, including giving information on a person's citizenship status, like my citizenship status, to the INS. So much for State rights, so much for the local municipalities know best. So much for all I have listened to for the last decade.

This is an unfunded mandate on all of those governmental entities making it an extension of what was the INS. That is what you really want to do.

Lastly, you can keep taking lessons in Spanish, but if this is your Hispanic outreach we want none of it. I urge a no vote.

Mr. BARTLETT of Maryland. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I am not a lawyer but in spite of that I think I understand the intent of this amendment. As I understand it, we have a law that has been in effect now for 7 years which is really being violated by a number of cities. The Mayor of San Francisco, for example, told her police not to give information to INS. This is a clear violation of the law.

No evil thing is going to happen to any city or any jurisdiction if they just follow the law. When you do not follow the law, you end up in jail if you are an ordinary citizen. These cities and jurisdictions that are violating this law need to understand that the law needs to be kept.

All this amendment says is if they do not follow the law which has now been in effect for 7 years, they are not going to get any money, and I think that is a very reasonable thing. I do not think there will be any violations of the law because they clearly want the money. And I just do not think there is anything sinister in this. We have a law that is grossly violated. There are no penalties in the law. All this does is put in reasonable penalties. The only penalties you can put in this bill is simply denying them funding under this bill. Nobody will get hurt. All they have to do is follow the law and they will get all the money they should get.

Mr. Chairman, I think this is very simple. It should not be necessary to discuss this any longer. It could not be simpler. They are breaking the law. This puts some teeth in the law. If they continue to break the law, they will not get money. If they do not get money, they will not continue to break the law.

Mr. GUTIERREZ. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I think the discussion that we are having tonight is really a discussion about immigration and the immigration policy of our country. And we might want to cloak it in national security but it is what it is.

Our Supreme Court has stated that when you matriculate a child in school, you do not ask the immigration status of that child or that child's parents. That is the Supreme Court decision. That is the law of this land. Children born here in the United States of America, they are citizens by constitutional right. When their parents go to enroll them in school, they must feel free to enroll them in school. Indeed, there are hundreds of thousands of children in our public school systems in this country whose parents do not have a legal status in this country. They do. They are the citizens of this great Nation of ours. We should allow those educational systems to continue to work.

There are police departments, over 400 of them in the Nation, that have made a decision that they want crime reported. That is a very local decision. And we should not be substituting it with a national policy by passing this amendment. I think the police chief of LA, the police chief of New York, the police chief of Chicago and the employees that work under them should be given the respect that this institution should give to them because they are on the front line fighting crime each and every day. And they should make the decisions about how best they can protect the welfare of the citizens of those cities.

We have talked a lot about the localities and making sure that everything works better back home. Well, this is an instance where things are working better back home and we should leave it alone. And we can have a debate all night, but I think clearly what is going to be read in the papers tomorrow and the evaluation that is going to be made of this vote is going to be that those that care to say that immigrants are bad to this country, and those that care to extol the virtues of immigrants are going to take different sides on this debate. But this is really a debate about immigration.

Let me end with this: I think that the President of the United States of America acknowledged that we have to do something about undocumented workers in this country. That is just a fact. There are 8 to 10 million undocumented workers and that is what this is really all about, and this is an attempt to deny them education and to deny their children education and to deny the police to protect them. That is what this is really all about.

The President of the United States sat down with the President of Mexico for one to try to work out some reasonable immigration policy. We should allow them and the Secretaries of State of those countries to bring back, to come to a reasonable solution. Listen, this is not going to get rid of one undocumented worker, as long as in the State of Washington 70 percent of the agricultural workers are undocumented. We know that we eat their apples. We eat the grapes from California. We eat the oranges from Florida. We know who picked those fruits in this Nation. We know who does some of the hardest work in this country each and every day.

So let us have a debate on immigration. Let us have a debate on immigration. Let us have a broad debate on immigration, and let us try to figure out how we streamline new immigrants to this country as we integrate those that are working hard, paying taxes and following the law of this land. Let us not have a debate here tonight where one person can go and put a claim, I got the immigrants today. I feel so proud.

America has a proud tradition in this country of respecting the work and the wealth of the contributions of immigrants, whether they be Italian or Irish or Polish. That is what has made this Nation so great.

Let us not belittle those contributions here with this debate tonight. Let us vote no on this amendment.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I will just say the following: The topic of immigration is a very much sensitive topic and it is emotional. It is perceived with a lot of emotion in the immigrant communities in this country. And so what I would ask is that we have the opportunity to review this amendment. I asked my friend, the gentleman from Colorado (Mr. TANCREDO) for a copy, and he said that the only copy is on the desk, so I have not had an opportunity to even read this amendment.

□ 2100

What I do know is the following, that this is a sensitive issue; that it requires that this House deliberate on it, and if it is an amendment that we have not even had an opportunity to read, then my suggestion would be to my friend that he give an opportunity to this House, through the regular process, for this to be studied; and if he will not, then I will vote against this amendment. I say so because this is a sensitive issue. This is an issue of extraordinary sensitivity to the immigrant communities in this country; and so I ask both sides of the aisle, if the amendment is not withdrawn, to vote it down.

Ms. JACKSON-LEE of Texas. Mr. Chairman, I move to strike the requisite number of words.

I hope that we can listen to my good friend from Florida; and for those who are still trying to struggle with their own conscience, let me just simply say that this is a sensitive issue, but what it does capture is our fear of politics, and I just want my colleagues to think of a local hamlet or rural area that inadvertently, inadvertently does not provide information. They too will lose their fund.

The other aspect of this amendment that the gentleman from Colorado (Mr. TANCREDO) has not spoken to is that they will make the teachers, doctors, nurses and others hunting down those they believe to be violators of the immigration laws and they will begin to approach not those who may be undocumented, but they will approach citizens who are, in fact, documented. It will be a politics of fear because our local communities will be fearful of losing the dollars that they are going to get.

Mr. Chairman, the gentleman from Florida has made a very good proposition. This House, the committees have not had an opportunity to review this amendment, nor have they had a full opportunity to review how we wish to go forward on immigration policy.

My question to the gentleman from Colorado (Mr. TANCREDO) would be, is the administration in support of this amendment? Is President Bush in support of this amendment? Is this an administration proposition? If it is, then we need to have a policy statement, a letter from the administration suggesting that this is an amendment that they support; and frankly, I believe, Mr. Chairman, that this is an amendment that will take us down that very thorny path of seeking out citizens who happen to have a foreign name, wherever they might be, because our cities and local governments, rural areas will be fearful that the long hand of the government will snatch their money away from them.

This is a bad amendment, and I hope that it goes down the tube; but I hope the gentleman will withdraw the amendment or vote it down.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Colorado (Mr. TANCREDO).

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. OBEY. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 102, noes 322, not voting 10, as follows:

[Roll No. 309]

AYES—102

Aderholt
Akin
Bachus
Baker
Barrett (SC)
Bartlett (MD)
Barton (TX)
Blackburn
Boozman
Brady (TX)
Burns
Burton (IN)
Buyer
Cantor
Carter
Chabot
Coble
Collins
Cox
Crane
Culberson
Davis, Jo Ann
Deal (GA)
DeLay
DeMint
Doolittle
Duncan
Emerson
Everett
Feeney
Flake
Forbes
Franks (AZ)
Gallegly
Garrett (NJ)
Gingrey
Goode
Goodlatte
Graves
Gutknecht
Hayes
Hayworth
Hefley
Herger
Hoekstra
Hostettler
Hulshof
Hunter
Hyde
Isakson
Istook
Jenkins
Johnson, Sam
Jones (NC)
King (IA)
Kingston
Lucas (OK)
Manzullo
McInnis
Mica
Miller (FL)
Miller, Gary
Musgrave
Myrick
Neugebauer
Norwood
Otter
Paul
Pence
Peterson (PA)
Petri
Pitts
Platts
Putnam
Ramstad
Rehberg
Rogers (AL)
Rogers (KY)
Rohrabacher
Royce
Ryun (KS)
Schrock
Sensenbrenner
Sessions
Shadegg
Shays
Shimkus
Shuster
Smith (MI)
Smith (TX)
Stearns
Sullivan
Tancredo
Taylor (NC)
Tiahrt
Toomey
Vitter
Wamp
Weldon (FL)
Whitfield
Wicker
Wilson (SC)

NOES—322

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Ballenger
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burr
Calvert
Camp
Cannon
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Castle
Chocola
Clay
Clyburn
Cole
Cooper
Costello
Cramer
Crenshaw
Crowley
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Dreier
Dunn
Edwards
Ehlers
Emanuel
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Ferguson
Filner
Fletcher
Foley
Ford
Fossella
Frank (MA)
Frelinghuysen
Frost
Gerlach
Gibbons
Gilchrest
Gillmor
Gonzalez
Gordon
Goss
Granger
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hensarling
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Houghton
Hoyer
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (NY)
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (MI)
Miller (NC)
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Nadler
Napolitano
Neal (MA)
Nethercutt
Ney
Northup
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Peterson (MN)
Pickering
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Quinn
Radanovich
Rahall
Rangel
Regula
Renzi
Reyes
Reynolds
Rodriguez
Rogers (MI)
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Shaw
Sherman
Sherwood
Simmons
Simpson
Slaughter
Smith (NJ)
Snyder
Solis
Souder
Spratt
Stark
Stenholm
Strickland
Stupak
Sweeney
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiberi
Tierney
Towns
Turner (OH)
Turner (TX)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Walden (OR)
Walsh
Waters
Watson
Watt
Waxman
Weiner
Weller
Wexler
Wilson (NM)
Wolf
Woolsey
Wu
Wynn
Young (FL)

NOT VOTING—10

Brown-Waite, Ginny
Conyers
Cubin
Gephardt
John
Skelton
Smith (WA)
Udall (CO)
Weldon (PA)
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The CHAIRMAN (during the vote). There are 2 minutes remaining in this vote.

☐ 2120

Mr. GIBBONS changed his vote from "aye" to "no."

Mr. GARY G. MILLER of California changed his vote from "no" to "aye."

So the amendment was rejected.

The result of the vote was announced as above recorded.

Stated against:

Mr. UDALL of Colorado. Mr. Chairman, I was inadvertently detained and did not arrive in the Chamber in time to vote on rollcall number 309, the Tancredo amendment to H.R. 2555, the Homeland Security appropriations bill. Had I been present, I would have voted "no."

Mr. ROGERS of Kentucky. Mr. Chairman, I move to strike the last word.

Mr. Chairman, as we wrap up debate on this bill, this historic bill, the very first appropriations bill that this Congress has taken up to fund the new Department of Homeland Security, truly a historic day, I want to say just briefly how much I appreciate all of the help that the members of the subcommittee gave to us as we crafted this bill in a bipartisan way, and for all of the Members who have conducted the debate today, I think, in a very high-minded way.

I want to especially thank my colleague, my ranking member, the gentleman from Minnesota (Mr. SABO), who has been of immense help as we constructed the bill, and all the members of the subcommittee and of the full committee.

I want to especially single out the vice chairman of the subcommittee, the full committee chairman, the gentleman from Florida (Mr. YOUNG), who was helpful in the drafting of this bill, but also, most importantly, had the courage back in the wintertime to have the Subcommittee on Homeland Security created in the full committee. It was courageous. The other body followed suit. Otherwise, this Department would be appropriated by seven or eight different subcommittees on the House and Senate side. So I want to thank Chairman YOUNG for doing a great job and having the courage to be a leader.

And lastly, Mr. Chairman, I want to thank the very excellent staff that we have had the good fortune to work with for only 3½ months since this subcommittee has existed. Just a short time, but this staff pulled together a bill from whole cloth and nurtured it through the process, and we owe a lot to this excellent staff on both sides of the aisle who put this very first bill together.

Mr. Chairman, I thank my colleagues for allowing me to thank these people for doing a great job.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. SHIMKUS) having assumed the chair, Mr. GILLMOR, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2555) making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes, pursuant to House Resolution 293, he reported the bill back to the House with sundry amendments adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

Pursuant to clause 10 of rule XX, the yeas and nays are ordered.

Pursuant to clause 8 and 9 of rule XX, this 15-minute vote on passage will be followed by a 5-minute vote on suspending the rules and passing H.R. 1416.

The vote was taken by electronic device, and there were—yeas 425, nays 2, not voting 7, as follows:

[Roll No. 310]

YEAS—425

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (FL)

NAYS—2

Flake
Paul

NOT VOTING—7

Brown-Waite, Ginny
Conyers
Cubin
Gephardt
Skelton
Smith (WA)
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SHIMKUS) (during the vote). Members are advised 2 minutes remain in this vote.

☐ 2141

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

HOMELAND SECURITY TECHNICAL CORRECTIONS ACT OF 2003

The SPEAKER pro tempore. The pending business is the question of suspending the rules and passing the bill, H.R. 1416, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. Cox) that the House suspend the rules and pass the bill, H.R. 1416, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 415, nays 0, not voting 19, as follows:

[Roll No. 311]

YEAS—415

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hinchey
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin

Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (FL)

NOT VOTING—19

Brown-Waite, Ginny
Calvert
Clay
Conyers
Cubin
Dooley (CA)
Gephardt
Hill
Hinojosa
Johnson, Sam
Jones (NC)
Matsui
Sanders
Skelton
Smith (MI)
Smith (WA)
Stark
Taylor (NC)
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SHIMKUS) (during the vote). Members are advised that 2 minutes remain in this vote.

☐ 2148

So (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2417, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mrs. MYRICK, from the Committee on Rules, submitted a privileged report (Rept. No. 108–176) on the resolution (H. Res. 295) providing for consideration of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, which was referred to the House Calendar and ordered to be printed.

SPECIAL ORDERS

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under the Speaker's announced policy of January 7, 2003, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

EXCHANGE OF SPECIAL ORDER TIME

Mr. BROWN of Ohio. Mr. Speaker, I ask unanimous consent to take the 5 minutes of the gentleman from New York (Mr. HINCHEY).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

PRESCRIPTION DRUG COSTS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. BROWN) is recognized for 5 minutes.

Mr. BROWN of Ohio. Mr. Speaker, 2003 promises to be the third straight year of double-digit premium increases in health insurance. Guess what else is increasing at double-digit rates? Drug industry profits. In 2001 while the rest of the Nation was reeling from a plummeting economy, the drug industry boosted their profits by 33 percent. In 2002, profits registered by the 10 drug companies on the Fortune 500 list were equal to more than half the $70 billion in profits netted by the entire roster of Fortune 500 companies. The top 10 drug companies raked in profits 5½ times greater than the median for all industries. Over the last 20 years, the drug industry has been the most profitable industry in America.

Return on investment, return on sales, return on equity, any way you measure it for the last 20 years, the drug industry has been the most profitable industry in America. And the drug industry has paid lower tax rates than any other industry in America. While the drug industry tells lawmakers that any limits on their profits will crimp innovation, they rarely acknowledge they spend more money on marketing their drugs than they do in research and development. They seldom mention, as I said, they pay the lowest tax rates of any industry in America; and they seldom mention that the government and foundations do literally half of all their research and development that leads to new drugs. Families USA found that in 2001 the nine drug companies selling the most drugs to American seniors spent more money, in fact spent more than twice as much money on marketing and on administration than they did on research and development.

The Republican majority would like us to accept a Medicare drug plan that is administered by profit-driven insurance companies, profit-driven HMOs who will negotiate with profit-driven drug companies on behalf of our most vulnerable populations. It is not hard to see who is going to lose out in those negotiations, Mr. Speaker.

This Republican plan will not guarantee seniors access to fair-priced drugs, it will not guarantee seniors access to health care, but you can bet the Republican plan will guarantee sustained double-digit profit margins for the Nation's drug companies. Responding to the public outrage at astronomical drug prices, the brand-name drug industry says not to worry, prescription drugs actually save money by reducing health care costs. That is true if prescription drugs were more reasonably priced, but under the Republican bill they will not be. There is no doubt prescription medicines reduce disability and can prevent illnesses which helps alleviate the need for other health care services. Unfortunately, though, Mr. Speaker, prescription drugs are priced so outrageously high that the costs associated with their increased use far outstrips any offsetting savings that might accrue. They are so high priced that millions of seniors and other Americans simply cannot afford them. The choice too often is between heat and their prescription drugs in winter. The choice too often is between food and prescription drugs. Even a miracle cure is worthless if people who need it cannot afford it.

Skyrocketing drug costs are jeopardizing employer-sponsored health insurance, undercutting the financial security of seniors and absorbing an enormous and increasing share of limited Federal and State tax revenues devoted to health care. Something has to give.

The reason the drug industry has spent millions of dollars lobbying for the Republican Medicare bill is because the industry knows that scattering seniors into multiple private plans undercuts the purchasing power that Medicare would provide. They know that squashing efforts to consolidate the purchasing power put 40 million seniors into one purchasing pool to save money. They know that mixing them up into smaller numbers in a multitude of plans enables the drug companies to sustain outrageous drug prices. That is why the drug companies lobbied so hard for the Republican prescription drug plan.

The government negotiates price on everything else. When the Architect of the Capitol bought the carpet for this room, he did not take the manufacturer's word that a fair price would impair his fiber research. When the National Park Service buys park rangers' uniforms, he does not take the first bid that comes in.

But not with prescription drugs. On prescription drugs, Republicans insist that the government take whatever price the drugmakers want to charge. If you want to talk about an incentive, that is an incentive. It is an incentive to turn the screws on American businesses who cannot afford the price of prescription drugs in their health plans, to turn the screws on American families and seniors who cannot afford the price of prescription drugs, and to turn the screws on government because taxpayers cannot afford the outrageous cost of these prescription drugs.

I do not lose sleep, Mr. Speaker, over sustaining double-digit profit margins for the drug industry. I am concerned, however, at the millions of Americans who are shouldering the burden for these double-digit profit margins at the expense of their health. The average Medicare beneficiary earns $14,000 a year. Many of the prescription drugs seniors use cost about $100 per prescription per month. Mr. Speaker, the Republican plan written by the drug companies does not make sense for American seniors. I ask my colleagues to vote for the Dingell-Rangel substitute which will provide drug coverage and will ratchet down prices so Americans no longer pay higher prices than any other country in the world for prescription drugs that are manufactured right here in the United States.

□ 2200

EXCHANGE OF SPECIAL ORDER TIME

Mr. MORAN of Kansas. Mr. Speaker, I ask unanimous consent to utilize the time of the gentleman from Indiana (Mr. BURTON).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kansas (Mr. MORAN)?

There was no objection.

TRIBUTE TO THE KANSAS WHEAT HARVEST

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Kansas (Mr. MORAN) is recognized for 5 minutes.

Mr. MORAN of Kansas. Mr. Speaker, in Kansas today the combines and harvest crews are rolling through day 13 of the 2003 wheat harvest. Farm trucks and semi-trailers crowd the highways and gravel roads bringing Kansas's most celebrated crop from the fields to the grain bins and local elevators.

After a few days of rain, harvest is now in full throttle in the southern half of the largest wheat producing State. And with just under 20 percent of the harvest in, there is some good news to report. The yields are good and the landscape is of golden waves of grain, a welcomed change from the scenery of a year ago.

Two thousand and two was one of the worst years that farmers in Kansas ever faced. Because of severe drought wheat yields were poor, many families had net incomes of zero and farm equities plunged, the trickle down effect of the hard hit causing cash-flow problems for rural businesses and closing down stores on main streets in many small towns across our State.

But after consecutive years of natural disaster, Kansans can finally be cautiously optimistic this year. The harvest reports from producers are more positive and even a little upbeat this year, and the cause for that improvement can best be described in one word, rain. Thanks to the spring rains, many producers are getting their first wheat crop in 3 to 4 years. By the time this harvest is completed the first part of July almost 10 million acres of wheat will have been cut, the largest acreage harvested in our State in the last 5 years.

Behind the numbers of wheat harvest, bushels per acre, test weights, yields, are stories of real people who make farming their way of life. Harvest is a family affair. Although the methods of harvest are constantly changing thanks to new technology, the work ethic passed down from generation to generation still exists. Fathers, sons, grandfathers, brothers work side by side from dawn to sunset. A story in yesterday's Salina Journal paints the typical picture in a profile of the Anderson family from McPherson County. Wheat producer Tim Anderson is on the combine harvesting a field near Roxbury, Kansas. His father, Bill Anderson, is on another combine, and the third is manned by Tim's son Scott, age 17. Younger son Shawn is in a tractor nearby pulling the grain cart. Meanwhile Tim's wife, Renee, arrives in the field in a farm truck bringing lunch to the family. Harvest is a team effort.

In addition to being a family affair, the annual wheat harvest is a trademark claimed by our entire State, and we have been growing wheat there in Kansas since before Kansas became known as "The Wheat State." Kansas's farmers produce more wheat than any other State, 20 percent of the Nation's total production, and Kansas ranks first in our Nation in flour milling, wheat gluten production and wheat stored. Kansas really is the "Breadbasket of the World."

Wheat harvest is a tradition, a legacy, and our livelihood, and as goes the wheat crop, so goes the Kansas economy. A good wheat harvest is the leading contributor to our State's revenue, about $1 billion annually.

So Mr. Speaker, as the combines roll northward and the harvest continues, it is good for all of us to take a few moments to recognize the lessons of the wheat field, to remember that there is satisfaction in making the right decisions and putting in the hard work to produce a bumper crop but ultimately mother nature has the final say in whether or not the yield is bountiful. That cautious optimism is the hallmark of every farmer who puts the seed in the ground hoping for a good harvest months later, and there are few things in life more rewarding than working with family side by side to complete the job of the wheat harvest. Wheat harvest is important to the Kansas economy but even more important as a way of life.

Kansans have been saying their prayers throughout the years of drought for rain and snowfall. Those prayers have been answered. Now we pray for abundant crops, good prices, and a safe harvest. Once again the old hymn reminds us: God our Maker doth provide.

PORT SECURITY

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. MILLENDER-MCDONALD) is recognized for 5 minutes.

Ms. MILLENDER-MCDONALD. Mr. Speaker, I rise tonight to talk about port security and the critical importance that increased funding for port security would have for my region of Long Beach and Los Angeles and to the American people.

Mr. Speaker, last night I appeared before the Committee on Rules about an amendment that would provide funding for container security and port security. Regrettably, this amendment was not made in order. If my amendment had been made in order, this germane amendment would designate $20 million to establish a secure container and safe mobility pilot program. Further, this project would be carried out at the Nation's port with the highest volume of container traffic. This program would work in conjunction with existing city and local infrastructure in developing fast, efficient, effective and secure ways to move containers through the port complex and through surrounding cities and communities throughout the Nation.

We recognize that not all containers that come into our country are inspected. We must provide resources to port security initiatives that help us utilize our existing infrastructure while making sure that our communities that receive these containers are protected. A program like this will set the standard for similar communities around the Nation that provide the infrastructure that move our Nation's goods out of the Nation and keep our economy moving forward.

Long Beach and Los Angeles, our port complex, the largest in the country and the third largest in the world, receive 45 percent of the Nation's containers. These ports are a vital economic link to the rest of the Nation. Eighty percent of the goods that come into the country from the Pacific rim comes into our ports. If these ports in the communities that support this supply chain of goods movement were ever threatened or damaged, our economy would be stalled.

In October of 2002 our Nation witnessed firsthand what happened to our economy when our ports are not moving goods out of the country. The lockout that occurred at the western ports served as a grim reminder of just how interconnected and how dependent we are on one another in moving our Nation's goods. The lockout that occurred at the western ports cost the U.S. economy an estimated $1 billion a day.

We must provide support and precious resources to our ports to ensure that they are secure. In addition, we must provide security to the communities that are connected and support our ports. We cannot view port security as merely inside the gates. Ports are a part of our communities. The resources that we provide for port security also provide security for our Nation's communities.

Mr. Speaker, I would have offered this amendment, and I offer this statement for the RECORD.

THE RURAL VETERANS ACCESS TO CARE ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska (Mr. OSBORNE) is recognized for 5 minutes.

Mr. OSBORNE. Mr. Speaker, I represent a rural area, 64,000 square miles, 68 counties, and it goes without saying it is a long ways between towns. In an area like this, veterans ofttimes have a hard time accessing healthcare. Let me give a real example. Let us say a veteran lives in Ogalala, Nebraska, which is in the western part of the State but is by no means the most remote part of the State, and let us say that individual has to go to Omaha, Nebraska to a VA hospital which is 350 miles away, and he may just be going for a routine blood test, diabetes checkup, blood pressure checkup, or any type of simple checkup of that nature. Ofttimes when he makes an appointment, the appointment will not be fulfilled for 6 months. So he waits for 6 months, and that veteran at that time then gets up at 4 a.m. and leaves for North Platte, Nebraska, which is 50 miles away. After he gets to North Platte, he boards a van to go to Grand Island, Nebraska, where he spends the night and that is another 140 miles, and early the next day he gets on another van, goes to the VA hospital in Omaha, a 3-hour trip. He completes the test that day and then he returns to Grand Island for the night, and the next day he takes the van from Grand Island to North Platte, another 140 miles, and then he gets a ride to Ogalala, another 50 miles. So he has waited 6 months, he has had a 3-day trip to go 660 miles for routine tests. This is ridiculous.

Had the veteran driven his own car or had somebody drive his own car, he still would have had an 11-hour trip and it would have taken at least 2 days, if not 3.

Let me give an urban example. Let us say that someone, a veteran with the same health problem lived in Richmond, Virginia. It would be the same as if that individual from Richmond, Virginia drove to New York City and back for basic medical care. Those same tests that were performed in Omaha, Nebraska at the VA hospital could have been done at the local hospital in a matter of three or four blocks away or maybe a couple of minutes away from that veteran, and sometimes because of their age some of our World War II veterans are having a hard time traveling today, maybe a disability, maybe the weather, a blizzard or a snowstorm, and the veteran simply does not get the healthcare at all. He does not even try because he is not able to make the trip.

So that is why I have introduced H.R. 2379, the Rural Veterans Access to Care Act. H.R. 2379 would allow the VA to contract for care with local medical facilities. The only stipulation is that the veteran must travel at least 60 miles or more for the care. Some people say that only happens in Montana or North Dakota or South Dakota or Nebraska. And it is true. Those States would be hard hit. But there probably are hardly any States in the Union with the exception of maybe Rhode Island or Connecticut or someplace like that where we do not have at least some veterans who are somewhat isolated from VA hospitals and are having to go great lengths to get their medical care. H.R. 2379 would set aside 5 percent of the VA funding to contract with local medical facilities for veterans living in rural areas. By contracting with local clinics in remote areas, number one, medical care would be prompt, it would not be a four to five to six-month wait. Number two, veterans who have difficulty traveling would be served. They would not have to just simply give up on getting medical care. Number three, there will be no additional cost and might even cost less. And number four, the local hospital or clinic, which is often struggling to survive in a small town, would receive added funds.

So I think this bill makes sense. I would urge my colleagues to support it.

MEDICARE

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) is recognized for 5 minutes.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise tonight to address the most important issue of Medicare reform. As a former nurse, I have spent much of my career working to ensure that our Nation's healthcare system provides a wide range of affordable services, and we as Members of Congress must be fiscally responsible when it comes to making decisions regarding our budget. Fiscal responsibility entails looking at the whole picture and seeing the effect it may have on all individuals in society. I will continue to work hard to ensure that those who have given to the system will receive their just rewards. This includes continuing to help those who would like to help themselves by providing a means for them to do just that. I will continue to favor programs such as welfare and Medicare that have this objective in mind, and I will oppose any legislation that provides tax cuts which do not benefit all of society.

In the year 2000 at my request the House Committee on Government Reform conducted research on prescription drug costs in the Dallas-Fortworth Metroplex. The results of this study were astounding. Seniors in my congressional district paid 122 percent more for prescription drugs than do members of managed care plans and Federal employees. Last Congress I was very disappointed when the House passed the Medicare Prescription Drug Benefit bill, H.R. 4954. This bill passed closely along party lines, did not entitle seniors to any particular drug benefit plan. Instead, this standard benefit is merely a suggestion for what private plans might offer. Unfortunately, we are poised to repeat history if we pass this Republican Medicare bill. I oppose the Republican Medicare bill because it does not ensure that citizens and people with disabilities get the long overdue Medicare prescription drug benefit that is available and affordable to all.

There are two essential changes that are needed for the Republican Medicare bill to become palatable. First, the bill must be amended to include a uniform, defined prescription drug benefit that is universally available through Medicare. Second, the bill must reject proposals to privatize the program. These two changes are critical. The Republican Medicare bill must provide a guaranteed drug benefit managed by

Medicare. Beneficiaries in traditional Medicare cannot be disadvantaged should private plans be allowed to compete to provide Medicare benefits. Our proposed Democratic amendment would have added a stable, defined drug benefit in Medicare.

It is time that we acknowledge that there is an America that is waiting for relief. It is also time for us to acknowledge that the people deserve a little attention rather than the corporations and pharmaceutical companies getting all of the breaks.

MICHIGAN AFFIRMATIVE ACTION CASES

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Iowa (Mr. KING) is recognized for 5 minutes.

Mr. KING of Iowa. Mr. Speaker, I would like to address the House and the United States of America with regard to the decision rendered by the Supreme Court that came down I believe it was yesterday in the case of Grutter v. Bollinger and Gratz v. Bollinger, University of Michigan undergraduate school and the University of Michigan School of Law. I went over to the Supreme Court. I believe that case was heard on April 19, and I was the only member of my conference to be there in that Supreme Court hearing room that day.

This Constitution means something to me. I have dealt with affirmative action. I am a contractor by trade. I have done so for 28 years. I have hired people of all different kinds of backgrounds and talents and ethnicities, and I have also done Federal contracts where I have run into a situation where there will be a certain situation quota or a goal assigned to me, and sometimes that is not available and we have had to drop contracts because we were not able to meet that requirement. So I paid real attention to this, and I think it is important that everyone have equal opportunity. That is what Martin Luther King asked for. That is what our Constitution calls for, and that is what we should provide by the laws that we promote here in this Congress and by the Supreme Court that meets over across the way.

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I thought I went over there to hear a constitutional argument. In my naivete I expected that would be the bulk of the discussion that took place that day in that little over-2 hours of discussion. In fact, I heard very little constitutional argument. About two-thirds to three-quarters of the comments and questions that were directed by the Justices had to do with the result, not the constitutionality, not the language, the definition, or the intent of Congress; simply the result of a decision that they might make.

And an interesting thing: as I tried to find my way into the Supreme Court room, it was packed out front, and it looked like they let out the D.C. schools for the day to go demonstrate at the U.S. Supreme Court. They were carrying signs that said: "Support equality, defend affirmative action."

Well, Mr. Speaker, I did not take a logic class, but those two things do not connect for me, and I do not think they connect for most Americans. We are either going to have equality or we are not going to have equality; but a preferential treatment program, by definition, is contrary to equality. And that is what affirmative action is, and that is what the case was there to be heard for.

So I went to the oral arguments in those cases, and I am profoundly disappointed that the Supreme Court did not outlaw racial preferences in their decision in the Grutter and the Gratz cases, and in the lack of focus on constitutional arguments.

As I left there, and I talked to attorneys about this, me not being one, and I told them that I was astonished that the Justices in the Supreme Court did not focus their arguments on the Constitution. They told me they were focusing their questions and their comments on Justice O'Connor, because well, all right, that is another issue then, and she has written the majority opinion. Apparently, they were focusing on her for the right reason. Apparently, she was not evaluating the Constitution, or we would have had an entirely different majority decision, certainly by the one that wrote the majority.

But I did hear one reference to the Constitution. I actually heard more than one, but the one that stands out in my mind was Justice Scalia's reference, when he asked the University of Michigan attorney, he said, If this court rules against you and it results in one minority in the School of Law, 100 percent minorities are no minorities, what possible constitutional difference can that make? And my colleagues can check the record, Mr. Speaker. I do not think they will see that there is a logical answer to that. So we ended up with the decision that we got.

Now, the Court got it right when they struck down the point system by the University of Michigan's undergraduate programs. University admissions should be color blind. A student's race should never matter more than a 4.0, a perfect SAT score, or a flawless essay.

I am not a lawyer, but it does not take a lawyer to know that the Supreme Court missed the mark when they upheld the program at the University of Michigan Law School that relies on race and the law school admissions decision-making process. The race-based admissions policy violates Martin Luther King's call for a color-blind society. Admission should be determined based on criteria that reward excellence, not race. It is paternalistic for minority students to be given preferential treatment. All students should have the same opportunities to succeed, regardless of color.

I agree with Justice Thomas when he said of the majority opinion in the Grutter case, "For the immediate future, however, the majority has placed its imprimatur on a practice that can only weaken the principle of equality embodied in the Declaration of Independence and the Equal Protection Clause." He then quoted the landmark case of Plessy v. Ferguson: "Our Constitution is color-blind, and neither knows nor tolerates classes among citizens."

Justice Thomas hit the nail on the head when he wrote of the lack of principle in the majority opinion: "I can only presume that the majority's failure to justify its decision by reference to any principle arises from the absence of any such principle." Justice Thomas, I agree. And I agree that the only principle in the majority opinion in Grutter was the principle of expediency to allow racial preferences. Certainly, constitutional principles were not involved. The Fourteenth amendment prohibits such race-based admissions decisions. Our Constitution is color-blind. Obviously, a majority of the Supreme Court is not.

SUPPORT THE FREE MARKET PRESCRIPTION DRUG BILL

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under a previous order of the House, the gentleman from Illinois (Mr. EMANUEL) is recognized for 5 minutes.

Mr. EMANUEL. Mr. Speaker, we are about to take up the prescription drug bill, and a group of Democrats and Republicans have come together on an amendment to the legislation that is the free market prescription drug bill. It has three components.

One is to bring generics to market so we can have competition between generics and name-brand drugs and force the prices down and make medications more affordable to more and more, not only of our elderly, but all consumers, and also help private businesses on their health care costs through their insurance policy.

The second provision allows consumers and also the government and also the private sector to buy prescription drugs in anywhere of the 27 countries, be they Great Britain, France, Germany, Canada, Italy, England. They allow it in Holland, where you can get competitive prices. Because today, in Germany, many of the name-brand drugs are 30, 40, 50 percent cheaper than they are here. And we can bring competition and the market forces to bear on the prices to make medications more affordable for our American consumers.

The third provision is that the taxpayers have been funding research through the National Institutes of Health. The truth is the NIH is one of the largest venture funds in the world. Yet American taxpayers get no return on their investment through the NIH. All the cancer drugs, all the AIDS drugs, a great deal of the blood thinner drugs and medications, and arthritis drugs were funded through government research.

In the private sector, many people who invest look for a 30 percent return on their investment. The taxpayer, through the government, gets no return on their investment. This legislation would call for a 10 percent return to the taxpayers for that research for all of the new medications the taxpayers have funded, and we could make the NIH and the FDA, Food and Drug Administration, self-funded in the future. In my view it would keep America in the forefront of new medication. We could bring medications down in price, and we could get real competition and make medications affordable.

What is really missing in this whole debate, in my view, is bringing the free market to play and to bear, and it would be successful. Unfortunately, the American taxpayer has been funding all the research and the only benefit we have gotten is that we pay the highest price. As we would say in Chicago, "such a deal."

Now, the truth is, in England, France, Canada, Germany, Italy, American-made pharmaceutical drugs are 30 to 40 to 50 percent cheaper in those countries than they are here at home. The American consumer, the American senior citizen, is the profit guinea pig for the pharmaceutical companies. For too long they have been gouging our seniors, using our elderly to make up their profit margins, while in Canada, in Germany, in France and in England they are getting cheaper prices. So it has a bipartisan approach around a commonsense set of principles to make medications, the drugs people need for their children, for themselves, or for their grandparents, more affordable, more accessible.

Now, why would it be that if we are about to go spend $400 billion over 10 years, why would we deny the government the ability, through the taxpayers, the ability to stretch that $400 billion to get more out of it? Nowhere else in the private sector would we do that. We are denying ourselves the right to use competition to bring down the price, to make medications more affordable to all of the folks, be they elderly or kids or families, so the family budget, the business budget, and the government's budget go cheaper.

I have confidence in the free market. I wish some of my colleagues here on the other side of the aisle would have as much confidence as we have in the free market. I do not know what they are all scared of. We would have generics competing against name-brand drugs, and we could pick based on price and quality. You would be able to buy drugs at the local pharmacy, or if you look on the Internet and find the same drug cheaper in Germany, you buy it there. If globalization is such a great thing, why do we not allow it to work for everybody, not just for a select few? Why let Germany get the advantages of cheaper medications made here in America by American companies funded by American taxpayers?

On the last account, allow our taxpayers to reap the benefits of their tax-funded research.

Mr. Speaker, in the private sector world, if you get less than 30 percent on your return, you know what you are called? Dumb money. I wonder how long we are going to treat the taxpayers as dumb money around here. This is taxpayer-funded research. Every drug related to cancer has been funded in part by taxpayer money; and the only thing we are guaranteed besides the medications, which we are not guaranteed, is to pay the highest price in the world for that medication. Yet people in Germany and England pay half that price.

I have full confidence, along with my colleagues on the other side and folks on this side of the aisle. We have come together on a common set of principles with a common set of values to ensure affordability and return for taxpayer rights on their investment.

I know the pharmaceutical companies do not want this bill because it would finally bring some real sensible principles like the free market to bear on the pharmaceutical industry and on the pricing of medication.

So I hope that we have the opportunity to offer this amendment and everybody can either start not just talking the talk, but start walking the walk when it comes to their views in espousing the free market.

REPUBLICAN PARTY PRINCIPLES OF LIMITED GOVERNMENT, ECONOMIC FREEDOM, AND INDIVIDUAL RESPONSIBILITY SHOULD PREVAIL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Arizona (Mr. FLAKE) is recognized for 5 minutes.

Mr. FLAKE. Mr. Speaker, I rise today out of some reluctance to take a position at variance with the leadership of my party. I do so, however, because I believe that the direction we are headed with this bill on prescription drugs is inconsistent with the Republican Party's principles of limited government, economic freedom, and individual responsibility.

I hope that my opposition to this bill does not imply my support for the Democratic alternative. While we Republicans are surely headed off the fiscal cliff, the Democrats' plan would only get us there much faster.

This legislation is a prime example of the question debated in high school civics classes all over the country: Are we as Members of Congress sent to Washington to vote the wishes of our constituents or the demands of our conscience?

We have all read the polls. It is clear that seniors want a prescription drug benefit as part of a traditional Medicare. Further, seniors seem skittish when it comes to substantive Medicare reform. These findings are often cited by supporters of the legislation. Rarely cited, but certainly understood, is the fact that seniors vote in numbers disproportionate to their size of the electorate.

But as sitting Members of Congress, we are also aware that adding a new entitlement of this size is wholly unsustainable. Even without this new entitlement, Medicare will go bankrupt within the next couple of decades. The $400 billion, 10-year estimate for this add-on will almost certainly spiral out of control, just as Medicare's costs have ballooned far beyond original estimates.

So what are we to do? Do we vote as the polls tell us we should vote? After all, if it is what our constituents want, can we not simply vote "aye" and wash our hands of the matter?

We are not the first Congress to face such questions. More than 200 years ago, the delegates to the Constitutional Convention had a similar dilemma. Many in this new country wanted a governmental structure similar to the one that they were used to, rather than what was envisioned by the Founding Fathers.

George Washington's words to the Constitutional Convention should instruct us today: "If, to please the people we offer what we ourselves disprove, how can we afterwards defend our work?"

George Washington understood what leadership is all about. It is not about riding the wave of public opinion, but in changing its course. It would have certainly been more comfortable for the Founding Fathers to go along with what they perceived to be the will of the people, rather than to persuade them that there was a better way. Many generations later, we are grateful for their leadership.

So here we are today. As Members of Congress, we know that adding a prescription drug benefit without reforming Medicare will only hasten its bankruptcy. By our own estimates, this plan will add about $7.8 trillion to Medicare's unfunded liability. Somehow, I doubt that generations to come who are saddled with this debt will be hailing us as leaders.

Knowing all of this, can we defend our work? No, Mr. Speaker, we simply cannot. I urge my colleagues to join me in voting "no."

MEDICARE PRESCRIPTION DRUG BENEFIT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington (Mr. McDERMOTT) is recognized for 5 minutes.

Mr. McDERMOTT. Mr. Speaker, the "Rubber Stamp Congress" is about to go back in session. The President sent the word down from the White House: he wants a bill. We have not seen the bill. It has been put together in two different committees. We do not know what the Committee on Rules is going to put out here, but I can tell my colleagues two things about it. It is very clear from what went on in the Committee on Energy and Commerce and what went on in the Committee on Ways and Means that the bill that will be before us in the next couple of days is not going to satisfy what senior citizens really want.

The senior citizens want no privatization. They do not want Medicare to become totally a private insurance operation. They like the program run by the government. It has worked very well for many years; not perfect, but it has worked very well, and the idea that we are going to have a drug benefit and we are going to say, here is some money, we are putting it on the table here, and the drug companies are going to run in or the insurance companies are going to run in and figure out how to give a benefit is simply nonsense, and people know it.

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They do not trust insurance companies. They have had the last couple of years dealing with the insurance companies around HMOs and they said, Why do we need more of that? How will we feel more safe if we know the insurance companies can come in one day and out the next and back in another day and another and out, in and out? We will not have any benefit.

They want a guaranteed Medicare benefit that they do not have to join a private program to get. They can get it through the government and it is just that simple. That is why they have rejected all these private HMOs, all of that stuff and have stayed in the basic Medicare program. It is partly because the way the insurance companies have treated them.

Insurance companies went out and promised benefits all over the place. They promised drug benefits and everything else. People joined and 6 months later they pulled out and left them hanging. So they expect the very same thing to happen with this drug benefit.

If this were something the insurance companies wanted to do, believe me they would have done it a long time ago but they do not want to do it. So it has got to be in the regular Medicare program. It cannot be privatized. And it has to have a guaranteed benefit.

You can say to people, well, here is $100 a month. Go out and see what kind of plan you get offered because you are not guaranteed anything in that. In some parts of the country it might buy more than it buys in another part of the country. But everybody will have the same amount to go out and try and buy with, so how is that going to work?

Why should it make a difference if you live in Tennessee or you live in Oklahoma or you live in Vermont or you live in Washington State or you live in Illinois? Why should you not be able to have this same plan no matter where you are in this country? Suppose you want to leave San Francisco and go and live with your children in Kansas City? Suddenly you have got to change plans. All of these are issues that come when you put it in the hands of a private insurance company.

Now, the second thing people want is to control the costs of medication. I live up in the Northwest. I live up in Seattle. Every day people get in their cars, drive across the border into Canada, and buy drugs at markedly reduced prices. Now, that went on for a long time and now there are organizations that will allow you to fill your prescriptions from Canada without ever leaving your home in the United States. Thousands and thousands of people are filling their prescriptions in Vermont and New Hampshire and Maine and New York and Michigan and Minnesota. All the States along the northern tier are doing that and it is going down in other States in the country.

Now, you ask yourself, why are drug costs lower in Canada? I mean, what is it about the Canadians that they are better negotiators or what have they done? They did one simple thing. They said you cannot charge a Canadian, they put this in law, you cannot charge a Canadian more than the average of the G–7 countries. Now, what are the G–7 countries? France, Britain, Germany, United States, Canada, Japan, and I think Italy is the other one. You take all those countries, add the price together on a drug and the average price is what Canadians pay.

All it would take for us to save all that traffic to Canada is to pass a law here that grants us the average price of the G–7 countries. This bill will not have it. It is a bad bill. And you should look very carefully at what you pay and what you do not get.

DO NOT PRIVATIZE MEDICARE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania (Mr. HOEFFEL) is recognized for 5 minutes.

Mr. HOEFFEL. Mr. Speaker, there are two things wrong with the Republican prescription drug bill. Perhaps more than just two but two I wanted to talk about this evening.

The first is this bill would privatize the program. It would privatize the prescription drug benefit and it would privatize Medicare itself. The second thing wrong with the Republican prescription drug bill is that it would actually forbid, prohibit, any negotiation by the government with pharmaceutical companies to bring down the cost of the drugs.

Now, let me address the first question. Privatization of this proposed drug benefit is a very bad thing. It would, instead of establishing a drug benefit in Medicare, a guaranteed benefit set by the government, responsible to the Congress as all of the rest of Medicare has been situated and constituted for the past 40 some years, the Republican plan would set up a prescription drug plan through private insurance companies and HMOs.

Now, those companies have a pretty bad track record in terms of delivering the same product year after year at the same price. In fact, they do not. And in the Medicare+Choice program, at least in the Philadelphia area that I represent, the private HMOs have been increasing the costs of Medicare+Choice, taking away the benefit, making a program that they offered a very elaborate benefit at a relatively low cost and taking away those benefits and increasing the costs.

The same thing would happen if we set up a prescription drug program through a privatized insurance based system.

The second thing wrong with this privatization is after 10 years they will privatize Medicare itself through this voucher concept that would have vouchers made available in a particular area based upon all of the bidding done by private companies and HMOs as well as Medicare. And that balanced figure, that blended figure would be the voucher provided for an individual to purchase Medicare. And what would happen is the companies would undercut Medicare, they would attract younger seniors and healthier seniors, they would be allowed, therefore, to save money because they would not be paying as many bills, and each year in each cycle of bidding those private companies would be able to drop their premiums lower than what Medicare would have to charge. Medicare would be stuck with older seniors and sicker seniors and it would be the end of Medicare as we know it. That is what is going to be achieved if we allow the privatization of Medicare in this bill.

The second major problem is the prohibition on negotiating with the drug companies for lower prices. I do not get it. I do not understand it. What is the point of setting up a Medicare based prescription drug plan if we do not use the Federal Government's bargaining power to negotiate with the large pharmaceutical companies for a lower price? That is the whole point. That is why other countries that have large bargaining units negotiating with the pharmaceutical companies have much lower prices than we do.

The Committee on Government Reform under the ranking member, the gentleman from California (Mr. WAXMAN), just did a study in my district. The seniors in the 13th Congressional District of Pennsylvania benefit paid twice as much for their drugs as seniors pay for the very same drugs on average in Canada, England, France, Germany and Italy, twice as much because those countries have a combination of bargaining power that they use to negotiate with the drug companies for lower prices.

This Republican bill prohibits such negotiation by the Secretary of HHS with the drug companies. That is nonsensical and that alone is a good reason to vote no. Those are two reasons. There are many more. We should defeat this bill. Pass the substitute proposed by the gentleman from New York (Mr. RANGEL) and the gentleman from Michigan (Mr. DINGELL) and give seniors a real prescription drug program.

REVISIONS TO THE 302(a) ALLOCATIONS AND BUDGETARY AGGREGATES ESTABLISHED BY THE CONCURRENT RESOLUTIONS ON THE BUDGET FOR FISCAL YEAR 2004

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Iowa (Mr. NUSSLE) is recognized for 5 minutes.

Mr. NUSSLE. Mr. Speaker, I submit for printing in the CONGRESSIONAL RECORD revisions to the 302(a) allocations and budgetary aggregates established by H. Con. Res. 95, the Concurrent Resolution on the Budget for Fiscal Year 2004. The authority to make these adjustments is derived from Section 404 of H. Con. Res. 95 (H. Rept. 108–71).

As reported, H.R. 2555, the Homeland Security appropriations bill for fiscal year 2004, provides new budget authority of $890,000,000 for medical countermeasures against biological terror attacks. That appropriation would be authorized under a bill (H.R. 2122) that has been reported to the House by the Committees on Energy and Commerce and Government Reform. Section 404 of the budget resolution permits the Chairman of the Budget Committee to increase the allocation to the House committee that provides such budget authority pursuant to a reported authorization bill in an amount not to exceed $890,000,000 in budget authority for fiscal year 2004 and outlays flowing therefrom.

While I am concerned that the reported bill provides an advance appropriation for fiscal year 2005 of $2.528 billion that, if enacted, could be limited next year to achieve budgetary savings for the fiscal year 2005 appropriations bill, I will exercise my discretion under the budget resolution and increase the fiscal year 2004 allocation to the House Committee on Appropriations since the requirements of Section 404 of the budget resolution have been met. I therefore increase the fiscal year 2004 302(a) allocation to the House Committee on Appropriations by $890,000,000 in new budget authority and $258,000,000 in outlays, making the allocation to that Committee $785,565,000,000 in budget authority and $861,342,000,000 in outlays.

Questions may be directed to Dan Kowalski at 67270.

MEDICARE BILL WILL HARM CANCER PATIENTS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Mrs. CAPPS) is recognized for 5 minutes.

Mrs. CAPPS. Mr. Speaker, the Medicare bill that we will vote on this week is a bad bill. It undercuts this critical program that has been providing health care to millions of seniors. It provides spotty coverage that will not help these seniors with their expensive medications. And it reneges on a promise that we have made to America's seniors by ending Medicare as we have known it. But I want to talk about a particularly objectionable provision in this bill that has not gotten much attention. The part that cuts funding for cancer care.

The Medicare bill is supposed to make it easier for patients to get health care, but it will actually make it harder for cancer patients to get the care they need. Cancer is a scourge that has touched nearly every person and family in this country. Cancer patients and their loved ones have a very strong loyalty to the medical professionals, this whole team of oncology care givers who deliver what is so often brutal treatment. This is especially true of the often unsung heros of quality cancer care, oncology nurses.

As a nurse and someone who lost a daughter to cancer, I have seen firsthand essential contributions made by these amazing men and women who monitor and support, deftly guide the delicate treatment regimen. But the House Medicare bill has a provision that will cut half a billion dollars from cancer care in America.

Anyone who thinks you can take this much money away from cancer care and not endanger the quality is fooling themselves. The bill does correct an overpayment for oncology drugs that goes on today. Medicare's system of paying for cancer drugs charges cancer payment and the government too much and doctors too much. There is no disagreement on that or on that it needs to be fixed. But while we have paid too much for cancer drugs, Medicare drastically underpays the oncology practice costs. The oncology community has been using this overpayment for medications as a way to make up for the underpayment in oncology services. And we should fix this overpayment for medications because the patients should not be overcharged for their medications. Of course, Medicare and taxpayers should not be overcharged either. But we also have to make sure oncologists are paid properly for their services.

Cancer care has changed a great deal since the creation of Medicare. In fact, most of cancer care has been developed since Medicare was created, moving out of the hospital and into doctors offices and clinics where having oncology nurses and support staff are even more important. They are the frontline providers of cancer care, managing therapies and side effects, helping to keep seniors out of the hospital, saving the Medicare program money, providing counseling to patients and their families and conducting clinical trials and research to improve and advance cancer treatment.

Yet, while patients value this high-quality hands-on loving care, Medicare dramatically undervalues and underpays the cancer care given by these nurses, pharmacists, social workers, and lab technicians who are part of the multidisciplinary cancer team.

Without adequate resources, the reality is that physicians will be unable to sustain the provisions of quality care and will reduce their practices or close them entirely. The first services to be let go will be oncology nurses. In addition to cutting funds from cancer care, the new payment system in this bill will make many cancer patients, 60 percent of the seniors on Medicare, go to the oncologists twice as often, frail, sick seniors doing this. It will actually cause cancer patients to pay more out of pocket costs and wait longer for treatment, increasing their health risks. It is so wrong.

The gentleman from Georgia (Mr. NORWOOD) and I joined with the cancer community to craft legislation to resolve inequities in the cancer care system and address concerns about the overpayment for oncology drugs. And we work hard during the recent markup to try to correct the Medicare bills flawed cancer provision.

Our proposal offers a more accurate payment for oncology drugs and would direct Medicare to establish new payment amounts for physician services related to the treatment of cancer patients, including the added work performed before and after patient visits and consultations. It is so essential. It recognizes the true cost of providing cancer care.

We will all go home after we pass this Medicare bill, and we will have to face our constituents. I, for one, do not want to tell the cancer patients in my district that Congress has decided to curtail their treatment and endanger their care. I hope no one here will.

Just listen to what the cancer community is saying about the House and Senate bills. Ellen Stovall of the National Coalition of Cancer Survivorship says, "Instead of expanding access to life saving drugs, these bills limit access to cancer treatments for some of the most seriously ill Medicare beneficiaries."

Susan Braun of the Susan G. Komen Breast Cancer Foundation says, "The millions of cancer patients in this country who rely upon Medicare need to know that their access to care will be severely disrupted if these bills go through."

□ 2245

They are going to hold us accountable, and they should.

Mr. Speaker, I hope that all my colleagues will join me in fixing these unfair and shortsighted provisions of this Medicare bill.

TIME IS NOW FOR REAL, MEANINGFUL, AFFORDABLE MEDICARE PRESCRIPTION DRUG BENEFIT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. HONDA) is recognized for 5 minutes.

Mr. HONDA. Mr. Speaker, the elderly and disabled have waited long enough for a prescription drug benefit in Medicare and for relief from the high cost of prescription drug prices. While the Republicans have been busy voting on permanent tax cuts, seniors throughout the country have been waiting for Congress to take action on prescription drugs. All seniors need relief from prescription drug prices, and they need it now.

However, the Republican prescription drug bill completely fails the test of a real Medicare drug benefit. The Republican bill has no guaranteed minimum benefit, no guaranteed, affordable monthly premium, and no guarantee of fair drug prices. To add insult to injury, their bill leaves a huge coverage gap. Seniors who need more than $2,000 worth of drugs must pay one hundred percent out-of-pocket, and keep paying premiums, until they reach the $3,500 out-of-pocket cap.

Mr. Speaker, the Democrats have an alternative we hope to offer. Under the Democratic plan, seniors and individuals with disabilities will be able to keep making the choices that matter to them. Seniors won't be forced to join an HMO. They won't have to join a private insurance plan that will restrict their access to needed drugs, deny coverage for the medicine their doctors prescribe, or force them to change pharmacies. And unlike the Republican plan, our plan has no gap—beneficiaries will always have coverage.

Mr. Speaker, the time is now for a real, meaningful, and affordable Medicare prescription drug benefit. Unfortunately, it looks like this Republican-led House won't be providing one anytime soon.

IMPACT OF PRESCRIPTION DRUG BILL

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, the gentleman from Arkansas (Mr. BERRY) is recognized for half the time until midnight as the designee of the minority leader.

Mr. BERRY. Mr. Speaker, we are here this evening to talk about the impact of this very cynical prescription drug bill that is proposed by the majority side and what would happen if that bill, were we so unfortunate as a Nation as to have that bill enacted into law and put upon our senior citizens.

We are indeed pleased that the gentleman from North Carolina (Mr. BALLANCE) is here with us, and at this time I would like to yield the floor to him and let him make whatever comments he sees fitting in regard to this particular issue; and we thank the gentleman from North Carolina.

Mr. BALLANCE. Mr. Speaker, I want to say at the outset that it is an honor for me to be standing in these hallowed halls as we address issues of such great import to the people of this country.

A little more than a year ago, I campaigned in rural eastern North Carolina. I spoke to citizens at AARP meetings, at senior centers, at residences and elsewhere; and like most of my colleagues in this 108th Congress, I made a solemn promise that I would support and vote for a prescription drug benefit program. Each of us, I believe, most of us I know, made that promise to our constituents; and I, and I hope most of my colleagues, will keep that promise. I know that I will keep mine, and I will not vote for a plan that simply has the label on it.

The plan that the Republican leadership of this Chamber has proposed would not benefit our seniors in the way that they need and deserve. It is not a real prescription drug plan. It is what I would call an empty promise.

Mexico, Canada, Germany, England and France, what do all these countries have in common? Their seniors all pay lower prices for the exact same prescription drug medication that American seniors today cannot afford. One month's supply of Zocor, a prescription commonly taken by seniors to lower their cholesterol, costs $124 in the United States. In Europe, the same medication costs $28. The antidepressant Prozac, also widely prescribed throughout America, costs nearly $100 for just 20 pills. In Canada, those same 20 pills cost $20.

Throughout America, seniors have for years been forced to choose between food on the table and medication, stories that we have heard about cutting pills in half or going without. Hardest hit are seniors and disabled of rural America, such as those in Arkansas and in North Carolina, the area that I represent.

We have three plans before this Congress: the House Republican measure that focuses on nothing less than the absolute dismantling of Medicare as we know it; a Senate bipartisan measure that is somewhat better, although still falls far short; and we have a Democratic plan that is affordable, it is available, guaranteed and will maintain Medicare. Our plan has no gap in coverage, no doughnut hole, does not depend on the whims of HMOs or private insurance companies. However, we all know full well that, because it is a real plan, it probably will never see the light of day.

Hopefully, however, the Democratic plan will force the Republican leadership to reconsider their devastating proposal and treat our seniors fair. So tonight we focus on the reality of how House Republican leadership efforts hurt seniors in rural America, disenfranchise, dismantle and ultimately devastate.

That is what we can expect in eastern North Carolina if the House GOP has its way with this prescription drug coverage. That plan will privatize the prescription drug benefits by relying heavily on HMOs to facilitate these programs.

Anyone who lives in rural America, such as eastern North Carolina, already knows the health crisis facing families and seniors, as big HMOs have abandoned them and consider them unprofitable.

I am going to close because I think we know what we are facing. We know what we must do. We must fight to ensure that even hard-to-reach rural communities are included equally and with real results in a much-needed drug coverage plan; and we, Mr. Speaker, must keep our solemn promise.

Mr. BERRY. Mr. Speaker, I thank the gentleman from North Carolina for his comments, and appreciate his leadership in this matter that is so critical to the senior citizens of this country and the tremendous impact it will have not only on our seniors but on all Americans because when the government makes it possible for one person or group of persons like the prescription drug manufacturers of this country, when the government makes it legal for them to rob and to steal from senior citizens, when the government allows that to go on day after day after day, it is our job to speak out. It is our job as best we possibly can to do something about it.

It is an interesting thing, every speaker that talks about this refers to the fact that the United States of America and American citizens pay three to four times as much for their medicines as any other nation in the world, and yet the President of the United States has within his power the ability to change that with the spoken word. All he has to do is tell the Secretary of Health and Human Services, Mr. THOMPSON, certify that we can put a stop to this, certify that we can safely reimport medicine and let our people be treated fairly, but the President refuses to do this.

So it is left up to us, once again, to attempt legislation that will make it possible for the senior citizens of this country to be treated fairly. How can we deny the pain and suffering that this policy, that this country has put in place, causes to our senior citizens and to their families? How can we continue to let that go on? Yet when a remedy is proposed, in this cynical way that we will be presented with before the end of this week, I think it is called the Thomas-Tauzin bill or the Tauzin-Thomas bill, but we cannot devise a more cynical attempt to trick the American people and the senior citizens of this country.

That bill, if we would be so unfortunate to see it enacted, specifically prohibits the government from trying to achieve the best possible price for our citizens. It specifically makes it possible for the drug companies to continue to rob the senior citizens.

It would privatize Medicare. Medicare came into being because private insurance did not want to insure people that were older and sicker, and yet now we are going to turn this back to the insurance companies. If anyone thinks that that is a good idea, I would suggest that they go out and try to buy some health insurance from a private company for a 65-year-old citizen.

It will end Medicare as we know it. One of the authors of this bill came before the Blue Dog Coalition this afternoon, very proud of his work. It was interesting as he sat there and described this; and he said, I have softened this part of the bill; instead of just ending Medicare as we know it in 2010, we are going to phase that, ending in over 3 or 4 years. So it just will not be quite as noticeable.

I could not help but think as I was listening to that about my brother when we were young boys. He had worked hard one summer and saved his money, and he wanted to buy himself a shotgun for hunting season. He went to town and went to the hardware store, and he asked this fellow how much will you take for a certain shotgun. The proprietor said, well, I do not have one; but if I did, I would sell it to you for $100. So since the fellow did not have one, he went on around the square, and he came to another hardware store and went in there and asked him if he had that gun. He said, yes, I do. He said, well, how much will you take for it? He said, I will take a $110. He said, well, the other fellow on the other side of the square said he would take $100 for his, but he did not have one. He said, well, if I did not have one, I would take $100 for mine.

That is the way this deal works. It does not even go into effect for 2 years, 2006. Our seniors have an urgent need today. We have the ability to provide relief today; and yet we are going to be presented with this cynical, horrible piece of legislation that is nothing more than an attempt to trick our senior citizens in desperate need into doing something that will make their desperation even worse.

What kind of a legislative body would do something like that? This is absolutely amazing that the leaders of the Republican Party in the House would be so cynical that they would be willing to attempt to take advantage of senior citizens who have already paid the price, done the work, lived by the rules, and built this great Nation into what it is today; and now they are going to be treated like this by those of us that inherited this wonderful place.

□ 2300

I am astounded that we have to come to this floor this evening and do everything we can to try to prevent such an outrageous act by the majority.

Mr. Speaker, I now yield to the gentleman from Texas (Mr. RODRIGUEZ).

Mr. RODRIGUEZ. Mr. Speaker, let me first of all thank my colleague, the gentleman from Arkansas (Mr. BERRY), for being out here. It is 11 p.m. eastern time, and people might wonder what we are doing here this late. Well, we are talking about an issue that is important. We are talking about an issue when I go to a church on Sunday where people still confront me and ask me what we are doing about this issue. I know myself and we have the gentleman from Texas (Mr. SANDLIN) out here tonight to talk about an issue that continues to confront us, yet we continue to play games with the American people and with our seniors. That is not right. We need to make sure that we do the right thing.

Mr. Speaker, we know that our seniors are having difficulties. We know that the majority of them do not have the resources to pay for their prescriptions. We also know on the Republican side and on the Democratic side that the private sector, the insurance companies, cannot make a profit on our seniors when it comes to prescription drug coverage. We recognize that.

When this all first started, with LBJ, there is a little story that is told about this. When LBJ was trying to put Medicare together, the biggest obstacles were the insurance companies back then, and the doctors. He finally got the insurance companies there and he told them, look, I am going to do you a favor. You have been making a profit off of the young people and insuring them while they are healthy, and as soon as they get sick on you, you have been dumping them and dropping them off your insurance rolls. So we know that the companies were doing that then and they are still continuing to do that now. So when he got them in there he said, look, I will do you a favor. You keep taking those profits while they are healthy but allow us to establish Medicare so that we can take care of them in their later years when they become seniors and they need the assistance, and you can continue to make your profits.

And so now we have a situation where our seniors still reach that age where they need that assistance, where they need our help, where they need prescription drug coverage, and what angers me the most is that the drug companies are the ones that are making a profit off the ones who can least afford to pay for these prescriptions.

We talk about the fact that those same prescriptions are sold, Mr. Speaker, in Mexico and Canada, the same company, same brand, only cheaper. And why? Because they are sticking it to the Americans. And we have allowed that to happen. We have allowed that to continue to occur.

We talk about free trade but yet we do not allow our own Americans to cross the border into Mexico to buy prescriptions. Why not allow free trade from that perspective? It is only good for companies, but not for the average person to do that.

So we need to make sure that, number one, the bill has to be affordable for people. The senior has to be able to purchase it. I can attest to my colleagues that the majority of my district, with a median income of $23,000, $21,000, and especially my seniors, who if you live in rural Texas or rural America you do not have a pension because you did not work for a major corporation or the government, so you do not have a pension. All you have is Social Security. So you do not have extra money to buy additional coverage. And if you did, believe me, the insurance companies do not want that because of the fact that they are not going to make a profit off you. We know the data. We know the seniors sometimes need up to $2,900 per year. So if you need $2,900 per year, close to $3,000, they are not going to make a profit from you. We know that. Yet we are playing games and doing gimmicks.

But this President and this administration has to come up this coming year in November for reelection and they are going to have to tell us what they have done when it comes to prescription drug coverage. They will be asked what they have done. Because I recall the last 2 years, and I want to ask my constituents to remember this, because any Republican who had serious opposition the last time there were ads that came out. We had an ad for the gentleman from Texas (Mr. BONILLA) back home, and that ad said, "Call Congressman BONILLA to thank him for the prescription drug coverage you received." Well, I am going to ask you right now: Have you received anything back home? No. It is a gimmick. It is all nothing but sarcasm. It angers me because they play games with the American people and they play games with our seniors.

So we have to make sure if we come up with a program that it is affordable. What the Republicans have is not affordable. Secondly, it has to be meaningful. It has to be real. It has to be guaranteed. We cannot afford to have these little gimmicks. The reality is that the bill that the Republicans have is meaningless. It is private insurers that can change the terms of the agreement.

We had the HMOs. I have rural counties. I had 13 counties, now I have 11 counties after redistricting, and those counties, wherever the HMOs and the managed organizations were not making profits, they did not cut the individuals, they cut the whole county. So we are not going to be able to have access in rural Texas, in rural America. So it is meaningless.

Finally, we also understand that we have to make sure that we guarantee our seniors the accessibility to these prescriptions. This is the most powerful country in the world. We have the capability and, yes, we have the best health care system in the world. But what good does it do if it is not affordable; if it is not accessible; if it is just not there? Yet we do have the best health care system. It is ridiculous for us to be doing this, and it is unfair to our seniors to be playing games with their lives, especially as they reach their twilight years when they need this the most and they have to sometimes go without buying all the prescriptions that are needed.

So, Mr. Speaker, I want to thank my colleague for being here tonight, and I thank the gentleman from Texas (Mr. SANDLIN) for being here and spending time talking about this critical issue. I want to personally just congratulate my colleagues and let them know that we have to keep this fight up. We have to keep talking about this, and we have to stop playing games.

When that Presidential race comes up again, we have to let everyone know what he has done for prescription drug coverage. The Republicans have control of the Presidency, they have control of the Senate, they have control of the House. What are they doing? They are playing games. This is not the time to do that.

Mr. BERRY. Mr. Speaker, I thank the gentleman from Texas and appreciate his passion and concern for all senior citizens in this country.

This bill would not only end Medicare as we know it, but, interestingly enough, it does not have a defined benefit. It does not have a defined premium. It turns this business over to insurance companies that have a very poor record of being able to deliver service when it is called on to do that.

We have been fighting the Patient's Bill of Rights battle in this House all the time that I have been here. We still do not have a Patient's Bill of Rights. But the pressure got to be so great on the insurance companies that they did stop the grossest abuses that they have engaged in to deny coverage and deny service to our American people. They would be allowed to define their own benefit. They would be allowed to set their own premium. They would be able to create many, many different plans, and it would be nearly impossible for a senior citizen to tell the difference.

I have to believe, Mr. Speaker, that our Founding Fathers would be saddened and sickened to see the great Nation that they brought in to being, that has succeeded and prospered beyond all imagination, to the point where we have the ability to do these wonderful things for our seniors, and yet when the opportunity presents itself, the majority chooses to use that opportunity in a cynical way and in a way that only serves to enrich a few people in this country.

I want to now yield to the gentleman from Texas (Mr. SANDLIN), who has worked tirelessly on this issue to defend our senior citizens against such activities as would be used against them if this bill were to be passed.

□ 2310

Mr. SANDLIN. Mr. Speaker, I would like to thank the gentleman from Arkansas (Mr. BERRY) who is both a good personal friend of mine and a political friend of mine, and I want to thank him for 7 years of political leadership in addition to his practical leadership due to the fact that he is a pharmacist and speaks with a great deal of authority on these issues.

Mr. Speaker, in looking at this bill it is clear, it is the old bait and switch. I rise today to join the gentleman from Arkansas (Mr. BERRY) and my colleagues in speaking to the Republican House leadership abandonment of rural America by crafting a sham prescription drug benefit. Because at the end of the day, it is no plan at all. What a cruel joke on America's seniors.

As the United States Representative of rural east Texas, I am gratified to have an opportunity on the Committee on Ways and Means to be a voice for my constituents at home. The seniors in my district have told me clearly that they need real relief for their soaring medical expenses; and yet once again this year the majority leadership in Congress has rejected its responsibility to deliver a true prescription drug benefit to our parents and grandparents and friends at home. Just like last year, the Republican majority has delivered an alleged prescription drug plan which favors profits over people, insurance companies over seniors, HMOs over American families.

Today I want to talk about choices and who is choosing what. Our Republican colleagues in the House of Representatives love to say that they are giving our parents and grandparents and friends choices for their prescription drug benefit. Mr. Speaker, that is simply not true. They also have stated that if our seniors and disabled folks want prescription drug coverage, then they have to look to HMOs and private insurance companies, not Medicare for help. That is the choice they have, and what kind of choice is that? It is clear, it is absolutely no choice at all.

Now anyone who lives in rural areas knows that this little rule is anything but a choice. Rural areas have been flat out abandoned by private insurance companies: We know this. Medicare+Choice, the great managed care experiment in our Nation's seniors, should have been named "Medicare Minus Choice." It has been a disaster.

Just look at the facts. Between 1998 and 2003, the number of Medicare+Choice plans dropped by more than half. In the great State of Texas, over 313,000 Medicare+Choice enrollees have been dropped just since 1999, 313,000 people in my State. Further, this is occurring all over the country. The 10 States, including the District of Columbia with the highest percentage of their enrollees dropped in any 1 year from 1998 to 2003 were South Dakota, the Mount Rushmore State, 99 percent; Delaware, the First State, 95 percent; Arkansas, the Land of Opportunity, 90 percent; New Hampshire, 85 percent; Maine, 82 percent; Maryland, 79 percent; Utah, 76 percent; District of Columbia, 71 percent; Kansas, 54 percent of the people dropped; Connecticut, 52 percent of the people dropped. It goes on and on.

Mr. Speaker, over 80 percent of rural Medicare beneficiaries today live in an area that private insurance companies have made a choice, that is the choice, they have made a choice not to serve. Now please note, this is not an entitlement program. This is not entitlement as we know it under Medicare. You have no guarantee. This is this kind of an entitlement, it is an entitlement to ask to be able to make an offer to purchase a plan from a reluctant, profit-seeking insurance company that may or may not accept your offer.

By the way, it is very important to note this: not a single insurance company in the United States of America has agreed to take part in this program. Let me say that again. Not one single insurance company in the United States of America has agreed to take part in this plan anywhere in America. That is a fact.

Furthermore, even if they do decide to participate at some time in the future because they think they can make big profits, under this latest Republican drug proposal, if the private drug plan or insurance company decides rural America is not lucrative enough for their company, they can withdraw every 12 months. So much for our seniors having the choice of continuity of care.

Knowing this, how can we approve a plan that does not even have a fallback option of traditional Medicare providing drug coverage if private care pulls out? How is that a fair choice for the 9.3 million seniors and disabled folks that live in America? What kind of choice is that?

Let us be clear, this legislation does not and this legislation cannot require insurance companies to offer prescription drug plans in rural America, and they will not. They have not and they will not. If we are going to talk about the choice of being fair, we are going to have to talk about prices. Under this bill, the HMOs and pharmaceutical companies are given the express choice, there is that word again, they are given the choice to determine how much to charge and what prescription drugs to offer seniors and the disabled.

Mr. Speaker, what do you think they are going to choose: high prices or low prices? More coverage or will they choose less coverage? Mr. Speaker, the answer is clear, it is profits over people. That is their choice.

Yesterday the President said, "When the government determines which drugs are covered and which illnesses are treated, patients face delays and inflexible limits on coverage." Yet now he wants to turn over those very decisions to insurance companies who have a financial interest, who have a financial gain to make in denying coverage to America's seniors. They make more money, the more seniors they deny, the more money they make and the circle goes on and on. That is not a good choice.

We have an opportunity to deliver a true prescription drug plan to our seniors this week, and to do so Congress must come together and choose to soundly reject this Republican albatross, this madness. If we shine a light on this, we can see the many problems with this sham prescription drug proposal. It does not provide a guaranteed, defined set of costs and benefits; it does nothing to reduce the high price Medicare beneficiaries are forced to pay for their prescription drugs. For seniors it is simply high on cost and low on benefits with a gap in coverage so large that our seniors would forget they have a drug benefit if they were not still writing a monthly check for the premium while they were not getting any benefits. Still paying a premium, not getting any coverage. That is not a nice choice.

Our Republican colleagues say we do not have enough money to give a better prescription drug benefit. Mr. Speaker, that, too, is just a bad choice they have made, to enact $1.7 trillion in tax cuts. While we are paying $1 billion a day in interest for the wealthy rather than serve our Nation's seniors is an outrageous and true reflection of their priorities. It shows you where their heart is. You can get lost in the details, but the result is clear. This is a terrible piece of legislation. Let us forget the gimmicks, it is time to deliver a real drug plan to our Nation's seniors. All they want is an affordable drug benefit with a reasonable premium cost that is defined and meaningful benefits, and that means a benefit without a $3,000 gap in coverage. They just want a benefit that is available to all seniors regardless of whether they live in Texas or California or New York City.

□ 2320

The Republican plan is just a shameless smoke and mirrors scheme. Let us reject this tired bait and switch scam. We know the end game, do we not? Everybody in here does. Former Republican Speaker of the House Newt Gingrich said Medicare should wither on the vine, and recently our Republican colleague in the other body, Senator SANTORUM, said traditional Medicare should be phased out. That is the goal. That is the object. That is the plan.

Let me read something I did not say, something the Republicans did not say, something the Democrats did not say. This is in Newsday June 23, 2003. "The House proposal would replace Medicare's guaranteed coverage with a guarantee only that the elderly would get a sum of money to buy whatever kind of benefits at whatever price private insurers chose to offer. Those who want traditional fee for service Medicare would be forced to pay higher premiums. So at least now we know the drug plan, skimpy and fraught with uncertainties, is merely a cover for achieving former House Speaker Newt Gingrich's dream of forcing Medicare to wither on the vine." Newsday. That is the plan.

This ill-conceived and inadequate plan is not an attempt to provide drug coverage to seniors. It is an attempt to set up the very destruction of Medicare and place HMOs and insurance companies in the catbird seat. It is as simple as that. We all know that.

Now Congress has to make a choice. Seniors and healthcare, HMOs and profits, privatization or Medicare. Mr. Speaker, it is our choice to make. Whom do we stand for? Whom do we stand for in the United States Congress?

Mr. BERRY. Mr. Speaker, I thank the gentleman from Texas for his great leadership in this matter and continued willingness to do the battle on behalf of our senior citizens in this country.

I yield to the gentleman from Massachusetts (Mr. OLVER).

Mr. OLVER. Mr. Speaker, I thank the gentleman for yielding, and I want to commend the gentleman from Arkansas for bringing this particularly important issue before us because this plan is a particularly cynical plan as far as it affects rural districts around America. People do not usually think of my Massachusetts district in the western and northwestern part of the State of Massachusetts as being a rural district, but it is in fact that.

Mr. Speaker, rural seniors like all seniors need help now paying for their prescription drugs. The Republican leadership's prescription drug plan leaves seniors waiting 3 years more for relief. But by 2006 when it finally goes into effect, this ingeniously devious legislation still will not give rural seniors a prescription drug benefit because there will not be a prescription drug plan available for them to access. The Republican leadership claims this plan will provide choice for all Medicare beneficiaries. The Republicans say that seniors all across the country including rural areas will have access to two different prescription drug plans, one, a private HMO health plan which includes prescription drugs, and, two, a prescription-only plan offered by a private insurance company but deliberately not a part of the Medicare that seniors trust.

Rural seniors know that private insurers are not going to offer such plans at an affordable price. The evidence is clear. The Medicare+Choice program shows how private HMO's role in Medicare has failed in rural areas. These Medicare HMOs have abandoned millions of Medicare recipients living in rural districts like mine all over this country. Currently four out of five seniors in rural areas have no access to an HMO managed care plan under Medicare leaving rural seniors with no choice. Why have HMOs abandoned the rural areas? It does not take an economist to figure that out. With the sparse populations in rural areas, these private HMOs could not turn a big enough profit; so they had no compelling reason to stay and provide services. Since Republican leadership knows rural seniors will not fall for promises of Medicare HMOs again, they have also provided the choice of a prescription-only benefit provided by private insurance companies while allowing seniors to stay in the Medicare that they do trust.

But this legislation makes a promise of insurance that does not currently exist and can never exist in any affordable form for the exact same reason that HMO insurance plans could not make a profit in rural areas. Prescription drug costs are exorbitantly high; yet the Republican leadership expects that private insurers will be eager to provide this prescription-only benefit to the segment of the population that uses the most prescription drugs but has the least available cost. There are no incentives for the insurance industry to provide this benefit.

In the end the high premiums and high costs will fall to seniors who will be left with the same exorbitant drug costs they currently pay. Worst of all, by the year 2010, the Republican leadership is determined to undermine Medicare and eliminate the fee for service program so Medicare can be exclusively run like an HMO. This will leave no choice whatsoever because rural seniors will have neither of the plans they have been promised.

The Republican leadership is placing the lives of our rural seniors in the hands of insurance companies that they do not and cannot trust, who have abandoned them in the past but in reality by 2006 the promises being made now to rural seniors to provide a prescription drug benefit and a Medicare HMO choice will never be kept. Rural seniors will have no choice. There will be no private insurance providers riding to the rescue, and rural Medicare beneficiaries will still pay the same exorbitant drug costs they now pay.

The Republican bill nullifies every promise to take care of our poorest and sickest seniors. It is a sham and a cruel hoax for rural America.

And I want to again thank the gentleman from Arkansas for his leadership in bringing this issue before the floor this evening.

Mr. BERRY. Mr. Speaker, I thank the gentleman from Massachusetts and the gentleman from Texas.

Mr. Speaker, rural pharmacies are the only professional healthcare providers we have in many of our rural communities. If this bill were to become law, it would wipe out those institutions. It would make it impossible for them to stay in business because they would be forced to compete with a mail order operation that would be so full of gimmicks that it would be impossible. These mail order operations would be set up by the prescription drug manufacturers with the cynical reason of taking the healthcare providers out of these communities. HMOs will have an incentive to put profits before patients. Headlines in the Wall Street Journal today documents a situation exactly like that where an insurance company or a pharmacy benefits manager chose to put profits before patients.

Let us not wipe out healthcare for senior citizens in rural America. Let us deny this bill and send it back until we can do what we know that we have the ability to do, and that is to provide to seniors citizens of this country with a reasonably priced prescription medicine program that will serve them well and serve this country well.

H.R. 2544, THE MEDICAL INDEPENDENCE, PRIVACY AND INNOVATION ACT OF 2003

The SPEAKER pro tempore (Mr. GARRETT). Under the Speaker's announced policy of January 7, 2003, the gentleman from California (Mr. ROHRABACHER) is recognized for the remaining time until midnight as the designee of the majority leader.

Mr. ROHRABACHER. Mr. Speaker, before my colleagues leave, let me just note that that quote from Newt Gingrich that was bandied around earlier, we have seen that quote used many times, and those of us who have been who have seen the full quote know that that quote was taken out of context and often Mr. Gingrich pointed that out as an example of the abuse of the public trust by presenting something that was totally misrepresented.

Mr. SANDLIN. Mr. Speaker, will the gentleman yield?

Mr. ROHRABACHER. No, I would not.

Mr. Speaker, I think I control the body. I have the floor.

Mr. SANDLIN. I am just asking if the gentleman would yield.

PARLIAMENTARY INQUIRY

Mr. SANDLIN. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman has not yielded for a parliamentary inquiry.

Mr. ROHRABACHER. I would ask that the gentleman be removed from the floor.

Mr. SANDLIN. Mr. Speaker, Parliamentary inquiry.

Mr. ROHRABACHER. Mr. Speaker, I am reclaiming my time. I would ask that the Sergeant at Arms remove the gentleman from the floor if he insists on taking my time.

Mr. SANDLIN. I do not want the gentleman's time.

Mr. ROHRABACHER. I would ask the Sergeant at Arms to remove him from the floor if he continues to interrupt.

The SPEAKER pro tempore. The gentleman from California has not yielded. The gentleman from California is recognized.

Mr. ROHRABACHER. Mr. Speaker, we have seen this misuse of this quote so often in this body, and I would just like to make sure that the public is aware when they hear it misused again that Mr. Gingrich has time and time again demonstrated that that quote was being misused by people who were trying to misrepresent what he said.

□ 2330

Mr. SANDLIN. Mr. Speaker, would the gentleman yield at this point?

Mr. ROHRABACHER. Mr. Speaker, I would be happy to yield.

Mr. SANDLIN. Mr. Speaker, I would just like to ask the gentleman, if that has been misquoted, I would like the gentleman, number one, to read the entire quote, because the gentleman will see that, in fact, he did say that it should wither on the vine; and possibly the gentleman could comment on Senator SANTORUM's comment that we should phase out traditional Medicare. I thank the gentleman for yielding.

Mr. ROHRABACHER. Mr. Speaker, I thank the gentleman. Let me just note that this quote, as I have stated, has been refuted over and over again and demonstrated by Mr. Gingrich in many public forums that it was being used in a very irresponsible and dishonest manner.

I would just note now that I would like to discuss a different approach to medical independence and privacy and health insurance and the whole issue that we have been discussing tonight and will be discussing further in the next few days.

I have a piece of legislation that I would like people to consider and that I would like them to look at; it is H.R. 2544. It is a piece of legislation that I believe offers a whole new approach to medical care and health care in America.

Unfortunately, all too often, the discussion of medical reform legislation has been focusing on the allocation of more funds. Sometimes those funds would help in our society those who are lacking resources to purchase their own adequate health care and medical care; but at other times when we are talking about spending more funds, what we are not talking about is helping those who really need it and cannot provide for themselves, but what we are talking about is subsidizing everybody, whether or not they need it. Rarely does Congress, when they are focusing on just spending more money, whether or not someone needs that help, rarely do we focus on how can we do things more wisely and more efficiently, and how can we bring down the costs of getting health care that would make more people able to take care of themselves. Rarely does government focus on how to create an environment which would spur the supply of medical services, and rarely do we focus on encouraging cost-cutting innovation or to provide incentives for those who create and innovate and bring up new, cost-effective methods of dealing with illness in our society.

In essence, what government does, and what this body often does, is focus on medical care demand rather than on medical care supply. This focus all but guarantees the price of drugs and hospital care and medical treatment will continue to soar and outpace the ability of many Americans to afford the price of being healthy and; certainly, as it brings the price of health care up, it then creates even more Americans, a pool of even more Americans who cannot take care of their own health care costs. So it is a cycle that leaves even more Americans dependent on the government, and then the government creates a situation where even more Americans cannot take care of themselves.

The Federal Government took over responsibility for the health care of America's seniors back in 1965. When

Medicare was first enacted into law back in 1965, very few people remember what it was like back then. But before then, our economically disadvantaged were taken care of by tax dollars. Yes, they were. But most Americans who became seniors were expected to take care of themselves. And we need to ask ourselves, what has happened to the price of health care since the government assumed responsibility of taking care of all Americans over a certain age? What has happened to our health care since the emergence of Medicare?

Today, I dare say the price of health care is so high that it is inconceivable that most of our seniors can take care of themselves. Before Medicare, people were expected, if they could, to take care of themselves. Medicare came in and decided to take care of everybody. Now, almost nobody is able to take care of themselves.

Of course, the massive escalation of health care prices have hit the rest of the population as well as our seniors. Now, the same can be expected, I might add, of the price of prescription drugs if, indeed, we end up having the government take over, providing prescription drugs for all seniors, whether or not those seniors can afford to take care of themselves. What will happen is the price of drugs will soar, not only for seniors who will be paid for by the government, but by everyone else as well, again, making it even more difficult for people, for American citizens, to take care of their own health needs.

Last week, I introduced a bill entitled the Medical Independence, Privacy, and Innovation Act of 2003. This legislation combines a creative mix of market-oriented reforms that will encourage independence and, hence, wise personal medical care choices. If enacted, this legislation will further expand the protection of our medical care privacy. It makes long overdue changes in the Federal Drug Administration procedures that will encourage innovation and invention of new pharmaceuticals and, thus, will have a major effect on bringing down the cost of health care. This legislation, if enacted, will expand the variety, quantity, and availability of medical innovation. It is innovation, new technology, and our creative genius that will enable Americans to overcome the monumental challenge of providing health care to the baby boomer generation as this generation slips into its senior years. Today, the entire system of health care delivery needs to be reshaped if we are to prevent a collapse as the baby boomer generation begins to retire and to go on Medicare.

In my legislation, I propose a program of reforms based on sound economic principles that are vital to improving medical care in America. It assures that people make choices for themselves rather than accept bureaucratic or political mandates. Today, nonseniors, as with seniors, in fact, find that health care decisions are being taken out of their hands. So even our nonseniors now, much less our seniors, are finding that they do not control their own destiny. They do not make those health care decisions that are so important to their lives. What we have done to the nonseniors in America, while co-opting the decision of every senior in America by just suggesting no one will be taking care of themselves, even those who could, we have now taken over full responsibility and taken the decision out of their hands; but we are doing that, in a way, to the people before they become seniors.

What we have done is structured a system where the employer has become the primary source of a health care service through employer-based health insurance plans. That is a fact of life, and we just had to accept it. Well, unfortunately, it means so many resources and so much power has been co-opted that consumer sovereignty and responsibility has been all but negated. Most people really do not have a choice. It is what the boss offers. If the boss offers it, it is take it or leave it.

There is an old economic truth, by the way, and that is, if the cost of a private or public good approach is zero, that means if you are being offered something and there is no cost to you taking advantage of it, there will be overuse and a waste of that good.

Today's system leaves us with almost no personal choices, but it leaves us with a system that does not rely at all on personal responsibility. We have no choices, and there is no personal responsibility as part of the system. It leaves people, American citizens, with a sense of helplessness and hopelessness and resigned to whatever is going to happen to them that is totally inconsistent with our heritage as a free people.

□ 2340

We spend more and more money on health care. We spend, in fact, more money on health care supposedly than any other country of the world. So as you are listening to people debate the issue of Medicare and debate the issue of prescription drugs and debate the issues of health care in America, remember we already spend more money by far than any other country of the world.

Perhaps part of this is due to the fact that individual responsibility has all been extracted from the system because what it is is we spend more money but we do not have the best health care system in the world and our people are not getting what they pay for or what is being paid for in the United States of America. We have, as I say, all but extracted from our system the idea of individual responsibility and personal authority over one's destiny, not to mention, of course, the profiteering and exploitation of the system by lawyers.

Now, it is time to make a new approach and our system and my bill does not reflect on the exploitation of our system by lawyers. That is another bill. That is a whole different area. But those are obviously one group of people who siphon money out of the system that should be going to people's health care. It is time to take a new approach and, again, over and above the medical malpractice situation.

It is time to take a new approach and what we need, for example, in my legislation, I am proposing that we establish medical checking accounts that incorporate both deductions and credits into our system so that our people will be free to control their own destinies.

Many American families would benefit through the ideas that I am proposing in my legislation. They would benefit by being able to purchase high deductible catastrophic health insurance plans and pay for the year to year or day to day doctor, dentist and pharmaceutical costs out of a medical checking account.

I have sat in my office with self-employed constituents who would love to be able to design their own package of medical care coverage. This approach would protect their family against the huge costs of serious medical illness, of accidents or some type of illness or disease, but it would allow them to pay out of their pocket for normal month to month costs.

Now, imagine how the intelligently a consumer spending his money would help to limit overspending and overutilization of insurance coverage. Imagine in a society where individual families could shop around for medical insurance plans that suit their needs and not have to squeeze their lifestyles into their employer options. My bill would, for example, in the end and it would end the unfair discrimination against individuals who seek independent alternatives to their employer health insurance plans that are mandated in many big businesses or many normal businesses as well, I might add. It would naturally integrate market discipline through personal choice and responsibility into Medicare spending.

My plan creates a medical checking account plan where the account base of $4,000 per family or $2,000 for an individual is built with tax deductible dollars and the estimated yearly variable costs are built in with a $1,000 tax credit replenished on a yearly basis. Now, we are beginning to find out that once we have been relegated, as we are in our current system, to cogs in a machine, either big government or big business machine, that the rights of privacy are no longer paramount or even considered. My legislation would reestablish the principle that a person owns his own medical history and must consent before it is passed on to others.

The emergence of big government and big insurance as the dominant force in health care has eroded the ideas of medical privacy, if not totally just extinguished it. It is time to swing the pendulum back. My bill restores the issue of prior consent and protects the private relationship information relationship between patient and doctor. It eliminates loopholes in the current law that will result in unsolicited merchandising, disclosures of private medical information and the diminishing privacy for millions of Americans.

Americans have visited their local pharmacy and many millions of have visited the pharmacy in the past several months and have been asked to sign a new HIPAA notice. Do these Americans realize that what they are signing is a set of rules that undermines their right to disclose or not to disclose their private and personal medical history?

This country was at one time based on the principle that you owned your medical history and that your property is your property and without your concept that that information should not be placed in the hands of another, whether that person is in big government or private corporations. We need to go back to that principle. When big government starts taking the power, of course, to protect us from ourselves, and that is what they always say, they are trying to protect us from ourselves, not just protect the people who cannot help themselves but protect everybody. They are protecting us from ourselves, you better watch out.

The government can and is protecting us to death. Not from death. They are protecting us to death. Today, for example, FDA approval standards require new pharmaceuticals not just be safe, new pharmaceuticals coming on the market, the requirement is not that they be safe, they have to be nearly 100 percent effective for everyone. It is a 96 percent efficacy rate that is demanded by the Federal Government. That makes it dramatically longer more difficult and more costly for a new drug to get on the mark. By doing this we are condemning hundreds of thousands of people to needless suffering with these overly high standards, we create hurdles to development of new drugs urgently needed and we end up preventing the use of drugs that are already available to help people, but it might only help 75 percent of the people. But if it only helps 75 percent, that cannot go on the market because the rule is it has to be 96 percent effective.

No, this is not fair and it is not right. And it is no coincidence that families of victims of leukemia, cancer, AIDS and other diseases plead to no avail for the abilities to use drugs that were legally available throughout the world. I have sat if my office with constituents who have children with leukemia or siblings with AIDS or patients with cancer who beg for us to do something to allow them to have those pharmaceutical products that are available to people in other countries. Tragically at the same time, as new drugs are provided, or excuse me, are approved for both safety and efficacy, those drugs who do manage to jump all the hurdles and become effective for almost everybody, it ends up where the price is sky high and very few people can afford them.

Then there is the case, of course, where inventors often place on their shelves and innovators and researchers and developers and scientists, they put on their shelves unused and undeveloped many innovative potential technologies and products because they can not afford the exorbitant costs of passing all of these FDA efficacy tests and are making it absolutely prove that 96 percent of the people will be totally cured by this drug.

Well, that makes no sense if 85 percent of the people are going to be cured by a drug, and I have sat in my office with inventors who have told me horror stories of these new inventions that they have but they will not bring them out because they cannot jump over these FDA hurdles.

Well, why does the FDA regulation concerning, for example, drug cocktailing today block the availability of new innovation? Why are we so afraid of new innovation? That new invasion can be set on the standard of it does no harm. I am proposing that we have the standard of it does no harm rather than a 96 percent or 100 percent efficacy rate. That is, it seems to me that that is what we should leave in the hands of the American people, the right to choose drugs that will do them no harm and they should have a right to take them if they feel, especially with the doctor's prescription that they can take that drug and treat themselves even if only 85 percent are cured rather than 96 percent.

Today, websites, consumer interest groups, investigative reporting will make the people of our country, with the help of their doctors who can help them with prescriptions and give them advice, they help the American people fully able to make these choices that were not possibly available to them or maybe the American people could not do it in the past.

Another oddity in the current system that drives up the price of drugs, not just this 96 percent efficacy standard that is insisted upon, one thing that drives up the price for drugs for Americans is the way we deal with the ownership rights of inventors, of those very same inventors and innovators that develop new drugs and find new ways of treating people more efficiently and for less costs in the long run.

□ 2350

What we do, if an individual or a corporation invests tens of millions or hundreds of millions of dollars in developing a new health alternative, all too often it takes years for them to get through this FAA approval process and the other governmental restrictions, and by the time a new drug or health care technology can be sold to the American people, almost all of the ownership time that the innovator and the patent owner has has been used up. So you only have about 20 years or 17 years with a patent, and if it takes them 15 years to get through the process, the company has to immediately charge a huge amount of money for that drug in order to cover its cost of development, to get it back, and then, of course, the drug has been held up for all of these other years. So it has not been available to the public; and then, of course, when it gets on the market we end up putting the company in a situation where it has to charge even more money to recoup its investment.

My bill speeds up the process. It basically establishes that the patent clock does not start ticking against that company until the drug can be put on the market, until it is actually sold. Thus, new drugs, rather than waiting for 20 years or waiting for 15 years, can be put on the market sooner because people want to get this thing on the market because they have lowered those FDA restrictions and the company will make money over that time period.

My bill also makes sure that once that patent term runs out, unlike today, there are many legal maneuvers these companies can play in order to keep the generic drug manufacturers from coming in and producing their drug. We eliminate those maneuvers.

So what we have done is put a drug available on the market and in the hands of the American consumer earlier and cheaper, and then we make sure that the drug companies can make a profit, and we end up making sure that the generic manufacturers can jump in earlier without being deterred by legal maneuvers.

In the end, my bill gives the people more access, more time with the drug. It can cure more people. Hundreds of thousands of people, if not millions of people, will be available to be treated with a new, innovative approach, drug, or a new health technology if my legislation sets these new standards and we move forward with a system based on those standards, rather than protecting the people of the United States to death, which is precisely what we have been doing. When we hear the FDA say we are approving the drug today and it is going to save the lives of 10,000 people a year who are dying from this disease, and then you find out it is taking 10 years for the drug to get on the market, that FDA official has just admitted that they have been in the process of participating in the unnecessary death of 100,000 people. That is ridiculous.

As we expand the ability of our drug innovators to create and make available new drugs that will, under my legislation, be protected, they will be able to make a profit at what they are doing; and the public will actually have more choice in their hands, and what we need to know, by the way, on the other hand, if the taxpayers end up financing, and there are some drug companies, we have to admit, they get money from the government to try to develop new drugs, they are subsidized by the taxpayers in developing new drugs. My bill will say if a company does that, if a private company does that, they will be subject to price controls, meaning if Uncle Sam pays the price of research and development, Uncle Sam will tell you what is a reasonable price to have on that drug; and the consumers will be protected right off the bat, even though there will be a reasonable profit margin made as well, but my bill insists that the government then put a reasonable price on that drug if the taxpayers did pay for that research.

If a company pays for its own research and development, which we want to encourage more companies to do, they will not be limited by this type of price control.

By encouraging private investment, and whether it is in the development and research of drugs or in other types of health care technology, we will thus be increasing the supply of health care of those things in our society which treat people's illnesses. By increasing that supply, it should help bring down the cost and thus the price of health care to our people. More new drugs and more new technology that can help bring health to our people being introduced on the market, that means a healthier life and a more affordable healthy life for our people.

The medical reform bill I have introduced is a creative package of reforms. I urge all of the Members and fellow colleagues to study these proposals and to support this legislation. As health care costs are obviously going up and even ordinary Americans are struggling to pay the bill and many Americans, of course, cannot pay it all, it is imperative that we begin to seriously think about new approaches to health care.

If the only thing that comes to us while we are looking at the Medicare system and the problem of health care in America is just the only thing we come up with is spending more and more money, we are going to increase the demand for drugs in our society. For example, if all we are doing is taking now a financial situation where the people who can pay for their own health care and their own prescriptions do so and we end up having the government take over all of that, we are going to end up not only dramatically increasing the price of drugs for the government but those people outside the government, younger people, the price of their drugs will dramatically go up.

No, we cannot just simply handle this Medicare system, of course, by dramatically increasing the price of drugs, which will happen, will make sure the Medicare goes bankrupt much earlier than is scheduled. Right now, in the outyears, we can try to do something to keep Medicare solvent. If we are just going to take responsibility for everyone, even the people who can take care of themselves in terms of a drug benefit, it is going to bankrupt the system; and we will all be worse off, and the price of drugs will soar for ordinary families who are not seniors.

We ignore half the problem if we only try to spend money. We need to free up the supply end of the medical care system, the supply of people who will be producing more health care for America. Yet we also have to be, of course, concerned about the escalating costs; but we cannot be stampeded into easy answers, quick fixes, because those just spending more money without creating any innovation in the system or any reforms in the system, it will make all of our problems worse. Backing up the Federal dump truck and just pouring in a mammoth load of tax money is not a quick fix. It will not work; and with new expenditures, it is going to bankrupt the system and cause the price of drugs to go sky high for all the American people, not just the seniors.

No, the tooth fairy is not going to leave the money that is going to be spent on health care and improving our health care system under our pillow. Each and every one of us will pay. So it is irresponsible not to try to make the system more competitive, less bureaucratic, more innovative as we are talk about expanding Medicare and trying to take care of those people who need prescription drugs but cannot afford it.

Our focus should be on those who cannot afford it rather than coopting this whole field and trying to take care of everybody. A government that tries to do everything for everybody is not going to be able to do anything for anybody in the long run as this economic insanity takes hold and has its effect on our society. We are going to make our problems for insurance worse if we do not try to make our system more effective and cost effective.

One last note about health care in America. In recent years, Americans have witnessed an explosion of alternative health care health-related nutrition, acupuncture, chiropractic, vitamins, exercise, mental health programs that are based on self-help and individual responsibility. These are exciting, new alternatives; and most of them are not even covered by insurance, much less being paid for by the tax dollars. The American people need to have these available to them, these and other vehicles for a good healthy life; and we must use mass communications and the Internet to make sure our people know what their alternatives are, but instead, now what are we focusing on here in the Federal Government, instead we are just trying to focus on spending more money.

New opportunities are needed. We do not need to just regulate these new approaches and these new things that people can do for health care. We do not need to regulate it, control it or ration it. We need, like my legislation will do, is to open up new opportunities. My legislation is based on the principles of freedom and the incentives of the market. This at least will have to be part of the solution, if not the entire solution, we seek to the challenges we face today.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Ms. GINNY BROWN-WAITE of Florida (at the request of Mr. DELAY) for today on account of medical reasons.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. PALLONE) to revise and extend their remarks and include extraneous material:)

Mr. HINCHEY, for 5 minutes, today.

Mr. BROWN of Ohio, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. EMANUEL, for 5 minutes, today.

Ms. KILPATRICK, for 5 minutes, today.

Ms. CORRINE BROWN of Florida, for 5 minutes, today.

Mr. MCDERMOTT, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. HOEFFEL, for 5 minutes, today.

Ms. EDDIE BERNICE JOHNSON of Texas, for 5 minutes, today.

Mr. HOLT, for 5 minutes, today.

Ms. WATSON, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Mrs. CAPPS, for 5 minutes, today.

Mr. WEXLER, for 5 minutes, today.

Ms. MILLENDER-MCDONALD, for 5 minutes, today.

Mr. BERRY, for 5 minutes, today.

Mr. BALLANCE, for 5 minutes, today.

Mr. SANDLIN, for 5 minutes, today.

Mr. STRICKLAND, for 5 minutes, today.

Mr. HONDA, for 5 minutes, today.

Mr. ROSS, for 5 minutes, today.

Mr. ALLEN, for 5 minutes, today.

Mr. DAVIS of Alabama, for 5 minutes, today.

Mr. THOMPSON of Mississippi, for 5 minutes, today.

Mr. TURNER of Texas, for 5 minutes, today.

Mr. TANNER, for 5 minutes, today.

Mr. STENHOLM, for 5 minutes, today.

(The following Members (at the request of Mr. MORAN of Kansas) to revise and extend their remarks and include extraneous material:)

Mr. KING of Iowa, for 5 minutes, today.

Mr. SHUSTER, for 5 minutes, today.

Mr. NUSSLE, for 5 minutes, today.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 239. An act to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes; to the Committee on Energy and Commerce.

S. 1157. An act to establish within the Smithsonian Institution the National Museum of African American History and Culture, and for other purposes; to the Committee on House Administration; in addition to the Committee on Transportation and Infrastructure for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

ADJOURNMENT

Mr. ROHRABACHER. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at midnight), the House adjourned until tomorrow, Wednesday, June 25, 2003, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2800. A letter from the Director, Regulatory Review Group, FSA, Department of Agriculture, transmitting the Department's final rule—2002 Marketing Quota and Price Support for Flue-Cured Tobacco (RIN: 0560–AG60) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2801. A letter from the Secretary, Bureau of Consumer Protection, Federal Trade Commission, transmitting the Commission's final rule—Rule Concerning Disclosures Regarding Energy Consumption and Water Use of Certain Home Appliances and Other Products Required Under the Energy Policy and Conservation Act (RIN: 3084–AA74) received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2802. A communication from the President of the United States, transmitting the bimonthly report on progress toward a negotiated settlement of the Cyprus question covering the period April 1, 2003 through May 31, 2003, pursuant to 22 U.S.C. 2373(c); to the Committee on International Relations.

2803. A letter from the Assistant Secretary for Export Administration, Department of Commerce, transmitting the Department's final rule—Export Administration Regulations: Encryption Clarifications and Revisions [Docket No. 030529136–3136–01] (RIN: 0694–AC78) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on International Relations.

2804. A letter from the Assistant Secretary for Export Administration, Department of Commerce, transmitting the Department's final rule—Implementation of the Understandings Reached at the June 2002 Australia Group (AG) Plenary Meeting and the AG Intersessional Decision on Cross Flow Filtration Equipment—Chemical and Biological Weapons Controls in the Export Administration Regulations [Docket No. 030523133–3133–01] (RIN: 0694–AC70) received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on International Relations.

2805. A letter from the Assistant Administrator for Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Atlantic Highly Migratory Species (HMS); Fishing Vessel Permits; Charter Boat Operations; Temporary Rule [Docket No. 020325070–3146–04; I.D. 071299C] (RIN: 0648–AM91) received June 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2806. A letter from the Deputy Assistant Administrator for Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Adminstration's final rule—Fisheries of the Northeastern United States; Atlantic Mackerel, Squid and Butterfish Fisheries; Framework Adjustment 3 [Docket No. 030314060–3126–02; I.D. 021003E] (RIN: 0648–AQ57) received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2807. A letter from the Assistant Administrator, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Atlantic Highly Migratory Species; Incidental Catch Requirements of Bluefin Tuna [Docket No. 001113318–3128–03; I.D. 110200D] (RIN: 0648–AO75) received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2808. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Fisheries of the Exclusive Economic Zone Off Alaska; Yellowfin Sole by Vessels Using Trawl Gear in Bering Sea and Aleutian Islands Management Area [Docket No. 021212307–3037–02; I.D. 06030F] received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2809. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety and Security Zones; First Lady's Visit, Boston, MA [CGD01–02–127] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2810. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety and Security Zones; Presidential Visit, Seaport Hotel/World Trade Center, South Boston, MA [CGD01–02–119] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2811. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Savannah River, Savannah, GA [COTP Savannah 02–134] (RIN: 2115–AE46) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2812. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Northeast Cape Fear River, Wilmington, North Carolina [COTP Wilmington 02–001] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2813. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; TUG NARRAGANSETT and Tow TRIPOLI, San Francisco Bay, CA [COTP San Francisco Bay 02–020] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2814. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Ohio River, Miles 468.5 to 473.0, Cincinnati, OH [COTP Louisville 02–008] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2815. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Elk River Miles 0.00 to 2.0, Charleston, WV [COTP Huntington 02–010] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2816. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone Regulations, Motor Vessel BRIGHT STATE, Puget Sound, Washington [CGD13–02–019] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2817. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Captain of the Port Chicago Zone, Lake Michigan [CGD 09–02–525] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2818. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Fore River and Long Creek, Portland, ME [CGD01–02–125] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2819. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Verrazano Narrows Bridge, New York [CGD01–02–126] (RIN: 2115–AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2820. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Security Zone; Port of

New York/New Jersey [CGD01-02-149] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2821. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zone; Chicago River, Chicago, IL [CGD09-02-524] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2822. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zone: San Diego Bay, San Diego, CA [COTP San Diego 02-020] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2823. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zone: San Francisco Bay, California [COTP San Francisco Bay; 02-021] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2824. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zone; Las Mareas Harbor, Guayama, Puerto Rico [COTP San Juan 02-126] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2825. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zone, York River, West Point, VA [CGD05-02-081] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2826. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zone; Norfolk Harbor Entrance Reach Channel, Chesapeake Bay, Hampton Roads, VA [CGD05-02-098] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2827. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zone; Closure of all navigable waterways to all marine traffic in the Captain of the Port (COTP) Port Arthur Area of Responsibility (AOR) as defined in 33 CFR 3.40-20 [COTP Port Arthur 02-007] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2828. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Regulated Navigation Area in Hampton Roads, VA [CGD05-02-099] (RIN: 1625-AA11 (Formerly RIN: 2115-AE84)) received June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2829. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Drawbridge Operation Regulations; Manasquan River, NJ [CGD05-02-054] (RIN: 1625-AA09) received June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2830. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Drawbridge Operation Regulation; Alabama River at Coy, AL [CGD08-03-018] (RIN: 1625-AA09) received June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2831. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting The Department's final rule—Safety Zone; Detroit River, Detroit, MI [CGD09-03-216] (RIN: 1625-AA00) received June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2832. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule—Safety Zones, Security Zones and Regulated Navigation Areas [USCG-2003-15023] received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2833. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—IFR Altitudes; Miscellaneous Amendments [Docket No. 30362; Amdt. No. 441] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2834. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule—IFR Altitudes; Miscellaneous Amendments [Docket No. 30354; Amdt. No. 440] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2835. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule—Determination of Interest Rate (Rev. Rul. 2003-63) received June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

2836. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule—Automatic Extension of Time to File Certain Information Returns and Exempt Organization Returns [TD 9061] (RIN: 1545-BB55) received June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

2837. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule—Coordination of sections 755 and 1060; Allocation of basis adjustments among partnership assets and application of the residual method to certain partnership transactions [TD 9059] (RIN: 1545-AX18) received June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

2838. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule—Minimum Vesting Standards (Rev. Rul. 2003-65) Recieved June 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mrs. MYRICK: Committee on Rules. House Resolution 295. Resolution providing for consideration of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes (Rept. 108-176). Referred to the House Calendar.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. EDWARDS (for himself, Mr. Evans, Mr. Skelton, Mr. Marshall, and Mr. Filner):

H.R. 2569. A bill to improve benefits for members of the Armed Forces and veterans and for their dependents and survivors; to the Committee on Armed Services, and in addition to the Committees on Veterans' Affairs, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. DeFAZIO (for himself, Mr. Markey, Mr. Frank of Massachusetts, Mr. Cardin, Ms. Slaughter, Mrs. Christensen, Mr. Etheridge, Ms. DeLauro, Mr. Case, Mr. Grijalva, Mr. McDermott, Mr. Crowley, Mr. Bell, Mr. Ballance, Mr. Rahall, Mr. McGovern, Ms. Linda T. Sánchez of California, Mr. Doyle, Ms. Jackson-Lee of Texas, Mr. Stark, Ms. Carson of Indiana, Mrs. Maloney, Mr. Hastings of Florida, Ms. Solis, Ms. Hooley of Oregon, Mr. Sanders, Mr. Lipinski, Mr. Costello, Mr. Gutierrez, Mr. George Miller of California, Mr. Farr, Mr. Thompson of California, Mr. Kucinich, Mrs. Davis of California, Mr. Blumenauer, Mr. Hinchey, Mr. Capuano, Mr. Tierney, Mr. Kennedy of Rhode Island, Mr. Honda, Ms. Berkley, Ms. Kaptur, and Ms. Baldwin):

H.R. 2570. A bill to direct the Secretary of Homeland Security to reimburse States for direct expenses and losses incurred by State and local government entities during the effective period of a high threat condition (Code Orange) or severe threat condition (Code Red) declared by the Secretary of Homeland Security, that are in excess of normal operating expenses; to the Committee on Transportation and Infrastructure, and in addition to the Committees on Energy and Commerce, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. YOUNG of Alaska (for himself, Mr. Oberstar, Mr. Quinn, and Ms. Corrine Brown of Florida):

H.R. 2571. A bill to provide for the financing of high-speed rail infrastructure, and for other purposes; to the Committee on Transportation and Infrastructure, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. YOUNG of Alaska (for himself, Mr. Oberstar, Mr. Quinn, and Ms. Corrine Brown of Florida):

H.R. 2572. A bill to authorize appropriations for the benefit of Amtrak for fiscal years 2004 through 2006, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. LATOURETTE (for himself, Ms. Norton, Mr. Young of Alaska, and Mr. Oberstar):

H.R. 2573. A bill to amend title 40, United States Code, to make reforms in the management and development of Federal real property; to the Committee on Transportation and Infrastructure.

By Mr. KUCINICH (for himself, Mr. Conyers, Mr. Serrano, Mr. Evans, Mr. Frank of Massachusetts, Mr. Sanders, Ms. Lee, Ms. Eddie Bernice Johnson of Texas, Mr. Ballance, Ms. Norton, Mr. Acevedo-Vilá, Mr. Cummings, Ms. Carson of Indiana, Mr. Rush, Mr. Langevin, Mr. Clay, Ms. Woolsey, Mr. Stark, Mr. Filner, Mr. Owens, Ms. Watson, Mr. Davis of Illinois, Mr. Hastings of Florida, Mr. Rangel, Ms. Waters, Mr. Delahunt, Mr. Towns, Mr. Lewis of Georgia, Mr. Clyburn, Mr. Jackson of Illinois, Mr. Hinchey, Ms. Slaughter, Ms. Majette, Mr. Watt, Mr. Fattah, Ms. Kilpatrick, Mr. Payne, and Ms. Baldwin):

H.R. 2574. A bill to abolish the death penalty under Federal law; to the Committee on the Judiciary.

By Mr. BAKER (for himself, Mr. Ose, Mr. Bachus, Mr. King of New York, Mr. Leach, Mr. Shays, Mr. Linder, Ms. Ginny Brown-Waite of Florida, Mr. Cox, Mr. Ryan of Wisconsin, Mr. Gary G. Miller of California, Mr. Renzi, Mr. Manzullo, Ms. Hart, Mr. Hoekstra, Mr. Jones of North Carolina, Mr. Toomey, Mr. Hensarling, Mr. Gillmor, Mr. Lucas of Oklahoma, and Ms. Harris):

H.R. 2575. A bill to reform the regulation of certain housing-related Government-sponsored enterprises, and for other purposes; to the Committee on Financial Services.

By Mr. BRADY of Pennsylvania (for himself, Mr. Evans, Mr. Weldon of Pennsylvania, Mr. Platts, Mr. Fattah, Mr. Abercrombie, Mr. Larson of Connecticut, Mr. Capuano, Mr. Pascrell, Mr. Israel, Mr. Markey, Ms. Kaptur, Mr. McGovern, Mr. Hoeffel, Mr. Towns, Mr. Filner, Mr. Acevedo-Vilá, Mr. Frost, Ms. Woolsey, Mr. George Miller of California, Mr. Lipinski, Mrs. Christensen, Mrs. Davis of California, Mrs. Tauscher, Mr. Meehan, Mr. Hill, Mr. Jefferson, Mr. Kanjorski, Mr. Murtha, Mr. Doyle, Mr. Holden, Mr. Ryan of Ohio, and Mr. Wu):

H.R. 2576. A bill to amend the Soldiers' and Sailors' Civil Relief Act of 1940 to enhance the protection of credit ratings of active duty military personnel who are activated for military service; to the Committee on Veterans' Affairs.

By Mr. BURGESS (for himself and Mr. Bishop of Utah):

H.R. 2577. A bill to require the Comptroller General to conduct a study and submit to Congress a report on price controls of foreign governments on pharmaceuticals; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BURR (for himself, Mr. Barton of Texas, Mr. Buyer, Mr. Norwood, Mr. Shadegg, Mr. Akin, Mr. Bartlett of Maryland, Mr. Burgess, Mrs. Cubin, Mr. Hoekstra, Mr. King of Iowa, Mr. Kline, Mr. Otter, Mr. Pitts, Mr. Toomey, Mr. Weldon of Florida, Mr. Garrett of New Jersey, and Mr. Jones of North Carolina):

H.R. 2578. A bill to amend title XVIII of the Social Security Act to establish a voluntary Medicare outpatient prescription drug discount and security program; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CAMP (for himself, Mr. Pomeroy, Mr. Goodlatte, Mr. Blunt, Mr. McInnis, Mr. Houghton, Mr. Peterson of Minnesota, Mr. Boehner, Mr. Holden, Mr. Gutknecht, Mr. Upton, Mr. Moran of Kansas, Mr. Janklow, Mr. Ross, Mr. Rehberg, Mrs. Miller of Michigan, Mr. Manzullo, Mr. Bereuter, Mr. Burns, Mr. Hoekstra, Mr. Rogers of Michigan, Mr. Graves, Mr. Nunes, Mr. Scott of Georgia, Mr. King of Iowa, Mr. Case, Mr. McHugh, Mr. Hayes, Mr. Ose, Mr. Pombo, Mr. Shimkus, Mr. Smith of Michigan, Mr. Lewis of Kentucky, and Mr. Ramstad):

H.R. 2579. A bill to amend the Trade Act of 1974 to establish procedures for identifying countries that deny market access for agricultural products of the United States, and for other purposes; to the Committee on Ways and Means.

By Mr. CLYBURN:

H.R. 2580. A bill to establish the Congaree Swamp National Park in the State of South Carolina, and for other purposes; to the Committee on Resources.

By Mrs. JO ANN DAVIS of Virginia:

H.R. 2581. A bill to authorize State and local governments to petition the Administrator of the Environmental Protection Agency for enforcement of certain violations of the Solid Waste Disposal Act, and to require the establishment of a manifest system for the interstate transportation of solid waste; to the Committee on Energy and Commerce.

By Mr. DEUTSCH:

H.R. 2582. A bill to amend the State eligibility provisions for grants under section 106 of the Child Abuse Prevention and Treatment Act to ensure that State foster care agencies meet certain requirements if the agencies have knowledge that foster children under the responsibility of the State are missing; to the Committee on Education and the Workforce.

By Mr. DUNCAN:

H.R. 2583. A bill to amend title II of the Social Security Act to allow remarried widows, widowers, and surviving divorced spouses to become or remain entitled to widow's or widower's insurance benefits if the prior marriage was for at least 10 years; to the Committee on Ways and Means.

By Mr. FALEOMAVAEGA (for himself, Mr. Gallegly, Mr. Burton of Indiana, and Ms. Bordallo):

H.R. 2584. A bill to provide for the conveyance to the Utrok Atoll local government of a decommissioned National Oceanic and Atmospheric Administration ship; to the Committee on Resources.

By Mr. FRANK of Massachusetts (for himself, Mr. Cannon, Mr. Filner, and Mr. Frost):

H.R. 2585. A bill to amend the Immigration and Nationality Act to permit certain long-term permanent resident aliens to seek cancellation of removal under such Act, and for other purposes; to the Committee on the Judiciary.

By Mr. GREEN of Wisconsin:

H.R. 2586. A bill to provide for the conveyance of certain National Forest System lands to the towns of Laona and Wabeno, Wisconsin; to the Committee on Agriculture.

By Mr. HOLDEN (for himself, Mr. Boyd, Mr. Engel, Mr. Hinchey, Mr. McGovern, Mr. Reyes, Mr. Gillmor, Mr. Frost, Mr. Upton, Mr. Simmons, and Mr. Weldon of Pennsylvania):

H.R. 2587. A bill to amend title 10, United States Code, to establish a combat badge for helicopter medical evacuation ambulance (Medevac) pilots and crews; to the Committee on Armed Services.

By Mr. KING of Iowa:

H.R. 2588. A bill to establish under the Medicare Program under title XVIII of the Social Security Act incentives to health care providers for delivering high-quality, cost-effective health care to Medicare beneficiaries; to the Committee on Ways and Means.

By Mr. LUCAS of Kentucky:

H.R. 2589. A bill to amend title 40, United States Code, to add Nicholas and Robertson Counties, Kentucky, to the Appalachian region; to the Committee on Transportation and Infrastructure.

By Mr. PALLONE:

H.R. 2590. A bill to amend the Immigration and Nationality Act to permit the admission to the United States of nonimmigrant students and visitors who are the spouses and children of United States permanent resident aliens, and for other purposes; to the Committee on the Judiciary.

By Mr. PORTER:

H.R. 2591. A bill to amend the Internal Revenue Code of 1986 to provide for Small Business Protection Accounts, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Small Business, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PUTNAM (for himself, Mr. Cardoza, Mr. Baca, Mr. Nunes, Mr. Filner, Mr. Foley, Mr. Radanovich, Mr. Boyd, Ms. Harris, and Mr. Pombo):

H.R. 2592. A bill to promote improved nutrition for needy Americans, including women, infants, children, and students, by revising and enhancing Federal nutrition programs to incorporate a greater role for fruits, vegetables, and 100 percent juice products; to the Committee on Education and the Workforce, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. RADANOVICH (for himself, Ms. Ros-Lehtinen, and Ms. Harman):

H.R. 2593. A bill to provide veterans benefits to certain individuals who serve in the United States Merchant Marine during a period of war; to the Committee on Veterans' Affairs.

By Mr. REYES (for himself, Mr. Rodriguez, Mr. Ortiz, Mr. Filner, and Mr. Hinojosa):

H.R. 2594. A bill to establish an Adult Job Corps demonstration program for the United States-Mexico border area; to the Committee on Education and the Workforce.

By Mr. SAM JOHNSON of Texas (for himself, Mr. CRANE, Mr. LINDER, Mr. TAUZIN, Mr. DOOLITTLE, and Mr. CULBERSON):

H.J. Res. 61. A joint resolution proposing an amendment to the Constitution of the United States to abolish the Federal income tax; to the Committee on the Judiciary.

By Mr. KOLBE (for himself, Mr. PASTOR, Mr. HAYWORTH, Mr. SHADEGG, Mr. FLAKE, Mr. FRANKS of Arizona, Mr. GRIJALVA, and Mr. RENZI):

H. Con. Res. 227. Concurrent resolution expressing profound sorrow for the death of the Honorable Bob Stump and gratitude to the Honorable Bob Stump for serving the United States and the State of Arizona with honor and distinction in his 26 years as a Member of the House of Representatives; to the Committee on House Administration.

By Ms. MILLENDER-McDONALD:

H. Con. Res. 228. Concurrent resolution expressing the sense of Congress that the National Family Caregiver Support Program should be fully funded to continue efforts to provide relief and necessary services to individuals who perform informal or unpaid care for the elderly and care for children under 18 years of age; to the Committee on Education and the Workforce.

By Mr. PAYNE:

H. Con. Res. 229. Concurrent resolution acknowledging the strong relationship between the United States and the Republic of Mali and recognizing Mali's role in building a participative democracy, providing leadership through conflict resolution and peacekeeping activities, and supporting the fight against terrorism; to the Committee on International Relations.

By Mr. LANTOS (for himself, Mr. DELAY, Ms. PELOSI, and Mr. HYDE):

H. Res. 294. A resolution condemning the terrorism inflicted on Israel since the Aqaba Summit and expressing solidarity with the Israeli people in their fight against terrorism; to the Committee on International Relations.

By Mr. KLECZKA (for himself, Mr. OBEY, Mr. SENSENBRENNER, Ms. BALDWIN, Mr. PETRI, Mr. KIND, Mr. RYAN of Wisconsin, Mr. GREEN of Wisconsin, Mr. PLATTS, Mr. GRAVES, Mr. DINGELL, Mr. LaTOURETTE, Mr. DAVIS of Illinois, Mr. ROGERS of Alabama, Mr. FRANKS of Arizona, Mr. GIBBONS, and Mr. SAM JOHNSON of Texas):

H. Res. 296. A resolution recognizing the 100th anniversary of the founding of the Harley-Davidson Motor Company, which has been a significant part of the social, economic, and cultural heritage of the United States and many other nations and a leading force for product and manufacturing innovation throughout the 20th century; to the Committee on Energy and Commerce.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 110: Mr. KING of Iowa, Mr. OTTER, Mr. BARTLETT of Maryland, Mr. PAUL, Mr. LEWIS of Kentucky, Mr. SIMPSON, Mr. GOODE, Mr. DOOLITTLE, and Mr. AKIN.

H.R. 111: Mrs. MILLER of Michigan and Mrs. MUSGRAVE.

H.R. 125: Mr. VAN HOLLEN.

H.R. 135: Mr. CANTOR and Mr. GOODLATTE.

H.R. 141: Mr. HAYWORTH.

H.R. 188: Mr. FRANK of Massachusetts.

H.R. 236: Ms. LOFGREN, Mr. GREEN of Texas, Mr. CARDOZA, Mr. RODRIGUEZ, and Mr. SANDLIN.

H.R. 303: Mr. RUPPERSBERGER, Mr. LANTOS, and Mr. HOEKSTRA.

H.R. 313: Mr. MURTHA.

H.R. 371: Mr. CAPUANO.

H.R. 372: Mr. DELAHUNT.

H.R. 375: Mr. ADERHOLT and Mrs. KELLY.

H.R. 438: Mr. GARRETT of New Jersey and Mr. NUNES.

H.R. 466: Mr. WU.

H.R. 501: Mr. SCHIFF.

H.R. 569: Mr. REYNOLDS and Mr. MEEHAN.

H.R. 571: Mr. OTTER.

H.R. 671: Mr. TERRY.

H.R. 678: Mr. LEWIS of Georgia.

H.R. 687: Mr. CRENSHAW and Mr. CULBERSON.

H.R. 716: Mr. RAHALL and Ms. KILPATRICK.

H.R. 721: Mr. HINOJOSA and Mr. LUCAS of Kentucky.

H.R. 738: Mr. CARDIN, Mr. GEORGE MILLER of California, Ms. SOLIS, Mr. PAYNE, and Mr. SANDERS.

H.R. 765: Mr. MANZULLO.

H.R. 767: Mr. BURR.

H.R. 779: Mr. STARK.

H.R. 785: Mr. LUCAS of Oklahoma, Mr. ABERCROMBIE, Ms. WOOLSEY, and Mr. DAVIS of Alabama.

H.R. 786: Mr. RYAN of Wisconsin.

H.R. 790: Mr. LUCAS of Oklahoma.

H.R. 792: Mr. WEINER, Mr. CUMMINGS, Mr. WAMP, Mr. RAMSTAD, Mr. McGOVERN, Ms. NORTON, Mr. MORAN of Virginia, Mr. BACHUS, Mr. ISRAEL, Mr. CLAY, Mr. SCOTT of Georgia, Mr. PICKERING, Mrs. MUSGRAVE, Mr. COOPER, Mr. WICKER, Mr. ANDREWS, Ms. BALDWIN, and Mr. WELDON of Pennsylvania.

H.R. 811: Mr. UDALL of New Mexico and Mr. BARTON of Texas.

H.R. 876: Mr. COLLINS, Mr. CHOCOLA, Mr. UDALL of New Mexico, and Mr. LAMPSON.

H.R. 882: Mr. SMITH of New Jersey.

H.R. 898: Ms. PRYCE of Ohio, Mr. HOEFFEL, Mr. NADLER, Ms. LINDA T. SÁNCHEZ of California, Mr. RUSH, Ms. BALDWIN, Mr. MOORE, and Mr. BELL.

H.R. 906: Mr. PORTER, Mr. SULLIVAN, Mr. HAYES, and Mr. BURGESS.

H.R. 919: Mr. PETRI.

H.R. 936: Ms. BALDWIN.

H.R. 965: Mr. ENGEL and Mr. GEPHARDT.

H.R. 997: Mr. DEMINT and Mrs. BONO.

H.R. 1068: Ms. KILPATRICK, Mr. SENSENBRENNER, Mr. GREEN of Wisconsin, Mr. SIMMONS, and Mr. DOYLE.

H.R. 1078: Mr. WILSON of South Carolina, Mr. OSE, Mr. GARRETT of New Jersey, Mr. KLINE, and Mr. LARSEN of Washington.

H.R. 1093: Mr. BERMAN, Mr. INSLEE, Mr. NEY.

H.R. 1105: Mr. JOHNSON of Illinois.

H.R. 1125: Mr. BACHUS, Mr. SCOTT of Georgia, Mr. CLAY, Mr. BISHOP of Utah, Mr. WALSH, Mrs. BLACKBURN, and Mr. KIND.

H.R. 1130: Mr. JOHNSON of Illinois.

H.R. 1167: Mr. FILNER and Mr. MICHAUD.

H.R. 1185: Mr. LARSON of Connecticut.

H.R. 1225: Mr. SIMMONS and Mr. STUPAK.

H.R. 1233: Mr. MANZULLO.

H.R. 1268: Mr. HINOJOSA.

H.R. 1305: Mr. LINDER, Mrs. CAPITO, Mr. OXLEY, and Mr. RYAN of Wisconsin.

H.R. 1306: Mr. SPRATT.

H.R. 1310: Mr. JOHN.

H.R. 1336: Mr. BURR, Ms. GINNY BROWN-WAITE of Florida, and Mr. KING of New York.

H.R. 1340: Mr. VAN HOLLEN.

H.R. 1348: Mr. BAIRD.

H.R. 1351: Mr. LARSON of Connecticut.

H.R. 1359: Mrs. CHRISTENSEN.

H.R. 1376: Mr. McGOVERN.

H.R. 1421: Mr. POMEROY and Mr. BACA.

H.R. 1473: Ms. LEE.

H.R. 1489: Mr. PETRI, Mr. KING of Iowa, Mr. HENSARLING, and Mr. ALEXANDER.

H.R. 1519: Mr. MATSUI.

H.R. 1543: Mrs. MALONEY.

H.R. 1565: Mr. OWENS.

H.R. 1622: Mr. WELDON of Pennsylvania and Mr. McHUGH.

H.R. 1628: Ms. JACKSON-LEE of Texas, Mr. OXLEY, Mr. RADANOVICH, Mr. RANGEL, Mr. FOLEY, and Mrs. BONO.

H.R. 1655: Ms. ROS-LEHTINEN.

H.R. 1660: Mr. RAMSTAD and Mr. CASE.

H.R. 1700: Mr. TOM DAVIS of Virginia, Ms. LORETTA SANCHEZ of California, and Mr. McCOTTER.

H.R. 1708: Mr. MEEK of Florida.

H.R. 1734: Mr. STENHOLM, Mr. CLYBURN, Mr. PRICE of North Carolina, Mr. KILDEE, Mr. BOYD, Mr. RUSH, Mr. ANDREWS, and Mr. DAVIS of Illinois.

H.R. 1749: Mr. PAYNE, Mr. CANNON, Mr. MICHAUD, and Mr. ISAKSON.

H.R. 1767: Mr. CHOCOLA, Mr. MORAN of Kansas, Mr. PLATTS, Mr. SHUSTER, Mr. RYAN of Wisconsin, Mr. MARIO DIAZ-BALART of Florida, and Mr. PUTNAM.

H.R. 1813: Mr. BERMAN, Mr. HASTINGS of Florida, Ms. NORTON, Mr. OBERSTAR, Mrs. MALONEY, and Mr. OWENS.

H.R. 1858: Mr. STRICKLAND, Mr. DEUTSCH, Mr. RAMSTAD, Mr. SHAYS, and Mrs. JONES of Ohio.

H.R. 1884: Mrs. MYRICK.

H.R. 1890: Mr. LEWIS of Kentucky.

H.R. 1900: Mr. THOMAS, Mr. KUCINICH, Mr. McNULTY, Mr. FRANK of Massachusetts, Mr. FILNER, Mr. VISCLOSKY, Ms. LINDA T. SÁNCHEZ of California, Ms. WATERS, Mr. ACEVEDO-VILÁ, Mr. BARTLETT of Maryland, Mr. SCOTT of Virginia, Mr. CHOCOLA, Mrs. CAPPS, Mr. DUNCAN, Mr. LANTOS, Ms. HARMAN, Mr. SIMPSON, Mr. ENGLISH, Mr. RAMSTAD, Ms. KILPATRICK, and Mr. CANNON.

H.R. 1902: Mr. TERRY.

H.R. 1905: Mr. WEINER.

H.R. 1907: Mr. BLUNT.

H.R. 1910: Mr. CARSON of Oklahoma, Ms. HARMAN, Ms. HOOLEY of Oregon, Mr. STUPAK, and Mr. SKELTON.

H.R. 1930: Mr. OWENS.

H.R. 1934: Mr. SMITH of Washington.

H.R. 1951: Mr. CAPUANO, Mr. CARSON of Oklahoma, Mr. GORDON, and Mr. BISHOP of Georgia.

H.R. 1958: Mrs. MALONEY.

H.R. 1963: Mr. COLE.

H.R. 1991: Mr. McDERMOTT.

H.R. 1998: Mr. CARSON of Oklahoma and Ms. CARSON of Indiana.

H.R. 2020: Mr. COLE, Ms. CORRINE BROWN of Florida, and Mr. ETHERIDGE.

H.R. 2022: Mr. DEUTSCH, Mr. OWENS, and Mr. WICKER.

H.R. 2028: Mr. GORDON.

H.R. 2035: Mrs. McCARTHY of New York, Mr. HINOJOSA, and Mr. MICHAUD.

H.R. 2068: Mr. ABERCROMBIE, Ms. ESHOO, Mr. WOLF, Mr. BOEHLERT, Mr. FROST, Mr. CARSON of Oklahoma, Mr. WEXLER, and Mr. ENGEL.

H.R. 2069: Mr. ABERCROMBIE, Ms. ESHOO, Mr. WOLF, Mr. BOEHLERT, Mr. FROST, Mr. CARSON of Oklahoma, Mr. WEXLER, and Mr. ENGEL.

H.R. 2079: Mr. GILCHREST.

H.R. 2118: Mr. BISHOP of Georgia.

H.R. 2124: Mr. SANDERS, Mr. COOPER, Mr. WEXLER, and Mr. ROTHMAN.

H.R. 2138: Mr. BAKER.

H.R. 2157: Mr. STRICKLAND and Mr. FROST.

H.R. 2190: Mr. BRADY of Texas, Mr. GREEN of Wisconsin, and Mr. BONNER.

H.R. 2193: Mr. OWENS and Ms. WATSON.

H.R. 2205: Ms. JACKSON-LEE of Texas, Mr. BLUMENAUER, Ms. LEE, Mr. SABO, Mr. JOHN, Mr. UDALL of Colorado, and Mr. McDERMOTT.

H.R. 2236: Mr. Grijalva and Mr. Lantos.

H.R. 2239: Mr. Brown of Ohio, Mr. Frank of Massachusetts, Ms. Eshoo, Ms. Schakowsky, Mr. Hoeffel, Mr. Scott of Virginia, Mr. Strickland, and Mr. Owens.

H.R. 2246: Mr. Peterson of Minnesota.

H.R. 2249: Mr. Gibbons and Mr. Thompson of California.

H.R. 2256: Mr. Wolf.

H.R. 2264: Ms. DeLauro.

H.R. 2295: Mr. Owens.

H.R. 2297: Mr. Gutierrez, Ms. Corrine Brown of Florida, Mr. Rodriguez, and Mr. Filner.

H.R. 2303: Mr. Akin, Mr. Lewis of Kentucky, Mr. Feeney, Mr. Barrett of South Carolina, Mr. Jones of North Carolina, Mr. Herger, and Mr. Kingston.

H.R. 2310: Mrs. Christensen, Mrs. Capps, Mr. Kildee, Mr. Farr, and Mr. Spratt.

H.R. 2318: Mr. Lipinski, Mr. Case, Mr. Kildee, and Mr. Scott of Virginia.

H.R. 2333: Mr. Goode.

H.R. 2346: Mr. Tancredo.

H.R. 2351: Mr. Barrett of South Carolina.

H.R. 2360: Mr. Cunningham.

H.R. 2372: Mrs. Jones of Ohio, Mr. Davis of Alabama, Mr. George Miller of California, Ms. Slaughter, and Ms. Norton.

H.R. 2377: Ms. Baldwin.

H.R. 2379: Mr. McIntyre.

H.R. 2382: Mr. Smith of Washington.

H.R. 2385: Mr. Acevedo-Vilá.

H.R. 2399: Mr. Kolbe and Mr. Jones of North Carolina.

H.R. 2418: Mr. Frost.

H.R. 2426: Mr. Hoeffel, Mr. Frost, Mr. Kennedy of Rhode Island, and Ms. Carson of Indiana.

H.R. 2427: Ms. DeLauro, Mr. Toomey, and Mr. Van Hollen.

H.R. 2446: Mr. Goodlatte, Mr. Burr, and Mr. Manzullo.

H.R. 2448: Mr. Ramstad.

H.R. 2462: Mr. Michaud, Mr. Miller of North Carolina, Mr. Wynn, Mr. Thompson of California, Mr. Filner, Ms. Kaptur, Mr. Ryan of Ohio, Ms. Millender-McDonald, Ms. Jackson-Lee of Texas, and Mr. McGovern.

H.R. 2464: Mr. Wexler.

H.R. 2475: Mr. Payne and Mr. Andrews.

H.R. 2488: Mr. Abercrombie.

H.R. 2494: Mr. Meeks of New York and Mr. Levin.

H.R. 2497: Ms. DeLauro, Mr. Meehan, and Mr. Evans.

H.R. 2498: Mr. Kildee.

H.R. 2505: Mr. McDermott.

H.R. 2516: Mrs. Musgrave.

H.R. 2542: Mr. Garrett of New Jersey.

H.R. 2545: Mr. Frost.

H.R. 2546: Mr. Rahall and Mr. DeFazio.

H.R. 2550: Mr. Bereuter and Mr. Mica.

H.R. 2556: Mr. Flake, Mr. Putnam, Mr. Wicker, Mr. Burton of Indiana, Mr. Schrock, and Mr. Barton of Texas.

H.R. 2568: Mr. Acevedo-Vilá.

H.J. Res. 56: Mr. King of Iowa, Mr. Isakson, Mr. Souder, and Mr. Kennedy of Mihnesota.

H. Con. Res. 30: Mr. Cummings and Mr. Baird.

H. Con. Res. 37: Mr. Rangel.

H. Con. Res. 49: Mr. Beauprez.

H. Con. Res. 67: Mr. McNulty, Ms. Jackson-Lee of Texas, Mr. McDermott, Ms. Lee, Mr. Shays, Ms. Norton, Ms. Kaptur, Mr. Owens, Mr. Reyes, Mr. Boswell, Mr. Berman, Mr. Carson of Oklahoma, Ms. Millender-McDonald, Mr. Lantos, and Mr. Emanuel.

H. Con. Res. 107: Mr. Lantos.

H. Con. Res. 126: Mr. Hayworth.

H. Con. Res. 192: Mr. Wexler, Mr. Cardoza, and Mr. Pitts.

H. Con. Res. 195: Mr. Davis of Illinois.

H. Con. Res. 202: Mr. Engel and Mr. Deutsch.

H. Con. Res. 217: Mr. Brown of Ohio, Mr. Nadler, Mr. Frost, Mr. Simmons, and Mr. Matsui.

H. Con. Res. 223: Ms. Jackson-Lee of Texas, Mr. Watt, Mr. Israel, Ms. Solis, Ms. Kaptur, and Mr. Berman.

H. Res. 60: Mr. Udall of New Mexico.

H. Res. 103: Mr. English.

H. Res. 136: Mr. Rush.

H. Res. 198: Mrs. Miller of Michigan.

H. Res. 246: Mr. Kucinich and Ms. Slaughter.

H. Res. 259: Ms. Lee.

H. Res. 285: Mr. Nadler, Mr. Wynn, Ms. Hart, Mr. Wexler, Mr. Berman, Mr. Shays, Mrs. Maloney, Mr. Cardoza, Mr. Andrews, Mr. Aderholt, Mr. Fossella, Mr. Reyes, and Mr. Beauprez.

AMENDMENTS

Under clause 8 of rule XVIII, proposed amendments were submitted as follows:

H.R. 1589

Offered By: Mrs. Capito

Amendment No. 1: Strike all after the enacting clause and insert the following new text:

SECTION 1. GRANTS FOR PRESERVATION OF HISTORIC COURTHOUSES.

(a) In General.—The Secretary of the Interior may make grants to States to distribute the grant funds to units of local government for activities to preserve eligible historic courthouses. Such activities shall meet applicable Secretarial Standards for Rehabilitation and may include period restoration, upgrades to current legal codes and requirements, and architecturally compatible additions and expansions. Each State which accepts a grant under this subsection shall determine the State agency responsible for compliance with the requirements of this section and for the administration of funds provided under this section.

(b) Requirements for Eligible Historic Courthouse.—For the purposes of this section, an eligible historic courthouse is a courthouse or courthouse facility—

(1) that is eligible to be listed on or is listed on the National Register of Historic Places;

(2) that is not less than 50 years old; and

(3) regarding which a grant under this section has not been previously awarded.

(c) Waiver of Certain Requirements.—The Secretary may waive the requirement in subsection (b)(2).

(d) Required Match.—As a condition of providing a grant under this section, the Secretary shall require the recipient of the grant to provide matching funds according to a 1-to-1 ratio of Federal-to-recipient contributions. Recipient matching funds—

(1) must be from non-Federal sources; and

(2) may be made in the form of in-kind contributions of goods or services.

(e) Limit on Administrative Use of Funds.—Not more than 10 percent of funds made available to a State under this section may be used by the State for administrative purposes.

(f) Report.—Five years after the date that funds are first made available for this section, the Secretary shall submit to Congress a report describing activities undertaken with grants awarded under this section.

(g) State Defined.—For the purposes of this section, the term "State" includes the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Virgin Islands, and any other territory or possession of the United States.

H.R. 2417

Offered By: Ms. Jackson-Lee of Texas

Amendment No. 1: At the end of title III add the following new section:

SEC. 345. STUDY ON PROVIDING ACCESS TO STATE AND LOCAL LAW ENFORCEMENT TO CLASSIFIED INFORMATION.

(a) In General.—The Director of Central Intelligence shall conduct a study to determine the feasibility of providing security clearances to specified State and local law enforcement personnel for access to classified information in the possession of agencies and departments of the United States that relate to homeland security and preventing terrorist attacks against the United States.

(b) Specified Officials.—For purposes of subsection (a), the Director shall, in consultation with appropriate State and local officials, establish criteria for the selection of State and local law enforcement personnel for such security clearances.

(c) Report.—Not later than 6 months after the date of the enactment of this Act, the Director shall submit to Congress a report on the study conducted under subsection (a).

H.R. 2417

Offered By: Ms. Jackson-Lee of Texas

Amendment No. 2: Add at the end the following new title:

TITLE VI—NATIONAL COMMISSION ON INTELLIGENCE CAPABILITIES AND ACTIVITIES

SEC. 601. ESTABLISHMENT.

There is established a commission to be known as the "National Commission on Weapons of Mass Destruction in Iraq" (hereinafter in this title referred to as the "Commission").

SEC. 602. DUTIES OF THE COMMISSION.

The Commission shall review and assess the knowledge in the possession of the executive branch with respect to the status of and threats posed by Iraq's weapons of mass destruction programs before the commencement of Operation Iraqi Freedom.

SEC. 603. COMPOSITION AND OPERATION OF COMMISSION.

(a) Numbers and Appointment.—The Commission shall be composed of 10 members appointed by the Director of Central Intelligence.

(b) Qualifications.—

(1) Political party affiliation.—Not more than five members of the Commission may be from the same political party.

(2) Nongovernmental appointees.—A member of the Commission may not be an officer or employee of the Federal Government or any State or local government.

(c) Meetings.—The Commission shall meet and begin the operations of the Commission as soon as practicable. After its initial meeting, the Commission shall meet upon the call of the chairman or a majority of its members.

(d) Quorum.—Six members of the Commission shall constitute a quorum.

(e) Nonapplicability of Federal Advisory Committee Act.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

(f) Vacancies.—A vacancy on the Commission shall not affect its powers, but shall be filled in the same manner in which the original appointment was made.

SEC. 604. POWERS OF COMMISSION.

(a) MEETINGS, HEARINGS, AND EVIDENCE.—

(1) IN GENERAL.—For the purpose of carrying out this Act, the Commission or, on the authority of the Commission, any subcommittee or member thereof, may—

(A) conduct meetings, hold hearings, sit and act at such times and places, take testimony, receive such evidence, and administer oaths as the Commission considers appropriate; and

(B) require, by subpoena or otherwise, the attendance and testimony of witnesses and the production of any evidence relating to any matter under investigation by the Commission which the Commission is empowered to investigate under this Act.

(2) PUBLIC HEARINGS AND MEETINGS.—The Commission shall hold public hearings and meetings to the extent practicable. Any public hearings and meetings of the Commission shall be conducted in a manner consistent with the protection of information provided to or developed for or by the Commission as required by any applicable statute, regulation, or Executive order.

(b) SUBPOENAS.—

(1) ISSUANCE.—

(A) IN GENERAL.—A subpoena may be issued by the Commission only—

(i) by the agreement of the chairperson and the vice chairperson; or

(ii) by the affirmative vote of six members of the Commission.

(B) SIGNATURE.—Subpoenas issued by the Commission shall be issued only under the signature of the chairman or any member designated by a majority of the Commission, and may be served by any person designated by the chairman or by a member designated by a majority of the Commission.

(2) ENFORCEMENT.—

(A) IN GENERAL.—If a person refuses to obey a subpoena issued by the Commission, the Commission may apply to a United States district court for an order requiring that person to appear before the Commission to give testimony, produce evidence, or both, relating to the matter under investigation. The application may be made within the judicial district where the hearing is conducted or where that person is found, resides, or transacts business. Any failure to obey the order of the court may be punished by the court as civil contempt.

(B) ADDITIONAL ENFORCEMENT.—In the case of any failure of any witness to comply with any subpoena or to testify when summoned under authority of this subsection, the Commission may, by majority vote, certify a statement of fact constituting such failure to the appropriate United States attorney, who may bring the matter before the grand jury for its action, under the same statutory authority and procedures as if the United States attorney had received a certification under sections 102 through 104 of the Revised Statutes of the United States (2 U.S.C. 192 through 194).

(c) CONTRACT AUTHORITY.—The Commission may enter into contracts to enable the Commission to discharge its duties under this Act.

(d) OBTAINING OFFICIAL DATA.—

(1) IN GENERAL.—The Commission may secure directly from any executive department, bureau, agency, board, commission, office, independent establishment, or instrumentality of the United States information necessary to enable it to carry out this Act. Each department, bureau, agency, board, commission, office, independent establishment, or instrumentality shall, to the extent authorized by law, furnish such information directly to the Commission, upon request made by the chairman, the chairman of any subcommittee created by a majority of the Commission, or any member designated by a majority of the Commission.

(2) RECEIPT, HANDLING, STORAGE, AND DISSEMINATION.—Information shall only be received, handled, stored, and disseminated by members of the Commission and its staff consistent with all applicable statutes, regulations, and Executive orders.

(e) ASSISTANCE FROM FEDERAL AGENCIES.—Upon request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, administrative support and other services necessary for the Commission to carry out its duties under this Act.

(f) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

SEC. 605. DIRECTOR AND STAFF OF COMMISSION.

(a) IN GENERAL.—The chairperson, in consultation with the vice chairperson may appoint and fix the compensation of a director and such other staff as may be necessary to enable the Commission to carry out its duties, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of the annual rate of basic pay for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(b) DETAILEES.—Any Federal Government employee may be detailed to the Commission without reimbursement from the Commission, and such detailee shall retain the rights, status, and privileges of his or her regular employment without interruption.

(c) EXPERTS AND CONSULTANTS.—The Commission may procure the temporary or intermittent services of experts and consultants under section 3109(b) of title 5, United States Code, but at a rate not to exceed the daily equivalent of the maximum annual rate of basic pay in effect for a position at level IV of the Executive Schedule under section 5315 of such title.

SEC. 606. COMPENSATION AND TRAVEL EXPENSES.

(a) COMPENSATION.—Members of the Commission shall serve without pay.

(b) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

SEC. 607. SECURITY CLEARANCES FOR COMMISSION MEMBERS AND STAFF.

The appropriate Federal agencies or departments shall cooperate with the Commission in expeditiously providing the members and staff with the necessary security clearances to the extent possible pursuant to existing procedures and requirements, except that no person shall be provided with access to classified information under this Act without the appropriate security clearances.

SEC. 608. REPORT.

(a) FINAL REPORT.—The Commission shall submit to the President and Congress, not later than 6 months after the date of the enactment of this Act, a report containing such findings, conclusions, and recommendations for corrective measures as have been agreed to by a majority of members, together with any dissenting opinions. The report shall also include any recommendations for investigation by the Attorney General or the Inspector General of the Central Intelligence Agency of matters investigated by the Commission.

(b) CLASSIFICATION OF REPORTS.—To the extent practicable, the final report shall be unclassified and made available to the public. Such reports shall be supplemented as necessary by a classified report or annex which shall be provided separately to the President and Congress.

SEC. 609. TERMINATION.

(a) IN GENERAL.—The Commission shall terminate 30 days after the date on which the final report is submitted under section 608.

(b) ADMINISTRATIVE ACTIVITIES BEFORE TERMINATION.—The Commission may use the 60-day period referred to in subsection (a) for the purpose of concluding its activities, including providing testimony to committees of Congress concerning its reports and disseminating its final report.

SEC. 610. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out this title.

SENATE—*Tuesday, June 24, 2003*

The Senate met at 9:30 a.m. and was called to order by the Honorable NORM COLEMAN, a Senator from the State of Minnesota.

The PRESIDING OFFICER. Today's prayer will be offered by our guest Chaplain, Father Richard S. Dalton, of Christ Our King Mission Church, Rochester, MI.

PRAYER

The guest Chaplain offered the following prayer:

Let us pray.

Mighty God,

We thank You for the gifts You have bestowed on our Nation: the gift of freedom, the gift of plenty, the gift of community, and the countless gifts of beauty You have given this land.

Awaken this land and its people to our accountability before You and our responsibilities to one another. Make us aware of both the gifts and stewardship granted to us, that each person in this Nation will discover their gifts and embrace their callings for our common benefit and to Your glory.

Lord, may Your grace and kindness abide with this Senate, the Senate staffs, and each related family. We pray Your protection and blessing on the mothers, fathers, grandparents, children and all, both young and old, associated with this United States Senate.

May Your care be upon all these gathered and may this Senate body labor during these days as Your ministers for our good.

I pray these things, as Your servant for Jesus' sake.

God may You now bless these Senators, Thy servants.

Amen.

PLEDGE OF ALLEGIANCE

The Honorable NORM COLEMAN led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. STEVENS).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, June 24, 2003.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable NORM COLEMAN, a Senator from the State of Minnesota, to perform the duties of the Chair.

TED STEVENS,
President pro tempore.

Mr. COLEMAN thereupon assumed the Chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, the Senate will immediately resume consideration of S. 1, the prescription drug benefits and Medicare bill. There are approximately 33 pending amendments from last week and yesterday. We continue to make good progress. Under the order from last night, we have two consecutive votes this morning at 11 o'clock on the Rockefeller amendment No. 976 and the Bingaman amendment No. 984. Also, last night we reached an agreement to vote at 2:25 this afternoon in relation to the Dodd amendment No. 969 on open enrollments. This morning, the two managers will be working through the pending amendments and will attempt to set up additional votes for this afternoon.

I reiterate once again we will finish this bill this week, possibly Thursday night. It could be a very late Thursday night. I predict it will be a late night tonight, Tuesday night, Wednesday night, and Thursday night. If we spill over to Friday or even Saturday, we will finish this bill before the recess. I do encourage Members to come forward with their amendments as soon as possible and make those available to the managers if you plan on offering those amendments. We have a lot of work to do. The cooperation of Members will be very much appreciated over the next 2, 3 days.

PASSAGE OF S. 1157 AND S. 239

Mr. FRIST. Mr. President, let me just make one final comment. In wrapup last night, we had two very important pieces of legislation pass through the body. We are debating throughout each day the prescription drug benefits and Medicare bill, yet we have other important matters.

Last night, we passed S. 1157, which establishes a National Museum of African American History. Senator BROWNBACK has been working on getting this bill cleared for full Senate action since its introduction on May 23 of this year. I publicly thank him for his efforts and attention on this important issue so that the Senate was able to pass it expeditiously.

Also last night, the Senate passed S. 239, the Trauma Care Systems Planning And Development Act, which I introduced in January of this year. This bill directs the Secretary of Health and Human Services to collect, compile, and disseminate information regarding trauma care and emergency medical services, and, in so doing, takes into special consideration people in rural areas who might not otherwise have access to that care.

I mention those two very important pieces of legislation because I want our colleagues to be aware we did pass them late last night.

RECOGNITION OF THE ACTING MINORITY LEADER

The ACTING PRESIDENT pro tempore. The assistant Democratic leader is recognized.

Mr. REID. Mr. President, if I could say through the Chair to the leader, as the leader indicated, we have more than 30 amendments. To vote on those would take 12 hours, or something like that. The two managers last night indicated they thought two-thirds of the amendments that are pending could be accepted by the two managers.

We have on our side probably no more than six more amendments to offer on this legislation. Senator BOXER is here to offer her amendment. We have several more that could follow that. Then we have an important amendment that Senators CONRAD and LINCOLN offered. Senator LINCOLN offered it on Friday, but she withdrew it, and she wants to reoffer that today.

I think if we do not have some flareup as a result of someone wanting to change the basic components of the bill, it is very likely we can finish this bill in a reasonably short period of time. I hope the two managers, who were meeting after we adjourned last night, have been able to make headway in working through the money we have left over that has created so much interest. Anytime there are a few dollars—and this is more than a few dollars—left on the table, so to speak, there are a lot of people who are after that money. I hope that can be resolved in some fair manner. But if that is the case, then I think you, the distinguished Republican leader, can complete this bill in a reasonably short period of time.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

On our side, we have done our best to have amendments ready to offer. Senator BOXER is in the Chamber. She will not take a great deal of time on her amendment. We have the other key amendments we believe are ready to be offered and can be done in a short period of time.

The ACTING PRESIDENT pro tempore. The majority leader.

Mr. FRIST. I thank the Chair. In brief response, through the Chair, I think it is a very accurate assessment of where we are. The managers continued to meet last night and will continue to meet this morning as we put together the various amendments. So I am very satisfied with the continued progress we are making and appreciate Members on both sides of the aisle coming forward with their amendments. With that, I think we will be able to stay on schedule, giving good, adequate time for debate and amendments.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of S. 1, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

Pending:

Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare Program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Dodd) amendment No. 969, to permit continuous open enrollment and disenrollment in Medicare Prescription Drug plans and Medicare Advantage plans until 2008.

Baucus (for Dodd) amendment No. 970, to provide 50 percent cost sharing for a beneficiary whose income is at least 160 percent but not more than 250 percent of the poverty line after the beneficiary has reached the initial coverage gap and before the beneficiary has reached the annual out-of-pocket limit.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare prescription drug plan, a Medicare Advantage organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Rockefeller amendment No. 976, to treat costs for covered drugs as incurred costs without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid Program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Pryor amendment No. 981, to provide equal access to competitive global prescription medicine prices for American purchasers.

Bingaman amendment No. 984, to carve out from payments to Medicare+Choice and Medicare Advantage organizations amounts attributable to disproportionate share hospital payments and pay such amounts directly to those disproportionate share hospitals in which their enrollees receive care.

Bingaman amendment No. 972, to provide reimbursement for federally qualified health centers participating in medicare managed care.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.

Baucus (for Edwards) amendment No. 985, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the Medicare Advantage benchmark determinations.

Harkin amendment No. 991, to establish a demonstration project under the Medicaid Program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 957, to provide that prescription drug benefits for any Member of Congress who is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the level of prescription drug benefits passed in the 1st session of the 108th Congress.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under Part D on January 1, 2004.

Baucus (for Stabenow) amendment No. 992, to clarify that the Medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the Medicaid Program.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare Program.

Grassley amendment No. 974, to enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

Durbin amendment No. 994, to deliver a meaningful benefit and lower prescription drug prices.

The ACTING PRESIDENT pro tempore. The Senator from California.

Mrs. BOXER. Mr. President, I ask unanimous consent the pending amendments be set aside.

The ACTING PRESIDENT pro tempore. Is there objection?

Hearing none, it is so ordered.

AMENDMENT NO. 1001

Mrs. BOXER. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The ACTING PRESIDENT pro tempore. The clerk will report.

The legislative clerk read as follows:

The Senator from California [Mrs. BOXER], for herself and Ms. MIKULSKI, proposes an amendment numbered 1001.

Mrs. BOXER. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the coverage gap)

On page 49, strike line 3 through page 50, line 2 and insert the following:

“(2) LIMITS ON COST-SHARING.—

“(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket limit under paragraph (4)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

“(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D-19(a).

Mrs. BOXER. Mr. President, I offer this amendment in the true spirit of making this bill work, making it a bill that isn't confusing for our seniors, a bill that doesn't cause a hardship, as the existing bill does, for those who are the sickest.

In this amendment I have the support not only of several colleagues but of the AARP, which very strongly supports it. As you know, they have been choosing their amendments very carefully. Also we are supported by the National Committee to Preserve Social Security and Medicare. So we have both the largest senior citizen organizations backing this amendment.

I was proud to give the national Democratic radio address on Saturday. I did it on this particular issue. The issue I will be addressing through this amendment is ending the benefit shutdown that occurs in this bill just at a point in time when seniors need their benefit the most. I will explain it because it isn't that complicated once you explain it.

Let me take a step back and say the best thing about the bill before us is it starts a Medicare benefit prescription drug benefit for our seniors. We have been talking about this for years. We have been pushing it for years. Since Medicare was created 38 years ago, seniors have been waiting for a prescription drug benefit. I must say, the older I get the more I realize the revolution we have seen in medicine, one that is now one of prevention. If one takes a high blood pressure medicine, if one can't control it any other way, it becomes absolutely a lifesaving benefit. If one doesn't do that or one can't afford to do that, the chances of stroke or heart disease go up immeasurably. So the best thing about the bill before us is that it begins something so many of us have fought for so long.

Unfortunately, the plan is wanting. The plan needs to be improved. It is very complicated. I have read this from a Senator on the Republican side. I heard from a Senator on the Democratic side:

> No one really understands this.

That was a reference to Senators. I have a handle on what this bill does. I have had to work; I have had my staff work. I am fortunate to have a good staff. I have talked to my colleagues. But if it took me so long to figure this out, what will it do to our people.

One of the improvements we should make is this amendment I offer. I want to explain exactly what I mean when I say a benefit shutdown. It has been called a number of things—a coverage gap, a donut hole. But a benefit shutdown really explains it because here is what happens. You are going about your business. You are paying your premium. You are getting your 50-percent benefit after you pay your deductible. And bingo, you hit a certain point and what happens? No more benefit.

I have studied 100 different plans that offer a benefit. Ninety-nine of them don't have any of this. One of them has this, but it is a very rich plan and the benefit shutdown is very small. So this is the only plan I have ever seen in existence that has this ridiculous benefit shutdown. I don't understand why it happened, but I guess the bill was a compromise so that is why we have it.

Let me explain what it means. I will show a couple of charts to you. After a senior pays $275 in a deductible, they start getting 50 percent of the cost of the drug reimbursed. So it is a 50-percent benefit, once you have paid your deductible. By the way, every month you have at least a $35 premium.

Now all of a sudden, you get to $4,500 worth of drugs and your benefit shuts down and the next $1,300 you have to pay out of your own pocket. I know the State of the Presiding Officer is not much different from mine in the sense that our seniors are mostly low income. Many of them are living on their Social Security checks, maybe a little more, but since the market went down, many of them are relying on their Social Security checks. For them to have to pay $1,300 right in the middle of a year is absolutely outrageous. That is why AARP is supporting my amendment. They sent out a letter on my amendment.

I ask unanimous consent to print the letter in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

AMERICAN ASSOCIATION
OF RETIRED PERSONS,
Washington, DC, June 19, 2003.

Hon. BARBARA BOXER,
U.S. Senate,
Washington, DC.

DEAR SENATOR BOXER: AARP supports your amendment to close the coverage gap that exists in the drug benefit design of S. 1.

Throughout the debate over a Medicare prescription drug benefit, AARP has voiced our members' concerns about the need for affordable and adequate coverage. Chief among these concerns continues to be the existence of a gap in the benefit. We appreciate the efforts made by the Finance Committee to close the gap and we believe the Senate should finish the job.

AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Thank you for your leadership on the issue. We look forward to working with you and other members of the Senate to enact a prescription drug benefit that will provide meaningful relief to current and future Medicare beneficiaries.

Sincerely,

WILLIAM D. NOVELLI.

Mrs. BOXER. I will read it. That is why they said I could mention on the national radio address that they support my amendment—a $1,300 cost after you hit $4,500.

Let's take the case of someone who has $7,000 a year in drug costs—and many people do. Their estimated annual premium? At least $420, maybe a little more. Their deductible? $275. They pay 50 percent of the cost of their medication, $2,113, until they get to $4,500. Now comes the benefit shutdown where they have to pay 100 percent of the cost between $4,500 and $5,812. It is actually $1,312. Then they get a good catastrophic benefit where they pay 10 percent. Look at what the senior is paying for this benefit: $4,239 out of a $7,000 bill.

The point is, because of this benefit shutdown and the huge penalty, a lot of our senior citizens would get a better drug benefit if they went to Canada and bought their drugs. This is a fact. They would be better off if they went to Canada and bought their drugs. But we can fix it today. We can end this benefit shutdown, and then the benefit will be far better.

Another way to look at the benefit shutdown is to see how unfair it is to our beneficiaries. You are paying your monthly premium every single month; $35 is what we are suggesting. But it could go up. We haven't reined in what they could charge you. Anyone who has dealt with insurance companies and HMOs knows that costs go up. Even Medicare has had to raise its costs a little bit. But by the way, because Medicare administrative costs are so low, at 3 percent, compared to these companies which could be as high as 25 percent, Medicare keeps the costs down. But under this bill, you only get Medicare if you can't get a private company. So I am telling you, we are going to have seniors maybe facing increases in their premiums. But let's give it a shot. Let's say it is only $35. It is $35 a month every single month. And guess what happens in October, if you have this kind of $500-a-month expense—just to use that as an example—you do not get that benefit for almost 3 months out of the year.

What kind of plan is this? Fortunately, it is voluntary so people have to think long and hard if it makes sense for them to do it. And I will give credit where credit is due. For our lowest income people, it may be a decent deal. But for your average recipient, to have to explain why they get no benefit for 3 months puts us in a terrible situation. It harkens back to the days when we did a catastrophic benefit and seniors took it. Then when they realized what it was, they were so angry, they were just throwing themselves on legislators' automobiles to protest. I am not kidding. This happened.

I don't want to see that happen. I want to see us do a good bill, one that is really straightforward, not confusing. So we have a real problem for our vulnerable citizens.

The last chart I am going to show is this chart because I said I would read to you from AARP's letter that they sent me. I hope colleagues will listen to what they say:

> AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Mr. President, that is exactly what my amendment does. Let me go through this one argument at a time.

> AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit.

Well, clearly, Mr. Novelli and the AARP understand the fact that you have a barrier when you know that perhaps for 3 months, even though you are paying your premium, you get no benefit. Again, we have studied all the plans. Virtually no plan in America has a benefit shutdown. So let's make this bill better.

Let's see the next thing AARP says:

> They tell us that they are unaware of similar features in any of the insurance products they routinely purchase.

Absolutely. Only in the Congress could somebody come up with this way to save money. It is ridiculous. You are penalized if you are really sick. You are penalized if you are really sick because if someone gets cancer and has to buy very expensive drugs, or a family member gets Alzheimer's and they are trying to treat the disease in a way so they can have their loved one around longer, that is when they get hit with a benefit shutdown. How unfair is that?

> Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk.

What does that mean? It means that as seniors learn what this program is about, they may well come to the conclusion, depending on the size of their drug bill, that they are better off making a trip to Canada. They will save more than going through all the rigmarole—Senator CLINTON showed on a chart the rigmarole you have to be involved in, and because the way the bill has tried to really privatize this benefit, you are at the risk of the marketplace. The risk of the marketplace is OK when you are buying a car; it is OK if you are buying a dishwasher. You are at the risk of the marketplace. Yes, if it was a year when people held back and didn't produce a new product, OK, you are disadvantaged; OK, that is the risk. But to put seniors at the risk of the marketplace for drugs is a very bad idea indeed.

> Therefore, we urge the Senate to eliminate this coverage gap.

This letter is signed by William Novelli, executive director and CEO of AARP. It is a nonpartisan organization that supports this amendment strongly. We want to close this gap. We want to stop this benefit shutdown. Again, a very graphic way to show what happens to you is to say that seniors will pay half of their annual drug cost from $276 to $4,500—that is their 50 percent benefit—and then they face a $1,300 benefit shutdown, just at the time they need their medicine the most. It makes no sense.

You know, $1,300 may not sound like a lot to some of our Senators here. We get good pay and, by the way, we have a pharmaceutical benefit in our health plan. It is a very good one. It is an excellent one. You know what. It doesn't stop when you hit a certain level. Our pharmaceutical benefit just keeps on going. It just keeps on coming, as do pharmaceutical benefits in practically all the plans in America today.

Just think about the administrative overhead to figure this one out. You are going along and, all of a sudden, this red arrow kicks in: Stop. I want to know how much it is costing us to administer this kind of deal. You can imagine, you get a note in the mail. Your benefit stops. You have paid $4,500. You go back and check your records. No. I didn't, I have only paid $4,200. You call up the administrator: You have made a mistake. Well, no, I didn't. Well, yes, you did.

How many hours will a senior who is confused and upset have to spend on the phone? How many hours will an administrator have to spend working on the details of this? Too long, I can tell you that.

This plan, as it is before us, if this amendment doesn't pass, pulls the rug out from underneath the people who are going to need the help the most. So if we are in this in order to offer a plan that people will utilize, then let's support this amendment. It is as simple as that.

Many seniors take medicines to manage chronic health problems. I discussed that at the beginning. How wonderful is it that today we can avoid horrible outcomes by taking pills that will help keep our blood pressure down, regulate our heart rate, keep our insulin in check—I could go on and on and on. Some of our seniors are cutting their pills in half because they cannot afford it. How tragic would it be if, after they think they are going to have this great benefit, they find out they could do better going up to Canada and buying the pills because maybe it comes out to 25 percent when all is said and done, when you put in the benefit shutdown, the premiums cost, and the deductible. It just may not add up. How sad it would be if, after all the hoopla we are associating with this bill, the bill itself is inadequate.

I received a letter from a constituent in San Marcos, CA. She has an annual prescription drug cost that will top $10,000. Well, she will be hit with this benefit shutdown.

Another constituent from Indio, CA, told me she has made five trips to Mexico over the last several years to purchase her prescriptions. This senior drives all day long to Mexico in order to purchase affordable heart medicine that she needs to survive, that she needs so that she can wake up every day and see her grandchildren, and take a walk, and have a quality of life. She is awaiting a benefit that will make it easy for her to go down to her corner pharmacy and say: Here is my card; I am ready to go. But this particular senior is going to be shocked to find out that if she is in the category of the benefit shutdown, it is going to cost her $1,300, plus at least $35 a month, plus a deductible.

A retired physician from Marina del Rey told me that a pill he takes for heart disease went up 600 percent—from $15 to $85. So for seniors who have to take an assortment of medicine to manage chronic diseases, the cost really starts to add up.

I have 4 million senior citizens who are part of the Medicare Program in my State. If you take the population of Delaware, that is five Delawares. That is how many senior citizens I have, and they deserve a break.

Unfortunately, this bill gives them a break, a break in coverage. Let's close that break in coverage. Let's close that gap, stop the benefit shutdown, and let's have a bill of which we all can be proud.

Again, this benefit shutdown is unheard of if we look at all the plans. It would not happen to you, Mr. President, if you have FEHBP. It will not happen to your wife, your kids, or you. It does not happen to me. I do not walk in and they say: Oh, Senator, sorry, you are in that time of the year; gee, just for these 3 months, you do not get any benefit at all. I guarantee you, if our plan did that, there would be shouting at the caucus lunches: What kind of plan do we have that we walk in, in the middle of the year, and somebody tells us we do not have coverage? We are paying our premium.

We would not stand for it.

Why are we giving a plan to the seniors we represent that is far worse than the plan we have? Because we want to give tax breaks for the wealthy few, and so we cannot afford to do this?

This is not a costly fix. CBO is telling us it is $60 billion out of a $400 billion bill. Let's figure out a way to pay for it. It is easy. I can tell you right now the administrative costs in this bill range from 15 percent to 25 percent. That is $100 billion. Why are the administrative costs so high? The private sector is doing it, not Medicare. Medicare has a 3-percent overhead. The private sector has a 10- to 20-percent overhead. Let's take the bill back and figure it out and close this benefit shutdown.

I do not want to be the Senator who stands up and votes for this with a smile on my face and then have a senior stand up and say: Senator, I walked into my pharmacy in October. I have $500-a-month drug expenses, and guess what, I have no benefit. I had to pay $1,300 out of my own pocket just when I needed the drugs the most. Why are you doing this to me? Why don't you do it to yourself?

That is what I hope they say.

I am so happy we are discussing a Medicare drug benefit, believe me. I share the views of a lot of my colleagues that it is time we have one, but to have this plan, the only plan in the country virtually that has a benefit shutdown, is an embarrassment to me. We do not have it in the Senate plan. They do not have it over in the House, I assure you of that.

We should not have a benefit that starts and stops. What is really frosting Senator GRAHAM is that seniors even have to pay a premium during this benefit shutdown. So he has an amendment—we have not voted on it yet—that says at least for October, November, and December, do not charge seniors a premium.

It is the same as if someone walked in a store and said: I want to buy a TV set, here is my money; I am going to pay it off over 3 months, here is my money. And they say, thank you very much; you are not getting a TV set; we will deliver it in 3 months. But you advertised it. No, you have to pay me 3 months, and then I will send you your TV set.

In a free market economy, this is a very sick idea. This does not make any sense. In our society, if you put money down, you pay for a benefit, you pay for a product, you get it.

I think BOB GRAHAM has a good idea: If you are going to do this to seniors, then do not make them pay their premium. At least show some regard for the person.

You are a senior; you are on several drugs; you are feeling good; the medicine really helps you; you have signed up for the plan; you have paid your deductible; you start getting your 50 percent benefit; and, boom, it is over, when you reach $4,500. Your benefit shuts down.

I cannot say it enough. It is unheard of to pay a $1,300 penalty for sickness. I cannot say it enough.

You have signed up. A few months go by, and you add the costs up in your head trying to figure out how much your medicine is costing. You realize you are going to hit the $4,500 benefit shutdown. Your doctor says you need to keep taking the medicine because you are worse, and he knows you are worried about entering the benefit shutdown. You are going to be hit with the full cost of those drugs for that period. What are you going to do?

You sit down and you crunch the numbers. You ask: How can I cut costs? You may well skip your medicine; you may well cut the pills in half; and you may well threaten your health and your life.

The benefit shutdown is wrong. It goes against everything we do in this country. Nobody else does this. It is not that expensive to fix. You are going to need a calculator every time you try to figure out what you have to save. You are going to need a good accountant.

A shutdown is going to cause trouble with the administration of this benefit. People will be calculating: Gee, Mr. THOMAS has used $3,925. Let's get him on the watchlist. Mrs. BOXER over there, she has used $4,000. Then suddenly you are cut off. You call up and you do not understand it. It is going to take hours to explain it to a senior citizen.

In closing my discussion of this amendment—and I will be asking for the yeas and nays on this amendment—the National Committee to Preserve Social Security and Medicare and the AARP, the two biggest senior citizen organizations in this country, endorse this amendment.

I am to again read from Mr. Novelli's letter because this says it all in a very clear way, and I hope my presentation has demonstrated that everything Mr. Novelli, the CEO of AARP, has stated is true:

> AARP members find the notion of a gap in coverage—

That is benefit shutdown—

> to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Signed William Novelli, AARP.

I thank the AARP because I know they are calling colleagues and explaining this. Just remember, do unto others as you would like them to do unto you. Do my colleagues want to have their drug benefit changed so that just when they need their pharmaceutical product the most, they tell you it is not covered for you; it is not covered for your wife; it is not covered for your husband; it is not covered for your children? Mr. President, you do not want that. Why are we doing it to the seniors? At least give them a break and close down this benefit shutdown because if we do not, if we do not vote for this amendment, people are going to be at our doors because they are not going to understand it.

If my colleagues vote for this amendment and we fix this, we can truly say we have made this a far better plan, a plan more like our own, a plan more like the other 100 plans I have looked at.

I yield the floor.

I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). Is there a sufficient second? At this time, there is not a sufficient second.

Mrs. BOXER. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. BOXER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. I renew my request for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask that all pending amendments be temporarily laid aside so the Senator from Arkansas can offer an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Arkansas.

Mrs. LINCOLN. I thank the ranking member of the Finance Committee, as well as the chairman, for their diligence in this very important issue.

I say to my colleagues, I do not think we will be taking up an issue quite as critical as this one for quite some time when we reflect both on the economy of our country and the quality of life we want to provide our seniors in this Nation and, more importantly, when we think about where our Nation is going in terms of the demographics and the number of seniors we actually have in this country, going from 41 million Americans over the age of 65 to an explosion in the next 15 to 20 years of almost 70 to 75 million Americans over the age of 65.

In looking at this prescription drug package, I hope we all will look at it not only as an ability to provide the seniors the kind of quality of life we want to provide them but that we also look at it as an economic issue in terms of what it is going to cost us in this great country to provide the kind of quality of care in the next 20 years if we do not look at a prescription drug package which is going to provide our seniors with the ability to live their lives in a way where it will be less costly to the more expensive areas of health care and, more importantly, they will be able to live the final years of their life in comfort and certainly more comfortable circumstances, hopefully at home, and have the quality of life we want them to have.

Medicare has been a successful, stable program for millions of seniors and individuals with disabilities for over 40 years. Medicare has succeeded in guaranteeing hospital coverage and physician coverage for a population which was largely uninsurable. Now we are debating adding prescription drug coverage to the Medicare Program and we should do it in a way that echoes that same stability in the program seniors enjoy.

AMENDMENT NO. 1002

Mrs. LINCOLN. Mr. President, at this time I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN], for herself, Mr. CONRAD, Mr. MILLER, and Mr. CARPER proposes an amendment numbered 1002.

Mrs. LINCOLN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow medicare beneficiaries who are enrolled in fallback plans to remain in such plans for two years by requiring the same contracting cycle for fallback plans as Medicare Prescription Drug plans)

On page 83, strike lines 1 through 7, and insert the following:

"(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

"(A) The contract shall be for a 2-year period.

"(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

"(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly; as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

Mrs. LINCOLN. I am extremely proud to offer this amendment with my colleagues, Senators CONRAD and MILLER. Our amendment seeks to make the drug benefit more predictable and reliable for seniors by allowing them to remain for 2 years instead of 1 year in what we are calling the fallback plan that is outlined in S. 1. As I mentioned when I began speaking this morning, Medicare is here because over 40 years ago more than a majority of seniors in this Nation were uninsurable. We were finding that private industry was not finding this group of individuals profitable enough to actually be in the marketplace and provide them a plan. So I think it is critical, as we look at what we are trying to do today in reforming Medicare and providing a prescription drug plan, that we look at what history has shown us and that we are careful to make sure the plan we provide is going to meet the needs as well as to be fair for all seniors in this great Nation and across the demographics of our country.

Senator CONRAD and I raised this issue in the Finance Committee several weeks ago, since our States are primarily rural and have not historically been attractive to the private insurance industry. This amendment we are offering today simply requires the same 2-year contracting cycle for fallback plans as is required for the private drug-only insurance plan.

We want to make sure the private plans that can come in for a 2-year contract for our seniors who are out in rural areas, who are disproportionately low income, who are less attractive in many ways for these private entities to serve, will have the same opportunity and the same stability other regions of the Nation will have because those fallback plans will be there for the same amount of time as the private insurance industry.

In the underlying bill, Senators GRASSLEY and BAUCUS took a number of steps to encourage private drug-only insurance plans to contract with Medicare and deliver the drug benefit. They created a special transition risk corridor in the first 2 years to encourage these plans to participate, and they gave the administrator of CMS additional tools to get the plans in there. If the administrator determines that at least two plans cannot stomach accepting the minimum requirements for accepting risks described in the bill, then the administrator can reduce the amount of risk plans needed to assume. Alternatively, the administrator can increase the reinsurance percentage or the subsidies to encourage drug-only insurance plans to participate.

By doing all of these things, this bill acknowledges these plans currently do not exist in nature, as has been the statement of our current CMS administrator, and they must be enticed to come in and do the job. In other words, we have basically bent over backwards in this bill to bring private plans into this arena of Medicare prescription drugs, particularly in areas where they traditionally have not come.

However, there is still no guarantee they will. That is why I am glad Senator GRASSLEY and Senator BAUCUS created a Medicare-guaranteed drug plan, or safety net, called the fallback. If the administrator exhausts all his options and still no two plans want to come in and deliver drugs to our elderly, then a Medicare-guaranteed plan or a fallback plan will deliver that drug benefit.

The only problem I have with the fallback is it is available for seniors for only 1 year at a time. This means if private insurers decide to test whether they want to offer the benefit in a community, seniors lose access to the fallback plan even if the new plan is significantly more expensive for them and/or more restrictive.

What does this mean in real life? Imagine this scenario in this chart. We have it on a chart so it certainly makes a lot of sense. There is an 85-year-old senior in rural Arkansas who enrolls in a fallback plan, fallback No. 1, in 2006 because there is only one private drug-only plan that is available in that area. Then in 2007, another private drug-only plan B enters the region so she must leave the fallback and enroll in one of them even if the new plans are not better for her.

She chooses private plan A. She suddenly has a different premium, a different cost sharing, a different formulary, and a different set of preferred network pharmacists. She must figure out if her drugs are going to be covered or not and where they must go to get them.

Then the next year, in 2008, private plan A leaves so she must again leave her plan. She enrolls then in plan B and gets used to the new premium, the new formulary. But then plan B departs in 2009. With no plans in the area, she enrolls in a new fallback plan with a whole new premium, a whole new formulary and pharmacy network, and it could go on and on.

I don't usually use charts, but I feel very comfortable with this chart because we have seen this happen before. We have seen it in rural areas where Medicare+Choice has come in, they have enticed our seniors, and then they have left very quickly, leaving seniors without any kind of coverage, having to go back to the traditional Medicare product. We know it can exist because we have seen it before.

What we want to do is to simply give seniors, particularly in rural areas, more stability in what we are proposing in this Medicare prescription drug plan. This is certainly a very real circumstance that could happen as the seniors move in and out—the fact that even in the fallback plans there is no standard design, so even when a fallback plan leaves and comes back 2 years later, it will still be a whole new scenario.

Both in the caring for my aging parent and my husband's aging parents, as well as my husband's grandmother who will be 106 this year—which is amazing in itself—providing them with more confusion is not where we want to go. We want to make this as simple as possible. We want to make it as easy a transition as we possibly can. Their management of multiple diseases or chronic problems is heavy enough in terms of the weight on their shoulders and their emotion. Providing them every year with the unfortunate circumstances of having to find a new formulary, find a new premium, a new pharmacist provider is absolutely not what we are trying to do.

I plead with my colleagues, I don't want to be in such a horrible position as this. I don't want to force my constituents in it either. It would be confusing to me. All we are asking of our colleagues is to give the fallback plan the same opportunity to succeed as we are giving those private plans, to make sure it will be there in a way that seniors will have some stability.

I hope our amendment can be adopted. It simply requires that 2-year contract, putting it in line with the current private sector business practices that happen in the real world. After all, that is what we are trying to do, make sure we provide a plan that is common in the real world. We use the analogies of plans that already exist—the FEHBP plan that we have as Federal employees. We look at what already exists in a traditional Medicare plan now. We want to make sure we provide as much continuity for our seniors as we possibly can.

This amendment goes a long way to ensure more consistency and stability for our seniors. This amendment improves seniors' choices by providing them the option not to bounce back and forth between plans with different benefits and premiums. It improves fairness by allowing seniors in both drug-only and fallback plans to remain in those plans for the same 2-year timeframe. It improves the stability of the benefit package by reducing the year-to-year variability in premiums, in cost sharing, in formularies, in local pharmacists.

I don't know how many questions other Members get from their seniors, but I get a ton of them. In my State offices, seniors call all the time for help with benefits and concerns about things that are not covered currently under Medicare. If you have not got it already, you can well imagine what the barrage on your staff and your offices is going to be when these seniors find themselves, particularly in rural areas, where they are flip-flopping back and forth from one plan to another every year without an understanding of what that plan actually is going to provide.

This amendment also aligns contract cycle with current business practices. The PBMs serving the private sector typically have 3- to 5-year contracts. Requiring the fallback plans to have a 2-year contract better reflects the real-world practices and increases the guarantee they will bid to serve regions where drug-only plans have failed to come. It also continues to allow seniors to enroll in drug-only plans even if a fallback plan is available for 2 years. Nothing prevents a senior from enrolling in a private drug-only plan if one is available in the region.

That goes back to one of the best arguments for this plan. That is, if the private plans are there and are working, you do not have to worry; the fallback plan is not even going to be there to begin with. It is not even going to exist if there are two competing private drug-only plans in the region. This is completely hypothetical if, in fact, the underlying premise that the private drug-only plans are going to reach out to every region of the country and they will be there offering a good benefit to all of our seniors.

The problem is we have history. We know it traditionally has not worked in our rural areas. We want to make sure our seniors get the same consideration other seniors in this great country get. It continues to give drug-only plans first bidding rights. Fallback plans only come to the regions after the CMS administrator has determined that two private drug-only plans will not be available, after he has exhausted all of these tools, of which we have given him many in order to entice these plans in there.

It has a very minimal scoring impact. This amendment buys a lot in making the system more stable but costs almost nothing. It is very reasonable in cost, and we pay for it, so there is no problem in terms of what we are talking about doing.

I am very proud to have worked on this amendment with my colleague, Senator CONRAD, who will speak about the importance of the amendment in making the drug benefit more predictable and reliable for seniors. I am pleased Senator MILLER has joined. Many other Senators I have visited are anxious to know about the policy we begin in this drug package for Medicare seniors, that we absolutely enter into what we are doing with the knowledge that legislation we work on here we understand is not a work of art, it is a work in progress; as we move through these processes to improve legislation, that we will take the time to understand small details. If we can supply the fallback the same opportunity, then we can also make sure this bill is going to be good for everybody.

We know as we move through the debate on this bill, as we move through the implementation, there will be multiple changes that will occur. It is important, as we take the time as we initially debate this issue, that we recognize all parts of our Nation are not exactly alike, that a one-size-fits-all is not going to fit every region of this Nation.

Most importantly, every senior in this great country is just as important as the other. If you are a low-income senior living in a rural part of this Nation and have worked hard your entire life and want to retire in the same area in which you grew up and where you raised your children, you are not going to be slighted in a prescription drug package simply because of where you live or the fact you worked at a lower income job and may not have as much to retire on as other seniors across this Nation.

I hope as we move forward in this amendment and in this bill, we will recognize there are places where we can improve it. We will lead the charge, knowing that is what our job is, that is what this great deliberative body is for. It is to make the improvements along the way and to push a bill forward that, in the long term, will provide a better benefit for people across this Nation. But, most importantly, we must recognize our Nation is diverse. That is a huge part of its strength. Those of us who come from rural areas recognize that sometimes our needs are met in different ways.

I encourage my colleagues to take a look at this very simple amendment that doesn't cost much but can make up a great deal of ground in this bill in bringing parity for all seniors across this Nation.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I see my friend from North Dakota is eager to address the Senate. I will just be a few minutes on this particular amendment.

AMENDMENT NO. 1001

Mr. President, I rise to commend the Senator from California, Senator BOXER, for her amendment. I will support this amendment for the very sound reasons she has outlined here on the floor of the Senate.

Just going back very quickly, in 1965 we passed Medicare and we said to our seniors: Pay into the fund, play by the rules, and your health benefits will be attended to. Therefore, we provided the hospitalization and the physician fees. At that time, only 3 percent of all private companies provided any kind of prescription drug protection.

We have made extraordinary progress in recent years with the development of prescription drugs to tend the needs of all of our citizens and particularly the elderly. Now prescription drugs are as important as hospitalization and physician fees.

What this overall debate has generally been about, in terms of the prescription drug program, is how and when are we going to pass a prescription drug program that will be worthy of our senior citizens and do for our senior citizens what the hospitalization program and the physician programs, which are under Medicare, Part A and Part B, do for our seniors.

This particular proposal we have before the Senate now has two very important gaps. The Senator from California has pointed out one very important gap, a failure to provide services to many of our elderly. There is a second important gap and that is how we treat our retirees.

Senator BOXER has outlined the benefit gap that exists under this proposal. What we are talking about is seniors are going to be spending $1.8 trillion over the next 10 years. This bill only provides for $400 billion. It is only really about 22 percent of all that is going to be necessary for our seniors over the period of the next 10 years.

The issue before us is, first, whether seniors will be able to get the prescription drug program through their Medicare program. I believe the way this bill is constructed they will be. Second, what will the amount available to them be. Clearly, this bill is short.

What the Senator is reminding us about, with her excellent presentation, is that if the Senate itself had the will we could be providing the complete amount necessary to meet all the needs of our senior citizens. I believe that is what we should do.

We have had this debate before in the Senate under the Graham-Miller proposal last year, which I was proud to support. That would have cost close to $600 billion over a period of 8 years. The House Democrats had a different proposal that would have been, actually, close to $1 trillion. But it would have made all the difference and would have attended to the needs of our elderly people.

The Senate has made a different judgment. They have decided they were going to provide $3 trillion in tax cuts for the wealthiest individuals, and give short shrift to our seniors with a $400 billion proposal. That is what we have here in the Senate.

We have had opportunities, even while we were debating the tax proposal. A number of us offered amendments and said let's just take the reduction in the top three rates and perhaps the dividend tax reduction and, instead of going ahead with those additional deductions, use those resources and put them onto a prescription drug program.

We got 49 votes here in the Senate. We got 49 votes here. This body is evenly divided, effectively, on the concept that the Senator from California has provided. Virtually half of this Senate wants to provide the full benefits which would be included in the Boxer amendment. That is what I think needs to be done if we are going to provide a meaningful benefit to seniors.

As this chart points out and as the Senator has explained, after paying the $275 dollar deductible, for expenditures up to $4,500, we are finding 50 percent of all the expenditures effectively are paid for. Then we have the benefit gap in here, which is sometimes known as the donut hole. And then we find the expenditures for our seniors up at 90 percent in the high-cost areas.

It is this area the Senator from California is addressing. I imagine she would like, as well, to try to do something about reducing this deductible or even the premiums as well. Her amendment certainly would do that.

We are back to the real choice of what is important. Are we as a Nation going to say it is more important to have a prescription drug program worthy of its name and support the Boxer amendment? Or, are we going to fail to do that? I, as one Senator, as long as I am in the Senate, am going to continue to fight to be sure we provide the resources to do for prescription drugs what we are doing for our seniors under hospitalization and also with physician fees. I think that is what is fair. That is what is necessary. That is what we mean when we talk about having a good prescription drug program. That is what is really called for if we are going to be true to our senior citizens.

I thank the Senator for raising this issue again. It is really a question of choices. It is a question of priorities. This Senate has made a judgment, a decision previously that what we ought to do is provide tax reductions of $3 trillion, and therefore there are those who say we cannot afford to do what we should be doing for the senior citizens of this country. I regret it. It does seem to me the amendment, which says let's go ahead and pass the Boxer amendment and then we will sort through the pressures we are going to have on our budget in the future and perhaps review some of those excessive tax reductions—it seems to me that is in the Nation's interest.

This is a question of priorities. It is a question of choice. It is a question of value. The Senator from California has made what I think is a compelling case about what is needed to do the job. Mr. President, 22 percent is what this downpayment is. I consider it a downpayment. As I mentioned on all occasions, I think the downpayment is out there. I am going to do everything I can—I am sure the Senator from California is as well—to make sure there is not just a downpayment, but there is going to be a continuing effort on our part to make sure the senior citizens are going to be treated fairly.

Mrs. BOXER. Will my friend yield?

Mr. KENNEDY. I am happy to yield.

Mrs. BOXER. I want to ask a couple questions. The Senator used the term "donut hole." I used the phrase "benefit shutdown." It's all the same. But on the chart, between the yellow and the red, is a big white space. That means that between $4.500 and $5,800 essentially there is no benefit. This is a cost.

My friend is right. All we had to do is tighten up a little bit on what our colleagues wanted to do for the people who earn $1 million a year. It would not have taken that much. The cost of this, after the $400 billion, is $60 billion. We got that from CBO, a $60 billion cost.

My question is basically this: Does he not believe, when you really take a look at this, the administrative costs of making this work are going to be quite large? Think about the accounting that has to go into it, to track everybody's benefit. You have to do it twice. Once between $4.500 and $5.800, and then it goes to 90 percent. I am convinced, I say to my friend, there will be some administrative savings here.

Also I would make the point that because this bill—I know he agrees with me on this—relies too much on the private sector, the administrative costs are sky high. Medicare runs a 3 percent administrative cost. The private sector runs between 15 and 25 percent. As a matter of fact, in the House bill they are saying it is a 25 percent cost of the entire bill.

So I say to my friend, this particular amendment is not that large a cost when you really look at administrative costs going in.

The reason I do not offset it, I say to my friend, is because I think our smart Senators and their smart staffs can sit down and figure out a way to pay for this thing where you can take a lot out of administration. I just wonder if my friend agrees that the complication involved here is worth removing.

Mr. KENNEDY. Well, the complication is costly. We know for a fact we spend $5,000 on health care for every man, woman, and child. We are spending $1.4 trillion a year for every man, woman, and child in America at the present time. That is even before we get into this. Forty percent out of every health care dollar is nonclinical. It is nonclinical. There is not an industry in the world that has that kind of, effectively, overhead.

If we reduce that from 40 cents to 35 cents, it would be $70 billion a year. If we took it down to 30 cents, which is not unreasonable, that would be $140 billion a year. It gives you some idea of what is in the health care system that is not really being translated into good kinds of services. And that is a very important issue and question.

I think the Senator is right, that there is a very high administrative cost generally in terms of our health care system, and there are things that can be done about it. I hope we will have the chance to address those. We have some ideas. But I must say, now the question really has to do with the questions of priorities, about how we are going to act. The fact is, we have the amount that is in the budget which is only the $400 billion, and you stretch it and stretch it, and pull it and pull it, and you get this kind of result. It isn't the kind of result that would be there if the Senator from California drafted the bill or if I drafted the bill, but this is where we are. I am going to do everything I possibly can to make sure we are going to have a complete system.

I thank the Senator.

AMENDMENT NO. 976

Mr. President, I know we are going to go to a vote at 11 o'clock. I would like to take just a minute on the amendment we are going to be voting on. As I understand it, it is the Rockefeller amendment that will be directed toward the retiree issue.

One of the great strengths of Medicare is that it is for everyone. Rich and poor alike contribute to the system. Rich and poor alike benefit from it.

At bottom, Medicare is a commitment to every senior citizen and every disabled American that we will not have two-class medicine in America. When a senior citizen enters a hospital, Medicare pays the same amount for their care whether they are a pauper and a millionaire. When a senior citizen goes to a doctor, she has the peace of mind of knowing that Medicare has the same obligation to pay for her treatment no matter what her financial circumstances and the doctor has no financial interest in rationing her care according to the contents of her bank account.

Through the Medicaid program, we do try to provide extra help for those who are poor. But the fact that Medicaid provides extra assistance for the poor does not reduce Medicare's obligation to provide equal treatment for all. Medicare always has primary payment responsibilities for the services it covers. Medicaid is always supplementary.

Medicaid provides critical help to the poor and the elderly, but it does not provide the same reliable guarantees of equal treatment that Medicare does. Under Medicaid, States have limited the number of days of hospital care they would provide or the number of doctors' visits they will support. States have placed arbitrary limits on the number of prescriptions.

This legislation sets an undesirable precedent for treatment of poor senior citizens who are eligible for both Medicare and Medicaid. For every other benefit, these senior citizens enroll in Medicare, and Medicaid supplements Medicare's coverage. But for this benefit, the bill says that the poor are excluded from Medicare. The only benefits they get are from the Medicaid program. Medicare is for all senior citizens who paid into the program during their working years not just some senior citizens. And it should stay that way.

This amendment rights this wrong. It says we will not take away the Medicare that the poor have earned by a lifetime of hard work. It deserves the support of the Members. I hope it is adopted.

The PRESIDING OFFICER. The Senator from North Dakota.

AMENDMENT NO. 1002

Mr. CONRAD. Mr. President, I rise to speak on the amendment of my colleague from Arkansas. This is an amendment we brought up in the Finance Committee.

Mr. SANTORUM. Mr. President, will the Senator from North Dakota yield for a unanimous consent request?

Mr. CONRAD. I am happy to yield.

Mr. SANTORUM. Mr. President, the managers of the bill have asked we enter a unanimous consent agreement that the time between 10:50 and 11 o'clock be equally divided on the Rockefeller amendment.

The PRESIDING OFFICER. Is there objection?

Mr. CONRAD. Mr. President, I would object to that because I don't want to be taken off my feet when I am finishing the presentation on our amendment. It is going to take me more than 2½ minutes, so I object to that.

The PRESIDING OFFICER. Objection is heard.

Mr. SANTORUM. I say to the Senator, let me know, if there is maybe 8 minutes equally divided, would you have time to do that?

Mr. CONRAD. I would be happy to do that.

Mr. SANTORUM. Mr. President, I ask unanimous consent that we have 8 minutes equally divided, starting at 10:52.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. CONRAD. Mr. President, as I stated earlier on the Senate floor, I believe the bill before us is a step in the right direction. It provides much-needed and long-awaited prescription drug assistance to Medicare beneficiaries across the Nation. I commend Senator GRASSLEY and Senator BAUCUS for putting this proposal together.

But while I support this effort, I also recognize its shortcomings. I think one of the biggest weaknesses of this bill—other than the fact that it is not the kind of full prescription drug plan that many had hoped for because there are not sufficient dollars to support such a plan—is the fact this underlying legislation has too much instability. It creates confusion.

We could have a senior being in four different plans in 4 different years. And if there is anything I think we know, it is that seniors want certainty. They want to know what they are getting. But under this plan, seniors could be bounced back and forth between different plans, depending upon how many private drug-only plans enter an area.

That is the first problem. If a senior is in a fallback plan and two private plans enter the area, they will be forced to leave a plan they may like, and they have no choice in the matter.

The second problem is, every time they switch between drug-only and fallback plans, their benefits could change. This chart demonstrates that uncertainty. Premiums are uncertain. Deductibles are uncertain. The coinsurance, coverage gap, the covered drugs, and even access to local pharmacies with no extra charge—all of those things are subject to change.

The third issue is this very ability isn't just a problem that could occur when a senior goes from a drug-only plan to a so-called fallback plan. It could also happen if seniors go from one fallback plan to another.

When you add this all up, this is the type of situation a senior could face, as shown on this chart. The Senator from Arkansas earlier used this chart. It shows what could happen to a senior being in four different plans in 4 different years, with different premiums, with different copays, with different formularies—that is, different drugs being covered—with different rules with respect to whether they can use their local pharmacy without additional cost.

All of these are subject to change from year to year. Every one of these—the premiums, the deductibles, the coinsurance, the coverage gap, the drugs that are covered—is subject to change. That is not the circumstance we want to construct for our seniors.

In one year of this benefit, only one drug-only plan enters a region. A senior enrolls in the fallback plan to get drug coverage. In 2007, another private plan enters, and the senior is compelled to leave the fallback plan. Whether they like that plan or don't like it, they are forced to leave it.

In the third year, we might see private plan A leave the program and the senior then be put in private plan B, again with different rules, with different copays, with different premiums, with a different coverage gap. And then again, if private plan B left the area, they could again be in a different fallback plan—four different plans in four different years.

I am particularly concerned that rural seniors could face the situation I just described. To date, private plans have not had much interest in coming into those areas. Only 2 percent of rural counties had two or more Medicare+Choice plans in August of 2001.

This amendment seeks to create more stability and to provide the kind of certainty our seniors want. I hope my colleagues will look upon this plan with favor.

I ask unanimous consent that a letter from the National Council on the Aging endorsing this amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE NATIONAL COUNCIL
ON THE AGING,
Washington, DC, June 23, 2003.

Hon. BLANCHE LINCOLN,
Dirksen Senate Office Building,
Washington, DC.

DEAR SENATOR LINCOLN: The National Council on Aging (NCOA)—the Nation's first organization formed to represent America's seniors and those who serve them—supports the amendment you are offering along with Senator Conrad to provide for a two-year contract cycle for the fallback plan in the Senate Medicare proposal.

It is clear from the prescription drug proposal being considered in the Senate that beneficiaries desperately need more stability and less confusion. We are concerned that under the structure currently proposed, vulnerable seniors could be forced to ping-pong back and forth every year from one plan to another—plans with potentially much different premiums, benefit structures, and formularies. We must do everything possible to avoid this kind of instability and confusion, which upset far too many seniors in recent years who enrolled in Medicare+Choice programs. This unfortunate experience must not be repeated.

We deeply appreciate the fact that, unlike the House bill, the Senate bill includes a failsafe mechanism to ensure that prescription drug coverage is guaranteed for every beneficiary choosing to participate.

Given the authority and flexibility in the Senate proposal to negotiate with private plans to reduce their risk in an effort to encourage their participation, we do not expect a significant number of beneficiaries to need the fallback plan. However, in those instances when it is necessary to guarantee access to drug coverage, seniors should not be disadvantaged by subjecting them to a system that could be disruptive and disturbing.

Thank you for your efforts and leadership on behalf of America's seniors. We urge Senators to support your amendment, which will further enhance the stability and fairness of the Senate Medicare proposal.

Sincerely,

JAMES FIRMAN,
President and CEO.

AMENDMENT NO. 976

The PRESIDING OFFICER. Under the previous order, there are 8 minutes of debate evenly divided on the Rockefeller amendment. Who yields time?

Mr. DODD. Mr. President, I ask to be yielded 2 minutes of the 4 minutes on the Rockefeller amendment.

The PRESIDING OFFICER. Who yields time?

Mr. ROCKEFELLER. Mr. President, I yield 3 minutes to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut is recognized for 3 minutes.

Mr. DODD. Mr. President, I thank my distinguished friend and colleague from West Virginia.

I hope the body will support this amendment. I have spoken about the bill generally and expressed my optimism about it despite the serious shortcomings I have. It is a major step in the right direction. We can enhance that by adopting what Senator ROCKEFELLER is offering us today: The ability to ensure that employers will continue to offer prescription drug coverage for their retirees.

What we don't want to do, as we move forward with this program, is to supplant existing retiree programs. That would be a great setback for us. The bill, as presently crafted, does not count payments made by the retiree benefit plan that are out-of-pocket expenditures by the individual beneficiary. This will vastly increase the amount of money an employer will have to pay in order to act as an effective supplement to the Medicare drug benefit, a so-called wraparound to Medicare. In other words, this bill would actually discourage employers from playing even that reduced role in terms of prescription drugs.

The Rockefeller amendment will address this problem so that employer contributions are counted toward an individual's out-of-pocket costs. We will offer an amendment ourselves that would add even a bit more. But this is a major amendment and a critical one. It would be a great irony indeed, as we move forward with our plan, that we end up discouraging employers from participating, as they have, in providing their retirees with the kind of protections they need. It would actually cost them more. It is very important we adopt this amendment. This is a critically important question.

Even before we got into this whole business, the benefits being provided by employers, by nonprofits, and others have been important in terms of enhancing a retiree's ability to pay for prescription drugs and not have to make the choice of food on the table or prescription drugs or to self-medicate by reducing the amount of prescription drugs they get. No one in this place wants to be a party to actually encouraging employers to step away from the very important part they already play in providing these benefits for their employees and retirees.

I thank the Senator from West Virginia. It is a very important amendment. I strongly endorse it and hope it will be adopted.

Ms. MIKULSKI. Mr. President, I rise in support of the amendment No. 976 offered by Senator ROCKEFELLER to protect retirees from losing their hard won health care benefits. I also support amendment No. 998 offered by Senator DODD to encourage employers to continue to provide retirees with health care coverage.

I have seen how a community is devastated when a company pulls the retiree health care plan out from under their feet. Last year, when Senator ROCKEFELLER and I worked on adding steel retirees to the trade adjustment assistance health care tax credit, the writing was on the wall for Bethlehem Steel. A once proud company, that was the backbone of several communities in Maryland, West Virginia, New York, and Pennsylvania had been crippled by illegal dumping of foreign steel.

Now Bethlehem Steel is no more and nearly 20,000 of their retirees and their families in Maryland, nearly 100,000 total, are left without the health care for which they worked their whole lives. We provided some relief for these retirees.

But we cannot let other retirees face the fear of losing their health care; face going bankrupt trying to afford their drugs, or face a confusing new system.

This legislation does not privatize Medicare: it does not coerce seniors to leave the Medicare they trust to get the drugs they need. Yet it does rely too heavily on private insurance companies. It should be a benefit for seniors and not a benefit for insurance companies that have let seniors down so many times before. Yet it puts the health care benefits of millions of seniors in jeopardy by creating an incentive for employers to drop retiree health care coverage.

That is why I will join my colleagues in offering amendments to strengthen the bill.

What would this amendment do?

CBO, our nonpartisan, unbiased analyst tell us that 37 percent of seniors with employer-sponsored coverage will lose that coverage if this bill is passed.

These retirees earned their retiree health care benefits. The benefit payments made on their behalf should be counted as their contributions toward the catastrophic cap. They earned their health care coverage. It is a part of their benefit package as a worker and should count just as the wages they pay for their prescription drugs count.

Why is this amendment important?

Employers want to do the right thing but are being squeezed at the bottom line. Prescription drug costs account for about 40 percent to 60 percent of employer retiree health care costs. What does that mean for U.S. employers? U.S. employers face competition from overseas where the cost of health care, including prescription drugs, is subsidized by the Government. What does this mean for U.S. retired workers? Unless this amendment is adopted, a senior could have closer to $10,000 in drug costs before they get the relief of the catastrophic cap. Unless this amendment is adopted millions of seniors could lose their retiree health care coverage.

Under some estimates, this bill would give insurance companies up to $25 billion to provide drug benefits to seniors. Yet thousands of employers already provide quality health care benefits to their retirees, benefits that include prescription drugs.

Congress should use the same test as a doctor would: Do no harm.

In passing this bill, we could decimate the ability of employers to provide health care coverage for their retirees. I think we should fix this.

In conclusion, I urge my colleagues to stand up for American businesses, stand up for America's workers, and stand up for America's seniors and support this amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I hear often from many on the other side of the aisle that the Republican Party is the party of big corporations and corporate bailouts: This is a $66 billion, big corporation bailout being offered by Members on the other side of the aisle, $66 billion to corporate America that is already getting a huge benefit under this bill. We are already, by providing prescription drugs to all retirees, giving them the ability to basically back away, as has been discussed, from providing basic prescription drugs and still add on, if they want to add on additional benefits to the bottom line benefit. The cost savings already in the bill to corporations are in the billions and billions of dollars. But that is not enough. We have to give big corporate America another $66 billion so they can provide even more generous benefits to their retirees on top of the generous benefit we have in this legislation.

I find it almost incomprehensible that we are arguing that at a time when we are providing literally tens of billions of dollars—maybe even more than that—to corporate America to help relieve some of their retiree health care costs, now we have to add $66 billion more over the next 10 years to corporate America.

This is a very unwise amendment. It is a very costly amendment, $66 billion. In addition, you are seeing already that corporate America is getting out of the retiree health care business because it is very expensive. One of the reasons we are moving forward with this legislation is because of that. We have seen the percentage of retiree health plans drop from 71 percent to 44 percent just in the last 15 years. This is a trend that is ongoing. One of the reasons we are stepping in with this universal benefit is to address that issue.

To in effect provide an additional amount of money to corporations to basically help them maintain their effort in this area is a folly. It is a very costly proposal and should be, hopefully, defeated.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, the argument made by the Senator from Pennsylvania is interesting because what he is basically saying is that it is more important that corporate America not be allowed to keep one out of three of their people they currently sponsor, who are retirees who worked for them and who have been getting health benefits from them, out of the picture.

He talked about the cost to corporate America. My sort of worry is about the cost to the U.S. Government. That is what we do if we don't pass my amendment; we just dump everything on the U.S. Government.

So this amendment will make sure we do not jeopardize the drug coverage of millions of retirees, one out of every three, who already receive drug coverage from employer-sponsored plans. This amendment is going to ensure that the contributions made on the beneficiaries' behalf by their former employers count toward that beneficiary meeting the catastrophic limit. That is not now the case.

Employer-sponsored retiree health benefits are the single greatest source of coverage for retirees—the Presiding Officer understands what I am saying—the single greatest source of retiree health benefits available. In fact, 37 percent of all retirees who have corporate-sponsored plans simply lose them if this does not pass.

The PRESIDING OFFICER. Time has expired.

Mr. ROCKEFELLER. I hope we will pass my amendment. It is worse for employees. It is worse for employers. I hope my colleagues will support the amendment.

Mr. REID. Have the yeas and nays been ordered?

The PRESIDING OFFICER. That is correct.

The Senator from Pennsylvania has 1 minute 39 seconds remaining of the majority time.

Mr. SANTORUM. Mr. President, under the existing legislation, employers are allowed to continue to offer benefits to their employees. Many will. Many will change the structure of the benefit in which they offer to wrap around the existing Medicare benefit, as they do now with Medicare.

Their retiree insurance plans currently wrap around the existing Medicare plan. Future retiree plans will wrap around. Giving corporations $66 billion over the next 10 years as an incentive to give more generous benefits is nothing but a corporate giveaway and costs the taxpayers literally billions of dollars. It is an unwise transfer of Government dollars, taxpayer dollars to big corporations, that already have very generous health care plans, as well as retirement plans. It is not focused on what we should be focusing on here, which is the poorest of the poor.

Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER (Mr. ENZI). Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Nebraska (Mr. HAGEL) and the Senator from Indiana (Mr. LUGAR) are necessarily absent.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from Florida (Mr. GRAHAM), and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 43, as follows:

[Rollcall Vote No. 233 Leg.]

YEAS—52

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hatch
Hutchison
Inhofe
Kyl
Lott
McCain
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NAYS—43

Akaka
Bayh
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Jeffords
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lieberman
Lincoln
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NOT VOTING—5

Biden
Graham (FL)
Hagel
Kerry
Lugar

The motion was agreed to.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 984, AS MODIFIED

Mr. GRASSLEY. It is my understanding that the Senator from New Mexico is ready to modify his amendment. With the modification, I accept that amendment. We would not have a vote. I urge we proceed to the amendment of the Senator from New Mexico for consideration of his modification.

Mr. BUNNING. Reserving the right to object, could we at least understand what the modification is.

Mr. GRASSLEY. The Senator from New Mexico will explain that.

Mr. BINGAMAN. Mr. President, when I came to the Senate floor a few minutes ago, we were just informed by the Republican staff that CBO estimates the amendment we were planning to vote on would cost $5 billion. This is all brandnew information. It is erroneous information, but I have no way to contradict what CBO is saying.

Therefore, I send an amendment to the desk to modify my amendment to request a study by MedPAC on this issue which would come back to us within a year. At that point, we could make a determination as to whether we want to take the action I had originally been proposing. Let me explain.

I ask unanimous consent that I be allowed to modify my amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 984), as modified, is as follows:

After section 404, insert the following:

SEC. 404A. MEDPAC STUDY AND REPORT REGARDING MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT PAYMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as "MedPAC") shall conduct a study to determine, with respect to additional payment amounts paid to subsection (d) hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

(1) whether such payments should be made in the same manner as payments are made with respect to graduate medical education under title XVIII and with respect to hospitals that serve a disproportionate share of low-income patients under the medicaid program; and

(2) whether to add costs attributable to uncompensated care to the formula for determining such payment amounts.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with such recommendations for legislation as MedPAC determines are appropriate.

Mr. BINGAMAN. Mr. President, the issue to which this study will give the answer is the question of whether disproportionate share hospitals that are the same net hospitals, that serve many of the individuals who would not have any health insurance, should continue to receive the DSH payments we have legislated they are entitled to, even after this prescription drug legislation becomes law. I strongly believe they should. My amendment was intended to ensure they receive those payments.

I fear the system we are adopting, which will move people into preferred provider organizations, will in fact reduce the payments to these disproportionate share hospitals, which I don't believe is the purpose or the intention of the Senate. That is the issue.

I urge my colleagues to support the study to give an answer as to whether that problem exists.

Mr. GRASSLEY. As I indicated, we accept that amendment, and I would like to have it adopted on a voice vote.

Mr. BAUCUS. Mr. President, it is unfortunate we did not get the score on the Senator's amendment until just recently. The chairman and I have been in constant contact. I have called several times today the CBO Director in order to get the scores in time for amendments. The good news is Senators have come to us so we are able to prioritize amendments and therefore calls to CBO are on amendments that will be sequenced so we can help them get the scores. We are trying our best to get CBO scores. The Senators can help us and help CBO get the scores by getting amendments to us early so we can sequence them.

On the other hand, it is very helpful if CBO can work as diligently as possible themselves and live up to their side of the bargain and get the scores to us. I hope we do not face this situation again where we get the score moments before an amendment is voted on, even though CBO knew this amendment was coming up; they had at least 24 hours' advance notice.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 984), as modified, was agreed to.

Mr. GRASSLEY. We have had so many Democrat amendments that have been offered. We have reserved time for Republicans to fit in. It is my understanding that Senator SMITH of Oregon is prepared to offer an amendment from our side. I ask unanimous consent that Senator SMITH be recognized.

Mr. REID. Reserving the right to object, will there be a unanimous consent offered for sequencing votes later this afternoon?

Mr. GRASSLEY. Mr. President, in answer to the distinguished Democrat whip, there is an effort being made at the staff level to put together a series of votes. In further response, we are not prepared at this point to ask unanimous consent, but we will have such a request to make for stacking of votes and an order for votes.

Mr. REID. For the information of Senators, my understanding is that the two leaders want to have a series of votes starting at 2:25 this afternoon; is that right?

Mr. GRASSLEY. That is my understanding.

The PRESIDING OFFICER. The Senator from Oregon.

AMENDMENT NO. 962

Mr. SMITH. Mr. President, I ask unanimous consent that the pending amendment be set aside and I send an amendment to the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Oregon [Mr. SMITH], for himself and Mr. BINGAMAN, proposes an amendment numbered 962.

Mr. SMITH. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide reimbursement for Federally qualified health centers participating in medicare managed care)

At the end of title VI, insert the following:

SEC. . REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) REIMBURSEMENT.—

(1) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

"(3) in the case of services described in section 1832(a)(2)(D)—

"(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

"(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

"(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

"(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);".

(b) CONTINUATION OF MEDICAREADVANTAGE MONTHLY PAYMENTS.—

(1) IN GENERAL.—Section 1853 (42 U.S.C. 1395w-23), as amended by this Act, is amended by adding at the end the following new subsection:

"(j) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with a MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

"(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

"(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).".

(2) CONFORMING AMENDMENTS.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w-21(i)(1)), as amended by this Act, are each amended by inserting "1853(j)," after "1853(i),".

(B) Section 1853(c)(5) is amended by striking "subsections (a)(3)(C)(iii) and (i)" and inserting "subsections (a)(3)(C)(iii), (i), and (j)(1)".

(c) ADDITIONAL MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—Section 1857(e) (42 U.S.C. 1395w-27(e)) is amended by adding at the end the following new paragraph:

"(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

"(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

"(B) COST-SHARING.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).".

(d) SAFE HARBOR FROM ANTIKICKBACK PROHIBITION.—Section 1128B(b)(3) (42 U.S.C. 1320a-7b(b)(3)) is amended—

(1) in subparagraph (E), by striking "and" after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

Mr. SMITH. Mr. President, I rise today to offer this amendment that will protect the health care safety net and ensure access to quality health care for low-income Medicare beneficiaries who rely on our Nation's community health centers. I am pleased to be joined in this by my colleague from New Mexico, Senator BINGAMAN, who has been a strong advocate for the medically underserved. It is a privilege to work with him on this amendment.

This is an issue that affects the entire country, not just my State of Oregon. We all have community health centers. Health centers are the family doctor to more than 13 million people, more than 5 million of whom are uninsured, and nearly 1 million are low-income Medicare beneficiaries.

For many of these individuals, their local health center is the only accessible provider of preventive and primary health care services. While the centers receive Federal Public Health Service Act grant funds to support care for their uninsured patients, they rely on adequate payments from both Medicaid and Medicare for care provided to beneficiaries under both programs.

In 1990, Congress recognized the importance of protecting the integrity of the PHSA grant funds and required that health centers receive reasonable cost payments under the traditional Medicare Part B Program. This action on the part of Congress helped both to ensure that the health centers are reimbursed sufficiently for the provision of care to beneficiaries under the traditional Medicare program, and to protect access to health center services for the uninsured. The amendment we are proposing today simply would extend the same requirement to new Medicare Advantage Programs.

Specifically, the amendment would ensure that health centers are provided with a wraparound or supplemental payment, equal to the difference between the payments they now receive under Medicare generally and the payments they will receive from Medicare Advantage plans. This is not a new concept.

Under current Medicaid law, a health center is reimbursed by a managed care organization the equivalent of what the managed care organization pays any other provider of similar services. In turn, the State Medicaid Program provides a wraparound or supplemental payment for the difference between the managed care organization's payment and the health center's reasonable cost. The absence of a wraparound payment system in the current Medicare managed care program, Medicare+Choice, has left many health centers struggling to provide services to seniors under the program while trying to protect Federal grant funds intended to support care for the uninsured.

In 2001, health centers in my home State of Oregon lost more than $55 for each patient's office visit when they were enrolled under a Medicare managed care plan. In the same year, Oregon health centers lost almost as much revenue as they gained from the Medicare managed care patients. It is estimated this new percentage will grow even larger under the new Medicare Advantage Program. In fact, if current estimates are correct, health centers nationwide can expect to experience an average loss of $35 per office visit under the Medicare Advantage Program. Simply put, what this means is that without a wraparound payment system for health care centers contracting with Medicare Advantage plans, these centers will have no choice but to reach deep into their Federal grant funds, money that is supposed to go for care to the uninsured, in order to make up for the loss in Medicare payments. This will only serve to put further strain on health centers as well as the public safety net overall.

The President and the Congress have called upon this Nation to double the capacity of health centers and build a stronger primary care infrastructure for America's communities. America's health centers are trying to meet that challenge and still meet the health care needs of the Nation's growing uninsured.

In the last 3 years alone, health centers added more than 800,000 new uninsured patients to their roles, raising the number of uninsured Americans served by these centers to one in every eight Americans.

Our amendment would protect the vital mission of health centers to provide access to care to underserved rural and inner city communities. It would also bolster the goal of the President and the Congress to strengthen our health care safety net.

I have a letter in support of my amendment. I ask unanimous consent the letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

OREGON PRIMARY CARE ASSOCIATION,
Portland, OR, June 23, 2003.

Senator GORDON SMITH,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR SMITH: On behalf of the 16 public and private, not-for-profit community health centers throughout the State of Oregon, I would like to extend our sincere gratitude for your sponsorship of the amendment to the Medicare reform bill which will implement "wrap around" payments for Federally Qualified Health Centers serving seniors under Medicare managed care.

As you know, Federally Qualified Health Centers (FQHCs) serve a critical role in their communities. In Oregon alone, more than 150,000 individuals rely on FQHCs for their primary health care needs each year. In the many rural areas of the state, in particular, FQHCs are often the only primary care providers available to serve Medicare, Medicaid and uninsured patients. The wrap around payments that you have proposed will ensure that FQHCs are adequately reimbursed for the cost of treating recipients of Medicare + Choice and the new Medicare Advantage program. Without adequate reimbursement for treating these Medicare managed care patients, FQHCs would be unable to continue to provide comprehensive, high-quality services to many of the seniors who rely on health centers for their care.

Senator Smith, our state is fortunate to have your leadership in Washington. Thank you again for your support and sponsorship of this measure that will significantly impact seniors and other underserved Oregonians being served by community health centers.

Sincerely,

CRAIG HOSTETLER,
Executive Director.

Mr. SMITH. Senator BINGAMAN and I are convinced that this amendment goes a long way toward answering the concerns of health centers about how the Medicare Advantage Program will impact their ability to continue to provide high-quality health care services to their patients.

I thank my distinguished colleague from New Mexico for his efforts and his cosponsorship of this amendment and I urge all our colleagues to support it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I congratulate my colleague from Oregon for his leadership on this important issue. We have all worked on a bipartisan basis with the administration to increase our support for community health centers. We have all begun to recognize the very vital role they play in providing health care to many of our citizens throughout the country.

This amendment is absolutely crucial if we are going to ensure that the unintended effect of the legislation before us is not to drain funds away from community health centers as more and more people decide they want to sign up for these preferred provider organizations.

This is crucial legislation. It is very important we do this in the case of the Medicare prescription drug area, just as we did in the case of Medicaid.

I again compliment my colleague and I am honored to be a cosponsor of this amendment.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BYRD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. TALENT). Without objection, it is so ordered.

PREWAR INTELLIGENCE INVESTIGATION

Mr. BYRD. Mr. President, the news is just on the wires that six British troops have been killed near Basra in Iraq. Every day—every day—brings us sad tidings of American and/or Allied troops being killed in Iraq.

How much longer—how much longer, Mr. President—are our American fighting men and women going to have to remain in harm's way in a foreign land? How much longer are our National guardsmen and women and reservists going to have to be away from home?

The President announced not too long ago that major hostilities had ended. Were we told by this administration how long our military forces will be required to run these terrible risks that daily confront them in this biblical land of Mesopotamia, land between the two great rivers? I often asked the question, before the war began, What is going to be the cost? What is the plan? What is the administration's plan? What about the morning after the war ends?

No announcement has been made at this point that the war has ended, only that major hostilities no longer exist. And then there were public disagreements as to how many Americans would be needed in Iraq to bring about a safe and secure society.

I try to put myself in the place of a father or a husband of one of our military personnel in Iraq. I try to imagine the pain and the suffering on the part of those who wait—who wait—at home for the return of their loved ones.

Last fall, the White House released a national security strategy that called for an end to the doctrines of deterrence and containment that have been a hallmark of American foreign policy for more than half a century.

This new national security strategy is based upon preemptive war—something unheard of in the past experiences, practices, and policies of our Nation—preemptive war against those who might threaten our security.

Such a strategy of striking first against possible dangers is heavily reliant upon interpretation of accurate and timely intelligence. If we are going to hit first, based on perceived dangers, the perceptions had better be accurate. If our intelligence is faulty, we may launch preemptive wars against countries that do not pose a real threat against us or we may overlook countries that do pose real threats to our security, allowing us no chance to pursue diplomatic solutions to stop a crisis before it escalates to war. In either case, lives could be needlessly lost. In other words, we had better be certain that we can discern the imminent threats from the false alarms.

Just 96 days ago, as of June 24, President Bush announced that he had initiated a war to "disarm Iraq, to free its people and to defend the world from grave danger." The President told the world:

> Our nation enters this conflict reluctantly—yet, our purpose is sure. The people of the United States and our friends and allies will not live at the mercy of an outlaw regime that threatens the peace with weapons of mass [destruction].

The President has since announced that major combat operations concluded on May 1. He said:

> Major combat operations in Iraq have ended. In the battle of Iraq, the United States and our allies have prevailed.

Since then, Mr. President, the United States has been recognized by the international community as the occupying power in Iraq. And yet we have not found any evidence that would confirm the officially stated reason that our country was sent to war; namely, that Iraq's weapons of mass destruction constituted a grave threat to the United States—a grave threat to the United States.

We have heard a lot about revisionist history from the White House of late in answer to those who question whether there was ever a real threat from Iraq. But it is the President who appears to me to be intent on revising history.

There is an abundance of clear and unmistakable evidence that the administration sought to portray Iraq as a direct, deadly, and imminent threat to the American people. But there is a great difference between the hand-picked intelligence that was presented by the administration to Congress and the American people when compared against what we have actually discovered in Iraq. This Congress and the American people, who sent us here, are entitled to an explanation from this administration.

On January 28, 2003, President Bush said in his State of the Union Address:

> The British Government has learned that Saddam Hussein recently sought significant quantities of uranium from Africa.

Yet, according to news reports, the CIA knew this claim was false as early as March 2002. In addition, the International Atomic Energy Agency has since discredited this allegation.

On February 5, Secretary of State Colin Powell told the United Nations Security Council:

> Our conservative estimate is that Iraq today has a stockpile of between 100 and 500 tons of chemical weapons agents. That is enough to fill 16,000 battlefield rockets.

But, the truth is, to date we have not found any of this material, nor those thousands of rockets loaded with chemical weapons.

On February 8, President Bush told the Nation:

> We have sources that tell us that Saddam Hussein recently authorized Iraqi field commanders to use chemical weapons—the very weapons the dictator tells us he does not have.

Well, I say to my fellow Senators, we are all relieved that such weapons were not used, but it has not yet been explained why the Iraqi Army did not use them. Did the Iraqi Army flee their positions before chemical weapons could be used? If so, why were the weapons not left behind? Or is it that the army was never issued chemical weapons?

We need answers. We need answers to these and other such questions.

On March 16, the Sunday before the war began, in an interview with Tim Russert, Vice President CHENEY said the Iraqis want "to get rid of Saddam Hussein and they will welcome as liberators the United States when we come to do that." Vice President CHENEY said the Iraqis want "to get rid of Saddam Hussein and they will welcome as liberators the United States when we come to do that."

He added:

> . . . the vast majority of them would turn Saddam Hussein in in a minute if, in fact, they thought they could do so safely.

But, today Iraqi cities remain in disorder. Our troops are under attack as well as our allies. Our occupation government lives and works in fortified compounds, and we are still trying to determine the fate of the ousted murderous dictator.

On March 30, Secretary of Defense Donald Rumsfeld, during the height of the war, said of the search for weapons of mass destruction:

> We know where they are. They're in the area around Tikrit and Baghdad and east, west, south, and north somewhat.

Well, Mr. President, Baghdad fell to our troops on April 9 and Tikrit on April 14, and the intelligence about which Secretary of Defense Rumsfeld spoke has not led us to any weapons of mass destruction. Whether or not intelligence reports were bent, stretched, or massaged to make Iraq look like an imminent threat to the United States, it is clear that the administration's rhetoric played upon the well-founded fears of the American public about future acts of terrorism. But upon close examination, many of these statements have nothing to do with intelligence because they are, at root, just sound bites based on conjecture. They are designed to prey upon public fear.

The face of Osama bin Laden morphed into that of Saddam Hussein. President Bush carefully blurred these images in his State of the Union Address. Listen to this quote from the President's State of the Union Address:

> Imagine those 19 hijackers with other weapons and other plans—this time armed by Saddam Hussein. It would take one vial, one canister, one crate slipped into this country to bring a day of horror like none we have ever known.

Judging by this speech, not only is the President confusing al-Qaida and Iraq, but he also appears to give a vote of no confidence to our homeland security efforts. Isn't the White House the brains behind the Department of Homeland Security? Isn't the administration supposed to be stopping those vials, canisters, and crates from entering our country rather than trying to scare our fellow citizens half to death about them?

Not only did the administration warn about more hijackers carrying deadly chemicals, the White House even went so far as to suggest that the time it would take for U.N. inspectors to find solid smoking gun evidence of Saddam's illegal weapons would put the United States at greater risk of nuclear attack from Iraq.

National Security Adviser Condoleezza Rice was quoted as saying on September 9, 2002, by the Los Angeles Times:

> We don't want the "smoking gun" to be a mushroom cloud.

"Threat by Iraq Grows," this is the headline that was in the Los Angeles Times.

Well, talk about hype. Mushroom clouds? Where is the evidence for this? Where is the evidence for that hype? There isn't any.

On September 26, 2002, just 2 weeks before Congress voted on the resolution to allow the President to invade Iraq and 6 weeks before the midterm elections, President Bush himself built the case that Iraq was plotting to attack the United States.

After meeting with members of Congress on that date, the President said:

> The danger to our country is grave. The danger to our country is growing. The Iraqi regime possesses biological and chemical weapons. . . . The regime is seeking a nuclear bomb, and with fissile material, could build one within a year.

Well, these are the President's words. He said that Saddam Hussein is seeking a nuclear bomb. Have we found any evidence to date of this chilling allegation? No.

But President Bush continued on that autumn day:

> The dangers we face will only worsen from month to month and from year to year. To ignore these threats is to encourage them. And when they have fully materialized, it may be too late to protect ourselves and our friends and our allies. By then, the Iraqi dictator would have the means to terrorize and dominate the region. Each passing day could be the one on which the Iraqi regime gives anthrax or VX—nerve gas—or some day a nuclear weapon to a terrorist ally.

Yet, 7 weeks after declaring victory in the war against Iraq, we have seen nary a shred of evidence to support the President's claims of grave, dangerous chemical weapons, links to al-Qaida, or nuclear weapons.

Just days before a vote on a resolution that handed the President unprecedented war powers, President Bush stepped up the scare tactics. On October 7, just 4 days before the October vote in the Senate on the war resolution, the President had this to say:

> We know that Iraq and the al-Qaida terrorist network share a common enemy—the United States of America. We know that Iraq and al-Qaida have had high-level contacts that go back a decade.

He continued:

> We've learned that Iraq has trained al-Qaida members in bomb-making and poisons and deadly gases. . . . Alliance with terrorists could allow the Iraqi regime to attack America without leaving any fingerprints.

President Bush also elaborated on claims of Iraq's nuclear program when he said:

> The evidence indicates that Iraq is reconstituting its nuclear weapons program. Saddam Hussein has held numerous meetings with Iraqi nuclear scientists, a group he calls his "nuclear mujahideen"—his nuclear holy warriors. . . . If the Iraqi regime is able to produce, buy, or steal an amount of highly enriched uranium a little larger than a single softball, he could have a nuclear weapon in less than a year.

Wasn't that enough to keep you awake, Senators? This is the kind of pumped-up intelligence and outrageous rhetoric that was given to the American people to justify a war with Iraq. This is the same kind of hyped evidence that was given to Congress to sway its vote for war on October 11, 2002.

We hear some voices saying, well, why should we care? After all, the United States won the war, didn't it? Saddam Hussein is no more. Iraq is no longer a threat. He is either dead or on the run, so what does it matter if reality does not reveal the same grim picture that was so carefully painted before the war. So what. So what if the menacing characterizations that conjured up visions of mushroom clouds and American cities threatened with deadly germs and chemicals were overdone. So what.

Our sons and daughters who serve in uniform answered the call to duty. They were sent to the hot sands of the Middle East to fight in a war that has already cost the lives of 194 Americans to this moment, thousands of innocent civilians, and unknown numbers of Iraqi soldiers. Our troops are still at risk. Hardly a day goes by that there is not another attack on the troops who are trying to restore order to a country teetering on the brink of anarchy. When are they coming home?

The President told the American people we were compelled to go to war to secure our country from a grave threat. Are we any safer today than we were on March 18, 2003? Our Nation has been committed to rebuilding a country ravaged by war and tyranny, and the cost of that task is being paid for in blood and in treasure every day.

It is in the compelling national interest to examine what we were told about the threat from Iraq. This is not revisionist history. These words are plain English words that I have quoted. It is in the compelling national interest to know if the intelligence was faulty. It is in the compelling national interest to know if the intelligence was distorted. It is in the national interest to know if the intelligence was manipulated.

Mr. President, Congress must face this issue squarely. Congress should begin immediately an investigation into the intelligence that was presented to the American people about the prewar estimates of Saddam's weapons of mass destruction and the way in which that intelligence might have been misused. This is no time for a timid, tippy-toe Congress. Congress has a responsibility to act in the national interest and to protect the American people, and we must get to the bottom of this matter.

Although some timorous steps have been taken in the past few days to begin a review of this intelligence—I must watch my words carefully, for I may be tempted to use the word "investigation" or "inquiry" to describe this review, and those are terms which I am told are not supposed to be used—the proposed measures appear to fall short of what the situation requires. We are already shading our terms about how to describe the proposed review of intelligence: cherry-picking words to give the American people the impression that the Government is fully in control of the situation, and that there is no reason to ask tough questions. This is the same problem that got us into this controversy about slanted intelligence reports. Word games, lots and lots of word games.

This is no game. For the first time in our history, the United States has gone to war because of intelligence reports claiming that a country posed a threat to our Nation. Congress should not be content to use standard operating procedures to look into this extraordinary matter.

We should accept no substitute for a full, bipartisan investigation by Congress into the issue of our prewar intelligence on the threat from Iraq and the use of that intelligence.

The purpose of such an investigation is not to play preelection year politics, nor is it to engage in what some might call "revisionist history." Rather, it is to get at the truth. The longer questions are allowed to fester about what our intelligence knew about Iraq, and when our intelligence knew it, the greater the risk that American people, whom we are elected to serve, will lose confidence in our Government.

This looming crisis of trust is not limited to the public. Many of my colleagues were willing to trust the administration and vote to authorize war against Iraq. Many Members of this body trusted so much that they gave the President sweeping authority to commence war. As President Reagan famously said, "Trust, but verify." Despite my opposition, the Senate voted to blindly trust the President with unprecedented—unprecedented, unprecedented—power to declare war. Shame. While the reconstruction continues, so do the questions, and it is time to verify.

I have served the people of West Virginia in Congress for half a century. I have witnessed deceit and scandal, coverup and aftermath. I have seen from both parties Presidents who once enjoyed great popularity among the people leave office in disgrace because they misled the American people. I say to this administration: Do not circle the wagons. Do not discourage the seeking of truth in these matters.

The American people have questions that need to be answered about why we went to war with Iraq. To attempt to deny the relevance of these questions is to trivialize the people's trust and confidence.

The business of intelligence is secretive by necessity, but our Government is open by design. We must be straight with the American people. Congress has the obligation to investigate the use of intelligence information by the administration in the open so that the American people can see that those who exercise power, especially the awesome power of preemptive war, must be held accountable. We must not go down the road of coverup. That is the road to ruin.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1004

Mrs. HUTCHISON. Mr. President, I ask that amendment No. 1004, which is at the desk, be called up.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from Texas [Mrs. Hutchison] proposes an amendment numbered 1004.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the medicare program at 6.5 percent)

At the end of subtitle A of title IV, add the following:

SEC. . FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) In General.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking "and" at the end; and

(2) by striking subclause (VII) and inserting the following new subclauses:

"(VII) during fiscal years 2003, 2004, 2005, 2006, 2007, and 2008, 'c' is equal to 1.35; and

"(VIII) on or after October 1, 2008, 'c' is equal to 1.6.".

(b) Conforming Amendment Relating to Determination of Standardized Amount.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking "1999 or" and inserting "1999,"; and

(2) by inserting ", or the Prescription Drug and Medicare Improvement Act of 2003" after "2000".

Mrs. HUTCHISON. Mr. President, today I rise, along with Senators Kennedy, Talent, Biden, Kerry, Murray, Reed, Specter, Bond, Clinton, Feinstein, and Durbin to offer an amendment for America's teaching hospitals.

The teaching hospitals in our country perform a vital role in training the doctors and nurses who conduct medical research and provide care to the needy. But the foundation of this essential public service is beginning to crack under the strain of Medicare reductions and a range of other financial pressures.

As my colleagues are aware, the Balanced Budget Act of 1997 made cuts to indirect medical education, called IME, which is an add-on for Medicare reimbursements to teaching hospitals. The add-on was reduced from 7.7 percent in 1997 to 6.5 percent in 1999. Further reductions were scheduled beginning in 2000, but those cuts were delayed until last October, and now the reimbursement rate has been dropped from 6.5 percent to 5.5 percent. That 1 percentage point means our Nation's teaching hospitals will lose almost $800 million this year, $4.2 billion over the next 5 years.

My amendment restores the reimbursement rate to 6.5 percent in fiscal year 2009. By putting this off until fiscal year 2009, of course, we are avoiding any Budget Act point of order.

There are 1,100 teaching hospitals in our country where Americans receive world-class care. Every State has at least one, so every Senator will have affected constituents. Teaching hospitals train nearly 100,000 doctors every year, and chances are, Mr. President, your physician and mine were trained at teaching hospitals.

In 1983, the Federal Government recognized that teaching hospitals cost more than their nonteaching counterparts because they incur costs to train our health care providers of the future. They provide clinical research in new procedures, technology, and treatments. Perhaps most importantly, they ensure a steady stream of high-quality physicians who are equipped to meet the health care challenges of the 21st century. They are also a major provider of indigent care in the United States. But education and training costs extra money.

The Government added the IME payment to encourage teaching hospitals to invest in our future, but, unfortunately, we have chipped away from 11.6 percent in 1983 to today's rate of 5.5 percent, which is a factor based on a hospital's resident-to-bed ratio included in Medicare reimbursement. We cannot continue to decimate funding at these hospitals that educate our medical students and expect quality medical care in the 21st century.

Teaching hospitals in Texas have lost $26.8 million in reimbursements in 2003 alone. Our State is not the hardest hit. New York lost $141 million; Pennsylvania, $78 million; and Michigan, $50 million.

One example in my State exemplifies what is happening in every teaching hospital in our country. Methodist Hospital in Houston trains more than 200 residents a year and works closely with Baylor College of Medicine to effectively train physicians in radiology, cardiology, and neurology with the newest technology. Methodist purchased an MRI machine for $4.5 million. That MRI will not only provide preventive medicine to help diagnose illnesses sooner, it also teaches the next generation of health care professionals what they cannot learn in the classroom.

This week, as we debate Medicare reform, it is imperative to reaffirm our commitment to America's teaching hospitals as these hospitals are in financial distress. If we do not restore funding, not only will they suffer, so will our health care system, particularly patient care.

I ask for the support for this amendment. I ask for the yeas and nays. I will ask for unanimous consent to stack the next two votes, but I also ask unanimous consent the vote on my amendment be in the next series of votes.

Mr. REID. Reserving the right to object, it is my understanding the Senator has asked that following the Dodd vote we vote on Pryor and Boxer.

Mrs. HUTCHISON. I was going to offer that unanimous consent.

Mr. REID. Did you ask unanimous consent on something else?

Mrs. HUTCHISON. I was going to ask unanimous consent for the Pryor amendment and the Boxer amendment and then ask my amendment be in the next series of votes.

Mr. REID. Mr. President, I reluctantly have to object. I personally could care less, but until the two managers are here—unless you have cleared it with the two managers.

Mrs. HUTCHISON. No, I have not.

The PRESIDING OFFICER. The objection is heard.

The Senator from Texas has requested the yeas and nays. Is there a sufficient second? There is a sufficient second. The yeas and nays are ordered.

Mrs. HUTCHISON. I ask unanimous consent following the vote this afternoon in relation to the Dodd amendment No. 969, the Senate vote consecutively in relation to the following amendments: Pryor amendment 981, Boxer amendment 1001; provided further that there be 2 minutes equally divided between each of the votes with no amendments in order to the amendments prior to the vote.

Mr. REID. We do not object.

Mrs. HUTCHISON. And I ask the Democratic leader work with me to be in the next series of votes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I say to the distinguished Senator from Texas we will try to do that. It seems the right thing to do.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENT NO. 969

The PRESIDING OFFICER. Under the previous order, the hour of 2:15 having arrived, there will now be 10 minutes evenly divided prior to a vote in relation to the Dodd amendment, No. 969.

Mr. DODD. Mr. President, do I need to ask unanimous consent the present amendment be temporarily set aside?

The PRESIDING OFFICER. That is unnecessary.

Mr. DODD. Mr. President, in the 5 minutes I have, let me discuss it very briefly with my colleagues.

This amendment would allow Medicare beneficiaries the freedom to move between plans for the first 2 years that this benefit is in effect, from 2006 to 2007. Under the present bill, you have to make a decision immediately and then you are locked into that decision for a year. Then you would have an open enrollment period for a month after that, and then you would be locked in for another year.

What we are offering with this amendment is initially seniors be given a 2-year window in order to decide which plan works best for them. Then you would go to the 1 year with the 1-month open enrollment. But, initially, given the tremendous amount of potential confusion about which of these various alternatives would work best for people, they ought to be given a bit more time than to have to make an almost instantaneous decision about which of these plans is best suited for them.

One of the hallmarks that has been used to describe this bill is it is to give people choice—flexibility and choice. All we are suggesting is an additional 2 years, if you will, not requiring an immediate decision but a 2-year window in order to make that choice so people are more well informed.

There are a number of areas in the underlying bill that do not go nearly far enough, in my view, to serve Medicare beneficiaries. But I believe this is a good first step, at least as presently proposed. I am inclined to be supportive of this bill. These are some small points I think could help make this a better bill.

If enacted, the underlying bill would require, as I mentioned, Medicare beneficiaries to choose a prescription drug plan and to stay with that plan for a minimum of 1 year. With the enactment of such broad and sweeping changes in the Medicare Program, I am fearful many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular needs. Beneficiaries would be faced with a menu of plans offering varying premiums, copayments or coinsurance, drug formularies, and all the other variables that make up a prescription drug benefit. It may not be immediately clear to people over the age of 65 which of these plans is going to best suit their needs. It is not difficult to imagine a scenario where this could become a significant problem, possibly even affecting the health and well-being of the beneficiary we are trying to assist with this legislation.

A senior on a tight budget might enroll in a plan in an area that offers slightly lower premiums and coinsurance. Perhaps that beneficiary is on blood pressure medication and, after enrolling in the plan, discovers the particular medication—which she has been taking for years and has proven to be effective for a condition, with minimal side effects—is not part of the formulary for the plan she chose immediately.

What I am suggesting is, What are her options? As the bill is currently written, she is stuck with that plan for at least a year. So she can try to navigate the hurdles and obstacles that would allow her to take an off-formulary drug, or switch to another drug that might not be as effective or cause severe side effects. These are not optimal choices.

One of our stated goals is to give seniors as much of a choice as possible, and I am firmly behind that goal, as I mentioned at the outset of these remarks.

I do not want to suggest for a second that we should reduce choice or create simplicity, nor do I question the importance of cost-control mechanisms such as formularies. However, with choice and differentiation comes uncertainty. I believe we can greatly relieve this uncertainty by allowing those initially choosing prescription drug plans for the very first time the opportunity to move from one plan to another to determine which of these plans offers the best plan to fit their needs, and to give them the opportunity of doing that for a 2-year period, and then go to the open enrollment period and a 1-year after that.

I asked people in my own State to take a look at this proposal. In fact, this language comes from them. Their suggestion is this language I have on this chart. I will read from it:

> The amendment which you are proposing is essential to ensure fair and informed access to the health plans which are planned under the terms of S. 1.

By the way, these people are very much supportive of what Senator GRASSLEY is doing in this bill. They say:

> Our experience with Medicare beneficiaries in Connecticut and nationally has shown that the ability of a Medicare beneficiary to change from plan to plan, especially during the period after initially choosing a plan, is of utmost importance. Making choices about which health plan is best is often confusing for a Medicare beneficiary, especially for those who are elderly, frail or having medical problems. Comparing plans and choosing the right plan can be a complicated process, and Medicare beneficiaries who discover they have not made the most informed choice, whose experience with a plan demonstrates it is not adequate to meet their needs, or who have changes in their life circumstances, need to have some ability to change from one plan to another. Only with this ability to change can they be assured the opportunity to receive the kind of health care they want, and the fullest health benefit they need, to meet their individual circumstances under the Medicare program.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. Mr. President, I ask unanimous consent for 30 additional seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DODD. All we are asking is, instead of forcing people to make that initial decision, they be given that 2-year window to sort this out. And then you move into the 1 year and the window opens, and so forth. I do not think this has any significant financial implications. It is just allowing people to make intelligent, good choices which all of us want to provide people, particularly older Americans who could be terribly confused by choosing formularies and coinsurance and copayment plans. All that has to be done at the outset once this bill becomes law.

I have used a little more time than I said I would to try to explain the amendment, but I want it to be clear to my colleagues why I think this is a very reasonable suggestion to make an improvement to this bill.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. I thank the Presiding Officer for his indulgence.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. Mr. President, I ask unanimous consent that my colleague, Senator LIEBERMAN, be added as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Who yields time?

Mr. DODD. Mr. President, if they don't want to talk, I will be glad to take a little more time to explain this amendment.

Mr. GRASSLEY. Mr. President, I will yield the man 1 minute of my time.

Mr. DODD. Mr. President, I thank the man from Iowa for yielding the 1 minute.

The PRESIDING OFFICER. The Senator is recognized for 1 minute.

Mr. DODD. The man from Connecticut appreciates the man from Iowa giving him 1 more minute.

Mr. President, very briefly, the existing underlying bill says you have to make this choice about which plan you want to go into almost immediately once this proposal becomes law. We are suggesting that at the outset you give people a 2-year window to shop wisely. They may make the decision right away. They may make it within a month or two. But knowing how confusing this can be, knowing that different formularies provide for different medications, we ought to provide people at least some opportunity to get this right to the extent they can. So this is merely opening up that window from an immediate choice to a 2-year choice—anytime within that 2 years to make that right choice.

There have been some who wondered, if you move from one plan to the next, what are the cost implications? I will be glad to respond to that. We do not think that is terribly complicated to figure out. If you have reached your deductible levels, obviously, the same would have to apply. You would not start all over in that 1-year period. So whatever costs you have incurred, whatever expenditures you have made or not made would move from one plan to the next, at least as far as the cost goes.

So the additional time should not have any additional financial or fiscal implications but merely the choice of saying to people, who are older Americans: You get a little more time to sort this out. That is all I am suggesting with this amendment.

I would hope the committee might support it. It is not a radical proposal.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. I thank the Senator.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume.

I know the Senator from Connecticut has well-intentioned motivations behind his amendment. The reason why I oppose the amendment is not because of any ill intent. But we have very carefully crafted this product before us after the Federal Employees Health Benefits Plan and the open season and the practice there. As far as I know, we do not run into Federal employees complaining because they cannot change more often than once a year. So I am going to ask my colleagues to vote against this amendment.

It has some costs. I will speak about that. The open enrollment period in S. 1, as I said, is modeled after the annual open enrollment period of the Federal Employees Health Benefits Plan. I believe this program has been in place for more than 40 years, so we have a lot of experience with it. Consequently, it is a good pattern for us to craft the legislation before us for senior citizens in retirement for their health benefits.

Each year seniors would be able to examine the choice of plans and select the plan that is best suited to their needs. The amendment before us proposes to allow seniors to change plans more than once during a continuous open enrollment period that would last for 2 years. While this may seem a good idea on the surface, it is an invitation, I believe, to more expensive health care for our seniors. I think it is going to lead to chaos and plan instability.

It is very important, at least in the opening years, as we get these new programs underway that there be some predictability in order to encourage more plans to compete. The more plans competing, the better benefits we ought to get for our seniors at a lower price.

It seems to me that providing a long, continuous open enrollment period allows any and all seniors to wait until they are sick before enrolling in a more comprehensive plan. You can understand that we need to have a situation where people are seen buying insurance and doing it in a way in which they manage their own risk as opposed to doing it in the case of only an emergency. This is where you get the insurance aspect that is so important in what we are trying to accomplish.

So if you do that, as the Senator from Connecticut suggests, it is going to add costs to the program because it permits healthy enrollees to stay in the cheaper basic plan until an illness drives them to a generous plan. The generous plan then would become the plan just for sick enrollees.

I have a statement here that the CBO says this would have a cost of $8 billion over the years 2004 to 2008, and $23 billion for the 10-year period 2004 to 2013.

I am going to yield back the remainder of my time.

The PRESIDING OFFICER. All time has expired.

Mr. DODD. I ask unanimous consent for an additional 30 seconds.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DODD. Mr. President, this is one time. Unlike Federal employees, who are 30 or 35 years of age, this plan is all new. What we are saying is, for the very first 2 years—that is all, just the first 2 years—give seniors the flexibility so they do not have to sign up for a plan immediately. You get a couple years within that timeframe to make your choice, then you go into the 1-year cycle as all the rest of us do. But for older Americans, it is very confusing—very confusing—for them to have to make that choice at the get-go, right at the very beginning. So that 2-year window, to have some flexibility to make a choice that best serves your interest, I think is a reasonable request to make for our older Americans. That is the end of it.

Mr. GRASSLEY. Mr. President, I ask unanimous consent for an equal 30 seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I have some sympathy for what the Senator from Connecticut says because so many times I have said to my constituents, this is voluntary. You are going to have your choice to go into another plan or change plans. I emphasize the ability to change plans. In addition, we have to have some stability even in the early years. Most importantly, when we are developing a new prescription drug benefit, the most vast improvement in Medicare in 35 years, I think it demands more stability than when you get down the road a ways.

I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion to table amendment No. 969. The clerk will call the roll.

The bill clerk called the roll.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 55, nays 42, as follows:

[Rollcall Vote No. 234 Leg.]

YEAS—55

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Lott
Lugar
McCain
McConnell
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NAYS—42

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Miller
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NOT VOTING—3

Graham (FL)
Kerry
Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. SANTORUM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the remaining two votes in this series be limited to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 981

The PRESIDING OFFICER. Who yields time on the Pryor amendment?

The Senator from Arkansas.

Mr. PRYOR. I thank the Chair.

Mr. President, the United States may be the only country in the world that does not protect its population from price gouging when it comes to prescription drugs. Last week, the Senate took a very important step in eliminating that by adopting the Dorgan-Cochran amendment by a vote of 62 to 28 to allow the reimportation of prescription drugs from Canada.

This amendment gives that amendment teeth. It gives HHS 2 years to act, and if they do not act within 2 years, then it becomes illegal for prescription drug companies to sell their products in the United States for more than they sell them in Canada.

Some people call this price control. I respectfully disagree, but if you call it price control, that means 62 of us last Friday stood up for price controls. What it does in reality is introduce competition on prices.

There is one drug called tamoxifen. Tamoxifen is a fantastic breast cancer drug. One could buy it before it became generic for $241 for 60 pills in the United States, and for $34 for 60 pills in Canada. The difference between $241 and $34 is very significant, and that is what we are trying to fix.

I thank the Chair.

Mr. SANTORUM. Mr. President, I hope my colleagues can hear me. What the Pryor amendment does has nothing to do with reimportation. What it says is, if the Secretary does not certify that the drugs are safe coming from Canada after 2 years, we will adopt the Canadian pricing scheme for pharmaceutical products in this country. So the Government of Canada will set prices for pharmaceutical drugs in this country. We will be ceding to the Government of Canada the right to set prices for drugs in the United States of America.

If we want to have price controls for drugs, we should have a debate to do that, but we should not be ceding to a foreign government the right to set drug prices in this country, and that is what this amendment does.

Whether you are for reimportation, whether you are for price controls for drugs, do not give up the right to set the price controls to a foreign government who will set them for the United States. And that is what this amendment does. I urge an overwhelming negative vote.

The PRESIDING OFFICER (Mr. CRAPO). The question is on agreeing to the amendment.

Mr. REID. The yeas and nays are not in order.

Mr. SANTORUM. I move to table the amendment and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The PRESIDING OFFICER. The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr.

KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 66, nays 31, as follows:

[Rollcall Vote No. 235 Leg.]

YEAS—66

Alexander
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Corzine
Craig
Crapo
DeWine
Dodd
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hollings
Hutchison
Inhofe
Jeffords
Kyl
Landrieu
Lott
Lugar
McCain
McConnell
Mikulski
Murkowski
Murray
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner
Wyden

NAYS—31

Akaka
Boxer
Byrd
Cantwell
Clinton
Conrad
Daschle
Dayton
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Inouye
Johnson
Kennedy
Kohl
Lautenberg
Leahy
Levin
Lincoln
Miller
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow

NOT VOTING—3

Graham (FL)
Kerry
Lieberman

The motion was agreed to.

AMENDMENT NO. 1001

The PRESIDING OFFICER. There are 2 minutes equally divided for consideration of the Boxer amendment.

Mrs. BOXER. Mr. President, I would like to explain in 1 minute a very important amendment that will really improve this bill. This amendment is endorsed by the AARP—they feel very strongly about it—in addition to the other major seniors organizations to preserve Social Security and Medicare. In the bill right now, there is a benefit shutdown when you reach $4,500 worth of purchased drugs. That means seniors will face a $1,300 deficit before they start getting the benefit. I will just implore my colleagues, there is not any other prescription drug plan in this country that does this. This is a really terrible problem for our people. Just when they need help the most, they stop getting help.

I conclude, since we have so little time, by reading what AARP says:

> AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase.

In closing, they say:

> . . . we urge the Senate to eliminate this coverage gap.

Please make this bill better, friends. It is the least we can do for seniors.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I rise in opposition to make four points.

First, we had an additional $30 billion when this bill was originally marked up in the Finance Committee. We put all $30 billion into filling the donut, so we have done as much as we can with the money allocated.

Second, this amendment costs $64 billion. We would bust the agreement, which is to stay within the budget of $400 billion.

Third, according to CMS, only 2 to 12 percent—depending on your estimates—are going to be affected by this "coverage gap."

Finally, there is no standard benefit. This is sort of a mystery I don't know why we don't talk about more. This is a typical design of what a benefit would look like. But under this bill, the companies bidding on these pharmaceutical contracts can design the benefit any way they want. They can have a donut. They do not have to have a donut. The only thing they are required to do is have a $275 deductible for those plans of 160 percent of poverty and above and have $3,700 in total spending before the catastrophic kicks in. The donut is illusory, and I ask my colleagues to vote no on the amendment.

Ms. MIKULSKI. Mr. President, I rise today in strong support of the amendment No. 1001 offered by my colleague from California, Senator BOXER.

The Senate is debating legislation to provide seniors with prescription drugs that is a start but there are also many shortcomings with this bill. One of most glaring shortcomings is the gap in drug coverage. It doesn't make sense. As drug costs rise, benefits get shut off and seniors with high drug costs have to pay all of their drug costs from $4,500 to $5,800. I think that is cruel.

How would this amendment address this shortcoming?

It is simple. This amendment would let seniors continue to have continuous coverage until you hit the catastrophic cap of $5,800 so that means no gap. And, then your copay would drop to 10 percent just like in the bill. No figuring out when you hit the coverage gap. No figuring out how long you are going to be in the hole. No paying premiums and not getting benefits. You simply get drug coverage.

Why is this amendment important?

The coverage gap imposes a "sickness tax" on seniors. Once drug spending reaches $4,500 and this is a senior who clearly is facing serious health problems this senior would now have to pay $1,300 of their own money without any help from the Government even though they are still paying premiums to stay in the plan.

What does this mean?

Millions of our seniors will have no drug coverage for several months out the year. Their coverage will just stop and for many; it may not start back up again until the next year.

This is wrong. I believe honor thy mother and father is not just a good commandment to live by, it is good public policy to govern by. That is why I feel so strongly about Medicare. Congress created Medicare to provide a safety net for seniors. I don't think there should be any holes in that net. That is why I support this amendment and urge my colleagues to also.

The PRESIDING OFFICER. The Senator's time has expired.

The yeas and nays have been previously ordered on this amendment.

Mr. SANTORUM. Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion to table amendment No. 1001.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 54, nays 42, as follows:

[Rollcall Vote No. 236 Leg.]

YEAS—54

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NAYS—42

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NOT VOTING—4

Campbell
Graham (FL)
Kerry
Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be laid aside so that the Senator from New Jersey may offer an amendment.

The PRESIDING OFFICER. Is there objection?

Mr. SESSIONS. Reserving the right to object, is the Senator going to speak? I could not hear.

Mr. BAUCUS. I withdraw the request. I ask unanimous consent that there be 30 minutes equally divided on the Lautenberg amendment and, immediately following that debate, the Senate vote on the Lautenberg amendment.

Mr. SESSIONS. Reserving the right to object, I just want to call up an amendment and set it aside. Will the Senator agree we can do that?

Mr. LAUTENBERG. I did not hear the request. Was the Senator asking a question of me?

Mr. SESSIONS. Mr. President, I was asking unanimous consent that I be allowed to call up an amendment for 30 seconds and set it aside before the Senator from New Jersey commences his remarks.

The PRESIDING OFFICER. The Senator from Montana has the floor.

Mr. BAUCUS. I yield the floor and withdraw my request.

The PRESIDING OFFICER. The Senator from Alabama may state his request.

AMENDMENT NO. 1011

Mr. SESSIONS. Mr. President, I call up amendment No. 1011.

The PRESIDING OFFICER: The Chair will interpret the Senator's request as a unanimous consent request to set aside all pending amendments. Is there objection to setting aside all pending amendments?

Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Senator from Alabama [Mr. SESSIONS] proposes an amendment numbered 1011.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under medicaid and SCHIP as part of the reauthorization of the temporary assistance for needy families program)

Strike section 605 and insert the following:

SEC. 605. SENSE OF THE SENATE REGARDING HEALTH INSURANCE COVERAGE OF LEGAL IMMIGRANTS UNDER MEDICAID AND SCHIP.

(a) FINDINGS.—The Senate makes the following findings:

(1) In 1996, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105)(commonly referred to as the "welfare reform Act"), Congress deliberately limited the Federal public benefits available to legal immigrants.

(2) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allows a State the option of electing to offer permanent resident legal aliens that have been living in the United States for at least 5 years the same benefits that their State citizens receive under the temporary assistance for needy families program (commonly referred to as "TANF") and the medicaid program.

(3) As of the date of enactment of this Act, 22 States have elected to give the permanent resident legal aliens who reside in their States the same TANF and medicaid benefits as the States provide to the citizens of their States.

(4) This Act, the Prescription Drug and Medicare Improvement Act of 2003, is not a welfare or medicaid reform bill, but rather is a package of improvements for the medicare program that is designed to provide greater access to health care for America's seniors.

(5) The section heading for 605 of this Act as reported out of the Committee on Finance, was titled "Assistance with Coverage of Legal Immigrants under the medicaid program and SCHIP," and, as reported, related directly to the provision of benefits under the medicaid and State children's health insurance programs, not to benefits provided under the medicare program.

(6) The reported version of section 605 would have directly overturned the reforms made in the 1996 welfare reform Act.

(7) The reported version of section 605 would have greatly expanded the number of individuals who could receive benefits under medicaid and SCHIP.

(8) No hearings have been held in the Committee on Finance of the Senate concerning why the 5-year residency requirement for legal aliens to obtain a Federal public benefit established in the welfare reform Act needs to be overturned or why the reported version of section 605 should be included in a medicare reform package.

(9) Congress must reauthorize the temporary assistance for needy families program later this year and should hold hearings regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit should be overturned as part of the reauthorization of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Committee on Finance should hold hearings in connection with the reauthorization of the temporary assistance for needy families program, or in connection with reform of the medicaid program, regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit that was established in the 1996 welfare reform Act should be overturned for purposes of the medicaid and State children's health insurance programs.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the amendment be set aside for consideration at the appropriate time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I want to be certain of the order. My amendment is at the desk. What I want to do is in the time allocated to me—which I understand is 15 minutes per side; is that correct?

The PRESIDING OFFICER. At this point, no such order has been entered.

Mr. LAUTENBERG. I thank the Chair.

AMENDMENT NO. 982

Mr. LAUTENBERG. Mr. President, I call up my amendment which is at the desk.

The PRESIDING OFFICER. Without objection, the pending amendments will be set aside. The clerk will report.

The legislative clerk read as follows:

The Senator from New Jersey [Mr. LAUTENBERG], for himself, Mr. REED, Mr. REID, Mrs. CLINTON, and Mr. CORZINE, proposes an amendment numbered 982.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To make prescription drug coverage available beginning on July 1, 2004)

At the end of title I, insert the following:

SEC. ____ . IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under part D of title XVIII beginning on July 1, 2004.

Mr. LAUTENBERG. Mr. President, I rise to talk about my amendment which is designed to change the effective date of this bill.

My amendment is cosponsored by Senators REED of Rhode Island, REID of Nevada, CLINTON, and CORZINE.

My amendment is very simple: Let's give our seniors a prescription drug benefit just as quickly as we can. They need it now. Let's not delay any longer than practicable to get it into place.

Under the current proposal, comprehensive drug coverage does not start until July 2006. Imagine that, 2006. It is not fair to seniors who are expecting a benefit almost immediately. They will have seen President Bush sign a bill with some fanfare and will have seen lots of Members of Congress crowding the stage with him, and everyone will say: We have put a prescription drug benefit into place. When seniors learn that the benefit begins in 2006, they are going to feel deceived, tricked, and angry.

My amendment changes the effective date of the coverage to July 1, 2004. There is not any reason to have our seniors wait any longer for a prescription drug benefit.

The original Medicare plan was signed into law by President Johnson on July 30, 1965, and 11 months later, July 1, 1966, all persons eligible were enrolled. The entire system for Medicare was created in just 11 months.

When we look at this chart, we see what is planned with the Bush/Senate prescription drug benefit. We are looking at 30 months, and we are looking at the creation of an entire Medicare system which took just 11 months to put in place. That was done without the luxury of today's high-speed computers. It was just President Johnson and his administration getting the entire system in place in 11 months.

My amendment essentially follows the same timetable. If President Johnson was able to create the entire Medicare system in just 11 months, then surely President Bush should be able to add a drug benefit in the same amount of time.

Look at the timeline the President has set for this Medicare drug proposal: 30 months. Why so long? Our clue is, what? Election day. That is illustrated on this chart. Sixteen months from now, this prolonged effective date is conveniently well past election day.

The administration's Medicare agency, CMS, says it needs 30 months. That is very convenient timing for political purposes, but it is terrible timing for America's seniors.

President Johnson, a true Texan, had a can-do attitude, and there is no reason this administration cannot dedicate itself to completing this task in 11 months. We need to give seniors meaningful drug coverage as soon as possible, not 2006.

The reality is that 5.5 million seniors currently on Medicare will not be alive in 2006. If there are insufficient funds in the budget for this amendment, then it is the result of choices made by the President and his party. They chose to provide a massive tax cut to the wealthiest among us, and they chose it at the price of Medicare.

The issue is simple: If we give a prescription drug benefit, why would we want to withhold it? This bill is about fooling the American people about the mission here. It is more about elections than correcting the problems associated with a prescription drug program. I urge my colleagues to support this amendment.

Mr. President, we have some time remaining. How much time remains on our side?

The PRESIDING OFFICER. There is no set amount of time. The Senator has consumed 5 minutes.

Mr. LAUTENBERG. Mr. President, I yield the floor. I know the Senator from Nevada is interested in speaking.

Mr. GRASSLEY. Mr. President, I yield myself such time as I may consume in opposition to the Lautenberg amendment.

The PRESIDING OFFICER. The Senator has the floor.

Mr. GRASSLEY. Maybe I should ask, are we under time constraints?

The PRESIDING OFFICER. There are no time constraints.

Mr. GRASSLEY. What the Senator from New Jersey wants to do I wish we could do. I personally was somewhat astounded when we asked experts at the Congressional Budget Office, experts at the Office of Management and Budget, experts in the Department of Health and Human Services, how much time it would take to get this new prescription drug program underway. We were advised to start it in the year 2006.

In an ideal world, all seniors would have access to our comprehensive prescription drug benefit next year. But our plan, I am sorry to say, cannot go into effect until 2006. Therefore, we need to do something to help our seniors right now. Part of S. 1 does that. They have been doing it because seniors, as I am sure the Senator from New Jersey is trying to respond to, have been waiting a very long time for Congress to act and pass a prescription drug benefit, in the end, helping them with the tremendous costs they are paying for prescription drugs.

This obviously is not satisfying to the Senator from New Jersey who would like to get this plan underway much sooner. Because of the waiting period until the year 2006 to get the very comprehensive program underway, we included in our plan a temporary prescription drug discount card. This is a voluntary program that all seniors can partake of next year. It is available for an annual fee costing no more than $25. Since our low-income seniors need extra help, this fee would be waived. It provides for a 10-percent to 25-percent discount on all costs of prescription drugs. There are some seniors for whom even a 10-percent to 25-percent discount is still a hardship to purchase prescription drugs. So we have added to this for really low-income seniors to receive a $600 annual help in purchasing prescription drugs during this interim period of time, 2004 and 2005. They will be required to pay a minimal copayment of 10 percent when the spending of the $600 subsidy is in place. Spouses who receive the low-income benefit are also allowed to pool share their deposits.

When the comprehensive drug program begins January 1, 2006, the discount card program automatically ends. However, low-income seniors will be able to use their allotment of $600 until June 2006.

Almost 10 million Medicare beneficiaries with significant prescription drug needs will realize savings from this endorsement program. The Center for Medicare Services projects that the Medicare beneficiaries will save between $1.2 billion and $1.6 billion in the program the very first year.

As I said, I feel, not for reasons I like to give to my fellow Senators, that we cannot expect this comprehensive new prescription drug program for seniors, which happens to be the first major improvement in strengthening of Medicare since 1965, to go into effect. Maybe we can push and push and push, but this first major expansion of Medicare in 38 years ought to be carefully done and done right. Consequently, that is why we have deferred to the judgment of the Congressional Budget Office, Office of Management and Budget, as well as the Secretary of HHS. We have tried to compensate for the long period of phasing with the discount card and the $600 subsidy.

I wish I could do more. I wish I could vote for the Senator's amendment but I cannot. I ask my colleagues to vote against it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. I say to our friend from Iowa, the discount card allows somewhere between 10 and up to 25 percent. With seniors spending an average $2.300 a year on medication, even a 20-percent discount does not provide nearly enough relief. Frankly, it is hard to understand why it has to take 2½ years to get the program into place. I rather suspect it has less to do with the perfection of the program than it has to do with some other cause. It cannot take that long. We have all of these seniors on record. They are medical enrollees now. Why can't we get this going?

As a matter of fact, my colleague from Minnesota, who is going to say something, thinks it should be done in an even shorter period of time than my amendment provides.

I ask my colleague if he would like to say something. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. DAYTON. Mr. President, I join with my Senator from New Jersey. He persuaded me to be reasonable. This is the reasonable alternative proposal, July 1 of 2004. I have great respect for the chairman of the Senate Finance Committee, the Senator from Iowa. I sense his difficulty because I don't believe the senior citizens of anywhere else in America will be any different from the senior citizens of Minnesota who will be, I believe, absolutely beside themselves to learn this program they have waited years for Congress to enact will be enacted but it will not be ready for 2½ years.

I suggest perhaps one of the reasons is that this is not a system that can be easily put in place or administered. The chairman is trying to accommodate, if I understand his remarks correctly, the administration, the Office of Management and Budget, and the Secretary of Health and Human Services. They said this program as designed cannot be put together and administered and operational until January 1, 2006.

I suggest that is pretty strong evidence that is not a very good system for delivery of these services. We have insurance companies that are going to be providing policies—they are in the business of providing insurance for people. It can't take them 2½ years to design this program. Regarding CMS or HHS, the Department itself, we hear from this administration how their management of Government is so much improved over their predecessor's. Is it going to take them 2½ years to design this program when, as my colleague from New Jersey, Senator LAUTENBERG, pointed out, 40 years ago they were able to take the whole Medicare Program and put that in effect in 11 months?

Not only do I support the amendment offered by Senator LAUTENBERG, but I have to say for those who are advocating this as the preferred alternative to extending Medicare to cover prescription drugs, if they cannot get the program up and running in a lot less than 2½ years—either 6 months as I would propose, or a year—then this is the wrong program because this is not a viable alternative, and it is not viable for the senior citizens of Minnesota or anywhere else, in my judgment.

To say people are going to get a discount card—they can get discount cards already. They don't need Congress to do anything more than that for 2½ years.

Just taking the figure the Senator from Iowa offered, if I understand it correctly, of savings for seniors in America, Medicare beneficiaries, of $1.26 billion the first year, it sounds like a lot of money—it is a lot of money—but there are 40 million Medicare beneficiaries in the country. If you divide $1.26 billion in savings by those 40 million, that is about $30 per Medicare beneficiary in the first year.

We are going to go back with this to the senior citizens of Minnesota, and those with disabilities who are being crushed by these prices, who see them going up all the time due to the greed and profiteering of the pharmaceutical industry. We are told here we have a bill, because it is the only one the majority of the Senate will agree to, that is not going to do anything—nothing at all, under our Government, on behalf of seniors and on behalf of all American consumers of prescription drugs, to bring these prices down. Instead, they are going to get a discount card that is going to save them on average $30 a year? We ought to be ashamed of ourselves, first of all. This bill is not what it is purporting to be, which is real relief for anybody who needs it now, not January 1, 2006.

If my colleagues do not support this, I think we are sending a very strong message to America that this is not a viable program to begin with, and the pharmaceutical industry has, one more time, succeeded in putting their profits ahead of the needs of people in America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I know the Senator from New Hampshire would like to go ahead. I will speak for just a minute or 2 before he does.

I very much agree with the Senator. It seems absurd that we have to wait until 2006 before this program goes into effect. I very much understand the concern of the Senator.

Let me say this to all of us who are concerned. Before the conference report comes back, I am going to do my level best by pushing the CBO and CMS, asking a lot of tough questions of these agencies, to see if there is some way we can get this put together earlier. It is my hope we could bring back a conference report that has an earlier date, significantly earlier date. My guess is the private sector could get this done pretty quickly. It would not take a full 2 years to get it done.

I just pledge to my colleagues, this is one Senator who is going to do his level best to try to get an earlier date. The current date just doesn't make sense. We need to ask some tough questions and get some answers.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. If the Senator from New Hampshire will just give me a minute, I have a unanimous consent request on votes coming up I would like to propound.

I ask unanimous consent that at 4:20 the Senate proceed to a vote in relation to Dayton amendment No. 957, to be followed by a vote in relation to the Lincoln amendment, No. 1002; to be followed by a vote in relation to the Lautenberg amendment, No. 982, with 2 minutes equally divided for debate for each succeeding vote after the first; further, that no amendments be in order to the amendments prior to the votes; and finally that the second and third votes be limited to 10 minutes in length.

I ask unanimous consent that prior to the first vote, Senator SUNUNU be recognized for up to 5 minutes in order to offer an amendment.

Mr. REID. Reserving the right to object, I ask the vote occur at 4:25 and I be given 5 minutes after Senator SUNUNU.

Mr. GRASSLEY. I modify my unanimous consent request accordingly.

The PRESIDING OFFICER. Is there objection?

Mr. DAYTON. Reserving the right to object, I ask the Senator, in terms of the motion, that 2 minutes be evenly divided for my amendment, the first amendment. Is there something different for that?

Mr. GRASSLEY. You would have 1 minute and I would have 1 minute.

Mr. DAYTON. I object to that. I was told by the Senator's staff I would have 2 minutes, 4 minutes equally divided.

Mr. REID. He can take a minute of my time.

Mr. GRASSLEY. You will get 2 minutes, one from your leader. Can we go ahead?

Mr. DAYTON. I have no objection.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from New Hampshire.

AMENDMENT NO. 1010

(Purpose: To improve outpatient vision services under part B of the medicare program)

Mr. SUNUNU. Mr. President, I ask unanimous consent that all pending amendments be set aside for purposes of offering an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SUNUNU. Mr. President, I have an amendment at the desk. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

> The Senator from New Hampshire [Mr. SUNUNU] proposes an amendment numbered 1010.

Mr. SUNUNU. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under "Text of Amendments.")

Mr. SUNUNU. Mr. President, I rise to offer an amendment that effectively mirrors a piece of legislation I introduced earlier this year. This amendment will extend benefits under Medicare for vision rehabilitative services: that is, rehabilitative services for those seniors with a vision impairment.

As we debate this important prescription drug legislation, I think one of the cornerstones, one of the principles that is at stake is the objective of giving seniors more options and more choices for their health care and, in doing so, to create an option for a more holistic approach to their health care that perhaps focuses, to a greater extent, on preventive measures and other services that improve independence and improve a senior's quality of life.

This legislation is very much in keeping with that objective and that goal. This will extend coverage for vision rehabilitative services under Medicare, but it does this under the existing physician fee schedule. It does it without creating a new provider network or a new fee schedule. As a result, the cost of this legislation is estimated, over a 5-year period, to be just $8 million. That was an independent estimate that has been done. Of course, I will seek scoring under the Congressional Budget Office for the purpose of this bill.

It is legislation and a set of services that is geared toward improving the level of independence and quality of life for those seniors who are affected by a vision impairment. For the sake of reference, there are over 3.5 million Americans who are affected by vision impairment in the United States. That means vision loss that cannot be treated with eye glasses, that cannot be treated with surgery or other techniques. These seniors need help in learning how to navigate in their own homes, how to deal with the obstacles of daily life, and how to learn to live and work with that vision impairment.

The cost of vision impairment to America and to our seniors can be huge. The CDC estimates over $20 billion in costs annually due to falls and due to injuries that have occurred as a result of vision loss. Hip fractures alone, due to vision loss, are estimated to cost our country over $2 billion per year.

For those reasons, I envision under this legislation cost savings in the long term to be quite significant for the modest cost of improving coverage for these vision rehabilitative services.

This is a piece of legislation I introduced earlier this year for which I was pleased to receive bipartisan support. We have 14 cosponsors—seven Republicans, seven Democrats—and among them a number of the members of the Finance Committee.

I certainly believe this takes the right approach toward strengthening Medicare in a way that gives more focus to the kind of preventive care and the kind of medical maintenance that improves the independence and quality of life for our seniors.

I urge my colleagues to support the amendment.

I yield the floor.

The PRESIDING OFFICER. The Democratic whip is recognized.

Mr. REID. Mr. President, under the consent we obtained, I was to have 5 minutes to speak. I would ask that 1 minute of that time be given to Senator DAYTON, so he can have his 2 minutes. I ask the Chair to notify me when I have used 3 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 982

Mr. REID. Mr. President, my first elective job was when Medicare came into being. I was the chairman of the board of trustees at a place called Southern Nevada Memorial Hospital. It is now called the University Medical Center. At that time it was the largest medical facility, hospital facility in Nevada.

At that time 40 percent of the seniors who came into that hospital had no insurance, and children, other relatives, and friends had to sign a piece of paper before they came into the hospital that they would be responsible for the bills. Medicare changed all that.

In 1965, when Medicare was created by Congress, it took 11 months after the bill was signed to put a new program in place. That was back in the days of slide rules and adding machines. That was, of course, before we had computers that had any ability to function.

Today our senior citizens need help with soaring drug prices. They deserve the security of knowing they will be able to buy the medicines that can keep them alive and healthy.

So today if we are telling our seniors to wait for that help and that security until the year 2006, I do not think they are going to accept that. It will be too late for millions of seniors, people who have worked hard all their lives to make this the greatest and richest country in the world—the only superpower left in the world. Certainly, if that, in fact, is the case, we should have a prescription drug benefit for senior citizens.

It might be too late for Alice and Frederick Williams of Reno. They worked hard all their lives and raised four children. But Alice contracted hepatitis C from a blood transfusion. Today she is also battling heart disease and a thyroid condition, and Frederick is recovering from prostate cancer. Together, they have to spend $350 every month on prescription drugs. That is $4,200 a year. They don't have it.

Jackie Ridley, it might be too late for her. She is a retired teacher, who spoke at a Committee on Aging hearing in Las Vegas. She and her husband had all kinds of problems: heart disease, high blood pressure, diabetes, and emphysema. Between them, they had 25 prescriptions. Before Jackie's husband passed away, they faced out-of-pocket expenses of more than $1,000 every month. And sometimes, to make it to the next month, they cut back on some of their medicine. We have heard that before.

These Nevada seniors, and millions more like them in every single State, need help now, not 3 years from now. They deserve security now, not in 2006. That is why I rise to support the Lautenberg amendment. It would make this prescription drug benefit effective sooner rather than later.

The bill is confusing enough without asking some senior citizens to apply for one benefit now, and then come back in 2 years to apply again. Our seniors have enough to worry about without wondering if they will be ruined financially before the benefit takes effect.

The American people know that when Congress really wants to get things done, we can take action quickly. Now they are looking for us to help them, seniors who have worked hard to make this country strong and prosperous.

I urge the support of the Lautenberg amendment.

I yield back whatever time I have.

The PRESIDING OFFICER. The Senator has used 3 minutes.

Mr. REID. I yield back.

The PRESIDING OFFICER. The Senator from Minnesota.

AMENDMENT NO. 957

Mr. DAYTON. Mr. President, I understand, under the previous order, I have 2 minutes.

The PRESIDING OFFICER. The Senator has 2 minutes.

Mr. DAYTON. Mr. President, I call up amendment No. 957 and ask the clerk to report it.

The PRESIDING OFFICER. The amendment is pending.

Mr. DAYTON. Thank you, Mr. President. I will proceed.

Mr. President, this amendment is a matter of simple fairness. It says that whatever prescription drug coverage we in Congress vote for for senior citizens and other Medicare beneficiaries in this legislation, then the Members of Congress will get for ourselves, our coverage, under prescription drugs for the life of this particular legislation.

I have heard many of my colleagues say we want to give seniors coverage that is as good as we get ourselves. I heard a lot of senior citizens in Minnesota say they want coverage as good as Members of Congress get for themselves. Well, unfortunately, the bill that is before us this week is not even close to that parity.

If you calculate the total benefits provided, the value of this bill is about half of what Members of Congress get, what we pay as part of the Federal Employees Health Benefits Plan system. But, nevertheless, it is about twice as good as what the seniors of America and those with disabilities and others are going to be able to obtain from what we are likely to pass.

Furthermore, as we have been discussing earlier, this does not even begin until January of 2006. Medicare beneficiaries will get a discount card instead. Well, then, Members of Congress should get a discount card—and nothing more—as well. I think after what I heard the Senator from Iowa say, I would include a few members of the administration since they are the culprits in this delay, but I will save that for another time. With the premiums, deductibles, and the absence of any coverage at all from $4,500 to $5,800, if it is good enough for the seniors of America, then it is good enough for the Members of Congress.

I point out to my colleagues who would like to keep the benefit level they have today——

The PRESIDING OFFICER. The Senator has used 2 minutes.

Mr. DAYTON. Mr. President, I ask unanimous consent for 30 seconds to conclude my remarks.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DAYTON. The amendment Senator DURBIN has offered, which we will have a chance to vote on and discuss later this week, would provide seniors with a comparable package to what we have in Congress. So I urge the support of that amendment, for that reason among many others. But if we are not going to be as generous to senior citizens as we are to ourselves today, then we are going to have to, in my view, bring ourselves down. I would rather bring everyone else up, but what is fair for them is fair for us.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. I yield back my time and wish to vote now.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is on agreeing to amendment No. 957.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.,

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote "yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 93, nays 3, as follows:

[Rollcall Vote No. 237 Leg.]

YEAS—93

Akaka
Alexander
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bond
Boxer
Brownback
Bunning
Burns
Byrd
Cantwell
Carper
Chafee
Chambliss
Clinton
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Crapo
Daschle
Dayton
DeWine
Dodd
Dole
Domenici
Dorgan
Durbin
Edwards
Ensign
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Harkin
Hatch
Hutchison
Inhofe
Inouye
Jeffords
Johnson
Kennedy
Kohl
Kyl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Lott
Lugar
McCain
McConnell
Mikulski
Miller
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Nickles
Pryor
Reed
Reid
Roberts
Rockefeller
Santorum
Sarbanes
Schumer
Sessions
Shelby
Smith
Snowe
Specter
Stabenow
Stevens
Sununu
Talent
Thomas
Voinovich
Warner
Wyden

NAYS—3

Bingaman
Breaux
Hollings

NOT VOTING—4

Campbell
Graham (FL)
Kerry
Lieberman

The amendment (No. 957) was agreed to.

AMENDMENT NO. 1002

The PRESIDING OFFICER. Under the previous order, there are 2 minutes equally divided prior to the vote on the Lincoln amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Arkansas. The Senator has 1 minute.

Mrs. LINCOLN. Mr. President, I plead with my colleagues to take a very serious look at the amendment before us. I know they are hearing differently from downtown perhaps, but I want them to take a look at a recent CBO study that has indicated to us there is negligible impact in giving parity to the fallback plan.

CBO has given us a recent study that indicates there is negligible impact on the private plans in allowing parity with the fallback plans that may be needed in some of our rural areas to ensure that all of our citizens across this great land get the same benefit in a prescription drug package.

Fifteen of our States have no Medicare+Choice or private plans currently. We know it is going to be difficult. Let's make sure a fallback plan is there for seniors, that the continuity is there for them. All we want to do is make sure they will have the same 2-year contract cycle that the private plans will have.

Again, approximately 80 percent of the people in this country are in fee-for-service plans. Let's make sure those who are in our rural States are going to see the parity in these two plans. Just remember, if the private plans are not there or happen to be there, there will be no fallback plan, so you do not have any problem with that.

I thank the Chair.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. LINCOLN. I encourage my colleagues to vote for this amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I oppose the amendment. First off, it is bad enough to have one fallback, which I believe will dramatically discourage private plans from participating in a stand-alone drug benefit. To have two is even worse.

The fact is, the Secretary has the authority under this legislation to balance the risk. With a fallback plan, there is no risk on the private sector. All the risk for a plan is on the public sector. We give the Secretary the ability to dial back the risk to everything but zero, and the fallback plan is zero. We believe giving the Secretary the discretion will at least encourage the private sector to come in, which they will under this bill, and take some risk, which means they will have some incentive to control costs. If they have no risk, they have no incentive and, thereby, the cost of the program goes up.

Having one fallback plan is a very bad idea. Expanding this very bad idea is a worse idea, and I hope we vote against the amendment.

I ask unanimous consent that the remaining two votes in this series be limited to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SANTORUM. Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote "no".

The PRESIDING OFFICER (Mrs. DOLE). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 51, nays 45, as follows:

[Rollcall Vote No. 238 Leg.]

YEAS—51

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Chambliss
Cochran
Coleman
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Lott
Lugar
McCain
McConnell
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NAYS—45

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Chafee
Clinton
Collins
Conrad

Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Miller
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NOT VOTING—4

Campbell
Graham (FL)
Kerry
Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 982

The PRESIDING OFFICER. Under the previous order, there are now 2 minutes for debate prior to a vote in relation to the Lautenberg amendment, No. 982.

Who yields time?

The Senator from New Jersey.

Mr. LAUTENBERG. Madam President, my amendment is very simple. It says, if you are going to give, then don't take it away. If you are going to give a prescription drug benefit, then, by golly, start it in a timely manner, and start it, let's say, by July of 2004 instead of 2006.

What kind of a benefit is this when 5.5 million of our present living seniors, I am sorry to say, will not be here at that time, 30 months hence. In 11 months, President Lyndon Johnson initiated the idea of Medicare and had it passed and in place—11 months. Why in the world is it going to take 30 months?

I do not believe we ought to be looking at these discount cards, which are available generally in the community today, as the stopover until 30 months have gone by. It is an outrage that this date is chosen, I think not because they want to delay the benefit for seniors but, rather, because it coincides with an election. I do not think we ought to stand for it.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Iowa.

Mr. GRASSLEY. Madam President, I sympathize with those who feel a need to get this program going sooner than we have it in this legislation. But the fact is, CMS has told us it is physically impossible to get this benefit up and running in the year 2004. Now, knowing that, we have provided a prescription drug discount card, starting on January 1, 2004, in order to get immediate relief from the high cost of prescriptions for our seniors.

The amendment would spend close to $24 billion in fiscal year 2004—the amendment that is before us—and that is money that is not in the budget. We deal with the needs of our seniors in a fair way with this bill, the discount card, and the $600 help for them for each of the next 2 years. So I urge my colleagues to take all this into consideration and oppose the amendment.

Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to amendment No. 982.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Kansas (Mr. BROWNBACK) and the Senator from Colorado (Mr. CAMPBELL) are necessarily absent.

I further announce that if present and voting the Senator from Kansas (Mr. BROWNBACK) would vote "no".

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 54, as follows:

[Rollcall Vote No. 239 Leg.]

YEAS—41

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Talent
Wyden

NAYS—54

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Bunning
Burns
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Landrieu
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Thomas
Voinovich
Warner

NOT VOTING—5

Brownback
Campbell
Graham (FL)
Kerry
Lieberman

The amendment (No. 982) was rejected.

Mr. GRASSLEY. Madam President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. Madam President, the two leaders have met and talked to the managers. We will have, in approximately 30 minutes, two votes. Senator DODD has agreed to take 20 minutes on his two amendments. He can divide it however he deems appropriate. Following that, the Senate will still be in session. People will offer amendments, if they desire, but it is contemplated these two votes will be the last votes of the evening.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Madam President, I ask unanimous consent that the pending amendment be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 998

Mr. DODD. Madam President, I call up amendment No. 998.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Connecticut [Mr. DODD] proposes an amendment numbered 998.

Mr. DODD. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To modify the amount of the direct subsidy to be provided to qualified retiree prescription drug plans)

On page 129, strike lines 3 through 20, and insert the following:

"(2) AMOUNT OF PAYMENT.—The amount of the payment under paragraph (1) shall be an amount equal to the monthly national average premium for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

Mr. DODD. Madam President, this first amendment is intended to address one of the major problems with this bill, and that is the impact the legislation could have on Medicare beneficiaries who are currently receiving prescription drug coverage under the employer-sponsored retiree benefit plans.

I will quickly point out to my colleagues who may be saying we voted on this with the Rockefeller amendment that this is very different. The Rockefeller amendment was designed to provide encouragement to employers to supplement the existing prescription drug benefit. This amendment is designed to provide that encouragement only to employers who would be picking up the total cost of the prescription drug benefit, not just acting as a supplement. So it is very different. It is not the wraparound. This is an optional choice by the retiree or the employer.

If they are the primary provider of the drug benefit, they would be covered by this amendment.

For employers intending to act as a supplement to the coverage, we decided that today; unfortunately, it was voted down. With that in mind, clearly in this bill most of us believe what we ought to be trying to do is support, not supplant, the valuable efforts of employers already providing prescription coverage to retirees.

As presently written, I am concerned the bill would lead many retiree benefit plans to scale back or drop entirely the prescription drug coverage they presently provide. However, this amendment would provide an increased subsidy to employers, because we want to encourage them to provide this benefit to retirees. It seems to me it is in our interest to encourage them to stay involved. They would get a subsidy, as long as they continue to offer prescription drug coverage to retirees only as the primary provider, not as a supplement—not as a wrap around the new Medicare benefit.

The scope of this problem is not small at all. In fact, I was surprised to learn how many seniors would be impacted by the unintended change to retiree benefit coverage. About one-third of all Medicare beneficiaries receive prescription drug coverage through an employer-sponsored health care plan. That is by far the largest source of prescription drug coverage for seniors.

These plans have played a very critical role in providing security to seniors, while Congress has been unable over the last number of years to pass a prescription drug benefit plan under Medicare. Retiree benefit plans should continue, in my view, to play that role even after a drug benefit plan is enacted. In many cases, the drug coverage provided by retiree benefit plans is significantly more generous than the plan we are debating here.

Furthermore, many seniors have become familiar and comfortable with the coverage offered by their former employers.

Understandably, they do not want to give it up for a plan about which they are confused and uncertain or may not be as beneficial to them.

We should be doing, in my view, everything in our power to provide these seniors with a choice, with the option of staying with their employer-sponsored plan. Thus, this amendment.

Unfortunately, the option may not be available for many seniors. That is why I put up this chart. I wish to focus the attention of those who may be following this debate to the left side of this chart. The right side I will talk about briefly, but the most significant numbers are on the left side of the chart. I will get to them in a minute.

While the numbers vary slightly, depending upon which study one consults, they come to the same conclusions, roughly the same numbers, and they are very disheartening. Between 1993 and 2001, the percentage of large employers, those who employ more than 500 people, offering coverage to Medicare-eligible retirees dropped from 40 to 23 percent, almost in half over 7 or 8 years. In the last 2 years, 13 percent of all employers offering future retiree coverage have elected not to do so. Those retaining coverage are experiencing annual cost increases on the order of 14 percent. It has been tremendously expensive. As a result, they are substantially raising the cost-sharing burdens for individuals enrolled in these plans.

The chart on the left-hand side illustrates the crisis that employer-sponsored plans are facing today and are going to continue to face in the future. The numbers are based on a survey conducted by the Kaiser Family Foundation and Hewitt Associates in December of 2002.

The graph shows that the actions large employers have taken over the last 2 years to deal with the rapidly increasing retiree health care cost—these numbers may not be clear to everyone, so I will recite them—a large number of employers have increased individual costs in some way. Forty-four percent have increased retiree contributions to premiums, while 36 percent increased cost sharing. In addition, 14 percent have shifted all costs to the individual retiree, and 13 percent have eliminated the plans altogether. Finally, nearly half of employers surveyed increased cost sharing for prescription drugs, as shown by the bar depicting 49 percent.

The numbers on this chart do not bode well, is the point I am trying to make, for those seniors who currently receive health care benefits from their former employers. Given the enormous financial pressures being felt by employers and the encouragement this bill already provides—in the form of a 64 percent subsidy—to keep employers from dropping coverage, it seems to me that if the employees decide to stay with their existing coverage, we believe that subsidy ought to go from 64 percent to 100 percent of the national average premium. That is what we are trying to do with this amendment.

The Congressional Budget Office has estimated that almost 40 percent of seniors who currently have their prescription drug medicines covered by retiree benefit plans would lose their coverage under the plan before us. So even with the 64 percent subsidy, 37 percent of retirees would be dropped from these plans. We are raising through this amendment that subsidy to 100 percent which we think will do a lot to keep these employer-based plans in place so that retirees would have that option of sticking with those retiree plans.

I supported the Rockefeller amendment. I mentioned that earlier. This is different. This is very different. If you are just supplementing the benefit plan, then you would not be covered by the Dodd amendment. That was the Rockefeller amendment, and the Senate voted it down. My amendment says only if you are the primary provider of the prescription drug benefit would you get the kind of subsidy we are talking about, from 64 to 100 percent. That would mean approximately an additional $400 a year per retiree paid to the employer. This would encourage employers to retain the full prescription drug coverage they presently provide rather than cutting back coverage and simply supplementing a new Medicare benefit.

The underlying bill has a provision that would provide a subsidy to employers for every Medicare-eligible retiree who elects to remain in an employer-sponsored plan as an alternative to the Medicare prescription drug plan. That subsidy would be approximately, as I mentioned, 64 percent of the national average premium for prescription drug coverage.

This amendment would very simply increase that subsidy to the full national average premium. This would mean an additional $35 a month per beneficiary or roughly $400 a year paid directly to employer-sponsored plans as long as they continue to offer an alternative to Medicare prescription drug coverage, bringing the total subsidies to almost $100 per month when we combine the 64 percent that is in the bill and what we are adding with this amendment.

To receive this subsidy, employers would have to offer a prescription drug plan that is competitive with the Medicare benefit because the subsidy would only be paid for beneficiaries who remain in the employer-sponsored plan and do not enroll in Medicare Part C or D.

We simply cannot allow retiree benefit plans to disappear. That would be a great mistake, in my view. This amendment is designed to keep them if we can. It is a modest amendment considering the benefits that could accrue to the retirees, giving them the option of sticking with an employer-based plan.

If CBO is right, under the plan before us, almost 40 percent of these retirees will lose that prescription drug coverage under their employer-based plans. I do not think we want to have that happen. I urge the adoption of this amendment, and I hope my colleagues will be supportive of it.

I see the chairman of the committee who I know wants to respond to my amendment.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I wish to propound a unanimous consent request.

I ask unanimous consent that Senator DODD have up to 20 minutes and

Senator GRASSLEY up to 10 minutes for debate on amendment Nos. 970 and 998 concurrently. I further ask unanimous consent that following that debate, the Senate proceed to a vote in relation to the amendment No. 970, to be followed by a vote in relation to amendment No. 998, with no second-degree amendments in order to the amendments prior to the vote. Finally, I ask unanimous consent that at 10 a.m. tomorrow the Senate proceed to a vote in relation to the Grassley, or his designee, amendment, regarding the benchmark, with no amendments in order to the amendment prior to the vote; provided further, that this vote be subject to the approval of both leaders.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, it is my understanding the Senator from Connecticut has graciously indicated the time he has used would be counted toward this time.

Mr. DODD. That is correct.

Mr. REID. That being the case, the vote will occur around 6:15 p.m., for the information of Members.

The PRESIDING OFFICER. Approximately 6:20 p.m. Is there objection? Without objection, it is so ordered.

Mr. DODD. Mr. President, if I can finish, I can give the chairman a chance to respond.

I ask unanimous consent that a letter signed by 33 of the labor unions in this country in support of my amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JUNE 23, 2003.

DEAR SENATOR: If the Medicare drug bill before the Senate, S. 1, becomes law, 37 percent of retirees who now have employer-sponsored health benefits will lose that coverage. That's 4.4 million retirees that will be made worse off if S. 1, as drafted, is enacted into law. Such an act will represent an enormous and irreversible blow to the employer-based system that is the backbone of our nation's health care system.

As you know, retiree health coverage is already in crisis. Drug costs constitute 40 to 60 percent of employers' retiree health care costs, and steep price increases are prompting employers to eliminate drug benefits, cap their contributions or drop retiree coverage altogether. In fact, just 34 percent of all large firms (200 or more employees) offered retiree benefits in 2002, down from 68 percent of all large firms in 1988.

Both public and private employers need immediate relief for their retiree prescription drug costs, but S. 1, as now drafted, will exacerbate an already dire situation for retiree coverage by discriminating against retirees with employer-sponsored coverage.

By using a trick definition of out of pocket costs—"true out of pocket"—S. 1 will effectively deny retirees catastrophic coverage by not counting any drug costs covered through an employer plan. This ensures seniors with retiree benefits will get less Medicare coverage than any other beneficiary. As a result, employers that choose to "wrap around" the Medicare benefit and provide assistance for costs not covered by Medicare will find the gap in coverage does not end for these retirees.

Two amendments will be offered to address this critical flaw. The first, offered by Senator Rockefeller, would eliminate the "true out of pocket" definition so that retirees receive the same benefit as all other beneficiaries. The second amendment, to be offered by Senator Dodd, would increase the subsidy to employers that retain retiree benefits.

Although some may claim that the "true out of pocket" trick will save money for Medicare, any provision that encourages employers to drop their retiree benefits will only end up costing the federal government more—and hurt millions of seniors in the process. Seniors who have retiree benefits have worked a lifetime and made wage concessions over the years with the expectation that they would have retiree benefits. To change the rules of the game at this point and give them less than other Medicare beneficiaries is patently unfair.

We urge you to support the amendments aimed at encouraging both public and private employers to continue providing retiree health benefits. Congress must enact a drug benefit that supports, not threatens our fragile employer-based system of health coverage.

We have many other concerns with the Senate bill, including the enormous gap in coverage and the reliance on uncertain and historically unstable private insurance plans. And we have very grave concerns that the conference report you will be asked to consider will incorporate elements of the House bill that are entirely unacceptable to the millions of American we represent. In particular, the House bill would introduce full competition into Medicare beginning in 2010—a blatant attempt to undermine the traditional Medicare program and start it on a "death spiral" of caring for the sickest beneficiaries and unsustainable costs.

We strongly believe that adding a prescription drug benefit to Medicare is the most urgently needed reform and one that has been promised to our nation's elderly and disabled. However, we cannot accept legislation that does so at the expense of retirees who now have employer-sponsored coverage and the very future of Medicare.

Thank you for your consideration.

Sincerely,

John J. Sweeney, President, AFL–CIO; Ron Gettelfinger, President, United Auto Workers; John J. Flynn, President, International Union of Bricklayers and Allied Craftworkers; Morton Bahr, President, Communications Workers of America; Harold A Schaitberger, President, International Association of Fire Fighters; Douglas H. Dority, International President, United Food and Commercial Workers.

James A. Grogan, Jr., President, Asbestos Workers, International Association of Heart and Frost Insulators; Frank Hurt, President, Bakery, Confectionary, Tobacco Workers and Grain Millers International Union; Edward C. Sullivan, President, Building and Construction Trades; Edwin D. Hill, President, International Brotherhood of Electrical Workers; Patricia Friend, International President, Association of Flight Attendants; Bobby L. Harnage Sr., President, American Federation of Government Employees.

David Holway, President, National Association of Government Union Employees/International Brotherhood of Police Officers; S. Richard Elliott, President, International Union of Journeymen, Horseshoers, United Services and Allied Trades; Terence M. O'Sullivan, President, Laborers' International Union; R. Thomas Buffenbarger, President, International Association of Machinists and Aerospace Workers; Thomas F. Lee, President, American Federation of Musicians of the United States and Canada.

Gregory Junemann, President, International Federation of Professional and Technical Engineers; Andrew L. Stern, President, Service Employees International Union; Gerald W. McEntee, President, American Federation of State, County and Municipal Employees; Sandra Feldman, President, American Federation of Teachers; Sonny Hall, President, Transport Workers Union of America; Donald Wightman, President, Utility Workers Union of America; George Tedeschi, President, Graphic Communications International Union; Joseph J. Hunt, General President, Iron Workers, International Association of Bridge, Structural, Ornamental and Reinforcing.

John M. Bowers, President, International Longshoremen's Association; Cecil E. Roberts, President, United Mine Workers of America; Boyd D. Young, President, PACE International Union; Joe L. Greene, President, American Federation of School Administrators; Michael J. Sullivan, General President, Sheet Metal Workers International Union; Leo W. Gerard, President, United Steelworkers of America; James P. Hoffa, General President, International Brotherhood of Teamsters; Robert A. Scardelletti, President, Transportation Communications International Union.

Mr. DODD. Mr. President, I will read a pertinent passage because this is really the heart of this issue. I mentioned earlier, one-third of all retirees get coverage under the private employer-based plans. If CBO is right, almost 40 percent of retirees will lose their coverage under this bill, and employers would start dropping them because they do not get the subsidies, then I think we have to understand what the implications mean for a lot of people. I do not believe my colleagues intend this to be the case, but this is what is going to happen if we are not careful.

The letter reads in part:

> If the Medicare drug bill before the Senate, S. 1, becomes law, 37 percent of retirees who now have employer-sponsored health benefits will lose that coverage.

That is according to CBO.

> That's 4.4 million retirees that will be made worse off if S. 1, as drafted, is enacted into law. Such an act will represent an enormous and irreversible blow to the employer-based system that is the backbone of our nation's health care system.

The letter goes on:

> . . . any provision that encourages employers to drop their retiree benefits will only end up costing the federal government more—and hurt millions of seniors in the process. . . .

> We urge you to support the [Dodd] amendment aimed at encouraging both public and private employers to continue providing retiree health benefits. Congress must enact a drug benefit that supports, not threatens, our fragile employer-based system of health coverage.

That is what my amendment is designed to do: to provide that subsidy if the retiree takes the option of continuing in the employer-based plan as the primary provider for health care coverage. If that is the case, then I think we ought to provide that encouragement and inducement. They make a huge difference in people's lives. If CBO is right and we do not adopt this amendment, and 4.5 million people have a worse plan as a result of our action, we have taken a step back rather than a step forward for that many seniors in our country. I don't know of anyone in this Chamber who would like to be a party to that.

For those reasons, I hope my colleagues could support the man from Connecticut on his amendment.

Mr. GRASSLEY. I am glad to speak about the man from Connecticut and his amendment but not to support it.

First of all, we need to remember, with or without this subject before the Senate, these plans could be dropped without any hesitation. We can have the prescription drug plan before the Senate, and there could be some reason some companies would drop that. But right now, remember, our passage of this legislation is very much to fill a gap. We are worried about people who do not have any coverage whatever.

As I have said before, we are all very concerned about the future of retirees' benefits and making sure retirees are treated fairly. Under the beneficial before the Senate, retirees get the same protection from high prescription drugs and the costs as any other beneficiary. That is a generous subsidy, far greater than they currently get, which would be zero.

The fact is, typical retiree plans provide much more generous coverage, and the beneficiaries spend much less out of pocket for their prescriptions.

There has been a great deal of interest in the assumption by the Congressional Budget Office that corporations are going to drop their coverage of prescription drugs for about 37 percent of the retirees in retiree health plans over the next 10 years. What we cannot forget is employers, as I indicated, are already dropping or, maybe more, scaling back retiree health benefits not because of our legislation but because retiree health benefits are rising because of very high health care costs. They have already been dropping plans or cutting them back for at least a decade, a point made by my colleague, Senator DODD.

We have worked hard to address this problem in the underlying legislation. One of the most significant future liabilities faced by retiree plans is the cost of prescription drugs. We have given employers serious and generous subsidies. The Dodd amendment proposes to boost subsidies for employers beyond the 64 percent we have given them already. This change would send millions more in taxpayers dollars to these corporations during the next decade. We had to put priorities first.

We have $400 billion. We have looked at States and the problems of dual eligibles. We looked at corporate retiree plans and what might happen and what can we do to keep those that are going out of business or dumping theirs on a government plan. We have worked with a lot of different problems. We have had to do the best we can to squeeze within that $400 billion. We have tried to help the States to some extent on dual eligibles. We are trying to help corporations with incentives not to dump their retirees on this plan. I can go down a long list we have tried to squeeze in and prioritize.

The overriding goal was to help those who had no drug plans whatever. That was very much a high priority. We have maybe 30 percent or a little more on private plans. We have people on Medicare with Medigap policies. We have people who are duly eligible subject to Medicaid. But we have 30 percent or more with zilch. We go beyond just helping those who do not have any plan. But that has been our priority. We tried to do it in a way that people who have better—and maybe most corporate retiree plans do have better incentives than what we can provide—and they can continue to have better. But we cannot control entirely what corporations are going to do. Particularly, you cannot do that on the amount of money we have here.

As I indicated, this is a very expensive amendment that we cannot squeeze into the $400 billion.

I urge my colleagues to defeat the amendment. I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. I will take 1 minute on this amendment and move to my second amendment.

This is an optional choice. We are not requiring employers to retain an employer-based plan. We are saying we know already, based on CBO's analysis, that close to 40 percent of people under the employer-based plans will be dropped. We know that.

Our primary responsibility in this bill is to provide a good prescription drug benefit for people. We do not want to be in a situation of actually causing people to have a worse plan than they have.

My point is not to increase spending but to say, if you are going to provide prescription drug coverage as an employer—and I want you to continue doing this; and we are being told 37 percent of the people will be dropped—we will increase the subsidy. To encourage employers to continue doing it seems to me to be in our interest. That is why I offer this amendment and why it is so strongly supported by labor unions who believe this will be a major blow to almost 4.5 million retirees in the country. I urge adoption of this amendment.

AMENDMENT NO. 970

The second amendment I call up is amendment No. 970, and I ask for its immediate consideration.

The PRESIDING OFFICER. That amendment is pending.

Mr. DODD. Let me briefly explain this amendment. I commend the committee.

This bill does an awful lot for people who are really hurting. I want the chairman to know I strongly support his efforts. Those who are really hurting get real help with this bill. I commend the committee for focusing on that. I commend him for it.

What this amendment does is a little different. We have all been talking about donut holes. People watching this debate may wonder what we are talking about, but the donut hole is in the plan when you reach a certain level of your costs of prescription drugs. Even though you keep paying the premiums of $35 a month, if your costs run somewhere around $4,500 to $5,800, during that period you are in the eye of the hurricane, and you do not get any help during that period.

That is not true if you are below 160 percent of poverty. If you are below 160 percent of poverty, we will provide help to you even while you are in the donut hole.

My amendment effects those in the donut hole who are between 160 and 250 percent of poverty. That is an individual who makes $22,000 a year or a couple earning $30,000 a year. These are people who are really hurting out there as well. They are not as desperately poor as those at 160 percent of poverty, but they are not much better off. But just in the donut hole, could we say that those people might get a 50/50 deal in the donut hole, between 160 and 250 percent of poverty? In that one set of circumstances where the costs are running from $4,500 to $5,800, you get a 50/50 deal if you are making $22,500, or a couple, $30,000, that is what the amendment does.

I know the chairman is going to say these are great ideas and there is a cost associated, and there is. But we ought to provide some help to people in those earnings groups—$22,000 if you are single or $30,000 as a couple. These are probably cancer patients or patients with serious medical costs. If you are paying somewhere around $4,500 a year, up to $5,800 a year, you have a serious health care problem. If you are making $22,000 or $30,000, as an individual or a married couple, then to provide 50 percent of the cost of those prescription drugs while you are in that donut hole I do not think is asking too much of us.

We should add just a little bit to accommodate these not even middle-income people. It would be an unfair description to say these are middle-income people. There is nothing magic about 250 percent. I just tried to reach out a bit to that constituency here that will continue paying the $35 a month. They have to do that. They do not get anything. If we could just reach a little further to that constituency, beyond the 160 percent, between $4,500 and $5,800 in total spending. We try to provide an additional bit of help for you, 50 percent of that cost. We can't pick up all of it, that would probably be too expensive. I don't know what the CBO numbers would be, but we will put you in the 50/50 bracket up to 250 percent of poverty just while you are in that situation. That is what the amendment does. It is no more complicated than that.

Again, I compliment the chairman. They have done a very good job taking care of the very desperately poor in the country. But for people who are not quite desperately poor—although I suggest some may tell you that living on $22,000 a year as a single person or a couple over the age of 65 with $30,000 worth of income, they are not out partying. These people probably make choices between food and rent and medicines, particularly if you are paying $4,500 a year or up to $5,800 a year for prescription drugs. That comes off the $22,000 or your $30,000. You do not have to do the math to know where you are living, what circumstances you are under.

So this is designed to provide some additional relief for people in that category, moving it up just a little bit, up to that 250 percent from 160 percent while you are in the donut hole, only there, to get a 50/50 break. You still pay 50 percent of the cost. You don't get 100 percent relief, but 50 percent of the cost, and that is what the second amendment is designed to do.

I apologize for racing, but I am trying to get this in in the 5 minutes. This is obviously complicated stuff. I am trying to accommodate my colleagues who I know have other engagements this evening to explain what the amendments do. The time does not justify the context, as to how important this would be to a lot of people in this country. I don't know the numbers of the people in this income category, but I have to believe before we get done with this, to provide some additional help for people in that category ought not to be too much of a stretch when you consider that $22,450 for an individual and $30,000 for a couple is going to put a lot of burden, a lot of pressure on you if you are already paying somewhere between $4,500 and $5,800 in prescription drug costs. This amendment would help those people.

I hope the man from Connecticut might impress the chairman on this one with his support. Hope springs eternal. I keep knocking on the door, seeing if I can't get some help.

Mr. KENNEDY. I commend Senator DODD for offering this important amendment today. This amendment will address one of the gaping holes in this plan—its failure to treat retirees and retiree health plans fairly. Today, we have the opportunity—and the obligation—to correct that unfairness.

Ten million senior citizens depend on retiree health plans to fill the gaps in Medicare. Especially given the limitations of the drug benefit we are debating, supplemental coverage from retiree health plans is crucial. But retiree health plans are being abandoned or cut back all over the country—and prescription drug costs are a key part of the problem. For retirees who are over 65, prescription drugs make up about half of all plan costs—and as much as 80 percent of recent cost increases.

But the prescription drug plan before us treats those plans unfairly, by taking the unprecedented step of making senior citizens with retiree health plans second class citizens under Medicare. The Congressional Budget Office has concluded that even with the new assistance provided under this plan, one-third of all retirees—4 million senior citizens—could lose their supplemental drug coverage. That should be unacceptable to every Senator.

The issue is not one of providing a bail-out or a windfall to retiree health plans. It is one of simple fairness. Currently, whenever Medicare covers a benefit or service, Medicare is the primary payer for that service. If a retiree health plan covers the service, it pays only for what Medicare does not cover.

The reason for that is straightforward. Employers pay taxes to support the Medicare Program. So do retirees. So do active workers who accept lower wages during their working years in order to have supplemental retirement health care in their retirement years.

But under this legislation, these workers and these employers do not get the full benefit of their contribution to the drug benefit. Because of the "true out-of-pocket" concept included in the bill, Medicare does not pay for catastrophic expenses of these workers, even though the cost of covering these expenses accounts for more than one-third the cost of the current bill.

And the higher the costs the retiree faces, the more the discrepancy between what Medicare pays for the retiree with employer-sponsored insurance and what Medicare pays for all other senior citizens grows. If the individual's drug costs are $6,000, Medicare pays $2,113 for the retiree with insurance but $2,281 for all other senior citizens. If the individual's drug costs are $8,000, Medicare still pays $2,113 for the retiree with employer-sponsored insurance, but $4,081 for all other senior citizens. And if the individual's drug costs are $10,000, Medicare still pays just $2,113 for the retiree, but pays $5,881 for all other senior citizens.

This is double taxation at its worst. These retired workers and companies are taxed twice. They pay once to support the Mecicare program. Then they are forced to pay again by being denied the Medicare benefits their contributions have earned. During the debate on the tax bill we heard a lot about the injustice of double taxation of dividends from the other side of the aisle. Apparently, for them, double taxation of the unearned income of millionaires and billionaires is wrong, but double taxation of moderate income retired senior citizens is just fine.

The fact is that it is not fine. The American people understand that it is wrong. American companies struggling to provide for their retired workers in this sour economy understand that is wrong. The Senate should understand that it is wrong, too, and right this injustice.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, how much time do I have?

The PRESIDING OFFICER. The Senator has 4 minutes.

Mr. DODD. I had 5.

Mr. GRASSLEY. First, let me explain to the distinguished Presiding Officer why we refer to "the man from Connecticut." When I was going to yield him some time, I didn't think of the word "Senator." I said I will give 1 minute to the man from Connecticut, and I apologize.

First of all, I wish I had an exact number for this amendment. It has some costs, but I do not have an official score from the Congressional Budget Office so I cannot say that this costs X number of billions of dollars at this point. But it does have some cost.

I am going to try to convince the Senator from Connecticut that we have done a lot in this legislation for people who are low income. Maybe it doesn't go as high up the economic ladder as he would like to have us go. But my point is we have done an awful lot.

We worked very hard to minimize the gap in coverage with resources provided in the budget resolution which would be roughly $400 billion. The bill also provides generous coverage to lower income beneficiaries, those who have income below about $15,000, and couples with incomes below about $20,000. They, in fact, have no gap in coverage. That is 44 percent of Medicare beneficiaries who are completely unaffected by the benefit limit.

In the writing of this bill, a conscious decision was made to devote excess dollars to filling in the gap in coverage for all seniors. Under the underlying bill, the average senior at this income level will still save more than $1,600 annually off the drug spending after paying an affordable monthly premium of $35 per month. This is a savings of about 53 percent off annual drug costs for the average senior who would enroll in the drug benefit.

Let me remind everybody, this drug benefit is optional. People do not have to join it. If anybody is saying I don't want to pay $35 per month to get this sort of coverage, then that person does not have to pay $35 per month for coverage because this is a voluntary program. So the people who enroll in this program would save that $1,600, even beyond the $35-per-month premium.

While I appreciate what the Senator from Connecticut is trying to do, it cannot possibly fit within the $400 billion that we have. We had to draw a limit someplace. We drew the limit at 160 percent of poverty. So I cannot support his amendment. I am sorry to say that to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. I thank the chairman. He has been very gracious. This is my last amendment. I have tried vainly over here in the last couple of days with some amendments—I don't know what the implications are; I appreciate his candor, in terms of not knowing the cost of this amendment—that would fill in the hole, to go from 160 to 250, for people in that category. The reason I offered it is it occurred to me if you are paying that much in prescription drugs, somewhere around $5,000 a year for prescription drugs, and you are making $30,000 as a couple or $22,000 as an individual, you probably have a pretty serious illness if you are paying about $5,000 in prescription drug costs.

It occurs to me that during that hole, we might try to do a little more. We have done that, as the chairman says, very graciously for the desperately poor in this country.

For those reasons, I urge the adoption of the amendment. I will let the chairman proceed. The first amendment, I guess, we will do in that order.

Mr. GRASSLEY. I yield any time I have and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 970.

Mr. DODD. There are two amendments. Amendment No. 998?

The PRESIDING OFFICER. We will vote on one at a time. Amendment No. 970 is first.

Mr. GRASSLEY. Mr. President, while I am at it, I would like to ask for the yeas and nays on both the Dodd amendments.

The PRESIDING OFFICER. Is there objection to that request?

Without objection, it is so ordered. The yeas and nays are in order.

Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the amendment. The yeas and nays have been ordered.

The clerk will call the roll on amendment No. 970.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from South Carolina (Mr. GRAHAM) are necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 54, as follows:

[Rollcall Vote No. 240 Leg.]

YEAS—41

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—54

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Landrieu
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—5

Campbell
Graham (FL)
Graham (SC)
Kerry
Lieberman

The amendment (No. 970) was rejected.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. NICKLES. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

VOTE ON AMENDMENT NO. 998

The PRESIDING OFFICER. The question is on agreeing to amendment No. 998. The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea".

The PRESIDING OFFICER (Mr. TALENT). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 55, as follows:

[Rollcall Vote No. 241 Leg.]

YEAS—41

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—55

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Landrieu
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—4

Campbell
Graham (FL)
Kerry
Lieberman

The amendment (No. 998) was rejected.

Mr. REID. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. I ask unanimous consent that the Democratic leader be recognized to speak next, and following his statement the Senator from Georgia be recognized to speak, both as if in morning business. The Senator from Georgia will speak for up to 7½ minutes; I don't know how long Senator DASCHLE is going to speak, but I don't think it will be long.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. While we are waiting for Senator DASCHLE, if we could reverse the order and have the Senator from Georgia proceed.

The PRESIDING OFFICER. The Senator from Georgia.

(The remarks of Mr. MILLER are printed in Today's RECORD under "Morning Business.")

(The remarks of Mr. DASCHLE are printed in Today's RECORD under "Morning Business.")

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I ask unanimous consent the pending amendment be set aside and Senator CONRAD be recognized to offer a series of amendments, and following his offering amendments the Senator from New York, Senator CLINTON, be recognized to offer her amendments.

I state for the information of Senators, the manager or I will also have some other amendments to offer on behalf of other Senators. Following that, there should be no more business of the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota.

AMENDMENTS NOS. 1019, 1020, 1021

Mr. CONRAD. Mr. President, I say to my colleague who is seeking to also introduce amendments. I will be very brief.

I rise to offer three amendments to the Prescription Drug and Medicare Improvement Act. I send the three to the desk.

The PRESIDING OFFICER. The clerk will report the amendments by number.

The legislative clerk read as follows:

The Senator from North Dakota [Mr. CONRAD], for himself, Mrs. MURRAY, Mr. SMITH, Mrs. LINCOLN, and Mr. JEFFORDS, proposes an amendment numbered 1019.

The Senator from North Dakota [Mr. CONRAD] proposes an amendment numbered 1020.

The Senator from North Dakota [Mr. CONRAD] proposes an amendment numbered 1021.

Mr. CONRAD. I ask unanimous consent the reading of the amendments be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT NO. 1019

(Purpose: To provide for coverage of self-injected biologicals under part B of the medicare program until Medicare Prescription Drug plans are available)

At the end of subtitle B of title IV, insert the following:

SEC. . MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by inserting "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

"(ii) a self-injected drug that is used to treat multiple sclerosis;".

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting ", except for any drug or biological described in subparagraph (W)," after "which".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)"; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

AMENDMENT NO. 1020

(Purpose: To permanently and fully equalize the standardized payment rate beginning in fiscal year 2004)

Strike section 401 and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking "(iv) For discharges" and inserting "(iv)(I) Subject to subclause (II), for discharges"; and

(2) by adding at the end the following new subclause:

"(II) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.".

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "IN DIFFERENT AREAS";

(B) in the matter preceding clause (i), by striking ", each of";

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking "and" after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking the period at the end and inserting "; and"; and

(E) by adding at the end the following new clause:

"(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

"(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.".

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting ", for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting ", for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region.".

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)"; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

AMENDMENT NO. 1021

(Purpose: To address medicare payment inequities)

At the end of subtitle A of title IV, add the following:

SEC. . GEOGRAPHIC RECLASSIFICATION OF CERTAIN HOSPITALS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2004 and each subsequent fiscal year, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospitals located in the Bismarck, North Dakota Metropolitan Statistical Area are deemed to be located in the Fargo-Moorhead North Dakota-Minnesota Metropolitan Statistical Area.

(b) TREATMENT AS DECISION OF MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD.—

(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of section 1886(d) of the Social Security Act (42 U.S.C 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(2) NONAPPLICATION OF 3-YEAR APPLICATION PROVISION.—Section 1886(d)(10)(D)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(v)), as it relates to a reclassification being effective for 3 fiscal years, shall not apply with respect to reclassifications made under this section.

(c) PROCESS FOR APPLICATIONS TO ENSURE THAT PROVISIONS APPLY BEGINNING OCTOBER 1, 2003.—The Secretary shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) ADJUSTMENTS TO ENSURE BUDGET NEUTRALITY.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or less than those that would otherwise be made if this section had not been enacted.

AMENDMENT NO. 1019

Mr. CONRAD. Mr. President, the first amendment would provide immediate prescription assistance to certain chronically ill beneficiaries. We have a very curious circumstance. Under current law, Medicare Part B covers injectable drugs if they are routinely administered by a physician in the office. However, if a similar drug is available that could be self-injected at home, it is not covered.

That makes no sense at all. This policy causes a significant burden for seniors with certain illnesses such as multiple sclerosis, rheumatoid arthritis, and other diseases. This amendment would address this problem by providing immediate coverage of drugs that could be administered at home when they are used to replace drugs that are covered when given in a physician's office. This transitional benefit would expire when a comprehensive Medicare drug benefit is implemented in 2006.

I am proud to say I am working on this effort with Senator MURRAY of Washington, who has introduced similar legislation in bill form; Senator SMITH, who is also on the Finance Committee, who has been a leading advocate of this approach; Senator LINCOLN; and Senator JEFFORDS. It is supported by more than 40 patient organizations.

This is a common-sense policy which provides real and immediate help to thousands of America's seniors. It is entirely paid for by codifying that Medicare is the secondary payer when beneficiaries have other private insurers that provide them with coverage.

I hope my colleagues will look with favor on this amendment.

AMENDMENT NO. 1020

The second amendment would address payment inequity that has hurt America's rural hospitals. As many know, rural health care providers are often forced to operate with significantly less resources than larger urban facilities. In my State of North Dakota, rural hospitals often receive only one-half the reimbursement their urban counterparts get for treating the exact same illness.

For example, a rural facility in North Dakota receives approximately $4,200 for treating pneumonia, while a hospital in New York receives more than $8,500 to treat that same illness. The funding disparity is simply unfair and has placed many rural providers on shaky ground.

To address this situation, MedPAC has recommended various policies, including equalizing the standard payment amount, which has been 1.6 percent higher for urban facilities. There is no policy basis for this difference.

Earlier this year the omnibus appropriations bill took steps to equalize the standardized amount but only until the end of fiscal year 2003. This amendment finishes the job by making this change permanent.

Again, this amendment is fully paid for by the legislation codifying that Medicare is the secondary payer when beneficiaries have alternative coverage.

AMENDMENT NO. 1021

Finally, I am offering a third amendment that would address a disparity related to whether certain hospitals are eligible to be reclassified for the purposes of the in-patient hospital wage index.

Under current law, hospitals have to meet certain mileage or proximity requirements in order to reclassify to the wage index value applied to another area of the State. In rural States such as North Dakota, this restriction has produced unfair, certainly unintended, consequences.

In my State, there are hospitals on the western side of North Dakota which are hundreds of miles from the eastern side of the State but compete for the same labor pool—compete for the same doctors, the same nurses—and have the same costs. However, because of this mileage restriction, they are not able to get paid the same. In fact, there is an 18-percent difference in the wage index between hospitals in Bismarck, ND, and hospitals in Fargo, ND—an 18-percent difference. It makes no earthly sense.

North Dakota hospitals have tried to address this situation by appealing to CMS on various occasions, to no avail. And the reason it has been to no avail is because the law says you have to be contiguous. Well, there is a 200-mile difference between Bismarck and Fargo, but they are in contiguous markets. They compete for the same doctors, the same nurses, and they need to be treated in the same way.

This amendment would address this situation by allowing certain hospitals in my State to reclassify to another area of the State for purposes of the wage index. This change would be budget neutral.

I urge my colleagues to support these three important amendments.

Let me just say, if I can, to my colleagues, I am also working on a fourth amendment, the dialysis annual update formula. I am working on that with Senator SANTORUM and the chairman and ranking member. We are hopeful of being able to work out that amendment at a later point.

Mr. President, these are the amendments I am seeking to have considered.

AMENDMENT NO. 1019

Mr. SMITH. Mr. President, I rise today with my colleague from North Dakota in support of critical drug coverage for beneficiaries who contend with the debilitating effects of Multiple Sclerosis. This amendment would provide transitional coverage for the four FDA-approved therapies in the 2-year interim until 2006, when the prescription drug plan will take effect.

Approximately 400,000 Americans have MS. In my home State of Oregon, it is estimated that there are 5,800 people living with MS. Currently, Medicare covers only one of the four FDA-approved MS therapies and only when administered by a physician.

This amendment would cover all four MS therapies, including when they are administered by the patients themselves, providing better coverage and better care for Americans with Multiple Sclerosis. While these therapies do not cure MS, they can slow its course, and have provided great benefit to MS patients.

It is critical that MS patients have access to all approved drugs because some MS patients do not respond well to, or cannot tolerate, the one MS therapy that is currently covered. Currently, many Medicare beneficiaries with MS are forced to take the less effective therapy, to pay the costs out of pocket, or forgo treatment.

Equally, this amendment is important to rural Medicare beneficiaries with MS. By administering drugs themselves, rural beneficiaries can avoid the costs and hassles of traveling long distances to health care facilities to receive their MS therapy.

In the spirit of providing all Medicare beneficiaries with increased choice, MS patients need and deserve the full range of treatment choices currently available and self-administration helps ensure access to needed medications. I urge my colleagues on both sides of the aisle to join me in support of this amendment and to provide adequate and comprehensive drug coverage for MS patients.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, with the graciousness of the Senator from New York, I ask unanimous consent that the Senator from Washington be recognized for up to 3 minutes to speak on one of the amendments offered by the Senator from North Dakota.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mrs. MURRAY. Mr. President, I thank my colleague from New York.

AMENDMENT NO. 1019

Mr. President, I have a statement I will give for the RECORD, but I also want to thank Senator CONRAD for his work on the self-injected biologics and the offering of this amendment tonight. I am delighted to be a cosponsor on this amendment. It is something I have worked on for over 2 years. And as Senator CONRAD said, we have patients today with MS, with rheumatoid arthritis, who are forced to go to a doctor, a medical clinic in order to get the drugs they need.

This will save us money in the long run because people will be able to stay home. But, most importantly, it will allow people quality of life in the care they need. I thank Senator CONRAD and Senator SMITH and the other cosponsors of this amendment.

Mr. President, I am pleased to join with Senator CONRAD and Senator SMITH in offering this amendment to give those on Medicare access to a new, exciting group of drugs known as self-injected biologics.

Senator CONRAD offered a similar amendment during the Senate Finance Committee markup and received a commitment from the chair to work with us on this effort.

As a result of this commitment, Senator CONRAD withdrew the amendment. We have been working with CBO and Senator BAUCUS' staff to address any concerns.

Currently, Medicare will only cover biologics if they are administered in a physician's office or clinical setting. That means patients must travel to the physician's office to receive treatment. This is not easy for many patients who have rheumatoid arthritis or MS—two diseases that can severely limit a person's mobility.

Fortunately, there are versions of these drugs that a patient can take in their own home. It is a great innovation that will improve a patient's access.

Unfortunately, Medicare won't cover biologics that are administered in the home. That just doesn't make sense. I have been working to correct this inequity for the past 2 Congresses.

The Murray-Conrad-Smith amendment would provide 2 years of coverage, under Part B, for those self-injected biologics that replace treatments currently available only in a physician's office.

We allow for 2-year coverage to bridge the gap to implementation of a Medicare prescription drug benefit.

We have received a CBO score for the 2 years and believe that we can find room in 2004 and 2005 to provide this important coverage for MS and RA patients.

This legislation is strongly endorsed by the Arthritis Foundation and will provide additional coverage to all four MS self-injected or self-administered treatments.

For MS, only one treatment is covered under Medicare, provided in a physician's office.

I am hopeful that the managers of this legislation will be able to accept our amendment and end this discriminatory practice in Medicare.

Mr. President, I thank the Senator from New York.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. CONRAD. Mr. President, I appreciate very much the leadership Senator MURRAY has provided on this issue. I really took her legislation and, because I am a member of the Finance Committee, I had an opportunity to offer it. But I want to make clear, this is a bill Senator MURRAY introduced. I was proud to pick it up in the Finance Committee so it could be offered at the appropriate time there.

I thank her for her leadership. I think we are close to getting this accomplished. It will be a great tribute to the Senator from Washington and the legislative leadership she has provided.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. Mr. President, I join with my colleague from North Dakota in thanking the Senator from Washington for championing this cause for so long because it is clearly long overdue. And I thank both Senators for presenting it to us in this context. I look forward to supporting it.

Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside so I may offer several amendments.

The PRESIDING OFFICER. That authority has already been granted.

AMENDMENTS NOS. 1000 AND 999

Mrs. CLINTON. Mr. President, I rise today to speak of four amendments I have filed. And I would like to discuss each in turn, starting with amendment No. 1000, offered on behalf of myself, Senator TIM JOHNSON, and Senator——

The PRESIDING OFFICER. If the Senator will suspend for a moment, we are trying to find the amendments here at the desk.

The clerk will report the amendments that are at the desk.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON], for herself, Mr. JOHNSON, and Mr. BINGAMAN, proposes an amendment numbered 1000.

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 999.

The amendments are as follows:

AMENDMENT NO. 1000

(Purpose: To study the comparative effectiveness and safety of important Medicare covered drugs to ensure that consumers can make meaningful comparisons about the quality and efficacy)

At the end of title VI, add the following:

SEC. . STUDY ON EFFECTIVENESS OF CERTAIN PRESCRIPTION DRUGS.

(a) IN GENERAL.—

(1) RESEARCH BY NIH.—The Director of the National Institutes of Health, in coordination with the Director of the Agency for Healthcare Research and Quality and the Commissioner of Food and Drugs, shall conduct research, which may include clinical research, to develop valid scientific evidence regarding the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(2) ANALYSIS BY AHRQ.—

(A) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, taking into consideration the research and data from the National Institutes of Health and the Food and Drug Administration, shall use evidence-based practice centers to synthesize available data or conduct other analyses of the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(B) SAFETY.—In any analysis of comparative effectiveness under this subparagraph, the Director of the Agency for Healthcare Research and Quality shall include a discussion of available information on relative safety.

(3) STANDARDS.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Commissioner of Food and Drugs, the Director of the National Institutes of Health, and with input from stakeholders, shall develop standards for the design and conduct of studies under this subsection.

(b) COVERED PRESCRIPTION DRUGS.—For purposes of this section, the term "covered prescription drugs" means prescription drugs that, as determined by the Director of the Agency for Healthcare Research and Quality in consultation with the Administrator of the Centers for Medicare & Medicaid Services, account for high levels of expenditures, high levels of use, or high levels of risk to individuals in federally funded health programs, including Medicare and Medicaid.

(c) DISSEMINATION.—

(1) ANNUAL REPORT.—Each year the Secretary shall prepare a report on the results of the research, studies, and analyses conducted by the National Institutes of Health and the Agency for Healthcare Research and Quality, and the Food and Drug Administration under this section and submit the report to the following:

(A) Congress.

(B) The Secretary of Defense.

(C) The Secretary of Veterans Affairs.

(D) The Administrator of the Centers for Medicare & Medicaid Services.

(E) The Director of the Indian Health Service.

(F) The Director of the National Institutes of Health.

(G) The Director of the Office of Personnel Management.

(H) The Commissioner of Food and Drugs.

(2) REPORTS FOR PRACTITIONERS.—As soon as possible, but not later than a year after the completion of any study pursuant to subsection (a)(2), the Director of the Agency for Healthcare Research and Quality shall—

(A) prepare a report on the results of such study for the purpose of informing health care practitioners; and

(B) transmit the report to the Director of the National Institutes of Health.

(3) FDA DRUG INFORMATION.—The Commissioner of Food and Drugs shall—

(A) review all data and information from studies and analyses conducted or prepared under this section; and

(B) develop appropriate summaries of such information for inclusion in adequate directions for use under section 502(f)(1) of the Federal Food, Drug, and Cosmetic Act and in summaries relating to side effects, contraindications, and effectiveness under section 502(n) of that Act.

(4) NIH INTERNET SITE.—The Director of the National Institutes of Health shall publish on the Institutes' Internet site and through other means that will facilitate access by practitioners, each report prepared under this subsection by the Director of the Agency for Healthcare Research and Quality.

(d) EVIDENCE.—In carrying out this section, the Director of the National Institutes of Health and the Agency for Healthcare Research and Quality shall consider only methodologically sound studies, giving preference to studies for which the Directors have access to sufficient underlying data and analysis to address any significant concerns about methodology or the reliability of data.

(e) AUTHORIZATIONS OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $75,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

AMENDMENT NO. 999

(Purpose: To provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level)

On page 389, between lines 6 and 7, insert the following:

SEC. . PRIORITY AREA QUALITY INDICATORS.

(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Quality Interagency Coordination Task Force, the Institute of Medicine, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, the American Health Quality Association, the National Quality Forum, and other individuals and organizations determined appropriate by the Secretary of Health and Human Services, shall assemble, evaluate, and, where necessary, develop or update quality indicators for each of the 20 priority areas for improvement in health care quality as identified by the Institute of Medicine in their report entitled "Priority Areas for National Action" in 2003, in order to assist medicare beneficiaries in making informed choices about health plans. The selection of appropriate quality indicators under this subsection shall include the evaluation criteria formulated by clinical professionals, consumers, data collection experts.

(b) RISK ADJUSTMENT.—In developing the quality indicators under subsection (a), the Director of the Agency for Healthcare Research and Quality shall ensure that adequate risk adjustment is provided for.

(c) BEST PRACTICES.—In carrying out this section, the Director of the Agency for Healthcare Research and Quality shall—

(1) assess data concerning appropriate clinical treatments based on the best scientific evidence available;

(2) determine areas in which there is insufficient evidence to determine best practices; and

(3) compare existing quality indicators to best clinical practices, validate appropriate indicators, and report on areas where additional research is needed before indicators can be developed.

(d) Report.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Director of the National Institutes of Health a report concerning areas of clinical care requiring farther research necessary to establish effective clinical treatments that will serve as a basis for quality indicators; and

(2) submit to Congress a report on the state of quality measurement for priority areas that links data to the report submitted under paragraph (1) for the year involved.

(e) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section $12,000,000 for fiscal year 2004, and $8,000,000 for each of fiscal years 2005 through 2009.

SEC. . STANDARDIZED QUALITY INDICATORS FOR FEDERAL AGENCIES.

(a) In General.—In addition to other activities to be carried out by the Quality Interagency Coordination Taskforce (as established by executive order on March 13, 1998), such Taskforce shall standardize indicators of health care quality that are used in all Federal agencies, as appropriate.

(b) Consultation.—In carrying out subsection (a), the Quality Interagency Coordination Taskforce shall consult with a public-private consensus organization (such as the National Quality Forum) to enhance the likelihood of the simultaneous application of the standardized indicators under subsection (a) in the private sector.

(c) Report.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the progress made by the Quality Interagency Coordination Taskforce to standardizing quality indicators throughout the Federal Government.

SEC. . DEMONSTRATION PROGRAM FOR COMMUNITY HEALTH CARE QUALITY DATA REPORTING.

(a) In General.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Quality and Research, shall award not to exceed 20 grants to eligible communities for the establishment of demonstration programs for the reporting of health care quality information at the community level.

(b) Quality Indicators.—

(1) In general.—For purposes of reporting information under the demonstration programs under this section, indicators of health care quality may include the indicators developed for the 20 priority areas as identified by the Institute of Medicine in the report entitled "Priority Areas for National Action", 2003, or other indicators determined appropriate by the Secretary of Health and Human Services.

(2) Type of data.—All quality indicators with respect to which reporting will be carried out under the demonstration program shall be reported by race, ethnicity, gender, and age.

(c) Eligibility.—The Secretary of Health and Human Services shall award grants to communities under this section based on competitive proposals and criteria to be determined jointly by the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality. Such criteria may include a demonstrated ability of the community to collect data on quality indicators and a demonstrated ability to effectively transmit community-level health status results to relevant stakeholders.

(d) Technical Advisory Committee.—The Secretary of Health and Human Services shall establish a technical advisory committee to assist grantees in data collection, data analysis, and report dissemination.

(e) Report.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Congress a report on the results of the demonstration programs under this section; and

(2) make such reports publicly available, including by posting the reports on the Internet.

(f) Evaluation.—The Secretary of Health and Human Services shall, upon awarding grants under subsection (a), enter into a contract for the evaluation of demonstration programs under this section. Such evaluation shall compare the effectiveness of such demonstration programs in collecting and reporting required data, and on the effectiveness of distributing information to key stakeholders in a timely fashion. Such evaluations shall provide for a report on best practices.

(g) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section $25,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. Thank you, Mr. President.

AMENDMENT NO. 1000

Mr. President, amendment 1000, offered on behalf of myself and Senators Tim Johnson and Jeff Bingaman, is being offered to ensure our seniors have information they need to make informed consumer choices about their drugs, and also to ensure practitioners have the information needed to choose the right drug for a patient, and, further, that the private plans this bill would create have the information they need to make formulary and benefit design choices based on sound science.

This amendment ensures that various Government agencies—NIH, FDA, CMS, and the others involved in this effort—conduct research comparing the efficacy and, if applicable, the comparative safety of the top drugs used by Medicare and Medicaid beneficiaries who are Medicare eligible.

Now often there are a number of competing drugs to treat the same condition. But which is more effective? Oftentimes we just do not know.

While the FDA is responsible for determining safety and effectiveness of prescription drugs compared to a placebo, there is no Government entity responsible for examining whether drug A is more effective at treating a particular condition than drug B. Meanwhile, drug companies do not always have an incentive to do head-to-head trials of the drugs they put out versus those of their competitors. But this information is critical to all decisionmakers, to patients and consumers, to practitioners, and to the private plans that are being created.

Now clinicians have told me they are frequently trying to decide whether to switch a patient from an old drug to a new drug. They are not deciding between the old drug and a placebo; they are deciding between a drug they have used for a particular patient and then one which has come to their attention because it is now on the market, and they are trying to decide: Which is best for my patient? They wish they had more information that would enable them, besides trial and error and possible adverse consequences, to make that determination.

Clearly, consumers will also benefit from more sources of information. Right now advertising is a source available to consumers, but this amendment will help us provide an unbiased, scientific source of information that consumers can compare side by side rather than just a beautiful advertisement of people running through a field or twirling their grandchildren and then being told: This is the drug for the condition you have. They will be able to say: Well, wait a minute. Here is the drug I have been prescribed, here is a drug I have heard about. Let me look on the Internet to see what the differences might be.

Now we have all heard of "me too" drugs, and there is nothing wrong with "me too" drugs. Sometimes a "me too" drug will work incrementally better than a previous drug or it may be better tolerated. Even if a "me too" drug does not have those characteristics, it might be superior for a certain portion of the population but not for others. The problem is, we do not have that kind of comparative data.

My amendment directs NIH to do comparative efficacy trials for the top Medicare drugs—the ones that are primarily prescribed for the Medicare population—for the kinds of conditions the Medicare population primarily suffers from.

No single study will settle that question once and for all, so my amendment then directs the Agency for Health Research and Quality, AHRQ, to do what it does best, which is to synthesize the literature that is out there as well as the NIH data to report information on the comparative efficacy of these medical interventions that we are subsidizing now in this bill for our seniors.

HHS will then make this comparative information available to clinicians, to Congress, to relevant Federal agencies. And it will, most particularly and importantly, make that available to seniors so they can make informed choices for themselves.

Under this amendment, we would put this information on the Internet. FDA would look at whether this information needs to be included in drug labels, and drug ads would also contain this information so that they do not mislead seniors.

One indicator of the rarity of these studies is that completion of a comparative efficacy study can make national news. For example, many of us read last December when the National Heart, Lung, and Blood Institute published a study and discovered that it corrected the assumption that newer drugs, such as calcium channel blockers and ACE inhibitors, which cost 30 to 40 times more than diuretics, were not more effective than those long-time treatments for high blood pressure. This is information we have needed for years. We have one of the most advanced health care systems, if not the most advanced, in the world. If the information stream our doctors count is such a tiny trickle that the daily news can keep track of all major developments, then this amendment must be passed in order to give us a sound scientific basis for the decisions that are going to be made with the $400 billion that we are allocating.

When the research is done, as we learned about in the calcium channel blockers and ACE inhibitors versus old-fashioned diuretics, it is important and its benefits are immediately obvious.

In January 2003, the American Journal of Ophthalmology published an article comparing the efficacy of two glaucoma drugs. One is latanoprost and the other bimatoprost. These were compared in an NIH-sponsored randomized clinical trial. Despite the fact that the Latanoprost is currently the most popular medication, the study found that Bimatoprost was more effective.

This is critically important because if we are going to be putting money into drugs and we are going to be holding out the promise to our seniors that finally help is on the way, then let's make sure these tax dollars are used to fund the drugs that are most effective.

In 1999, an NIH-sponsored study showed that a well-known, safe, cheap generic drug, Metoprolol, was just as effective for treating patients with heart failure as a more expensive drug which had come on to the market just a few years earlier. Some may say these studies could promote a one-size-fits-all approach to prescribing, but to the contrary, these studies can actually help make prescribing more nuanced and appropriate to each subpopulation.

For instance, in March 2003, the American Journal of Cardiology reviewed numerous clinical trials of medications used to treat what is called atrial fibrillation, a type of heart arrhythmia, and came up with recommendations about what are the most effective drugs for use for this condition based on what the underlying cause of the condition was in each case.

As someone who is fast approaching the age of Medicare eligibility, I want, both for my pocketbook and my health, to know that my doctor and I have the best information available about which drug is appropriate for me. And I certainly think that we can, through this amendment, begin to provide that information to ensure that seniors and their physicians have good, solid data on which to make their decisions.

This amendment is supported by a number of groups that are aware of the significance of trying to put into this bill some scientifically based data on which to make these decisions. The RxHealth Value Coalition is supporting the amendment. I have a letter from them. They consist of not only large employers—Verizon, General Motors, Ford, et cetera—but Blue Cross, Blue Shield, Kaiser, AARP, and many others.

I ask unanimous consent to print the RxHealth Value letter of June 24, 2003, supporting this amendment, in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

RXHEALTHVALUE,
Washington, DC, June 24, 2003.

Hon. HILLARY RODHAM CLINTON,
U.S. Senate,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR CLINTON: As the 108th Congress considers reforming the Medicare program and addressing one of the programs major shortcomings—lack of an outpatient prescription drug benefit, we want to express support for your amendment to the Medicare legislation being considered by the Senate that would provide limited support for the Centers of Medicare and Medicaid Services, the Center for Medicare Choices, which would be created by S. 1, the National Institutes of Health and the Agency for Healthcare Research and Quality to collaborate on studies to compare the relative efficacy and safety of prescription medicines designed to treat the same condition. It is this very information that is vital to patients, practitioners, and purchasers. With comparative information on prescription medicines patients, practitioners and purchasers can make better decisions with respect to choosing the prescription medicines to take, prescribe, cover, and pay for.

RxHealthValue is a national coalition of large employers, consumer groups, labor unions, health plans, health care providers and pharmacy benefit managers that, through its members, represents almost 100 million Americans. RxHealthValue is committed to research, education and both public- and private-sector solutions to ensure that Americans receive the full health and economic value from their prescription drugs. The Coalition's definition of "value" includes effectiveness, cost, appropriate use and safety.

Your amendment is a very important component of any Medicare prescription drug benefit proposal, since it is imperative that the federal Centers for Medicare & Medicaid Services (CMS) and the proposed Center for Medicare Choices (CMC) have the needed information to be a prudent purchaser of prescription drugs. We are pleased that you ask the National Institutes of Health (NIH) to add to the very limited research results from which evidence-based reviews get their information, and that you recognized the importance of dissemination so that information gets to providers and consumers when they need it. We agree that AHRQ's Evidence-based Practice Centers (EPCs), which have been involved in the innovative Oregon prescription drug program, would be an outstanding vehicle for such reviews.

This legislation is especially important as Congress works to provide Medicare beneficiaries with high quality outpatient drug coverage. We applaud your efforts on this important amendment and look forward to working with you and others to ensure that improved information on prescription drugs is available to all.

For more information on RxHealth's position on this and other drug value initiatives, please contact Steve Cole, RxHealthValue Policy Committee Chair, at 202–296–1314.

Again, thank you from the member organizations of RxHealthValue:

Blue Cross/Blue Shield.
Kaiser.
AARP.
National Consumers League.
Verizon.
Association of Community Health Plans.
General Motors.
Ford.
Daimler Chrysler.
Families USA.
National Organization of Rare Disorders.
American Academy of Family Physicians.
Academy of Managed Care Pharmacy.
UAW.
AFSCME.
Pacific Business Group on Health.
Midwest Business Group on Health.
Washington Business Group on Health.
Advance-PCS.
Caremark Rx.
AFL-CIO.

Mrs. CLINTON. Similarly, I have a letter from Consumers Union, dated June 24, 2003, which also supports amendment No. 1000, and I ask unanimous consent that letter, too, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONSUMERS UNION,
June 24, 2003.

Hon. TIM JOHNSON,
U.S. Senate,
Washington, DC.

DEAR SENATOR JOHNSON: Consumers Union strongly supports your amendment that would provide for study by the National Institute of Health and the Agency for Healthcare Research and Quality of the comparative effectiveness of prescription drugs. The development of scientific evidence-based information about the relative effectiveness of drugs has the potential to dramatically increase consumers' (and taxpayers') bang-for-the-buck paid for prescription drugs.

Millions of Medicare beneficiaries (in addition to the tens of millions of uninsured and underinsured consumers nationwide) are paying increasing out-of-pocket costs for their prescription drugs. Despite these escalating costs, it is often difficult for consumers and health care professionals to ensure that consumers receive value for each healthcare dollar spent.

The proposed amendment would create a resource for independent information about the comparative medical effectiveness of important medicines. We believe that this information will substantially reduce the nation's prescription drug expenditures, because consumers and doctors will be able to make decisions using reliable evidence-based information about comparative effectiveness. The amendment would require this information to be made available through the Internet to the public. As a result, consumers, employers, state governments and the federal government will have access to information that will enable them to choose more cost-effective medicines without sacrificing medical effectiveness or quality of care.

Sincerely,

GAIL E. SHEARER,
Director, Health Policy Analysis,
Washington Office.

Mrs. CLINTON. Finally, I have a letter from Families USA, dated June 24, 2003, that similarly supports the amendment. I will read the following paragraph from it:

> It would be unfortunate if Congress decides to spend $400 billion on pharmaceuticals over the next decade, without providing a few dollars to ensure that what we are buying is indeed worth buying.

I ask unanimous consent that letter be printed in the RECORD as well.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FAMILIES USA,
June 24, 2003.

Hon. HILLARY RODHAM CLINTON,
U.S. Senate,
Washington, DC.

DEAR SENATOR CLINTON: Congratulations on your amendment to help Americans understand which prescription drugs are truly effective and safe. Families USA, the national health consumer advocacy organization, strongly endorses the effort of you and Senator Johnson to provide reliable, unbiased information on pharmaceuticals.

Too often today, prescription drug information is influenced by the manufacturer, by advertisements, and by clinical studies financed by those who will gain from favorable reports. Americans need an objective, reliable source of information on which prescription drugs are most effective.

It would be unfortunate if Congress decides to spend $400 billion on pharmaceuticals over the next decade, without providing a few dollars to ensure that what we are buying is indeed worth buying.

Thank you again for you leadership on this important health consumer initiative.

Sincerely,

RONALD F. POLLACK,
Executive Director.

Mrs. CLINTON. Mr. President, if we are serious about making changes that will improve the health of our seniors on Medicare, I hope that we look to establish in this bill the proposition that good information, solid science that can be made available to seniors, to clinicians, to plans, be part of what we are establishing with the proposition that this money needs to be well spent, well spent not only to safeguard the taxpayers' dollars but well spent to ensure that our doctors and patients get the best possible treatment.

I also am offering amendment No. 999 that is intended to ensure that Medicare plans compete to improve rather than cut corners on quality. This bill already includes a measure that I have supported, along with Senator HATCH and others, to commission the Institute of Medicine to ensure the Medicare Program pays plans for providing higher quality care.

Unfortunately, even for the many common diagnoses and treatments that are part of a senior's medical history, we lack the quality standards that the Medicaid Program would use to help consumers make informed comparisons and choices among health plans.

For some diseases, the National Commission for Quality Assurance does collect information about health plans by providing data, for example, on how well HMOs screen for breast cancer or provide flu shots for older adults.

For many other diseases, however, we do not know which plans make sure that their diabetic patients get their eyes examined for retinal damage, what percent of asthmatics receive adequate therapy to control their asthma; or many other issues that go to the heart of the quality of health care that is being provided to our seniors.

The data tells us that Medicare beneficiaries are often not receiving the care they need to maintain their health. In 2001, for example, 23 percent of Medicare beneficiaries in private health plans did not have their cholesterol managed after a heart attack.

Now, my amendment is based on recommendations made by the Institute of Medicine. It authorizes a collaborative effort among the relevant Government agencies to develop quality indicators in the 20 most important areas identified in this Institute of Medicine report entitled "Priority Areas for National Action." It authorizes the Quality Interagency Coordination Task Force—that is a task force that brings together all the Federal agencies that are needed to collect health quality data—to implement these indicators so that they are all collecting quality information in the same way. The Secretary of Health and Human Services would then develop demonstration programs for communities to engage in communitywide reporting, according to these quality indicators.

This amendment also has the potential to lower the cost of the Medicare Program. Because plans will provide quality measures that consumers will use, health plans will want to implement those quality improvement measures that have also been proven to lower health care costs. One such program, as an example, is a diabetes intervention program implemented by Group Health Cooperative, a group model health plan in Washington State. This intervention program improved diabetic blood sugar control and saved between $685 and $950 annually from reduced hospital admissions, emergency department visits, and physician consultations.

This is the kind of emphasis on quality that I think we need to put into this bill. Otherwise, as we try to make sense of the variety of options and choices that are available, we are not going to know what improved quality or what decreases costs. That should be one of our goals, and this amendment holds out the promise that the Medicare Program, with proper implementation of quality indicators, can do both—improve health and quality control and decrease costs.

AMENDMENT NO. 953

Mrs. CLINTON. Mr. President, I will also be talking about amendment No. 953, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

> The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 953.

Mrs. CLINTON. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide training to long-term care ombudsman)

On page 608, between lines 10 and 11, insert the following:

SEC. . TRAINING FOR LONG-TERM CARE OMBUDSMAN.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Administration on Aging and in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall authorize a program, to be developed and implemented by the National Long-Term Care Ombudsman Resource Center, for the training of long-term care ombudsmen in the use of quality of care information.

(b) TRAINING.—Under the program developed under subsection (a), training shall be provided to long-term care ombudsman to enable such ombudsman to educate consumers concerning—

(1) nursing home quality of care issues;

(2) available nursing home quality of care reports, including existing quality data that the Administrator of the Centers for Medicare & Medicaid Services has released for use by the public in choosing long-term care facilities; and

(3) the manner in which an individual can successfully integrate quality information into health care decision making regarding nursing home decisions.

(c) DUTIES OF RESOURCE CENTER.—The National Long-Term Care Ombudsman Resource Center shall—

(1) develop and maintain a curriculum for ombudsmen;

(2) develop, produce, and maintain training materials;

(3) conduct train-the-trainer programs at regional and national levels; and

(4) act as a clearinghouse for best practices in communicating the significance of nursing home quality indicators to residents and their caregivers.

(d) PILOT PROGRAMS.—The Secretary of Health and Human Services shall award grants for the establishment of 1-year pilot demonstration programs in 10 States using long-term care ombudsmen to educate consumers regarding home health care quality. Such pilot demonstration programs shall test the effectiveness of having a committed position within the State dedicated to helping consumers use home health care quality indicators.

(e) REPORT.—Not later than 18 months after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report concerning the effectiveness of the program established under this section, including the benefits of providing for dedicated staff who are responsible for educating consumers to use home health quality indicators in their health care decision-making.

(f) AUTHORIZATION.—In addition to any other amounts authorized to be appropriate for long-term care ombudsman programs, there are authorized to be appropriated to carry out this section $4,000,000 for fiscal year 2004 (of which $1,000,000 shall be used to carry out subsection (d)), and $2,000,000 for each fiscal year thereafter.

Mrs. CLINTON. Mr. President, amendment No. 953 would empower Medicare beneficiaries and their families in making decisions about nursing homes and home health services. Data on nursing home quality is publicly available through a project strongly supported by Administrator Scully, and I am very appreciative of that because that information is imperative.

However, I know from talking with people throughout New York that there are still many problems in nursing homes with respect to errors and mishaps that undermine the quality of care, the quality of life and, in some respects, even the health of the nursing home residents. Many people still don't know about this existing quality data and about the existing ombudsman program within the administration on aging that is intended to help families navigate nursing home decisions.

This amendment would establish a national long-term care ombudsman resource center, which will help to develop and train ombudsmen. The amendment would establish pilot programs, including grants to create ombudsman offices in 10 States. These are the people—it should really be "ombudspeople," I guess—who are uniquely positioned to know about the facilities they serve. They visit the facilities regularly. They are often located at agencies in the local communities. They have firsthand knowledge. They are very valuable resources. However, their knowledge, if it doesn't actually get to the users, the nursing home residents and, more importantly, their family members or advocates, doesn't help anyone.

This pilot project would fund specific ombudsman programs to provide comprehensive outreach, public education, and individual consultation that integrate quality information into health care decisionmaking. Through this pilot project, the ombudsman center would be able to identify the resources needed to actually provide consumer education on long-term care and home health, as well as best practices and collaborative models that could then be replicated around the country.

I ask my colleagues also to support this amendment because, again, I think information is critical. We talk about trying to create more of a market for these health care resources. Markets exist on information. A market without good information is not really a market at all. So if we are going to move toward the private market and provide these private health plans as competition to the existing Medicare delivery system, then I think we have to do more than just talk about the market. We need to empower the consumers within the marketplace. Information is that basis for empowerment.

AMENDMENT NO. 954

Mrs. CLINTON. Mr. President, I ask the clerk to report amendment No. 954, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 954.

Mrs. CLINTON. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information)

On page 46, between lines 13 and 14, insert the following:

"(i) HEALTH LITERACY STANDARDS.—

"(1) IN GENERAL.—For purposes of assisting eligible entities in providing quality assurance measures as described in subsection (c)(1)(B), the Secretary, acting through the Director of the Agency for Healthcare Research and Quality, the Administrator of Health Resources and Services Administration, the Director of the National Library of Medicine, and the Commissioner of Food and Drugs, shall develop standardized materials that pharmacists may use to assist non-English speaking or functionally illiterate patients in the safe and appropriate use of prescription drugs. Such materials may include the use of pictures and the development of standardized translations in multiple languages of prescription labels and bottle labels and other patient safety initiative information. Such materials shall be available electronically for direct access by pharmacists.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2004 and 2005.

Mrs. CLINTON. Mr. President, this amendment is intended to improve the safety of the prescription drug program. As our seniors are using a growing number of medications to stay out of the hospital, to live healthier and longer lives, we are inadvertently, but inevitably, creating a burden on our seniors to understand and know how to use all of these prescription drugs. There are interactions, there are other issues, there are many problems with trying to sort out for our seniors how drugs work, how they interact with one another. This is a very important issue that I think, again, we need to address at the beginning of this process, not after some additional problems have been discovered.

In a recent study of adverse drug events published in the Journal of the American Medical Association, 21 percent of preventable adverse drug events were caused by patients not following drug prescription instructions. That is just human nature. People make mistakes and, as you get older, it is harder to read all that little writing on the prescription bottles. That is something that just kind of comes with the process. Of course, we have many people for whom English is not their first language. We have others who have challenges with eyesight and literacy. So, clearly, our seniors, like the rest of us, could make mistakes.

Studies have found that one-third of patients often don't take the prescription the way they are supposed to because they don't understand it. Now, if you have a dose of a three-times-a-day antibiotic, and you also have other prescription drugs to be taken five, six, seven times a day, or whatever the combination is, there are all kinds of opportunities for confusion because many seniors take complex drugs with multiple dangerous side effects, often much more serious than those from antibiotics. They are more likely to suffer injuries and hospitalizations as a result. As many as 60 percent of the elderly have these problems about understanding and following the directions. This is a very critical statistic. Twenty-three percent of nursing home admissions in our country result from the inability of older Americans to manage their medication at home.

That is why I am offering this amendment to ensure that the Secretary of HHS works to ensure the use of health literacy standards and information that will minimize adverse drug events, to ensure that we develop drug informational materials for non-English-speaking people and the functionally illiterate patients that can be made available to pharmacists who can access them electronically for easy use.

So, Mr. President, these amendments can be summed up in a very few words: enhanced quality, lower cost.

If we enhance quality, we avoid a lot of the problems that exist in our system today. We learn more about quality. We empower patients, as well as clinicians, with information that can better determine quality outcomes, and we save money. We do not have people being admitted to the hospital because they mix up their drugs. We do not have people trying to figure out how they can get good information about quality standards in nursing homes. We have all kinds of issues that cost money, as well as put the health and well-being of our seniors at risk.

I ask that my colleagues favorably consider these amendments. There is no cost attached to these amendments, but they will do what we hope to achieve by this significant legislation: improve quality for our seniors and lower costs in the long run by making prescription drugs readily available and understanding appropriately their use.

Mr. President, I thank you for your kind attention, and I yield the floor.

AMENDMENT NO. 1000

Mr. JOHNSON. Mr. President, I join my colleagues Senators CLINTON and BINGAMAN today to offer an amendment to S. 1 that will provide consumers and practitioners with real, objective information regarding the comparative effectiveness of prescription drugs.

Too often, prescription drug information is influenced by drug manufacturers, through advertisements, and by clinical studies financed by those who will gain from favorable reports. Consumers are just inundated with information—from direct-to-consumer advertising on drugs which can paint a misleading picture, to a sea of free drug samples from their physicians—with all this information it can be extremely difficult to make a sound decision which can be just overwhelming for average Americans.

But what does the data really say about differing prescription drug options? Does a newer drug that costs more than an earlier version necessarily do a better job for most patients? Is it possible that a Medicare beneficiary may get the same, or even better outcome from the drug that has been on the market for a longer time? We just really don't have the answers to these—questions at least from independent, objective sources.

We are about to create a massive new program that will effect 40 million Americans and with this comes responsibility to deliver a program that ensures the availability of appropriate prescription drugs for all beneficiaries. This amendment will create a reliable source for valid, evidence-based information about the comparative medical effectiveness of medicines used by Medicare beneficiaries. It will provide unbiased information on how drugs that treat particular diseases and conditions compare to one another.

By authorizing the National Institutes of Health, in coordination with the Agency for Healthcare Research and Quality to conduct research on comparative effectiveness of drugs, consumers, employers, State governments and the Federal Government will finally have access to information that will enable them to choose medicines based on clinical research. This information will be made available to help them make better decisions with respect to choosing the prescription medicines to take, prescribe, cover and pay for. By using the objective, scientific expertise available at NIH and AHRQ, this amendment assures that the information received comes from independent and impartial sources.

This amendment is supported by RxHealthValue, a national coalition of large employers, consumer groups, labor unions, health plans, health providers and pharmacy benefit managers that through its members represent almost one-hundred million Americans. It is also supported by Families USA and Consumers Union.

This amendment preserves individuals' freedom to get any medicine that they want, but would encourage the use of medicines that are scientifically proven more effective for patients. It will not create "one-size-fits-all" medicine as Republicans will try and tell you. It does nothing to prevent independent decisionmaking by practitioners and their patients, just better educated decisionmaking.

Our Republican colleagues believe in the strength of the free market. Well, a well functioning marketplace depends on the free flow of information. Denying consumers and providers, as well as other purchasers of prescription drugs access to comparative information about effectiveness means that decisions in the marketplace are made without perfect information—which should not be the case in an open market. You are not going to buy a car without taking a look at Consumer Reports are you? Are you only going to base your purchase on the glitzy adds in "Car and Driver" magazine? I think we all know the answer to this is "no", and most certainly Medicare beneficiaries should have access to similar information for drugs they put in their bodies as they do for the car they drive.

AMENDMENT NO. 985, AS MODIFIED

Mr. REID. Mr. President, on behalf of Senator EDWARDS of North Carolina, I send a modification to the desk, and I ask unanimous consent the amendment be so modified.

The PRESIDING OFFICER. Without objection, it is so ordered. The amendment will be so modified.

The amendment (No. 985), as modified, is as follows:

At the end, add the following:

TITLE —DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. 01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following "(including, if the Secretary so requires, whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)"; and

(2) in subsection (d)(5)—

(A) by inserting "(A)" after "will"; and

(B) by inserting after "thereof" the following: "or (B), if the Secretary has required information related to comparative safety and effectiveness, offer a benefit with respect to safety or effectiveness (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug".

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after "effectiveness" the following: "(including effectiveness in comparison to other drugs for substantially the same condition or conditions if such comparative information is available)".

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions if such comparative information is available);

(ii) information relating to side effects and contraindications; and

(B) any advertisement present a fair balance comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual representations relating to side effects and contraindications, provided that, nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

"(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

"(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

"(A) the Secretary provides the person written notice of the violation; and

"(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

"(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

"(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

"(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

"(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).".

SEC. 03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. 04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

AMENDMENT NO. 1036

Mr. REID. Mr. President. I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator BOXER. This is an amendment to eliminate the coverage gap for individuals with cancer.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mrs. BOXER, proposes an amendment numbered 1036.

Mr. REID. Mr. President. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the coverage gap for individuals with cancer)

On page 53, between line 8 and 9, insert the following:

"(6) NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

"(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

"(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

"(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

"(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A)."

AMENDMENT NO. 1037

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Mr. CORZINE. This is a technical amendment regarding federally qualified health centers.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. CORZINE, proposes an amendment numbered 1037.

Mr. REID. Mr. President. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To permit medicare beneficiaries to use Federally qualified health centers to fill their prescriptions)

At the end of subtitle A of title I, add the following:

SEC. . CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

(a) PERMITTING FQHCS TO FILL PRESCRIPTIONS.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(1) in subparagraph (A), by striking "and" after the comma at the end;

(2) in subparagraph (B), by inserting "and" after the comma at the end; and

(3) by adding at the end the following new subparagraph:

"(C) drugs and biologicals for which payment may otherwise be made under this title,".

(b) ELIMINATION OF PER VISIT LIMIT.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting ", except that such regulations may not limit the per visit payment amount with regard to drugs and biologicals described in section 1861(aa)(3)(C)" after "the Secretary may prescribe in regulations".

AMENDMENT NO. 1038

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator JEFFORDS dealing with critical access to hospitals.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. JEFFORDS, proposes an amendment numbered 1038.

Mr. REID. Mr. President. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To improve the critical access hospital program)

At the end of section 405 add the following:

(g) EXCLUSION OF CERTAIN BEDS FROM BED COUNT AND REMOVAL OF BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i-4(c)(2)) is amended by adding at the end the following:

"(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 25.".

(2) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CRITICAL ACCESS HOSPITALS.—Section 1886(d)(1)(B) (42 U.S.C. 195ww(d)(1)(B)) is amended by striking "a distinct part of the hospital (as defined by the Secretary)" in the matter following cause (v) and inserting "a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations with respect to distinct part unit status, and with respect to designations, that are made on or after October 1, 2003.

AMENDMENT NO. 1039

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator INOUYE dealing with Native Hawaiians.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. INOUYE, proposes an amendment numbered 1039.

Mr. REID. Mr. President. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system)

At the appropriate place, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Native Hawaiian Medicaid Coverage Act of 2003".

SEC. 2. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ", and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider" before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the pending amendments be set aside so that I may speak on my amendment No. 1011.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1011

Mr. SESSIONS. Mr. President, the bill we are moving forward today is a prescription drug bill, a Medicare reform bill. It is not a welfare reform bill. Unfortunately, through the process, as it often happens when legislation moves through this body, the Finance Committee, without having hearings, faced an amendment that came up and it became a part of the bill that is on the Senate floor today. It would provide benefits not to American citizens but to non-citizens. It would amend the law that was passed some time ago prohibiting such actions.

So I have sent to the desk an amendment which would strike section 605 of the bill, the section that allows Medicaid and State health insurance program coverage to be given to noncitizens, and insert a sense of the Senate that this section should be referred back to the Finance Committee.

In 1996, with a vote of 74 to 24, this body made a principled, purposeful decision during reform of welfare in this country, that non-citizens should not access Federal programs such as TANF and Medicaid for the first 5 years they are in the United States. That is because these costs are supposed to be incurred by the sponsors of those people who come into the United States. That is why we make the sponsor of an immigrant who comes into the United States lawfully sign an affidavit that they will be responsible for that person's health care benefit. Of those Senators who are still in service in this body, 45 voted for it. That is quite a significant number.

Section 605 would lift the 5-year ban for pregnant women, and children, from fiscal year 2005 through fiscal year 2007. In other words, we would allow pregnant women and children who have sponsors in the United States to access the welfare system of America to pay for their health care, contrary to the fully debated and wisely established rule in 1996 not to do that.

The President is concerned about that. The administration is opposed to this change. They note that the administration has proposed substantial new flexibility on the part of Medicaid and SCHIP reform, and coverage for legal immigrants should be examined as part of this context.

So we will be examining Medicaid, the SCHIP program, and Medicare reform later this year. That is the time we should be discussing changing our current policy as to what benefits are available to noncitizens, not slipping it through as part of this important bill.

This is not a decision that we should change, not a policy that ought to be altered, without some significant study and debate. We are amending the welfare reform bill as part of a prescription drug bill. This is a major policy shift. It ought not to be added in this fashion. This bill is for America's senior citizens, not for non-citizens. If we want to make such important changes in funding eligibility and criteria for these programs, we ought to be ready to have a full and open debate on welfare policy. That is the kind of debate we had in 1996. I think some good decisions were made then that helped this country tremendously. It helped poor families move from welfare to work and did a lot of things for children in this country.

The Finance Committee, which added section 605, should have hearings and go about it as part of the welfare reform bill. I feel strongly about that.

Before 1996, the cost of welfare for immigrants had skyrocketed in America to $8 billion a year. That was in 1996. Harvard economist George Borjas found that immigrant households were 50 percent more likely to use Federal welfare programs than were citizen households. So this was the untenable position and situation in 1996, and that is what was ended by the legislation then.

In 1996, Congress dealt specifically with the issue of welfare and immigration. In an overwhelming manner they passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 which was signed by President Clinton and became law.

The 1996 welfare and immigration reforms significantly restricted participation of new immigrants in Federal means-tested poverty programs and dramatically curtailed the access of permanent resident aliens to Federal welfare programs. That was exactly our goal. The 1996 reform strengthened the welfare system and made more funds available for citizens in need. In passing this law in 1996, this Senate specifically stated certain national policy concerns related to welfare and immigration that should not be changed haphazardly.

They said self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration status. Self-sufficiency is a key part of our whole concept of immigration.

> It continues to be the immigration policy of the United States that:
> (A) Aliens within the Nation's borders not depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations, and the availability of public benefits not constitute an incentive for immigration to the United States.
>
> Despite the principle of self-sufficiency, aliens have been applying for and receiving public benefits from Federal, State, and local governments at increasing rates.
>
> It is a compelling government interest to enact new rules for eligibility and sponsorship agreements in order to assure that aliens be self-reliant in accordance with national immigration policy.
>
> It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.

That is what we are talking about. That sums it up. That was a thoughtful policy and change made in 1996. We ought not to have it slip through here on this important bill today without full hearings and discussion.

Section 605, which now in this bill, would repeal the general prohibition of nonqualified aliens being eligible for any Federal public benefits, as it applies to protect women and children, even though ample exceptions for certain public benefits are already provided, such as emergency medical assistance. That is available now. Short-term disaster relief. Immunization, housing, and communities development assistance, and any assistance specified by the Attorney General.

Section 605 waives the 5-year waiting period before immigrants are allowed to receive Federal benefits, thus creating a huge incentive for the benefited class of citizens to rush the borders for instant care. A person who has the possibility of coming to this country, has considered it and decided not to, if their child has a health problem, would not they, therefore, be incentivized to try to come across this border, knowing they could apply for and have public benefit of the United States?

And we would like to do that. Do we do that for the entire world? It is just not possible. It is not good public policy. A nation has to have policy that is rational and defensible.

A wide range of Federal programs are exempted from this requirement, including emergency Medicaid, certain immunizations, short-term disaster relief, school lunch programs, the WIC program, foster care, adoptive assistance, and Head Start. Those are available now.

Section 605 will dissolve the financial accountability requirement of the sponsor. If section 605 passes, sponsors will no longer be held responsible to the Government for the cost of the Federal means-tested benefits to the aliens they sponsor.

The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, coupled with the 1996 welfare reform law, purposefully altered the obligations of persons whose sponsored immigrants arrived or are adjusting status in the United States.

In 1996, as part of the immigration reform, we required that affidavit of support be rewritten as a legally binding contract, enforceable against the sponsor through the time the sponsor immigrant becomes a citizen or has contributed to Social Security for 10 years. Affidavits of support are intended to implement the provisions of the INA that excludes aliens who appear "likely at any time to become a public charge." No nation accepts people into their country who are likely to be a public charge of the country. A nation accepts people who are going to be contributors and will benefit that society.

This is consistent with the recommendation of the Commission on Immigration Reform. In a report to Congress the commission stated sponsors of immigrants should be held financially responsible for the immigrants they bring into this country.

Under the INA code a sponsor is defined as a person who is a citizen, national or lawfully admitted, of the United States, 18 years of age, lives in the United States and demonstrates the means to financially maintain a sponsorship. They can petition the Federal Government through an affidavit of support for the admittance of an individual residing outside the United States.

In other words, a sponsor has to be a person who has the means to financially maintain a sponsorship. If they cannot sign that affidavit honestly, then the person should not be admitted into the country. The sponsor requirement allows for the admission of any person into the United States who is unable to take care of himself or herself without becoming a charge to the taxpayers by assuring, via affidavit, that the sponsor will financially support the person.

An affidavit for support may not be accepted unless the sponsor agrees to, one, provide financial support to maintain the sponsored alien; two, be legally bound to the Federal Government of any entity that provides any means-tested public benefit which includes Medicaid; and three, submit to the jurisdiction of any Federal court.

If a sponsored alien received any means-tested public benefits, the entity which provided such benefits can request to be reimbursed by the sponsor, and if reimbursement is not satisfied, then the sponsor will face civil penalty.

Under this proposed legislation, the sponsors of these new immigrants would be absolved from their liability under the program. Aliens will no longer be supported and maintained by their sponsors and would become a charge on the public once again, a problem we sought to and did remedy in 1996.

As we finish here tonight, we have a lot of important matters involved in this legislation, involving a lot of money. CBO estimates that this provision would cost half a billion over three years. It spends that money by changing what I think to be a good policy by creating a bad policy, a policy that will incentivize people to come to the United States for free health care when they may not otherwise wish to come or may not otherwise benefit from coming here. We really have not had the kind of debate, as a comprehensive review of welfare, that should be made a part of that.

The Finance Committee will be considering welfare reform. It will be considering these issues in the months to come. They have a lot on their plate.

This amendment simply says let's not rush this through now. Let's not move it through on this important bill that is going to move through Congress. Let's send it back to the Finance Committee. Let's encourage them to give thoughtful and serious concern to it. Let's have them come forward with a program that would justify us changing this important rule, established in 1996.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

MEXICAN BARRIERS TO IMPORTS OF U.S. AGRICULTURAL PRODUCTS

Mr. GRASSLEY. Mr. President, it has been almost 10 years since the North American Free Trade Agreement—NAFTA—went into effect. Overall, this agreement has been a great success for America's farmers and ranchers. Between 1994 and 2002, U.S. Agricultural exports to Mexico grew by 95 percent.

Mexican agriculture has benefited as well from NAFTA. Exports of Mexican agricultural products to the United States increased by almost 97 percent from 1993 to 2001. At the present time, some 78 percent of all agricultural products exported by Mexico are sent to the United States, making the United States by far the largest market for Mexico's agricultural exports. Clearly, the agricultural sectors of both the United States and Mexico have on the whole profited from NAFTA. For this reason, I am confounded by some of the recent actions of the Mexican government that undermine the spirit, if not the letter, of NAFTA.

Allow me to elaborate on some of these actions. Mexico has recently imposed, or threatened to impose, trade barriers to a wide variety of U.S. agricultural products. These products include pork, beef, corn, high fructose corn syrup, rice, apples, and dry beans. Apparently ignoring that increased competition in the Mexican market has benefited that country's consumers, some in Mexico have spoken of renegotiating the agriculture provisions of the NAFTA. Mexico's measures against U.S. agricultural products have certainly caught the attention of many members of the Senate, including me.

Let me explain Mexico's actions that are directly impacting producers in my state of Iowa.

I'll start with high fructose corn syrup. It's true that U.S. producers of agricultural products have, on the whole, benefited from NAFTA. And, at one point, that was the case with U.S. producers of high fructose corn syrup. Mexico was formerly the largest export market for U.S. produced high fructose corn syrup. But in January 2002, the Mexican Congress imposed a tax of up to 20 percent on soft drinks containing high fructose corn syrup.

This move was undoubtedly intended to provide Mexican sugar producers with an unfair advantage in the Mexican market over U.S. high fructose corn syrup producers. As a result of this discriminatory tax, U.S. exports of high fructose corn syrup to Mexico are now at almost zero levels.

Mexico's high fructose corn syrup tax was imposed following WTO and NAFTA panel rulings that found that a 1998 Mexican antidumping order on U.S. high fructose corn syrup did not comply with Mexico's trade obligations.

Clearly, Mexico is going out of its way to prevent the sale of high fructose corn syrup in its market. Mexico's high fructose corn syrup tax is causing great harm to U.S. corn producers and U.S. high fructose corn syrup manufacturers. The U.S. corn refining industry estimates that it is losing up to $620 million annually on account of Mexico's discriminatory tax. It estimates that U.S. corn farmers are losing over $300 million each year due to lost sales to both U.S. and Mexican high fructose corn syrup producers.

I find it especially ironic that Mexico, a country that is actively seeking foreign investment, is treating so poorly the U.S. high fructose corn syrup industry, an industry that has invested heavily in Mexico.

Based upon the promises of NAFTA, U.S. high fructose corn syrup producers made major investments in the United States and Mexico. Mexico has now pulled the rug out from under them. This certainly sends, at best, mixed signals to foreign investors.

Let me give you another example of Mexico's actions against U.S. agricultural products, this one impacting Iowa's pork producers. In January of this year, Mexico initiated an antidumping investigation on U.S.-produced pork. The petition that initiated this investigation has serious deficiencies. for example, the petition was filed by Mexican hog producers, not pork processors, so it is my understanding that the party bringing the case lacks standing under the Antidumping Agreement of the WTO.

While Mexico's antidumping investigation on pork is ongoing, I recognize that Mexican officials last month terminated the Mexican antidumping order on imports of live hogs from the United States. I am pleased with Mexico's decision regarding the live hog order. I strongly hope that this decision provides an indication that Mexican officials will act reasonably and not impose an antidumping order on U.S. pork.

But there are other problems. Large quantities of U.S.-produced pork have been rejected at the Mexican border during the past year due to alleged sanitary problems. But millions of Americans consume U.S.-produced pork each day, and we know that this product is safe. Mexico's rejection of U.S. pork for non-scientific reasons violates Mexico's WTO obligations.

Iowa's beef producers are also being harmed by Mexico's actions. In April 2000, Mexico imposed antidumping duties on imports of U.S. beef, and this trade measure remains in place. Mexico's investigation resulted in numerous probable violations of Mexico's commitments under the WTO Agreements. On June 16, the U.S. Trade Representative announced that the United States is filing a case at the WTO over Mexico's antidumping order. I fully support the U.S. trade Representatives' actions at the WTO regarding this matter.

Despite the ongoing Mexican antidumping order on U.S. beef, Mexican cattle producers earlier this year filed a safeguard petition on beef from the United States.

Mexican officials have neither confirmed nor denied the existence of this petition. Lack of certainty with regard to this safeguard petition has made it even more difficult for the U.S. cattle and beef industry to plan sales in Mexico.

White corn producers in Iowa are also threatened by potential Mexican trade actions. Mexican officials are hinting at initiating a safeguard investigation on imports of U.S. white corn. In addition, these officials have suggested limiting import permits for white corn for periods of short supply. Such a policy would not comport with Mexico's NAFTA obligations.

Mexico's actions, and threatened actions, against U.S. agricultural products such as high fructose corn syrup, pork, beef, and white corn are having real effects on U.S. producers. Sales in Mexico are being lost or threatened. Uncertainty is making it difficult for U.S. producers to plan for future sales in Mexico.

But Mexico's actions are having a broader effect than lost sales. Mexico's policies are indirectly threatening the entire U.S. trade agenda.

Most of U.S. agriculture was solidly behind the passage of the NAFTA. But with Mexico failing to abide fully with its NAFTA commitments, many U.S. producers are beginning to question the worth of trade agreements.

If America's farmers and ranchers back away from their strong support for new trade agreements, the U.S. trade agenda will lose its biggest proponents. And if the United States falters in its support for trade liberalization, the whole world will suffer.

Given the importance of maintaining the U.S. trade agenda, I urge the administration to make the removal of Mexican barriers to U.S. agricultural products a top priority. The U.S. Government must not overlook systematic efforts by Mexico to keep U.S. farm products out of the Mexican market in disregard of Mexico's international trade commitments.

Finally, I urge Mexican officials to think twice about the effects of their decisions involving U.S. agricultural products. Mexico's actions are threatening that country's trade relations with its largest export market. Damaged trade relations between the United States and Mexico are certainly not in the best interests of either country.

NAFTA can, and will, continue to provide great benefits to farmers, ranchers, and consumers on either side of the border. But this trade agreement will work only if all parties to it abide by their NAFTA commitments.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent to be recognized as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

IMMIGRATION AND DRUG COSTS

Mr. DURBIN. Mr. President, one of the most fascinating aspects of this job in the Senate is the myriad of issues that come before us in the course of a day or week. If you followed over the last few moments the two speakers—one from Alabama and one from Iowa—they both were speaking about related issues.

My friend from Iowa and I share an interest in agriculture. His State and mine lead the Nation in the production of corn and soybeans, and naturally we try to export our goods to expand our trade. And he is concerned—and I share his concern—about Mexico. We both voted for the North American Free Trade Agreement in the belief of opening up—and it has opened up—trade substantially between these two neighboring countries, the United States and Mexico. But we have run into some problems here, problems related to corn, as my colleague from Iowa noted, whether we can export white corn to Mexico, which, of course, is a major staple of their diet, being the basis for tortillas, part of the Mexican cuisine, and also whether we can export a product made from corn called high fructose sweetener.

For people who may not be familiar with that term, trust me, virtually every soft drink that you consume in America has high fructose sweetener in it rather than sugar. We want to sell it in Mexico, and they do not want us to sell it there. Frankly, they want to export more sugar to the United States.

So this trade battle is on. The Senator from Iowa is right, this has been going on too long, and it has to come to an end.

I would say to our friends in Mexico—and they are our friends and allies and neighbors—we have to resolve this.

We have to resolve it equitably and honorably, but it has to be done with dispatch. So I certainly support what the Senator from Iowa said.

Now, before he spoke, the Senator from Alabama got up to speak about immigration. And here is the story, as I see it, related to this trade issue.

If the farmers in Mexico—who are struggling to grow their crops, with much less efficiency and productivity than the farmers in the United States—are unsuccessful in their farms, many of them move to the city. It is very common. It happens throughout the developing countries of the world. If they move to the large cities in Mexico and they cannot find a way to sustain their families, there is an alternative: El Norte. They head north. And we have seen a dramatic migration from Mexico to the United States.

In the last 10 years, my State of Illinois has seen a substantial increase in the Mexican-American population. I know it; I see it; I feel it. It is now part of our life in Illinois. The people who have come here I have found overwhelmingly to be some of the finest people I have ever had a chance to meet. It takes real courage to get up and leave your village, your family, your church, your language, your tradition, and to head thousands of miles north into the bitter cold, trying to find a job, to make enough money to sustain yourself and maybe sending back some money to your family in Mexico. Thousands have done it. Many have done it undocumented and illegally, and that is another issue.

I will say, it is naive for us to believe these undocumented immigrants to the United States have not become an integral part of our economy. They are. A leading restaurateur in Chicago said to me: If you removed all of the undocumented people from the restaurants of this great city, you would have to close them down. Every time you turn around and see who is washing the dishes, busing the tables, doing the work—some of the hardest work in my State and others—you will find a lot of people who are here perhaps without legal documentation.

A few minutes ago, the Senator from Alabama said he objected to a provision in the bill we have been debating, S. 1, the prescription drug bill, because this provision says that those women who are legally in the United States—legally in the United States—would be able to qualify for Medicaid coverage and their children for basic health insurance coverage if a State decided to offer that coverage.

That is what the bill says. So if the State of Missouri or the State of Illinois or Iowa or Alabama says: We are not interested in offering Medicaid coverage to legal immigrants who have not been here 5 years—legal immigrant women—then they do not have to. Twenty States have decided, though, it makes good sense to go ahead and enroll these legal immigrant women and their children into Medicaid at their own expense.

Why would a State Governor and legislature decide to pick up and cover these people? Well, for obvious reasons. Women who come to this country in a legal immigrant status often become pregnant and during the course of that pregnancy need prenatal care. If they do not receive prenatal care during their pregnancy they could end up with complications in the pregnancy or some serious illness facing the child.

Now, Governors and legislatures have said it is far better for us to offer prenatal care to that legal immigrant woman and her child, once born, than to run the risk they are going to be unhealthy, not only for their own sakes but for the cost it would bring to society. I think that is perfectly sensible.

The Senator from Alabama objects. He says we should not give States the option to provide, with Federal assistance, that kind of medical care. I think that is a mistake. I think the bill is right. The bill understands that these women, during their pregnancy, are carrying future American citizens. Those babies, once born on our soil, are citizens.

Is it important for us to make sure—or do the best we can to make sure—those mothers are healthy and the babies are healthy. Well, if not for the sake of humanity, certainly from an economic point of view it is. A sick baby is not only a family tragedy, it becomes a social cost. So this bill, by giving to States the option of offering Medicaid to legal immigrant women and health insurance to their children, once born, I think just makes common sense.

It will be interesting to watch the vote tomorrow to see how many Senators in this Chamber, who feel very strongly about the so-called pro-life position, who want to make certain that we avoid abortions and that we honor the children who are being born, join the Senator from Alabama in denying prenatal care to legal immigrant women and denying their babies, once born, health insurance.

I would think it is obvious, whatever your position on the issue of abortion, that if you believe in families, you would vote against the amendment by the Senator from Alabama.

Let me just say very briefly, when I was a young student, I read a Sherlock Holmes book that I still remember. It was entitled "The Dog That Didn't Bark." Sherlock Holmes solved this mystery by not hearing something but by realizing that he hadn't heard something. The witnesses to this crime had not heard a dog bark. And that was an important piece of evidence for him to determine what happened that led up to the actual murder.

The reason I remembered that is I am listening carefully to this national debate on the floor of the Senate about a prescription drug bill. I am waiting for the barking of the pharmaceutical lobby. Where are the drug companies? Why haven't we heard from the drug companies?

This is a bill that will affect some 40 million senior citizens and provide assistance for them to pay their prescription drug bills, and the drug companies are silent. Why? There are two reasons for it.

First, they believe the passage of a Federal prescription drug benefit is going to reduce the likelihood that more and more States will establish their own State prescription drug plans, bringing down the cost of prescription drugs in each State. I commend to those who follow it a "Frontline" program of last week on public television that analyzed this.

As the States of Maine and Oregon and my State of Illinois and others developed prescription drug plans, the pharmaceutical industry challenged them in court, particularly in the case of Maine, and lost the challenge.

So it was at that point that they became more intent on seeing us pass a prescription drug benefit on a national level to try to diffuse this growing public sentiment against increasing drug prices and the growing public sentiment that local and State legislatures had to act on this because the Congress was inept, unable to do it.

So we have this bill before us that is one of the reasons why the pharmaceutical lobby has been strangely silent during this debate. They are happy that we are considering a Federal prescription drug benefit program.

The second reason is even more important. This bill, S. 1, before us now for consideration, is a pretty long bill. As a matter of fact, it is 654 pages long. You will have to search this bill line by line and page by page and I am afraid you will find that after that search, there are few, if any, efforts in this entire bill to control the runaway cost of prescription drugs. So the pharmaceutical companies see this as a win/win situation. We pass a national prescription drug program that takes the heat off the States, and at the same time we do nothing to reduce the cost of prescription drugs to seniors and others across America. So these already very successful companies have to view this as the greatest windfall that has ever come their way.

The Federal Government will pay a percentage of the cost of prescription drugs, but the Federal Government will do little or nothing to control the cost of those drugs.

The senior citizens of this country understand this issue far better than Members of the Senate. In fact, when they were recently asked the question: What is more important to you, to provide a prescription drug benefit under Medicare to help you pay for your prescription drugs or to establish a policy and program that will bring down the excessive costs and the increasing rise in cost of prescription drugs across the Nation, by a margin of almost 2 to 1, they said go after the cost of the drugs. Don't tell me how much you are going to give me if you are not going to control the cost.

Last year, the cost of prescription drugs went up 10 percent in my State of Illinois. Nationally, the figures are higher. If those increases continue, no matter what we pass this week in the Senate, it will not be enough. The cost of drugs will go off the end of the chart, and private insurance companies, HMOs that are being lauded by conservatives, by the President, and the White House as the answer to our prayers, frankly, don't have the interest or the power to make a difference in the cost of these prescription drugs. So the seniors will find themselves at the end of the day with a very limited benefit from this program.

But hope is on the way. Tomorrow I will be offering an amendment which is a dramatically different approach to dealing with prescription drugs. We are going to make cost containment part of our prescription drug program. We are going to follow the model of the Veterans' Administration which said, in serving the millions of America's veterans, drug companies had to give a discount to the Veterans' Administration on the drugs that were provided, and the drug companies did—a discount of 40 to 50 percent. This isn't radical or innovative. It is a fact. This is what is happening.

We believe using the same logic and the same Government effort to bring competition and lower costs under my amendment will mean that drug costs will start coming down and this program will go a lot further in helping seniors. And once the drug costs start coming down, let me tell you what we can do: This bill does not guarantee a monthly premium for prescription drug benefits. It suggests $35 a month. But I think the sponsors will tell you, there is no guarantee that it won't be $50 or $75 a month for this prescription drug program being offered by HMOs and private insurance companies under the Grassley-Baucus bill.

Under MediSAVE, which is my alternative plan, we mandate a $35-a-month maximum monthly premium. Second, there is a $275 deductible before anybody can get the first dollar in Government benefits under the Grassley-Baucus bill. Under the amendment I will offer, there is no deductible. Third, under the Grassley-Baucus bill, they will pay 50 percent of the cost of prescription drugs after the deductible is applied. Under the MediSAVE Program, which I am going to introduce, it is 70 percent.

How can I offer all this? How can I offer a program that has no gap in coverage so that it continues to cover you right up to a $5,000 annual cost in drugs and then you switch over to catastrophic coverage? How can I do all this? Because I go after the price of the drugs. The underlying bill doesn't touch the cost of drugs. As a result, $400 billion, as large a sum as that may sound, does not go very far. When we bring in cost containment, we can offer a real prescription drug program.

And there is one more thing. The amendment I will offer will allow Medicare itself to compete with the private insurance companies. I have listened carefully to the debate for the last week or so. I can tell you that most of my Republican friends are loathe to concede the obvious. There is no private insurance company that can effectively compete with Medicare when it comes to offering prescription drug benefits. Why? Because Medicare doesn't have a profit motive. Medicare has a low overhead. Medicare can bargain on behalf of millions of seniors to get a formulary or a list of drugs at discount prices.

These private insurance companies cannot do any of those things. They are out for the profit. They have high administrative costs, and they won't have the power to bargain down the price of the cost of the drugs. So by putting Medicare in the mix, saying every senior can always turn to the Medicare prescription drug program, we have real choice and real competition and a real scare for the Republicans who believe that competition only involves private insurance companies. They don't want a Government agency competing with them.

The amendment I will offer tomorrow has been endorsed by a number of my colleagues on this side of the aisle, as well as the AFL-CIO, the United Auto Workers, a variety of unions across the United States, as well as senior citizens organizations. They understand this is a real prescription drug benefit program that tries to keep the costs under control and makes sure we maximize the benefits to seniors across the United States.

It will be interesting to note the vote tomorrow. I believe there have been clear indications that many people here are not going to do anything to ruffle the feathers of the drug companies and pharmaceutical lobby. I hope they will keep in mind that the senior citizens they represent understand full well that these drug companies are the most profitable companies in America.

They can bring down costs. They have done it in Canada and in other countries. They can still make enough profit to reward shareholders for their risk and have money left to invest in research. I hope this MediSAVE amendment will have the positive response of my colleagues tomorrow when it is offered on the floor.

I am prepared to yield the floor at this time, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

Mr. FRIST. Mr. President, as we bring this very busy day to a close, I wish to reflect on where we are with this very historic bill that will provide prescription drugs and, at the same time, strengthen and improve Medicare for our seniors and individuals with disabilities.

It is a historic week in many ways, but primarily because we will accomplish something that many thought would be impossible even a couple of months ago that will benefit America's seniors; historic because during this week, both Houses will likely pass the first major reform of Medicare in the almost 40 years of that program's existence.

Thanks to the strong leadership of President Bush, as well as the bipartisan support of this body, I am optimistic that by the end of this week, we will have added a $400 billion prescription drug benefit for our deserving seniors for their health care security. And indeed, it has been a long time in coming. A lot of us have talked about it, have known we should move in that direction, and now after a lot of participation we will be able to deliver on that for which we have all worked so hard. Both parties have promised action in the past. America's seniors have demanded it. Indeed, America's seniors deserve it.

As part of this current legislation, not a lot has been said on this particular aspect of it, so I do want to mention it. Within 8 months or 9 months after the President signs the final product of our discussions, when he signs this bill, seniors will have access to a prescription drug card that will provide immediate savings for them. This is an important interim move that allows us to say to seniors: Help is, indeed, on the way.

During this period of time of a year and a half or a couple years while they have that prescription drug card, we will be constructing the appropriate infrastructure to provide that prescription drug benefit for that population that wishes to stay in traditional Medicare or that population that wishes to take advantage of a new, transformed type of Medicare that will allow continuous, ongoing quality care in a more seamless fashion, a fashion that will involve preventive medicine and chronic disease management, as well as prescription drugs.

The great aspect about what we are doing, at the same time we are offering this new benefit of prescription drugs, which our seniors deserve, is that we are modernizing the Medicare Program, strengthening it, improving it in a way that can be sustained long term, and hopefully there will even be some cost savings in the future, but at the same time I am absolutely positively sure that the quality of care will be better. I say that because of this focus on preventive medicine, chronic disease management, and overall disease management which is simply not provided in traditional Medicare.

I wish to list a couple of principles.

First, individual choice versus a one-size-fits-all system. Seniors, for the first time, will be given an opportunity to choose the health care coverage which will best meet their individual needs. It is very different from the one-size-fits-all type program that is provided today.

Second, private sector competition versus Government price setting. Private insurers—I mention private insurers and private plans because we hear a lot today from certain think tanks that not very much is new in this bill. There is not very much reform, there is not very much modernization.

My simple response to them is, yes, there is a new entitlement in terms of this drug benefit, but it is going to be delivered 100 percent through the private sector, through private plans. Yes, regulated by Government, but the entities, the mechanisms of delivering these prescription drugs, whether it is in a freestanding plan or part of the traditional Medicare+Choice or part of a new PPO system, are 100 percent competitively bid with market-based principles.

That allows us to step back and say: Yes, there is something new that over the long haul, if carried out well, if appropriately structured, will allow seniors to have better value, a higher quality of care for the same input, the same amount of money that is spent.

So this market-based competition is important and, I would argue, is very important to the long-term sustainability of the program because of this huge demographic shift of the doubling of the number of seniors.

Third, innovation versus bureaucratic delays. The participation of private health plans in Medicare will help ensure up-to-date coverage. Because Medicare is so rigid, it takes a long time for Medicare to incorporate innovation, new technology, new and better ways of doing things. When you have Government bureaucrats making the decisions or politicians or political figures deciding what is covered and what is not, it simply takes a longer time than occurs in the more responsive private sector.

Four, long-term savings versus spiraling costs. There is a lot of debate in this Chamber, but I would argue, consistent with what the Medicare actuaries tell us, that the most efficient private plans today have the potential for beating Medicare costs by as much as 2.3 percent. Compounded over time, that can result in significant cost savings to the program. Thus, for the same input of dollars, you will have better output, better care delivered, and better quality of care.

The final point I will close with is regulatory relief versus the redtape of bureaucracy that is so characteristic of our Medicare system today. In this bill, there are several rulemaking and regulatory relief changes for health care providers that will allow them to focus on what they should be doing; that is, providing that clinical care, that patient care, instead of filling out paperwork or spending a lot of time on redtape activity.

A recent study by Price Waterhouse estimated that for every hour in the emergency room, there are about 30 minutes of paperwork required by emergency personnel. There is just no reason for that today, and this bill helps address that regulatory relief.

So a new benefit, individual choice, market-based competition, rapid assimilation of new technology, as well as new medicines, long-term savings, relief from this red tape, health security for seniors, that is what this bill is all about.

VOTE EXPLANATION

Mr. BROWNBACK. Mr. President, I regret that due to a previously scheduled White House event celebrating Black Music History Month, I was unable to cast a vote on Amendment No. 982 offered by my friend, Mr. LAUTENBERG. I would like the RECORD to reflect that had I been present, I would have voted against the amendment.

Mr. JOHNSON. Mr. President, as we move forward with debate on Medicare prescription drugs, it is important to recognize that this bill does very little to address the unrestrained costs of prescription drugs. I find it disconcerting that as we are discussing one of the most major public program expansions of all time, we have neglected to have a real discussion about how to ensure that taxpayers get the most bang for their buck in this program, and that seniors who will have significant cost sharing responsibilities have as minimal a burden as possible.

For many years, I have been a strong advocate for implementing reforms to reduce prescription drug costs for consumers in this country. I believe one way to do that is through increasing consumers' access to approved, safe and affordable generic prescription drugs. Last week the Senate passed an amendment that would accomplish this very goal. I was pleased to see that the Gregg-Schumer-McCain-Kennedy amendment passed the Senate with wide bipartisan support and I want to thank my colleagues for their dedication and hard work on this issue. This represents one encouraging step towards leveling the playing field and ensuring that prescription drug costs under this program are indeed reasonable.

The generics amendment, which I have cosponsored along with many of my colleagues will allow generic drug companies to compete with brand-name manufacturers by clearing the major obstacles that delay generic drug approval. The act levels the playing field for generic drug makers to better compete against large, brand-name manufacturers, and it represents a bold step in putting consumer health and savings first. The legislation seeks to bolster the Hatch-Waxman Act passed in 1984, which promoted the growth of the generic drug industry. Loopholes in the patent laws, which benefited brand-name drug manufacturers, prohibited the bill from ever realizing its full potential.

Efforts to promote the value of generic drugs are competing with some powerful forces, such as direct-to-consumer advertising and the unwillingness of many doctors to prescribe generic drugs more regularly. However, I believe this amendment, along with greater public education efforts directed at consumers and doctors about the effectiveness of safe and approved generic drugs, will go a long way towards improving greater access and utilization of generic prescription drugs.

I will continue to fight for lower prescription drug costs and will oppose any efforts that would deny generic drugs equal access into the market. With the enactment of this amendment, we are one major step closer to achieving this goal and I hope the House will follow suit and make similar provisions a part of their Medicare prescription drug legislation. Passage of the generics amendment paved the way, but we must not stop here. We must continue the discussion and debate on the cost containment of prescription drugs under this program and I urge my colleagues to support all amendments that work towards that goal.

Mr. SMITH. Mr. President, I would like to join my distinguished colleague from Iowa as a cosponsor of the "Money Follows the Person Amendment" to the Prescription Drug and Medicare Improvement Act of 2003.

This amendment would authorize the 2004 "Money Follows the Person" initiative in Medicaid, a part of the President's New Freedom Initiative to integrate people with disabilities into the communities where they live.

This amendment would create a 5-year program to help States move people with disabilities out of institutional settings and into their communities. For example, under this legislation, Oregon's effort to help an individual move out of an institutional care facility and into a community home would be 100 percent federally funded for 1 year. After that first year, the Federal Government would pay its usual rate. Under the provisions of this amendment, States like Oregon can take advantage of $350 million dollars of Federal assistance for 5 years for a total of $1.75 billion.

This amendment is important to the disabled community for several reasons. First, by supporting States' efforts to help Americans who have been needlessly placed in institutional settings move into community settings, this amendment will help States increase access to home and community-based support for people with disabilities.

Second, by assisting the movement of people who are not best served by an institution into a community care facility, this amendment gives them the freedom to make choices. Too often, Americans with disabilities are unable to take advantage of opportunities others take for granted—to choose where they want to live, when to visit family and friends, and to be active members of their communities.

Finally, this amendment would help States comply with the Americans with Disabilities Act. As my colleagues in the Senate are well aware, we are nearing the 13th anniversary of the

Americans with Disabilities Act and of the Olmstead Supreme Court decision. That decision ruled that needless institutionalization of Americans with disabilities constitutes discrimination under the Americans with Disabilities Act.

I urge my colleagues on both sides of the aisle to support this important amendment and to support the freedom of choice for Americans with disabilities.

AMENDMENT NO. 974

Mr. LEAHY. Mr. President, last November, the Drug Competition Act passed the Senate by unanimous consent. This morning, I am proud to join Senator GRASSLEY, along with Senators CANTWELL, DURBIN, FEINGOLD, KOHL, and SCHUMER in offering our bill as an amendment to the Prescription Drug and Medicare Improvement Act of 2003, S. 1. I hope that in this Congress it is actually enacted into law as part of the larger effort to improve the health care of millions of Americans. Prescription drug prices are rapidly increasing, and are a source of considerable concern to many Americans, especially senior citizens and families. Generic drug prices can be as much as 80 percent lower than the comparable brand-name version.

While the Drug Competition Act is small in terms of length, it is large in terms of impact. It will ensure that law enforcement agencies can take quick and decisive action against companies that are driven more by greed than by good sense. It gives the Federal Trade Commission and the Justice Department access to information about secret deals between drug companies that keep generic drugs off the market. This is a practice that hurts American families, particularly senior citizens, by denying them access to low-cost generic drugs, and further inflating medical costs.

Last fall, the Federal Trade Commission released a comprehensive report on barriers to the entry of generic drugs into the pharmaceutical marketplace. The FTC had two recommendations to improve the current situation and to close the loopholes in the law that allow drug manufacturers to manipulate the timing of generics' introduction to the market. One of those recommendations was simply to enact our bill, as the most effective solution to the problem of "sweetheart" deals between brand name and generic drug manufacturers that keep generic drugs off the market, thus depriving consumers of the benefits of quality drugs at lower prices. Indeed, at a hearing just yesterday in the Judiciary Committee, Chairman Timothy Muris of the FTC praised the Drug Competition Act in his testimony, and urged its passage. In short, this bill enjoys the unqualified endorsement of the current FTC, which follows on the support by the Clinton administration's FTC during the initial stages of our formulation of this bill. We can all have every confidence in the common sense approach that our bill takes to ensuring that our law enforcement agencies have the information they need to take quick action, if necessary, to protect consumers from drug companies that abuse the law.

Under current law, the first generic manufacturer that gets permission to sell a generic drug before the patent on the brand-name drug expires enjoys protection from competition for 180 days—a head start on other generic companies. That was a good idea—but the unfortunate loophole exploited by a few is that secret deals can be made that allow the manufacturer of the generic drug to claim the 180-day grace period—to block other generic drugs from entering the market—while, at the same time, getting paid by the brand-name manufacturer not to sell the generic drug.

Our legislation closes this loophole for those who want to cheat the public but keeps the system the same for companies engaged in true competition. I think it is important for Congress not to overreact and throw out the good with the bad. Most generic companies want to take advantage of this 180-day provision and deliver quality generic drugs at much lower costs for consumers. We should not eliminate the incentive for them. Instead, we should let the FTC and Justice look at every deal that could lead to abuse, so that only the deals that are consistent with the intent of that law will be allowed to stand. The Drug Competition Act accomplishes precisely that goal, and helps ensure effective and timely access to generic pharmaceuticals that can lower the cost of prescription drugs for seniors, for families, and for all of us.

The effects of this amendment will only benefit the effort to bring quality health care at lower costs to more of our citizens. The Drug Competition Act enjoyed the unqualified support of the Senate last year, and I hope my colleagues will recognize that it fits well within the framework of the Prescription Drug and Medicare Improvement Act of 2003. It will do nothing to disrupt the balance struck in the larger bill, while aiding the ultimate goal of that legislation. I urge all Senators to embrace this effort on behalf of Medicare recipients, and of all Americans.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate now proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

TRIBUTE TO MAYNARD JACKSON

Mr. MILLER. Mr. President, I rise this evening to pay tribute to one of Georgia's finest, one of this Nation's finest. I pay tribute to the life and legacy of former mayor of Atlanta, Maynard Jackson. In a city known for its great civil rights leaders, Maynard Jackson was truly one of the greatest. The people of Atlanta and Georgia have lost one of our strongest and most articulate fighters. Indeed, the State of Georgia tonight is mourning the passing of one of our greatest citizens.

Maynard Jackson was such a positive presence in all that has happened in Atlanta and in Georgia over the past 30 years that I simply cannot imagine what our city and our State would be like if he had not come our way.

His impact stretched far beyond the red clay hills of Georgia. He touched the lives of many people all around this world. For me, Maynard Jackson was a good friend, a friend whose counsel I always sought because I knew he would give it to me straight. In Atlanta the City Hall and the State Capitol are right across the street from each other. He and I crossed that street to talk on many occasions.

Maynard's rise to prominence began at an early age. As a child prodigy he entered Morehouse College at age 14. He graduated in 1956 with a bachelor's degree of political science and history. In 1964 he graduated from North Carolina Central University Law School. Maynard then returned to Atlanta as an attorney for the National Labor Relations Board followed by a time at the Emory Community Legal Services Center where he provided legal counsel for low-income Atlantans.

He ran for the Senate in 1968 and lost. But we all knew at that time the world would come to know the voice of this very remarkable, articulate, and passionate young man. In 1973, at the age of 35, he became mayor of Atlanta after winning nearly 60 percent of the vote in a runoff against incumbent mayor Sam Massell. This great-grandson of slaves served 12 years as mayor of the South's largest city. His tenure saw the construction of what would become the world's busiest airport, Hartsfield International.

He was a fierce advocate for those who thought they were forgotten. He became their voice. In him, they found a great fighter.

The New York Times wrote of Maynard's tenure as mayor it created "a political revolution in the heart of the South. Seemingly overnight, it transformed Atlanta into a mecca for talented, aspiring blacks from all across the country."

The Washington Post described Maynard's impact this way:

> African Americans around the country looked at Jackson's win . . . and saw even greater possibilities. If they did it in Atlanta in the heart of the Confederacy, they could do it at home, too . . .

Vernon Jordan, himself a native of Atlanta, said his most dramatic awareness the South had changed and the city of Atlanta had changed was the day Maynard took the oath of office as mayor of Atlanta. Vernon said it was an unforgettable moment.

As the angels now sing the praises of Maynard Jackson on the other side of that river, I join the chorus of those who yet remain in glorious song to this glorious individual, his life and legacy truly an example for all of us. And he will not be forgotten anytime soon.

HONORING THE STUDENTS OF EUREKA, SOUTH DAKOTA

Mr. DASCHLE. Mr. President, I rise today to recognize an outstanding achievement of the town of Eureka, SD. Eureka has the honor of being the only South Dakota town where three students have won the National Discover Card Tribute Award Scholarship.

The Discover Card Tribute Award Scholarship is awarded each year to 9 outstanding high school juniors in each state and the District of Columbia. These students are selected based on their leadership skills, special talents, personal obstacles, and commitment to community service.

In South Dakota, the state winners for 2003 hail from such cities as Aberdeen, Brookings, Eureka, Milbank, Presho, Salem, Sioux Falls, and Sturgis. Out of these winners, the top three students are selected to compete with students from across the country for 9 national-level scholarships, and it is in this category that the town of Eureka has excelled.

Since the award was first created 12 years ago, only 4 South Dakotans have won at the national level, beginning with Lori Heilman Leidholt of Bowdle, South Dakota, in 1994. The other 3 come from Eureka.

Sarah Anderson won her scholarship in 2000. Sarah is an award-winning photographer and a tireless advocate for diabetes education. Her renowned kitten calendars sell throughout the state and help raise funds for the Juvenile Diabetes Foundation."

As a diabetic herself, she is able to draw from her own experiences as she speaks with adults and children across South Dakota about the disease. In 1999, she successfully lobbied the South Dakota Legislature to enact legislation expanding health insurance coverage for diabetic supplies and equipment.

Loni Schumacher was next in 2002. A member of her local chapter of Family, Career and Community Leaders of America, she was selected to visit Japan in 2001 on a 6-week exchange.

An only child, she has since adopted "sisters" from across the globe. Experiencing a new culture broadened her view of the world, and she has brought those ideals back home to Eureka where she and her family have opened their family farm to exchange students from Brazil and Germany.

Loni has also been closely involved in her school's "Teens Against Tobacco Use" organization, and teaches elementary school students about the hazards of tobacco use.

Amanda Imberi is Eureka's winner for 2003. I had the honor of meeting this young woman when I visited Eureka several weeks ago. Just last week, here in Washington, I presented her with the 2003 Tradition of Caring Jefferson Award.

At the age of 9, Amanda lost her mother to cancer. She had to grow up faster than any child should.

Even with all of her schoolwork, cooking, and managing the family's finances, she has still found the time to be active with the American Cancer Society, speaking at rallies across the state on the importance of cancer awareness and prevention, as well as producing a variety show style fundraiser at her high school.

Two more Eureka students have won the scholarship at the state level—John Ostrowski in 1997 and Alisha Lutz in 1998. For a town of approximately 1,200 people, that is a remarkable achievement. It is not only an indication of the desire to succeed shared by these students, it is also a testament to the quality of teachers and schools that produced such outstanding young adults.

I don't know what they are putting in the water in Eureka but, whatever it is, I hope they continue. These young people are an inspiration to their communities and their fellow students. They have proven there is no obstacle you cannot overcome, and that you should always pursue your dreams.

I commend them and the entire town of Eureka for their achievement, and hope to see even more Discover Card Tribute Award winners from South Dakota in the future.

RECOGNIZING COURTNEY STADD

Mr. STEVENS. Mr. President, I would like to a moment of the Senate's time to recognize someone who has served our Nation with great dignity, humility and energy. For more than two decades, Mr. Courtney Stadd has worked tirelessly to secure America's future in technology, aeronautics, and space. His leadership as a team builder, policymaker, entrepreneur, and senor administration official are evidenced around this city, our Nation and in the horizons that surround the Earth.

In my home State of Alaska, Mr. Stadd helped guide the construction of Kenai and the Alaskan Spaceport Authority. As a board member, he played a critical role in enabling America's newest spaceport to serve the well-being of commercial, public sector, and military interests.

As a member of the Reagan and Bush administrations he was an active voice and proponent for creating commercial markets in geospatial imagery, launch services, information technology and other critical sectors that will advance America's economy far into the 21st century.

In his service to this President, Mr. Stadd led the transition team for NASA and ultimately assumed the role of National Aeronautics and Space Administration, NASA, Chief of Staff/White House Liaison. In this role, he served then administrator, Mr. Dan Goldin—working to support missions and nationwide personnel through the September 11th attacks and anthrax threat, which struck NASA Headquarters, just blocks away from this very body. He served Administrator Goldin until the end of his tenure in November 2001 and provided for a smooth and orderly transition for NASA's current administrator, my friend, Mr. Sean O'Keefe.

During his transition into NASA, Administrator O'Keefe found a valued partner and ally to support his vision and charge for fundamental management and financial reform within the agency. He asked Courtney to lead the Freedom to Manage Initiative, which focused on empowering NASA's extraordinary workforce to identify policies and regulations that impeded performance. The administrator also took advantage of Stadd's distinguished commercial background and asked for his assistance in restructuring NASA's accounting systems and management strategies. Both efforts have put NASA on solid ground and will enable the agency that revealed the secrets of the heavens to once again soar with abandon.

His service to this administrator and its workforce know no boundary and for that reason, Mr. O'Keefe called upon Courtney's talents and energies for support during the Columbia accident and its subsequent investigation. His care for the crew, their families, and the entire NASA workforce truly distinguished itself during some very challenging days.

As my words have chronicled, Courtney Stadd has been a faithful and valuable colleague for Administrator O'Keefe and the NASA workforce to depend upon. He has been a model to his peers and colleagues at NASA, the aerospace community and throughout the administration of integrity and poise in service to the American public. We are blessed in a Nation as bountiful as this one to have people such as him who take upon the cloak of public service and perform so admirably.

In the coming days, Mr. Stadd will be departing from his position at NASA to return to private life. As he leaves public service, the Members of this body and administration should pause to recognize him for his distinguished service. He has contributed much in his distinguished career to better America and I am grateful to honor him today.

I wish him well in all of his endeavors.

SUPREME COURT DECISION IN MICHIGAN

Mr. DURBIN. Mr. President, I rise in praise of yesterday's Supreme Court decision in the Michigan case—the most important affirmative action case in a generation. I along with 11 of my colleagues—Senators DASCHLE, KENNEDY, CLINTON, CORZINE, EDWARDS, FEINGOLD, KERRY, LANDRIEU, LAUTENBERG, SCHUMER, and STABENOW—filed an amicus brief in support of the university's affirmative action programs.

I am disappointed that the Court struck down the undergraduate admissions program, but I believe that the opinion upholding the law school program represents a significant victory for affirmative action and for America.

The Court's decision reaffirms the compelling interest in racial and ethnic diversity—universities may continue to include race as one factor among many when selecting its students. Diversity programs promote the integration and full participation of all groups in our society. The core holding of Grutter v. Bollinger, the law school case, and Gratz v. Bollinger, the undergraduate case, boils down to this: universities must look at each applicant individually.

Michigan Law School's program was upheld because the law school performs an individualized consideration of every applicant. Race is considered, but not in a mechanical manner. The University of Michigan's undergraduate program was struck down because the Court said its point system was too rigid and too mechanical. The bottom line is that university affirmative action—when done right—is alive and well in America. Not surprisingly, the law school opinion was 5-4 and, not surprisingly, Justice O'Connor was the swing vote. She has been the crucial swing vote in so many important Supreme Court cases over the past 20 years that she is now routinely referred to as "the most powerful jurist in America," and indeed, as "the most powerful woman in America." Both descriptions may well be true.

I would like to briefly discuss what I think are the three most important aspects of yesterday's decision.

First, the Court set out a clear roadmap for affirmative action. The question is no longer whether race can be used to further diversity, but how it can be used. The majority of universities are already practicing affirmative action the right way. As discussed in today's Washington Post, most universities currently have admissions programs that are similar to Michigan Law School's. And for those that don't, a quick fix would be to go out and hire more admissions officers. Many universities have large endowments, so I am confident they have the ability to hire a few more staff. As a result, they will be able to conduct the flexible, individualized analysis that the Court now demands.

I personally agree with Justice Souter's dissent in the undergraduate case—their point system is a far cry from the quota system that was struck down in Bakke. Underrepresented minorities automatically get 20 points out of a possible 150, but so do athletes, low-income applicants, and those who attended disadvantaged high schools. To me, this type of point system does not seem unconstitutional.

But in any event, universities now have clear guidance. I think Justice Scalia will be proven wrong in his dire prediction that the Michigan decisions will lead to an avalanche of new affirmative action litigation.

Another important aspect of yesterday's decision is that it recognizes the value of diversity not only on campus, but for other critical areas of our society as well. Eliminating affirmative action in universities would have harmful ripple effects for the nation.

For universities, the Court noted that "classroom discussion is livelier, more spirited, and simply more enlightening and interesting" when the students have "the greatest possible variety of backgrounds."

For society at large, diversity has even more tangible benefits. Citing to an amicus brief filed by a large number of Fortune 500 companies, Justice O'Connor wrote that "American businesses have made clear that the skills needed in today's increasingly global marketplace can only be developed through exposure to widely diverse people, cultures, ideas, and viewpoints."

Referencing an amicus brief filed by dozens of retired U.S. military leaders—including Generals Norman Schwarzkopf, John Shalikashvili, Hugh Shelton, Anthony Zinni, and Wesley Clark—the Court wrote that "high-ranking retired officers and civilian leaders of the United States military assert that, 'based on their decades of experience,' a 'highly qualified, racially diverse officer corps . . . is essential to the military's ability to fulfill its principal mission to provide national security'".

In addition, the Court brought the issue of diversity close to home. Noting that law schools represent "the training ground or a large number of our Nation's leaders," the Court observed that individuals with law degrees occupy more than half the seats in the United States Senate (59), a third of the seats in the House of Representatives (161), and roughly half the state governorships.

A third important aspect of yesterday's decision is the rejection of the Bush Administration's position that both Michigan programs were unconstitutional and should be struck down. It gives you an idea of how conservative the Bush Administration is. Even this Supreme Court—in which 7 of 9 members were appointed by Republican Presidents—rejected its arguments.

Contrary to the misleading assertions of President Bush and other opponents of affirmative action, the Court held that Michigan Law School's policy of seeking a "critical mass" of minority students did not as a de facto quota.

Between 1993 and 2000, the number of African Americans, Native Americans, and Latinos in each class varied from 13% to 20%. As the Court noted, diminishing stereotypes about "minority viewpoints" is "a crucial part of the Law School's mission, and one that it cannot accomplish with only token numbers of minority students."

The Court also rejected the Bush Administration's position that you could attain diversity through race-neutral means, such as the "percentage plans" in Texas, Florida, and California, which guarantee admission to all students above a certain class-rank threshold in every high school in the state.

The Court rejected this argument for two main reasons: 1, percentage plans don't work for graduate and professional schools, and 2, they are, ironically, even more mechanical and inflexible than the Michigan undergraduate program.

The Court shot down another central argument of the Bush Administration—that affirmative action programs were invalid unless they had a definitive end date. As Justice O'Connor observed: "It has been 25 years since Justice Powell first approved the use of race to further an interest in student body diversity in the context of public higher education. Since that time, the number of minority applicants with high grades and test scores has indeed increased. We expect that 25 years from now, the use of racial preferences will no longer be necessary to further the interest approved today."

I hope that Justice O'Connor is right.

The Michigan case is yet another reminder of the fragile balance on the Supreme Court, and how high the stakes will be if a Justice retires.

If there were a switch of a single Justice in yesterday's case, things would be dramatically different today. If there had been a fifth vote to end race-conscious affirmative action in America's universities, we would face a sudden reduction in minority students on our Nation's college campuses, especially at the elite ones.

The dean of Georgetown Law School—my alma mater—speculated yesterday that if the decision had gone the other way, Georgetown's minority enrollment would have been cut in half.

America cannot afford to turn back the clock on opportunity for all of our citizens and—by a 5-4 margin—the Supreme Court agrees.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred on October 8, 2001. In Hyannis, MA, a 31-year-old man attacked two convenience store clerks from Pakistan. The suspect walked into the store, approached the two clerks and asked them if they were from Pakistan. The two men responded affirmatively, which further enraged the suspect. The perpetrator began cursing and accusing the pair for "almost killing" his family and attacking the United States. One of the clerks attempted to calm the man down and led him outside. Once outside, the man punched the clerk, sending him to the ground. The attacker proceeded to kick him until the second clerk rushed outside to halt the attack. The man was later arrested by police.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

VIOLENCE AGAINST WOMEN OFFICE

Mr. BIDEN. Mr. President, I rise to speak today to mark several important developments in our Nation's fight to end domestic violence, sexual assault, and stalking. First, I recently had the honor of addressing domestic violence advocates from across the country who have convened in Washington, DC, to attend the annual meeting of the National Network to End Domestic Violence. These are the women and men on the front lines, transforming the Violence Against Women Act from words on a piece of paper into real solutions for battered women and children.

These advocates witness the terrible toll of family violence. They, in essence, know the statistics by heart. Statistics like 20 percent of all nonfatal violence against females over 12 years of age were committed by intimate partners, according to government statistics released in February 2003. Or the statistics that tell us that in 2000 alone, 1,247 women were killed by an intimate partner. These advocates experience what the studies confirm; that is, in almost half of the households with domestic violence, there are children under the age of 12.

In the face of such daunting numbers, I was pleased to tell these advocates that our fight for an independent and separate Violence Against Women Office is over. I have been assured by Attorney General Ashcroft that his department will comply with the directive for an independent office that was in the law passed by the Congress last session. I want to make clear that my Violence Against Women Office Act and subsequent push to ensure compliance was not a fight about office space or bureaucratic in-fighting. I introduced this legislation because I know that a separate office means that the office's leadership and agenda cannot be marginalized or pushed to a back office. A separate office means that violence against women issues stay at the forefront and that its director appointed by the President and confirmed by the Senate will have an office with the stature and status to use it as the bully pulpit on domestic violence issues that I intended when I authored the Violence Against Women Act.

Nor is the independent office simply a Joe Biden issue. The Violence Against Women Office Act was voted on favorably—with no objections—in the Senate Judiciary Committee. The act passed unanimously in the Senate and passed overwhelmingly in the House. The mandate for freestanding Violence Against Women Office is Congress' law, not a whim.

Despite the law's clear language and intent, the Department of Justice formally announced in February 2003 that it "interpreted" the new law to permit the office to remain as a part of the Office of Justice Program, the arm of the Justice Department which handles grant making, rather than implementing significant policy decisions. I vigorously protested this "interpretation," informing the Justice Department that it was inconsistent with both the plain letter of the law, as well as congressional intent. In fact, I personally called Attorney General Ashcroft on February 13 to discuss this issue and to urge him to reconsider the Department's position.

On March 24, the Attorney General called to inform me that he had personally reviewed this issue and that he was reversing the Department's February decision. More specifically, he pledged to me that the Office would be moved outside of the Office of Justice Programs to become an independent and distinct office, as called for by the law. He also pledged that the Director of the Office would have a direct line of report to him, and not be required to report through the Assistant Attorney General for the Office of Justice Programs, as the Department had previously required. I am grateful that Attorney General Ashcroft took the time to turn his full attention to this matter, to examine the law and legislative history, and to ensure that his Department correctly implemented the act. I commend the Attorney General for doing "the right thing" with respect to the office.

The strength and stature of the Violence Against Women Office will be matched by the strength and stature of its director, Diane Stuart. Pursuant to the new law that requires Senate confirmation, Ms. Stuart testified before the Judiciary Committee earlier this month, and the committee will vote on her nomination on Thursday. Ms. Stuart has been acting director of the office for almost 2 years, and during that time has done terrific work. I am particularly impressed with the extraordinary outreach Ms. Stuart has done thus far, meeting with law enforcement, prosecutors, and service providers from Montgomery County, MD, to Portland, OR. She is truly an expert in the areas of domestic violence, sexual assault, and stalking, and I look forward to working with her as we fight to end family violence in our communities.

REACH-BACK TAX

Mr. COCHRAN. Mr. President, I am concerned about an unfair tax on coal companies and other businesses which is sometimes referred to as the "reach-back tax." It was enacted as part of the Coal Act in the 1992 Energy bill. The Coal Act requires companies to pay a tax on the retirement benefits of miners. The tax applies not only to companies active in the coal mining business but also to companies that are no longer in the coal mining business.

There is one company in the State of Washington that has not employed any miners since the 1950s and is still obligated to pay. Another company that is subject to the tax is the Mississippi Lignite Mining Company, which operates a powerplant at Red Hills near Ackerman, MS. It is time for the Congress to repeal this unfair tax.

If we do not act soon, the combined benefit fund, which provides the money for the retirement benefits, will be bankrupt. I understand that the distinguished chairman of the Senate Finance Committee, Mr. GRASSLEY, and the Senator from Oregon, Mr. SMITH, have asked the House Ways and Means Committee to send a bill to the Senate to resolve this issue. I join them in this request and hope the Finance Committee will act with favor on such a bill when it comes over from the House.

HONORING OUR ARMED FORCES

IN MEMORY OF STAFF SERGEANT AARON WHITE

Mr. INHOFE. Mr. President, I rise today to honor the memory of a remarkable man. SSG Aaron Dean White was an Oklahoman through and through. People say he was a hard worker, dedicated, friendly, and that he loved his family and country. Those who knew him best remembered him as being always willing to help others. He even served alongside his father as a volunteer firefighter for the town of Sasakwa, OK. A former resident of both Sasakwa and Shawnee, OK, he graduated from Shawnee High School in 1994. He entered the U.S. Marine Corps shortly thereafter, gladly serving his Nation for 9 years, and eventually moving up to the position of crew chief on a CH-46 Sea Knight Helicopter.

Staff Sergeant White was passionate about his job—excited to serve—proud to be a marine. After being deployed to Iraq in January of 2003, he was upset because he was not as close to the action as he had hoped. A passionate lover of flying who had earned his pilot's license, he volunteered to be a gunner on a helicopter, just so he would have the opportunity to fly more often.

On Monday, May 19, Staff Sergeant White was one of four individuals on board a helicopter on a resupply mission when the chopper went down into the Shat Ahilala River in Iraq. Tragically he, along with four other marines, did not survive the incident. This courageous man who was living out his dreams lost his life while defending his country.

Staff Sergeant White's remarkable life of helping others was commemorated at his funeral ceremony in Wewoka, OK, at which friends and family filled the chapel. His many loved ones grieved, including his parents, Shawnee, OK, residents Darrell and Karen White; his wife Michele; his daughter Brianna Nicole; and his sister, Sergeant Patricia LaBar, who was serving with the U.S. Army in Germany when her brother passed into the next life. However, I know they are incredibly proud of this man—son, husband, father, and brother—lover of life and soldier of freedom. He is a man who has set a higher standard for all of us to follow. We will never forget him, SSG Aaron Dean White.

IN MEMORY OF PETTY OFFICER BOLLINGER

Mr. INHOFE. Mr. President, no one can truly put into words the magnitude of respect and admiration we feel for those who sacrifice their lives so that we might continue to live in freedom. However, I am honored today to try, since the young man whom I pay tribute to was a proud son of my home State the great State of Oklahoma.

Petty Officer 3rd Class Doyle Wayne Bollinger grew up in the community of Poteau, OK. A member of the Poteau Valley Baptist Church, he was remembered by those who knew him best as one with a generous heart—never thinking of himself, but devoting his time to the service of others.

Upon graduating from Poteau High School, Petty Officer Bollinger heard the call to serve his country. He joined the United States Navy, becoming a member of the Naval Mobile Construction Battalion 133, based in Gulfport, MS. In January of 2003, he and his fellow patriots were sent to Iraq, and possibly into harm's way.

On Friday, June 6, 2003 Petty Officer Bollinger was with his battalion, repairing a bridge across the Tigris River in Iraq. He was tragically killed when unexploded ordnance accidentally detonated nearby. At the age of 21 this man lost his life so that we might stand here today, without fear, and in freedom.

I cannot fully describe to you the pain in the hearts of his loved ones as they sat at his funeral on the grounds of Poteau High School, where they had watched him graduate only a few years earlier. Our thoughts and prayers are with them now. And though we are all grieved at the loss of this man, we shall never cease to be proud of him—Oklahoma's son—Petty Officer 3rd Class Doyle Wayne Bollinger.

IN MEMORY OF PRIVATE FIRST CLASS JEROD R. DENNIS

• Mr. INHOFE. Mr. President, I rise today to honor the memory of a man who, at such a young age, displayed the courage and valor of a true American hero. Private First Class Jerod R. Dennis was a proud son of the great State of Oklahoma, growing up in the community of Antlers. Remembered as being energetic, outgoing, and humorous, he graduated in 2002 from Antlers High School, where he was a standout tennis player, twice making it to the State championships.

Even before the attacks on America on 9/11, PVT Dennis knew that he wanted to dedicate himself to service in the United States Army. He enlisted prior to his graduation from high school, and arrived in boot camp merely 3 weeks after receiving his diploma. His parents, Jerry and Jane Dennis of Antlers, realized that their son was proud to be answering the call to serve his country. Despite their worry for his safety, they sent with him their support and love as he was assigned to the 3rd Battalion, 504th Parachute Infantry Regiment based out of Fort Bragg, NC.

As a part of the U.S. effort to stamp out the threat of terrorism, PVT Dennis, now an Army sharpshooter, along with the rest of his regiment, was sent to fight in Afghanistan. On April 25, 2003, PVT Dennis was on patrol in eastern Afghanistan with other soldiers when they drove into an ambush. A firefight with rebel fighters quickly followed. When his sergeant was shot, PVT Dennis made his way to a foxhole and provided cover fire as his comrades took the sergeant to safety. Tragically, PVT Dennis was mortally injured in the process.

At just 19 years of age, PVT Dennis lay dying from his wounds, worrying more about the physical condition of his fellow soldiers than his own health and well being. PVT Dennis passed on to the next life that day, but no one could deny the bravery displayed by this young man from a small town in far southeastern Oklahoma.

Hundreds gathered at the funeral for PVT Dennis, held at the First Baptist Church in Antlers. They will never forget this incredible young man who displayed such great love for his country. As Army Brigadier General Abe Turner stated so eloquently at the funeral ceremony, "We will remember you. We will honor you, and you will always be a hero." He is Oklahoma's hero—Private First Class Jerod R. Dennis.

ADDITIONAL STATEMENTS

TRIBUTE TO LINCOLN COUNTY AND MESCALERO APACHE INDIAN HEROES

• Mr. DOMENICI. Mr. President, I rise today as we move toward the American Independence Day holiday to honor a group of dedicated people in Lincoln County and the Mescalero Apache Tribe of New Mexico who have launched a major project to ensure that their war dead are never forgotten.

These citizens, led by Walter Patrick Limacher of Hondo, are compiling and publishing the "Lincoln County and Mescalero Apache Tribe Honor List." This list includes the names of all those from this mountainous southern New Mexico region who gave their lives defending the United States in World War I, World War II, the Korean war, and Vietnam.

As families and communities rally on July 4th to celebrate the 227th birthday of our Nation, the honor list organizers understand that our celebrations are made possible by the servicemen who came from their very own small communities and ranches to take up arms in the name of liberty and freedom.

The honor list serves to unify this region of New Mexico, equally paying tribute to those who made the ultimate sacrifice. The list reads like the history of New Mexico itself, including warriors of American Indian, Hispanic, Anglo and other descents.

The collection has been a joint effort of a great many, from tribal and county citizens and officials, to the Department of Defense. My distinguished colleague from Arizona, Senator MCCAIN, Secretary of State Colin Powell, General Norman Schwarzkopf, and former New Mexico Governor Gary Johnson have all issued citations to the list. I want to take this opportunity to thank Mr. Limacher for his dedication and tireless work.

I, too, take pride in honoring these servicemen. They are all specially honored in this record.

The Lincoln County and the Mescalero Apache Indian Tribe Honor List will be presented to surviving family members of those who served, and placed in libraries located throughout south central New Mexico so all can remember these great men. The stories of these brave servicemen from Lincoln County and the Mescalero Apache Indian Reservation are forever unfinished because of the circumstance of their deeds, but their sacrifices do not go unnoticed. The honor list will create a unique bond between future generations and the past fallen heroes.

They are all heroes who fought for their country and gave their lives for our freedom, liberty, and independence. Because of their courage we are what we are. To them and their families, and to all our men and women of our armed services past and present, I salute you this Independence holiday.●

AL BRAIMAN: DEPAUL UNIVERSITY CLASS OF 2003

● Mr. DURBIN. Mr. President, I rise today to honor Al Braiman, graduate of DePaul University's Class of 2003. Al was the oldest graduate of DePaul's Class of 2003 when he graduated on June 14. Al completed a degree in liberal arts at DePaul's College of New Learning with a grade point average of 3.92 out of a possible 4.0.

Born in Kiev, Russia, in 1920, Al immigrated to the United States at the age of one. His family took up residency in Chicago, where he lived most of his life. After high school, Al turned down an academic scholarship for college to support his family. Al joined the Army and served with distinction in WWII, spending most of his time on Guadalcanal.

After leaving the Army, Al owned and operated Lakeview Grocerland until the mid 1960s when he became an insurance salesman with Equitable Life Insurance Company. He became a certified life underwriter and chartered financial consultant. Al won many awards in the industry, including induction to the Equitable Hall of Fame.

After retiring in 1985, Al decided to earn a college degree, something he promised his mother earlier in his life. Al's interest in politics led him to take many political science and history courses at DePaul University. Some of his favorites included a class on American Presidents and a course on race relations. He also enjoyed learning many new things such as use of the Internet, photography, and art. Al has proven that it is never too late to learn and we could all learn a great deal from his perseverance.

I know my fellow Senators will join me in congratulating Al Braiman, DePaul Class of 2003. His story contains all the elements of a great American life and I am honored to share it with my colleagues in the Senate.●

NASHUA CELEBRATES ITS SESQUICENTENNIAL

● Mr. GREGG. Mr. President, I rise today in honor of Nashua, NH, the Gate City of New Hampshire. As the United States prepares to observe the 227th anniversary of our independence, the citizens of Nashua will be celebrating the city's sesquicentennial. It is therefore timely and appropriate that we recognize this great American community .

With its rich heritage and the continuing role it plays in New Hampshire's economic and cultural vitality, I am proud to be a native of Nashua. We cannot accurately talk about this city without praising its most distinctive asset: the people of Nashua. From its founding as the Township of Dunstable in 1673 to its incorporation as the City of Nashua in 1853 through today, they have shown a unique entrepreneurial flair, a dedication to their neighbors and the courage to oftentimes place their own lives at risk for the well-being of our country. Their involvement in the American Revolution is one of many episodes which vividly illustrate these characteristics. The residents in what was then called Dunstable, upon hearing of the fight at Lexington, rushed to take up arms. According to historical accounts, nearly one-half of the able-bodied men in Dunstable enlisted in the Army by the time of the Battle of Bunker Hill. CAPT William Walker organized a company of 66 of these men for this battle. They were placed at the high point of the British attack. To be stationed here was actually a great honor as it reflected their fighting expertise and commitment to the cause of independence.

Since then, Nashuans have continued to serve and defend their country when our freedoms were at risk: 1,348 men served in the Civil War; 4,160 in World War Two. Nashua's airport is named after Paul Boire, a young navy pilot who died in March, 1943. Women, too, have greatly contributed to these causes, oftentimes on the front lines. Mrs. Adelaide Johnson Stevens was a volunteer nurse during the Civil War and was wounded during the assault on Fort Harrison.

In the early part of the 1800s, the community was quickly becoming a center for commerce and industry. Daniel Abbott was the man perhaps most responsible for this reputation. He, along with partners Joseph Greeley and Moses Tyler, founded the Nashua Manufacturing Company which became one of the world's preeminent manufacturers of cotton, woolen, and iron goods. Throughout the 19th century, Nashua was well known as a center for innovation. For example, the Nashua Iron and Steel Works made the stoppers for the ports in the turrets of the S.S. *Monitor*. The Rollins Engine Company made the famous steam engine which help power the economic expansion not only in New Hampshire but throughout our country. As Nashua grew, so did its reputation as a home for entrepreneurs. Royden Sanders turned Sanders Associates into one of the top defense contractors in our country. In an interesting sidenote, Ralph Baer, who worked as a manager for Sanders in the 1960s, developed the first television video game and is often called the Tom Edison of video games. Sanders is now owned by BAE Systems but continues to be a pioneer in the design, development, and manufacture of electronic systems for both military and commercial use.

What is perhaps the most distinguishing characteristic of the city's people has always been their commitment to helping their neighbors and to constantly improving the quality of life here. Nashua's history is full of stories which illustrate their dedication. On April 20, 1861, the city passed a soldiers aid resolution providing one dollar per week for the wife of an enlistee and one dollar per week for each dependent child. Today, Nashua has organizations like Marguerite's Place which has done so much to turn around the lives of women and their children who have been victims of domestic violence. The city's current mayor, Bernie Streeter, has long served the public and is continuing in the honorable tradition started by Nashua's first mayor, Josephus Baldwin. My father, Hugh Gregg, has also served as mayor of Nashua and Governor of New Hampshire. It was in large part through his work that the city's economic vitality was restored after the mills moved and closed in the early 1950s.

All of these people, and their stories, demonstrate how Nashua has maintained its vitality, adapted to changing times, and continues to be a leader in so many areas. It is no wonder that the city has twice been named as the best place to live in the United States. I do not think any other community in the country can make that claim. With that, I am proud to honor and salute them as they celebrate the sesquicentennial of Nashua, NH.●

TRIBUTE TO JUDGE LEE AND HARRY FIRST

● Mr. LIEBERMAN. Mr. President, a great thinker once said that there is no more lovely, friendly, and charming relationship, communion, or company than a good marriage. Judge Lee and Harry First of Riverdale, New York, have certainly demonstrated the truth of those stirring words. For 50 years, they have set an example of commitment, faith, and values. They have been blessed with a strong and happy marriage and a loving family. I am delighted to wish our very good friends, Lee and Harry, a happy 50th wedding anniversary and a joyous celebration.●

MESSAGE FROM THE HOUSE

ENROLLED BILLS SIGNED

At 9:33 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the Speaker has signed the following enrolled bills:

S. 342. An act to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act, and for other purposes.

S. 1276. An act to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

H.R. 2312. An act to amend the Communications Satellite of 1962 to provide for the orderly dilution of the ownership interest in Inmarsat by former signatories to the Inmarsat Operating Agreement.

H.R. 658. An act to provide for the protection of investors, increase confidence in the capital markets system, and fully implement the Sarbanes-Oxley Act of 2002 by streamlining the hiring process for certain employment positions in the Securities and Exchange Commission.

The enrolled bills were signed subsequently by the President pro tempore (Mr. STEVENS).

At 2:15 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2465. An act to extend for six months the period for which chapter 12 of title 11 of the United States Code is reenacted.

The message further announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 209. Concurrent resolution commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia.

The message also announced that pursuant to 22 U.S.C. 3003 note, and the order of the House of January 8, 2003, the Speaker appoints the following Members of the House of Representatives to the Commission on Security and Cooperation in Europe: Mr. SMITH of New Jersey, acting Chairman, Mr. WOLF, of Virginia, Mr. PITTS, of Pennsylvania, Mr. ADERHOLT, of Alabama, Mrs. NORTHUP, of Kentucky, Mr. CARDIN, of Maryland, Ms. SLAUGHTER, of New York, and Mr. HASTINGS, of Florida.

MEASURE REFERRED

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 209. Concurrent resolution commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia; to the Committee on Foreign Relations.

MEASURE READ THE FIRST TIME

The following bill was read the first time:

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, June 24, 2003, she had presented to the President of the United States the following enrolled bills:

S. 342. An act to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act, and for other purposes.

S. 1276. An act to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-2842. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Allocation of Fiscal Year 2003 Operator Training Grants" received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2843. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Implementation Plans; Revisions to the Kentucky Nitrogen Oxides Budget and Allowance Trading Program" (FRL7516-1) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2844. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Implementation Plans: State of Missouri" (FRL7513-9) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2845. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Implementation Plans; Wisconsin; Revised Motor Vehicle Emissions Inventories and Motor Vehicle Emissions Budgets using MOBILE6" (FRL7515-5) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2846. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Change of Address for Submission of Certain Reports; Technical Amendment" (FRL7513-8) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2847. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Correction of Designation of Areas for Air Quality Planning Purposes; California—PM-10 Nonattainment Area" (FRL7516-9) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2848. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Criteria for Classification of Solid Waste Disposal Facilities and Practices and Criteria for Municipal Solid Waste Landfills: Disposal of Residential Lead-Based Paint Waste" (FRL7514-7) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2849. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "National Pollutant Discharge Elimination System—Amendment of Final Regulations Addressing Cooling Water Intake Structures for New Facilities; Final Rule" (FRL7514-9) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2850. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "OMB Approvals Under the Paperwork Reduction Act; Technical Amendment" (FRL7314-5) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2851. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Polychlorinated Biphenyls; Use of Porous Surfaces; Amendment in Response to Court Decision" (FRL7314-2) received on June 18, 2003 ; to the Committee on Environment and Public Works.

EC-2852. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Supplemental Allocation of Fiscal Year 2003 Operator Training Grants for Wastewater Security" received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2853. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Virginia: Final Authorization of State Hazardous Waste Management Program Revision" (FRL7516-4) received on June 18, 2003; to the Committee on Environment and Public Works.

EC-2854. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, a report entitled "Guidance on the Use of Environmental Management Systems in Enforcement Settlements as Injunctive Relief and Supplemental Environmental Projects"; to the Committee on Environment and Public Works.

EC-2855. A communication from the Acting Chair, Federal Subsistence Board, Fish and Wildlife Service, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled "Subsistence Management Regulations for Public Lands in Alaska, Subpart C and D—2003-2004 Subsistence Taking of Wildlife Regulations" (RIN1018-AI62) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2856. A communication from the Chairman of the Nuclear Regulatory Commission, transmitting, pursuant to law, the March 2003 report on the status of its licensing and regulatory duties; to the Committee on Environment and Public Works.

EC–2857. A communication from the Associate Administrator, Office of Veterans' Business Development, Small Business Administration, transmitting, pursuant to law, a report describing the activities the Advisory Committee on Veterans Business Affairs; to the Committee on Veterans' Affairs.

EC–2858. A communication from the Director, Regulations Management, Police and Security Service, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled “Privacy Act of 1974; Implementation—Exemption of Police and Security Records” (RIN2900–AL33) received on June 13, 2003; to the Committee on Veterans' Affairs.

EC–2859. A communication from the Director, Regulations Management, Veterans' Benefits Administration, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled “Increase in Rates Payable Under the Montgomery GI Bill—Active Duty and Survivors' and Developments' Educational Assistance Program” (RIN2900–AL17) received on June 18, 2003; to the Committee on Veterans' Affairs.

EC–2860. A communication from the Director, Regulations Management, Veterans' Benefits Administration, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled “Veterans Education: Additional Opportunity to Participate in the Montgomery GI Bill and Other Miscellaneous Issues” (RIN2900–AK81) received on June 18, 2003; to the Committee on Veterans' Affairs.

EC–2861. A communication from the Director, Regulations Management, Veterans' Benefits Administration, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled “Compensation and Pension Provisions of the Veterans Education and Benefits” (RIN2900-AL29) received on June 18, 2003; to the Committee on Veterans' Affairs.

EC–2862. A communication from the Assistant Attorney General, Department of Justice, transmitting, a draft of proposed legislation relating to sexual abuse and contraband offenses relating to Federal prisoners; to the Committee on the Judiciary.

EC–2863. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the Annual Report on the Refugee Resettlement Program for the period from October 1, 2000 through September 30, 2001; to the Committee on the Judiciary.

EC–2864. A communication from the Under Secretary and Director, United States Patent and Trademark Office, transmitting, pursuant to law, the report of a rule entitled “Elimination of Continued Prosecution Application Practice as to Utility and Plant Patent Applications” (RIN0651–AB37) received on June 19, 2003; to the Committee on the Judiciary.

EC–2865. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to law, the report of the texts and background statements of international agreements other than treaties; to the Committee on Foreign Relations.

EC–2866. A communication from the Assistant Secretary of Legislative Affairs, Department of State, transmitting, pursuant to law, Presidential Determination number 2002–26, relative to Suspension of Limitations under the Jerusalem Embassy Act

EC–2867. A communication from the Assistant Secretary of Legislative Affairs, Department of State, transmitting, pursuant to law, a report concerning the program recommendation of the Amman, Jordan, Accountability Review Board relative to Laurence Foley; to the Committee on Foreign Relations.

EC–2868. A communication from the President of the United States, transmitting, pursuant to law, a report concerning the Authorization for Use of Military Force Against Iraq Resolution of 2002; to the Committee on Foreign Relations.

EC–2869. A communication from the Chairman and President of the Export-Import Bank of the United States, transmitting, pursuant to law, a report relative to a transaction involving U.S. exports to Vietnam; to the Committee on Banking, Housing, and Urban Affairs.

EC–2870. A communication from the Chairman and President of the Export-Import Bank of the United States, transmitting, pursuant to law, a report relative to a transaction involving U.S. exports to Australia; to the Committee on Banking, Housing, and Urban Affairs.

EC–2871. A communication from the Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Imposition and Expansion of Controls on Designated Terrorists” (RIN0694–AC60) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2872. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled “Final Flood Elevation Determinations” (44 CFR Part 67) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2873. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled “Changes in Flood Elevation Determinations” (44 CFR Part 65) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2874. A communication from the Assistant General Counsel for Regulations, Office of the Secretary, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled “Open Competition and Government Neutrality Towards Government Contractors' Labor Relations on Federal and Federally Funded Construction Projects” (RIN2501–AC98) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2875. A communication from the Assistant Secretary, Investment Management, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled “Certain Research and Development Companies” (RIN3235–AI57) received on June 17, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2876. A communication from the Secretary of Education, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1, 2002 through March 31 , 2003; to the Committee on Governmental Affairs.

EC–2877. A communication from the Secretary of the Treasury, transmitting, pursuant to law, the report of the Office of the Inspector General and the Treasury Inspector General for Tax Administration Report for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2878. A communication from the Comptroller General of the United States, transmitting, pursuant to law, the report of the list of General Accounting Office reports for April 2003; to the Committee on Governmental Affairs.

EC–2879. A communication from the Secretary of the Interior, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2880. A communication from the Secretary of Agriculture, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2881. A communication from the Chairman, National Credit Union Administration, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2882. A communication from the Chairman, Consumer Product Safety Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2883. A communication from the Chairman, United States Parole Commission, Department of Justice, transmitting, pursuant to law, the Commission's report under the Government in the Sunshine Act for the years 2000 through 2002; to the Committee on Governmental Affairs.

EC–2884. A communication from the Federal Co-Chair, Appalachian Regional Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2885. A communication from the Chairman, National Science Board, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2886. A communication from the Chairman of the Board of Governors, United States Postal Service, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2887. A communication from the Chairman, United States Government National Labor Relations Board, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2888. A communication from the Assistant Administrator for Procurement, National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled “NASA Grant and Cooperative Agreement Handbook—Incremental Funding” (RIN2700–AC53) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2889. A communication from the Chief of Regulations and Administrative Law, United States Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled “Drawbridge Regulations: (4)” (RIN1625–AA09) received on June 13, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2890. A communication from the Chief of Regulations and Administrative Law, United States Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Licensing and Manning for Officers of Towing Vessels" (RIN1625–AA41) received on June 13, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2891. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Closure; Prohibiting Directed Fishing for Species that Comprise Deep-Water Species Fishery by Vessels Using Trawl Gear in the Gulf of Alaska" received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2892. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Closure; Prohibiting Directed Fishing for Yellowfin Sole by Vessels Using Trawl Gear in Baycatch Limitation Zone 1 of the Bering Sea and Aleutian Islands Management Area" received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2893. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Antarctic Marine Living Resources; CCAMLR Ecosystem Monitoring Permits; Vessel Monitoring System; Catch Documentation Scheme; Fishing Season; Registered Agent; and Disposition of Seized AMLR" (RIN0648–AP74) received on June 19, 2004; to the Committee on Commerce, Science, and Transportation.

EC–2894. A communication from the Assistant Administrator for Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Atlantic Highly Migratory Species; Commercial Shark Management Measures; Emergency Rule; Extension of Expiration Date ; Request for Comments; Fishing Season Notification" (RIN0648–AQ39) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2895. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Framework Adjustment 2 to the Monkfish Fishery Management Plan" (RIN0648–AQ29) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2896. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Final Rule: Regulations Governing the Taking and Importing of Marine Mammals; Eastern North Pacific Southern Resident Killer Whales" (RIN0648–AQ00) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2897. A communication from the Secretary, Federal Trade Commission, transmitting, pursuant to law, the report of a rule entitled "Rule Concerning Disclosures Re. Energy Consumption and Water Use of Certain home Appliances and Other Products Required Under the Energy Policy and Conservation Act—Final Rule and Conditional Exemption for Clothes Washer Labels" (RIN3084–AA74) received on June 21, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2898. A communication from the Attorney Advisor, Department of Transportation, transmitting, pursuant to law, the report of a nomination for the position of Assistant Secretary for Governmental Affairs; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. GRASSLEY, from the Committee on Finance, without amendment:

S. 312. A bill to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (Rept. No. 108–78).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BROWNBACK (for himself, Mr. Dorgan, Mr. Grassley, Mr. Baucus, Mr. Daschle, Mr. Roberts, Mr. Burns, Mr. Bond, Mr. Allard, Mr. Hagel, Mr. DeWine, Mr. Craig, Mr. Levin, Mr. Leahy, Mr. Conrad, Mr. Harkin, and Mr. Jeffords):

S. 1316. A bill to treat payments under the Conservation Reserve Program as rentals from real estate; to the Committee on Finance.

By Mr. SMITH (for himself, Mr. Biden, and Mr. Durbin):

S. 1317. A bill to amend the American Servicemember's Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance; to the Committee on Foreign Relations.

By Ms. SNOWE:

S. 1318. A bill to deauthorize the project for navigation, Tenants Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1319. A bill to deauthorize the project for navigation, Northeast Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1320. A bill to modify the project for navigation, Union River, Maine; to the Committee on Environment and Public Works.

By Mrs. CLINTON (for herself, Mrs. Murray, and Mr. Bingaman):

S. 1321. A bill to authorize resources to foster a safe learning environment that supports academic achievement for all students by improving the quality of interim alternative educational settings, providing more behavioral supports in schools, and supporting whole school interventions; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SCHUMER:

S. 1322. A bill to require States to make certain information regarding sexually violent predators accessible on the Internet; to the Committee on the Judiciary.

By Mr. GRASSLEY (for himself, Mr. Leahy, and Mr. Sessions):

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months; read the first time.

By Mr. GRASSLEY (for himself and Mr. Baucus):

S. 1324. A bill to amend the Trade Act of 1974 to establish procedures for identifying countries that deny market access for agricultural products of the United States, and for other purposes; to the Committee on Finance.

By Mr. BURNS (for himself, Mr. Graham of South Carolina, Mr. Hagel, and Mr. Fitzgerald):

S. 1325. A bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies; to the Committee on Commerce, Science, and Transportation.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. SCHUMER (for himself and Mrs. Clinton):

S. Res. 181. A resolution congratulating all New Yorkers on the occasion of their first Kentucky Derby victory and the subsequent Preakness Stakes victory with New York-bred gelding, Funny Cide; to the Committee on the Judiciary.

By Ms. STABENOW:

S. Res. 182. A resolution congratulating the American Dental Association for establishing the "Give Kids a Smile" program, emphasizing the need to improve access to dental care for children, and thanking dentists for volunteering their time to help provide needed dental care; to the Committee on Health, Education, Labor, and Pensions.

ADDITIONAL COSPONSORS

S. 202

At the request of Mr. DeWine, the names of the Senator from New York (Mr. Schumer) and the Senator from New York (Mrs. Clinton) were added as cosponsors of S. 202, a bill to amend the Internal Revenue Code of 1986 to allow as a deduction in determining adjusted gross income that deduction for expenses in connection with services as a member of a reserve component of the Armed Forces of the United States, to allow employers a credit against income tax with respect to employees who participate in the military reserve components, and to allow a comparable credit for participating reserve component self-employed individuals, and for other purposes.

S. 215

At the request of Mrs. Feinstein, the name of the Senator from Maine (Ms. Snowe) was added as a cosponsor of S. 215, a bill to authorize funding assistance for the States for the discharge of homeland security activities by the National Guard.

S. 224

At the request of Mr. Daschle, the name of the Senator from Vermont

(Mr. JEFFORDS) was added as a cosponsor of S. 224, a bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal minimum wage.

S. 451

At the request of Ms. SNOWE, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 451, a bill to amend title 10, United States Code, to increase the minimum Survivor Benefit Plan basic annuity for surviving spouses age 62 and older, to provide for a one-year open season under that plan, and for other purposes.

S. 518

At the request of Ms. COLLINS, the names of the Senator from Minnesota (Mr. COLEMAN), the Senator from Wisconsin (Mr . FEINGOLD) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. 518, a bill to increase the supply of pancreatic islet cells for research, to provide better coordination of Federal efforts and information on islet cell transplantation, and to collect the data necessary to move islet cell transplantation from an experimental procedure to a standard therapy.

S. 623

At the request of Mr. WARNER, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 623, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 735

At the request of Mr. BOND, the name of the Senator from Minnesota (Mr. DAYTON) was added as a cosponsor of S. 735, a bill to amend the Internal Revenue Code of 1986 to clarify the exemption from tax for small property and casualty insurance companies.

S. 780

At the request of Mr. LOTT, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 780, a bill to award a congressional gold medal to Chief Phillip Martin of the Mississippi Band of Choctaw Indians.

S. 852

At the request of Mr. DEWINE, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 852, a bill to amend title 10, United States Code, to provide limited TRICARE program eligibility for members of the Ready Reserve of the Armed Forces, to provide financial support for continuation of health insurance for mobilized members of reserve components of the Armed Forces, and for other purposes.

S. 863

At the request of Mr. EDWARDS, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 863, a bill to amend the Higher Education Act of 1965 to allow soldiers to serve their country without being disadvantaged financially by Federal student aid programs.

S. 875

At the request of Mr. KERRY, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 875, a bill to amend the Internal Revenue Code of 1986 to allow an income tax credit for the provision of homeownership and community development, and for other purposes.

S. 877

At the request of Mr. BURNS, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 877, a bill to regulate interstate commerce by imposing limitations and penalties on the transmission of unsolicited commercial electronic mail via the Internet.

S. 939

At the request of Mr. HAGEL, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 939, a bill to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding of such part, to provide an exception to the local maintenance of effort requirements, and for other purposes.

S. 955

At the request of Mr. ALLEN, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 955, a bill to provide liability protection to nonprofit volunteer pilot organizations flying for public benefit and to the pilots and staff of such organizations.

S. 973

At the request of Mr. NICKLES, the names of the Senator from Pennsylvania (Mr. SPECTER) and the Senator from Arizona (Mr. KYL) were added as cosponsors of S. 973, a bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period for the depreciation of certain restaurant buildings.

S. 976

At the request of Mr. WARNER, the names of the Senator from North Carolina (Mrs. DOLE) and the Senator from Texas (Mrs. HUTCHISON) were added as cosponsors of S. 976, a bill to provide for the issuance of a coin to commemorate the 400th anniversary of the Jamestown settlement.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 1046

At the request of Mr. STEVENS, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1082

At the request of Mr. BROWNBACK, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1082, a bill to provide support for democracy in Iran.

S. 1092

At the request of Mr. CAMPBELL, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 1092, a bill to authorize the establishment of a national database for purposes of identifying, locating, and cataloging the many memorials and permanent tributes to America's veterans.

S. 1110

At the request of Mr. BINGAMAN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1110, a bill to amend the Trade Act of 1974 to provide trade adjustment assistance for communities, and for other purposes.

S. 1129

At the request of Mrs. FEINSTEIN, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1153

At the request of Mr. SPECTER, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 1153, a bill to amend title 38, United States Code, to permit medicare-eligible veterans to receive an out-patient medication benefit, to provide that certain veterans who receive such benefit are not otherwise eligible for medical care and services from the Department of Veterans Affairs, and for other purposes.

S. 1218

At the request of Mr. HOLLINGS, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1218, a bill to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program.

S. 1236

At the request of Mr. CAMPBELL, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 1236, a bill to direct the Secretary of the Interior to establish a program to control or eradicate tamarisk in the western States, and for other purposes.

S. 1248

At the request of Mr. GREGG, the names of the Senator from New York

(Mrs. CLINTON), the Senator from Connecticut (Mr. DODD), the Senator from Rhode Island (Mr. REED) and the Senator from Washington (Mrs. MURRAY) were added as cosponsors of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1289

At the request of Mr. GRAHAM of Florida, the names of the Senator from Georgia (Mr. MILLER) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 1289, a bill to name the Department of Veterans Affairs Medical Center in Minneapolis, Minnesota, after Paul Wellstone.

S. 1290

At the request of Mr. HOLLINGS, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 1290, a bill to amend the Internal Revenue Code of 1986 to allow an additional advance refunding of tax-exempt bonds issued for the purchase or maintenance of electric generation, transmission, or distribution assets.

S. 1293

At the request of Mr. LEAHY, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1293, a bill to criminalize the sending of predatory and abusive e-mail.

S. 1293

At the request of Mr. HATCH, the names of the Senator from Montana (Mr. BURNS) and the Senator from Arkansas (Mr. PRYOR) were added as cosponsors of S. 1293, supra.

S. 1294

At the request of Mrs. MURRAY, the names of the Senator from Hawaii (Mr. INOUYE) and the Senator from Minnesota (Mr. DAYTON) were added as cosponsors of S. 1294, a bill to authorize grants for community telecommunications infrastructure planning and market development, and for other purposes.

S. 1303

At the request of Mr. BROWNBACK, the name of the Senator from South Carolina (Mr. HOLLINGS) was added as a cosponsor of S. 1303, a bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration services, and chemotherapy support services.

S. CON. RES. 40

At the request of Mrs. CLINTON, the names of the Senator from Vermont (Mr. JEFFORDS) and the Senator from Kansas (Mr. BROWNBACK) were added as cosponsors of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as "National Purple Heart Recognition Day".

S. RES. 151

At the request of Mr. GRASSLEY, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. Res. 151, a resolution eliminating secret Senate holds.

S. RES. 164

At the request of Mr. ENSIGN, the names of the Senator from Oregon (Mr. WYDEN) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. Res. 164, a resolution reaffirming support of the Convention on the Prevention and Punishment of the Crime of Genocide and anticipating the commemoration of the 15th anniversary of the enactment of the Genocide Convention Implementation Act of 1987 (the Proxmire Act) on November 4, 2003.

S. RES. 169

At the request of Mrs. CLINTON, the names of the Senator from Georgia (Mr. MILLER) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. Res. 169, a resolution expressing the sense of the Senate that the United States Postal Service should issue a postage stamp commemorating Anne Frank.

AMENDMENT NO. 956

At the request of Mr. GRAHAM of Florida, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 956 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 969

At the request of Mr. DODD, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of amendment No. 969 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 974

At the request of Mr. LEAHY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of amendment No. 974 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 976

At the request of Mr. SARBANES, his name was added as a cosponsor of amendment No. 976 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 982

At the request of Mr. LAUTENBERG, the names of the Senator from Rhode Island (Mr. REED), the Senator from New York (Mrs. CLINTON), the Senator from New Jersey (Mr. CORZINE) and the Senator from Nevada (Mr. REID) were added as cosponsors of amendment No. 982 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 982

At the request of Ms. MIKULSKI, her name was added as a cosponsor of amendment No. 982 proposed to S. 1, supra.

AMENDMENT NO. 998

At the request of Mr. DODD, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of amendment No. 998 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 998

At the request of Ms. MIKULSKI, her name was added as a cosponsor of amendment No. 998 proposed to S. 1, supra.

AMENDMENT NO. 1000

At the request of Mrs. CLINTON, the names of the Senator from South Dakota (Mr. JOHNSON) and the Senator from New Mexico (Mr. BINGAMAN) were added as cosponsors of amendment No. 1000 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BROWNBACK (for himself, Mr. DORGAN, Mr. GRASSLEY, Mr. BAUCUS, Mr. DASCHLE, Mr. ROBERTS, Mr. BURNS, Mr. BOND, Mr. ALLARD, Mr. HAGEL, Mr. DEWINE, Mr. CRAIG, Mr. LEVIN, Mr. LEAHY, Mr. CONRAD, Mr. HARKIN, and Mr. JEFFORDS):

S. 1316. A bill to treat payments under the Conservation Reserve Program as rentals from real estate; to the Committee on Finance.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the "Conservation Reserve Program Tax Fairness Act of 2003" be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1316

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Conservation Reserve Program Tax Fairness Act of 2003".

SEC. 2. TREATMENT OF CONSERVATION RESERVE PROGRAM PAYMENTS AS RENTALS FROM REAL ESTATE.

(a) INTERNAL REVENUE CODE.—Section 1402(a)(1) of the Internal Revenue Code of 1986 (defining net earnings from self-employment) is amended by inserting "and including payments under section 1233(2) of the Food Security Act of 1985 (16 U.S.C. 3833(2))" after "crop shares".

(b) SOCIAL SECURITY ACT.—Section 211(a)(1) of the Social Security Act is amended by inserting "and including payments under section 1233(2) of the Food Security Act of 1985 (16 U.S.C. 3833(2))" after "crop shares".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made before, on, or after the date of the enactment of this Act.

Mr. DORGAN. Mr. President, I'm pleased to join Senator BROWNBACK and a number of our colleagues today in reintroducing the Conservation Reserve Program Tax Fairness Act. This legislation is virtually identical to the bill we introduced in the 107th Congress, which garnered nearly twenty Senate cosponsors. It clarifies that Conservation Reserve Program, CRP, payments received by farmers are treated for Federal tax purposes as rental payments from real estate, not self-employment income subject to self-employment taxes.

Despite past strong bipartisan support for this legislation, the Congress did not make this long overdue tax law clarification in the major tax reduction bill that was recently signed into law. This is regrettable and I hope that the Congress will move expeditiously to reverse the IRS's wrong-headed position on this matter.

Let me take a moment to describe this problem. For many years, the IRS has been taking the erroneous position that CRP payments received by farmers are income from self-employment and therefore are subject to self-employment taxes. This position imposes a significant financial hardship on family farmers farmers who have voluntarily agreed to take environmentally-sensitive lands out of farm production and place them in the Conservation Reserve Program in return for an annual rental payment from the Commodity Credit Corporation of the U.S. Department of Agriculture.

In our judgment, the IRS's tax treatment of CRP payments is not what Congress intended, nor is it supportable in law. The U.S. Tax Court shares our view that the IRS position is improper. In fact, the U.S. Tax Court ruled in 1998 that CRP payments are properly treated by farmers as rental payments and, thus, not subject to self-employment taxes. Unfortunately, the IRS challenged the Tax Court decision and the Tax Court was later reversed by a federal appellate court.

Today, North Dakota has some 3.3 million acres with $110 million in rental payments in the CRP program. Left unchanged, the IRS's interpretation means that farmers in North Dakota will owe an additional $16 million in federal taxes this year. A typical North Dakota farmer with 160 acres in CRP would have a CRP payment of $5,280 and would owe nearly $800 in self-employment taxes because of the IRS's ill-advised position. If the IRS also decides to pursue back taxes on returns filed by farmers in past years, the amount of taxes owed by individuals farmers for CRP payments could amount to thousands of dollars.

I believe that it is absolutely wrong for the IRS to load up farmers with an added tax burden, especially when most of our Nation's family farmers are still struggling from day to day to make ends meet. With the legislation we are introducing today, Congress can tell the IRS that its effort to treat CRP payments as net earnings from self-employment is inappropriate and will not be allowed to stand.

Senator BROWNBACK and I ask our colleagues to support this much-needed tax relief for family farmers by cosponsoring the Conservation Reserve Program Tax Fairness Act. And we hope you will work with us to get this legislation enacted into law at the first available opportunity.

By Mr. SMITH (for himself, Mr. BIDEN, and Mr. DURBIN):

S. 1317. A bill to amend the American Servicemember's Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance; to the Committee on Foreign Relations.

Mr. SMITH. Mr. President, on behalf of myself and my colleagues Mr. BIDEN of Delaware and Mr. DURBIN of Illinois, I ask unanimous consent that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1317

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ELIGIBILITY OF CERTAIN COUNTRIES FOR UNITED STATES MILITARY ASSISTANCE.

(a) AMENDMENT.—Section 2007(d)(1) of the American Servicemembers' Protection Act of 2002 (title II of the 2002 Supplemental Appropriations Act for Further Recovery From and Response To Terrorist Attacks on the United States (Public Law 107–206; 116 Stat. 905)) is amended by inserting "or a country that has concluded a protocol with NATO for the accession of the country to NATO" before the semicolon.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on July 1, 2003.

By Ms. SNOWE:

S. 1318. A bill to deauthorize the project for navigation, Tenants Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1319. A bill to deauthorize the project for navigation, Northeast Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1320. A bill to modify the project for navigation, Union River, Maine; to the Committee on Environment and Public Works.

Ms. SNOWE. Mr. President, I rise today to introduce three bills for harbors in Maine, two of them that will deauthorize the Federal Navigation Projects in Tenants Harbor and Northeast Harbor in Mt. Desert, and the third will redesignate the Upper Basin of the Union River Federal Navigational Channel in Ellsworth as an anchorage. The bills will help strengthen the economic viability of these three popular Maine harbors.

My first bill, S. 1318, pertains to Tenants Harbor, ME. Officials of the Town of Tenants Harbor have requested that the harbor be deauthorized. The original project was authorized in 1919, and was dredged that same year so that steamboats could access the Harbor. The channel has a width of 375 feet and extended out to 1,100 feet from Steamboat Wharf. Times have certainly changed as no steamboat has landed in the Harbor for 75 years. Over the years there have been mounting problems with the Army Corps of Engineers' mooring permit process as people seeking permits for moorings that have existed for 30 years continue to be notified that the mooring locations are prohibited because they fall within the Federal navigational channel. Deauthorizing the FNC would be of great help to the town in appropriately managing the Harbor to maximize mooring areas.

My second bill S. 1319 concerns Northeast Harbor in Mt. Desert, ME. The Town of Mount Desert has requested that Northeast Harbor be withdrawn from the Federal Navigation Project because of changing harbor usage over the last 45 years. This removal will allow the town to adapt to the high demand for moorings and will allow residents to obtain moorings in a more timely manner. The Harbor has now reached capacity for both moorings and shoreside facilities and has a waiting list of over sixty people, along with commercial operators who have been waiting for years to obtain a mooring for their commercial vessels.

The Harbor was authorized in 1945 and constructed in 1954 as a mixed-use commercial fishing/recreational boating harbor—and it still is today. It was dredged in the early 1950s to provide more space for recreational boating and the U.S. Army Corps of Engineers has informed the town that Northeast Harbor would be very low on its dredging priority list as it has become primarily a recreational harbor. The town says it realizes that, once it is no longer part of the Federal Navigational Project, any further dredging within the harbor would be carried out at town expense.

The language will not only allow for more recreational moorages and commercial activities, it will also be an economic boost to Northeast Harbor, which is surrounded by Acadia National Park, one of the nation's most visited parks—both by land and by water.

My third bill, S. 1320, addresses the Union River in Ellsworth, ME. The bill supports the City of Ellsworth's efforts to revitalize the Union River navigation channel, harbor, and shoreline. The modification called for in my legislation will redesignate a portion of the Union River as an anchorage area. This redesignation will allow for a greater number of moorings in the harbor without interfering with navigation and will further improve the city's revitalization efforts for the harbor area.

I have worked with the New England Division of the Corps to draft these bills and the language has been approved by Army Corps Headquarters in Washington. I look forward to working with my colleagues for their passage, either as stand alone bills or as separate provisions in the Corps reauthorization bill, the Water Resources Development Act of 2003, that Congress is currently drafting.

By Mr. GRASSLEY (for himself, Mr. LEAHY, and Mr. SESSIONS):

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months; read the first time.

Mr. GRASSLEY. Mr. President, I rise today to introduce a bill to extend Chapter 12 of the Bankruptcy Code until January 1, 2004. This measure will provide our family farmers with the necessary bankruptcy protections during hard times. However, I remain hopeful that the Senate will take up and pass the comprehensive bankruptcy legislation that the House passed not long ago. That bill makes Chapter 12 of the Bankruptcy Code permanent, so family farms are guaranteed the ability to reorganize. The bill also makes significant improvements to Chapter 12 so that it will be more accessible and helpful to farmers. So while I urge quick passage of this temporary Chapter 12 measure, I would like to see the comprehensive bankruptcy Reform bill and permanent Chapter 12 enacted into law as soon as possible. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1323

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Family Farmer Bankruptcy Relief Act of 2003".

SEC. 2. SIX-MONTH EXTENSION OF PERIOD FOR WHICH CHAPTER 12 OF TITLE 11, UNITED STATES CODE, IS REENACTED.

(a) AMENDMENTS.—Section 149 of title I of division C of Public Law 105-277 (11 U.S.C. 1201 note) is amended—

(1) by striking "July 1, 2003" each place it appears and inserting "January 1, 2004"; and

(2) in subsection (a)—

(A) by striking "December 31, 2002" and inserting "June 30, 2003"; and

(B) by striking "January 1, 2003" and inserting "July 1, 2003".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on July 1, 2003.

By Mr. GRASSLEY (for himself and Mr. BAUCUS):

S. 1324. A bill to amend the Trade Act of 1974 to establish procedures for identifying countries that deny market access for agricultural products of the United States, and for other purposes; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, I'm pleased to introduce today the United States Agricultural Products Market Access Act of 2003. This bill will be yet one more tool for the United States to use to expand its exports of agricultural products.

Agricultural exports are key to the economic health of rural America. Just last year, $53.1 billion worth of U.S.-produced agricultural products were exported. About one-third of America's farm products are sold outside of our borders. These sales in foreign markets translate to improved incomes for our country's farmers. Today, approximately one-fourth of gross farm income for U.S. producers comes from exports.

Agricultural exports are particularly important to farmers in my State of Iowa. In 2001, some $3.3 billion worth of Iowa's agricultural production was exported. This makes Iowa the second largest agricultural exporting State in the country. Iowa's largest commodities—corn, soybeans, pork, and beef—greatly benefit from sales abroad. Approximately one-half of U.S. soybean production, and 20 percent of our country's corn production, is exported. Last year U.S. pork exports set record levels. Since the implementation of the NAFTA, exports of U.S. beef and beef variety meats to Mexico have increased five-fold. Iowa's producers clearly benefit from exports.

While Iowa's agricultural exports are already high, they have the potential to grow even more in coming years. Demand in the U.S. market for agricultural products is relatively stable. But populations, as well as disposable incomes, are increasing rapidly in foreign countries. With the hardest-working farmers and ranchers in the world, and with productivity increasing through improved technologies, the United States clearly has the ability to continue feeding a growing world.

But trade barriers imposed by foreign governments often cloud this bright spot for U.S. agriculture. Too frequently, misguided foreign governments overlook the wants and needs of their consumers and take measures to restrict, or prevent, imports of U.S. farm products. These policies hurt U.S. farmers. They also hurt foreign consumers.

In fact, due in part to foreign trade barriers, U.S. agricultural exports declined from $60.4 billion in 1996 to $53.1 billion in 2002.

Unfortunately, even countries that should be our closest trade allies are proving adept at imposing measures that block imports of U.S. farm products. As an example, our NAFTA-partner Mexico is imposing, or threatening to impose, barriers to imports of a wide variety of U.S. agricultural products. These products include corn, high fructose corn syrup, pork, beef, rice, apples, and dry beans. Iowa is a major producer of four of these products—corn, high fructose corn syrup, pork, and beef.

Not surprisingly, much of U.S. agriculture is upset with Mexico and other of our trading partners at this time. U.S. agricultural producers have traditionally been the strongest supporters of new trade deals. But due to foreign trade barriers, some in U.S. agriculture are beginning to question their support for new trade agreements.

The U.S. Trade Representative, in conjunction with Congress, is working hard to remove trade barriers imposed by Mexico and other countries. But the current tools available to the USTR, including negotiations, NAFTA challenges, and WTO challenges, don't always accomplish the job.

Let me give you an example. For several years now, Mexico has gone to great lengths to block imports of U.S.-produced high fructose corn syrup. In 1998, Mexico imposed antidumping duties on imports of this product from the United States. The United States challenged this antidumping order under the NAFTA. Mexico lost at the NAFTA. The United States challenged this order at the WTO. Mexico lost at the WTO. Following its defeats at the NAFTA and the WTO, Mexico revoked this antidumping order.

But, no, that wasn't the end of the story. Mexico turned around and imposed a 20 percent tax on sales of soft drinks containing high fructose corn syrup. This discriminatory tax was designed to boost sales of Mexican sugar at the expense of U.S.-produced high fructose corn syrup.

Mexico's tax in effect shut down the Mexican market for this product. Iowa's high fructose corn syrup producers are now being locked out of what was at one time their largest export market. This discriminatory tax is hurting Iowa's high fructose corn syrup producers. It's hurting Iowa's corn farmers.

This example clearly demonstrates that existing tools aren't always enough to remove entrenched trade barriers. Despite losing at the NAFTA, despite losing at the WTO, and despite lengthy negotiations, Mexico is still blocking imports of U.S. high fructose corn syrup.

It's time to add yet another tool to our arsenal.

That's why I'm introducing the United States Agricultural Products Market Access Act of 2003. This bill creates a new mechanism with which to confront foreign trade barriers. The new mechanism operates in a similar fashion to the existing special 301 provision for intellectual property. The bill requires USTR to identify and report on those foreign countries that deny fair and equitable market access for U.S. agricultural exports, or countries that apply to U.S. agricultural products sanitary or phytosanitary measures that are not based on sound science. USTR would annually issue a report on its findings.

Out of the countries identified in USTR's report, USTR would identify which ones have the most egregious practices impacting U.S. agricultural exports and, further, are not entering into good faith negotiations with the United States to end these practices.

This legislation also authorizes additional staffing for USTR to focus on these agricultural enforcement issues.

This bill will further strengthen the ability of the United States to enforce its existing market access rights for agricultural exports. Perhaps just as important, it will help Congress and the Administration prioritize barriers imposed by our trading partners. Through such prioritization, U.S. negotiators will be better able to focus upon removing the most egregious of these barriers.

The United States Agricultural Products Market Access Act will not solve all of our agricultural market access problems. We need to move ahead vigorously in bilateral and multilateral negotiations to tear down barriers to our exports. At the top of this list is successful completion of agricultural negotiations in the WTO. However, the United States Agricultural Products Market Access Act of 2003 will help us identify the most egregious problems, so we can focus our energy on fixing them. It will also provide a new enforcement tool to help make sure American farmers are getting the benefit of our hard fought trade bargains.

This bill is strongly supported by Iowa's agricultural community, including the Iowa Corn Growers, the Iowa Farm Bureau Federation, and the Iowa Soybean Association.

I would like to thank my distinguished colleagues Senator MAX BAUCUS, Ranking Member of the Finance Committee, and Representative DAVE CAMP for their hard work on this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1324

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "United States Agricultural Products Market Access Act of 2003".

SEC. 2. FINDINGS; PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) The export of agricultural products is of vital importance to the economy of the United States.

(2) In 2002, agriculture was a large positive contributor to the United States merchandise trade balance with a trade surplus of $12,300,000,000.

(3) The growth of United States agricultural exports should continue to be an important factor in improving the United States merchandise trade balance.

(4) Increasing the volume of agricultural exports will increase farm income in the United States, thereby protecting family farms and contributing to the economic well-being of rural communities in the United States.

(5) Although the United States efficiently produces high-quality agricultural products, United States producers cannot realize their full export potential because many foreign countries deny fair and equitable market access to United States agricultural products.

(6) The Foreign Agricultural Service estimates that United States agricultural exports are reduced by $4,700,000,000 annually due to unjustifiable imposition of sanitary and phytosanitary measures that deny or limit market access to United States products.

(7) The denial of fair and equitable market access for United States agricultural products impedes the ability of United States farmers to export their products, thereby harming the economic interests of the United States.

(b) PURPOSES.—The purposes of this Act are—

(1) to reduce or eliminate foreign unfair trade practices and to remove constraints on fair and open trade in agricultural products;

(2) to ensure fair and equitable market access for exports of United States agricultural products; and

(3) to promote free and fair trade in agricultural products.

SEC. 3. IDENTIFICATION OF COUNTRIES THAT DENY MARKET ACCESS.

(a) IDENTIFICATION REQUIRED.—Chapter 8 of title I of the Trade Act of 1974 (19 U.S.C. 2241 et seq.) is amended by adding at the end the following:

"SEC. 183. IDENTIFICATION OF COUNTRIES THAT DENY MARKET ACCESS FOR AGRICULTURAL PRODUCTS.

"(a) IN GENERAL.—Not later than the date that is 30 days after the date on which the annual report is required to be submitted to Congressional committees under section 181(b), the United States Trade Representative (in this section referred to as the 'Trade Representative') shall identify—

"(1) those foreign countries that—

"(A) deny fair and equitable market access to United States agricultural products, or

"(B) apply standards for the importation of agricultural products from the United States that are not related to public health concerns or cannot be substantiated by reliable analytical methods, and

"(2) those foreign countries identified under paragraph (1) that are determined by the Trade Representative to be priority foreign countries.

"(b) SPECIAL RULES FOR IDENTIFICATIONS.—

"(1) CRITERIA.—In identifying priority foreign countries under subsection (a)(2), the Trade Representative shall only identify those foreign countries—

"(A) that engage in or have the most onerous or egregious acts, policies, or practices that deny fair and equitable market access to United States agricultural products,

"(B) whose acts, policies, or practices described in subparagraph (A) have the greatest adverse impact (actual or potential) on the relevant United States products, and

"(C) that are not—

"(i) entering into good faith negotiations, or

"(ii) making significant progress in bilateral or multilateral negotiations,

to provide fair and equitable market access to United States agricultural products.

"(2) CONSULTATION AND CONSIDERATION REQUIREMENTS.—In identifying priority foreign countries under subsection (a)(2), the Trade Representative shall—

"(A) consult with the Secretary of Agriculture and other appropriate officers of the Federal Government, and

"(B) take into account information from such sources as may be available to the Trade Representative and such information as may be submitted to the Trade Representative by interested persons, including information contained in reports submitted under section 181(b) and petitions submitted under section 302.

"(3) FACTUAL BASIS REQUIREMENT.—The Trade Representative may identify a foreign country under subsection (a)(1) only if the Trade Representative finds that there is a factual basis for the denial of fair and equitable market access as a result of the violation of international law or agreement, or the existence of barriers, referred to in subsection (d).

"(4) CONSIDERATION OF HISTORICAL FACTORS.—In identifying foreign countries under paragraphs (1) and (2) of subsection (a), the Trade Representative shall take into account—

"(A) the history of agricultural trade relations with the foreign country, including any previous identification under subsection (a)(2), and

"(B) the history of efforts of the United States, and the response of the foreign country, to achieve fair and equitable market access for United States agricultural products.

"(c) REVOCATIONS AND ADDITIONAL IDENTIFICATIONS.—

"(1) AUTHORITY TO ACT AT ANY TIME.—If information available to the Trade Representative indicates that such action is appropriate, the Trade Representative may at any time—

"(A) revoke the identification of any foreign country as a priority foreign country under this section, or

"(B) identify any foreign country as a priority foreign country under this section.

"(2) REVOCATION REPORTS.—The Trade Representative shall include in the semiannual report submitted to the Congress under section 309(3) a detailed explanation of the reasons for the revocation under paragraph (1) of the identification of any foreign country as a priority foreign country under this section.

"(d) DENIAL OF FAIR AND EQUITABLE MARKET ACCESS DEFINED.—For purposes of this section, a foreign country denies fair and equitable market access if the foreign country effectively denies access to a market for a product through the use of laws, procedures, practices, or regulations which—

"(1) violate provisions of international law or international agreements to which both the United States and the foreign country are parties, or

"(2) constitute discriminatory nontariff trade barriers.

"(e) PUBLICATION.—The Trade Representative shall publish in the Federal Register a list of foreign countries identified under subsection (a) and shall make such revisions to the list as may be required by reason of the action under subsection (c).

"(f) ANNUAL REPORT.—The Trade Representative shall, not later than the date by which countries are identified under subsection (a), transmit to the Committee on Ways and Means and the Committee on Agriculture of the House of Representatives and the Committee on Finance and the Committee on Agriculture, Nutrition, and Forestry of the Senate, a report on the actions taken under this section during the 12 months preceding such report, and the reasons for such actions, including a description of progress made in achieving fair and equitable market access for United States agricultural products.".

(b) CLERICAL AMENDMENT.—The table of contents for the Trade Act of 1974 is amended by inserting after the item relating to section 182 the following:

"Sec. 183. Identification of countries that deny market access for agricultural products.".

(c) ADDITIONAL STAFF FOR OFFICE OF ASSISTANT TRADE REPRESENTATIVE FOR AGRICULTURAL AFFAIRS AND OFFICE OF ASSISTANT TRADE REPRESENTATIVE FOR MONITORING AND ENFORCEMENT.—

(1) IN GENERAL.—There is authorized to be appropriated such sums as may be necessary for fiscal year 2004 for the salaries and expenses of 1 additional specialist employee position within the Office of the Assistant United States Trade Representative for Agricultural Affairs and 1 additional specialist employee position within the Office of the Assistant United States Trade Representative for Monitoring and Enforcement.

(2) AVAILABILITY.—Amounts appropriated pursuant to the authorization of appropriations under paragraph (1) are authorized to remain available until expended.

SEC. 4. INVESTIGATIONS.

(a) INVESTIGATION REQUIRED.—Subparagraph (A) of section 302(b)(2) of the Trade Act of 1974 (19 U.S.C. 2412(b)(2)) is amended by inserting "or 183(a)(2)" after "section 182(a)(2)" in the matter preceding clause (i).

(b) CONFORMING AMENDMENT.—Subparagraph (D) of section 302(b)(2) of such Act is amended by inserting "concerning intellectual property rights that is" after "any investigation".

By Mr. BURNS (for himself, Mr. GRAHAM of South Carolina, Mr. HAGEL, and Mr. FITZGERALD):

S. 1325. A bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies; to the Committee on Commerce, Science, and Transportation.

Mr. BURNS. Mr. President, today I am introducing legislation that will protect an existing exemption for farmers and agribusinesses from the Department of Transportation's, DOT, limitations on maximum driving time in transporting agricultural commodities or farm supplies during peak planting and growing seasons.

In 1995, Public Law 104-59 passed by Congress granted farmers and retail farm suppliers a limited exemption from DOT limitations on maximum driving time in transporting agricultural commodies or farm supplies within a 100-mile radius of a final distribution point. This legislation recognized the special needs of rural America, understanding that drivers employed by farm retailers generally operate in local areas to farmers' fields delivering and applying crop inputs. Much of their time is spent waiting at the field or the farm store loading and unloading their trucks. In short, farm retail drivers stay in a local area and return to their homes each night to sleep. The work of these crop input suppliers is essential to the Nation's farmers, who often have short windows of time to plant and harvest their crop around changing weather patterns.

The agricultural exemption is seasonal, applying only during designated months throughout the year as determined by each State. Every State has now taken this action, and to my knowledge this exemption has not had any impact on public safety.

It is important to note that under my clarifying legislation, the farm supply/farm commodity exemption would remain limited in scope.

My legislation reiterates original Congressional support for the agricultural exemption. The DOT has no expertise in this area nor, in my opinion, does the definition of agricultural commodity come under the jurisdiction of this agency. In addition, the term "agricultural commodity" is already defined by Section 102 of the Agricultural Trade Act of 1978 (7 U.S.C. 5602). Therefore, in my legislation, Section 345 (e) of the National Highway System Designation Act of 1995 is amended to reflect the definition in the Agricultural Trade Act.

A bipartisan group of House Members are also seeking clarifying legislation in this regard with Representative BEREUTER of Nebraska taking the lead.

I urge all my colleagues to join me in passing this legislation to protect the agricultural exemption to hours of service rules and prevent DOT from diminishing or revoking the exemption.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 181—CONGRATULATING ALL NEW YORKERS ON THE OCCASION OF THEIR FIRST KENTUCKY DERBY VICTORY AND THE SUBSEQUENT PREAKNESS STAKES VICTORY WITH NEW YORK-BRED GELDING, FUNNY CIDE

Mr. SCHUMER (for himself and Mrs. CLINTON) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 181

Whereas on Saturday, May 3, 2003, Funny Cide won the 129th Kentucky Derby by 1¾ lengths, with a time of 2:01:19, and became the first New York-bred horse to win the Run for the Roses and the first gelding to win the Derby since Clyde Van Dusen in 1929;

Whereas on Saturday, May 17, 2003, Funny Cide won the 128th Preakness Stakes by 9¾ lengths, with a time of 1:55:61, and became the first New York-bred horse in 107 years, and the first gelding since Prairie Bayou in 1993, to win the Preakness;

Whereas Funny Cide is the great-great grandson of the 1977 Triple Crown winner, Seattle Slew;

Whereas Funny Cide was trained by Barclay Tagg and ridden by jockey Jose Santos;

Whereas high school friends from Sackets Harbor, New York, along with friends made thereafter, are the proud owners of Funny Cide,

Whereas Funny Cide races out of Sackatoga Stables, named after the hometown of the original owners — Sacket Harbor, New York — and the home of another owner — Saratoga Springs, New York; and

Whereas Funny Cide, a horse with a reputation as being "from the wrong side of the track", has become the pride and joy of all New Yorkers: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates Sackatoga Stables for Funny Cide's victories at the 129th Kentucky Derby and the 128th Preakness Stakes; and

(2) directs the Secretary of the Senate to make available enrolled copies of this resolution for appropriate display to the owners of Funny Cide, trainer Barclay Tagg, and jockey Jose Santos.

SENATE RESOLUTION 182—CONGRATULATING THE AMERICAN DENTAL ASSOCIATION FOR ESTABLISHING THE "GIVE KIDS A SMILE" PROGRAM, EMPHASIZING THE NEED TO IMPROVE ACCESS TO DENTAL CARE FOR CHILDREN, AND THANKING DENTISTS FOR VOLUNTEERING THEIR TIME TO HELP PROVIDE NEEDED DENTAL CARE

Ms. STABENOW submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 182

Whereas access to dental care for children is a vital element of overall health care and development;

Whereas dental caries—more commonly known as tooth decay—is the most common chronic childhood disease;

Whereas untreated tooth decay in children results in thousands of children experiencing poor eating and sleeping patterns, suffering decreased attention spans at school, and being unable to smile;

Whereas, due to a confluence of factors, children eligible for Medicaid and the State Children's Health Insurance Program are 3 to 5 times more likely than other children to have untreated tooth decay;

Whereas dentists provide an estimated $1,700,000,000 annually in nonreimbursed dental care;

Whereas dentists participating in the American Dental Association established the "Give Kids a Smile" program to serve as a reminder to the Nation about the need to end untreated childhood dental disease; and

Whereas the "Give Kids a Smile" program treated an estimated 1,000,000 children on February 21, 2003, at approximately 5,000 locations in all 50 States: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates the American Dental Association for establishing the "Give Kids a Smile" program;

(2) emphasizes the need to improve access to dental care for children; and

(3) thanks the thousands of dentists who volunteered their time and brought a smile to faces of an estimated 1,000,000 children on February 21, 2003.

Ms. STABENOW. Mr. President, someone once said, "A smile costs nothing, but gives much. It enriches those who receive, without making poorer those that give." I rise today to offer a resolution to congratulate the American Dental Association for establishing the "Give Kids a Smile" program.

This program emphasizes the need to improve dental care access for children. Tooth decay is the most common chronic childhood disease. Tooth decay can cause poor eating and sleeping patterns, decreased attention spans at school, and sadly, prevents children from showing their smiles.

Low income children are much more likely to suffer from tooth decay. Children who are eligible for Medicaid and State Children's Health Insurance Program, SCHIP, are 3 to 5 times more likely than other children to have untreated tooth decay. The "Give Kids a Smile" program is helping these children.

Along with helping children get the dental care that they need, this program brings attention to the fact that this is a serious issue that children in our nation are facing. This program provides for and promotes education on dental care, good dental hygiene, dental screenings, exams and radiographs, and even gives sealants and fillings.

On February 21st, my State, Michigan, brought healthier teeth and brighter smiles to 12,800 low-income and disadvantaged children. Nearly 1 million children were treated nationwide.

Dentists, such as Dr. John Buchheister, Dr. Sara Wassenaar, Dr. Dale Nester, Dr. Martha Bamfield, and Dr. Gary Schluckebier in Michigan, volunteered their time, resources, and services to give children dental screenings, exams, sealants, and fillings.

Nearly 8,300 children in Michigan also listened to dental education presentations by dental professionals.

I am pleased to stand here today and congratulate the American Dental Association for their leadership on this important children's health issue and for establishing the "Give Kids a Smile" program.

I also want to thank the Michigan Dental Association for participating in this program and I want to thank all of the dentists in Michigan and across the Nation that took the time to make the inaugural "Give Kids a Smile" day a great success. After all, "A smile can open a heart faster than a key can open a door."

AMENDMENTS SUBMITTED & PROPOSED

SA 1001. Mrs. BOXER (for herself and Ms. Mikulski) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

SA 1002. Mrs. LINCOLN (for herself, Mr. Conrad, Mr. Miller, Mr. Carper, Mr. Johnson, Ms. Mikulski, Mrs. Clinton, and Mr. Dorgan) proposed an amendment to the bill S. 1, supra.

SA 1003. Mr. BROWNBACK (for himself and Mr. Nelson, of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1004. Mrs. HUTCHISON proposed an amendment to the bill S. 1, supra.

SA 1005. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1006. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1007. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1008. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1009. Mr. INOUYE (for himself and Mr. Akaka) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1010. Mr. SUNUNU submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1011. Mr. SESSIONS proposed an amendment to the bill S. 1, supra.

SA 1012. Mr. HAGEL (for himself and Mr. Ensign) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1013. Mr. BOND (for himself and Mr. Roberts) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1014. Mr. BOND submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1015. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1016. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1017. Mr. ALLARD (for himself, Mr. Fitzgerald, and Ms. Collins) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1018. Mr. LIEBERMAN (for himself and Ms. Collins) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1019. Mr. CONRAD (for himself, Mrs. Murray, Mr. Smith, Mrs. Lincoln, and Mr. Jeffords) proposed an amendment to the bill S. 1, supra.

SA 1020. Mr. CONRAD proposed an amendment to the bill S. 1, supra.

SA 1021. Mr. CONRAD proposed an amendment to the bill S. 1, supra.

SA 1022. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1023. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1024. Mr. ENSIGN (for himself and Mrs. Lincoln) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1025. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1026. Mr. HAGEL (for himself, Mr. Ensign, Mr. Lott, and Mr. Inhofe) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1027. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1028. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1029. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1030. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1031. Mr. CRAPO submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1032. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1033. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1034. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1035. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1036. Mr. REID (for Mrs. Boxer) proposed an amendment to the bill S. 1, supra.

SA 1037. Mr. REID (for Mr. CORZINE) proposed an amendment to the bill S. 1, supra.

SA 1038. Mr. REID (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, supra.

SA 1039. Mr. REID (for Mr. INOUYE) proposed an amendment to the bill S. 1, supra.

SA 1040. Mr. SCHUMER (for himself, Mr. CORZINE, Mrs. CLINTON, and Mr. LAUTENBERG) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1041. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1042. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1043. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 1001. Mrs. BOXER (for herself and Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 49, strike line 3 through page 50, line 2 and insert the following:

"(2) LIMITS ON COST-SHARING.—

"(A) IN GENERAL.—The 'coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket limit under paragraph (4)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

"(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a).

SA 1002. Mrs. LINCOLN (for herself, Mr. CONRAD, Mr. MILLER, Mr. CARPER, Mr. JOHNSON, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DORGAN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 83, strike lines 1 through 7, and insert the following:

"(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

"(A) The contract shall be for a 2-year period.

"(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

"(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1003. Mr. BROWNBACK (for himself and Mr. NELSON of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . RURAL COMMUNITY HOSPITAL ASSISTANCE.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end of the following new subsection: "Rural Community Hospital; Rural Community Hospital Services "(ww)(1) The term 'rural community hospital' means a hospital (as defined in subsection (e)) that—

"(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

"(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

"(C) makes available 24-hour emergency care services;

"(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2003; and

"(E) applies to the Secretary for such designation.

"(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

"(3) Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

"(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) with the same service area (as defined by the Secretary in regulations in effect on such date).

"(B) A facility obtaining a new provider number pursuant to a change of ownership.

"(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2003.

"(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.".

(2) PAYMENT.—

(A) INPATIENT SERVICES.—Section 1814 (42 U.S.C. 1395f) is amended by adding at the end the following new subsection: "Payment for Inpatient Services Furnished in Rural Community Hospitals

"(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(ww)(1)(E)—

"(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

"(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).".

(B) OUTPATIENT SERVICES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(n) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(ww)(1)(E)—

"(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

"(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).".

(C) HOME HEALTH SERVICES.—

(i) EXCLUSION FROM HOME HEALTH PPS.—Section 1895 (42 U.S.C. 1395fff) is amended by adding at the end the following:

"(f) EXCLUSION.—

"(1) IN GENERAL.—In determining payments under this title for home health services furnished on or after October 1, 2003, by a qualified RCH-based home health agency (as defined in paragraph (2))—

"(A) the agency may make a one-time election to waive application of the prospective payment system established under this section to such services furnished by the agency shall not apply; and

"(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

"(2) QUALIFIED RCH-BASED HOME HEALTH AGENCY DEFINED.—For purposes of paragraph (1), a 'qualified RCH-based home health agency' is a home health agency that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554; Appendix F, 114 Stat. 2763A–506)) of a rural community hospital that is located—

"(A) in a county in which no main or branch office of another home health agency is located; or

"(B) at least 35 miles from any main or branch office of another home health agency.".

(ii) CONFORMING CHANGES.—

(I) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting "or with respect to services to which section 1895(f) applies" after "equipment" in the matter preceding paragraph (1).

(II) PAYMENTS UNDER PART B.—Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) is amended by striking "the prospective payment system under".

(III) PER VISIT LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended by inserting "(other than by a qualified RCH-based home health agency (as defined in section 1895(f)(2)))" after "with respect to services furnished by home health agencies".

(iii) CONSOLIDATED BILLING.—

(I) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended by inserting "and excluding home health services to which section 1895(f) applies" after "provided for in such section".

(II) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended by inserting before the period at the end of the second sentence the following: "and paragraph (21) shall not apply to home health services to which section 1895(f) applies".

(D) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)) is amended—

(i) by inserting "(i)" after "(P)"; and

(ii) by adding at the end the following:

"(ii)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(g)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital on or after October 1, 2003, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i).

"(II) The services referred to in subclause (I) are inpatient hospital services, outpatient hospital services, home health services furnished by an RCH-based home health agency (as defined in section 1895(f)(2)), and ambulance services.

"(III) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.".

(E) EXEMPTION FROM 30 PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting "(other than a rural community hospital)" after "In determining such reasonable costs for hospitals".

(3) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(n) (as added by paragraph (2)(B)) is amended—

(A) by inserting "(1)" after "(n)"; and

(B) by adding at the end the following:

"(2) The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

"(A) For items and services that would have been paid under section 1833(t) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

"(B) For items and services that would have been paid under section 1833(h) if furnished by a provider or supplier, no cost-sharing shall apply.

"(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.".

(4) CONFORMING AMENDMENTS.—

(A) PART A PAYMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting "other than inpatient hospital services furnished by a rural community hospital," after "critical access hospital services,".

(B) PART B PAYMENT.—

(i) IN GENERAL.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(I) in paragraph (2), in the matter before subparagraph (A), by striking "and (I)" and inserting "(I), and (K)";

(II) by striking "and" at the end of paragraph (8);

(III) by striking the period at the end of paragraph (9) and inserting "; and"; and

(IV) by adding at the end the following:

"(10) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(n).".

(ii) AMBULANCE SERVICES.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(I) in the heading, by striking "CRITICAL ACCESS HOSPITALS" and inserting "CERTAIN FACILITIES";

(II) by striking "or" at the end of subparagraph (A);

(III) by redesignating subparagraph (B) as subparagraph (C);

(IV) by inserting after subparagraph (A) the following new subparagraph:

"(B) by a rural community hospital (as defined in section 1861(ww)(1)), or"; and (V) in subparagraph (C), as so redesignated, by inserting "or a rural community hospital" after "critical access hospital".

(C) TECHNICAL AMENDMENTS.—

(i) CONSULTATION WITH STATE AGENCIES.—Section 1863 (42 U.S.C. 1395z) is amended by striking "and (dd)(2)" and inserting "(dd)(2), (mm)(1), and (ww)(1)".

(ii) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting "section 1834(n)(2)," after "section 1833(b),".

(iii) BIPA AMENDMENT.—Paragraph (8) of section 1834(l) (42 U.S.C. 1395m(l)), as added by section 221(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–486), as enacted into law by section 1(a)(6) of Public Law 106–554, is redesignated as paragraph (9).

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after October 1, 2003.

(b) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY RCH AND CAH FACILITIES.—

(1) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by striking "a distinct part of the hospital (as defined by the Secretary)" in the matter following clause (v) and inserting "a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital or a rural community hospital".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to determinations with respect to distinct part unit status that are made on or after October 1, 2003.

(c) IMPROVEMENTS TO MEDICARE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

"(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph

(B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.".

(2) PAYMENTS TO HOME HEALTH AGENCIES OWNED AND OPERATED BY A CAH.—Section 1895(f) (42 U.S.C. 1395fff(f)), as added by subsection (a)(2)(C), is further amended by inserting "or by a home health agency that is owned and operated by a critical access hospital (as defined in section 1861(mm)(1))" after "as defined in paragraph (2))".

(3) PAYMENTS TO CAH-OWNED SNFS.—

(A) IN GENERAL.—Section 1888(e)(42 U.S.C. 1395yy(e)) is amended—

(i) in paragraph (1), by striking "and (12)" and inserting "(12), and (13)"; and

(ii) by adding at the end thereof the following:

"(13) EXEMPTION OF CAH FACILITIES FROM PPS.—In determining payments under this part for covered skilled nursing facility services furnished on or after October 1, 2003, by a skilled nursing facility that is a distinct part unit of a critical access hospital (as defined in section 1861(mm)(1)) or is owned and operated by a critical access hospital—

"(A) the prospective payment system established under this subsection shall not apply; and

"(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under subsection (a).".

(B) CONFORMING CHANGES.—

(i) IN GENERAL.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by subsection (a), is further amended in the matter preceding paragraph (1)—

(I) by inserting "other than a skilled nursing facility providing covered skilled nursing facility services (as defined in section 1888(e)(2)) or post hospital extended care services to which section 1888(e)(13) applies," after "inpatient critical access hospital services"; and

(II) by striking "1813 1886," and inserting "1813, 1886, 1888,".

(i) CONSOLIDATED BILLING.—

(I) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by inserting "services to which paragraph (7)(C) or (13) of section 1888(e) applies and" after "other than".

(II) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended by inserting "(other than services to which paragraph (7)(C) or (13) of section 1888(e) applies)" after "section 1888(e)(2)(A)(i)".

(4) PAYMENTS TO DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS OF CAHS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(A) in paragraph (1), by inserting ", other than a distinct part psychiatric or rehabilitation unit to which paragraph (8) applies," after "subsection (d)(1)(B)"; and

(B) by adding at the end the following:

"(8) EXEMPTION OF CERTAIN DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS FROM COST LIMITS.—In determining payments under this part for inpatient hospital services furnished on or after October 1, 2003, by a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of subsection (d)(1)(B)) of a critical access hospital (as defined in section 1861(mm)(1))—

"(A) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

"(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services.".

(5) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)), as amended by subsection (a)(2)(D), is further amended by adding at the end the following:

"(iii)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(8)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a critical access hospital on or after October 1, 2003, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i).

"(II) The services referred to in subclause (I) are inpatient critical access hospital services (as defined in section 1861(mm)(2)), outpatient critical access hospital services (as defined in section 1861(mm)(3)), extended care services provided pursuant to an agreement under section 1883, posthospital extended care services to which section 1888(e)(13) applies, home health services to which section 1895(f) applies, ambulance services to which section 1834(l) applies, and inpatient hospital services to which section 1886(b)(8) applies.

"(III) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.".

(6) TECHNICAL CORRECTIONS.—

(A) SECTION 403(b) OF BBRA 1999.—Section 1820(b)(2) (42 U.S.C. 1395i-4(b)(2)) is amended by striking "nonprofit or public hospitals" and inserting "hospitals".

(B) SECTION 203(b) OF BIPA 2000.—Section 1883(a)(3) (42 U.S.C. 1395tt(a)(3)) is amended—

(i) by inserting "section 1861(v)(1)(G) or" after "Notwithstanding"; and

(ii) by striking "covered skilled nursing facility".

(9) EFFECTIVE DATES.—

(A) ELIMINATION OF REQUIREMENTS.—

The amendments made by paragraphs (1) and (2) shall apply to services furnished on or after October 1, 2003.

(B) TECHNICAL CORRECTIONS.—

(i) BBRA.—The amendment made by paragraph (6)(A) shall be effective as if included in the enactment of section 403(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–321), as enacted into law by section 1000(a)(6) of Public Law 106–113.

(ii) BIPA.—The amendments made by paragraph (6)(B) shall be effective as if included in the enactment of section 203(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

SA 1004. Mrs. HUTCHISON proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking "and" at the end; and

(2) by striking subclause (VII) and inserting the following new subclauses:

"(VII) during fiscal years 2003, 2004, 2005, 2006, 2007 and 2008, 'c' is equal to 1.35; and

"(VIII) on or after October 1, 2008, 'c' is equal to 1.6.".

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking "1999 or" and inserting "1999,"; and

(2) by inserting ", or the Prescription Drug and Medicare Improvement Act of 2003" after "2000".

SA 1005. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. . EXTENSION OF PHASE-IN OF NEW RISK ADJUSTER.

(a) UNDER MEDICARE+CHOICE.—Section 1853(a)(3)(C)(ii) is amended—

(1) in subclause (I), by striking "2003" and inserting "2005";

(2) in subclause (II), by striking "2004" and inserting "2006";

(3) in subclause (III), by striking "2005" and inserting "2007";

(4) in subclause (IV), by striking "2006" and inserting "2008"; and

(5) in subclause (V), by striking "2007" and inserting "2009".

(b) UNDER MEDICAREADVANTAGE.—Section 1853(a)(3)(A) (42 U.S.C. 1395w–23(a)(3)(A)), as amended by section 203, is amended to read as follows:

"(A) APPLICATION OF METHODOLOGY.—

"(i) IN GENERAL.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to the applicable percentage of the amount of payments to plans under subsection (d)(4)(B).

"(ii) APPLICABLE PERCENTAGE DEFINED.—For purposes of clause (i), the term 'applicable percentage' means—

"(II) for 2006, 30 percent;

"(III) for 2007, 50 percent;

"(IV) for 2008, 75; and

"(V) for 2009 and each subsequent year, 100 percent.".

(c) EFFECTIVE DATES.—The amendments made—

(1) by subsection (a) shall take effect on the date of enactment of this Act; and

(2) by subsection (b) shall apply to plan years beginning on or after January 1, 2006.

SA 1006. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. . REVISION OF REQUIREMENTS FOR REVIEW OF MARKETING MATERIALS.

(a) Under Medicare+Choice and MedicareAdvantage.—Section 1851(h) (42 U.S.C. 1395w–21(h)) is amended—

(1) in paragraph (1)(A), by striking "45 days (or 10 days in the case described in paragraph (5))" and inserting "30 days (or 10 days in the case described in paragraph (5) or if the Medicare+Choice organization has submitted to the Secretary requested corrections following review of the submitted material)"; and

(2) by striking paragraph (2) and inserting the following new paragraph:

"(2) Review.—

"(A) In general.—Except as provided in subparagraph (B), the standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(B) Exception.—Notwithstanding any other requirements of section 1856(h), the Secretary shall establish policies that permit, under appropriate circumstances, the distribution of marketing materials by a Medicare+Choice organization prior to review.".

(b) Effective Date.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to section 1851(h) of the Social Security Act (42 U.S.C. 1395w–21(h)) as in effect on such date and as amended by section 201.

SA 1007. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table: as follows:

At the end of subtitle C of title II, add the following:

SEC. . AUTHORIZATION OF DIRECT PAYMENTS TO PROVIDERS FOR SERVICES PROVIDED TO MEDICARE ADVANTAGE ENROLLEES PARTICIPATING IN MEDICARE COVERED CLINICAL TRIALS.

(a) Under Medicare+Choice and MedicareAdvantage.—

(1) In general.—Section 1852(a)(1)(A) (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting "and items and services that are covered under part A or B as a result of a national coverage determination for qualifying clinical trials" after "hospice care".

(2) Payment.—Section 1853 (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

"(j) Special Rule for Covered Costs Associated With Qualifying Clinical Trials.—

"(1) Information.—The Medicare+Choice organization shall inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization that the medicare program covers certain costs associated with the participation by a medicare beneficiary in a qualifying clinical trial.

"(2) Payment.—If an individual who is enrolled with a Medicare+Choice organization under this part participates in a qualifying clinical trial, payment for the medicare covered costs associated with that clinical trial shall be made by the Secretary directly to the provider or supplier furnishing such services.".

(b) Effective Date.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to sections 1852 and 1853 of the Social Security Act (42 U.S.C. 1395w–22 and 1395w–23) as in effect on such date and as amended by sections 202 and 203.

SA 1008. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 134, between lines 9 and 10, insert the following:

"(d) Zero Premium Stop-Loss Protection and Access to Negotiated Prices For Certain Eligible Beneficiaries Enrolled in the Original Medicare Fee-For-Service Program After 2013.—

"(1) In general.—Notwithstanding the preceding provisions of this part, the following rules shall apply with respect to an applicable eligible beneficiary enrolled in a Medicare Prescription Drug plan or under a contract under section 1860D–13(e):

"(A) No premium.—Notwithstanding sections 1860D–13(e)(2) and 1860D–17, the monthly beneficiary obligation for enrollment in the Medicare Prescription Drug plan or under a contract under section 1860D–13(e) shall be zero.

"(B) Beneficiary receives access to negotiated prices and stop-loss protection for no additional premium.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

"(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

"(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4).

"(ii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

"(C) Application of low-income subsidies.—Notwithstanding section 1860D–19, the Administrator shall not apply the following provisions of subsection (a) of such section:

"(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

"(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

"(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

"(2) Applicable eligible beneficiary.—For purposes of this subsection, the term 'applicable eligible beneficiary' means an eligible beneficiary who—

"(A) is enrolled under this part; and

"(B) became an eligible beneficiary for the first time on or after January 1, 2014.

"(3) Procedures.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part to the extent necessary to carry out this subsection.

"(4) No effect on beneficiaries enrolled in a MedicareAdvantage plan that provides qualified prescription drug coverage.—This subsection shall have no effect on eligible beneficiaries enrolled in this part and under a MedicareAdvantage plan that provides qualified prescription drug coverage.".

SA 1009. Mr. INOUYE (for himself and Mr. Akaka) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. . 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) Medicaid.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ", and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider" before the period.

(b) Effective Date.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SA 1010. Mr. SUNUNU submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . IMPROVEMENT OF OUTPATIENT VISION SERVICES UNDER PART B.

(a) Coverage Under Part B.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" after the semicolon at the end;

(2) in subparagraph (V)(iii), by adding "and" after the semicolon at the end; and

(3) by adding at the end the following new subparagraph:

"(W) vision rehabilitation services (as defined in subsection (ww)(1));".

(b) Services Described.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Vision Rehabilitation Services; Vision Rehabilitation Professional

"(ww)(1)(A) The term 'vision rehabilitation services' means rehabilitative services (as determined by the Secretary in regulations) furnished—

"(i) to an individual diagnosed with a vision impairment (as defined in paragraph (6));

"(ii) pursuant to a plan of care established by a qualified physician (as defined in subparagraph (C)) or by a qualified occupational therapist that is periodically reviewed by a qualified physician;

``(iii) in an appropriate setting (including the home of the individual receiving such services if specified in the plan of care); and

``(iv) by any of the following individuals:

``(I) A qualified physician.

``(II) A qualified occupational therapist.

``(III) A vision rehabilitation professional (as defined in paragraph (2)) while under the general supervision (as defined in subparagraph (D)) of a qualified physician.

``(B) In the case of vision rehabilitation services furnished by a vision rehabilitation professional, the plan of care may only be established and reviewed by a qualified physician.

``(C) The term `qualified physician' means—

``(i) a physician (as defined in subsection (r)(1)) who is an ophthalmologist; or

``(ii) a physician (as defined in subsection (r)(4) (relating to a doctor of optometry)).

``(D) The term `general supervision' means, with respect to a vision rehabilitation professional, overall direction and control of that professional by the qualified physician who established the plan of care for the individual, but the presence of the qualified physician is not required during the furnishing of vision rehabilitation services by that professional to the individual.

``(2) The term `vision rehabilitation professional' means any of the following individuals:

``(A) An orientation and mobility specialist (as defined in paragraph (3)).

``(B) A rehabilitation teacher (as defined in paragraph (4)).

``(C) A low vision therapist (as defined in paragraph (5)).

``(3) The term `orientation and mobility specialist' means an individual who—

``(A) if a State requires licensure or certification of orientation and mobility specialists, is licensed or certified by that State as an orientation and mobility specialist;

``(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in orientation and mobility; and

``(ii) has successfully completed 350 hours of clinical practicum under the supervision of an orientation and mobility specialist and has furnished not less than 9 months of supervised full-time orientation and mobility services;

``(C) has successfully completed the national examination in orientation and mobility administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

``(D) meets such other criteria as the Secretary establishes.

``(4) The term `rehabilitation teacher' means an individual who—

``(A) if a State requires licensure or certification of rehabilitation teachers, is licensed or certified by the State as a rehabilitation teacher;

``(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in rehabilitation teaching, or holds such a degree in a health field; and

``(ii) has successfully completed 350 hours of clinical practicum under the supervision of a rehabilitation teacher and has furnished not less than 9 months of supervised full-time rehabilitation teaching services;

``(C) has successfully completed the national examination in rehabilitation teaching administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

``(D) meets such other criteria as the Secretary establishes.

``(5) The term `low vision therapist' means an individual who—

``(A) if a State requires licensure or certification of low vision therapists, is licensed or certified by the State as a low vision therapist;

``(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in low vision therapy, or holds such a degree in a health field; and

``(ii) has successfully completed 350 hours of clinical practicum under the supervision of a physician, and has furnished not less than 9 months of supervised full-time low vision therapy services;

``(C) has successfully completed the national examination in low vision therapy administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

``(D) meets such other criteria as the Secretary establishes.

``(6) The term `vision impairment' means vision loss that constitutes a significant limitation of visual capability resulting from disease, trauma, or a congenital or degenerative condition that cannot be corrected by conventional means, including refractive correction, medication, or surgery, and that is manifested by 1 or more of the following:

``(A) Best corrected visual acuity of less than 20/60, or significant central field defect.

``(B) Significant peripheral field defect including homonymous or heteronymous bilateral visual field defect or generalized contraction or constriction of field.

``(C) Reduced peak contrast sensitivity in conjunction with a condition described in subparagraph (A) or (B).

``(D) Such other diagnoses, indications, or other manifestations as the Secretary may determine to be appropriate.''.

(c) PAYMENT UNDER PART B.—

(1) PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting ``(2)(W),'' after ``(2)(S),''.

(2) CARVE OUT FROM HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting ``vision rehabilitation services (as defined in section 1861(ww)(1)) or'' after ``does not include''.

(3) CLARIFICATION OF BILLING REQUIREMENTS.—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ``and'' before ``(G)''; and

(B) by inserting before the period the following: ``, and (H) in the case of vision rehabilitation services (as defined in section 1861(ww)(1)) furnished by a vision rehabilitation professional (as defined in section 1861(ww)(2)) while under the general supervision (as defined in section 1861(ww)(1)(D)) of a qualified physician (as defined in section 1861(ww)(1)(C)), payment shall be made to (i) the qualified physician or (ii) the facility (such as a rehabilitation agency, a clinic, or other facility) through which such services are furnished under the plan of care if there is a contractual arrangement between the vision rehabilitation professional and the facility under which the facility submits the bill for such services''.

(d) PLAN OF CARE.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) in subparagraph (E), by striking ``and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ``; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

``(G) in the case of vision rehabilitation services, (i) such services are or were required because the individual needed vision rehabilitation services, (ii) an individualized, written plan for furnishing such services has been established (I) by a qualified physician (as defined in section 1861(ww)(1)(C)), (II) by a qualified occupational therapist, or (III) in the case of such services furnished by a vision rehabilitation professional, by a qualified physician, (iii) the plan is periodically reviewed by the qualified physician, and (iv) such services are or were furnished while the individual is or was under the care of the qualified physician.''.

(e) RELATIONSHIP TO REHABILITATION ACT OF 1973.—The provision of vision rehabilitation services under the medicare program under title XVIII (42 U.S.C. 1395 et seq.) shall not be taken into account for any purpose under the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.).

(f) EFFECTIVE DATE.—

(1) INTERIM, FINAL REGULATIONS.—The Secretary shall publish a rule under this section in the Federal Register by not later than 180 days after the date of enactment of this Act to carry out the provisions of this section. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period for public comment of not less than 60 days.

(2) CONSULTATION.—The Secretary shall consult with the National Vision Rehabilitation Cooperative, the Association for Education and Rehabilitation of the Blind and Visually Impaired, the Academy for Certification of Vision Rehabilitation and Education Professionals, the American Academy of Ophthalmology, the American Occupational Therapy Association, the American Optometric Association, and such other qualified professional and consumer organizations as the Secretary determines appropriate in promulgating regulations to carry out this section.

SA 1011. Mr. SESSIONS proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Strike section 605 and insert the following:

SEC. 605. SENSE OF THE SENATE REGARDING HEALTH INSURANCE COVERAGE OF LEGAL IMMIGRANTS UNDER MEDICAID AND SCHIP.

FINDINGS.—The Senate makes the following findings:

(1) In 1996, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105)(commonly referred to as the ``welfare reform Act''), Congress deliberately limited the Federal public benefits available to legal immigrants.

(2) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allows a State the option of electing to offer permanent resident legal aliens that have been living in the United States for at least 5 years the same benefits that their State citizens receive under the temporary assistance for needy families program (commonly

referred to as "TANF") and the medicaid program.

(3) As of the date of enactment of this Act, 22 States have elected to give the permanent resident legal aliens who reside in their States the same TANF and medicaid benefits as the States provide to the citizens of their States.

(4) This Act, the Prescription Drug and Medicare Improvement Act of 2003, is not a welfare or medicaid reform bill, but rather is a package of improvements for the medicare program that is designed to provide greater access to health care for America's seniors.

(5) The section heading for 605 of this Act as reported out of the Committee on Finance, was titled "Assistance with Coverage of Legal Immigrants under the medicaid program and SCHIP," and, as reported, related directly to the provision of benefits under the medicaid and State children's health insurance programs, not to benefits provided under the medicare program.

(6) The reported version of section 605 would have directly overturned the reforms made in the 1996 welfare reform Act.

(7) The reported version of section 605 would have greatly expanded the number of individuals who could receive benefits under medicaid and SCHIP.

(8) No hearings have been held in the Committee on Finance of the Senate concerning why the 5-year residency requirement for legal aliens to obtain a Federal public benefit established in the welfare reform Act needs to be overturned or why the reported version of section 605 should be included in a medicare reform package.

(9) Congress must reauthorize the temporary assistance for needy families program later this year and should hold hearings regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit should be overturned as part of the reauthorization of that program.

(b) Sense of the Senate.—It is the sense of the Senate that the Committee on Finance of the Senate should hold hearings in connection with the reauthorization of the temporary assistance for needy families program, or in connection with reform of the medicaid program, regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit that was established in the 1996 welfare reform Act should be overturned for purposes of the medicaid and State children's health insurance programs.

SA 1012. Mr. HAGEL (for himself and Mr. Ensign) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Title I is amended by adding at the end the following:

Subtitle E—Voluntary Medicare Prescription Drug Discount and Security Program

SEC. 141. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) Establishment of Program.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 101, is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

"Part E—Voluntary Medicare Prescription Drug Discount and Security Program

"DEFINITIONS

"Sec. 1860E. In this part:

"(1) Covered drug.—

"(A) In general.—Except as provided in this paragraph, the term 'covered drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

"(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) Exclusions.—

"(i) In general.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(ii) Avoidance of duplicate coverage.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(C) Application of formulary restrictions.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860E–4(a)(4)(B).

"(D) Application of general exclusion provisions.—A prescription drug discount card plan or MedicareAdvantage plan may exclude from qualified prescription drug coverage any covered drug—

"(i) for which payment would not be made if section 1862(a) applied to part E; or

"(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860E–4(a)(4).

"(2) Eligible beneficiary.—The term 'eligible beneficiary' means an individual who is—

"(A) eligible for benefits under part A or enrolled under part B; and

"(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

"(3) Eligible entity.—The term 'eligible entity' means any—

"(A) pharmaceutical benefit management company;

"(B) wholesale pharmacy delivery system;

"(C) retail pharmacy delivery system;

"(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

"(E) MedicareAdvantage organization;

"(F) State (in conjunction with a pharmaceutical benefit management company);

"(G) employer-sponsored plan;

"(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

"(I) combination of the entities described in subparagraphs (A) through (H).

"(4) Poverty line.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(5) Secretary.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

"ESTABLISHMENT OF PROGRAM

"Sec. 1860E–1. (a) Provision of Benefit.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part. Notwithstanding any other provision of this title, an eligible beneficiary may elect to enroll in the program under this part in lieu of the program established under part D. An eligible beneficiary may not be enrolled under both this part and part D.

"(b) Endorsement of Prescription Drug Discount Card Plans.—

"(1) In general.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

"(2) National plans.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

"(c) Voluntary Nature of Program.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

"(d) Financing.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"ENROLLMENT

"Sec. 1860E–2. (a) Enrollment Under part E.—

"(1) Establishment of process.—

"(A) In general.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

"(B) Requirement of enrollment.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

"(2) Enrollment periods.—

"(A) In general.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

"(B) Special enrollment period.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

"(C) Open enrollment period in 2005 for current beneficiaries.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

“(i) enroll under this part; or

“(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

“(3) Period of coverage.—

“(A) In general.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

“(B) Enrollment during open and special enrollment.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

“(4) Part E coverage terminated by termination of coverage under parts A and B or eligibility for medical assistance.—

“(A) In general.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual's coverage under this part if the individual is—

“(i) no longer enrolled in part A or B; or

“(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

“(B) Effective date.—The termination described in subparagraph (A) shall be effective on the effective date of—

“(i) the termination of coverage under part A or (if later) under part B; or

“(ii) the coverage under title XIX.

“(b) Enrollment With Eligible Entity.—

“(1) Process.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

“(2) Election periods.—

“(A) In general.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the MedicareAdvantage program under section 1851(e), including—

“(i) annual coordinated election periods; and

“(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a MedicareAdvantage election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

“(B) Initial election periods.—

“(i) Individuals currently covered.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

“(ii) Individual covered in future.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

“(C) Additional special election periods.—The Administrator shall establish special election periods—

“(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

“(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

“(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

“(D) Enrollment with one plan only.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

“(3) MedicareAdvantage enrollees.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the MedicareAdvantage organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

“(4) Continuous prescription drug coverage.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

“(A) Coverage under prescription drug card plan or MedicareAdvantage plan.—Prescription drug coverage under a prescription drug card plan under this part or under a MedicareAdvantage plan.

“(B) Medicaid prescription drug coverage.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a MedicareAdvantage project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

“(C) Prescription drug coverage under group health plan.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(D) Prescription drug coverage under certain medigap policies.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(E) State pharmaceutical assistance program.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(F) Veterans' coverage of prescription drugs.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

“(5) Competition.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

“PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

“Sec. 1860E–3. (a) Activities.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

“(b) Special Rule for First Enrollment Under the Program.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860E–2(c).

“ENROLLEE PROTECTIONS

“Sec. 1860E–4. (a) Requirements for All Eligible Entities.—Each eligible entity shall meet the following requirements:

“(1) Guaranteed issuance and nondiscrimination.—

“(A) Guaranteed issuance.—

“(i) In general.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860E–2(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

“(ii) MedicareAdvantage limitations permitted.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

"(B) Nondiscrimination.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

"(2) Disclosure of information.—

"(A) Information.—

"(i) General information.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

"(ii) Specific information.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

"(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

"(II) How any formulary used by the eligible entity functions.

"(III) Information on grievance and appeals procedures.

"(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

"(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

"(B) Disclosure upon request of general coverage, utilization, and grievance information.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

"(C) Response to beneficiary questions.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

"(3) Grievance mechanism, coverage determinations, and reconsiderations.—

"(A) In general.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

"(B) Application of coverage determination and reconsideration provisions.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

"(C) Request for review of tiered formulary determinations.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(4) Appeals.—

"(A) In general.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

"(B) Formulary determinations.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(5) Confidentiality and accuracy of enrollee records.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

"(b) Eligible Entities Offering a Discount Card Program.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

"(1) Access to covered benefits.—

"(A) Assuring pharmacy access.—

"(i) In general.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860E–4(a)(3) that ensure such convenient access.

"(ii) Use of point-of-service system.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

"(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

"(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860E–6(b).

"(B) Use of standardized technology.—

"(i) In general.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860E–6(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

"(ii) Standards.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

"(C) Requirements on development and application of formularies.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

"(i) Pharmacy and therapeutic (P&T) committee.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

"(ii) Formulary development.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

"(iii) Inclusion of drugs in all therapeutic categories.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

"(iv) Provider education.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

"(v) Notice before removing drugs from formulary.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

"(vi) Grievances and appeals relating to application of formularies.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860E–4(a).

"(2) Cost and utilization management; quality assurance; medication therapy management program.—

"(A) In general.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

"(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

"(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

"(iii) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

"(B) Medication therapy management program.—

"(i) In general.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(ii) Elements.—Such program may include—

"(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

"(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

"(III) detection of patterns of overuse and underuse of prescription drugs.

"(iii) Development of program in cooperation with licensed pharmacists.—The program shall be developed in cooperation with licensed pharmacists and physicians.

"(iv) Considerations in pharmacy fees.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

"(C) Treatment of accreditation.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to MedicareAdvantage plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

"(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

"(ii) Subsection (c)(1) (relating to access to covered benefits).

"(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

"(D) Public disclosure of pharmaceutical prices for equivalent drugs.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug covered under the plan that is therapeutically equivalent and bioequivalent.

"ANNUAL ENROLLMENT FEE

"Sec. 1860E–5. (a) Amount.—

"(1) In general.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

"(2) Annual percentage increase.—

"(A) In general.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

"(i) such dollar amount; multiplied by

"(ii) the inflation adjustment.

"(B) Inflation adjustment.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

"(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

"(ii) such aggregate expenditures for the 12-month period ending with July 2005.

"(C) Rounding.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

"(b) Collection of Annual Enrollment Fee.—

"(1) In general.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

"(2) Direct payment.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

"(c) Waiver.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

"BENEFITS UNDER THE PROGRAM

"Sec. 1860E–6. (a) Access to Negotiated Prices.—

"(1) Negotiated prices.—

"(A) In general.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860E–8(b). For purposes of this subparagraph, the term 'prescription drugs' is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

"(B) Limitations.—

"(i) Formulary restrictions.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

"(ii) Avoidance of duplicate coverage.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

"(2) Discount card.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

"(3) Ensuring discounts in all areas.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

"(b) Catastrophic Benefit.—

"(1) Ten percent cost-sharing.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

"(2) Annual out-of-pocket limits.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

"(A) Beneficiaries with annual incomes below 200 percent of the poverty line.—In the case of an eligible beneficiary whose income (as determined under section 1860E–9) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

"(B) Beneficiaries with annual incomes between 200 and 400 percent of the poverty line.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to $3,500.

"(C) Beneficiaries with annual incomes between 400 and 600 percent of the poverty line.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to $5,500.

"(D) Beneficiaries with annual incomes that exceed 600 percent of the poverty line.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary's income for that year (rounded to the nearest multiple of $1).

"(3) Application.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

"(4) Annual percentage increase.—

"(A) In general.—In the case of any calendar year after 2005, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

"(i) such dollar amount; multiplied by

"(ii) the inflation adjustment determined under section 1860E–5(a)(2)(B) for such calendar year.

"(B) Rounding.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

"(5) Eligible entity not at financial risk for catastrophic benefit.—

"(A) In general.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

"(B) Provisions relating to payments to eligible entities.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860E–8.

"(6) Ensuring catastrophic benefit in all areas.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

"REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

"Sec. 1860E–7. (a) Establishment of Bidding Process.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

"(b) Submission of Bids.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

"(c) Administrative Fee Bid.—

"(1) Submission.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

"(2) Bid submission requirements.—

"(A) Administrative fee bid submission.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

"(i) Enrollment, including income eligibility determination.

"(ii) Claims processing.

"(iii) Quality assurance, including drug utilization review.

"(iv) Beneficiary and pharmacy customer service.

"(v) Coordination of benefits.

"(vi) Fraud and abuse prevention.

"(B) Negotiated administrative fee bid amounts.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

"(C) Payment to plans based on administrative fee bid amounts.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

"(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

"(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

"(d) Awarding of Contracts.—

"(1) In general.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

"(2) Terms and conditions.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

"(3) Requirements for eligible entities providing discount card program.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

"(A) Level of savings to medicare beneficiaries.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

"(B) Prohibition on application only to mail order.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

"(C) Level of beneficiary services.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

"(D) Adequacy of information.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

"(E) Extent of demonstrated experience.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

"(F) Extent of quality assurance.—The entity has in place adequate procedures for assuring quality service under the program.

"(G) Operation of assistance program.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

"(H) Privacy compliance.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(I) Additional beneficiary protections.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(4) Beneficiary access to savings and rebates.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

"(5) Negotiated agreements with employer-sponsored plans.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

"(e) Requirements for Other Eligible Entities.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

"PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

"Sec. 1860E–8. (a) In General.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

"(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860E–6(b); and

"(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860E–7.

"(b) Payment for Covered Drugs.—

"(1) In general.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860E–6(b).

"(2) Limitations.—

"(A) Formulary restrictions.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860E–4(a)(4)(B).

"(B) Negotiated prices.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860E–6(a) or the price negotiated for insurance coverage under the MedicareAdvantage program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

"(C) Cost-sharing limitations.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

"(3) Payment in competitive areas.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

"(c) Secondary Payer Provisions.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

"DETERMINATION OF INCOME LEVELS

"Sec. 1860E–9. (a) Determination of Income Levels.—

"(1) In general.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E–5(c) and 1860E–6(b).

"(2) Procedures.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

‘‘(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

‘‘(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E–5(c) and 1860E–6(b); and

‘‘(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

‘‘(c) QUALITY CONTROL SYSTEM.—

‘‘(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

‘‘(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

‘‘APPROPRIATIONS

‘‘SEC. 1860E–10. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E–5.

‘‘MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

‘‘SEC. 1860E–11. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the ‘Board’).

‘‘(b) ADVICE ON POLICIES; REPORTS.—

‘‘(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

‘‘(2) REPORTS.—

‘‘(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

‘‘(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

‘‘(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

‘‘(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

‘‘(A) PRESIDENTIAL APPOINTMENTS.—

‘‘(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

‘‘(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

‘‘(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

‘‘(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

‘‘(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

‘‘(3) COMPOSITION.—Of the members appointed under paragraph (1)—

‘‘(A) at least 1 shall represent the pharmaceutical industry;

‘‘(B) at least 1 shall represent physicians;

‘‘(C) at least 1 shall represent medicare beneficiaries;

‘‘(D) at least 1 shall represent practicing pharmacists; and

‘‘(E) at least 1 shall represent eligible entities.

‘‘(d) TERMS OF APPOINTMENT.—

‘‘(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

‘‘(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

‘‘(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

‘‘(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

‘‘(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

‘‘(I) 2 years;

‘‘(II) 4 years; and

‘‘(III) 6 years.

‘‘(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

‘‘(I) 3 years; and

‘‘(II) 6 years.

‘‘(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

‘‘(I) 4 years; and

‘‘(II) 5 years.

‘‘(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

‘‘(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

‘‘(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

‘‘(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

‘‘(g) MEETINGS.—

‘‘(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

‘‘(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

‘‘(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

‘‘(i) PERSONNEL.—

‘‘(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

‘‘(2) STAFF.—

‘‘(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

‘‘(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

‘‘(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

‘‘(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

‘‘(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.’’.

(b) CONFORMING REFERENCES TO PREVIOUS PART E.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part E of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part E of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860E of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part E of title XVIII of the Social Security Act (as added by section 101).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART E COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking "attributable to the application of section" and inserting "attributable to—

"(1) the application of section";

(2) by striking the period and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part E.".

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

"(1) PROMULGATION OF MODEL REGULATION.—

"(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

"(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

"(ii) a uniform format is used in the policy with respect to such revised benefits; and

"(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2006 NAIC Model Regulation').

"(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2006 Federal Regulation').

"(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

"(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part E of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

"(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part E.

"(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

"(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

"(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

"(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

"(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.".

SA 1013. Mr. BOND (for himself and Mr. ROBERTS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. . COMMITTEE ON DRUG COMPOUNDING.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an Committee on Drug Compounding (referred to in this section as the "Committee") within the Food and Drug Administration on drug compounding to ensure that patients are receiving necessary, safe and accurate dosages of compounded drugs.

(b) MEMBERSHIP.—The membership of the Advisory Committee shall be appointed by the Secretary of Health and Human Services and shall include representatives of—

(1) the National Association of Boards of Pharmacy;

(2) pharmacy groups;

(3) physician groups;

(4) consumer and patient advocate groups;

(5) the United States Pharmacopoeia; and

(6) other individuals determined appropriate by the Secretary.

(c) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Committee shall submit to the Secretary a report concerning the recommendations of the Committee to improve and protect patient safety.

(d) TERMINATION.—The Committee shall terminate on the date that is 1 year after the date of enactment of this Act.

SA 1014. Mr. BOND submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 483, line 7, strike "and" and insert ", pharmacy services, and".

SA 1015. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . STUDY ON MAKING PRESCRIPTION PHARMACEUTICAL INFORMATION ACCESSIBLE FOR BLIND AND VISUALLY-IMPAIRED INDIVIDUALS.

(a) Study.—

(1) In general.—The Secretary of Health and Human Services shall undertake a study of how to make prescription pharmaceutical information, including drug labels and usage instructions, accessible to blind and visually-impaired individuals.

(2) Study to include existing and emerging technologies.—The study under paragraph (1) shall include a review of existing and emerging technologies, including assistive technology, that makes essential information on the content and prescribed use of pharmaceutical medicines available in a usable format for blind and visually-impaired individuals.

(b) Report.—

(1) In general.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study required under subsection (a).

(2) Contents of report.—The report required under subsection (a) shall include recommendations for the implementation of usable formats for making prescription pharmaceutical information available to blind and visually-impaired individuals and an estimate of the costs associated with the implementation of each format.

SA 1016. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 654, after line 18 and before the amendment to the title, insert the following:

SEC. . INFORMATION TECHNOLOGY.

(a) Improving Clinical Practices.—

(1) Telemedicine.—

(A) Licensing.—Section 1834(m)(4)(C)(i) (42 U.S.C. 1395m(m)(4)(C)(i)) is amended—

(i) in subclause (II), by striking "or" at the end;

(ii) in subclause (III), by striking the period and inserting "; or"; and

(iii) by adding at the end the following:

"(IV) in a State in which the respective State medical board has adopted a formal policy regarding licensing or certification requirements for providers at distant sites who do not have a license to practice medicine at the originating site.".

(B) Expanding eligibility for reimbursement.—Section 1834(m)(4)(C)(i)(I) (42 U.S.C. 1395m(m)(4)(C)(i)(I)) is amended by striking "rural".

(2) NIH trials to study impact of technology on cost and quality of health care.—

(A) Findings.—Congress makes the following findings:

(i) An estimated 80,000 to 100,000 patients die every year from errors suffered during hospitalization.

(ii) Many of these errors could have been avoided with changes to the system of health care delivery.

(iii) These systemwide changes have the potential to decrease the cost of providing health care and to increase the quality of services provided.

(iv) These improvements in cost and quality can be as dramatic as improvements seen with new technology or pharmaceutical advances.

(v) Currently new medical devices and medications undergo rigorous randomized controlled clinical trials to document their effect on a patient's health.

(vi) These clinical trials form the basis for providers to practice evidence-based medicine and to change their practices to improve their patients' outcomes.

(vii) Similar controlled clinical studies of systems-based approaches to changing practice, if available, can help providers implement systems-based measures to improve outcomes.

(B) Research on systems-based approaches to changing clinical practice.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

"SEC. 409J. RESEARCH ON SYSTEMS-BASED APPROACHES TO CHANGING CLINICAL PRACTICE.

"(a) Establishment.—The Secretary shall establish within the Office of the Director of NIH a Medical Systems Safety Initiative (referred to in this section as the 'Initiative') to conduct and support research regarding systems-based approaches to improving and advancing medical care. The Initiative shall be headed by the Director of NIH (referred to in this section as the 'Director').

"(b) Purpose.—The purpose of the Initiative is to enable the Director of NIH—

"(1) to conduct and support basic and applied research (including both intramural and extramural research), research training, the dissemination of health information, and other programs with respect to systems research, user-centered design, and human factors engineering within the National Institutes of Health to realize the expanding opportunities for improving health outcomes through the analysis and redesign of medical systems;

"(2) to enhance collaborative efforts among the Institutes to conduct and support multidisciplinary research in the areas that the Director determines to be most promising; and

"(3) to encourage and support clinical studies to provide scientifically and statistically rigorous and meaningful information about the utility and effectiveness of various systems-based interventions.

"(c) Appropriate Scientific Expertise and Coordination With Institutes and Federal Agencies.—The Director of NIH, after consultation with the Division of Research Grants, shall ensure that scientists with appropriate expertise in research on health systems, user-centered design, and human factors engineering are incorporated into the review, oversight, and management processes of all research projects and other activities funded by the Initiative. In carrying out this subsection, the Director, as necessary, may establish review groups with appropriate scientific expertise. The Director shall coordinate efforts with other Institutes and Federal agencies to ensure appropriate scientific input and management.

"(d) Ensuring High Quality, Rigorous Scientific Review.—In order to ensure high quality, rigorous scientific review with respect to the Initiative, the Director of NIH shall conduct or support the following activities:

(1) Outcomes research and investigations.

(2) Epidemiological studies on the incidence and prevalence of various systems, practices, and processes within the health care system and their effect on health outcomes, both beneficial and harmful.

(3) Health services research.

(4) Basic science research.

(5) Clinical trials.

(6) Other appropriate research and investigational activities.".

(b) Improving and Promoting Electronic Medical Records.—

(1) Authentication standards.—The Director of the National Center for Vital and Health Statistics shall provide assistance to the Secretary of Health and Human Services in the development of authentication standards for health records. In developing such standards, the Secretary shall take into consideration the following:

(A) Recommendations for authentication technology and identification information standards that—

(i) provide for the reliable identification and retrieval of a patient's electronic medical data;

(ii) allow the patient to have detailed control over the access of individual components of his or her electronic medical record by being able to specify specific providers, each of whom will have access to limited portions of the electronic medical record;

(iii) minimize security risks, including the potential for—

(I) the patient to misrepresent his or her true identity;

(II) a health care provider to access data for which the patient has not consented to grant such access;

(III) a third party to access identification information; or

(IV) a third party to circumvent or exploit the authentication process in order to access electronic medical data without the consent of the patient;

(iv) allow for the timely and convenient creation of identification information at the time of contact between a patient and a provider, so as to minimize any disruption or delay in the provision of needed medical services to a patient who does not already have identification information; and

(v) maximize the probability of accurate identification, secure authentication, and rapid access to medical data even in situations where the patient—

(I) does not possess the identification information that is usually required for successful authentication, but wishes to grant consent to the provider to access necessary medical data;

(II) possesses the identification information but is not able to provide consent for the emergency access of medical data due to incapacitation; and

(III) is not able to provide identification information nor consent for emergency data access due to incapacitation.

(2) Personal health record.—

(A) Federal health information exchange standards initiative.—The Secretary of Health and Human Services, the Secretary of Defense, and the Secretary of Veterans' Affairs, in carrying out activities under the Federal e-Goverment Health Information Exchange Standards Initiative, shall jointly recommend standards for the implementation of personal health records that—

(i) includes the capability for patients to append to their electronic record information about—

(I) illnesses for which the patient did not seek professional medical care; and

(II) health information not related to a specific disease, episode, or illness; and

(ii) provides convenient access to the individual's full electronic medical record.

(B) Medical translation research.—

(i) In general.—The Director of the National Science Foundation shall award grants to public and nonprofit private entities for the conduct of basic research on innovative approaches to improve patients' understanding and comprehension of their electronic medical record. Research areas may include technology for the automated—

(I) translation of medical information to language more easily understandable by the patient;

(II) reorganization of the electronic medical record into a structure more useful to the patient; and

(III) integration of links to relevant information from other sources into the electronic medical record.

(ii) MERIT REVIEW; COMPETITION.—Grants shall be awarded under this subparagraph on a merit-reviewed competitive basis.

(iii) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the National Science Foundation to carry out this subparagraph—

(I) $5,000,000 for fiscal year 2004;

(II) $10,000,000 for fiscal year 2005; and

(III) $15,000,000 for fiscal year 2006 and each fiscal year thereafter.

(3) DEFINITIONS.—In this subsection:

(A) IDENTIFICATION INFORMATION.—The term "identification information" with respect to the medical records of a patient, means the data necessary to identify the patient.

(B) AUTHENTICATION.—The term "authentication" means the process of using the identification information to validate the patient's identification and gain access to his or her electronic medical data.

(c) IMPROVING INFORMATION TECHNOLOGY INFRASTRUCTURE IN THE BASIC LIFE SCIENCES.—Not later than 18 months after the date of enactment of this Act, the Director of the National Institute of General Medical Sciences shall submit to Congress a report on the activities of the Biomedical Information Science and Technology Initiative. Such report shall include—

(1) a description of current activities of the Biomedical Information Science and Technology Initiative Consortium;

(2) a summary of recently completed and ongoing grant programs; and

(3) recommendations for the further advancement of the Biomedical Information Science and Technology Initiative and bioinformatics and computational biology research in general.

(d) IMPROVING EDUCATION AND TRAINING.—Subpart 3 of part D of title IV of the Public Health Service Act (42 U.S.C. 286c et seq.) is amended by adding at the end the following:

"SEC. 478B. CERTIFICATION OF INFORMATION WEBSITES.

"(a) IN GENERAL.—The National Information Center on Health Services Research and Health Care Technology (in this section referred to as the 'Center') shall develop a voluntary certification program for health information websites on the Internet. As part of such program, websites shall be deemed to be certified if they meet criteria that includes the following:

"(1) The website provides references to peer-reviewed rigorous scientific research for any conclusions or recommendations that it advocates.

"(2) The website is easy to navigate and comprehend by a general audience that does not have any specific medical training.

"(3) The website accommodates, to the maximum extent practicable, cultural, language, and literacy variation among its target audience.

"(b) LIMITATION.—In determining whether a website meets criteria for certification under the program under subsection (a), the Center may not consider—

"(1) the specific nature of the conclusions or recommendations of the website themselves, so long as they meet criteria for evidence as specified in subsection (a)(1); and

"(2) the person or organization responsible for the website.

"(c) PERIOD RECERTIFICATION.—In establishing the program under subsection (a), the Center shall develop a policy for the periodic expiration and renewal of certifications so as to ensure that websites are reviewed on a periodic basis for compliance with the criteria of certification.

"(d) SEAL.—The Center shall develop a seal or marker that can be used by a website that is certified under the program under subsection (a) to indicate to its audience that the website has obtained the Center's certification.

"(e) FEE.—The Center may assess an application fee for websites in order to cover the costs of evaluating the website.".

SA 1017. Mr. ALLARD (for himself, Mr. FITZGERALD, and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c)

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SA 1018. Mr. LIEBERMAN (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. COLON CANCER SCREENING.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) colorectal cancer screening tests (as defined in section 1861(pp) of the Social Security Act (42 U.S.C. 1395x(pp)) covered under the medicare program have been severely underutilized, with the Comptroller General of the United States reporting in 2000 that since coverage of such tests was implemented, the percentage of beneficiaries under the medicare program receiving either a screening or a diagnostic colonoscopy has increased by only 1 percent;

(2) the Centers for Medicare & Medicaid Services should encourage health care providers to use more effective screening and diagnostic health care technologies in the area of colorectal cancer screening;

(3) in recent years, the Centers for Medicare & Medicaid Services has subjected colorectal cancer screening tests to some of the largest reimbursement reductions under the medicare program;

(4) unlike other preventive screening tests covered under the medicare program, health care providers must consult with beneficiaries prior to furnishing a screening colonoscopy in order to—

(A) ascertain the medical and family history of the beneficiary; and

(B) inform the beneficiary of preparatory steps that must be taken prior to the procedure; and

(5) reimbursement under the medicare program is not currently available for the consultations described in paragraph (4) despite the fact that reimbursement is provided under such program for similar consultations prior to a diagnostic colonoscopy.

(b) INCREASE IN REIMBURSEMENT FOR COLORECTAL CANCER SCREENING AND DIAGNOSTIC TESTS.—

(1) IN GENERAL.—Section 1834(d) (42 U.S.C. 1395m(d)) is amended by adding at the end the following new paragraph:

"(4) ENHANCED PAYMENT FOR COLORECTAL CANCER SCREENING AND DIAGNOSTIC TESTS.—

"(A) FACILITY RATES.—Notwithstanding paragraphs (2)(A) and (3)(A), the Secretary shall establish national minimum payment amounts for CPT codes 45378, 45380, 45385 and HCPCS codes GO105 and GO121 for items and services furnished during the last 6 months of 2003 and in subsequent years which reflect a 30 percent increase above the relative value units in effect as the facility rates for such codes on June 30, 2003, with such revised payment level to apply to items and services performed in a facility setting.

"(B) ANNUAL ADJUSTMENTS.—In the case of items and services furnished on or after January 1, 2004, the payment rates described in subparagraph (A) shall, subject to the minimum payment amounts established in such subparagraph, be adjusted annually as provided in section 1848.".

(2) Effect on part A payments.—The Secretary shall not consider the national minimum payment described in section 1834(d)(4)(A) (42 U.S.C. 1395m(d)(4)(A)), as added by paragraph (1), when determining the hospital outpatient prospective payment system payment amounts under the relevant APC codes for colorectal cancer screening and diagnostic tests.

(3) Effective date.—The amendment made by this subsection shall apply to items and services furnished on or after July 1, 2003.

(c) Medicare Coverage of Office Visit or Consultation Prior to a Screening Colonoscopy or in Conjunction With a Beneficiary's Decision To Obtain Such a Screening.—

(1) Coverage.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by inserting "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(W) an outpatient office visit or consultation for the purpose of beneficiary education, assuring selection of the proper screening test, and securing information relating to the procedure and sedation of the beneficiary, prior to a colorectal cancer screening test consisting of a screening colonoscopy or in conjunction with the beneficiary's decision to obtain such a screening, regardless of whether such screening is medically indicated with respect to the beneficiary;".

(2) Payment.—

(A) In general.—Section 1833(a)(1) (42 U.S.C. 1395*l*(a)(1)) is amended—

(i) by striking "and" before "(U)"; and

(ii) by inserting before the semicolon at the end the following: ", and (V) with respect to an outpatient office visit or consultation under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount established under section 1848, except that no payment shall be made for such a visit or consultation if no payment would be made for a colorectal cancer screening test consisting of a screening colonoscopy for the individual furnished on the date of such visit or consultation because of the frequency limits described in section 1834(d)(3)(E)".

(B) Payment under physician fee schedule.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting "(2)(W)," after "(2)(S),".

(C) Requirement for establishment of payment amount under physician fee schedule.—Section 1834(d) (42 U.S.C. 1395m(d)), as amended by subsection (b), is amended by adding at the end the following new paragraph:

"(5) Payment for outpatient office visit or consultation prior to screening colonoscopy.—With respect to an outpatient office visit or consultation under section 1861(s)(2)(W), payment under section 1848 shall be consistent with the payment amounts for CPT codes 99203 and 99243.".

(D) Frequency limitation.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (H), by striking "and" at the end;

(ii) in subparagraph (I), by striking the semicolon at the end and inserting ", and"; and

(iii) by inserting after subparagraph (I) the following new subparagraph:

"(J) in the case of an outpatient office visit or consultation under section 1861(s)(2)(W), which is performed more frequently that is covered under section 1833(a)(1)(V);".

(3) Effective date.—The amendments made by this subsection shall apply to items and services provided on or after July 1, 2003.

(d) Waiver of Deductible for Colorectal Cancer Screening Tests.—

(1) In general.—The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended—

(A) by striking "and" before "(6)"; and

(B) by inserting before the period at the end the following: ", and (7) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))".

(2) Conforming amendments.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are each amended—

(A) by striking "deductible and" in the heading; and

(B) in subclause (I), by striking "deductible or" each place it appears.

(3) Effective date.—The amendment made by this subsection shall apply to items and services furnished on or after July 1, 2003.

SA 1019. Mr. CONRAD (for himself, Mrs. Murray, Mr. Smith, Mrs. Lincoln, and Mr. Jeffords) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes;

At the end of subtitle B of title IV, insert the following:

SEC. . MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) Coverage.—

(1) In general.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by inserting "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

"(ii) a self-injected drug that is used to treat multiple sclerosis;".

(2) Conforming amendment.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting ", except for any drug or biological described in subparagraph (W)," after "which".

(b) Effective Date.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority To Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)"; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against

any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such". before "paragraphs".

SA 1020. Mr. CONRAD proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Strike section 401 and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) In General.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking "(iv) For discharges" and inserting "(iv)(I) Subject to subclause (II), for discharges"; and

(2) by adding at the end the following new subclause:

"(II) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.".

(b) Conforming Amendments.—

(1) Computing DRG-specific rates.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "IN DIFFERENT AREAS";

(B) in the matter preceding clause (i), by striking ", each of";

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking "and" after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking the period at the end and inserting "; and"; and

(E) by adding at the end the following new clause:

"(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

"(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.".

(2) Technical conforming sunset.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting ", for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting ", for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region,".

At the end of title VI, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority To Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)"; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1021. Mr. CONRAD proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . GEOGRAPHIC RECLASSIFICATION OF CERTAIN HOSPITALS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) In General.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2004 and each subsequent fiscal year, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospitals located in the Bismarck, North Dakota Metropolitan Statistical Area are deemed to be located in the Fargo-Moorhead North Dakota-Minnesota Metropolitan Statistical Area.

(b) Treatment as Decision of Medicare Geographic Classification Review Board.—

(1) In general.—Except as provided in paragraph (2), for purposes of section 1886(d) of the Social Security Act (42 U.S.C 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(2) Nonapplication of 3-year application provision.—Section 1886(d)(10)(D)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(v)), as it relates to a reclassification being effective for 3 fiscal years, shall not apply with respect to reclassifications made under this section.

(c) Process for Applications To Ensure That Provisions Apply Beginning October 1, 2003.—The Secretary shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) Adjustments To Ensure Budget Neutrality.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or less than those that would otherwise be made if this section had not been enacted.

SA 1022. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

SEC. . This Act may be cited as the "Quality Cancer Care Preservation Act".

SEC. . MEDICARE PAYMENT FOR DRUGS AND BIOLOGICALS.

(a) In General.—Section 1842(o)(1) of the Social Security Act (42 U.S.C. 1395u(o)(1)) is amended by striking "95 percent of the average wholesale price" and inserting "the payment amount specified in section 1834(n)(2)".

(b) Determination of Payment Amount.—Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(n) Payment for Drugs and Biologicals—

"(1) Reports by manufacturers—

"(A) In general.—Every drug manufacturer shall report to the Secretary, in the manner prescribed in this paragraph, its average sales price (as defined in subparagraph (B)) in the United States during each calendar quarter for drugs and biologicals covered under this part.

"(B) Definitions.—For purposes of this subsection—

"(i) the term "manufacturer" means, with respect to a drug or biological, the entity identified by the Labeler Code portion of the National Drug Code of such drug or biological; and

"(ii) the term "average sales price" means the weighted average of all final sales prices to all purchasers, excluding sales specified in subparagraph (C). In determining such average sales prices, such prices shall be net of volume discounts, chargebacks, short-dated product discounts, free goods contingent on purchases, rebates (other than those made or authorized under section 1927), and all other price concessions that result in a reduction of the ultimate cost to the purchaser.

"(C) Consideration in calculation of average sales prices.—The calculation of average sales price under this subsection shall not include-

"(i) prices that are excluded from the calculation of "best price" under section 1927(c)(1)(C);

"(ii) prices offered to entities that are considered under subparagraph (B)(i) to be the manufacturers of the drugs or biologicals involved;

"(iii) prices offered by a manufacturer to a hospital, nursing facility, hospice, or health maintenance organization;

"(iv) prices to governmental entities; and

"(v) nominal prices offered to bona fide charitable organizations.

"(D) Quarterly reports.—Each manufacturer shall submit the report required by subparagraph (A) to the Secretary by electronic means no later than 30 days after the end of a calendar quarter with respect to sales that occurred during such quarter. The Secretary shall prescribe the format and other requirements for the report.

"(E) Enforcement.—

"(i) Failure to timely report.—The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a manufacturer that fails to provide the information required under this paragraph on a timely basis and in the manner required.

"(ii) False information.—For each item of false information, the Secretary may impose a civil money penalty in an amount not to exceed $100,000 on a manufacturer that knowingly provides false information under this paragraph.

"(iii) Manner of imposition of civil monetary penalties.—The provisions in section 1128A (other than subsections (a) and (b)) shall apply to a civil monetary penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(F) Confidentiality of information.—Notwithstanding any other provision of law, information disclosed by manufacturers under this paragraph is confidential and shall not be disclosed by the Secretary in any form other than as specifically authorized by this subsection.

"(2) Calculation of payment amount—

"(A) In general.—Except as otherwise provided in this paragraph, the payment amount for a drug or biological furnished during a calendar quarter shall be 120 percent of the average sales price of the drug or biological for the second preceding calendar quarter as determined under paragraph (1).

"(B) Methodology.—In determining payment amounts under subparagraph (A), the Secretary may, in the Secretary's discretion, use either the average sales price for each drug or biological by specific drug or biological, or a cumulative average sales price based on sales data for all versions of a multiple-source drug that the Secretary, acting through the Food and Drug Administration, has determined are therapeutically equivalent (as evidenced by "A" ratings in the publication Approved Drug Products with Therapeutic Equivalence Evaluations).

"(C) Increase to reflect additional costs attributable to state and local taxes.—In the case of a drug or biological that was subject to a State or local sales tax or gross receipts tax when administered or dispensed, the payment amount determined under subparagraph (A) shall be increased by the amount of such tax paid with respect to such drug or biological.

"(D) Substitution of higher payment amount.—If a physician's, supplier's, or any other person's claim for payment for services under this Act documents that the price paid for a drug or biological was greater than the payment amount determined under subparagraph (A), the actual amount paid shall be substituted for the payment amount determined under subparagraph (A), unless the Secretary determines that the actual amount paid was unreasonable under the circumstances.

"(E) Increase for Bad Debt and Certain Other Costs.—Upon the submission of supporting information, the Secretary shall make an additional payment to a physician or supplier to cover—

"(i) uncollectible deductibles and coinsurance due from Medicare beneficiaries with respect to drugs and biologicals furnished to such beneficiaries; and

"(ii) costs incurred in procuring and billing for drugs and biologicals furnished to Medicare beneficiaries.".

SEC. . MEDICARE PAYMENT FOR DRUG ADMINISTRATION SERVICES.

(a) General.—The Secretary of Health and Human Services (hereafter in this Act referred to as "the Secretary") shall revise the practice expense relative value units for drug administration services for years beginning with the year 2005 in accordance with this section. For purposes of this section, "drug administration services" includes chemotherapy administration services, therapeutic and diagnostic infusions and injections, and such other services as the Secretary specifies.

(b) Direct Costs Equal to 100 Percent of Cpep Estimates.— Using the information, including estimates of clinical staff time, developed in the clinical practice expert panel process, including refinements by American Medical Association committees, the Secretary shall estimate the costs of the nursing and other clinical staff, supplies, and procedure-specific equipment (exceeding a cost specified by the Secretary) used in furnishing each type of drug administration service. The Secretary shall utilize without revision the minutes of clinical staff time determined in such process. The Secretary shall convert the information from such process to estimated costs by applying the most current available data on staff salary, supply, and equipment costs, and such costs shall be updated to 2005 based on estimated changes in prices since the date of such data.

(c) Total Practice Expenses.—The Secretary shall estimate the total practice expenses of each drug administration service by assuming that the direct costs for the service determined under subsection (b) are 33.2 percent of such total practice expenses.

(d) Conversion to Relative Value Units.—The Secretary shall convert the total practice expenses determined under subsection (c) to practice expense relative value units for each drug administration service by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(e) Updates.—For years after 2005, the relative values determined under subsection (d) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this section.

(f) Multiple Pushes.—In establishing the payment amounts under this section, the Secretary shall establish the payment amount for intravenous chemotherapy administration by push technique based of the administration of a single drug. The Secretary shall make the same payment for each additional drug administered by push technique during the same encounter, except to the extent that the Secretary finds that the cost of administering additional drugs is less than the cost of administering the first drug.

SEC. . PAYMENTS FOR CHEMOTHERAPY SUPPORT SERVICES.

(a) General.—Beginning in the year 2005, the Secretary shall recognize and make payments under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for chemotherapy support services furnished incident to physicians' services. For the purposes of this section, "chemotherapy support services" are services furnished by the staff of physicians to patients undergoing treatment for cancer that were not included in the computation of clinical staff costs under section 3(b). Such services include social worker services, nutrition counseling, psychosocial services, and similar services.

(b) DIRECT COSTS.—The Secretary shall estimate the cost of the salary and benefits of staff furnishing chemotherapy support services as they are provided in oncology practices that furnish these services to cancer patients in a manner that is considered to be high quality care. The estimate shall be based on the weekly cost of such services per patient receiving chemotherapy.

(c) TOTAL COSTS.—The Secretary shall estimate the total practice expenses of chemotherapy support services by assuming that the direct costs for the service determined under subsection (b) are 33.2 percent of such total practice expenses.

(d) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under subsection (c) to practice expense relative value units for chemotherapy support services by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for chemotherapy support services under such section 1848.

(e) UPDATES.—For the years after 2005, the relative values determined under subsection (d) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this section.

SEC. . CANCER THERAPY MANAGEMENT SERVICES.

The Secretary shall recognize and establish a payment amount for the service of cancer therapy management to account for the greater pre-service and post-service work associated with visits and consultations conducted by physicians treating cancer patients compared to typical visits and consultations. The payment amount may vary by the level and type of the related visit or consultation.

SEC. . OTHER SERVICES WITHOUT PHYSICIAN WORK RELATIVE VALUE UNITS.

The Secretary shall develop a revised methodology for determining the payment amounts for services that are paid under the fee schedule established by section 1848 of the Social Security Act (42 U.S.C. 1395w-4) and that do not have physician work relative value units, including radiation oncology services. Such methodology shall result in payment amounts that fully cover the costs of furnishing such sefvices. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of any one specialty's services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

SEC. . PHYSICIAN SUPERVISION OF SERVICES.

Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 2, is further amended by adding at the end the following new subsection:

"(o) SUPERVISION REQUIREMENTS—If the Secretary requires direct supervision of a service by a physician, that supervision requirement may be fulfilled by one or more physicians other than the physician who ordered the service. If the supervising physician is different from the ordering physician for a particular service, the ordering physician may nevertheless bill for such service provided that the medical records for the service involved identify the supervising physician or physicians.".

SEC. . REPORT TO CONGRESS.

No later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that are projected to be adopted under sections 2, 3, 4, and 5 of this Act.

SEC. . INSTITUTE OF MEDICINE STUDY.

(a) GENERAL.—The Secretary of Health and Human Services shall request the Institute of Medicine to conduct the study described in this section.

(b) BASELINE STUDY.—The first phase of the study shall include the following objectives:

(1) An assessment of the extent to which the current Medicare payment system, prior to implementation of the amendments made by this Act, facilitates appropriate access to care by cancer patients in the various treatment settings.

(2) The identification of the comprehensive range of services furnished to cancer patients in the outpatient setting, including support services such as psychosocial services and counseling, and recommendations regarding the types of services that ought to be furnished to Medicare patients with cancer.

(3) A discussion of the practice standards necessary to assure the safe provision of services to cancer patients.

(4) An analysis of the extent to which the current Medicare payment system supports the role of nurses in the provision of oncology services and recommendations for any necessary improvements in the payment system in that respect.

(5) The development of a framework for assessing how the amendments made by this act affect the provision of care to Medicare patients with cancer in the various treatment settings.

(c) SECOND PHASE OF STUDY.—After the implementation of the amendments made by this Act, the study shall determine whether and how those amendments affected the provision of care to Medicare patients with cancer.

(d) CONSULTATION.—The Institute of Medicine shall consult with the National Cancer Policy Board and organizations representing cancer patients and survivors, oncologists, oncology nurses, social workers, cancer centers, and other healthcare professionals who treat cancer patients in planning and carrying out this study.

(e) DUE DATES—

(1) The study required by subsection (b) shall be submitted to the Congress and the Secretary of Health and Human Services no later than June 30, 2004.

(2) The study required by subsection (c) shall be submitted to the Congress and the Secretary of Health and Human Services no later than December 31, 2006.

SEC. 10. EFFECTIVE DATES.

(a) GENERAL.—Except as provided in this section, the provisions of this Act shall apply to drugs, biologicals, and services furnished on or after January 1, 2005.

(b) REPORTS FROM MANUFACTURERS.—The first report by manufacturers required by the provisions of section 2 shall be submitted no later than October 30, 2004, with respect to sales that occurred in the quarter ending September 30, 2004.

(c) SUPERVISION OF SERVICES.—The amendment made by section 7 shall be effective upon enactment.

(d) SERVICES OTHER THAN DRUG ADMINISTRATION.—The Secretary shall implement the requirements of section 6 no later than January 1, 2005.

SA 1023. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in subtitle B of title IV, insert the following:

SEC. . DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration

project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) Construction.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) Authorization of Appropriations.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) Definitions.—In this section:

(1) Medicare beneficiary.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) Home health services.—The term "home health services" has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) Activities of daily living defined.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

(4) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

SA 1024. Mr. ENSIGN (for himself and Mrs. Lincoln) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. . OUTPATIENT THERAPY CAP REPEAL.

(a) In General.—Section 1833 of the Social Security Act (42 U.S.C. 1395*l*) is amended by striking subsection (g).

(b) Effective Date.—The amendment made by subsection (a) shall take effect on January 1, 2005.

SA 1025. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . COST-BENEFIT EVALUATION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION II DEMONSTRATION PROJECT AND EXTENSION OF PROJECT AUTHORITY.

(a) Extension.—Notwithstanding any other provision of law, the Social Health Maintenance Organization II demonstration project described under section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended, shall be conducted for an additional period of 5 years beginning October 1, 2004 under applicable contractual provisions existing on December 31, 2002. Such demonstration project shall be evaluated by an independent organization in accordance with subsection (b). The report on the evaluation and related recommendations shall be provided as described in subsection (c).

(b) Evaluation.—

(1) Research design.—The Secretary shall provide for a project research design that includes information on the Medicare beneficiaries who are participating in the project and on other Medicare beneficiaries who are covered under fee-for-service and other Medicare+Choice plans and that allows for an appropriate statistical analysis and evaluation of the demonstration project by an independent organization.

(2) Data collection.—The Secretary shall require the Social Health Maintenance Organization II to comply with such data collection and reporting requirements as the Secretary determines necessary in order that the assessments can be made as described under subsection (c)(2); and

(3) Duration.—The project evaluation period shall last for a period of 3 years.

(c) Report.—

(1) In general.—The Secretary shall issue to the Congress a final report on the project not later than 9 months after the date of the completion of the evaluation period.

(2) Contents of report.—The report under paragraph (1) shall include the following:

(A) A description of the demonstration project and the distinguishing characteristics of the Social Health Maintenance Organization II project, including the project's geriatric approach to patient care, extensive care coordination and patient assessments, provision of extended benefits to beneficiaries with targeted health risks, and risk adjusted payment methodology.

(B) An evaluation of—

(i) the cost-effectiveness of the project compared to the comparison group with respect to the extent of any delay or reduction in the incidence or length of stay in nursing homes or similar institutions and the estimated Medicare and Medicaid cost savings relating to such delay or reductions,

(ii) the extent to which the utilization of physician, home health, coordinated care, geriatric, prescription drug, extended care benefits and other services which are unique to the project result in any reduction in the incidence or length of inpatient stays and in the improvement or lessening in the deterioration of the physical status and mental health functioning of beneficiaries, and

(iii) the feasibility of replicating the elements of the Social Health Maintenance Organization II model under other Medicare+Choice plans.

To the extent feasible, an evaluation of the elements described in this subparagraph shall be conducted on a longitudinal basis for noninstitutionalized beneficiaries who are at high risk of hospitalization or institutionalization, for other noninstitutionalized beneficiaries who are not at high risk, and for institutionalized beneficiaries. To the extent feasible such evaluations shall be conducted for appropriate age and gender beneficiary categories.

(C) A description of the data and criteria and methodology used in conducting the evaluation.

(D) Any other information regarding the project that the Secretary determines to be appropriate and any recommendations the Secretary may make regarding the extent to which changes should be made in connection with the project or the extension of the project as a model under the Medicare+Choice program.

(d) Definitions.—In this section:

(1) Demonstration project.—The term "demonstration project" means the demonstration project described under subsection (a).

(2) Medicare beneficiary.—The term "Medicare beneficiary" means an individual entitled to benefits under part A and covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) Medicare.—The term "Medicare" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) Medicare+choice.—The term "Medicare+Choice" means the Medicare+Choice health benefits program described under part C of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and for years after 2005, the MedicareAdvantage program described under such part.

(5) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

(6) Social health maintenance organization II.—The term "Social Health Maintenance Organization II" means the project described under section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended.

(e) Effective Date.—The effective date of this section is the date of the enactment of this Act.

SA 1026. Mr. HAGEL (for himself, Mr. Ensign, Mr. Lott, and Mr. Inhofe) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

(Purpose: To provide Medicare beneficiaries with a drug discount card that ensures access to privately-negotiated discounts on drugs and protection against high and out-of-pocket drug costs)

Strike title I and insert the following:

TITLE I—MEDICARE PRESCRIPTION DRUG DISCOUNT

SEC. 101. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) Establishment of Program.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

"Part D—Voluntary Medicare Prescription Drug Discount and Security Program

"DEFINITIONS

"Sec. 1860. In this part:

"(1) Covered drug.—

"(A) In general.—Except as provided in this paragraph, the term 'covered drug' means—

“(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

“(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

“(B) Exclusions.—

“(i) In general.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

“(ii) Avoidance of duplicate coverage.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

“(C) Application of formulary restrictions.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D(a)(4)(B).

“(D) Application of general exclusion provisions.—A prescription drug discount card plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered drug—

“(i) for which payment would not be made if section 1862(a) applied to part D; or

“(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D(a)(4).

“(2) Eligible beneficiary.—The term ‘eligible beneficiary’ means an individual who is—

“(A) eligible for benefits under part A or enrolled under part B; and

“(B) not eligible for prescription drug coverage under a State plan under the Medicaid program under title XIX.

“(3) Eligible entity.—The term ‘eligible entity’ means any—

“(A) pharmaceutical benefit management company;

“(B) wholesale pharmacy delivery system;

“(C) retail pharmacy delivery system;

“(D) insurer (including any issuer of a Medicare supplemental policy under section 1882);

“(E) Medicare+Choice organization;

“(F) State (in conjunction with a pharmaceutical benefit management company);

“(G) employer-sponsored plan;

“(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

“(I) combination of the entities described in subparagraphs (A) through (H).

“(4) Poverty line.—The term ‘poverty line’ means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

“(5) Secretary.—The term ‘Secretary’ means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

“ESTABLISHMENT OF PROGRAM

“Sec. 1860A. (a) Provision of Benefit.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

“(b) Endorsement of Prescription Drug Discount Card Plans.—

“(1) In general.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

“(2) National plans.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

“(c) Voluntary Nature of Program.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

“(d) Financing.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

“ENROLLMENT

“Sec. 1860B. (a) Enrollment Under Part D.—

“(1) Establishment of process.—

“(A) In general.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

“(B) Requirement of enrollment.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

“(2) Enrollment periods.—

“(A) In general.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary’s initial enrollment period under part B (as determined under section 1837).

“(B) Special enrollment period.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the Medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

“(C) Open enrollment period in 2005 for current beneficiaries.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

“(i) enroll under this part; or

“(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

“(3) Period of coverage.—

“(A) In general.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary’s coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

“(B) Enrollment during open and special enrollment.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

“(4) Part D coverage terminated by termination of coverage under parts A and B or eligibility for medical assistance.—

“(A) In general.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual’s coverage under this part if the individual is—

“(i) no longer enrolled in part A or B; or

“(ii) eligible for prescription drug coverage under a State plan under the Medicaid program under title XIX.

“(B) Effective date.—The termination described in subparagraph (A) shall be effective on the effective date of—

“(i) the termination of coverage under part A or (if later) under part B; or

“(ii) the coverage under title XIX.

“(b) Enrollment With Eligible Entity.—

“(1) Process.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

“(2) Election periods.—

“(A) In general.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

“(i) annual coordinated election periods; and

“(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

“(B) Initial election periods.—

“(i) Individuals currently covered.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

“(ii) Individual covered in future.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

“(C) Additional special election periods.—The Administrator shall establish special election periods—

“(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

“(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

“(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

“(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

“(3) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

“(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

“(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICARE+CHOICE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a Medicare+Choice plan..

“(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a Medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly Medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

“(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a Medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(F) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

“(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

“PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

“SEC. 1860C. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract .under this part.

“(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860B(c).

“ENROLLEE PROTECTIONS

“SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

“(1) GUARANTEED ISSUANCE AND NONDISCRIMINATION.—

“(A) GUARANTEED ISSUANCE.—

“(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

“(ii) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

“(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

“(2) DISCLOSURE OF INFORMATION.—

“(A) INFORMATION.—

“(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

“(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

“(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

“(II) How any formulary used by the eligible entity functions.

“(III) Information on grievance and appeals procedures.

“(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

“(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

“(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

“(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

“(3) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

“(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

“(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

“(4) APPEALS.—

“(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

“(5) Confidentiality and accuracy of enrollee records.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

“(b) Eligible Entities Offering a Discount Card Program.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

“(1) Access to covered benefits.—

“(A) Assuring pharmacy access.—

“(i) In general.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(a)(3) that ensure such convenient access.

“(ii) Use of point-of-service system.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

“(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

“(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860F(b).

“(B) Use of standardized technology.—

“(i) In general.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860F(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

“(ii) Standards.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

“(C) Requirements on development and application of formularies.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

“(i) Pharmacy and therapeutic (P&T) committee.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

“(ii) Formulary development.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

“(iii) Inclusion of drugs in all therapeutic categories.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

“(iv) Provider education.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

“(v) Notice before removing drugs from formulary.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

“(vi) Grievances and appeals relating to application of formularies.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860D(a).

“(2) Cost and utilization management; quality assurance; medication therapy management program.—

“(A) In general.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

“(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

“(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

“(iii) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

“(B) Medication therapy management program.—

“(i) In general.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

“(ii) Elements.—Such program may include—

“(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

“(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

“(III) detection of patterns of overuse and underuse of prescription drugs.

“(iii) Development of program in cooperation with licensed pharmacists.—The program shall be developed in cooperation with licensed pharmacists and physicians.

“(iv) Considerations in pharmacy fees.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

“(C) Treatment of accreditation.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

“(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

“(ii) Subsection (c)(1) (relating to access to covered benefits).

“(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

“(D) Public disclosure of pharmaceutical prices for equivalent drugs.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug covered under the plan that is therapeutically equivalent and bioequivalent.

“ANNUAL ENROLLMENT FEE

“Sec. 1860E. (a) Amount.—

“(1) In general.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

“(2) Annual percentage increase.—

“(A) In general.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

“(i) such dollar amount; multiplied by

“(ii) the inflation adjustment.

“(B) Inflation adjustment.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

“(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

“(ii) such aggregate expenditures for the 12-month period ending with July 2005.

“(C) Rounding.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

“(b) Collection of Annual Enrollment Fee.—

“(1) In general.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

“(2) Direct payment.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

“(c) Waiver.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

"BENEFITS UNDER THE PROGRAM

"Sec. 1860F. (a) Access to Negotiated Prices.—

"(1) Negotiated prices.—

"(A) In general.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term 'prescription drugs' is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

"(B) Limitations.—

"(i) Formulary restrictions.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

"(ii) Avoidance of duplicate coverage.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

"(2) Discount card.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

"(3) Ensuring discounts in all areas.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

"(b) Catastrophic Benefit.—

"(1) Ten percent cost-sharing.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

"(2) Annual out-of-pocket limits.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

"(A) Beneficiaries with annual incomes below 200 percent of the poverty line.—In the case of an eligible beneficiary whose income (as determined under section 1860I) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

"(B) Beneficiaries with annual incomes between 200 and 400 percent of the poverty line.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to $3,500.

"(C) Beneficiaries with annual incomes between 400 and 600 percent of the poverty line.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to $5,500.

"(D) Beneficiaries with annual incomes that exceed 600 percent of the poverty line.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary's income for that year (rounded to the nearest multiple of $1).

"(3) Application.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

"(4) Annual percentage increase.—

"(A) In general.—In the case of any calendar year after 2006, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

"(i) such dollar amount; multiplied by

"(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

"(B) Rounding.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

"(5) Eligible entity not at financial risk for catastrophic benefit.—

"(A) In general.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

"(B) Provisions relating to payments to eligible entities.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

"(6) Ensuring catastrophic benefit in all areas.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

"REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

"Sec. 1860G. (a) Establishment of Bidding Process.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

"(b) Submission of Bids.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

"(c) Administrative Fee Bid.—

"(1) Submission.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

"(2) Bid submission requirements.—

"(A) Administrative fee bid submission.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

"(i) Enrollment, including income eligibility determination.

"(ii) Claims processing.

"(iii) Quality assurance, including drug utilization review.

"(iv) Beneficiary and pharmacy customer service.

"(v) Coordination of benefits.

"(vi) Fraud and abuse prevention.

"(B) Negotiated administrative fee bid amounts.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

"(C) Payment to plans based on administrative fee bid amounts.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

"(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

"(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

"(d) Awarding of Contracts.—

"(1) In general.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

"(2) Terms and conditions.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

"(3) Requirements for eligible entities providing discount card program.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

"(A) Level of savings to medicare beneficiaries.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

"(B) Prohibition on application only to mail order.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

"(C) Level of beneficiary services.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

"(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

"(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

"(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

"(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

"(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

"(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

"(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

"PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

"SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

"(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860F(b); and

"(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

"(b) PAYMENT FOR COVERED DRUGS.—

"(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860F(b).

"(2) LIMITATIONS.—

"(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(B).

"(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a) or the price negotiated for insurance coverage under the Medicare+Choice program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

"(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

"(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

"(c) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

"DETERMINATION OF INCOME LEVELS

"SEC. 1860I. (a) DETERMINATION OF INCOME LEVELS.—

"(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E(c) and 1860F(b).

"(2) PROCEDURES.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

"(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

"(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E(c) and 1860F(b); and

"(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

"(c) QUALITY CONTROL SYSTEM.—

"(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

"(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

"APPROPRIATIONS

"SEC. 1860J. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E.

"MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

"SEC. 1860K. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the 'Board').

"(b) ADVICE ON POLICIES; REPORTS.—

"(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

"(2) REPORTS.—

"(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

"(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

"(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

"(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

"(A) PRESIDENTIAL APPOINTMENTS.—

"(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

"(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

"(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

"(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

"(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

"(3) COMPOSITION.—Of the members appointed under paragraph (1)—

"(A) at least 1 shall represent the pharmaceutical industry;

"(B) at least 1 shall represent physicians;

"(C) at least 1 shall represent medicare beneficiaries;

"(D) at least 1 shall represent practicing pharmacists; and

"(E) at least 1 shall represent eligible entities.

"(d) TERMS OF APPOINTMENT.—

"(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

"(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

"(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

"(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

"(I) 2 years;

"(II) 4 years; and

"(III) 6 years.

"(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

"(I) 3 years; and

"(II) 6 years.

"(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

"(I) 4 years; and

"(II) 5 years.

"(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

"(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

"(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

"(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

"(g) MEETINGS.—

"(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

"(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

"(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

"(i) PERSONNEL.—

"(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

"(2) STAFF.—

"(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

"(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

"(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.".

(b) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 101).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking "attributable to the application of section" and inserting "attributable to—

"(1) the application of section";

(2) by striking the period and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part D.".

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

"(1) PROMULGATION OF MODEL REGULATION.—

"(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

"(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

"(ii) a uniform format is used in the policy with respect to such revised benefits; and "(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2006 NAIC Model Regulation').

"(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2006 Federal Regulation').

"(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

"(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

"(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

"(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

"(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

"(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

"(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

"(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.".

SA 1027. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING IMPLEMENTATION OF THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003.

(a) IN GENERAL.—It is the sense of the Senate that the Committee on Finance of the Senate should hold not less than 4 hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003 (hereinafter in this section referred to as the "Act") during which the Secretary or his designee should testify before the Committee.

(b) INITIAL HEARING.—It is the sense of the Senate that the first hearing described in subsection (a) should be held not later than 60 days after the date of the enactment the Act. At the hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) The progress toward implementation of the prescription drug discount card under section 111 of the Act.

(2) Development of the blueprint that will direct the implementation of the provisions of the Act, including the implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(3) Any problems that will impede the timely implementation of the Act.

(4) The overall progress toward implementation of the Act.

(c) SUBSEQUENT HEARINGS.—It is the sense of the Senate that the additional hearings described in subsection (a) should be held in each of May 2004, October 2004, and May 2005. At each hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) Progress on implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(2) Any problems that will impede timely implementation of the Act.

SA 1028. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title II, add the following:

SEC. ___. ESTABLISHMENT OF MEDICAREADVANTAGE CONSUMER-DRIVEN HEALTH PLAN OPTION.

(a) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w-21 et seq.), amended by section 205, is amended by inserting after section 1858A the following new section:

"CONSUMER-DRIVEN HEALTH PLAN OPTION

"SEC. 1858B. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—Beginning on January 1, 2006, there is established a consumer-driven health plan program under which consumer-driven health plans offered by consumer-driven health plan sponsors are offered to MedicareAdvantage eligible individuals in preferred provider regions.

"(2) DEFINITIONS.—

"(A) CONSUMER-DRIVEN HEALTH PLAN SPONSOR.—The term 'consumer-driven health plan sponsor' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to consumer-driven health plan sponsors.

"(B) CONSUMER-DRIVEN HEALTH PLAN.—The term 'consumer-driven health plan' means a MedicareAdvantage plan that—

"(i) provides 100 percent coverage for preventive benefits (as defined by the Secretary);

"(ii) includes a personal care account from which enrollees must pay out-of-pocket costs until the deductible is met; and

"(iii) has a high deductible (as determined by the Secretary).

"(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' has the meaning given that term under section 1858(a)(2)(C).

"(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

"(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to consumer-driven health plans offered by a consumer-driven health plan sponsor.

"(2) SERVICE AREA.—The service area of a consumer-driven health plan shall be a preferred provider region.

"(3) AVAILABILITY.—Each consumer-driven health plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

"(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

"(5) ASSURING ACCESS TO SERVICES IN CONSUMER-DRIVEN HEALTH PLANS.—The requirements of section 1858(a)(5) shall apply to consumer-driven health plans.

"(6) PERSONAL CARE ACCOUNTS.—

"(A) ESTABLISHMENT.—Each consumer-driven health plan shall establish a personal care account on behalf of each enrollee from which such enrollee shall be required to pay out-of-pockets costs until the deductible described in subsection (a)(2)(B)(iii) is met.

"(B) ROLLOVER.—Subject to subparagraph (C), any amounts remaining in a personal care account at the end of a year shall be credited to such an account for the subsequent year.

"(C) CHANGES OF ELECTION.—If, after electing a consumer-driven health plan, a beneficiary elects a plan under this part that is not a consumer-driven health plan during a subsequent year or elects to receive benefits under the original medicare fee-for-service program option (whether or not as a result of circumstances described in section 1851(e)(4)), any amounts remaining in the account as of the date of such election shall be credited to the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 in such proportion as the Secretary determines is appropriate.

"(c) PAYMENTS TO CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

"(1) PAYMENTS TO ORGANIZATIONS.—

"(A) MONTHLY PAYMENTS.—

"(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsections (e) and (i), and section 1859(e)(4), the Secretary shall make, to each consumer-driven health plan sponsor, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

“(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

“(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

“(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a consumer-driven health plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

“(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

“(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

“(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

“(2) APPLICATION OF PREFERRED PROVIDER BENCHMARKS.—The benchmark amounts calculated under section 1858(c)(2) shall apply with respect to consumer-driven health plans.

“(3) APPLICATION OF PREFERRED PROVIDER PAYMENT FACTORS.—The provisions of section 1858(c)(3) shall apply with respect to consumer driven health plans.

“(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

“(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii).

“(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The preferred provider regional benchmark calculated under section 1858(c)(4)(B) shall apply with respect to consumer-drive health plans amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii).

“(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

“(i) the payment amount under subparagraph (D); and

“(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

“(D) DETERMINATION OF PAYMENT AMOUNT.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a consumer-driven health plan sponsor for a consumer-driven health plan as follows:

“(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

“(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

“(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in section 1858(c)(3)(A)(ii).

“(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

“(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to consumer-driven health plan sponsors in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

“(5) PAYMENTS FROM TRUST FUND.—The payment to a consumer-driven health plan sponsor under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

“(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect consumer-driven health plan sponsors.

“(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to consumer-driven health plan sponsors.

“(d) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLANS; PREMIUMS.—

“(1) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

“(A) IN GENERAL.—For the requirements on submissions by consumer-driven health plans, see section 1854(a)(1).

“(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

“(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan must reasonably and equitably reflect the cost of benefits provided under that plan.

“(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the consumer-driven health plan sponsor with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

“(E) NO LIMIT ON NUMBER OF PLANS IN A REGION.—The Secretary may not limit the number of consumer-driven health plans offered in a preferred provider region.

“(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a consumer-driven health plan offered by a consumer-driven health plan sponsor shall be equal to the sum of the following:

“(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

“(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

“(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

“(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to consumer-driven health plan sponsors.

“(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a consumer-driven health plan sponsor to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

“(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

“(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

“(A) IN GENERAL.—For 2007 and 2008, the consumer-driven health plan sponsor offering a consumer-driven health plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

“(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

“(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

“(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

“(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a consumer-driven health plan may not exceed an amount determined appropriate by the Administrator.

“(2) ADJUSTMENT OF PAYMENT.—

“(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the consumer-driven health plan sponsor offering the plan.

"(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

"(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

"(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

"(II) 10 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

"(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

"(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

"(ii) 10 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

"(3) ESTABLISHMENT OF RISK CORRIDORS.—

"(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each consumer-driven health plan. The risk corridor for a plan for a year shall be equal to a range as follows:

"(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 5 percent of such target amount.

"(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 10 percent of such target amount.

"(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (i)(II).

"(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (ii)(II).

"(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a consumer-driven health plan offered by a consumer-driven health plan sponsor in a year, an amount equal to the sum of—

"(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

"(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

"(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A consumer-driven health plan sponsor that offers a consumer-driven health plan that provides enhanced medial benefits under section 1852(a)(3)(D) shal! be at full financial risk for the provision of such benefits.

"(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

"(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a consumer-driven health plan sponsor and a consumer-driven health plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

"(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—A consumer-driven health plan sponsor shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a consumer-driven health plan.

"(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to consumer-driven health plan sponsors.

"(h) CONTRACTS WITH CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—The provisions of section 1857 shall apply to a consumer-driven health plan offered by a consumer-driven health plan sponsor under this section.

"(i) BUDGET NEUTRALITY.—Notwithstanding any other provision of this section, in conducting the program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under this title do not exceed the amount the Secretary would have paid if this section had not been enacted.".

(b) CONSUMER-DRIVEN HEALTH PLAN TERMINOLOGY DEFINED.—Section 1859(a) (42 U.S.C. 1395w–29(a)), as amended by section 211(b), is amended by adding at the end the following new paragraph:

"(4) CONSUMER-DRIVEN HEALTH PLAN SPONSOR; CONSUMER-DRIVEN HEALTH PLAN.—The terms 'consumer-driven health plan sponsor' and 'consumer-driven health plan' have the meaning given such terms in section 1858B(a)(2).".

SA 1029. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . MEDICARE COVERAGE OF CRITICAL ACCESS HEALTH CENTER SERVICES.

(a) IN GENERAL.—

(1) COVERAGE.—Section 1861(s)(2)(E) (42 U.S.C. 1395x(s)(2)(E)) is amended—

(A) by striking "services and" and inserting "services,"; and

(B) by striking "center services" and inserting "center services, and critical access health center services".

(2) DEFINITIONS.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is amended—

(A) in the heading—

(i) by striking "Services and" and inserting "Services,"; and

(ii) by striking "Center Services" and inserting "Center Services, and Critical Access Health Center Services";

(B) in paragraph (1)(B), by striking "paragraph (5)" and inserting "paragraph (7)";

(C) by redesignating paragraphs (5), (6), and (7) as paragraphs (7), (8), and (9), respectively; and

(D) by inserting after paragraph (4) the following:

"(5) The term 'critical access health center services' means—

"(A) services of the type described in subparagraphs (A) through (C) of paragraph (1); and

"(B) preventive primary health services of the type that a health center is required to provide under section 330 of the Public Health Service Act,

when furnished to an individual who is an outpatient of a critical access health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a critical access health center or a physician at the center, respectively.

"(6) The term 'critical access health center' means an entity that—

"(A) is sponsored by a private, nonprofit entity with a religious affiliation; and

"(B) based on the recommendation of the Centers for Medicare and Medicaid Services, is determined by the Secretary to meet the requirements for receiving a grant under section 330 of the Public Health Service Act (other than the requirement of subsection (n)(3)(H)(i) of such section).".

(3) PAYMENTS.—

(A) SCOPE OF BENEFITS.—Section 1832(a) (42 U.S.C.1395k(a)) is amended—

(i) in paragraph (1), by striking "subparagraphs (B) and (D)" and inserting "subparagraphs (B), (D), and (K)"; and

(ii) in paragraph (2)—

(I) by striking "and" at the end of subparagraph (I);

(II) by striking the period at the end of subparagraph (J) and inserting "; and"; and

(III) by adding at the end the following:

"(K) critical access health center services.".

(B) PAYMENT OF BENEFITS.—Section 1833(a) (42 U.S.C.1395*l*(a)) is amended—

(i) in the matter preceding subparagraph (A) of paragraph (2), by striking "and (I)" and inserting "(I), and (K)"; and

(ii) in paragraph (3), by inserting "or section 1832(a)(2)(K)" after "section 1832(a)(2)(D)".

(C) PART B DEDUCTIBLE NOT APPLICABLE.—The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended by inserting "or critical access health center services" after "Federally qualified health center services".

(D) EXCEPTION TO EXCLUSIONS FROM COVERAGE.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (2), by inserting "or critical access health center services (as defined in section 1861(aa)(5))" after "Federally qualified health center services";

(ii) in paragraph (3), by inserting "in the case of critical access health center services (as defined in section 1861(aa)(5))," after "section 1880(e),"; and

(iii) in the second sentence, by inserting "or critical access health center services described in section 1861(aa)(5)(B)" after "section 1861 (aa)(3)(B)".

(E) EXCEPTION TO ANTI-KICKBACK LAW FOR WAIVER OF COINSURANCE.—Section 1128B(b)(3)(D) (42 U.S.C. 13206-7b(b)(3)(D)) is amended—

(i) by inserting "(i)" before "a waiver";

(ii) by inserting "and" after "Act;"; and

(iii) by adding at the end the following:

"(ii) a waiver of—

"(I) any coinsurance under part B of title XVIII by a critical access health center with respect to an individual who qualifies for subsidized services under a provision of section 330 of the Public Health Service Act (as made applicable to such centers by section 1861(aa)(6)); and

"(II) the deductible and any coinsurance under such part by any provider of services, physician, or supplier to which such an individual is referred by a critical access health center for the provision of services that are not critical access health center services;".

(F) CONFORMING AMENDMENTS.—

(i) Section 1842(b)(18)(C)(1) (42 U.S.C. 1395u(b)(18)(C)(1)) is amended by striking "section 1861(aa)(5)" and inserting "section 1861(aa)(7)".

(ii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended in subparagraph (H)(i), by striking "subsection (aa)(5)" and inserting "subsection (aa)(7)".

(iii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended in subparagraph (K)—

(I) by striking "subsection (aa)(5)" each place it appears and inserting "subsection (aa)(7)"; and

(II) by striking "subsection (aa)(6)" and inserting "subsection (aa)(8)".

(b) EFFECTIVE DATE.—The amendments made this section shall apply to items and services furnished on or after October 1, 2004.

SEC. . DEMONSTRATION TO IMPROVE ACCESS AND CONTINUITY OF CARE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—The Secretary shall—

(1) conduct a demonstration project to test the use of alternative payment methodologies to health care providers to improve access to ambulatory health care services and continuity of care for vulnerable populations such as low-income beneficiaries under title XVIII; and

(2) waive any provisions of the Social Security Act that are necessary to implement such demonstration.

(b) DURATION.—The demonstration project conducted pursuant to subsection (a) shall be for a term of at least 3 years and shall begin operation not later than 1 year after the date of the enactment of this Act.

(c) REPORTS.—

(1) INTERIM AND FINAL REPORTS REQUIRED.—The Secretary shall submit interim and final reports on the demonstration project conducted pursuant to subsection (a) to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives. Such reports shall describe—

(A) the alternative payment methodologies in use under the demonstration;

(B) the provisions of law waived by the Secretary in order to conduct the demonstration; and

(C) the extent to which the demonstration has achieved the objectives described in subsection (a).

(2) TIMING OF REPORTS.—The Secretary shall submit the interim report required by paragraph (1) not later than 2 years after the commencement of the demonstration and the final report not later than 6 months after the termination the demonstration.

SA 1030. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 356, strike lines 8 through 11, and insert the following:

"(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting—

"(i) the persons from whom enrollees under such plan may obtain covered benefits; or

"(ii) the categories of licensed health professionals or providers from whom enrollees under such a plan may obtain covered benefits if the covered services are provided to enrollees in a State where 25 percent or more of the population resides in health professional shortage areas designated pursuant to section 332 of the Public Health Service Act."

SA 1031. Mr. CARPER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . INCREASING TYPES OF ORIGINATING TELEHEALTH SITES AND FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

"(VI) A skilled nursing facility (as defined in section 1819(a)).

"(VII) An assisted-living facility (as defined by the Secretary).

"(VIII) A board-and-care home (as defined by the Secretary).

"(IX) A county of community health clinic (as defined by the Secretary).

"(X) A community mental health center (as described in section 1861(ff)(2)(B)).

"(XI) A long-term care facility (as defined by the Secretary).

"(XII) A facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) directly, or under contract or other arrangement.".

(b) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—

(1) IN GENERAL.—For purposes of expediting the provision of telehealth services for which payment is made under the medicare program under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), across State lines, the Secretary shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of State provisions allowing for multistate practitioner licensure across State lines.

(2) DEFINITIONS.—In this subsection:

(A) TELEHEALTH SERVICE.—The term "telehealth service" has the meaning given that term in subparagraph (F)(i) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(B) PHYSICIAN, PRACTITIONER.—The terms "physician" and "practitioner" have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(C) MEDICARE PROGRAM.—The term "medicare program" means the program of health insurance administered by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SA 1032. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "clinical social worker services," after "qualified psychologist services,".

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking "and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.

SA 1033. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. . EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking "December 31, 2004, but only with respect to" and all that follows and inserting "December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.".

SA 1034. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) In General.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) Permanent treatment for cancer hospitals and children's hospitals.—

"(I) Cancer hospitals.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) Children's hospitals.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and for which the PPS amount is less than the pre-BBA amount the amount of payment under this subsection shall be increased by the amount of such difference. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

SA 1035. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) In General.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) Permanent treatment for cancer hospitals and children's hospitals.—

"(I) In general.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) Special rule for certain children's hospitals.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

SA 1036. Mr. REID (for Mrs. Boxer) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 53, between line 8 and 9, insert the following:

"(6) No coverage gap for eligible beneficiaries with cancer.—

"(A) In general.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

"(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

"(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

"(B) Procedures.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A)."

SA 1037. Mr. REID (for Mr. Corzine) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. . CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

(a) Permitting FQHCs To Fill Prescriptions.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(1) in subparagraph (A), by striking "and" after the comma at the end;

(2) in subparagraph (B), by inserting "and" after the comma at the end; and

(3) by adding at the end the following new subparagraph:

"(C) drugs and biologicals for which payment may otherwise be made under this title,".

(b) Elimination of Per Visit Limit.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting ", except that such regulations may not limit the per visit payment amount with regard to drugs and biologicals described in section 1861(aa)(3)(C)" after "the Secretary may prescribe in regulations".

SA 1038. Mr. REID (for Mr. Jeffords) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of section 405 add the following:

(g) Exclusion of Certain Beds From Bed Count and Removal of Barriers to Establishment of Distinct Part Units.—

(1) Exclusion of certain beds from bed count.—Section 1820(c)(2) (42 U.S.C. 1395i-4(c)(2)) is amended by adding at the end the following:

"(E) Exclusion of certain beds from bed count.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 25.".

(2) Removing barriers to establishment of distinct part units by critical access hospitals.—Section 1886(d)(1)(B) (42 U.S.C. 195ww(d)(1)(B)) is amended by striking "a distinct part of the hospital (as defined by the Secretary)" in the matter following cause (v) and inserting "a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital".

(3) Effective date.—The amendments made by this subsection shall apply to determinations with respect to distinct part unit status, and with respect to designations, that are made on or after October 1, 2003.

SA 1039. Mr. REID (for Mr. Inouye) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Native Hawaiian Medicaid Coverage Act of 2003".

SEC. 2. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) Medicaid.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ", and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider" before the period.

(b) Effective Date.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SA 1040. Mr. SCHUMER (for himself, Mr. Corzine, Mrs. Clinton, and Mr. Lautenberg) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 294, line 6, strike "or (C)" and insert "(C), or (D)".

On page 294, line 21, insert "(other than in 2004 and 2005)" after "multiplied".

On page 297, strike lines 5 through 9, and insert the following:

"(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(D) ANNUAL FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—For 2004 and 2005, the adjusted average per capita cost for the year, as determined under section 1876(a)(4) for the Medicare+Choice payment area for items and services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B and not enrolled in a Medicare+Choice plan under this part for the year, except that such amount shall be adjusted—

"(i) to exclude costs attributable to payment adjustments described in subsection (a)(5)(B)(ii), and

"(ii) to include an amount equal to the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 298, line 10, strike "subparagraph (B)" and insert "subparagraphs (B) and (E)".

On page 301, between lines 8 and 9, insert the following:

"(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 302, line 23, insert "(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)" after "medicare beneficiaries".

On page 303, line 9, insert "other than 2004 and 2005" after "for each year".

On page 349, between lines 4 and 5, insert the following:

(3) PAYMENT RATES BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—

(A) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1)(A), in the flush matter following clause (ii), by inserting "(other than in 2004 and 2005)" after "multiplied"; and

(ii) in paragraph (5), by inserting "other than 2004 and 2005" after "for each year".

(B) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(C) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting "(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)" after "medicare beneficiaries".

(D) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

"(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.".

SA 1041. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas of Alaska are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SA 1042. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(b) (42 U.S.C. 1395w–4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "paragraph (2)" and inserting "paragraphs (2) and (4)"; and

(2) by adding at the end the following new paragraph:

"(4) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.—

"(A) IN GENERAL.—With respect to physicians' services furnished in Alaska on or after January 1, 2004, and before January 1, 2014, the fee schedule for such services shall be determined as follows:

"(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

"(I) in the case of services furnished in calendar year 2004, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

"(II) in the case of services furnished in each of calendar years 2005 through 2013, the amount determined under this clause for the previous year, increased by the annual update determined under subsection (d) for the year involved.

"(ii) In the case of a service for which there was no VA Alaska fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to the sum of—

"(I) the amount of payment for the service that would otherwise apply under this section; plus

"(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

"(B) VA ALASKA FEE SCHEDULE AMOUNT.—For purposes of this paragraph, the term 'VA Alaska fee schedule amount' means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians' services associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38.

"(C) APPLICABLE PERCENT.—For purposes of this paragraph, the term 'applicable percent' means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount for physicians' services exceeded the amount of payment for such services under this section that applied in Alaska in 2001.".

SA 1043. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title

XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 377, between lines 12 and 13, insert the following:

"(I) Section 1851(d) (relating to the provision of information to promote informed choice).

"(J) Section 1851(h) (relating to the approval of marketing material and application forms).

"(K) Section 1852(e)(4) (relating to treatment of accreditation).

"(L) Section 1857(i) (relating to Medicare+Choice program compatibility with employer or union group health plans).".

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. COCHRAN. Mr. President, I announce that the Committee on Agriculture, Nutrition, and Forestry will conduct a hearing on June 26, 2003 in SR-328A at 9 a.m. The purpose of this meeting will be to review H.R. 1904, The Healthy Forests Restoration Act of 2003.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 24, 2003, at 10 a.m. to conduct a hearing on "Bus Rapid Transit and Other Bus Service Innovations."

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, June 24, 2003, at 9:30 a.m. on Reform of the USOC.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Tuesday, June 24 at 10 a.m. in room SD-366. The purpose of this oversight hearing is to receive testimony on issues associated with changes in the relationship between the U.S. Department of Energy and the contractors operating its National Laboratories, other laboratories and sites.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Tuesday, June 24, 2003 at 2:30 p.m. to hold a hearing on U.S. Relations With A Changing Europe: Differing Views on Technology Issues.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Tuesday, June 24, 2003, at 10 a.m. for a hearing entitled "Controlling the Costs of Federal Health Programs by Curing Diabetes: A Case Study."

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on Tuesday, June 24, 2003, at 9:30 a.m. in SDG 50.

Agenda

1. Indexing All Awards for Future Inflation: This amendment indexes claim award values to inflation.

2. Removing Collateral Source Offsets: This amendment ensures that more money will go to claimants by striking all existing collateral source offsets in the bill except for compensation from past settlements and judgments for the same asbestos-related injury.

3. Doubling the Statute of Limitations: This amendment doubles the statute of limitations from 2 to 4 years to allow more claimants access to the fund and to help alleviate the potential backlog of claims at the beginning of the Fund's creation.

4. Coverage for Claimant Exposures on U.S. Flag Ships or While Working for U.S. Companies Abroad: This amendment broadens eligibility to include claims made by U.S. citizens exposed to asbestos while serving on any U.S. flagged or owned ship or exposed to asbestos while working for U.S. companies overseas.

5. Strengthening Enforcement of Contributions: This amendment strengthens the Administrator's cause of action to enforce contributions by permitting the assessment of punitive damages for willful failure to pay.

6. Recoupment Authority for the Administrator: This amendment protects the funds available to pay claimants by permitting the Administrator to recover any financial hardship or inequity adjustment in future years if a company later becomes financially capable of paying its full allocation into the fund.

7. Criminal Penalties for Fraud or False Information: This amendment protects the integrity of the claims administration process by imposing criminal penalties for fraud and false statements made against the Fund.

8. Bankruptcy Certification: Requires the bankruptcy court to certify whether or not asbestos liabilities were the cause of the bankruptcy.

9. Congressional Oversight—Administrator Annual Reports: This amendment provides appropriate Congressional oversight by requiring the Administrator of the Asbestos Fund to submit an annual report on the functioning of the Fund to Congress.

Technical Amendments

10. Hatch Technical Amendment: Technical amendments to S. 1125.

Other Agreed Upon Amendments

11. Hatch Libby Amendment: Senator BAUCUS has agreed to this Amendment, which ensures that claimants from Libby, Montana will be compensated from this Fund and that their claims will be evaluated by the exceptions panel due to the unique nature of the asbestos there.

12. Hatch Asbestos Ban: This amendment prohibits the manufacture, distribution and importation of the consumer products to which asbestos is deliberately or knowingly added. The amendment also contains specific exemptions and authorizes the Administrator to hear and grant exemptions on a case by case basis.

13. Feinstein Second Degree to Hatch Asbestos Ban: This amendment adds certification requirements for the Government Use exemption, and authorizes the Administrator of the EPA to review the exemption for roofing cements and related products.

Medical Criteria Amendments

14. Hatch Medical Exceptions Panel Amendment: This panel will review claims which do not fit the criteria but may have an exceptional case to merit payment. Libby claims will automatically go through this panel.

15. Hatch Striking Product ID Amendment: (Leahy co-sponsor)—Drops requirements to identify particular asbestos product.

16. Hatch Latency Period Amendment: (Leahy co-sponsor)—Clarifies the 10-year latency period for all claims.

17. Hatch Medical Monitoring Amendment: Requires the administrator to notify qualifying claimants about medical monitoring options.

18. Hatch Doctor Evaluation Amendment: Requires physician to evaluate smoking and exposure history before making a diagnosis.

19. Hatch Deceased Claimant Amendment: Eliminates in-person examination requirement for persons who have died prior to filing their claim.

20. Hatch Disease Categories and Standards Amendment: (Sec. 124)—Replaces the previous criteria with a new

level for severe asbestosis (V); a mixed-causation level (II); three levels of lung cancer payments; substantial occupational exposure measured in "weighted" years.

21. Hatch Independent Review Amendment: This allows the Asbestos Court to conduct its own reviews of medical evidence to ensure quality control.

22. Hatch Smoking Assessment Amendment: Allows the Asbestos Court to make a limited investigation into a claimant's smoking history to determine veracity.

23. Hatch Treating Doctor Amendment: Requires that a doctor making a diagnosis be the "claimant's doctor," as opposed to "treating" doctor.

24. Hatch IOM Study Amendment: Directs the Institute of Medicine to study the link between asbestos and "other cancers."

25. Hatch Weighted Exposure Amendment: For substantial occupational exposure requirement, the weighted exposure gives more credit for exposure in earlier years, or in certain occupations, than exposure in more recent, post-regulation years.

26. Hatch Take Home Exposure Amendment: Amendment clarifies that claimants exposed to asbestos by cohabitants who brought home asbestos on their clothes from their jobs will meet the exposure requirement in the bill.

27. Kyl Significant Amount Amendment: This amendment amends section 124(a)(8)(B) and (C) of S. 1125 to require "significant amounts" of exposure to qualify for having "significant occupational exposure."

28. Kyl Significant Amount Amendment: This amendment amends section 124(a)(16)(B) and (C) of amended medical criteria to require "significant amounts" of exposure to qualify for having "significant occupational exposure."

29. Kyl Lock Box Amendment: Inserts a new section 223(e) into the introduced bill that requires a "lock box" mesothelioma account used solely to make payments for claimants at Levels IV, VII, and VIII.

30. Kyl Lock Box Amendment: Inserts a new section 223(e) into S. 1125 as amended with new Hatch criteria that requires a "lock box" mesothelioma account used solely to make payments for claimants at Level IX, Lung Cancer II, Severe Asbestos II and Severe Asbestos I.

31. Leahy Colorectal Cancer Amendment: Adds colorectal cancers as compensable cancers in the fund.

32. Leahy Take Home Exposure Amendment: A claimant meets the medical requirements if they can show exposure to asbestos was result of living with a person who was occupationally defined.

33. Kennedy Medical Advisory Committee/Exceptional Medical Claim Amendment: Adds to section 114 to grant the chief judge the authority to appoint a Medical Advisory Committee of doctors with certain qualifications. Also creates, in section 124, a process for a claimant to submit an application for an "exceptional medical claim" that does not fall within the medical criteria parameters within the bill.

34. Kennedy Awards Amendment: Amends the awards allowed by increasing the amounts for: (1) Lung Cancer I to "individual determination"; (2) Lung Cancer II to $500,000 or $1,500,000; (3) Mesothelioma to $1,500,000; (4) Increases amounts non-smokers receive by lots of money.

35. Kohl Mesothelioma Amendment: Increases the mesothelioma compensation award from $750,000 to $1,500,000.

36. Feingold Medical Monitoring Amendment: Establishes a medical monitoring system within 180 days of the Act's implementation. Creates criteria required to obtain medical monitoring and the protocols used for medical screening. Screening shall occur within 5 years. The administrator will promulgate procedures and regulations establishing medical monitoring program.

Other Amendments

37. Hatch Back-End Amendment: Provides defendant contributors the option to continue paying into the fund after year 27 or be subject to a civil claim filed in federal court.

38. Hatch Silica/Mixed Dust Amendment: This amendment clarifies that asbestos related mixed dust claims are covered by the bill.

39. Grassley Asbestos Court Amendment: Eliminates the Court of Asbestos claims, instead housing the tribunal in the Federal Court of Claims. The Chief Judge may appoint up to 20 special asbestos masters without Congressional approval. A special master will make the determination, appealed to the Court of Claims and the Federal Circuit.

40. Grassley Federal Liability Amendment: Amendment provides that nothing in the act establishes liability against the Federal Government nor should it be construed to obligate funding from the United States government.

41. Leahy Environmental Crimes Amendment: Amendment enhances the penalties for environmental crimes by expanding the available crimes covered involving asbestos and applies the provision retroactively and requires the person who discovers the crime report to the proper State law enforcement authorities within 30 days.

42. Sessions Cap on Attorneys' Fee Amendment: Amendment imposes a 10 percent cap on attorneys fees.

43. Sessions Pro Bono Amendment: Amendment requires the Asbestos Court to provide information to claimants of pro bono representation. Attorneys must provide notice of pro bono representation.

44. Sessions Substitute Amendment: Amendment substitutes S. 1125 with language from Senator Nickles alternative tort reform proposal.

45. Leahy FOIA Amendment for the Commission: Amendment extends the Freedom of Information Act to apply to the Asbestos Insurance Commission.

46. Leahy FOIA Amendment for the Office of Asbestos Injury Claims Resolution: Amendment extends the Freedom of Information Act to apply to the Office of Asbestos Injury Claims Resolution.

47. Leahy Successor in Interest Amendment: Requires that a business that changes its formal structure, yet "substantially continues" to maintain the same function, will remain obligated to fund the Trust.

48. Kennedy Purpose of S. 1125 Amendment: Amendment specifies that the purpose of S. 1125 should be expeditious compensation to individuals exposed to asbestos, provide compensation based on a system "flexible enough to accommodate individuals whose conditions worsen", to establish a trust fund to create certainty and predictability, and relieve federal and state courts of asbestos litigation burdens.

49. Kohl Contingent Call and Fund Certification Amendment: Amendment permits the Administrator to assess additional contributions during the first 27 years of the fund and/or decline any scheduled allocation reductions unless the Administrator certifies. Amendment also requires the Administrator, prior to reducing defendant allocations, to certify that the fund will have sufficient money to compensate past, present and future claimants, for various segments during the life of the fund, including a procedure for making the determination.

50. Feinstein Occupational Related Disease Study Amendment: Amendment requires any excess funds from the Trust to be directed to NIH for the study of occupational-related diseases.

51. Feinstein Date of Occupational Exposure Amendment: This amendment strikes the December 31, 1982 cutoff dates for occupational exposures.

52. Feinstein Back End Proposal: Requires mandatory payments to continue after year 27 at year 26 levels if the Administrator deems it necessary to ensure adequate funding of the Fund. The Administrator will provide a report to Congress if additional future funds are necessary.

53. Feinstein Asbestos Ban Amendment: Adds Title V to ban the use of asbestos in commercial products. Provides for exceptions with a list of products and provides for civil penalties. Amends title 18 U.S.C. to add chapter 34 enumerating an asbestos related crime. Provides money for research into asbestos-causing diseases, a mesothelioma registry and establishes

Mesothelioma research and treatment centers. The amendment is superfluous after Senators Hatch, Feinstein, Kohl and Murray agreed to the Hatch Asbestos ban Amendment.

54. Feingold Sunset Amendment: Provides a check on liability that (c) and (d) has no effect on January 1, 2010 unless the Administrator certifies prior to that date that 95 percent of all compensable claims file on or before May 1, 2006 have been paid in full.

55. Feingold Payments Amendment: Amendment changes the word "less" to "more" on page 40 line 4 so that all payments will be made within 3 years.

56. Durbin Lawsuit Filing Date Amendment: Amendment does not require any lawsuit filed before June 1, 2003 to be dismissed prior to adjudication.

57. Durbin Prior Asbestos Expenditure Amendment: Amends the term "prior asbestos expenditure" to exclude defense costs mounted in a successful defense against an asbestos claim.

58. Durbin FELA Amendment: Amendment removes the FAIR Act's preemption of FELA claims for asbestos injuries.

59. Durbin Hardship Amendment: Doubles the current caps for the financial hardship and inequity adjustments while revising the definition of "inequity adjustments" to include costs incurred in cases where the defendant mounted a successful defense.

60. Hatch Congressional Findings.

61. Leahy Congressional Findings.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Tuesday, June 24, 2003, at 9:30 a.m., to consider the markup of pending legislative and administrative business, including any other items that may be ready for consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON CHILDREN AND FAMILIES SUBCOMMITTEE ON PERSONNEL

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions, Subcommittee on Children and Families, and Committee on Armed Services, Subcommittee on Personnel be authorized to meet for a hearing on Supporting Our Military Families during the session of the Senate on Tuesday, June 24, 2003, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON FISHERIES, WILDLIFE, AND WATER

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Subcommittee on Fisheries, Wildlife, and Water be authorized to meet on Tuesday, June 24 at 9:30 a.m. to examine implementation of the National Marine Fisheries Service's 2000 Biological Opinion for listed anadromous fish regarding operation of the Federal Columbia River Power System.

The hearing will take place in SD 406, Hearing Room.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON PERSONNEL

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Subcommittee on Personnel of the Committee on Armed Services be authorized to meet during the session of the Senate on Tuesday, June 24, 2003, at 2:30 p.m., in open session to continue to receive testimony on issues affecting families of soldiers, sailors, airmen and marines.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. DODD. Mr. President, I ask unanimous consent that Meghan Taira, a fellow on Senator DASCHLE's staff, be granted floor privileges during the consideration of S. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. CLINTON. Mr. President, I ask unanimous consent that Dr. Leonardo Trasande and Dr. Murali Raju, legislative fellows in my office, be granted floor privileges for the duration of this debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that Jessica Donze and Michelle Curtis, two fellows in Senator BINGAMAN's office, be granted the privilege of the floor during the pendency of the debate on S. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE READ THE FIRST TIME—S. 1323

Mr. FRIST. I understand that S. 1323 is at the desk and I ask for its first reading.

The PRESIDING OFFICER. The clerk will read the bill by title.

The legislative clerk read as follows:

A bill (S. 1323) to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

Mr. FRIST. I now ask for its second reading and object to further proceeding on this matter.

The PRESIDING OFFICER. Objection having been heard, the bill will receive its second reading on the next legislative day.

ORDERS FOR WEDNESDAY, JUNE 25, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:30 a.m., Wednesday, June 25. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of S. 1, the prescription drug benefits bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Mr. President, today we made great progress toward finishing the prescription drug/Medicare reform legislation. We debated many amendments. We had nine rollcall votes in relation to the pending amendments during today's consideration of this bill.

Tomorrow morning, we will resume consideration of S. 1. I would anticipate another busy day on this bill as well tomorrow. On Wednesday, the first rollcall vote was anticipated to be at 10 a.m. However, at this time the final legislative draft is not ready. We will continue to work on that draft over the course of the evening and into the morning, but at this juncture I will likely have to notify our Members as early as possible tomorrow morning as to whether we will actually call that rollcall vote at 10 a.m. I am hopeful that we can. If the legislative language is not ready, we will not have that vote at 10 a.m., but I hope to be able to announce that at 9:30 in the morning.

I do want to remind my colleagues that at this juncture we have approximately 42 amendments still pending to the bill. These amendments will have to be addressed by the Senate in some fashion, although I am very hopeful that many of these amendments can be disposed of without a rollcall vote. In any event, we have a lot of work to do before we have passage of this bill.

I, once again, will state that it is my intention that we will finish consideration of the prescription drug/Medicare reform bill prior to the July 4 recess—many hours, a lot of hard work, but we are on course to accomplish that, and I expect that we will do so.

I look forward to another productive day tomorrow as we begin the final consideration of this bill.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. FRIST. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 9:13 p.m., adjourned until Wednesday, June 25, 2003, at 9:30 a.m.

EXTENSIONS OF REMARKS

AFFIRMATIVE ACTION RULING

HON. JOE BACA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. BACA. Mr. Speaker, yesterday, Supreme Court decided to support the hopes and dreams of millions of Hispanic children. It tells them they will have the same opportunities, the same choices, the same future that others will. The Court was loud and clear when it said that diversity can be used by colleges and universities in their admissions policies.

This is a victory for the American people and for everything our country stands for. And we have this victory despite President Bush's efforts to undermine minority access to higher education. While saying he supports diversity, President Bush has actively worked to outlaw affirmative action at the University of Michigan and across the country. We cannot accept excuses. We cannot justify smoke and mirrors. The President says that considering race or ethnic background is unfair, but affirmative action programs are forward-focused to combat discrimination and promote diversity. I know that, the military knows that, corporate America knows that, and the 39 million Hispanics in this country know that. Today, the Supreme Court has said that it knows that too. The Supreme Court ruled over 25 years ago that diversity in admissions policies added to the educational and social experiences on our college and university campuses. The Court reaffirmed that decision today.

This ruling also sends a strong message to colleges and universities in California. At the University of California, the percentage of black and Hispanic students in medical and law schools has dropped since race-conscious admissions were eliminated a few years ago.

This year, black and Hispanic students make up only 16 percent of first-year students at California's five state-run medical schools and public law schools. In contrast, in the final years of race-conscious admissions, black and Hispanics consistently accounted for more than 20 percent of enrollment at these same schools. Acceptance rates for Hispanic applicants in the entire University of California system has dropped from 64 percent in 1997 to 47 percent in 2002. What is happening to those other students? They are not just numbers!!! They are people whose lives will be changed forever.

Today, fewer than 10 percent of college-aged Hispanics go on to higher education. Only 16 percent of Hispanics between the ages of 25–29 have Bachelor's degrees. What do these numbers tell us? It tells us that we do not have the same educational opportunities that others have.

President Bush says that we should not be satisfied with the current numbers of minorities on American college campuses. He's right. But other than nice words, what does he offer? He says one thing, then does another. He has followed budget cuts and funding freezes of programs that benefit Hispanic children with an attack on Hispanic educational opportunities.

The Bush Administration tried to find yet another way to hinder our children's chances to an equal and quality education. We are fortunate that he failed in his effort to leave even more children behind.

This loss for the Bush Administration and for its policies is a victory for every child that wants an opportunity for a better education and a better life.

TRIBUTE TO CHANDLER A. HATCH AND PETER NOTIER

HON. WILLIAM O. LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. LIPINSKI. Mr. Speaker, I rise today in recognition of Chandler Hatch, a senior at Lyons Township High School in LaGrange, Illinois. On June 22, 2003, Chandler will receive the Presidential Scholars Medallion from the Department of Education.

Chandler was selected by a 32 member commission from a field of over 2,600 candidates. The commission honors students based on their academic achievements, leadership abilities, community service, and continued commitment to excellence. Chandler will be awarded as part of the 39th Class of Presidential Scholars.

In addition to winning this award, Chandler was able to invite a teacher who has proven to be most influential and inspiring. Chandler selected Mr. Peter Notier, a distinguished English literature teacher at Lyons Township High School.

I would like to recognize Mr. Notier for his continued commitment to education and proven excellence in teaching. I commend Mr. Notier for his dedication and outstanding service in the field of education.

Mr. Speaker, I ask my colleagues to join me in recognizing both Chandler and Peter and wish them success in the future.

VETERANS ENTREPRENEURSHIP AND BENEFITS IMPROVEMENT ACT OF 2003

SPEECH OF

HON. RAHM EMANUEL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Monday, June 23, 2003

Mr. EMANUEL. Mr. Speaker, I rise today in support of H.R. 1460, the Veterans Entrepreneurship Act of 2003. This is essential legislation which ensures that those courageous and honorable men and women who served in our armed forces have the opportunity to receive valuable educational and professional opportunities in the areas of entrepreneurship and business.

Veterans have served this country with distinction throughout its history, and many have risked their lives for our benefit. Especially in the wake of Operations Enduring Freedom and Iraqi Freedom, we should take steps to help our veterans successfully transition to civilian life.

The educational assistance provided by the Department of Veterans' Affairs is a benefit these veterans have earned, and it is important that they be able to use this assistance for valuable courses in the field of entrepreneurship, which teaches pragmatic and creative business practices useful in any field. In addition, by making it easier for disabled veterans to receive government contracts for their small businesses, this bill continues the partnership between these individuals and the government, and helps them to succeed in today's struggling economy. Operating a small business is a difficult but worthwhile endeavor, and veterans should have every opportunity to use their talents to aid the U.S. economy by starting new ventures based on their personal ingenuity.

Mr. Speaker, I applaud Representative RENZI and the other Members of the Committees on Veterans' Affairs and Small Business for introducing this legislation and bringing it to the floor today. It serves as a symbol of support for the heroes who have admirably protected our freedom and served this Nation in the armed forces.

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2003

SPEECH OF

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. CRANE. Madam Speaker, one of the biggest challenges facing our country today is the fact that nearly 41 million working Americans do not have health insurance. While some opt out of purchasing health insurance, a majority of people simply do not have access to affordable health insurance coverage. Routinely I hear from constituents in my district about this very problem. They are struggling to keep up with ever increasing insurance premiums and are left with few coverage options. Few can afford premium increases of 12 percent or more each year, especially in a slow economy. This is a problem in communities across the United States. In fact, the annual. cost to the United States for uninsured

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

Americans is estimated to be somewhere between $65 and $130 billion.

More than 60 percent of the 41 million uninsured Americans work for a small business or are a dependent of a small business worker, and small businesses have been hardest hit by skyrocketing premiums. Currently, labor unions, medium-sized businesses and Fortune 500 companies like Ford, Chrysler and Wal-Mart have the ability to offer health benefits to their employees without complying with the diverse benefit-laden insurance mandates that exist in each of the 50 states. This exemption keeps health insurance costs down. Unfortunately, small businesses, less able to shoulder the burden of such mandates, end up paying almost 18 percent more than their big business counterparts for similar health insurance coverage. This is simply unacceptable.

Today, I join my colleagues in supporting, The Small Business Fairness Act (H.R. 660). H.R. 660 allows small businesses to form Association Health Plans (AHPs). I believe that AHPs can help reduce the number of uninsured, and I am proud to be an original cosponsor of this important legislation. By creating AHPs, small business may pool their resources and increase their bargaining power with insurers, which will allow them to negotiate better rates and purchase quality health care at a lower cost. H.R. 660 is an important first step toward making health insurance more affordable and accessible.

The time has come for all Members of this House to support small businesses. It is time to pass the Small Business Fairness Act.

IN MEMORY OF RAY ABRIL, SR.

HON. JOE BACA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. BACA. Mr. Speaker, it is with a great sense of pride that I rise today, on the floor of the United States House of Representatives, to pay tribute to the memory of Ray Abril, Sr.

Ray Abril, Sr. was a pillar of the community, a surrogate father, a molder of character, a counselor, a coach, a builder of men. Mr. Abril passed away Sunday, May 18, 2003. He was 93 years old. To the youth of Boy Scout Troop 45 of south Colton during 1942 to 1962, he was their mentor and Scoutmaster.

On May 17, 2003, former Scouts, members of the Abril family, and community leaders gathered to pay tribute to this great man of honor. They came from near and far, over 300 strong to honor him and to provide the testimony to the positive impact Mr. Abril had on the young people of San Bernardino County.

To Ray Abril, the Boy Scouts of America and the organization of his troop was paramount. His patrol leaders were as older brothers, who taught and quizzed the new members on their way to the rank of "Tenderfoot." They learned knot tying, how to roll up sleeping bags, and how to pitch a tent. Through all of this, he did not coddle them; he let them move forward at their own pace and make mistakes. But he was always there to guide them when necessary. And guide them he did, but always in a clear direction and the young boys always admired and respected him.

I will remember Ray Abril, Sr. as a man who left his mark on history as a devoted and supportive husband, father, statesman, community leader, Boy Scout leader, mentor and a man of irrefutable wisdom. His remarkably full life is a model to all as an embodiment of the vibrant and dynamic spirit of a true American. My Barbara and I extend to the Abril family the thoughts and prayers of a grateful Nation.

SOLILOQUY

HON. JOHN J. DUNCAN, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. DUNCAN. Mr. Speaker, one of my constituents has written a poem that showcases our Nation's flag in a glorifying manner. Mr. Victor Miller of Madisonville, Tennessee is the author of a poem titled "Soliloquy." Mr. Miller is the son of Jeanette Miller, who passed this poem along to me. Our Country's morale and heritage is strong today because of patriots like Victor Miller. I would like to call "Soliloquy" to the attention of my colleagues and other readers of the RECORD.

SOLILOQUY

Imagine as a flag
on all folks passing by
with edifying waves
influencing their lives.

Esteemed a lofty reign
& honored to belong
all would offer tribute
in oaths, salute or songs!

Recognition could abound
for victories secured
defending liberties
despite many injured.

A patriotic stance
of opportunities
advocating, freedoms
by land, the air & sea!

In each of fifty stars
& else where when observed
the glory of your stripes
would valiantly be served!

Halleluah!!!!

PERSONAL EXPLANATION

HON. MAX BURNS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. BURNS. Mr. Speaker, I rise today to make note of how I cast my vote on roll number 293 on Thursday, June 19, 2003. As the record illustrates, I was present and cast my vote on roll number 292 at 1:44 p.m.; on roll number 293 recorded at 1:51 p.m., however, I was present but my vote was not recorded. While I cast my vote on roll number 293, technical difficulties prevented my vote from being recorded. My vote on roll number 293 as cast was in the affirmative.

TRIBUTE TO COMMANDER JEFF TAYLOR

HON. KEN CALVERT

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. CALVERT. Mr. Speaker, I rise today to honor and pay tribute to an individual whose dedication and contributions to our country are exceptional. The United States has been fortunate to have dynamic and dedicated military personnel who willingly and unselfishly dedicate their lives to service and make our country a safer place to live and work. Navy Commander Jeff Taylor is one of these individuals. On July 21, 2003, he will be honored as he retires from the U.S. Navy.

Jeff was raised in Southern California and graduated from Southern California College with a B.A. in Business Administration in 1978. After working for three years for a major defense contractor in Newport Beach, California, he accepted an appointment to Naval Officer Candidate School and received his commission in 1981.

Commander Taylor first served as the Combat Information Center Officer aboard the USS Cochrane based in Yokosuka, Japan and as the Fire Control Officer and Main Propulsion Assistant on the USS Leahy based in San Diego, California. He also served as an instructor at the Surface Warfare Officers School in Coronado teaching combat systems and ship control curriculum.

After completing Department Head School, Commander Taylor served as Chief Engineering Officer on the USS Worden based in Pearl Harbor, Hawaii. During this time he participated in Operations Desert Shield and Storm. Jeff also served as Maintenance Officer at Assault Craft Unit 5 at Camp Pendleton, California where he directed maintenance and repair of Navy hovercraft and subsequently served as an Engineering Branch Head and instructor at the Surface Warfare Officers School in Newport, Rhode Island. Jeff then returned to sea duty as Executive Officer on the USS Kidd based in Norfolk, Virginia and later served as Chief Staff Officer for Destroyer Squadrons 20 and 32.

Upon completing his sea duty, Jeff reported to the Naval Surface Warfare Center, Corona Division in March of 1999. Commander Taylor also earned a Masters Degree in Business Administration and a Diploma from the United States Naval War College. His personal decorations include the Meritorious Service Medal and Navy Commendation Medals.

Commander Taylor is happily married to his wife Bonnie and enjoys surfing and long distance running in his spare time.

Jeff's lifetime dedication to military service has contributed immensely to the betterment of our country and I am proud to call him a fellow community member, American and friend. I know that many community members are grateful for his service and salute him as he retires.

HONORING HARLEY-DAVIDSON ON ITS 100TH BIRTHDAY

HON. GERALD D. KLECZKA

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. KLECZKA. Mr. Speaker, today I am introducing legislation that would recognize the 100th anniversary of one of America's greatest corporations and a treasure of Milwaukee, Wisconsin—the Harley-Davidson Motor Company. 100 years ago this August in the Davidson family backyard at 38th Street and Highland Boulevard, William Harley and the Davidson brothers, Arthur, Walter, and William, finished work on their first motorcycle.

Shortly afterwards the Harley-Davidson Motor Company was built on the site of the company's current world headquarters in Milwaukee. Over the next 100 years Harley-Davidson has gone on to outstanding success, releasing innovative and unique designs that have become so easily recognizable on roads worldwide. Harleys are known as the preeminent motorcycle both in this country and around the world and have become a staple of the U.S. Armed Services as well as police and fire departments throughout the country.

Harley-Davidson will be celebrating its 100th birthday this August in its hometown of Milwaukee, Wisconsin. This three-day event will include festivities on Lake Michigan, a never-before-seen exhibit of sketches, videos, clay models, and mock-up motorcycles demonstrating various stages of the design used process by Harley-Davidson's Styling and Engineering departments, as well as a parade of 10,000 Harleys through downtown Milwaukee.

The national celebration will have events leading up to the grand celebration in cities across America including Las Vegas, Nashville, Indianapolis, and Dearborn. I want to invite all Harley-Davidson enthusiasts, young and old, to come out and take part in this once in a lifetime event.

I urge my colleagues to join me in honoring this great American company by cosponsoring this resolution.

RECOGNIZING R.G. MORRIS

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. GRAVES. Mr. Speaker. I rise today to acknowledge the impeccable motor carrier safety record of Mr. R.G. Morris of Blue Springs, Missouri. Mr. Morris is a professional motor carrier operator for Yellow Transportation.

According to the most recent information from the Federal Motor Carrier Safety Administration, large trucks drove 7 percent of all vehicle miles traveled. In motor vehicle crashes, large trucks represented 9 percent of vehicles in fatal crashes, 3 percent of vehicles in injury crashes, and 5 percent of vehicles in property-damage-only crashes.

Mr. Morris reached a safety milestone when he recently surpassed one million miles driven without a preventable accident. This outstanding achievement, obtained by few drivers, demonstrates Mr. Morris' commitment to safety. To put this accomplishment in perspective, the average car driver would have to travel around the world forty times to equal this milestone.

Mr. Speaker, please join me in congratulating Mr. R.G. Morris for reaching this noteworthy milestone. I am proud to have a constituent as dedicated to highway safety as he is, and I wish him continued safe driving in the future.

TRIBUTE TO ABINGTON SENIOR HIGH SCHOOL

HON. JOSEPH M. HOEFFEL

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. HOEFFEL. Mr. Speaker, I rise today to honor Abington Senior High School as the recipient of the 2003 Harris Wofford Award presented by Youth Service America and the State Farm Companies Foundation.

The Harris Wofford Award, named for former US Senator Harris Wofford of Pennsylvania, was established in 2002 for the first annual State Farm Awards Luncheon as part of the 13th Annual National Service-Learning Conference. This award honors Harris Wofford's life long "mission of making service to others the common expectation and common experience of every young person in America".

An award like this is long overdue for Abington Senior High School since they have been dedicated to community service for years. The service-learning program, which started in 1995, has encouraged the student body to take an active interest in helping the community. The positive impact this program has had on the community as well as the students is immeasurable. The 60,000 hours that students spent last year helping the community is an outstanding accomplishment. As a proud parent of two Abington Senior High School alumni, I am sincerely honored to be able to recognize the students of Abington for their dedication and commitment to helping others. Programs like these not only help the community but also teach our youth the power of working together and helping others.

NATO ALLIED COMMAND TRANSFORMATION

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. BEREUTER. Mr. Speaker, this Member wishes to note the establishment of Allied Command Transformation in Norfolk, Virginia, on June 19, and to congratulate Admiral Edmund P. Giambastiani, Jr., the commander of U.S. Joint Forces Command, on his appointment as the first Supreme Allied Commander Transformation.

The establishment of the first functional strategic command for the North Atlantic Treaty Organization (NATO) is an important step for the Alliance as it reforms its command structure to better carry out the missions needed to defend its member countries against today's threats. Allied Command Transformation replaces the old Allied Command Atlantic, which had been responsible for keeping open sea lanes between North America and Europe during the Cold War. Today, NATO faces a more pressing task: transforming allied forces from static formations designed for territorial defense to expeditionary forces able to deploy wherever needed to combat security threats. By locating Allied Command Transformation in Norfolk, home to U.S. Joint Forces Command, the transformation lessons being learned by the U.S. military can be shared with our NATO allies.

The establishment of Allied Command Transformation is an important part of the new NATO command structure, which reduces the number of NATO headquarters from 20 to 11 and eliminates geographic responsibilities. This leaner, deployable command structure will allow the Alliance to command missions wherever the member countries decide that NATO is needed.

This Member wishes to commend to his colleagues the attached speech by Lord Robertson, the Secretary General of NATO, at the ceremony to commission Allied Command Transformation on June 19, 2003.

REMARKS BY THE SECRETARY GENERAL OF NATO, LORD ROBERTSON, AT THE CEREMONY TO THE COMMISSION OF THE NEW ALLIED COMMAND TRANSFORMATION

Admirals, Generals, Ladies and Gentlemen, this is a unique ceremony, because we are not only welcoming a new commander—we are also changing fundamentally the very nature and purpose of this strategic headquarters. Indeed, we are creating a new organisation all together. That, in the history of this great Alliance, makes this a very special day.

Our first task is to thank the man who has led Allied Commander Atlantic since last October—Admiral Sir Ian Forbes. Admiral Forbes, your predecessor, General Kernan, once described Allied Command Atlantic as NATO's bridge to the future. When you took command of this headquarters, you vowed to continue that mission. You have done so and with true distinction. Your staff here at Norfolk has nothing but the highest praise for the work you have done here. That is an most important testimonial.

Let me add my own thanks, and congratulations, for the important work you have done here since January 2002, first as Deputy and then as Acting Supreme Allied Commander Atlantic. You have provided sound leadership in Norfolk through a critical period of concluding SACLANT's successful mission and defining the role—and I might add, daring role—this new command will play in the Alliance. We will continue to value your leadership as Deputy Supreme Allied Commander, Transformation.

Admiral Giambastiani—or Admiral "G", as you are already known here—this is your first day on the job. But you have already made history, as the first commander of the new Allied Command Transformation. This is an honour that is well deserved. I would like to congratulate you, as well, on this appointment.

In the coming years, Admiral, you will have a key role to play in shaping NATO's transformation. It is a transformation that has already begun, and the establishment of this Command—ACT—is proof positive.

ACT will shape the future of combined and joint operations. It will identify new concepts, and bring them to maturity. It will then turn these transformational concepts into reality; a reality shared by the entire NATO Alliance. And it will do so in close cooperation with the U.S. Joint Forces Command co-located here, to ensure that NATO's transformation stays in lock step with the changes taking place in the United States.

Indeed, the creation of a new permanent command here in Norfolk—one dedicated solely to transformation—demonstrates the investment NATO is making in preparing itself for 21st century operations.

This Command underscores NATO nations' commitment to a continuous, permanent process of transforming and modernising our armed forces.

ACT is, in a very real sense, both the symbol of the new NATO, and the architect that will shape its future. It will play an invaluable role in ensuring that the Atlantic Alliance can continue to defend the security and interests of its members against threats and challenges which we cannot even imagine today.

ACT is a symbol of this Alliance's confidant embrace of the future and its challenges.

Admiral Giambastiani, as I said last week to NATO Defence Ministers in Brussels, your new title, Supreme Allied Commander Transformation, means that you more than anyone else will personify the critical importance this Alliance places on transforming its capabilities for the 21st century. An awesome responsibility. But welcome nevertheless to the NATO family.

SUPPORT INCREASED TRANSPORTATION INVESTMENT

HON. ANÍBAL ACEVEDO-VILÁ

OF PUERTO RICO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. ACEVEDO-VILÁ. Mr. Speaker, the House of Representatives is fortunate to have the leadership and commitment to critical transportation investment in Chairman DON YOUNG, Ranking Member JIM OBERSTAR, Subcommittee Chairman TOM PETRI, and Subcommittee Ranking Member WILLIAM O. LIPINSKI. As Congress moves toward consideration of the reauthorization of the Transportation Equity Act of the 21st-Century, we need to provide the necessary increased investment to meet the growing needs of surface transportation. I am confident that with the strong leadership on the Transportation and Infrastructure Committee, the reauthorization process will provide growth in the surface transportation program in order to ensure safe and efficient surface transportation networks.

Investment in surface transportation is critical to our economy, the environment, and quality of life. Transportation related investment produces new jobs and is directly related economic activity. Investment in efficient transportation networks also relieves and prevents congestion, a serious environmental challenge and costly burden facing regions throughout the U.S. and Puerto Rico.

Transportation investment goes beyond moving people and goods and providing fertile ground for economic growth and prosperity. Transportation is about safety and the health of our citizenry, whether they travel on highways, urban arteries, subways, bikes or as pedestrians.

Puerto Rico has tremendous mobility related challenges that we are addressing through an important partnership between the Commonwealth, Congress, and the federal government. While Puerto Rico is a small island only 100 miles by 30 miles in size, our population is nearing 4 million people.

Puerto Rico has one of the highest vehicles per mile of road ratio in the world. Congestion and related economic and environmental problems are a serious challenge facing Puerto Rico. Geographical constraints, a growing population, and economic growth all necessitate significant continued transportation investment.

Puerto Rico is nearing the completion of Phase 1 of the New Start Tren Urbano project in metropolitan San Juan. I will seek authorization of Phase 2 of this important project, for transportation that will enable necessary continued growth in the program so that safe, efficient intermodal networks result throughout.

Through adequate investment, we can build today to meet the increasing demands of the future. Investment in transportation infrastructure produces more than highways, new start light rail projects, or high-speed ferryboats. Transportation investment is also about safety, economic development and quality of life. I urge my colleagues to support the leadership of the Transportation and Infrastructure Committee who will fight for necessary investment in transportation to meet the growing needs of tomorrow by necessary investment today.

TRIBUTE TO ROBERT PATRICK

HON. MARION BERRY

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. BERRY. Mr. Speaker, I rise today to pay tribute to a great Arkansan, an outstanding citizen and one of our state's enduring treasures, Robert Patrick. I am proud to recognize Mr. Patrick in the United States Congress for his invaluable contributions and dedicated service to the people of Arkansas County and the nation.

Mr. Patrick was born and raised in DeWitt, which is located in the same county where I was raised. While he was still a teenager, Mr. Patrick left the small community where he grew up to serve his country in the United States Navy. After returning home from his distinguished military service, Mr. Patrick married his lovely wife Doris, a fellow Arkansas County native.

Mr. Patrick built a successful career as an energetic and successful salesman traveling the country to make a living and support his family. He, Doris and their two children, Pam and Kevin, lived in locales as varied as California, Missouri and even Connecticut, where the Patrick family owned and operated a sports and hobby shop.

As Mr. Patrick neared retirement age, he and Doris decided to move back to her hometown, St. Charles, where his dedication to community service took root. Just two years after moving to St. Charles, Mr. Patrick was elected mayor, and it seems like he hasn't rested since.

Personally, I think of him as the consummate utility man—and not because he has worked tirelessly to upgrade the natural gas, water and sewer infrastructure in St. Charles. Rather, just like a good utility player on a baseball team that's willing to play any position in the field to help his team, Mr. Patrick has been willing to do anything to improve his town. He has done everything from securing a full-time police officer for St. Charles to erecting the city's annual Christmas light display.

Mr. Patrick embodies everything that's wonderful about living in small town America. He has generously shared his time and talent with the citizens of Arkansas County and it's a better place to live because of him. On behalf of Congress, I salute Mayor Robert Patrick of St. Charles, and thank him for his tireless service to his community, his state and his nation.

HONORING THE RETIREMENT OF MAJOR GARY L. BERGOSH

HON. JEFF MILLER

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. MILLER of Florida. Mr. Speaker, I rise today to recognize Major Gary Bergosh and celebrate his safe return home from active duty in Operations Enduring Freedom and Iraqi Freedom. Gary is the ultimate example of a citizen soldier by serving his country for four years of active duty in the Marine Corps Reserves and the state of Florida for the past ten years practicing law.

Gary was raised in a Navy family and attended elementary, middle and high school in Pensacola, Florida. Gary attended Pensacola Junior College and graduated from The University of West Florida. Shortly after graduation, Gary attended Marine Corps Officer Candidate School, where he was commissioned as a Second Lieutenant.

Gary attended law school at the University of Memphis while serving in the Marine Corps reserves. Upon completion, Gary entered active duty with the Marine Corps and served three years in Okinawa, Japan as a prosecutor and a defense attorney.

After leaving active duty with the Marine Corps, Gary decided to return home to Pensacola and became a prosecutor for the State Attorney's office.

Gary is currently a senior attorney for the Federal Government, a Major in the United States Marine Corps Reserves, and in November of 2000 was appointed by Florida Governor Jeb Bush to serve as a member of the Escambia County School Board.

Gary's Marine Corps unit, the 4th Assault Amphibian Battalion, was activated on January 27, 2003 to fight the nation's war against terrorism.

Gary served as the Battalion's Executive Officer in Kuwait and Iraq during Operations Enduring Freedom and Iraqi Freedom. Gary returned with his Battalion to the United States on June 6, 2003. Gary will be demobilized from active duty on September 1, 2003.

While at the Marine Corps Officer Candidate School, Gary married the former Carissa Borders, a native of Pensacola. Gary and Carissa are currently the proud parents of Alexander. The Bergosh family are active members of their church and community.

Mr. Speaker, I would like to recognize Major Gary Bergosh for the example he has set in his community. I offer my sincere thanks for all that he has done for Northwest Florida and this great nation.

PERSONAL EXPLANATION

HON. JIM KOLBE

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. KOLBE. Mr. Speaker, yesterday, I was unavoidably detained and missed votes on the following measures:

1. H. Res. 264—Expressing sympathy for the victims of the devastating earthquake that struck Algeria on May 21, 2003 (#297). Had I been present, I would have voted "aye."

2. H. Res. 177—Commending the people of the Republic of Kenya for conducting free and fair elections, for the peaceful and orderly transfer of power in their government, and for the continued success of democracy in their nation since that transition (#298). Had I been present, I would have voted "aye."

3. H. Con. Res. 209—Commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia (#299). Had I been present, I would have voted "aye."

4. H.R. 2465—Family Farmer Bankruptcy Relief Act of 2003 (#300). Had I been present, I would have voted "aye."

TRIBUTE TO SAM JOHNSON

HON. MIKE ROGERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. ROGERS of Michigan. Mr. Speaker, I rise today to pay tribute posthumously to Fort Campbell's Deputy Garrison Commander, Sam Johnson for his vital role and tireless commitment to his duties and country.

Sam Johnson began his career at Fort Campbell in 1972. He was the first civilian to fill the position of Youth Activities Director. Mr. Johnson quickly rose to the top at Fort Campbell, continually becoming the first civilian to fill the posts of Outdoor Recreation Director, Recreation Services Officer, and even being transferred to Panama in the Cold War to oversee the entire Army Recreation Program.

After serving in Panama, Mr. Johnson returned to Fort Campbell to, yet again, become the first civilian to hold the title and responsibility of Deputy Director of Personnel and Community Activities. In just a few years, he became Director of Personnel and Community Activities. Mr. Johnson's excellent administrative skills shined in his position as Deputy Resource Manager, which helped him to obtain his appointment as the only civilian to ever serve as Deputy Garrison Commander.

For the past 11 years, Mr. Johnson has served as Deputy Garrison Commander. His love for his country is evident by his devotion to his job. Despite his diagnosis of non-Hodgkin's lymphoma, he still continued with his duties. Mr. Johnson was able to perform his responsibilities as Deputy Garrison Commander until his recent death. Deputy Garrison Commander Sam Johnson emulated his principles of hard work and never giving up.

Mr. Speaker, I wish to extend the gratitude of myself and the entire Nation to Sam Johnson in recognition of his outstanding commitment and service to Fort Campbell and to our country. I ask my colleagues to join me in thanking him and offering comfort to his family and Fort Campbell, as they will truly miss Sam Johnson, a man of true courage and character.

CONGRATULATIONS CONTINENTAL MICRONESIA ON 35TH ANNIVERSARY

HON. MADELEINE Z. BORDALLO

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Ms. BORDALLO. Mr. Speaker. I rise today to congratulate Continental Micronesia on its 35th anniversary and to wish a happy birthday to CEO Mark Erwin and employees of Continental Micronesia.

I also want to take this time to commend the services rendered by Continental Micronesia to the island of Guam. Guam is the regional hub for Continental Micronesia, and we are proud of the network that strengthens ties between Guam and our Pacific neighbors. Tourism is the leading private sector industry on Guam, and Continental has provided consistent, reliable service to Guam and to destinations across the entire Pacific Rim including: Cairns, Australia; Denpasar, Indonesia; Hong Kong; Honolulu, Hawaii; Koror, Palau; Kosrae, Micronesia; Kwajalein, Marshall Islands; Majuro, Marshall Islands; Nagoya, Japan, Niigata, Japan, Osaka/Kenai, Japan; Pohnpei, Micronesia; Saipan, Commonweath of the Northern Mariana Islands; Sapporo, Japan; Sendai, Japan; Taipei, Taiwan; Chuuk, Micronesia; and Yap, Micronesia.

Continental Airlines moved its headquarters to Los Angeles, California in July, 1963, as it provided important transportation services to members of the armed forces between the United States and Asia during the Vietnam War. In response to its increased importance in the Pacific during the Vietnam War, Continental formed Air Micronesia in 1968. Air Micronesia, now known as Continental Micronesia, has become one of the principal passenger airlines for the islands of the Pacific, providing services between the islands and nations along the Pacific Rim and the mainland.

Under trailblazing CEO Robert F. Six, Continental Airlines mixed creativity with ingenuity in establishing many of its flight routes in the Pacific. During the 1960's, Continental Micronesia would staff flights with mechanics and carry spare materials on board in order that passenger airliners could land on and embark from coral island landing strips. The company was also innovative in that it opened hotels and restaurants at its island destinations in order to stimulate tourism.

In 1976, Air Micronesia began providing services between Saipan and Japan. This additional service would prove to be vital to the future economic growth of Guam, for the vast majority of the over one million tourists that visit Guam each year are Japanese. In fact, Continental Micronesia's Guam-Tokyo, Japan route became the airline industry's single most profitable route in the world. We on Guam are grateful for this mutually beneficial relationship, and we look forward to working together with Continental to perpetuate further growth of the visitor industry on Guam.

I want to express my deepest gratitude to Continental Micronesia and its employees for their years of hard work and dedication to the people of Guam, as they celebrate their 35th birthday. Without their commitment, the visitor industry on Guam could not thrive.

HONORING THE MEMORY OF MR. HOWARD D. SAMUEL

HON. PETER J. VISCLOSKY

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. VISCLOSKY. Mr. Speaker, it is with great admiration that I rise today to honor the memory of Mr. Howard D. Samuel, and his lifelong contributions to our great country. Howard passed away on June 19, 2003. His efforts as a veteran of the labor movement, as well as his numerous positive accomplishments during his long career, are worthy of the highest commendation.

Howard began his work in the labor movement in 1949 as an organizer with the Amalgamated Clothing Workers of America. He was then elected as international vice president in 1966. His dedication and unrelenting service to the movement paved the way for new and innovative solutions to labor problems and issues. In 1977, he was appointed U.S. Deputy Secretary of Labor for International Labor Affairs by President Carter. His role as Deputy Secretary allowed him the opportunity to be involved with many facets of the department such as international trade, trade adjustment assistance, and the International Labor Organization.

In 1979, Howard was elected President of the Industrial Union Department, a federation consisting of over 50 national and international unions affiliated with the AFL–CIO. During his presidency, he founded the Collective Bargaining Forum, a study group of union presidents and various company CEOs. This Forum initiated several groundbreaking reports on industrial relations issues. In 1991, Howard was the first labor representative to ever be appointed to the Defense Science Board, a key advisory organization to the Secretary of Defense.

Howard, by serving in the U.S. Army from 1943 to 1945, exhibited his true sense of patriotic duty to our nation. He also served as vice chairman of both the New York Coalition and the Council on Competitiveness. Along with his many other contributions to society, he was also a trustee and board member of the Carnegie Corporation, the Martin Luther King, Jr. Center in Atlanta, as well the American Civil Liberties Union, to name just a few.

Mr. Speaker, Howard D. Samuel dedicated his life to supporting the labor movement and serving as a leader and role model for all Americans. I respectfully ask that you and my other distinguished colleagues join me in remembering Mr. Samuel and his lifetime of achievement and devotion to our great country. He will be remembered honorably and truly missed.

IN RECOGNITION OF JOSEPH C. SPICUZZO

HON. FRANK PALLONE, JR.

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. PALLONE. Mr. Speaker, I rise today to recognize Joseph C. Spicuzzo, a friend and distinguished public servant who has dedicated much of his life to improving the lives of others. Joe is being awarded the Americanism Award by the Anti-Defamation League tonight in New Brunswick, New Jersey not only for his distinguished public service but for his dedication to raising funds for important charitable causes.

Joe began his long career of public service with his election as Mayor of Spotswood in 1976 and currently is the Middlesex County Sheriff and the Chairman of the Middlesex County Democratic Organization. Joe was also asked by Governor McGreevey to take on the added responsibility of being the "Chair of Chairs", an informal position that allows him direct access to the Governor and his staff to help resolve outstanding issues affecting the individual counties in the State. Joe has demonstrated great success in leadership positions mainly because of the confidence people have in his interpersonal skills, his ability to settle disputes, and his affable manner.

In addition to the dedication Joe has illustrated in his public service, he has been a tireless fundraiser for important charitable causes. He has raised funds for the American Heart Association, a cause especially dear to him because of the death of his father at an early age from this silent killer. Joe became a key figure in the annual fundraising drive, Operation Heartbeat, held every February on WCTC radio station. He has been recognized with an American Heart Association Testimonial, the March of Dimes Franklin Award, the Salvation Army OTHERS Award and the B'nai B'rith International Humanitarian Award. He was also named Man of the Year by the George Otlowski Citizens League, the North Brunswick Italian American Club, and awarded the Hubert H. Humphrey Friend of Labor Award in recognition of his friendship and outstanding work.

Joe and his wife, the former MaryAnn Longo, and their daughter, JoAnn now reside in South River, New Jersey. Their son, Charlie and his wife, Denise, returned to the Borough of Spotswood to begin their life together.

Mr. Speaker, on this day I rise up to acknowledge a truly remarkable individual and I ask that my colleagues join me in honoring the distinguished Joseph C. Spicuzzo for his untiring dedication and devotion to serving his community.

HONORING FATHER MICHAEL P. BAFARO

HON. JAMES P. McGOVERN

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. McGOVERN. Mr. Speaker, I rise today to honor Father Michael P. Bafaro for his service to the local and international community.

Father Bafaro studied at St. Thomas Seminary in Bloomfield, CT; Seminary of Philosophy in Montreal, Canada; and Vesovile Seminary in Pordenone, Italy. At Vesovile, Father Bafaro was ordained on June 28, 1953. He worked for 11 years at Our Lady of Lourdes and Our Lady of Mt. Carmel in Worcester, Massachusetts before volunteering to travel to Sicuani, Peru to work with the often neglected Andean community.

His experience in Peru was a critical step towards his role as an international community leader and activist. He returned to Worcester to work with the Latino community. In Worcester, he founded the only Latino community-based organization in the city. His role as founder and executive director of Centro Las Americas, in addition to his longtime participation in the community thereafter, caused the organization to grant Father Bafaro the first Annual Lifetime Achievement Award.

Father Bafaro earned the position of Pastor/Administrator of Our Lady of Mt. Carmel-St. Ann in Worcester in 1986. This position had a special spiritual meaning for the Father Bafaro due to his close relationship with the Carmelites of Peru. Once again Father Bafaro excelled as a leader and defender of human rights and equality. He has proven to be a loyal advocate for children's education, cultural awareness, low-income housing, and employment opportunities for those in need. He built the Mt. Carmel Apartments for low-income and handicapped people in 1991 and the Italian-American Cultural Center.

Father Bafaro has been honored with the Worcester Sons of Italy Achievement Award and Social Justice Award; the Beacon Award from the Unitarian Universalist Church of Worcester; the Pro-Deo Ad Juventudem Medal; and on four separate occasions, he received the key to the City of Worcester. Father Bafaro also participated in organizations such as the Affirmative Action Commission for the City of Worcester; the Board of Directors of the Northeast Hispanic Catholic Pastoral Center; the Priest Senate of the Diocese of Worcester; the Governor's Commission of Puerto Ricans and Hispanics; the Executive Board of Worcester Cooperative Council; City Managers Manpower Commission; Coalition for Peace and Justice; the Federation of New England Catholic Charities and Social Services; the Order of Sons of Italy; the United Way Task Force; and Ad Hoc Committee for Statewide Education.

Father Bafaro supported the Worcester community in December 1999 after the fire that claimed the lives of six firefighters. He provided support and guidance to the families and friends of the fallen heroes.

He is the president of Worcester Community Cable Access television station where important community issues are presented and discussed. These examples show his devotion to raising the consciousness of others and the extent to which he stands for peace and justice. Father Bafaro has touched many lives, and has spent most of his life working to improve the lives of others. He has struggled alongside the underprivileged and promoted open-mindedness among people from multiple backgrounds.

I can attest to the extent at which Father Bafaro has assisted and guided the community of Worcester because he has collaborated with my staff and me on various projects, including the Latino Education Institute. I have witnessed the accomplishments of Father Bafaro as a local community activist and leader who has based his work on the broader goal of promoting justice and equality at home and abroad.

Mr. Speaker, I am sure that the entire U.S. House of Representatives joins me in thanking Father Michael P. Bafaro for his contribution to the community.

TAIWAN'S INCLUSION IN THE WHO

HON. PETER T. KING

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. KING of New York. Mr. Speaker, today I rise in strong support of Taiwan's entry into the World Health Organization (WHO). Time and time again Taiwan has been thwarted from joining this international organization solely because of objections from the People's Republic of China. Most recently this occurred in May at the World Health Assembly in Geneva; even after Congress passed legislation (P.L. 108–028) authorizing the U.S. Government to implement a plan for Taiwan to obtain observer status and Secretary of Health Human Services Tommy Thompson publicly and firmly expressed U.S. support for Taiwan's inclusion in the WHO.

The recent SARS outbreak in Asia has made it very clear how important it is to allow Taiwan to participate in the WHO. While the People's Republic of China was suppressing information and statistics about the disease and covering up its scope, Taiwan, on the other hand, was reporting freely and accurately on SARS. It immediately offered to work with the WHO yet was denied; only later were two WHO experts dispatched to Taiwan. In addition, Beijing was quite unhelpful in alerting the WHO and neighboring countries as to when and where this outbreak originated causing additional infections and deaths.

We all have a responsibility to assist the WHO and inform the world when it comes to global health. For too long, however, Taiwan has not been given this opportunity because of political motivations. It is now time to allow Taiwan to join the WHO or at least allow it to obtain observer status. With the threat of outbreaks such as SARS sweeping across continents and infecting thousands, it is not only absurd but also immoral to keep the 23 million Taiwanese citizens from receiving its assistance. Taiwan, and the world for that matter, will be far better protected when it finally obtains WHO membership.

WHY ME? CLUB

HON. KATHERINE HARRIS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Ms. HARRIS. Mr. Speaker, I rise to recognize an extraordinary group of high school students, who have set the gold standard for leadership, compassion, and selflessness in my hometown of Sarasota, FL.

In September of 2002, Zak Tanjeloff, a student attending Sarasota High School, founded the Why Me? Club to implement his vision of providing relief to the poverty-stricken children of South America.

Demonstrating amazing dedication and skill, Zak and his fellow students have organized and managed major relief efforts entirely on their own.

Motivated by a soul-searching question—"Why am I lucky enough to live the life I live when so many suffer so greatly throughout the world?"—they have collected and delivered medical supplies, school supplies, sporting goods, dental supplies, toiletries, toys, and other items that most children and adults take for granted to impoverished locations in Mexico, Guatemala, Honduras, and Surinam.

While their fellow students vacationed on Florida's beaches during Spring Break 2003, the Why Me? Club, in partnership with Operation Serving Children, delivered over $100,000 worth of much-needed medical supplies to the people of Chisec, Guatemala. Moreover, a second group of Why Me? members recently traveled once again to Chisec with yet another $100,000 in medical supplies.

Mr. Speaker, these exceptional young men and women deserve our thanks and our acclaim. Their generosity, their global awareness, and their commitment to the most vulnerable members of the human family demonstrate that the greatest virtues of our Nation still illuminate the hopes and dreams of our children.

HONORING SERGEANT DORIS HIGGINS

HON. CHRISTOPHER COX

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. COX. Mr. Speaker, on July 6, 2003, the Laguna Beach Police Department will say farewell to retiring Sergeant Doris Higgins.

Sergeant Higgins began her career with the Laguna Beach Police Department on June 29, 1970, as a police dispatcher. Seven years later, she became a full-time officer assigned to the field services division of the department, where she worked until 5 years ago, when she was assigned to the traffic division.

What makes Sergeant Doris Higgins stand apart from other officers is the fact that she began serving her community as a police officer when women were just beginning to make inroads in the profession.

She has been a role model for women looking to break into the profession. She has guided many employees as they have begun and ended their law enforcement career. She has been a noticeable strength of the local law enforcement community. Now, the Laguna Beach Police Department must say goodbye after 33 years.

Today, I ask my colleagues to join with me in congratulating Sergeant Higgins on her retirement and thanking her for years of dedication to the citizens of Laguna Beach.

PERSONAL EXPLANATION

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. DAVIS of Illinois. Mr. Speaker, I was unable to cast votes on June 11 because I was attending a very important meeting involving healthcare with the President of the United States in my district in Chicago, Illinois. If I was present for rollcall votes for the following bills:

Rollcall 258 on agreeing to the resolution H.R. 2115, Flight 100—Century of Aviation Reauthorization Act;

Rollcall 259 on motion to suspend the rules and agree to Expressing Support for the Goals and Ideals of Human Genome Month and DNA Day;

Rollcall 260 on motion to Suspend the Rules and Pass, as Amend the Commercial Spectrum Enhancement Act;

Rollcall 261 on motion to suspend the rules and pass the Welfare Reform Extension Act;

I would have voted Yeas to all of these bills.

TORTURE DEATHS IN UZBEKISTAN REVEAL LACK OF PROGRESS

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. SMITH of New Jersey. Mr. Speaker, in March 2002, the United States and Uzbekistan signed a declaration proclaiming a "Strategic Partnership" between our countries. This former Soviet republic, with the largest population of the five Central Asian countries, has played an important role in assisting the United States after 9/11, and I am grateful for that.

At the same time, as Chairman of the Helsinki Commission, I have deep concerns about the human rights situation in Uzbekistan, where no political opposition, no freedom of speech nor freedom of association are permitted. As a result of this situation, Congress has conditioned the release of financial assistance to Uzbekistan upon a determination by the Secretary of State that Tashkent is making "substantial and continuing progress" in meeting commitments specified in the March 2002 bilateral declaration, including in the field of human rights. The Secretary has twice—on August 26, 2002 and May 14, 2003—made such a determination.

Regrettably, there has been no "substantial and continuing progress" in the field of human rights in Uzbekistan. True, a human rights group has been registered, censorship has formally been lifted, and there have been amnesties, but these are largely token deliverables meant to give the appearance of progress. Uzbekistan has also admitted the U.N.'s Special Rapporteur on Torture. But all these gestures are more cosmetic than substantial. In fact, the U.N. Special Rapporteur concluded that torture is "systematic" in Uzbekistan. Instead of claiming credit for allowing him into the country at all, President Karimov should renounce this barbaric practice and Tashkent should take urgent measures to prevent and punish acts of torture.

Unfortunately, thus far President Karimov has refused to take even the simple step of acknowledging and renouncing torture. More to the point, just after the Secretary's most recent determination last month, Orif Ershanov and Otamaza Gafaro joined the unconscionably long list of individuals who have died as a result of torture or other abuse inflicted by Uzbek officials.

Once again, Uzbek officials maintain that these most recent deaths in custody were the result of "natural causes." But the country's deplorable record undermines the credibility of such assertions. Frankly, I am surprised by Tashkent's claims; last year, there were two cases when Uzbek policemen who tortured prisoners, in some cases to death, received long prison terms. Their sentences constituted a sad form of progress in Uzbekistan, allowing observers to hope that law enforcement officials would have reason to fear serious consequences for mistreating people in their care. The latest assertions about "natural causes" signal clear regression to old positions that damage Uzbekistan's government and should be an embarrassment to the United States.

Particularly with respect to torture, Tashkent should immediately take several steps to demonstrate to the international community a serious commitment to make meaningful progress.

First, the Government of Uzbekistan should provide immediate access, organized by the OSCE, for independent medical experts to examine the bodies of Ershanov and Gafaro. Unfortunately, we have received indications that Uzbekistan is balking at admitting independent forensic specialists. Furthermore, Tashkent should establish a system of access for independent experts to investigate all cases of alleged torture and should act on the recommendations of the U.N. Special Rapporteur on Torture.

It is equally important that Uzbekistan unconditionally release those who have been jailed because of their political opposition or religious affiliation. I have repeatedly urged Uzbek officials, including President Karimov during his visit to Washington in March of last year, to release the writer Mamadali Makhmudov, for example. One of the

Bekjanov brothers has indeed been freed, but two of his siblings remain in prison, and we have received reports from family members of their declining health. As the most recent deaths in custody demonstrate, fears that such prisoners may die from their mistreatment during incarceration are well founded.

Mr. Speaker, improved relations are in the interest of both Uzbekistan and the United States. But closer, deeper ties will not be built on the graves of Uzbekistan's citizens who have been tortured to death. I hope, Mr. Speaker, that I will soon be able to report back to my colleagues that President Karimov has taken meaningful steps to confront torture and bring a measure of justice to its victims.

BIOTECH DECISIONS SHOULD BE SCIENCE-BASED

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. BEREUTER. Mr. Speaker, this Member commends to his colleagues the following editorial from the June 23, 2001, Omaha World-Herald. The editorial emphasizes the need to take a science-based approach regarding the issue of biotech crops and highlights a positive example in India. On the other hand, the European Union's continued moratorium on approving new agriculture biotech lacks a scientific basis. This discriminatory and protectionist stance harms U.S. farmers, consumers worldwide, and developing countries. The U.S. is correctly challenging the EU's position, which is transparently devoid of any relationship to sound science.

A TALE OF TWO MIND-SETS

Recent days have shown a big contrast in how some governments abroad approach the issue of genetically modified foods.

One development, from India, reflects a commendable, science-based approach to biotech crops. The other from the European Union, indicates the E.U.'s continuing insistence on using bogus claims about biotech crops as an excuse to shut out U.S. food exports.

In India, the government says it is nearing regulatory approval of a genetically modified potato that has one-third more protein than normal. The new potato is to be distributed to school children as part of their midday meal.

The head of India's biotechnology department voiced strong support for the new product, calling it part of "a technology for the future." Many of India's more than 1 billion people are plagued by dietary deficiencies in protein and vitamin A, she said, and biotech foods such as the new potato can help address the need.

In another encouraging sign, a group of Indian scientists stepped forward in April to rebut the claim by anti-biotech activists that the new potato is the brainchild of profit-seeking Western corporations: As reported by The Associated Press, "the Indian scientists made clear they are on the front lines of such developments."

Last week, representatives of India's biotech sector' spoke out, saying that their industry' is in a state of "near paralysis" due to opposition from critics of genetically modified foods. One Indian biotech consultant lamented that the "protest industry" has "exploited a few—technical violations and has made the entire system rigid."

In Europe, anti-biotech activists enjoy particular clout, and last week talks between U.S. and E.U. officials over genetically modified foods broke down. The United States will now turn,to the World Trade Organization to appoint a panel to rule on the case. The United States is said to have a good chance of gaining a ruling that would compel the E.U: to end its ban on American biotech crops.

Don Lipton, a spokesman for the American Farm Bureau Federation, was right when he said that "countries shouldn't be able to erect barriers for nonscientific reasons." In India, the government, to its credit, acknowledges that point. Regrettably, European governments are content to ignore it and continue their opportunistic stonewalling.

CONGRATULATING FRANK J. WSOL OF CHICAGO

HON. RAHM EMANUEL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. EMANUEL. Mr. Speaker, I rise to congratulate Frank J. Wsol, the Secretary Treasurer of Teamsters Local 710, on being presented the Distinguished Community Service Award by the Anti-Defamation League at their annual dinner.

Frank Wsol epitomizes the principles of organized labor and the role it plays in our community. He has served loyally as a Teamster since 1946, and has ascended the ranks first as an Organizer, and later as Chairman of the Union's Health, Welfare and Pension Fund.

In addition to proudly serving as a Teamster, Frank has been a leader for all of labor including service as Chairman of the Illinois Joint State Grievance Committee and on the Executive Committee of the Chicago Federation of Labor. He currently serves as a member of the Executive Board for Joint Council 25.

Many of the principles of the organization and community that Frank has embodied for the last half century have come from his service to our country as a member of the U.S. Air Force. Frank served in both Japan and Korea, and has stayed active as a member of the Neer-Goudie American Legion Post 846.

Frank's care for his community has always included his love for children and his dedication to providing them with a bright future. He has dedicated time and energy to the Children's Advocacy Center in both Chicago and Hoffman Estates, and the Little City Foundation in Palatine.

Mr. Speaker, I join the Anti-Defamation League in recognizing Frank Wsol. I also congratulate Frank and his wonderful family: Florence, his wife of over 50 years, his late daughter Maureen, his son Michael and his fiancée Marlene Demuzio, his son Frank Jr. and his wife Madeline, and his grandsons Frank, Brian, Kevin and Steve. And I applaud the Anti-Defamation League for the work that they do to protect our liberty, and for honoring one of our most distinguished citizens.

CONGRATULATIONS TO MOSAIC

HON. TOM OSBORNE

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. OSBORNE. Mr. Speaker, On July 1, 2003, two organizations deeply rooted in Nebraska will join hands to form a new organization dedicated to caring for people with developmental disabilities. I rise today to recognize and commend the beginning of this new organization—Mosaic.

Bethphage, founded in 1913 in Axtell, Nebraska, which is located in my congressional district, and Martin Luther Home Society, founded in 1925 in Sterling, Nebraska, is my colleague from Nebraska's, Mr. Bereuter's congressional district, bring 168 years of experience to the field of developmental disabilities. The consolidation of the two organizations will give Mosaic secure financial strength, fiscally responsible stewardship and diverse professional choices as it works to make life better for people with disabilities.

Mosaic will serve approximately 3,700 people in 16 states and Great Britain, and will employ more than 5,100 direct support professional, regional management and home office staff. Mosaic will have two corporate offices, both of which will be located in Nebraska.

Finally, Mosaic will provide a full range of supports and advocacy for people with disabilities from early intervention through elderly care. Services will include residential group home, host home, in-home supports, behavioral skills, and spiritual development.

As Mosaic officially begins operations on July 1, 2003, I want to congratulate this exceptional organization for their visionary leadership in the field of developmental disabilities. I feel I can speak for many Nebraskans when I say that I am proud that Mosaic calls Nebraska home.

REPRESSION SPREADING IN BELARUS

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. SMITH of New Jersey. Mr. Speaker, Europe's last dictator, Belarus' Alyaksandr Lukashenka, appears determined to ignore the voices of the people of Belarus calling for basic respect for human rights and democratic principles a decade after that country gained its independence and joined the Organization for Security and Cooperation in Europe (OSCE).

As Chairman of the Helsinki Commission, I am disturbed by recent developments which demonstrate the growing repression in Belarus. There have been further restrictions imposed on the independent media, with the recent suspension of independent newspapers Navinki and Ekho. Just a few days ago, the publication Predprinimatelskaya Gazeta was suspended for three months. The offices of the trade union paper Solidarnost have been sealed by the authorities. Still other publications have received warnings that could lead to their closure. These actions were preceded by the three-month suspension of two prominent independent newspapers—Belaruskaya Delovaya Gazeta and BDG—For Internal Use Only.

The Lukashenka regime is also targeting schools. The National Humanities Lyceum, a highly respected high school promoting study of the Belarusian language and culture, is under fire, with its acting head to be replaced by a reportedly non-Belarusian-speaking official. Why? Because professors at the school support democracy and the Belarusian language and culture which ironically is anathema to the Belarusian strongman. Mr. Speaker, what kind of leader actively suppresses his nation's language and culture?

Moreover, a new crackdown on Pentecostal home meetings in western Belarus is underway, with fines being handed down on church members who permit their homes to be used for prayer meetings—a result of last year's restrictive religion law.

Non-governmental organizations (NGOs) are also facing increasing scrutiny, often for truly spurious reasons such as minor mistakes in registration documents. Several, including Ratusha, Varuta and the Youth Christian Social Union, are under threat of liquidation. Just a few days ago, the Homel regional court ordered the closure of the area's largest NGO, Civic Initiatives. The intensified campaign against NGOs and the independent media are widely regarded among domestic and international observers as a concerted attack on active and independent civil society structures.

Repressive actions against individuals continue as well. Recently, 18-year-old ZUBR activist Tatiana Elovaya was sentenced to 10 days imprisonment for manifesting her support in an April 3 demonstration outside the U.S. Embassy for the campaign to liberate Iraq. Several others, including 19-year-old Lyubov Kuchinskaya had served 10-day sentences earlier. Unfortunately, these are just some recent examples of a longstanding pattern of the Lukashenka regime's flouting of its OSCE commitments and continued disregard for the four OSCE criteria set forth three years ago by the Parliamentary Troika for Belarus.

Despite steps by the OSCE community, including the re-opening of the OSCE Office in Miensk (albeit under a more limited mandate), the seating of the National Assembly and the lifting of a visa ban, not only have reciprocal steps not been taken by the Belarusian authorities but the situation has indeed deteriorated further.

Earlier this year, I introduced H.R. 854, the Belarus Democracy Act, designed to assist the people of Belarus in regaining their freedom and enable them to join the European community of democracies. Key provisions of this Act also have been incorporated into the Foreign Relations Reauthorization bill. Mr. Speaker, the Lukashenka regime's continuing suppression of the longsuffering Belarusian people underscores the need for the Belarus Democracy Act and other efforts—including within the OSCE—to restore respect for human rights and institutions of democratic governance.

HONORING CLIFFORD THEODORE SHUMATE

HON. ERNIE FLETCHER

OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. FLETCHER. Mr. Speaker, it is an honor to rise today to pay tribute to a wonderful father and grandfather, resourceful businessman, and lifelong Kentuckian that, unfortunately, passed away on June 21, 2003. I speak of Clifford Theodore Shumate, a self-made man that rose from humble beginnings to build a successful textile-manufacturing outfit that now stretches across Kentucky's Bluegrass Region.

Clifford Shumate was born on September 9, 1914 in Fleming County, Kentucky. The eldest of seven children, Mr. Shumate struggled to provide for his family. When he was just eight years old, Mr. Shumate completed the third grade and was sent to work the land as a tenant farmer. Although he received only a limited formal education, Mr. Shumate was, nevertheless, a knowledgeable man that learned a great deal from his own experiences and self-determination.

In 1933, Mr. Shumate married Carrie Spivey and, together, they founded Griffin Manufacturing in Carlisle, Kentucky. In 1948, with resources totaling about $6,000 and a workforce of only eight employees, Mr. and Mrs. Shumate oversaw a modest t-shirt manufacturing operation. It took little time, however, for this small company to grow.

Within a year, Mr. Shumate expanded his company to include a second Carlisle factory with 150 employees. Following the construction of a third factory in Mt. Sterling, Kentucky, Mr. Shumate consolidated all of his plants into a new 36,000 square foot facility in Nicholas County. By 1973, with new plants in Paris, Cynthiana, and Maysville, Kentucky, Mr. Shumate administered a company with over 3,000 employees.

Clearly, Mr. Shumate's accomplishments in his home state of Kentucky cannot be questioned. However, his personal resolve and desire to grow led Mr. Shumate to open international facilities in Merelbeke, Belgium and Carlton Place, Canada.

After 33 years of service, Mr. and Mrs. Shumate retired in 1980. They left the company, now known as Kentucky Textiles, in the same manner in which they created it—together. Mr. Shumate's international textile firm, which began 55 years ago as a small t-shirt manufacturer in Carlisle, still remains in family hands. Mr. Shumate's son, Wayne, and his grandchildren, Cliff and Paige, are continuing the legacy that Clifford Shumate began long ago, at the age of eight, on the family farm in Fleming County, Kentucky.

PERSONAL EXPLANATION

HON. NITA M. LOWEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mrs. LOWEY. Mr. Speaker, during an absence yesterday, I regrettably missed rollcall votes 297–300. Had I been present, I would have voted in the following manner: rollcall No. 297: "Yea"; rollcall No. 298: "Yea"; rollcall No. 299: "Yea"; rollcall No. 300: "Yea."

80TH ANNIVERSARY OF MAPE'S RANCH

HON. DENNIS A. CARDOZA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. CARDOZA. Mr. Speaker, I rise to commemorate the 80th anniversary of Mape's Ranch in Modesto, California.

Mape's Ranch was founded by E.T. Mape in 1923. The historic 10,000 acres of farmland and wetlands is nestled against the Stanislaus, Toulumne and San Joaquin Rivers, about ten miles west of Modesto. The primary crops produced by Mape's Ranch include wheat, corn, almonds, watermelons, tomatoes, and plums. The ranch also raises beef cattle, and is known as "The Home Of One-Ton Bulls," and has as its famous slogan, "Breed the Best, and Forget the Rest."

These days, Mape's Ranch is owned and operated by the nephew of E.T. Mape, William "Bill" Lyons, Sr., his wife Mary Lynn Houghtaling Lyons, and their six children. Bill and Mary Lyons were both born in Minnesota, and married in 1949. This third generation family ranching business has built itself on family values, hard work, and dedication, and is looking forward to celebrating eighty years of active involvement with the California agriculture community.

The Lyons family, encompassing Bill and Mary, their six children, twenty-one grandchildren and three great-grandchildren, is recognized throughout the state as community leaders. Bill Sr. has been honored with the following community awards: Modesto Chamber of Commerce President's Award, 1991, the "Fred Prince Memorial" Good Egg Award, and the Stanislaus/San Joaquin County Cattlemen of the Year Award, 1984.

I am honored to personally know each member of the Lyon's family and it is with great honor that I commemorate the 80th anniversary of Mape's Ranch, a true icon of the Central Valley of California.

WORLD REFUGEE DAY

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. SMITH of New Jersey. Mr. Speaker, as a co-chair of the newly formed Refugee Caucus, I rise on behalf of the world's 15 million refugees on the eve of World Refugee Day, which occurred last Friday, June 20th.

We know that the plight of refugees throughout the world is precarious. They have fled war, persecution, natural disasters, and severe poverty in their home countries. The lucky few live in camps, where attempts are made to provide the basic necessities but disease and hopelessness run rampant.

Those not in the camps are left to fend for themselves, aliens in a foreign land where they often lack food and shelter. Refugees who try to find work are often exploited and many women and children refugees become victims of forced sex trafficking rings.

It is not only important to remember the plight of the refugees, but also to remember those who have reached out to help the refugees. We know that UNHCR, The Hebrew Immigrant Aid Society, International Rescue Committee, Immigration Refugee Services of America, International Catholic Migration Agency, Lutheran Immigration and Refugee Services, Episcopal Migration Ministries, Church World Service, and many others provide tremendous and compassionate support for refugees throughout the world.

We also know that numerous governments have been generous in accepting refugees into their borders, including many in Africa. I would like to take a moment to recognize one of these governments—The Republic of Zambia.

For the last three decades, Zambia has been one of the most generous hosts of refugees in the world. Zambia's history of refugee protection began with its independence in 1964, when it hosted refugees fleeing wars in Angola, Mozambique, Namibia, South Africa and Zimbabwe. By 1967, UNHCR was operational in Zambia and remains today, working in partnership to protect refugees. Through the years, Zambia has afforded refugees freedom of movement, access to educational and social services including medical treatment, and land for farming.

In recent years Zambia has generously hosted over 280,000 refugees. Last year, Zambia launched an innovative and collaborative response to under-developed in local communities greatly impacted by large-scale and long-term refugee populations. The United States contributed $1 million to the "Zambian Initiative" which has worked to integrate long-staying Angolan refugees in Zambia's West Province. By promoting longer-term development of the education, health, environment and agriculture sectors and by allowing refugees and local populations to have equal access to these programs, the Zambian Initiative has offered a model to all countries hosting refugees.

I commend the continuing efforts of the Zambian government in seeking progressive national policies that have helped integrate refugees into their nation. I hope that the generosity of Zambia towards refugees and asylum seekers can be fully recognized by both our government and governments throughout the world. I am confident that they will continue to remain a generous supporter of refugees and hope that other nations will follow their example.

GROWING CONCERNS ABOUT IMPLEMEMTATION OF THE PATRIOT ACT OF 2001

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. HOLT. Mr. Speaker, in the immediate aftermath of the September 11th attacks, Congress enacted and the President signed into law the Patriot Act of 2001. As we all know, the country was in a state of shock over the events of September 11th, and the bill was an immediate reaction to that—being drafted, briefly debated, approved, and signed into law by October 26, 2001, a mere six weeks after the attacks.

The Patriot Act is a wide-ranging statute designed, as its stated purpose, to "unite and strengthen America by providing appropriate tools required to intercept and obstruct terrorism." These tools include increased authority to intercept telephone and electronic communications, to conduct surveillance of private citizens, to seize electronic and voice mail messages, to execute and delay notice of the execution of warrants, and to access the business and private records of American citizens and others living in our country. It includes some provisions that most people would not question, such as making wiretapping court orders apply to all of a suspect's phone lines.

The Patriot Act also expands the authority of U.S. government intelligence agencies to invoke the Foreign Intelligence Surveillance Act (FISA), which was originally enacted to track and capture international spies as distinct from domestic citizens and residents. It is worth noting that FISA surveillance requests in 2002 outnumbered all of those under domestic law for the first time since FISA was enacted.

Although the recognition of terrorist cells (like the hijackers) within our country led Americans to demand stronger action to identify and bring to justice those responsible for the terrorist attacks on our country on September 11th and to prevent any other such tragedy, the balance between liberty and security is notoriously difficult to strike. I voted in favor of the Patriot Act recognizing that, in that period of national anxiety, we would probably get the balance wrong and so I insisted that it incorporate sunset provisions for its most onerous provisions. Accordingly, some of this law's most troubling provisions granting increased police powers to our Federal government will expire at the end of 2005.

Now, nearly 22 months after the September 11th attacks, we should question whether we are more united and strengthened as a Nation in fact? The answer is yes in some ways, but probably not by operation of the Patriot Act. Although 1,200 men were immediately detained following the September 11th attacks on America and more subsequently, only one suspect—Zacarias Moussaoui—is actually being tried for his alleged involvement in those terrorist attacks.

At the same time, substantial numbers of suspects are being held in detention without counsel, without charges having been filed and without trials taking place. Moreover, countless numbers of citizens and legal residents have had assets seized and business transactions interrupted and have suffered many other disruptions in their personal and professional lives. These actions have caused much more widespread public unease and dissention than any feelings of national unity or strength that might result should a suspect actually be tried, convicted and brought to justice through operation of the Patriot Act.

In fact, soon after the initial round-up of detainees, the principal focus of the Bush Administration and many resources were diverted away from using the Patriot Act to find and rout al-Qaeda terrorism cells operating in the United States and around the world to waging and winning the war to topple Saddam Hussein's regime in Iraq. This was done even though U.S. intelligence agencies and the Bush White House could not demonstrate any clear and convincing connection between the Iraqi regime and Osama bin Laden, al-Qaeda or the events of September 11th or other terrorist connections to the U.S. that prompted the passage of the Patriot Act in the first place.

So what has the Patriot Act accomplished in terms of increasing the unity and strength of our Nation? 112 cities, counties, and towns across the country have passed resolutions urging federal authorities to show great respect for the rights of our citizens, when carrying out activities designed to fight terrorism and improve homeland security. Just last week, Alaska became the second state after Hawaii to approve a resolution in opposition to key elements of the Patriot Act. The Alaska State legislature is firmly controlled by Republicans, nevertheless they overwhelmingly supported a resolution that "implores the United States Congress to correct provisions in the USA Patriot Act and other measures that infringe on civil liberties, and opposes any pending and future Federal legislation to the extent that it infringes on Americans' civil rights and liberties." In the words of one Alaskan state legislator: "Guys are dying on the battlefield to protect our freedoms. It is up to us to protect those freedoms here at home."

It is altogether fitting that you are gathered in the Princeton Public Library for this forum. I highly commend the sponsors and organizers of this two-part forum. Many organizations and individuals are expressing opposition to the provisions of the Patriot Act that prohibit library personnel from informing patrons if Federal agents have obtained records about their reading habits. In Washington, I was early co-sponsor of legislation sponsored by U.S. Congressman Bernie Sanders to exempt libraries and booksellers from orders requiring that they produce this sort of information about their patrons.

In a similar spirit, more Americans from all walks of life are joining with Muslim Americans and people of Middle Eastern descent to protest nationality-based registrations by the Immigration and Naturalization Bureau, which U.S. Attorney General Ashcroft began ordering last November for all men over 16 years of age in America from Iran, Iraq, Syria, Libya, Sudan, Afghanistan, Algeria, Bahrain, Eritrea, Liberia, Morocco, North Korea, Oman, Qatar, Somalia, Tunisia, the United Arab Emirates, Yemen, Pakistan and Saudi Arabia.

Congressman JAMES SENSENBRENNER, Republican Chairman of the House Judiciary Committee, has called for extensive hearings into the uses and implementation of the Patriot Act, expressing serious concerns. I support him in that, although the Bush Administration appears to be stonewalling. I have also personally asked FBI Director Robert Mueller for his account of the need, usefulness, and future justification of the Patriot Act.

But it is having another effect unintended by the strongest supporters of the Patriot Act and who want to see it extended and expanded. It is reminding more Americans daily of the importance of our precious civil liberties and how much more strongly they must be preserved and protected in times of war.

I voted in favor of the Patriot Act with great reservation at the outset, and my reservations have only increased over time. Seeing little evidence that it has increased our security, I expect to oppose any effort to extend those provisions of the current Patriot Act that will expire next year and I will most certainly oppose any effort to strengthen and extend the reach of the Patriot Act with new provisions that facilitate incursions into and violations of the fundamental civil and constitutional rights of our citizens and other legal residents in America, including proposals to revoke citizenship of people who are thought to give material aid to terrorists. The police and prosecution powers of the government are important and necessary to preserving life, liberty, and the pursuit of happiness, but they are also the most fearsome powers of government.

LEADERS OF TAIWAN'S LEGISLATIVE BRANCH BRIEF CONGRESSIONAL LEADERS IN CAPITOL

HON. STEVE CHABOT

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. CHABOT. Mr. Speaker, earlier today Members were honored to be joined by a bipartisan delegation of colleagues from the legislative branch of Taiwan, one of the world's most vibrant democracies. In an event hosted by the Congressional Taiwan Caucus here in the Capitol, President Wang and leaders from the Defense and Foreign Affairs committees of the Legislative Yuan briefed Members on important security, economic and health issues of mutual concern. I greatly welcome such direct exchanges and look forward to more such opportunities in the future.

I commend to my colleagues' attention the impressively candid observations of the leadership of Taiwan's delegation:

PREPARED REMARKS, HONORABLE WANG JIN-PYNG, PRESIDENT LEGISLATIVE YUAN

Members of the Congressional Leadership, Mr. Chairman, Members of the Taiwan Caucus of the United States Congress, it is a distinct privilege and honor to be here in this cradle of democracy with you today.

On behalf of the members of my traveling party of fellow Parliamentarians from your brother democracy in Taipei, permit me to thank you for your time, your interest, and your enduring friendship.

This building, targeted by terrorists, is revered by all citizens of Taiwan. It stands as a beacon for our national cause, for those who believe in the right of all people on this planet to choose their own form of government.

On behalf of the freely elected President of Taiwan, I bring you greetings.

President Chen Shui Bian has asked me to express to you his personal appreciation for the strong support shown by this Caucus—by this entire Congress—for building a strong Taiwan. He particularly asked me to thank you for supporting our efforts to maintain a robust defense. By approving sales of appropriate arms to Taiwan, you aid our ability to deter attack and to provide security for peoples throughout our region. By increasing confidence in our self-defense capabilities, you have helped provide stability in Asia.

Taiwan is moving forward deliberately to secure the resources for our prudent defense procurement program. We deeply appreciate your continued support and that of the Bush Administration.

As President of the Legislative Yuan, the 'congress' in Taiwan, I am honored to represent some twenty three million citizens. On their behalf, I thank you for the support of this Congress—support that has time and again proven essential if we are to continue to live in an open, free and democratic society. Please continue this support—which has brought political liberty, economic freedom and a vigorous (I can assure you!), a vigorous and energetic free press for Taiwan!

In our Legislative Yuan we have four major parties and one independent group. You will be 'shocked' to know we sometimes quarrel, we shout, we argue, we debate into the night. But on matters concerning the mutual interests of the free people of Taiwan and the United States, we—like you--stand firmly united.

I pledge that we will continue to do all in our power to strengthen US-Taiwan ties and to advance mutual economic, diplomatic and security interests.

On two issues in particular I want to ask your help. Both concern our cousins across the Taiwan Strait, the People's Republic of China.

The people of Taiwan earnestly hope for a dialogue with the authorities in Beijing. We want to discuss matters of health. We want to discuss trade, security, transportation, improving people-to-people exchanges.

We have many issues of common interest to explore with the PRC. There is much we can learn from each other. There is much we can accomplish together. The peoples of the entire region desire peace and security, but there must be a mutual willingness for dialogue. So we ask our friends in the United States to use your important relationship with the authorities in Beijing. Encourage them to engage us in a dialogue unburdened by preconditions. It can only advance the interests of all concerned.

The second issue where we ask your help is in the area of health and Taiwan's international human rights.

Taiwan has weathered a terrible scourge in recent months as SARS swept the region. Lives have been lost. Livelihoods have been threatened. Commerce has been disrupted. People throughout the world have suffered from the PRC's cover-up of the SARS epidemic. At the same time the leaders in Beijing prevented Taiwan from receiving support from WHO, and other countries, by insisting that all assistance had to be approved and channeled through the PRC. Although the PRC could not handle its own problems with SARS it had the audacity to claim it was helping Taiwan, which did not receive anything.

Throughout this time, Taiwan has been seeking to participate in the programs of the World Health Organization. Not as a member state—we recognize that nomenclature would offend some in Beijing—but simply as an observer. Yet the stubborn rejection of our effort by the PRC—their international arm-twisting, bullying and threatening trade partners--has been shameful, a clear violation of Taiwan's international human rights. It is a crystal clear example for all to see of how a dictatorship places power politics above the interests of people—people on both sides of the Taiwan Strait who have suffered. Advice and support from the WHO did not arrive in time because of the PRC's interference. Health should not be a political issue used for gain and punishment. It is a life and death people issue and those who are chosen to govern must look to the people's interests first.

The fact is the SARS crisis will pass. But other health and economic challenges of an interdependent world will surely confront us. Taiwan can make its own contributions to the world's fight against disease, but it cannot be treated as a pariah. The time for the people of Taiwan to secure the benefits of international organizations, especially one as important as the WHO, has surely come. Taiwan's international human rights demand that its people should not be prevented from participating in international organizations and programs that will further their health and welfare and that of the world at large.

Under the landmark Taiwan Relations Act, the U.S. has pledged to work to benefit the welfare and human rights of the free people of Taiwan. I call upon you and your colleagues to hold hearings—consistent with this legislative requirement–on how the U.S. can advance Taiwan's health, human rights and security by pressing for Taiwan's inclusion in appropriate international organizations. We hope the American belief in fair play will encourage you to reach out to other friends and allies and urge their support for Taiwan's place in the community of international organizations.

Dear Friends, let me close with a personal note.

I have been honored by my colleagues and placed in a position of leadership in our national legislature. I have been honored by my president and asked to convey a message to our most important allies. Today, I have even been honored to work in that arsenal of democracy where the fighting forces of freedom are captained, the Pentagon.

But it is a signal honor of my career to be with you here today in the United States Capitol, truly the people's house, where the beacon of liberty shines forth for all around the globe to see.

Thank you so very much. May God bless you, and God bless the American people.

COMMENDING MRS. DEPOALA'S FIFTH GRADE CLASS ON THE CREATION OF THEIR PEACE QUILT

HON. MAURICE D. HINCHEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. HINCHEY. Mr. Speaker, it is with great pleasure that I rise today to commend the children of Mrs. Sally DePoala's Fifth Grade class at Cahill Elementary School in Saugerties, New York for their contribution to the national dialogue in support of peace and hope. Last Friday I had the good fortune to spend some time with these young people and receive from them a Peace Quilt that they had spent a good part of the year creating. After reading an African folk tale earlier in the year, the students were inspired to create an artistic quilt that expressed their deeply held commitment to peace here in the United States of America and throughout the world. All of the students in the class contributed to the beautiful quilt and asked to present it to me so I may assist them in eventually having it displayed at a memorial for the World Trade Center in New York City.

The tragic events of September 11, 2001 have had a profound effect on the Nation and the world. Together, we have sought out ways to deal with the fear, anger and grief that struck us all on that fateful day. Indeed, we as a nation have come together to find strength in the masses and to recommit ourselves to our families, our communities and our country.

Mr. Speaker, I am very proud that the fifth grade students in Mrs. DePoala's class at Cahill Elementary decided to express themselves in this very thoughtful and traditional way. In a simple way, they have profoundly communicated the dream of our future generations to embrace peace and hope and to seek out strength from within our communities. I'm grateful to have been chosen as the messenger of the spirit of these young people and I will enthusiastically seek to have their wonderful Peace Quilt displayed prominently at the site where the world will remember the tragic events of September 11, 2001. In the meantime, I will proudly display this quilt in my Kingston district office so that our local community can appreciate this profound statement by our future generation.

HONORING THE ACCOMPLISHMENTS OF BRITTANY ATKINS

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. GORDON. Mr. Speaker, I rise today to congratulate Brittany Amber Atkins of Smyrna, Tennessee, for being chosen as the National Exchange Club Youth of the Year.

Brittany recently graduated from Battle Ground Academy with a 4.1 GPA. Her list of accomplishments while in high school are long. Among the honors and awards Brittany has received are Tennessee District Youth of the Year for the National Exchange Club, Brentwood Exchange Club Youth of the Year, Helen and Ralph Brown School Spirit Award, Daughters of the American Revolution Good Citizen Award, President's Award for Outstanding Academic Excellence, Music Medal, Drama Medal and Harvard Book Award.

Brittany was also involved in a host of extracurricular activities, including Student Council, Leadership Council, Speech and Debate, plays, choirs, Students Against Destructive Decisions, Spanish Club, Key Club and Dance Team.

While her awards and extracurricular activities contributed to Brittany becoming the National Exchange Club Youth of the Year, I found her essay, "America's Young Patriots: Believing and Achieving for a Better America," to be most impressive. She writes, "America's future rests in the hearts, dreams, and preparations of these young patriots—no matter race, religion, place of residence, or economic status. It is through the beliefs and achievements of today's youth that America will thrive in the future." Brittany believes patriotism is found within the unlimited opportunities for one's education, profession and service to his or her community.

Brittany concludes her essay by pledging to "concentrate on service before reward, to introduce problems with solutions, and when encountering conflict, to interject love and humor." I commend Brittany for her many accomplishments and awards, and wish her the best of luck in future endeavors.

CONGRATULATING JOE GUNN ON HIS RETIREMENT

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. GREEN of Texas. Mr. Speaker, after 14 years as president of the Texas AFL–CIO, Joe Gunn has announced that he will retire. I rise today to congratulate Joe and to wish him well in his retirement.

Joe Gunn has actively served the workers of the State of Texas for many years.

He went to work for Southwestern Bell in 1949 and joined the Communications Workers of America, Local 6222 on the same day. During his 22 years with Southwestern Bell, Joe spent 11 years in full-time service to Local 6222.

Joe ran for job steward and was easily elected. Within a very short time, he ran for Chief Steward and was again elected. Always looking for more challenges, Joe ran for and was elected first as a vice president and then as president of Local 6222. That is when I met Joe in 1972.

In a short time, Joe was elected and served as a vice president and as the president of the Harris County AFL–CIO.

In January, 1979, Joe was elected as the secretary-treasurer of the Texas AFL–CIO. He served in this capacity until his election as president on July 29, 1989.

But Joe's life has involved more than the CWA or the AFL–CIO. Joe also served for seven years as a Commissioner on the Texas Employment Commission, the precursor to the Texas Workforce Commission. He was first appointed to this position by former Governor Dolph Briscoe.

He has also served his community by holding such positions as vice president of the Harris County United Way, the Houston Council Boy Scouts Executive Council,and youth director of his church.

Joe is married to Dorothy Ann Taylor Gunn. They have ten children, six of which were foster children. He and his wife attend the United Methodist Church in Austin.

Joe Gunn never forgot that his purpose was to improve the working conditions of all Texans. He has always represented workers and has worked tirelessly for a safe workplace, fair pay and respect for all employees, union and non-union.

He is a legend and a force in Texas politics and will not be forgotten or easily replaced.

Mr. Speaker, I ask my colleagues to join me in thanking Joe Gunn for his many years of service and to wish him well in his retirement.

PERSONAL EXPLANATION

HON. CHRISTOPHER SHAYS

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. SHAYS. Mr. Speaker, on June 23, I was participating in the World Economic Forum in Amman, Jordan with Congressman JIM KOLBE and other Members of the House and Senate. As a result, I missed four recorded votes.

I take my voting responsibility very seriously and would like the CONGRESSIONAL RECORD to reflect that, had I been present, I would have voted yes on recorded vote number 297, yes on recorded vote number 298, yes on recorded vote number 299, and yes on recorded vote 300.

HONORING THE DISTINGUISHED PUBLIC SERVICE OF BILL JONES

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. GORDON. Mr. Speaker, I rise today to recognize the outstanding service of Murfreesboro, Tennessee, Police Commissioner Bill Jones, who will retire from his post on August 31 after 47 years of law enforcement work.

Bill Jones became the police commissioner in my hometown of Murfreesboro 16 years ago. Since then, he has initiated a number of programs that have bolstered law enforcement and enhanced the quality of life in Murfreesboro. My hometown has experienced tremendous growth during Bill's tenure as police commissioner. The police department has doubled in size, but more importantly, the expansion of the department has been an efficient one.

Bill started his career in law enforcement as a Tennessee state trooper shortly after returning home from service in the United States Navy during the Korean conflict. Bill rose through the ranks of the Tennessee Highway Patrol before finally leading the organization as its safety commissioner.

After nearly half a century in law enforcement, Bill has decided to remove the badge and enjoy his family without any distractions. The community of Murfreesboro, as well as the state of Tennessee, has been served well and with distinction by Commissioner Jones. I congratulate him for his tireless, dedicated service to law enforcement and wish him well in his retirement.

EXPRESSING SYMPATHY FOR VICTIMS OF ALGERIAN EARTHQUAKE

HON. JOSEPH R. PITTS

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. PITTS. Mr. Speaker, I stand in strong support of H. Res. 264 expressing sympathy for the victims of the devastating earthquake in Algeria on May 21, 2003.

Natural disasters, such as earthquakes, can wreak havoc in a community or nation.

At times like these, it is vital to come to the support and aid of our friends.

I am pleased that our nation has assisted the Algerians in the emergency phase of their response to the earthquake and I encourage our government to support the Algerians as they seek to rebuild their homes and communities.

Algeria is an important partner and friend of the United States in many respects, not the least of which is in the war against terror—the Algerians have experienced the horrors of terrorism in their own land for many years.

I urge my colleagues to support this resolution.

TRIBUTE TO PUEBLO COMMUNITY

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress today to recognize an academic institution that has served Pueblo, Colorado for the last 70 years. Pueblo Community College (PCC) has maintained its focus on quality education over the course of a lifetime as it has expanded to meet the state's needs. As we reflect upon this 70th anniversary, I commend Pueblo Community College for the positive impact that it has had upon individuals and families throughout the State of Colorado.

Pueblo Community College traces its origins back to the incorporation of Southern Colorado Junior College in 1933. Since the original graduating class of 17 in 1935, enrollment at PCC has increased enough to warrant expanding to three additional campuses in Cañon City, Durango, and Cortez. The total enrollment in PCC now exceeds 5,000 students, all of whom value PCC's affordability, flexible hours, and varied degree programs.

More than half of Pueblo Community College's students are employed and would not have access to higher education if not for the flexibility offered by Pueblo Community College. Students at PCC have the opportunity to work toward Certificates of Completion, Associate of Science, Associate of Arts, Associate of General Studies, and Associate of Applied Science degrees. The assortment of programs allows first-time college students and working adults alike the opportunity for a brighter future.

Mr. Speaker, I am honored to pay tribute to Pueblo Community College before this body of Congress and this nation. PCC provides many Coloradans access to higher education and the skills necessary for a successful career. I congratulate Pueblo Community College on its success and commend the institution for the positive impact that it has made upon Colorado's citizens for the past 70 years.

PERSONAL EXPLANATION

HON. EARL POMEROY

OF NORTH DAKOTA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. POMEROY. Mr. Speaker, on June 23, 2003, due to flight delays, I missed rollcall votes Nos. 297, 298, 299, and 300. Had I been present, I would have voted "yea" on all four votes.

IN REGARD TO MR. CHARLES MULCAHY

HON. RON KIND

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. KIND. Mr. Speaker, I rise today to commend Wisconsin native Mr. Charles Mulcahy for his nomination by HM King Albert II of Belgium to become a Knight in the Order of Leopold.

Mr. Mulcahy has served with distinction as Honorary Consul of Belgium since 1985. He has provided guidance to the development of bilateral economic, commercial, cultural, scientific and educational relations, assisted Belgian citizens, and promoted Belgian interests over the past 15 years.

Mr. Mulcahy has been an active participant in business and economic development matters for over 25 years. He is a senior partner with the law firm of Whyte Hirschboeck Dudek in Milwaukee, Wisconsin, and is known for his representation of commercial business concerns, from initial organizations, capital formation, developing strategic alliances and joint ventures between Wisconsin companies and overseas business interests. He has guided numerous companies through various growth and development phases involved in building a business. He has worked closely with businesses on their legal matters, including negotiating distributor agreements and establishing subsidiary or branch operations for clients throughout the United States, Europe and Asia, and serves on the Board of many companies engaged in international trade.

Mr. Mulcahy's leadership in the area of world trade is reflected in his role as founder of the Wisconsin World Trade Center (WWTC) in 1987. He served as the initial President of WWTC and continues to serve as a member of the Executive Committee and the Board of Directors. Mr. Mulcahy is past president of the Milwaukee World Trade Association and is also past chairman of the Advisory Committee of the Institute of World Affairs of the University of Wisconsin-Milwaukee.

Mr. Mulcahy's record of service to Wisconsin businesses and to the Belgian of is distinguished and worthy of praise. His nomination to become a Knight in the Order of Leopold is truly deserved.

IN HONOR OF THE 100TH ANNIVERSARY OF THE SOUTH HAVEN LIGHTHOUSE

HON. FRED UPTON

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. UPTON. Mr. Speaker, I rise today to recognize the centennial of one of southwest Michigan's most famous landmarks: the three-story red lighthouse located in the beautiful community of South Haven. Artifacts such as this lighthouse are of tremendous historical value. These symbols of our heritage stand as a remembrance for generations to come. This 11-foot wide, 36-foot tall structure was constructed in 1903. Its red-case iron structure has always been one of its defining characteristics, making it easily identifiable to lighthouse enthusiasts and area historians. In fact, a new book has been published by the Michigan Maritime Museum depicting history of this lighthouse in honor of its 100th anniversary. As all folks who live, work, or grew up on the shores of Lake Michigan know, lighthouses provide an invaluable service to communities and commerce of the Great Lakes. I am proud that the South Haven lighthouse has reached its 100th anniversary and I am hopeful that it will survive 100 years more.

TRIBUTE TO DANNY GALLACHER

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. McINNIS. Mr. Speaker, I would like to take this opportunity to honor the life of Danny Gallacher who recently passed away. A longtime resident of Glenwood Springs, Colorado, Danny made significant contributions to his community as a leader and role model for others.

Danny and Mary raised four boys, eventually enlisting their help in running a number of family business ventures, which included a service station and a diner that eventually became a full-service restaurant and bar. One of Danny's major contributions to his community was his service as a counselor at the drug and alcohol detoxification center he helped establish.

Mr. Speaker, it is with profound sadness that I recognize the life and passing of Danny Gallacher. Danny will be especially missed by his family, friends, and the many people who knew him in the Glenwood Springs community. My thoughts and prayers are with them during this difficult time.

TRIBUTE TO BOB STUMP

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. SMITH of New Jersey. Mr. Speaker, I am deeply saddened by the loss of a former colleague, friend, and mentor, the Honorable Bob Stump of Arizona. My thoughts and prayers are with his wife Nancy, his children, Karen, Hoot, and Bruce, as well as his grandchildren, other family members and friends who loved him.

From his enlistment in the Navy during World War II at the age of 16, to his extraordinary leadership as chairman of the Veterans' Affairs and Armed Services Committees in the House of Representatives, Bob Stump was a true American hero.

Bob Stump served with distinction in Congress for 26 years, including 6 years as chairman of the Committee on Veterans' Affairs, and 2 years as chairman of the committee on Armed Services. Chairman Stump used his influence to promote responsible legislation to assist and honor our nation's veterans.

Under Bob Stump's leadership, Congress increased funding for veterans health care; expanded access to long term care for aging veterans, including nonhospital alternative care; reformed eligibility standards for access to VA health care; extended the national cemetery system, including Arlington National Cemetery; increased assistance to disabled veterans and their survivors; and strengthened the Montgomery GI Bill that has helped millions of veterans fulfill their educational and career goals.

A modest man who preferred to shun the spotlight, Bob Stump's life and his legacy will continue to shine brightly for generations of service men and women to come.

Mr. Speaker, Bob Stump was the chairman of the Committee on Veterans' Affairs from 1995–2000, and its ranking minority member for the 2 previous years. He served as a member of the Committee for a total of 14 years. During his tenure as chairman, he compiled a distinguished record of legislation that is a major part of his legacy of public service. As his successor as chairman of the Veterans' Affairs Committee, I particularly know and appreciate all that he did for our Nation's veterans, servicemembers and their families by working on a bipartisan basis in cooperation with veterans' service organizations. I want to take this opportunity to recall the major veterans' legislation he authored, because Bob Stump was not one to trumpet his accomplishments.

In 1996, Chairman Stump initiated and Congress passed important health care eligibility reforms for veterans that removed barriers to outpatient care and allowed greater flexibility to the Department of Veterans Affairs (VA) in paying for care closer to veterans' homes. The savings generated by shifting away from inpatient care and budget increases Bob supported were used to increase ambulatory care visits in fiscal year 2000 to more than 40 million total outpatient visits nationwide, an increase of 5.3 million outpatient visits per year over 1997. As a result of this legislation, the VA established hundreds of new community-based outpatient clinics throughout the Nation to improve veterans' access to health care.

In 1998, Bob Stump initiated and Congress passed the largest benefits expansion for veterans since the Persian Gulf war, including: allowing spouses of veterans who died from a service-connected disability to resume receiving assistance under the Dependency and Indemnity Compensation program if their subsequent remarriage ended; increasing adaptive housing and automobile allowances; increasing the monthly pension benefit for disabled veterans in need of the full time aid and attendance of another person by $600 per year; and increasing the monthly Montgomery GI Bill payment from $440 to $528, a 20-percent increase.

Then in 2000, our former chairman initiated and Congress passed the landmark Veterans Millennium Health Care and Benefits Act, popularly known by many veterans as the Millennium Act, the most comprehensive benefits improvement legislation in decades. Some of its more significant provisions included: mandating nursing home and long-term care for seriously disabled veterans; allowing the VA to pay for emergency care for veterans lacking access to other health care plans; improving priority health care access for Purple Heart recipients and military retirees; improving benefits for surviving spouses of disabled veterans; and increasing programs providing employment and housing assistance to homeless veterans.

Also, Bob Stump greatly appreciated the value of education, and initiated Montgomery GI Bill benefits enhancements that increased the value of the monthly education benefit for veterans by nearly $100 per month to $650. The resulting 4-year total basic benefit of $23,400 for a full-time student at a 4-year institution in the year 2000 was almost 50 percent higher than it was in 1997. This law also contained provisions that allowed servicemembers to contribute more up front to achieve an $800 per month benefit, and it provided active duty servicemembers a new opportunity to convert their post-Vietnam Era Veterans Educational Assistance Program benefits to the Montgomery GI Bill if they had not done so before or had withdrawn all the funds from their VEAP accounts.

Bob Stump had a particular interest in the national cemetery system, and worked for its expansion. Thanks to his efforts while he was chairman, five new national veterans' cemeteries were opened, adding approximately 835,000 gravesites to our national cemetery capacity. Additionally, legislation he sponsored was enacted to require the VA to plan 6 new national cemeteries in Atlanta, Miami, Pittsburgh, Oklahoma, Sacramento, and Detroit. He also authorized legislation to expand the boundaries of Arlington National Cemetery, extending its useful life beyond the projected closing date of 2025 so that in-ground burials of veterans can continue until approximately the year 2041.

Mr. Speaker, this impressive record of legislative accomplishment has resulted in immeasurable good for veterans, servicemembers and their families. Bob Stump's leadership was the strongest kind—leadership by example. His lifetime of service to America left this country a better place, and I am honored to have served in the House with our departed colleague, Bob Stump.

MR. STUMP, IT WAS AN HONOR TO KNOW YOU

HON. JEFF MILLER

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. MILLER of Florida. Mr. Speaker, I rise this evening to honor a great American, a great Congressman and my friend, Mr. Bob Stump of Arizona.

Like my colleagues, my memories of Bob reflect an honest individual, and as true as the day is long. His departure last year was difficult, his death—sad.

I first met Mr. Stump when I was running for Congress. My predecessor brought me around to show me the Committee on Armed Services and to meet those I hoped would be my colleagues.

Bob, the chairman of the Armed Services, took a few minutes to visit, shared a few thoughts on his experience in Congress and we snapped a photo. It's kind of funny now, but that picture was used in my campaign brochure. One of my opponents was outraged that I would use the photo. He managed to call Chairman Stump, making him aware of the photo. He further asked Bob if he had endorsed me. Put in the corner, asked to judge me by the few minutes we visited or to judge my opponent by the call he was now taking, Mr. Stump told my opponent yes, yes he would endorse me.

Of course we laughed about that story a couple of times but we always had plenty to talk about. Both Mr. Stump and my family were cotton farmers. We would talk about farming methods, the weather, a very easy give and take.

Every Thursday, at the prayer breakfast, Mr. Stump would be there in his western suit, boots and a smile, pouring coffee. Not a cup in the house was dry with Bob around. It was his job; it was something he wanted to do, he was a public servant.

I am fortunate to have known Bob Stump. I was fortunate to serve under his chairmanship on Armed Services and to now serve under his portrait in both the Veterans' Affairs Committee and the Armed Services Committee. It is as if he is always looking over my shoulder, making sure my decisions are the right ones.

Mr. Stump's commitment to the warfighter is to be emulated. He was a shining example of a statesman and a fantastic public servant. A good man has left this Earth and we are going to miss him. I honestly believe that the House of Representatives, the institution and this country is better today due to Bob Stump's efforts. It was an honor to know you, Mr. Chairman.

TRIBUTE TO THE LATE CONGRESSMAN BOB STUMP

HON. TERRY EVERETT

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

Mr. EVERETT. Mr. Speaker, it is with great sadness that I learned of the passing of recently-retired Arizona Congressman Bob

Stump. Bob was not only a senior statesman and a great patriot, but he was a good friend.

Bob was tough and hard working, always willing to do more than his share. The day after his sixteenth birthday, he enlisted in the Navy and later joined American forces in the World War II liberation of the Philippines and the invasion of Iwo Jima and Okinawa. After the war, he came home to attend Arizona State University and try his hand at cotton farming. His work ethic and humble nature served him well in politics.

Bob's long and distinguished career of public service spanned 40 years beginning with the Arizona State House of Representatives and Senate and ending as a senior member of the U.S. House of Representatives.

Despite becoming the "dean" of Arizona congressional delegation and chairing the House Veterans' Affairs and Armed Services Committees, Bob preferred a low-key style. He was often seen opening constituent mail and answering the phone.

Nevertheless, Bob was effective. No member of the House Armed Services Committee could have performed as well as he in shepherding critical funding increases for our military after nearly a decade of neglect by the Clinton Administration. The 2003 defense budget appropriately bore his name: "The Bob Stump National Defense Authorization Act."

One of the highlights of my career was serving as the chairman of the House Veterans' Affairs subcommittee on Oversight and Investigations while Bob was full chairman of the House VA Committee. Under his watch, we made great strides in overseeing the protection and well-being of the nation's 26 million veterans.

Bob was not afraid to take a stand when he knew it was in the nation's best interest. I'm reminded of the time he took to the floor to sternly defend the American flag in the face of court protection of desecration. "Anyone who burns a flag will have to deal with me," he warned.

As someone who regularly joined Bob for dinner, I was aware that he was suffering health problems which led to his retirement decision last year. I, and many others in the House, will miss his friendship. My condolences go out to Bob's family, friends, and former constituents.

SENATE—*Wednesday, June 25, 2003*

The Senate met at 9:30 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, Rabbi Milton Balkany of the Congregation Bais Yaakov of Brooklyn, NY.

PRAYER

The guest Chaplain offered the following prayer:

Our Father in heaven!

I sing You a song for the blessed United States of America. I sing a hopeful song for the peace and tranquility that we seek. Every patriotic soul joins me and our voices blend in heartfelt harmony. Let our notes wend their way from the hot Mojave sands to the cool waters of the Great Lakes. Let our song echo in the footsteps of Lewis and Clark as they courageously unraveled the mysteries of this free land. Let our lyrical prayer soar up the peaks of Mount Hood and Mount McKinley until they reach the summit of Your glory and Your mercy.

Though our voices are many, though our accents and inflections are as different as the day is long, our song is one and our one song is plain and true and unchanging. We sing: peace. Peace. True Peace. Bring us back to the times of fearless skies and unbridled New York nerve, of tranquil school yards and cool back porch nights. Return these times to us, O G-D. And we will return to You—with a new song, a mighty, rapturous chorus of jubilation!

Amen!

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The acting majority leader is recognized.

SCHEDULE

Mr. MCCONNELL. Mr. President, we will shortly resume consideration of S. 1, the prescription drug benefits bill. We have been in discussion with the distinguished assistant Democratic leader about votes later this morning. We hope to be able to have an announcement shortly about when the votes will commence. Obviously we will stay on this bill all day today. We will be finishing it this week, hopefully Thursday night. We are going to press forward and encourage Members to continue to offer their amendments. We will try to get votes as rapidly as we can.

Mr. REID. Mr. President, the amendment I understand that has been the focus of so much the last few days is prepared and the two leaders are looking this over. We hope to be able to have a vote on that soon. In the meantime, I have a lot of amendments lined up that we can move on and I will work with my distinguished friend, the majority whip, in determining when we can do that. We hope in the next hour we will start a bunch of votes. We will work on that and the majority will make an announcement soon.

Mr. MCCONNELL. I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The PRESIDENT pro tempore. Under the previous order, the hour of 9:30 having arrived, the Senate will proceed to consideration of S. 1, which the clerk will report.

The legislative clerk read as follows:

> A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

Pending:

Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a MedicareAdvantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Bingaman amendment No. 972, to provide reimbursement for Federally qualified health centers participating in medicare managed care.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics.

Baucus (for Edwards) modified amendment No. 985, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the MedicareAdvantage benchmark determinations.

Harkin amendment No. 991, to establish a demonstration project under the Medicaid program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under part D on January 1, 2004.

Baucus (for Stabenow) amendment No. 992, to clarify that the Medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the Medicaid program.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare program.

Grassley amendment No. 974, to enhance competition for prescription drugs by increasing the ability of the Department of

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

Durbin amendment No. 994, to deliver a meaningful benefit and lower prescription drug prices.

Smith/Bingaman amendment No. 962, to provide reimbursement for Federally qualified health centers participating in Medicare managed care.

Hutchison amendment No. 1004, to amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the Medicare program at 6.5 percent.

Sessions amendment No. 1011, to express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under Medicaid and SCHIP as part of the reauthorization of the temporary assistance for needy families program.

Sununu amendment No. 1010, to improve outpatient Vision services under part B of the Medicare program.

Conrad amendment No. 1019, to provide for coverage of self-injected biologicals under part B of the Medicare program until Medicare Prescription Drug plans are available.

Conrad amendment No. 1020, to permanently and fully equalize the standardized payment rate beginning in fiscal year 2004.

Conrad amendment No. 1021, to address Medicare payment inequities.

Clinton amendment No. 1000, to study the comparative effectiveness and safety of important Medicare covered drugs to ensure that consumers can make meaningful comparisons about the quality and efficacy.

Clinton amendment No. 999, to provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level.

Clinton amendment No. 953, to provide training to long-term care ombudsman.

Clinton amendment No. 954, to require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information.

Reid (for Boxer) amendment No. 1036, to eliminate the coverage gap for individuals with cancer.

Reid (for Corzine) amendment No. 1037, to permit Medicare beneficiaries to use Federally qualified health centers to fill their prescriptions.

Reid (for Jeffords) amendment No. 1038, to improve the critical access hospital program.

Reid (for Inouye) amendment No. 1039, to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system.

AMENDMENT NO. 988

Mr. THOMAS. I ask unanimous consent to lay aside the pending amendments.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. THOMAS. I send an amendment to the desk.

The PRESIDENT pro tempore. The clerk will report.

The Senator from Wyoming [Mr. THOMAS], for himself and Mrs. LINCOLN, proposes an amendment numbered 988.

Mr. THOMAS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for the coverage of marriage and family therapist services and mental health counselor services under part B of the medicare program, and for other purposes)

At the end of subtitle B of title IV, add the following:

SEC. . COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" after the semicolon at the end;

(B) in subparagraph (V)(iii), by inserting "and" after the semicolon at the end; and

(C) by adding at the end the following new subparagraph:

"(W) marriage and family therapist services (as defined in subsection (ww)(1)) and mental health counselor services (as defined in subsection (ww)(3));".

(2) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

"(ww)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(2) The term 'marriage and family therapist' means an individual who—

"(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

"(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

"(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(4) The term 'mental health counselor' means an individual who—

"(A) possesses a master's or doctor's degree in mental health counseling or a related field;

"(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.".

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

"(v) marriage and family therapist services and mental health counselor services;".

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) (42 U.S.C. 1395*l*(a)(1)) is amended—

(A) by striking "and (U)" and inserting "(U)"; and

(B) by inserting before the semicolon at the end the following: ", and (V) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)".

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended in section 301(a), is amended by inserting "marriage and family therapist services (as defined in subsection (ww)(1)), mental health counselor services (as defined in section 1861(ww)(3))," after "qualified psychologist services,".

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

"(vii) A marriage and family therapist (as defined in section 1861(ww)(2)).

"(viii) A mental health counselor (as defined in section 1861(ww)(4)).".

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking "or by a clinical social worker (as defined in subsection (hh)(1))," and inserting ", by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (ww)(2)), or by a mental health counselor (as defined in subsection (ww)(4)),".

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting "or a marriage and family therapist (as defined in subsection (ww)(2))" after "social worker".

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting "marriage and family therapist (as defined in subsection (ww)(2))," after "social worker,".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2004.

Mr. THOMAS. This extends the opportunity to directly pay medical health consultants. I will discuss it later. In the meantime, I will set it aside for later discussion.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from California.

Mrs. BOXER. Mr. President, I take a couple of minutes to explain an amendment we will be voting on later that was introduced on my behalf by Senator REID and to let my colleagues know I think it is a stunning situation when suddenly, after fighting back all the amendments that we had to try to improve the benefits, that we are giving our seniors—miraculously there is $12 billion found and it will start a whole new experiment, which may be very interesting and may be just fine. It will push some people out of Medicare and see if it works better in the private sector. I hate to say we have tried it and it hasn't worked but that is fine.

At the same time, we are going to allow Medicare to do more prevention and do more pharmaceutical benefit. We will see what that looks like when it comes to us.

The point I am making, yesterday the Senator from Pennsylvania was railing against some Members who wanted to make this plan better because there was no money. It was so expensive. But they found money to do some experiment.

Today I have an amendment to give people a chance to decide if they want to help people with cancer, if they want to help people who are diagnosed with cancer.

I don't know if you have ever had the experience of having cancer in your family, but surely we all know people who have had that experience. Life in that family comes to a halt. People are reeling from the diagnosis of cancer, whether it is breast cancer, lung cancer, prostate cancer, colon cancer, stomach cancer, blood cancer which is leukemia, lymphoma; millions of Americans are touched. And we have a drug benefit that stops at $4,500 and then $1,300 later you start getting help for your medication.

Yesterday, I gave the Senate a chance to close that benefit shutdown, close that coverage gap, and the Senate refused to do it, mostly on a party-line vote.

Today I offer an amendment to let people redeem themselves. What I say is, if you are diagnosed with cancer, you should never have your drug benefit shut down. You are reeling from this diagnosis. You are sick with this disease. And you should not have to worry about whether you can afford your medicine.

Later in the day we are going to have a chance to see if people are willing to have enough compassion in their heart to stop the benefit shutdown for families where there is a cancer diagnosis. Why do I choose cancer? I could have chosen a number of other diseases. I chose that one because it touches so many families. If it passes, I am going to offer one where there is an Alzheimer's diagnosis. If that passes, I will offer one where there is a Parkinson's diagnosis.

There are a couple of good things in this bill. It starts a prescription drug benefit. That is a plus. We are going to have to fix it. It is a mess. It is the only plan in the country I have found that has such a benefit shutdown. The premiums can go up at any time. HMOs and PPOs can drop out of the business and then you do not know what you are going to do. The fact there is a benefit is important. And it is generous to those who are very poor.

But I want it to be fair to those in the middle class and I want it to be fair to those who need their pharmaceutical products the most. So I am going to give my colleagues a chance to end the benefit shutdown for people who have cancer. If you want to vote no, vote no. If you want to tell people you had a chance to make sure they have those pharmaceutical products through a period of their lives when they are frightened, when they are fighting a disease, go ahead. Do it. Do it.

But I ask you to look inside your soul. You are about to vote on a new program of $12 billion. Don't walk away from the people with cancer just to give money to HMOs, because that vote will come back to haunt you. That is how I feel.

I was very disappointed yesterday that we had a straight party-line vote, pretty much, on my amendment to end the benefit shutdown. But around here you have to be held accountable for what you do. So I am going to give people a chance to come back and say, OK, in the case of cancer, people are not going to have their benefits shut down. Just imagine what it is like, going through chemotherapy, taking all kinds of risks so you can live, because chemotherapy, as you know, basically kills a lot of healthy cells, too.

And, if that is not enough, you are going to have to deal with the accountants with their eyeshades in the HMOs, who will say, What have you done? You really didn't get to $4,500. Why are you shutting down my benefit? You will be begging them not to shut you out because your doctor says if you miss this medicine you could reverse the progress you are making on this disease.

I am going to stop discussing this amendment. I think it is pretty clear. Senators will have a chance to help people with cancer. If you do not want to do it, then you have to live with that vote.

Mr. President, I yield the floor and I look forward to this vote on my amendment.

The PRESIDENT pro tempore. The Democratic leader.

Mr. DASCHLE. Mr. President, under the unanimous consent agreement we reached last night, there was scheduled an amendment to be voted upon, the so-called Grassley benchmark amendment, at 10 o'clock. We have not yet had the opportunity to review the amendment. As I understand it, it is still being negotiated. So we are not in a position, obviously, to agree to the amendment at 10 o'clock. We look forward to consulting with both managers of the bill. Certainly I will be talking to the majority leader as we continue to work to bring the amendment to the floor.

Given the fact we are not yet at a position to vote, it would not be my expectation that there would be a vote at 10 o'clock.

I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 972

Mr. BINGAMAN. Mr. President, I ask unanimous consent to call up amendment No. 972 on Medicare community health center payments.

The PRESIDING OFFICER. That amendment is pending before the Senate.

Mr. BINGAMAN. I ask unanimous consent to revise the list of sponsors of the amendment to read: Senators SNOWE, BINGAMAN, SMITH, HOLLINGS, and HATCH.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BINGAMAN. Mr. President, I thank the chairman and ranking member for agreeing to this very important amendment related to our Nation's community health centers. I also thank Senator SNOWE, with whom all who are now cosponsoring this amendment introduced S. 654, the Medicare Safety Net Access Act of 2003. Her leadership on the Nation's community health centers has been unwavering and has made it possible to get to the point where we can adopt this amendment.

I also thank Senator SMITH, Senator HOLLINGS, Senator HATCH, and Senator CONRAD for their longstanding advocacy support for community health centers. Senator SMITH and Senator HOLLINGS need to be thanked for their constant advocacy and push to see this amendment pass.

In addition, it should be noted that Senators HATCH and CONRAD spearheaded a very similar effort to protect community health centers in the Medicaid Program back in 1997.

As we proceed with the passage of S. 1, we need to be careful not to create potential unintended consequences as a result of our actions. This amendment corrects an important unintended consequence that this legislation could have had on our Nation's community health centers. Community health centers have broad bipartisan support. The President and the Congress have committed to doubling the funding for community health centers over a 5-year period. The health centers provide care for over 13 million people annually. Nearly one million of those are low-income Medicare beneficiaries. They receive section 330 Federal Public Health Service Act grant funds to support care for the uninsured and for low-income patients. To ensure those grant funds are used entirely for that purpose, Congress has specifically taken action to ensure that both Medicare and Medicaid are fully reimbursing health centers for the costs associated with the care provided for Medicare and Medicaid beneficiaries.

Simply put, the funding intended for low-income and uninsured people should not be diverted and instead used to subsidize Medicare underpayments. Therefore, health centers are reimbursed by Medicare under a cost-base system. This amendment would simply extend the same requirement to the new Medicare Advantage programs by ensuring that community health centers are provided with a wraparound or supplemental payment equal to the difference between the payments they now receive under Medicare generally and the payment they would receive from Medicare Advantage plans. This is not a new concept.

In 1997, Congress allowed States to dramatically increase the number of patients who were enrolled in Medicaid managed care. We recognized the potential adverse impact on community health centers, and to deal with that we required the Medicaid Program to provide a wraparound or supplemental payment for the difference between the managed care organizations payment and a health centers reasonable cost. Again, Senators HATCH and CONRAD were instrumental in that effort.

With this important amendment we are proposing today we would do the same in the Medicare Program. According to testimony Tom Scully gave at the Center for Medicare and Medicaid Services and testimony that the Congressional Budget Office gave on the 13th of June, their estimates for how many Medicare beneficiaries actually were enrolled in the private health plans ranged all over the board. It went from 9 percent in one estimate, the CBO estimate, to 43 percent, the estimate that Tom Scully's actuaries developed. It was a fivefold difference in those estimates.

In the words of Dr. Holtz-Eakin, the head of the CBO, these are honest differences in trying to read a very uncertain future.

We do have clearly ahead of us a very uncertain future as to how many people will choose to leave traditional Medicare and move into the private plans. Mr. Scully is correct that health centers will lose their guarantee of cost-base reimbursement to 43 percent of their Medicare patients. Potentially, this could result in centers having to dip into their Federal grant fund money intended to provide care to the uninsured, and they would have to dip into those Federal grant funds in order to make up for losses they were incurring trying to provide services to Medicare patients.

Our Nation's safety net is already fragile. We need to take this action to ensure we are not jeopardizing it through the passage of this legislation.

Again, both the President and Congress have committed to double the capacity of our Nation's health centers to deal with the growing number of uninsured in this country. In light of this, the amendment we are offering today would protect the vital role that health centers play. It would ensure that health centers are not forced to decide either between subsidizing the Medicare Program with their grant dollars or refusing to provide services to some of the 1 million low-income Medicare beneficiaries that currently depend upon them for services.

I thank the chairman and ranking member for agreeing to accept this amendment. I thank all the chief sponsors, Senator SNOWE, and all cosponsors for their hard work. I believe it is a very important amendment. I urge my colleagues to support it.

Ms. SNOWE. Mr. President, I rise today to speak on behalf of the amendment that I am offering today with Senator BINGAMAN, a longtime champion of community health centers and the original cosponsor of the legislation that we introduced, S. 654, the Medicare Safety Net Access Act, from which this provision has been taken. I also would like to thank my colleagues, Senators HATCH and SMITH for their help in moving this important policy change forward. Chairman GRASSLEY and Senator BAUCUS also should be recognized for their work on behalf of Community Health Centers. Their willingness to work with me has made adoption of this policy possible.

This amendment will help ensure that Community Health Centers remain a viable and integral part of the health care delivery system for Medicare beneficiaries and rural communities at large. Community Health Centers, also known as Federally qualified health centers, provide care to millions of medically underserved Medicare beneficiaries. In many cases, Community Health Centers are the only source of primary and preventive services to which these beneficiaries have access. This is especially true for people living in America's rural and inner-city medically underserved areas.

As many of you know, under the traditional fee-for-service program Community Health Centers currently are reimbursed by Medicare bases on the cost to deliver care. However, because managed care plans, such as those expected to be used under the new MedicareAdvantage program, use capitated rates, which are negotiated rates based on patient volume and often are lower than the fee-for-service cost-reimbursement rate, Community Health Centers would likely experience substantial reductions in payments.

If, as CMS predicts, over 40 percent of seniors enter the new MedicareAdvantage program, Community Health Centers would experience a substantial loss of revenue because their payment for almost half of their clients would be based on a capitated rate. If this happens, Community Health Centers would be unable to meet the growing demand of serving the Medicare population.

This amendment ensures that doesn't happen. Starting in 2006, if the capitated rate that a Community Health Center receives from a participating MedicareAdvantage plan is less than the fee-for-service cost reimbursement rate, the Medicare program will pay the difference in the amount. This is done presently under the Medicaid program and it should be no different under the Medicare program.

Community Health Centers are an invaluable component in the health care delivery system in rural communities and I am pleased that this amendment has been accepted into S. 1.

Mr. HATCH. Mr. President, I rise in strong support of the Bingaman-Snowe-Hatch amendment. This amendment addresses an important issue for both Medicare beneficiaries and community health centers by ensuring that Medicare beneficiaries, regardless of their Medicare health coverage choice, would receive seamless coverage if they choose to receive services from a community health center. And, it provides the Community Health Centers the ability to give the Medicare beneficiaries that they serve seamless health coverage as well.

I have been a strong supporter of community health centers for many years. These health centers provide care to over 13 million people annually; nearly one million are low-income Medicare beneficiaries. These health centers receive funding under the Public Health Service Act in order to provide quality care to their uninsured and low-income patients. To ensure those dollars are used only to provide health care to health center patients, Congress has taken action to ensure that both the Medicare and Medicaid programs are reimbursing health centers for the costs associated with care to Medicare and Medicaid beneficiaries. Therefore, community health centers are reimbursed by Medicare and Medicaid under a cost-based system.

In 1997, Congress allowed States to increase greatly the number of patients enrolled in Medicaid managed care by requiring the Medicaid program to provide a “wrap-around” payment for the difference between the managed care organization's payment and a health center's reasonable costs.

This amendment ensures that we do the same thing for Medicare beneficiaries in the MedicareAdvantage program. More specifically, the amendment ensures that community health centers are provided with a “wrap-around” or supplemental payment equal to the difference between the payments they now receive under Medicare through the cost-based system and the payment they would receive from MedicareAdvantage plans.

Officials at the Centers for Medicare and Medicaid Services and the Congressional Budget Office estimate that nine to 43 percent of Medicare beneficiaries will enroll in private health plans offered through the MedicareAdvantage program. If these estimates are accurate, then health centers will lose their guarantee of cost-based reimbursement for up to 43 percent of their Medicare patients. This could result in centers having to dip into their Federal funding received through the Public Health Service Act. This funding is intended to provide care to the uninsured—not to fill in the gaps for certain Medicare health center patients.

The Bingaman-Snowe-Hatch amendment would not only protect the vital role of health centers but would also ensure that these health centers would continue to provide seamless health coverage to one million low-income Medicare beneficiaries. I urge my colleagues to support this amendment.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that at 11 o'clock today, the Senate proceed to a vote in relation to amendment No. 972 and that the amendment now be considered as being proposed by Senators SNOWE, BINGAMAN, and HATCH; further, that following that vote, there be 2 minutes equally divided for further debate prior to a vote in relation to the Edwards amendment, No. 985, to be followed by 2 minutes equally divided and a vote in relation to the Graham amendment, No. 956, with no second-degree amendments in order prior to the vote.

Finally, I ask unanimous consent that the time until the votes be equally divided between the two managers or their designees, and I further modify the request to allow 4 minutes equally divided prior to the Edwards vote.

The PRESIDING OFFICER. Is there objection?

AMENDMENT NO. 985, AS MODIFIED FURTHER

Mr. EDWARDS. Mr. President, reserving the right to object, I have a modification at the desk with additional modifications. I ask unanimous consent, first, that the modification be accepted.

The PRESIDING OFFICER. The amendment is further modified.

The amendment (No. 985), as modified further, is as follows:

At the end, add the following:

TITLE —DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. 01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following “(including, if the Secretary so requires, whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)”; and

(2) in subsection (d)(5)—

(A) by inserting “(A)” after “will”; and

(B) by inserting after “thereof” the following: “or (B) if the Secretary has required information related to comparative safety or effectiveness, offer a benefit with respect to safety or effectiveness (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug”.

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after “effectiveness” the following: “(including effectiveness in comparison to similar drugs for substantially the same condition or conditions)”.

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including effectiveness in comparison to other drugs for substantially the same condition or conditions);

(ii) information relating to side effects and contraindications; and

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided that*, nothing in this section shall require explicit images or sounds depicting side effects and contraindication.

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

“(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

“(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

“(A) the Secretary provides the person written notice of the violation; and

“(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

“(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

“(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

“(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

“(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).”.

SEC. 03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. 04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, for the information of Senators, we are going to have this block of votes. Then there is going to be a period of time where the two leaders have agreed there would be no amendments voted on. At about 2:30 or quarter to 3, we are going to try to line up a batch of votes to take up time this afternoon.

So for the information of Senators, at 2:30 or quarter to 3, the two managers and leaders are going to try to line up a bunch of votes.

AMENDMENT NO. 985, AS MODIFIED FURTHER

Mr. EDWARDS. Mr. President, I rise today, together with my friend, Senator TOM HARKIN from Iowa, to introduce an amendment to bring down the cost of prescription drugs. As everyone knows, the cost of prescription drugs has been skyrocketing. We have to bring these costs under control, not only to lower the drug costs for seniors but also to lower drug costs for all Americans, including those who will not get a prescription drug benefit under the Medicare Program.

There are lots of reasons drug costs are rising, and I have offered several proposals to address that in the past. This amendment addresses two particular concerns. The first is what is called the "me too" drugs that provide minimal benefits for people but large profits for drug companies. The second is the massive growth in the direct-to-consumer advertising that does not genuinely educate consumers.

This amendment, from TOM HARKIN and me, would address these problems with two steps. First, we call on the Secretary of HHS to require drug manufacturers to prove that "me too" drugs actually provide benefits before they are approved. Second, we would impose new requirements for fairness and balance in drug advertising.

Drug companies provide a very important service to America and to the sick. They deserve to make a profit for that, all of us agree on that. But they should also fulfill their mission as businesses, to generate innovative drugs that reduce pain, alleviate suffering, and cure disease.

Unfortunately, many drug companies seem to be giving that mission short shrift. We know they spend far more on marketing, advertising, and administration than they spend on research and development. We also know that instead of focusing on truly innovative breakthroughs, drug companies are focusing on "me-too" drugs to compete against blockbuster treatments for chronic conditions like allergies and high cholesterol. I want to talk about that for a minute.

Me-too drugs can be good things. They can help a specific population, or they can be safer and more effective. Of course those are good things. But here is the problem. Companies should not be able to profit off of a me-too drug just by misleading consumers about the benefits compared to existing drugs. Consumers should know how exactly the new drug stacks up against the existing drug.

Senator CLINTON spoke of the same need last night, when she introduced her very sound amendment. Consumers need to be given the ability to make an informed choice about the best drug for them.

This amendment would give the Secretary of HHS the authority to require drug companies to test drugs against their competitors. And if the drug company is going to advertise its "me-too" drug, it should tell the consumer how that drug compares to what they may already be taking for that condition.

Now, I want to talk about the larger point, which is drug advertising.

Some drug advertising is a good thing. Drug ads can let people know about drugs about which they don't otherwise hear. The drug industry's major trade group, PhRMA, says the purpose of direct-to-consumer advertising is:

> . . . to educate consumers about diseases, about the symptoms that may help them identify diseases, and the available therapies developed to treat them.

Those are good. Those are good goals. Here is the problem. Does anyone think drug advertising today is genuinely about educating consumers, as PhRMA says, rather than marketing? Does anyone believe that?

Are drug companies educating consumers about allergy medicines by showing this picture of a woman running through a field? I think all of us know, when this kind of advertisement, as in this picture, is shown on television, it is clearly about selling and about marketing. This is not for the purpose of educating consumers, and the American people know that. They know that without anyone telling them that.

Are they educating consumers about arthritis with images of a couple dancing in their kitchen? If this were about education, would an announcement read: "Health warnings: Headache, nausea," and so on, while the picture on the screen still shows happy pictures of a mom and her kids? Absolutely not. These ads are not about education; they are about marketing.

There is nothing wrong with marketing and persuasion in most contexts. If they are selling paper towels or shaving cream, companies should go ahead and market as aggressively as they can. But prescription drugs are different. There is nothing more important in our lives than our health, and there is nothing more important than drugs for our health. These are matters of life and death for families, for seniors, and for kids. Advertisements for these products should be held to a much higher standard. They should educate, not just market.

That is not what these ads do. You don't have to take my word for it; that is what Consumer Reports says, that is what doctors say, and, most importantly, it is what common sense says. These ads make promises they cannot keep. They overstate benefits and they understate risks. Let me give just a couple of examples from recent research.

This is from a study from the magazine Consumer Reports. They studied drug ads and they found:

> . . . a broad and disconcerting range of misleading messages: ads that minimize the product's risk, exaggerated its efficacy, made false claims of superiority over competing products; promoted unapproved uses for an approved drug; or promoted use of a drug still in the experimental stage.

In a recent FDA survey of 500 general practitioners, family doctors, 7 out of 10 said advertisements about drugs confused patients about the risks and benefits of medicines. In another study, 75 percent of doctors said their patients came away with the impression that the drugs they saw in advertisements work better than they actually do.

The Kaiser Family Foundation did a survey of nearly 2000 adults who saw drug advertisements; 7 out of 10 said they learned little or nothing about what the treated condition; 6 out of 10 said they learned little or nothing about the drug. Here are comments from Arnold Relman and Marcia Angell, two former editors-in-chief of the New England Journal of Medicine. They said:

> DTC ads mainly benefit the bottom line of the drug industry, not the public. They mislead consumers more than they inform them, and they pressure physicians to prescribe new, expensive, and often marginally helpful drugs, although a more conservative option might be better for the patient.

So this amendment is simple. It says that drug ads should be balanced. They should include information about other drugs that may address conditions better. And they should have a real balance between the images selling the drug and the images questioning the drug.

Now, the Bush administration sees it differently. They think see it as drug companies should be able to use whatever marketing gimmicks they want to sell their drugs.

The FDA is supposed to stop ads that are misleading. But last year the Bush administration's FDA instituted a new policy that slows down the FDA's efforts. As a result, the FDA issued two-thirds fewer warning letters last year than the year before. The GAO looked into this and found that warning letters are often "not issued until after the advertising campaign has run its course."

This is a gift to the drug companies. Without the threat of a warning letter, they can basically air whatever kind of ad they want and just ask for forgiveness afterwards.

Take the case of an ad for the prescription drug Tamiflu that ran on the radio last year. It featured Eric Bergoust, the Olympic gold-medal skier, who said "I felt better so soon that I didn't miss a single day of training." The FDA told the drug maker Hoffmann-La Roche to stop running the ad because Bergoust's words "misleadingly overstated the drug's efficacy." But the FDA's request came nearly three months after the company had submitted the ad for review, a month after the flu season had ended, and well after the company stopped running the ad.

Our amendment would make sure this kind of thing cannot happen. The FDA should speed up the review process and use their authority to have misleading ads pulled before millions of consumers have already seen them. And drug companies need to be held accountable when they repeatedly violate FDA regulations. In this amendment, Senator HARKIN and I call for stiff civil penalties for such offenders.

So, in short, this amendment would not bar all direct-to-consumer advertising. It would simply require the advertising to educate, rather than simply market. I urge my colleagues to support this amendment.

This amendment is for the purpose of doing something to control drug advertising, to make sure that it is, in fact, about education, and to make sure these "me too" drugs actually have a benefit before they are approved by the FDA.

Thank you, Mr. President.

VOTE ON AMENDMENT NO. 972

The PRESIDING OFFICER. The hour of 11 a.m. having arrived, the question is on agreeing to amendment No. 972, proposed by Senators Snowe, Bingaman, and Hatch.

Mr. EDWARDS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. McCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. McCAIN) would vote "yea."

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 94, nays 1, as follows:

[Rollcall Vote No. 242 Leg.]

YEAS—94

Akaka
Alexander
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Boxer
Breaux
Brownback
Bunning
Burns
Byrd
Cantwell
Carper
Chafee
Chambliss
Clinton
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Crapo
Daschle
Dayton
DeWine
Dodd
Dole
Domenici
Dorgan
Durbin
Edwards
Ensign
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham (SC)
Grassley
Hagel
Harkin
Hatch
Hollings
Hutchison
Inhofe
Inouye
Jeffords
Johnson
Kennedy
Kohl
Kyl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Lott
Lugar
McConnell
Mikulski
Miller
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Nickles
Pryor
Reed
Reid
Roberts
Rockefeller
Santorum
Sarbanes
Schumer
Sessions
Shelby
Smith
Snowe
Specter
Stabenow
Stevens
Sununu
Talent
Thomas
Voinovich
Warner
Wyden

NAYS—1

Gregg

NOT VOTING—5

Campbell
Graham (FL)
Kerry
Lieberman
McCain

The amendment (No. 972) was agreed to.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. BROWNBACK. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the time for the next two votes be limited to 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 985, AS MODIFIED FURTHER

The PRESIDING OFFICER. There are 4 minutes equally divided on the Edwards amendment prior to a vote.

Who yields time?

The Senator from North Carolina.

Mr. EDWARDS. Mr. President, the purpose of this amendment is to do something about the skyrocketing costs of prescription drugs in this country. Whatever we do to provide a real prescription drug benefit for seniors under Medicare, both for the purpose of keeping the cost of that plan down and for the purpose of doing something for all Americans who have no prescription drug coverage, we have to bring the cost of prescription drugs under control.

There are two abuses at which this amendment is aimed: First, stopping the proliferation of "me too" drugs that have no meaningful benefit; second, stopping the abuses in advertising.

Everyone has seen the ads: Couples dancing in the kitchen; people running through fields. These are not for the purpose of education. They are for the purpose of marketing. We are trying to bring this under control by putting fairness, honesty, and accuracy in that advertising.

The purpose of the amendment is to help control both those activities and, in the process, bring down the cost of prescription drugs.

Mr. President, I ask my colleague, the coauthor of this amendment, Senator HARKIN from Iowa, what he believes we need to do to bring down the cost of prescription drugs. I yield to Senator HARKIN.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, parliamentary inquiry: What type of time agreement are we under now?

The PRESIDING OFFICER. Four minutes equally divided. The Senator has 31 seconds.

Mr. HARKIN. Mr. President, I thank my colleague from North Carolina for offering his amendment of which I am a cosponsor. Every time I go back to Iowa, I hear from consumers and others: Why do I get inundated with all these ads, and I cannot buy them unless I go to the doctor?

Right now, the drug companies are spending more on advertising every year than they are on research, and we wonder why the price of drugs keeps going up.

This all changed a few years ago. If my colleagues will remember, before 1997, we did not see all these ads. Now it is time to cut out this massive advertising of drugs that we cannot even buy in the marketplace.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. GRASSLEY. Mr. President, I yield the 2 minutes on this side to the Senator from Wyoming.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask the body to vote no on the Edwards amendment to increase drug costs. This is a new drug approval. The amendment masquerades as a direct-to-consumer advertising amendment while sweeping away carefully calibrated FDA drug approval standards.

While the Edwards amendment masquerades as an amendment to "strengthen protections against misleading direct-to-consumer advertising," the amendment drastically changes the requirements for drug approval in the United States.

We have a great system that is working. Under the current law, pharmaceuticals must demonstrate they are safe and effective to be approved by the Food and Drug Administration. Under the Edwards amendment, the Secretary of Health and Human Services would be authorized to vary this standard on a drug-by-drug basis to create new hurdles to drug approvals.

These new hurdles include lengthy, costly comparative trials and a showing that the drug is safer or more effective for a subpopulation or condition than a previously approved drug.

These changes to fundamental, longstanding law could hurt patients by delaying, and possibly denying, the approval of new drugs that patients need; by dramatically adding to drug development costs, discouraging companies from developing additional drugs to treat the same conditions; and increasing drug spending by reducing brand-to-brand competition.

We know far more about pharmaceuticals than many other medical interventions since, unlike most other interventions, they must obtain approval under FDA's safe and effective standard before they can be used. We should reject this amendment as it would add another regulatory hurdle to the already long and costly drug development and approval process.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to amendment No. 985, as modified further.

Mr. EDWARDS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The bill clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote "yea."

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 26, nays 69, as follows:

[Rollcall Vote No. 243 Leg.]

YEAS—26

Akaka
Boxer
Byrd
Cantwell
Clinton
Daschle
Dayton
Durbin
Edwards
Feingold
Feinstein
Harkin
Inouye
Johnson
Kohl
Leahy
Levin
Lincoln
Miller
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Schumer
Stabenow

NAYS—69

Alexander
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Breaux
Brownback
Bunning
Burns
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Crapo
DeWine
Dodd
Dole
Domenici
Dorgan
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hollings
Hutchison
Inhofe
Jeffords
Kennedy
Kyl
Landrieu
Lautenberg
Lott
Lugar
McConnell
Mikulski
Murkowski
Murray
Nelson (NE)
Nickles
Roberts
Santorum
Sarbanes
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner
Wyden

NOT VOTING—5

Campbell
Graham (FL)
Kerry
Lieberman
McCain

The amendment (No. 985), as modified further, was rejected.

Mr. REID. I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 956

The PRESIDING OFFICER (Ms. MURKOWSKI). The order of business is amendment numbered 956, the Graham of Florida amendment.

Mr. REID. Madam President, it is my understanding the next matter is the Graham amendment.

The PRESIDING OFFICER. That is correct.

Mr. REID. Madam President, on behalf of Senators GRAHAM, FEINSTEIN, MURKOWSKI, JOHNSON, and this Senator, this is a tremendous piece of work Senator GRAHAM has done. It is good legislation. At least 12 percent of our seniors would be subject to a gap in coverage under this bill. Standard coverage would require seniors to pay 100 percent of the cost of prescriptions between $4,500 and $5,812 in total spending. At the same time, they are paying 100 percent of each prescription, and they are still required to pay a monthly premium.

Collecting a premium while a senior is in the gap is equivalent to levying a tax on the sick. This amendment suspends the payment of premium once the beneficiary hits the gap in coverage. This amendment is endorsed by the National Committee to Preserve Social Security, the Alliance of Retired Americans, and the National Council on Aging.

The amendment is offset by clarification of the Medicare secondary payer provision. This noncontroversial offset, which yields $8.9 billion over 10 years, is fully supported by the Department of Justice and is in the House Republican drug bill.

Mr. GRASSLEY. Madam President, I have to ask my colleagues to vote against this amendment because it costs $200 billion. We are working within a $400 billion package. I wish we could eliminate the gap, as well. What we are trying to do is help the most people who have the most need with the money we have. Most seniors will not be affected by the gap in coverage. Most seniors will not have drug spending in a year that exceeds the benefit limit.

According to the CBO, about 88 percent of the seniors will not even have prescription drug spending that exceeds the $4,500 limit.

The Senator from Florida calls the benefit limit a "sick tax" because he believes that seniors should not pay a premium for coverage for catastrophic costs. This is as if to say you should not pay for fire insurance if your house is not going to be on fire. Of course, that is not how insurance works. People purchase insurance to protect them against an unfortunate accident.

The PRESIDING OFFICER. All time is expired.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote "yea."

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 56, as follows:

[Rollcall Vote No. 244 Leg.]

YEAS—39

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Harkin
Hollings
Inouye
Johnson
Kohl
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—56

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Chafee
Chambliss

Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kennedy
Kyl
Landrieu
Lott
Lugar
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—5

Campbell
Graham (FL)
Kerry
Lieberman
McCain

The amendment (No. 956) was rejected.

Mr. REID. I move to reconsider the vote.

Mr. ENSIGN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I ask unanimous consent that Senator EDWARDS be recognized to offer an amendment—and he will speak, if necessary, at a later time—and, following the offering of his amendment, Senator ENZI be recognized to offer two amendments; and following that, Senator DURBIN—we hope at 12:30 or 12:35—be recognized to offer his amendment; that following the offering and the speech by Senator DURBIN, we ask that Senator ENSIGN be recognized to offer an amendment—sometime around 1 o'clock this afternoon.

For the information of Senators, the two managers are working to get a list of at least four amendments to vote on starting at 3 o'clock this afternoon. I ask unanimous consent for what I asked previously except for the voting at 3 o'clock.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from North Carolina.

Mr. EDWARDS. Madam President, I ask unanimous consent to lay aside the pending amendments.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1052

Mr. EDWARDS. Madam President, I have an amendment I send to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from North Carolina [Mr. EDWARDS], for himself and Mr. HARKIN, proposes an amendment numbered 1052.

Mr. EDWARDS. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To strengthen protections for consumers against misleading direct-to-consumer drug advertising)

At the end, add the following:

TITLE —DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. 01. DIRECT-TO-CONSUMER ADVERTISING.

Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by inserting at the end of the following:

REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including, if available, effectiveness in comparison to other drugs for substantially the same condition or conditions); and

(ii) information relating to side effects and contraindications;

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided*, that nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

"(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

"(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

"(A) the Secretary provides the person written notice of the violation; and

"(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

"(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

"(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

"(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

"(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).".

SEC. 03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. 04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisement except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

Mr. EDWARDS. Madam President, I ask unanimous consent that the amendment be laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. EDWARDS. I suggest the absence of a quorum.

The PRESIDING OFFICER. Will the Senator withhold?

Mr. EDWARDS. Yes.

The PRESIDING OFFICER. The Senator from Wyoming.

AMENDMENT NO. 1051

Mr. ENZI. Madam President, I ask unanimous consent to set the pending amendments aside and call up amendment No. 1051.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

The Senator from Wyoming [Mr. ENZI], for himself and Mrs. LINCOLN, proposes an amendment numbered 1051.

Mr. ENZI. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To ensure convenient access to pharmacies and prohibit the tying of contracts)

On page 37, between lines 20 and 21, insert the following:

(C) CONVENIENT ACCESS TO PHARMACIES.—In this section, the term 'convenient access' means access that is no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TriCare retail pharmacy program. Such rules shall include adequate emergency access for enrolled beneficiaries.

On page 48, between lines 4 and 5, insert the following:

(4) TYING OF CONTRACTS.—No eligible entity with a contract under this part, or its agent, may require a pharmacy to participate in a medicare prescription drug plan as a condition of participating in nonmedicare programs or networks, or require a pharmacy to participate in a nonmedicare program or network as a condition of participating in a medicare prescription drug plan.

Mr. ENZI. Madam President, I rise to offer an amendment that would build upon the protections for seniors and pharmacists that the Senate approved last week. I am pleased to be joined by my distinguished colleague from Arkansas, Senator LINCOLN, in offering this amendment.

This amendment would ensure that seniors have convenient access to local pharmacies. The amendment would accomplish this in two ways.

First, there is language in the Finance Committee's bill that requires the Government to develop a standard for ensuring that seniors have convenient access to local pharmacies. This amendment would further define what we mean by "convenient access."

The amendment would ensure that access to retail pharmacies under Medicare is "no less favorable to enrollees" than the access standards under the TRICARE retail pharmacy program.

TRICARE is the health care program for active-duty and retired members of the uniformed services, their families, and survivors. TRICARE is a regionally managed program that offers eligible beneficiaries three choices for their health care.

First, there is TRICARE Prime, where military facilities such as Department of Defense hospitals are the principal source of health care services. There is also TRICARE Extra, a preferred provider option. Finally, there is a TRICARE Standard, the fee-for-service option that used to be known as CHAMPUS.

For all three options, TRICARE offers pharmacy benefits that include access to a retail pharmacy network. To win an award to manage TRICARE benefits for the military, a contractor must maintain a retail pharmacy network that "minimizes the number of eligible beneficiaries who will have to change pharmacies" to use the contractor's network.

There are three minimum beneficiary access standards for the TRICARE retail pharmacy network.

In urban areas, the contractor must have a network pharmacy within 2 miles of 90 percent of eligible beneficiaries. In suburban areas, the standard is a pharmacy within 5 miles of 90 percent of the beneficiaries. In rural areas, the standard is a pharmacy within 15 miles of 70 percent of the beneficiaries.

The Enzi-Lincoln amendment would not require Medicare drug plans to meet these exact standards. It would only require that a Medicare drug plan's network be "no less favorable" to seniors than the TRICARE program is for active-duty military and retirees, including those who participate in the new TRICARE Senior Pharmacy Program, provided by the 2001 National Defense Authorization Act. If the Administrator of the new Center for Medicare Choices or a Medicare drug plan had a better way of meeting or exceeding the TRICARE standard, they would not be restrained from doing so.

As I mentioned earlier, there is another way this amendment would ensure that seniors have convenient access to their local pharmacies. The amendment includes a provision that prohibits a Medicare drug plan operator from requiring pharmacies to accept non-Medicare business and reimbursement rates as a condition of participating in the plan's Medicare business, or vice versa.

I expect that health plans and pharmacy benefits managers that operate in the commercial insurance market will be the same companies that will compete to provide Medicare drug plans and Medicare Advantage preferred provider options to seniors. If a plan wins a bid to provide a Medicare drug benefit, they may offer reimbursement rates to retail pharmacies that are better or worse than the rates they offer in their private sector commercial business. That is fine with me.

What concerns me is the possibility of these large plans "tying" their Medicare and non-Medicare business together. A Medicare drug plan should not be able to require a community pharmacist to accept an unprofitable reimbursement rate for its private sector business as a condition of participating in its Medicare network. Likewise, a community pharmacist should not have to take a money-losing Medicare reimbursement rate in order to keep its non-Medicare business from the same large plan.

We should allow community pharmacists to refuse unprofitable private sector business from a health insurer or a pharmacy benefits manager yet participate in a Medicare drug plan run by the same entities. By doing so, we will further ensure that seniors have convenient access to local pharmacies based on fair reimbursement rates that should take into account the added costs pharmacies incur in providing counseling and advice to Medicare beneficiaries, especially since pharmacists are rarely reimbursed directly for the time and effort it takes to provide that counseling and advice.

I urge my colleagues to join with Senator LINCOLN and me in continuing to improve this Medicare bill by ensuring that seniors have convenient access to their local pharmacists.

I yield the floor to my colleague on this amendment.

The PRESIDING OFFICER. The Senator from Arkansas.

Mrs. LINCOLN. Madam President, I thank my colleague from Wyoming. I am extremely pleased to offer this amendment with him to help our seniors by ensuring that local pharmacists can continue providing their services under the new prescription drug program created under this bill. I compliment him on his leadership—as well as the hard work of his staff—in crafting a very plausible solution to many of our problems.

I was proud to have supported another amendment offered by my friend Senator ENZI and Senator REED of Rhode Island which sought to ensure that PBMs can't force seniors into mail order programs. For those of us, such as the Presiding Officer and others, who represent large tracts of rural areas in our States, it is important to know that all seniors across this great Nation are going to get a fair shake when it comes to a prescription drug package. We want to make sure that the package we design and the law we produce are going to ensure that every senior has the same quality of care, the same quality of product, and the same quality of access through this prescription drug package.

Many Arkansas pharmacists, including Gene Boeckmann, owner of Wynne Apothecary, have explained to me the many problems with mail order pharmacy operations. For one, it weakens the personal contact between customer and pharmacist, a vital connection when it comes to one's health and particularly when you live in a rural area where medical professionals may not be there full time. I know many of our communities—the one just mentioned—have medical facilities that are satellites of hospitals from larger communities. Consequently, many of their medical professionals are not full-time residents. Oftentimes the only medical professional they have happens to be the pharmacist, someone they can call on a weekend or late at night if they run into problems.

Mail order pharmacies that are owned by PBMs also take money out of local communities. In many small towns across Arkansas, pharmacists such as Mr. Boeckmann are the ones paying the taxes. They support the local community baseball and softball teams. They donate money so the school band can go to competitions. They are serving their communities. They have the right and responsibility to do that and, through this bill, we want them to continue. Our communities need leaders such as Mr. Boeckmann. It is for this reason I am proud to support the Enzi-Reed amendment.

As we began drafting the amendment, we attempted to include a provision to prevent conflicts of interest. I hope we will be able to address this issue in conference. Our original amendment would have prohibited a PBM from favoring a mail order contractor it owns. Regrettably, we could not work out language agreeable to everyone, but I do hope we can continue to address the conflict of interest issue in conference. I will be working diligently with others to see that we can.

The amendment seeks to build on that effort by ensuring that seniors have access to their community pharmacists. Over the many years of this debate, I have heard from countless seniors who have told me how important their community pharmacist is to their health care.

I have told them time and time again, they are preaching to the choir with me. I can look back in my own life to when my grandmother was diagnosed with cancer. She lived with us the last 2 years of her life in the back of the house in the room next to mine. I can remember when she would suffer from discomfort, she didn't want to talk to the doctor. She knew what her ailment was. She wanted to talk to the pharmacist.

She would call him. He would say: Mrs. Adne, you need to stop taking your blue pill and keep your yellow pill, but remember it is going to upset your stomach if you don't take it with a glass of milk or a biscuit.

She found great relief in the knowledge that the pharmacist could provide her. There was nothing more the doctors could do for her. Yet the pharmacist could provide her that information.

I look back on the journey my family had with my own father when we traveled down almost 10 years of a road through the disease of Alzheimer's, recognizing very little could be done by the physicians. Yet the pharmacist was the one we could call in our small community who actually could tell us how we could provide relief, ways we could enhance the quality of life for my father as he lived out those last few years and then those last few days in his own home, in the very woods he grew up in as a little boy.

These are the qualities of life we are talking about for our families, for our loved ones in rural areas, to make it possible essentially for them to be able to do that. What we are talking about is really putting common sense into the bill and recognizing how important it is to maintain that contact in rural areas. Seniors like my late grandmother or my father don't need a mail order service with a 1-800 number and a recording. They need their local pharmacist to talk to.

This amendment seeks to guarantee seniors convenient access to pharmacists. "Convenient access" would be defined as access standards that are at least as favorable as the Department of Defense's TRICARE program, to which Senator ENZI referred. That should be the minimum level of access. The TRICARE program requires that at least 90 percent of beneficiaries in urban areas have access to a network pharmacy within 2 miles, 90 percent of beneficiaries in suburban areas have access to a network pharmacy within 5 miles, and 70 percent of beneficiaries in rural areas have access to a network pharmacy within 15 miles.

Second, our amendment seeks to prevent PBMs from tying one contract with a pharmacist to another contract. The practice of committing pharmacists with one contract to another simply ties their hands from being able to provide the kind of service they should be able to provide.

As several of my colleagues have mentioned, PBMs play a major role in the negotiating process between pharmacists and drug companies. Some PBMs have the market power to require a pharmacy provider to accept one contract rate as a condition of participating in a totally unrelated program. This "tying," as it is termed, of one contract to another is an abuse of market power, and it should be prohibited in the Medicare Program. Our amendment would prohibit tying.

I encourage my colleagues to join us by supporting this important amendment that will make Medicare a better program for our seniors and for our pharmacists. Let's make this easier for the seniors and keep the pharmacists in the business.

As I urge my colleagues to support the amendment Senator ENZI and I have offered, I also encourage them to think back to a circumstance, perhaps, in which they found themselves or a story they have heard from one of their rural constituents who can best describe to them in their own words how vital it is to have these important health care providers remain in our communities.

I thank my colleague from Wyoming for his great leadership and the hard work of his staff. I am proud to join him in offering the amendment. I do encourage all of our colleagues to support it and to support rural America so that all seniors across the Nation will have a benefit that will be equal in terms of access and for the information they need in order to find quality of life through the prescription drug package we believe they can.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I thank the Senator from Arkansas for her diligent effort. I ask my colleagues to vote for it.

Mrs. LINCOLN. I thank the Senator.

AMENDMENT NO. 1030

Mr. ENZI. Madam President, I ask unanimous consent to set aside the pending amendment and call up amendment No. 1030.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI] proposes an amendment numbered 1030.

Mr. ENZI. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To encourage the availability of MedicareAdvantage benefits in medically underserved areas)

On page 356, strike lines 8 through 11, and insert the following:

(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting—

(i) the persons from whom enrollees under such plan may obtain covered benefits; or

(ii) the categories of licensed health professionals or providers from whom enrollees under such a plan may obtain covered benefits if the covered services are provided to enrollees in a State where 25 percent or more of the population resides in health professional shortage areas designated pursuant to section 332 of the Public Health Service Act.

Mr. ENZI. Madam President, this amendment would make the Medicare Advantage preferred provider organization option more attractive to people in areas of the country that have shortages of doctors and other health care providers.

The proposed amendment would ensure that Medicare Advantage plans pay for covered services provided by any properly licensed health professionals to seniors in "medically underserved States."

In other words, if a MedicareAdvantage plan covers a service, then the plan must pay for the service if it is provided by a licensed provider in a medically underserved State, regardless of other plan limitations on the types of health professionals that may provide the service.

I assure my colleagues that this is nothing new. The law that governs the Federal Employees Health Benefits Program provides special consideration for enrollees of preferred-provider plans who live in States with critical shortages of physicians and other health professionals. Such States are designated as "medically underserved areas" for purposes of the Federal employees program, and the law requires preferred provider organizations to pay for services provided by any qualified providers in these States.

As a result, in medically underserved areas, Federal employees' health plans must treat any licensed health professional as a "covered provider" for any covered services performed within the scope of that State's licensure laws.

This amendment simply would require the same treatment by MedicareAdvantage plans of seniors who live in medically underserved States. If the plan says that a physician must provide a service, but a nurse practitioner is permitted under State law to provide the service, a senior in a medically underserved State could get that service from his or her local nurse practitioner.

The amendment would define a "medically underserved State" in the same way it is defined for the Federal Employees Health Benefits Program. The Federal employees program law defines a "medically underserved State" as one in which 25 percent or more of the population lives in health professional shortage areas, as defined by the Secretary of Health and Human Services. This amendment would transfer that language to MedicareAdvantage.

In 2003, the following States were considered "medically underserved" for purposes of the Federal employees health plan: Alabama, Idaho, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.

By the way, Louisiana, Maine, and West Virginia were added to the list in 2003, which demonstrates that the list is flexible enough to recognize States that may not have shortages of health professionals right now, but may have a shortage in the future.

Here's an example of how this provision works in the Federal employees program. The Rural Letter Carrier Benefit Plan allows physical and occupational therapy services to be provided by qualified and licensed physical therapists, occupational therapists, and physicians. However, the Government Employees Hospital Association Benefit Plan, or the G-E-H-A plan, does not generally allow qualified physicians to provide physical or occupational therapy services. As a result, physicians who may have special expertise in rehabilitation medicine, for example, cannot provide such services to members of the G-E-H-A plan.

However, in medically underserved States, the G-E-H-A plan must allow Federal employees to receive physical or occupational therapy services from any physician who is qualified to do so and whose State license permits him or her to do so.

As a result, Federal employees in medically underserved States who live 50 miles from the nearest physical or occupational therapist don't have to drive 50 miles to receive a service they could get from the local physician.

Here's another example. The Rural Letter Carriers plan allows chiropractors to perform manipulation of the spine and extremities, as well as related procedures such as ultrasound and cold-pack application. The G-E-H-A plan allows chiropractors to perform manipulation of the spine and certain X-rays to detect and determine nerve interferences, but it doesn't allow for chiropractors to perform ultrasound or other related procedures like the Rural Letter Carriers plan does. Both plans also reserve certain procedures for other types of health professionals.

However, in medically underserved States, both plans must permit chiropractors to perform any service that the plans cover—provided that the services are within the scope of the chiropractor's State license.

Now that I have explained what this amendment would accomplish, let me be clear about what this amendment would not do.

First, the amendment would not require MedicareAdvantage plans to pay for services that they would not ordinarily cover. It would only require that plans pay for covered services in medically underserved States without limiting the types of professionals who may provide the service. Again, this provision only applies to services that the plan has already decided to cover.

Second, this amendment is not an "any willing provider" amendment. A number of States have "any willing provider" laws that require health plans to permit all providers to participate in the network if they agree to accept the plan's contract terms, especially their payment rates.

This amendment, however, would not require MedicareAdvantage plans to allow any health care provider to participate in the plan's network just because he or she is willing to do so. Nor would this amendment provide that a MedicareAdvantage plan could not pay a non-network provider any less than whit it pays a network provider.

This amendment simply directs plans to pay either their in-network or out-of-network for covered services that are provided by any type of health professional who is licensed to provide the service in a medically underserved State.

Finally, this amendment is not intended to favor physicians versus physical therapists, nurse practitioners, or other health professionals, or for that matter, to favor those other health professionals versus physicians.

This amendment simply would recognize the reality of healthcare in rural and frontier America—there simply aren't enough healthcare providers to go around. In States like Wyoming, the problem is getting worse, not better. Many of our doctors and other health professionals are growing older and retiring, while others are leaving our State to move to places with better medical liability laws.

In States with dire shortages of doctors and other healthcare providers, seniors shouldn't have to get into the car in the heat of summer or the cold of winter to drive to the nearest city to get healthcare services that they could get in their own town, or the town next door.

Even going to the town next door can be a challenge in Wyoming, because the town next door may be many miles away!

I want seniors in Wyoming and other sparsely populated States to be able to choose a MedicareAdvantage plan if they want comprehensive health coverage. These plans will be competing to offer seniors an integrated medical and drug benefit, innovative services like disease management, and more complete preventive services to keep seniors healthier.

For seniors in rural States to choose MedicareAdvantage, they need to know that a plan's network provides real access. There's a big difference between a network of health care providers being available, and a network of health care providers being accessible.

This amendment would provide protection and peace-of-mind to seniors who might consider joining a MedicareAdvantage plan. It's the same safeguard enjoyed by other Federal employees, including the Members of this Body. I ask my colleagues to join me in passing this amendment to ensure that seniors in rural and frontier States receive the same protection and piece-of-mind that we have in our own Federal health plan.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Illinois is recognized.

Mr. DURBIN. I see my colleague from Nebraska. There as a unanimous consent that I was to be recognized. I know the Senator has come to the floor. I hope we can work out a time that the Senator from Nebraska might be able to speak.

Mr. HAGEL. Senator ENSIGN and I are teaming up on a couple of amendments. We will follow the distinguished Senator from Illinois.

Mr. DURBIN. I will finish at no later than 1 o'clock.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Madam President, understand what this debate is about. It is the first time Congress has seriously considered offering help to senior citizens to pay for prescription drugs. I have said to Senators GRASSLEY and BAUCUS, who bring S. 1, the bill that is before us, to the floor, that I congratulate them for their good efforts. It is not an easy achievement.

For the first time in American history, we will offer this kind of assistance to seniors. But I have to say, having conceded their valiant effort, this prescription drug plan they have brought to the floor still has major deficiencies and major problems. I think it is going to run into a firestorm of criticism, primarily from senior citizens and their families, once they understand the specifics of S. 1.

For example, a lot has been said about a $35 monthly premium. This bill, S. 1, doesn't guarantee a $35 monthly premium for prescription drug coverage. It is a suggestion. It is not even worth the paper it is printed on. What is guaranteed is a $275 deductible, which means you really don't get any drug coverage until you have spent at least $275. For some people, that is not a major outlay from their own personal budget. For others, it could be.

There also is no assurance in terms of the amount of money that will be paid for your prescription drugs by the Government. The goal is 50/50—that you would split it with the Government. There is no assurance that will happen.

There is also going to be a gap in coverage. In other words, if you sign up for this voluntary program, if you pay your monthly premium of $35 plus, and if you start receiving checks from the Government, you may find a time, perhaps during the end of the year, when the Government checks stop coming because there is a gap in coverage.

My friend, Senator BOXER of California, will offer an amendment later to say what are we going to do about cancer victims—people who take expensive drugs that are necessary to save their lives. Under the bill before us, there will come a point in time each year when the Government stops helping cancer victims pay for the prescription drugs they need to stay alive. That gap in coverage is troubling, and it should be.

Also, there is no allocation for money spent by employers on behalf of retirees, that that be counted for the employee's benefit to qualify for this plan, which means that some employers might be tempted not to provide coverage at all to their retirees, and others won't see the benefit of that coverage because it doesn't translate into help under S. 1.

Those who push this plan believe in competition, so long as the competition is limited to two HMOs that can offer private insurance coverage for prescription drugs. That is the only competition they are interested in. The interesting thing is, when you go to the seniors of America and say what are you looking for in a prescription drug plan, it is an amazing response.

Over 600 seniors were asked in a survey of a week or so ago: Which should be a higher priority of Congress, passing prescription drug coverage for seniors under Medicare or passing a bill to control excessive prices for prescription drugs? The choice: S. 1, prescription drug coverage for seniors under Medicare or passing a bill to control the excessive, runaway, skyrocketing prices.

Look at what they said. Of all seniors—people over 55—25 percent want Medicare drug coverage; 53 percent said control drug prices. Then look as you go down here. That portion here, 55 to 64 years of age, said 25 percent want Medicare drug coverage; 57 percent said control drug prices. For seniors, 65 and older, 26 percent want Medicare drug coverage and 50 percent said control drug prices.

In each instance, by a margin of more than 2-to-1, seniors—people over the age of 55—have said to Congress: Don't miss the ball here. The object has to be controlling the excessive cost of drugs. You can offer a helping hand to us, and that is good—25 percent believe that is good—but it won't mean anything if you don't do something about the cost of prescription drugs.

I am sorry to report to you that S. 1—I always have to look to see how many pages this is—with 654 pages doesn't dedicate a paragraph or a page to bringing down the excessive cost of prescription drugs. So the No. 1 issue, by a margin of 2-to-1, for people over 55 in America is controlling excessive drug prices, and it is ignored by S. 1. So here we are with this historic opportunity, and we are completely missing what most seniors in America believe to be the highest priority.

I went to my staff and said: Let's start from the beginning. What kind of a prescription drug program would we create if we had a blank slate? I said to them: Here is what I would like to see us come up with. Let me give a comparison between what we are proposing as my substitute amendment and the underlying bill.

The Grassley-Baucus bill has a $275 deductible. I said: Let's eliminate that deductible, and we did. Under the MediSAVE amendment, there is no deductible.

The premium under Grassley-Baucus is estimated to be $35, which means it could be much higher. I said: Let's require that the premium for this volunteer prescription drug plan be $35 defined in statute.

Cost sharing, under the best of circumstances, is 50/50 under the Grassley-Baucus plan, and under the MediSAVE plan, which we propose, it is 70/30, a substantially greater benefit for every senior covered by this plan.

The coverage gap I mentioned earlier in Grassley-Baucus says if you reach a point where you had $4,500 in prescription drugs in a given year—not an outrageous possibility; that is a little more than $350, $400 a month; a lot of seniors face that—that at some point during the course of the year your benefits will stop. I said: Eliminate that gap. I want full coverage all the way up to the catastrophic level of $5,000 in prescription drugs, which then kicks in at 90-percent reimbursement. And we did.

Then we got to this issue: Will we have lower prescription drug prices? Under Grassley-Baucus, no. That is why the pharmaceutical companies love this bill. We have not heard a word from them. They think this is great. Uncle Sam is going to provide some assistance to seniors to pay for prescription drugs, and the drug companies can continue to hike the prices of the drugs every single year without any restraint in S. 1. But we know there is a better way, and the better way is not socialism, as some of my critics might say.

The better way is the Veterans' Administration of the United States of America. They look at their hospitals across America and the millions of veterans they serve and they go to the drug companies and say: If you want your drug used in our Veterans' Administration hospitals, you have to give us a discount, and they do. The drug companies give a 40- to 50-percent discount, and that should be part of this Medicare plan as well.

Probably the most important single element in this MediSAVE plan I am offering is we are going to have Health and Human Services negotiating group purchasing. Drug companies are not going to like this. Pharmaceutical companies do not like to see their profit margins come down. But these are the most profitable corporations in America. I do not believe it is the responsibility of the Senate to find ways to reward the special interest groups, the pharmaceutical companies, and the HMOs at the expense of senior citizens. That is exactly what this bill does.

As I mentioned earlier, more benefits would count toward out-of-pocket spending. Medicare would have a deliberate benefit available. That is what I think is equally important. We say: Fine, competition in choice. Private insurance companies can offer prescription drug benefits but allow Medicare, the Government agency, to have a prescription drug program available to every senior across the United States.

Why is that important? Medicare, as an agency, has no profit motive. Medicare, as an agency, has a lower administrative cost than health insurance companies across America, and Medicare, an agency speaking for tens of millions of seniors, can negotiate lower prices. They can do what the Veterans' Administration has done, and that is why many of the most conservative Members of this Chamber live in dread for fear that Medicare would be able to compete with private insurance companies. Put that competition in place. Give the seniors a choice. MediSAVE does it. Grassley-Baucus does not.

We have an option for private coverage. Of course, it is in both bills.

We have a fallback which says if a senior citizen wants to go to the Medicare plan, they can always go to it, whether there is a private insurance plan in their region.

The benefit begins, incidentally, under the Grassley-Baucus bill, conveniently after the next Presidential election. So the White House can go around crowing about S. 1, prescription drug coverage is on the way, we delivered for seniors of America, and it is going to show up a few days after the election. What is wrong with this picture?

Seniors need help right now. A discount card is nice, but let's put a prescription drug policy in place that helps seniors right now. So we call on the establishment of this program as soon as practicable.

How did we do this? How did we put together all these benefits, which are much more generous than Grassley-Baucus, and still have CBO score it at $400 billion? I learned a little trick from the Republican side of the aisle when it came to tax cuts. When they could not get enough money for tax cuts, they decided they would sunset them at some point and reauthorize them. We did the same thing.

Grassley-Baucus costs $400 billion scored through 2013. Our MediSAVE substitute costs $400 billion scored to sunset at 2010. At that point, Congress can take a look at it. If we reach the point where we want to reauthorize the program or change it, it is up to us. In the meantime, we offer seniors in America a quality program, something they want, something they can use, and something that will truly help them.

If we do not address the cost of prescription drugs as part of a prescription drug program, we are going to fail. There is nothing we can do offering a percentage helping hand to seniors that will keep up with the dramatic increase in the cost of prescription drugs, which happens every single year. This substitute I am offering will provide that kind of competition.

Before I yield to my friend from Minnesota, who is a cosponsor of this amendment, let me give a couple other items that I believe might be of interest to my colleagues.

The Durbin MediSAVE amendment is cosponsored by Senator DAYTON of Minnesota, who is here, Senator BOXER, Senator BYRD, Senator CORZINE, Senator HARKIN, Senator LANDRIEU, Senator STABENOW, and Senator JOHNSON. It also has been endorsed by the AFL–CIO, United Auto Workers, AFSME, Alliance for Retired Americans, the American Federation of Teachers, and the National Committee to Preserve and Protect Social Security.

At this point, I wish to yield, for the purpose of debate, to my colleague from Minnesota, Senator DAYTON, without yielding the floor.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Minnesota.

Mr. DAYTON. I thank the Chair.

Madam President, I thank Senator DURBIN. I commend my distinguished colleague from Illinois, Senator DURBIN, who has spearheaded the development of this amendment, and for the leadership he has shown in this and so many other areas. I stand proudly with the Senator today.

The Durbin amendment is the essential test for this body. It is going to be the measure of our commitment to seniors and to other Medicare beneficiaries all over America. It is going to be a test of our sincerity of what we said we intend to do for those people who are either disabled, through no choice of their own and are required to be on Medicare at an early age, or senior citizens who have worked throughout this country who have served this country so well and now are in their retirement years, the largest users by age of prescription drug medicines. So they are the ones most dependent on the quality of coverage we provide for them.

I heard again today from colleagues on the other side of the aisle, as I have heard others say throughout this Chamber, and as I have said many times in Minnesota, that our senior citizens deserve prescription drug coverage that is as good as Members of Congress receive; that is as good as the Federal employees receive through the plan of which we are all part. Yes, we pay into that plan, but it is also very well covered—"subsidized" would be the right word—by our employer, the Federal Government; the same in the case of Senator DURBIN's amendment, at a level of parity to our plan.

If we want to provide senior citizens and other Medicare beneficiaries with the same level of coverage that we get in Congress, then Senator DURBIN's amendment is the way to do that.

S. 1, by contrast, provides half of those benefits overall—one-half of what we get in Congress. That is not right, that is not fair, and that is contrary to what I have heard most of my colleagues rhetorically say over the last month, and even the last couple of years, about the intent.

We cannot have it both ways. It is either going to be only half as good under S. 1 for senior citizens as it is for Members of Congress or it is going to be as good as Members of Congress receive under the Durbin amendment.

Do we have the resources? Yes, we have the resources. We surely had plenty of resources when I came to the Senate 2½ years ago, surpluses for a decade, as far as the eye could see. Now that we have been shifted into deficit mode, suddenly we are talking about a bill that is inadequate.

It is not lack of money. It is a lack of priorities. It is a lack of the right priorities for people in this country, and Senator DURBIN's amendment would say we are going to go back to the drawing board and do what is right for seniors and Medicare, and then we are going to turn around and do what we must to balance that equation.

As the Senator from Illinois also pointed out so well, if we want to do anything to address the ravaging of budgets of people of all ages by these prescription drug prices, it has to be through the kind of structured program which the Senator has proposed; otherwise, it is just a continued license to steal for the pharmaceutical industry.

S. 1 does nothing except say taxpayers are going to pay the costs of these rapidly escalating drug prices. Seniors will have to pay for a part of it as well. And then all of the taxpayers who are not senior citizens who are paying for part of this program for seniors are going to have to go to the drugstores for their families and themselves and keep paying prices that go higher and higher.

I had a deck of cards made that I am handing out in Minnesota. They compare the prices of these drugs now in Canada and the United States. Aside from the exchange rates, they show a fair comparison of prices for the same medicine, same manufacturer, same packaging, everything exactly the same in Canada as the United States. The prices in Canada are sometimes as low as 10 percent of what they are in the United States, 20 percent quite common, a third—one can get the same medicine in Canada for one-third the price in the United States.

Why? Because the Canadian Government stands up for its citizens. The Canadian Government says: We are not going to allow you to charge these exorbitant prices and make these excessive profits out of the pockets of our people. Tragically, our Government does nothing of the sort. This bill would continue that policy: Hands off; pharmaceutical industry, take whatever you can get.

So I commend the Senator from Illinois. I am grateful to him for putting this amendment together. I am proud to cosponsor it. I commend it to my colleagues, and I ask the people of America to keep an eye on this vote because it is going to determine whether we mean what we say.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, I thank the Senator from Minnesota, and I think it really does come down to whether we are going to pass a prescription drug plan in name only or something that seniors truly want and can use and is fair for them.

The Senator from Minnesota led us yesterday in an amazing rollcall vote, 93 to 3. We, as Members of the Senate, said we would live by the prescription drug plan that is created by this bill. Well, stay tuned. See if that amendment survives the conference committee or ever comes back to us.

If it does not, if it is taken out, the Senator from Minnesota has made a point. As Members of Congress, we will have a benefit twice as generous as what we are now offering to seniors across America, and what we are offering is not that generous to the seniors.

Look at what it is. We estimate over the next 10 years the cost of prescription drugs for seniors in America will be $1.8 trillion. In that period of time, we are going to spend $400 billion in this prescription drug benefit. So that is less than one-fourth of the total cost of prescription drugs.

How can that one-fourth, $400 billion, go further? If the overall costs are reduced down from $1.8 trillion.

Let me give an idea of how that works. The Veterans' Administration has cut drug prices for veterans by as much as 50 percent by negotiating with drug companies. There is no provision in S. 1 that requires the Federal Government or Medicare or anyone to negotiate with the drug companies on behalf of senior citizens—none. At best, we hope some private insurance companies will work out a formulary that gives them an opportunity for a profit by reducing the cost of drugs. That is as good as it gets. That is as close as this Senate will come to saying to the drug companies that they have to do better.

When it came to our veterans, we stood up as a government and said: We are going to stand behind them. When it comes to this situation for prescription drugs for seniors, we do not.

Health and Human Services has a similar formulary of drugs available across America for community health centers and the like. They bargain down prices. But when it comes to seniors, the largest unprotected group of prescription drug users across America, this bill is silent; it does nothing. The alternative which I am proposing will do something.

Medicare has 25 times the number of people as the Veterans' Administration. It has bargaining power. It can reduce the cost of drugs. At this point, we know the inspector general of HHS compared a list of 24 drugs covered by both Medicare and VA and found that VA spent 52 percent less for the same drugs. The inspector general estimated that Medicare would have saved $760 million in 1 year on those 24 drugs alone.

Let me say parenthetically, when we went to the Congressional Budget Office to score this, incredibly, they refused to even concede that we could get a discount on drugs. Now, I like the Congressional Budget Office. I am sure they are the greatest people in the world. But to whom are they listening? They are ignoring the reality of the Veterans' Administration. There is real cost savings that we can anticipate.

Let me tell my colleagues what the savings are for seniors when we move from the 50/50 split that is proposed by this bill to a 70/30 split, 70 percent paid by the Government for prescription drugs, assuming a $35 monthly premium.

Take a look at it. If a senior in 1 year spent $1,000 for prescription drugs, they would end up spending out of pocket $720 under our proposal—that is under MediSAVE—but under the Grassley-Baucus bill, they would actually spend over $1,000.

How is that possible? A thousand dollars of prescription drugs and it costs more than $1,000? Do not forget the monthly premium. The monthly premium has to be added in. That has to be paid. So if a senior signs up for this voluntary prescription drug benefit under this plan, for the first $1,000 in drugs they have spent, they are not going to get anything back; they are still going to be out of pocket.

Now let's look at what happens with $2,300, which is the average that seniors pay for prescription drugs. Under our MediSAVE plan, it says a senior will spend out of pocket $1,110—that counts your monthly premium. Under the Grassley-Baucus bill, it is $1,708. We are going to save them about $600 if they are the average senior with the average annual cost for prescription drugs of $2,300. Our bill will save seniors $600 over the Grassley-Baucus plan.

As we go up to $4,000, $1,620 is what a senior would pay out of the $4,000 prescription drug bill under our plan, $2,558 under the Grassley-Baucus plan. For the $5,000 plan, the situation is a senior would pay $1,920 under MediSAVE, $3,307 under the Grassley-Baucus bill. And then for $10,000, here is a situation where a senior would have out of pocket $2,420 for a $10,000 bill—and prescription drugs can reach that cost; ask people on cancer therapies—$4,539 if they took the Grassley-Baucus plan.

So by every single measure at every single stop along the road, the plan I am proposing is going to offer much better and real savings for seniors.

Some I have talked to on the Republican side of the aisle say: DURBIN, there you go again; this would be a price control. Well, the Veterans' Administration bargains with drug companies. We do not call it price control. When Canada stands up for its citizens to the same American drug companies, I think they are standing up for a national value and a family value. It is not a matter of corrupting the marketplace. The marketplace now is being driven by a handful of prescription drug companies that have little or no competition.

So unless and until some force such as the Government or the Veterans' Administration or the Department of Health and Human Services steps in, the average family, the average senior, does not have a fighting chance.

Incidentally, we brought this other chart out so people can see that even under this administration, we have had efforts by the Secretary of Health and Human Services to bargain down the cost of drugs.

Remember the anthrax scare? They said perhaps everybody should be prepared to buy Cipro. They took a look at Cipro market prices, and it was $4.67 per tablet. People said: If we have an anthrax problem across America, how will we afford this?

The Secretary of Health and Human Services, Tommy Thompson, went in and bargained it down to 95 cents and ultimately to 75 cents a pill from $4.67, and they made a profit at 75 cents. Do you want to know what the markup is on your prescription drugs? Look at what he achieved.

I will quote Secretary Thompson, who achieved this, and I commend him for it:

> Everyone said I wouldn't be able to reduce the price of Cipro. I'm a tough negotiator.

He obviously was, but when it comes to tough negotiations, this bill is silent. S. 1, the bill before us, is silent when it comes to these negotiations. We need to have someone who will stand up for seniors, families, and against the excessive prices charged by drug companies. The reason the drug companies want this bill is that no one is standing against them.

The bill I am offering, the MediSAVE substitute, will have exactly the opposite impact. We will bring down the excessive costs of prescription drugs. We will guarantee a $35 monthly premium, no deductible. We will make certain there is no gap in coverage so the private insurance companies cannot yank the chains of seniors across America. We will always give you a Medicare option so, as a senior, you can turn back to that agency and you can have a not-for-private low administrative overhead cost formulary that is discounted always available to you.

That is what seniors want. That is what they need. That is why so many organizations endorsed this bill. This is the bill we should be passing. We should send this to the House and say: What you are offering is a pale alternative to the real thing; MediSAVE is the real thing.

I commend it to my colleagues. I hope they join in voting for passage of this amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Madam President, I ask unanimous consent the pending unanimous consent be modified so I be allowed to offer an amendment in the slot allocated to the Senator from Nevada, since we are cosponsor, and I ask unanimous consent I be allowed to offer two amendments.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1012

(Purpose: To provide medicare beneficiaries with an additional choice of Medicare Prescription Drug plans under part D that consists of a drug discount card and protection against high out-of-pocket drug costs)

Mr. HAGEL. Madam President, I ask unanimous consent that the pending amendment be laid aside and the Senate proceed to the consideration of amendment No. 1012.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nebraska [Mr. HAGEL], for himself and Mr. ENSIGN, proposes an amendment numbered 1012.

(The amendment is printed in today's RECORD under "Text of Amendments.")

AMENDMENT NO. 1026

(Purpose: To provide medicare beneficiaries with a discount card that ensures access to privately-negotiated discounts on drugs and protection against high out-of-pocket drug costs)

Mr. HAGEL. Madam President, I ask unanimous consent that the pending amendment be laid aside and the Senate proceed to the consideration of amendment 1026.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nebraska [Mr. HAGEL], for himself, Mr. ENSIGN, Mr. LOTT, and Mr. INHOFE, proposes amendment numbered 1026.

(The amendment is printed in today's RECORD under "Text of Amendments.")

Mr. HAGEL. Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

AMENDMENT NO. 1012

Mr. ENSIGN. Madam President, I will speak on the pending amendment that Senator HAGEL and I have offered. This amendment is similar to the bill we offered in last year's Medicare prescription drug debate. We offered it as a complete substitute last year. I will describe this legislation.

What we are proposing to do is substitute our piece of legislation for the prescription drug portion of the pending legislation. It is very important to have a prescription drug benefit for those seniors, especially those who are low or middle income, who have serious diseases and sometimes have to choose between prescription drugs and rent or prescription drugs and maybe even the type of food they eat.

I have heard story after story around my State of seniors who literally sometimes do not take their medications or maybe take half a dose because they cannot afford the prescriptions their doctor has recommended.

The Hagel-Ensign amendment has several advantages over the current portion of the committee bill. First, it takes effect one full year earlier than the committee bill. Second, we do not have monthly premiums for our prescription drug benefit. Under the committee's mark, seniors pay $35 a month; under ours, it is a one-time annual fee of $25, that is all. They pay that once a year, unless they are low-income, and then we waive that annual fee. Under the committee's mark, it is $35 a month.

We have several other differences in the bill. In the committee's mark, low-income seniors have a very generous benefit for those above Medicaid income but who are below 160 percent of poverty. We recognize it is very generous. As a matter of fact, I submit it is overly generous and we will see an overutilization by those senior citizens because they do not have anything at stake. One to two dollar co-pays when you are paying 97.5 percent of their out-of-pocket expenses is not enough to discourage overutilization. We are going to see an explosion of utilization of drugs, especially in the low-income market.

Let me explain the amendment. We offer a prescription drug benefit with the seniors paying up to a certain percent depending on income, up to a certain dollar figure, and after that the Government will pick up 90 percent of the cost. For people who are below 200 percent of poverty, which is around $18,000 a year for an individual or $24,000 for a couple, they would be capped at an out-of-pocket expense of $1,500, and after that the Government picks up 90 percent. Between 200 and 400 percent of poverty, incomes for an individual up to nearly $36,000, and for a couple a little over $45,000, they would be capped at an out-of-pocket expense once again of $3,500 a year, and the Government pays 90 percent above that. Between 400 and 600 percent they are capped at $5,500 out-of-pocket a year. For people above that, the wealthier seniors, 20 percent of their income is their deductible under this plan.

All of these people get a prescription drug discount card. That prescription drug discount card can provide a discount of 25 to 40 percent on the drugs they purchase. Before these ever kick in they have already saved money for every senior. This is a completely voluntary plan. If seniors like the coverage they have today, they can stay in the coverage they have today. If they want to try something guaranteed to cap their out-of-pocket expenses, this is the plan for them.

We have several real-life examples to compare with the committee mark. First, James Johnson is 68 years old with an income of around $16,000. He is above 160 percent of poverty. He is being treated for diabetes. These are typical medications of someone being treated for diabetes: glucophage, glyburide, neurontin, lescol, zoloft. This totals $5,736 a year that this person pays for prescription drugs.

Let's compare under the committee mark versus the Hagel-Ensign approach. Under the committee mark, this person would have a total out-of-pocket expense of $4,000. Under the Hagel-Ensign, this person would have about $1,900. This person would do a little over $2,000 better under Hagel-Ensign than under the committee mark. For those low-to-middle income seniors who have a serious disease, they do better under our approach.

Everyone wants to help the most those who need it the most. Under our approach that is exactly what happens. Those people who are sick, who need the most help, get the most help under our plan.

Here is another real life example. Doris Jones is 75 years old with an income of around $17,000 per year and is being treated for diabetes, hypertension, and high cholesterol. She takes lipitor, glucophage, insulin, coumadin, with total drug costs around $3,600. To compare the committee mark, the bill before us compared to Hagel-Ensign would spend around $2,380 a year under the committee bill; under the Hagel-Ensign approach she spends about $1,700. Although she did not have as much out-of-pocket drug costs for the year, she saves almost $700 a year under the Hagel-Ensign approach.

And the last real-life example, Betty Smith is 66 years old. She has an income of around a little over $15,000 per year and is being treated for breast cancer. She is still receiving low-dose radiation therapy with nolvadex. Her medication profile is as follows: morphine, paxil, dexamethasone, aciphex, and nolvadex, with total costs for drugs around $8,000 a year. To compare Betty's costs between the Hagel-Ensign approach and the committee mark: her total out-of-pocket expenses will be $4,340 with the committee mark; under our bill, she will spend around $2,100, which would be a savings to her of almost $2,200 a year.

Once again, comparing the two approaches, those middle- to low-income seniors who have serious diseases are going to get much more help under the Hagel-Ensign plan.

Our bill actually costs less money than the committee approach and because of that we are going to be offering an amendment, which subsidizes the costs for people with incomes 160 percent of poverty and under; I will talk about that in just a minute. But the reason our bill comes in at less money is because the seniors are paying the first dollars out of pocket. After that, the Government kicks in to subsidize their costs. So, by them paying the first dollars out of pocket, we encourage people to be accountable in the system. The person who is receiving the drugs is responsible for paying those first dollars. Guess what: that causes them to go out and shop. They call the various pharmacies and find out what the best price is. They ask their doctor, Is there a generic drug available that is just as effective? If it is something maybe not life-threatening and they want to take the generic version of the drug, the doctor can say, Yes, I have had good experience with patients with this. They can take the generic drug, saving themselves money and saving the whole system money.

That is why our bill overall would cost less money. What Senator HAGEL and I have decided to do is, because there is $400 billion available to spend under the budget, we have taken around $60 billion, spread over 10 years, to put toward those people who are truly poor, below 160 percent of poverty. Our plan would give them, in a pharmaceutical benefit account, $700 to spend on prescription drugs. If they do not use it, it rolls over to the next year. By the way, if it rolls over 2 years in a row, and the third year they get another $700, at the end of the year they get to keep anything above $1,500. So there is an incentive; they have something at stake, so they will still shop around for the best price for their drugs. So it keeps market forces at play within our Medicare prescription drug system. That is one of the strong points, we feel, about our plan.

There are several other advantages that we think are in our bill that are not included in the committee mark. I asked this question yesterday; I asked the administration, I asked Secretary Thompson, and I asked the director who oversees Medicare, What will happen under the committee's mark to the State plans? My State of Nevada and many other States, New York, Massachusetts, West Virginia—have State plans that help senior citizens with prescription drugs. What will happen to those state low-income plans—above Medicaid level but below around 160 percent of poverty—if the committee mark is enacted?

The simple answer is: all of those plans will go away because, for those seniors under this plan, there is no reason for the States to pick them up anymore. The committee mark will pick them up completely.

Our plan works with the States, instead of substituting for the States. Those plans in the States that are already working, and working well, will continue. As a matter of fact, each State can learn from the other. If they want to be a little more generous, a little less generous, they can do that. But it doesn't supplant the States, like the committee mark does.

The other big problem I have heard articulated with the committee's prescription drug benefit is that private companies that currently have plans are going to start dropping their plans left and right. Under our bill, because we offer a higher deductible than most of the plans offer, there is not going to be the incentive for them to drop their plans. So it is not going to be a transfer from the private sector onto the public sector. And when I say public sector, I mean the taxpayer—younger people paying the taxes for older citizens.

There are many benefits to our plan, we think, over the committee mark. Let me just quickly repeat those.

First, we help those seniors, especially in the middle- to low-income, much more than the committee mark does, those who have serious diseases.

Second, we have no monthly premiums. The committee mark has a $35-a-month monthly premium.

Third, our plan does not replace State plans, it works with State plans.

Fourth, our plan also does not encourage the replacement of private plans that companies have set up for their retirees.

Fifth, I believe our bill will control drug costs into the future. I applaud the committee. They have gotten together in a bipartisan way, trying to come up with a fix to a serious problem. But the problem I see is that it is right now scored by the Congressional Budget Office at around $400 billion. I think there is going to be so much overutilization in that, that it is going to end up being more like $800 billion or a $1 trillion plan. Young people are going to have to pay that.

That is just how much it is going to cost in the next 8 to 10 years. When you start extending that out into the 10 years beyond that, you start doubling and tripling those costs as we get the new, more expensive drugs into the marketplace.

So I think we should do the responsible thing. That is why we are encouraging our colleagues to take a look at this. We had the same bill voted on last year. We got a bipartisan vote. We had 51 Senators vote for this plan. If we got that for this amendment, this amendment would be adopted as part of the bill.

I know there have been deals made: Let's just defeat all amendments. I encourage people to say, If we can improve this bill, let's improve this bill. Let's make it responsible to the next generation. But let's also do what we say we all want to do, and that is to help those seniors who truly need the help. Let's help those who are the sickest and those who are in the lower-income categories, who end up having to make those decisions I talked about: choosing between prescription drugs and rent, between prescription drugs and food, or maybe only taking one of their prescriptions or a half dose of their prescription because they cannot afford the full dose.

In conclusion, I plead with my colleagues to study this issue. I know this bill is being rushed through, so people have not had a chance to take a look at all the options. This is so serious. This is the biggest entitlement program that any Senator who is currently serving will ever vote on. This has incredible implications for generations to come. We'd better do it right the first time because coming back for a fix a couple of years from now—we have seen how difficult it was to get to this point—is going to be virtually impossible.

So we'd better do it right the first time—at least get as close to right as we can. That is why we are encouraging our colleagues to take a serious look at the Hagel-Ensign amendment and do something right for the country.

I yield the floor.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1060

(Purpose: To provide for an income-related increase in the part B premium for individuals with income in excess of $75,000 and married couples with income in excess of $150,000)

Mr. BAUCUS. Mr. President, on behalf of Senators FEINSTEIN and NICKLES, I send an amendment to the desk regarding an income-related increase in Part B premiums and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mrs. FEINSTEIN, for herself, Mr. NICKLES, Mr. CHAFEE, and Mr. GRAHAM of South Carolina, proposes an amendment numbered 1060.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under "Text of Amendments.")

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1061

Mr. BAUCUS. Mr. President, on behalf of Senator AKAKA, I send an amendment to the desk regarding the treatment of Hawaii as a low-DSH State and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. AKAKA, proposes an amendment numbered 1061.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for treatment of Hawaii as a low-DSH State for purposes of determining a medicaid DSH allotment for the State for fiscal years 2004 and 2005)

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).".

Mr. AKAKA. Mr. President, I rise in support of my amendment to restore a Medicaid disproportionate share hospital, DSH, allotment for Hawaii. Medicaid DSH payments are designed to provide additional support to hospitals that treat large numbers of Medicaid and uninsured patients.

The Balanced Budget Act of 1997, BBA, created specific DSH allotments for each State based on each of their actual DSH expenditures for fiscal year 1995. In 1994, the State of Hawaii implemented the QUEST demonstration program that was designed to reduce the number of uninsured and improve access to health care. The prior Medicaid DSH program was incorporated into QUEST. As a result of the demonstration program, Hawaii did not have DSH expenditures in 1995 and was not provided a DSH allotment.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 made further changes to the DSH program, which included the establishment of a flood for DSH allotments. However, States without allotments were again left out. Other States that have obtained waivers similar to Hawaii's have retained their DSH allotments. Only two States, Hawaii and Tennessee, do not have DSH allotments.

As currently drafted, S. 1 provides that States without DSH allotments could obtain an allotment if their waiver was terminated or removed. It is my understanding that while this language would permit an allotment for Tennessee, it would prevent Hawaii from obtaining its DSH allotment as long as the QUEST program remains in place.

My amendment would provide a DSH allotment to Hawaii and allow for my home State to participate in the Medicaid DSH program. This amendment is needed because many of our hospitals in Hawaii are struggling to meet the elevated demands placed upon them by the increasing number of uninsured people. DSH payments will help Hawaii hospitals meet the rising health care needs of our communities and reinforce our health care safety net. All 50 States need to have access to Medicaid DSH support.

My amendment is similar to language included in the Senate passed version of S. 2, the Jobs and Growth Tax Act of 2003, that would have provided assistance to low DSH States and would have provided an allotment for Hawaii. Unfortunately, the DSH provisions were not retained in the conference report. A Hawaii specific provision is necessary as we attempt to provide additional support for hospitals in low DSH States in this legislation.

I appreciate all of the work done by my colleague from New Mexico, Senator BINGAMAN, to provide additional support for low DSH States. I urge that my colleagues support this amendment to allow the State of Hawaii to be treated like other extremely low DSH States and finally receive a Medicaid DSH allotment.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1062 TO AMENDMENT NO. 974

Mr. REID. Mr. President, I call for the regular order with respect to Grassley amendment No. 974 and send an amendment to the desk on behalf of Senator BOXER.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mrs. BOXER, proposes an amendment numbered 1062 to amendment No. 974.

Mr. REID. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the coverage gap for individuals with cancer)

At the end of the amendment add the following:

SEC. . NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.

"(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

"(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

"(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D-19(a).

"(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D-16 that are necessary because of the rules under subparagraph (A)."

Mr. REID. Mr. President, we on this side have been as cooperative as we could be. We have done everything we can to move this legislation along. And I have said publicly that I appreciate how Senator FRIST has handled legislation since he has become the Republican leader. He has not tried to shut off debate. He has rarely filed cloture, and that is commendable. And I have said, on more than one occasion, I appreciate that.

But we are in a situation now where, as part of the regular process of doing business here, we have a difficult amendment. It is a tough vote for a lot of people. It is a Boxer amendment. In effect, it would allow coverage—without exception—for prescription drugs for people who are diagnosed as having cancer.

We have been told by various people on the side of the majority that we are not going to have a vote on this. Well, my response to that is, we are going to do nothing else on the bill. This is now the regular order. And until there is an agreement made that we are going to vote on this, we are going to do nothing else. This is it. We have a lot of tough votes here, and this is one of them.

Now, Mr. President, we could have, if we had been mischievous, done other things. Some said: Why don't we have Alzheimer's? Why don't we have diabetes? Why not have juvenile diabetes? Why not have Parkinson's? The Senator from California, acting in good faith, recognizing the need to move this legislation, said she would limit her amendment to cancer. And that is what has happened.

So, Mr. President, we are now at a point where there is going to have to be a decision made by the majority when we are going to vote. We want a vote. That is all we want. We want a vote. We will do it at any time, but until there is an agreement, there will be an agreement on nothing on this bill.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I would like to speak about the underlying bill.

Mr. President, I think one of the greatest achievements of the Medicare bill that has been reported out by the Senate Finance Committee is the compromise Senator GRASSLEY and I worked out on the issue of private prescription drug plans.

Over the course of this 4-year debate over prescription drugs—and I might add, it has been very frustrating for a lot of Senators. We have been trying to find a way to get prescription drug benefits passed for seniors but have been at loggerheads the last 4 years. Both sides wanted their view and neither was willing to compromise. But I think, finally, it is clear we have reached an agreement.

I commend the chairman of the committee, Senator GRASSLEY, and all those who helped to work to make this possible. Frankly, a lot of people are to be complimented—everybody from Senator BREAUX to Senator KENNEDY. And the list is just endless. Senator SNOWE, for example, has been a great advocate, tirelessly trying to get a compromise agreement over the years.

We finally agreed private entities should administer a Medicare prescription drug program. I know that is something that many, particularly on the Republican side of the aisle, are very interested in.

Both sides of the aisle envision these entities might include pharmacy benefit managers, so-called PBMs. They could include insurance companies, chain store pharmacies, or partnerships among these entities. Any one of those groups would contract with HHS and be the private entity or the contracting company that would contract out the prescription drug benefits to beneficiaries.

The main disagreement was whether these private plans should be required to bear insurance risk for the prescription drug benefit. Without being too arcane, there is a question of performance risk and insurance risk. Performance risk has traditionally been borne by the pharmacy benefits manager. But the performance risk means the administrative risk and the cost of doing a good job just administratively; that is, without addressing the question of insurance risk as to whether people are going to buy these prescription drugs and how much the subsidy is or is not.

Now, some argue if plans are required to bear insurance risk in addition to the performance risk, they will be more efficient and prudent managers of prescription drug costs, the argument clearly being if you are a company or a PBM, and you have to bear the entire cost, the entire risk, including not only performance risk but insurance risk, you are probably going to be more efficient and probably a more prudent manager than you otherwise might be.

Plans will have stronger incentives, if they have that risk, to negotiate better prices and implement cost-containment strategies to minimize unnecessary utilization, the argument goes, if these plans bear at least some level of insurance risk.

Now, there have been critics of this model. Those critics argue if plans are required to bear insurance risk, they would structure their benefit design to discourage high-cost patients from enrolling in their plans; that is, they would cherry pick. We would be in the unfortunate world of adverse selection, where some plans would model their program they would offer to seniors in a way to discourage high-cost patients and encourage lower cost patients, and they therefore would be more profitable, leaving some of the higher cost patients, that is, those who really need drugs, out in the cold.

The health insurance industry has not been exactly rushing to the table to offer these benefits. The insurance industry does not seem willing to offer prescription drug benefits to seniors, even with the subsidies they would get if they are required to bear all of the risk.

Without a strong commitment from the health insurance industry, many fear that the insurance risk structure would lead to an unstable benefit. There would be a lot more instability because we don't know whether companies would be participating by offering plans. After all, this is something that is new. Plans would come in and out at will, forcing seniors to switch plans and possibly their medication.

In writing this bill, one of the greatest challenges Senator GRASSLEY and I faced was how to find the right balance between efficiency and plan stability. There have been several major prescription drug benefit bills and approaches. One we hear a lot about is the tripartisan bill of last year. Another one which explains this phenomenon was the so-called Graham or Kennedy bill of last year. The tripartisan model, in trying to resolve the dilemma between efficiency and stability, tilted more toward efficiency and away from stability. It had many more competitive components in it to allow companies to be more efficient and cut costs and be more likely to participate. On the other hand, it was more unstable from the point of view of beneficiaries, probably more unstable from the point of view of the company as well, and that was a problem that many on the Democratic side had with that benefit design, particularly that model.

On the other hand, last year a major bill that was considered by the Senate was the so-called Graham-Kennedy bill. That bill tilted much more toward stability at the expense of efficiency. It was more expensive. More than $400 billion had been allocated over 10 years, and seniors would have had more predictability. They would know what they were getting because there was more money for companies. On the other hand, companies would not be able to compete among themselves, and there was much less competition and, therefore, under that model, much less efficiency.

One of the main merits of this bill is that it is in the middle. It is between the so-called tripartisan bill and the Graham bill. In trying to find the right balance between efficiency and stability, we are pretty much in the middle. We have found that balance. We both agreed that we needed to create strong incentives to keep prescription drug prices low. We also agreed that we needed stronger assurances that private plans would be ready and willing to enroll beneficiaries come January 1, 2006, when the benefit begins.

We have found that balance in this bill. This bill was passed out of the Finance Committee by a large bipartisan margin, which is some indication that we found the balance.

There are several important elements of this compromise I would like to highlight. First, our proposal would phase in insurance risk carefully over time through the use of reinsurance payments and risk corridors. Those are pretty big terms. What do they mean? Plans would receive Federal reinsurance payments for 80 percent of their enrollees' costs above the stop-loss level. These payments are intended to ensure that plans have strong incentives to enroll high-cost beneficiaries. That is, Federal reinsurance payments would cover 80 percent of the enrollees' costs above the stop-loss levels contained in the bill.

In addition, our proposal added another component to moderate risk through the use of what we call risk corridors. What in the world is a risk corridor? Simply put, it would limit a plan's loss if the plan sustained substantial financial losses. And by the same token, risk corridors would limit a plan's gains if it earned potential profits. We phase in risk over the first couple of years so that the private plans would have a little cushion, a little better opportunity to know how well their plan is working, and that errs a little bit more on stability at the expense of efficiency. But after a couple years, the tilt is a little more toward efficiency, having gained a couple years of experience, hopefully, of more stability.

During the first couple years the bill would establish a narrow corridor of risk. Over time the risk corridor would be expanded, thereby shifting a greater share of the risk on to the health plan. By phasing in risk over time, this bill addresses one of the biggest concerns plans had in considering whether to participate in the new program. That is, the uncertainty during the first couple years of the benefit.

This uncertainty takes many forms. For example, who will sign up for the benefit? That is a big question. Very few people know. Second, will drug costs increase faster than Congressional Budget Office projections? That is a big question. Moreover, will beneficiaries consume more prescription drugs once the benefit has been implemented?

That is another big question. It is hard to know. That is why we believe it is important to phase in risk rather than just cold turkey, 100 percent insurance risk the first day of the first year.

So during this period of uncertainty, we will ask the plans to bear a minimal level of insurance risk. As plans develop more experience, we will require them to assume more risk.

I am more confident than I was last year that private drug plans will provide a stable delivery system for Medicare beneficiaries under this new plan both in urban and rural areas. I remain concerned that not all seniors will have a choice of two or more prescription drug plans in the region. Plans may simply, given all the provisions we have added to this bill to help give them a little bit of reassurance, not be willing to participate in some parts of the country. After all, it is their choice whether plans want to participate.

This concern is why I insisted that any private plan delivery system must offer all beneficiaries the choice of at least two private plans, and if any part of the country does not have at least two choices, the Secretary would be required to contract with a plan that is a Federal fallback or a backup plan that would offer the standard benefit at the national average premium. Some might argue this delivery model does not provide enough efficiency and cost management. Others might argue that this will prove to be too unstable, too much efficiency, too much instability, despite the changes we have made. Plans may come and go. Worse, they may not even appear and seniors will be confused. That is a concern, and it is a legitimate concern, believe me.

Nevertheless, I believe that given the competing forces of efficiency on the one hand—competition and cost containment—and stability on the other—making sure that seniors have the prescription drugs they want—we have found a balance between these two fairly legitimate concerns.

I am not here to say it is the perfect balance. Clearly, others have better ideas how to address the question of where the balance is. I do believe the provisions of this bill are pretty close to it.

As we implement this benefit, we will have to carefully monitor the new delivery system very closely to ensure that, in fact, it is fair to our seniors and also fair to our taxpayers and to our private sector partners.

There are a lot of concerns here. One surely is making sure the senior citizens get the prescription drug benefit. But then equally important is that the American taxpayers' concerns are respected, and that we get savings, where we can honestly get savings, not at the expense of beneficiaries. That is why I believe an inclusion of private competition is important. It is very important.

Health care in our country is evolving, as you know, very quickly, and into areas we can hardly even imagine. I believe that in the next 10 to 20 years, when we are also faced with the problem of the baby boomers, there are going to be dramatic changes. What are the three areas going to be?

First of all, with the massive computational power that is developing, nanotechnology, married with the biotechnology, we will be able to, in not too many years from now—10, 12, 15 years—predict, with the human genome project, the interaction of systems in our bodies and the effect of DNA and predict what maladies or illnesses people are going to have in the future. We will develop machines that will detect things at a molecular level, with thousands of tests, that will be able to predict what will happen to each individual, or whether some of us are more inclined to get cancer or to have coronary disease—you name it. We are going to be able to predict very precisely in not too many years from now.

In addition, we will then be able to take actions to prevent illnesses with much greater certainty than we can today. We will be able to prevent it, since we know better what will happen to each of us with respect to our health, by deciding whether to take this pill or that pill or that new medicine that addresses a potential coronary disease that may occur with absolute certainty, or near certainty, 30 years later, or a cancer disease that may, with almost near certainty, occur 20 years later. That is where we will be in Medicare. It is changing so much.

Then, basically, health care will change from remedial care to personal wellness care. That is, doctors and people in the health care industry will be working with individuals to determine what illnesses they may or may not get and things they can do right now to prevent those illnesses from occurring. It will be a big shift from remedial care, which is about 90 percent of today's health care, to wellness and preventive care.

What else will happen? Seniors are going to live a lot longer. The quality of our lives will be a lot better. It will change the demographics of the country and the health care in our country. The main point is that there are going to be a lot of changes in health care in the not-too-distant future.

What we are passing today on prescription drug benefits will also change. It is almost impossible for us to predict what the legislation should be in the years 2009, 2014, as this bill does. Yet we are doing the very best we can.

My point is that, given where we are today, in June 2003, I think this is a very good and aggressive attempt to try to find the right balance given all the different considerations we face. We can be very sure—and the chairman and I will give it utmost vigilance and oversight to make sure—that this delivers what is being promised to all our Medicare beneficiaries, the seniors of our country.

I respectfully urge my colleagues to closely evaluate the provisions and the merits of this compromise proposal. I have mentioned components that I think some Senators haven't had time to look at yet. I am talking about the balance between efficiency and stability. I am talking about phasing in risks, the risk corridors, as a good-faith effort to try to help make competition work—if it does work. If it does not work, we will know after a period of time. If it does not work, the bill provides a safety backup plan so that seniors are protected.

As I said, with all of the health care changes and the changes in the medical care that will happen over the years, we will probably revisit this in the not-too-distant future to address current conditions and the provisions of this bill.

As Senators study it more closely, they will realize there is a little more good in this bill than a lot of Senators originally thought. A lot of people have just not had an opportunity to focus on this.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

AMENDMENT NO. 1062 WITHDRAWN

Mr. REID. Mr. President, we have had conversations while the manager has been speaking. We have been assured by the majority that we will have a vote on the Boxer amendment in the next 24 hours. Having said that, I withdraw the Boxer amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. ALEXANDER). Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I address an issue that many of my colleagues have asked me about over the past 2 weeks. It is an issue of great concern to many, particularly on my side of the aisle. That is, if this bill is enacted, how much will premiums vary and what will the actual effect of premium variation be for seniors?

Now, we have had a couple of votes already on this subject. I have not had a chance to address it directly and I would like to do so at this point. The issue again is the extent to which benefits and premiums may vary under this new Medicare drug benefit.

My Democratic colleagues are concerned that if benefits and premiums for participating drug plans are allowed to vary seniors will be confused and they will be unable to make informed choices, that is, the premiums seniors would pay, the monthly amounts they would pay for prescription drug coverage, should they volunteer to participate—that is, if they volunteer to participate, because it is an entirely voluntary program. It is not mandatory like the old catastrophic coverage bill was—in 1989 I think it was. This is voluntary. Seniors have a choice of whether they want to sign up for this new prescription drug benefit plan. If they do sign up, they pay a monthly premium of $35 a month for participating in the prescription drug plan.

Then the question is: How much can premiums vary and how much confusion might that cause among people trying to figure out the various merits of the various plans?

I might say they will not be able to make an apples-to-apples comparison between plans that are available in their own area. That is their concern; they just will not be able to compare fairly. As I said, these concerns are legitimate.

Certainly, those who believe in competition believe choice should be based on price and on quality. It should not be based on a plan's effort to select the healthiest beneficiaries and jettison the sickest. It should also not be based on distortions in the market. That is, we want fairness. We want equity. We do not want so-called cherry picking. We do not want to have certain plans pick the healthiest seniors, adjust premiums to get the healthiest, and leave out other seniors who require more prescription drugs that are not as healthy. That would just not be fair.

At the same time, we want to have some competition, and this bill does provide for private plans to provide a drug delivery benefit. The reason for relying on the competitive delivery system rather than the Government-based program is to allow for innovation and benefit design, to let companies look to try to find a better way of doing things, that is, of containing costs, and be more efficient, without sacrificing quality and stability to our seniors.

I think most of us believe that kind of innovation will lead to efficiency. The attempt is to design it in a way that does not lead to a risk in selection because that would be very unfair. So the question is: How can we ensure that choice is in fact based on the right factors, that is on price and on quality? How can we make sure there is enough flexibility so plans can adapt to changing needs and to a marketplace innovation, without providing so much flexibility that seniors have a difficult time choosing among plans? That is the challenge. That is what we are trying to resolve in this bill.

I think the proposal before us, the legislation reported out of the Finance Committee that has come to the floor, does a pretty good job of constructing that balance, and I will explain why I believe that is true.

First, on benefit variation—that is different benefits seniors may get because of different plans—the Grassley-Baucus bill limits benefits variation at several levels. First, the $275 deductible and the $3,700 out-of-pocket limit are fixed in the statute. Those two figures cannot vary. So plans are permitted to improve the benefit, but they cannot go higher than the deductible outlined in the law, and they cannot raise the stop loss beyond the level specified in the law. So that is one check. It does leave some potential variation on the premium and copay, but at least two components—deductible and stop loss—are fixed in the law.

All plans, whatever the benefit design is, whatever they offer, have to have those two provisions as prescribed in the statute.

Now, a benefit variation is also constrained through various limitations in what the Congressional Budget Office calls actuarial value or expected cost of the benefit. In plain English, that means the value of the benefit must be roughly equal to the standard benefit package outlined in the legislation.

We have all heard about the standard benefit package, the deductible, the stop loss, the premium, and what the copays are, so that the value of the benefit of any plan any company offers must be roughly equal to the standard benefit package outlined in the legislation.

As I understand from actuaries who spend their time thinking about these things, the practical effect of these provisions combined is there will not be significant variation in benefit packages. There just cannot be. All companies are going to know pretty much what they can charge. The actuaries do not predict much variation.

The bill also, however, attempts to minimize premium variation. How? Well, the bill includes various provisions that are intended to control variation in the premiums so beneficiaries will not be faced with widely varying premiums within their own region or across different parts of the country.

For example, if my mother learned her friends in Florida were paying far less in monthly premiums than she was paying in Montana, I believe I would get an earful. I would hear from my mother. She would wonder whether the system we created is fair. And she would be right; it probably would not be fair.

What do we try to do about this? It is not perfect, but I think it is a major effort, and I think it is a good effort.

First, all Medicare beneficiaries who are enrolled in the new drug program will be combined for purposes of calculating premiums and payments to plans, regardless of whether those beneficiaries are in fee for service, enrolled in a drug-only plan, or whether they are enrolled in a private PPO or HMO. All senior citizens who are enrolled in Medicare will be combined for the purposes of calculating premiums and payments to plans, regardless.

Mr. ALLEN. Mr. President, will my good colleague from the State of Montana please yield for the purpose of an introduction of an esteemed guest? I know this is very important, but I ask if he will yield for a moment.

Mr. BAUCUS. Mr. President, I yield 1 minute to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia.

VISIT TO THE SENATE BY THE HONORABLE PATRICK COX, PRESIDENT OF THE EUROPEAN PARLIAMENT

Mr. ALLEN. I thank the Senator because I know he is talking about a very important issue to all the people of America.

I do have the honor of presenting to my Senate colleagues the Honorable Patrick Cox, who is the President of the European Parliament. As my colleagues know, the European Parliament is the only directly elected body in the European Union and the only popularly elected international assembly in the entire world.

Every 5 years, Europe's 375 million citizens have the chance to vote for 626 representatives. President Cox's position is the equivalent of the Speaker of the House and the President of the Senate combined. So he is TED STEVENS and DENNY HASTERT together.

I appreciate the indulgence of the Senator from Montana, and I request my colleagues to take a moment to introduce themselves to President Cox because we do have so many transatlantic bonds, not only philosophically but also economically for jobs.

I yield the floor.

Mr. BAUCUS. We are very honored to have our guest. I don't know how long he wants to stay. There are so many transatlantic issues we can address.

I see my very good colleague from Iowa in the Chamber, and we have lots of agricultural issues. We would also like to learn from Europe about European health care systems. I am sure there are provisions in Europe we could look at and adopt. No country has a monopoly on good ideas and no region of the country has a monopoly on good ideas.

I urge our guest to stay as long as he possibly can and hopefully have time to converse over some of these issues so we can get a better idea of how we can resolve some of these huge issues, including agricultural and other trade issues. We all know the more we work together, the better we will be on both sides of the Atlantic.

Mr. ALLEN. Thank you, Mr. President.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—CONTINUED

Mr. BAUCUS. I have been explaining various provisions in the bill that I think largely address concerns that some on the Democrat side have and I suppose on the Republican side of the aisle, too; namely, potential premium variation. Premiums that seniors pay might vary. Much confusion might occur for seniors and anyone else involved in prescription drug benefits that would be distributed under this legislation.

As I mentioned, the actuaries say there should not be much change. Also, the risk pool will include all Medicare beneficiaries, ensuring an adequate number of low-drug-cost beneficiaries will be able to subsidize the few beneficiaries with the high drug costs. Already, there is a huge risk pool. There is kind of a cross subsidization. Those with very low drug costs will help pay for those much higher costs of other seniors. The larger risk pool will prevent premium variation because we use the whole pool.

In addition, the bill will calculate Federal contributions toward plan premiums based on the national average of all plan bids. This contribution is then adjusted geographically for differences in prices. This is a so-called geographic adjustor. We want to make sure one part of the country is not discriminated against compared to another part of the country or vice versa, and we included the geographic adjustment on prices.

We have not included so far, because it is difficult to calculate, geographic adjustment based on utilization. As we know, in some parts of the country there is more utilization. That is a fancy term for saying there is a lot more care given to people than in other parts of the country. More care, the greater utilization, tends to be in parts of the country with more hospitals, more specialty health care providers.

There is an interesting study I urge my colleagues to read by Dr. Wennberg. I have not found anyone who refutes it. Looking at the country as a whole, there are parts of the country where utilization is twice as high and more than twice as high as other parts of the country. People, because of where they live, get twice as much health care in some parts of the country than in other parts of the country. This is adjusted for age, for race, for gender. It is adjusted for all the factors that can possibly be thought of.

The more interesting part of this study, even though some parts of the country get twice as much health care as other parts of the country—and it is because there are twice as many doctors or hospitals in some parts of the country as in others—the interesting part of the study is, the actual care given is no better, and in fact in some cases it is worse. That is, if you get twice as much health care, that is, twice as many visits to the doctor or the hospital, particularly for chronic diseases, you will not be twice as healthy; you will not be any healthier, on average, than you will be in parts of the country where there is less utilization.

The point is that we are trying to adjust, as I mentioned earlier, and have a geographic adjustment based on the costs. We have not yet figured out a way to adjust for different utilization mainly because, when it comes to prescription drug benefits for seniors, there is virtually no data because we have not had prescription drug benefits for seniors yet. Obviously, it is hard to get the data if we have not had the program.

There are other provisions in the bill that enable us to get more data, so fairly quickly we can get better utilization data and therefore have a geographic adjustment based not only on price but also on utilization. That will go a long way to address some of the concerns people have about potential premium variation and complexity. When we get that data, as I said, we will have a lot more information, but there is enough information already to have the effect of minimizing concern about premium variations.

There is another provision in the bill to help address this potential problem. That is, we have included in this bill a provision based on the Federal Employees Health Benefits Program—otherwise known as FEHBP—that prohibits plans from changing premiums that are unreasonably higher than the costs of the benefits provider. In other words, plans are prohibited from price gouging. That standard currently is in the law with respect to the FEHBP plan. That is in the law. There is a provision in current law that prohibits the FEHBP plans from charging premiums that are unreasonably higher than the cost that has been provided. I believe that same provision as applied to prescription drug pricing is an additional guarantee against gouging and certainly against unconscionable premium variation.

Finally, this bill allows the Secretary to refuse to contract with the plan. That is in the bill. Maybe a plan leans toward enrolling healthier beneficiaries. Maybe the Secretary determines that this plan is not a good actor; this plan is price gouging; this plan is engaging in cherrypicking; it is engaging in adverse selection at the expense of an American; or maybe it seems less committed to staying in the program; maybe there is a shady operation; who knows, maybe it seems more likely to drop out fairly quickly and it is not solvent or financially healthy; maybe the premiums seem inconsistent with others in the region.

For any of these reasons and reasons not contemplated at this time, the Secretary can decide, at his discretion, not to contract with a drug plan that has submitted a bid to participate in Medicare. That option is still there as a protection for our senior citizens. It is my hope that this discretion will help assure better plan choices for seniors and the benefits and premiums will, in fact, be fair and reasonable.

In short, in developing this compromise bill, Senator GRASSLEY and I have tried to allow a level of variation in premiums and benefits so as to foster innovation and to foster efficiency but not so much variation that seniors will be confused or plans will game the system.

I think we have done a pretty good job of ending confusion and a pretty good job of preventing plans from gaming the system. I hope my colleagues will agree this proposal strikes at that.

Madam President, I yield the floor.

AMENDMENT NO. 1040

(Purpose: To provide for equitable reimbursement rates in 2004 and 2005 for Medicare+Choice organizations making the transition to MedicareAdvantage organizations)

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, the Senator from New York, Mr. SCHUMER, and I are in the Chamber now to offer a amendment. Unfortunately, I have to withdraw that amendment because of budgetary constraints with which we are going to be dealing.

This is an amendment that we believe is critically important as a bridge from where we are right now on the Medicare Program to where this bill takes us. The bridge is in the area of Medicare+Choice, which is the Medicare option that is available in certain counties in this country for a health maintenance organization, the only place in Medicare that provides prescription drug coverage today.

About 10 to 12 percent of beneficiaries under Medicare participate in Medicare+Choice or Medicare HMO programs. Their satisfaction rate is as high or higher than in the traditional Medicare Program. The problem with Medicare+Choice or the Medicare HMOs is they are funded at a level which does not increase at the same rate that the Medicare Program increases. They are held at an artificially low level, which makes it very difficult for them to survive.

The concern of Senator SCHUMER, who has been a great leader on this issue, and my concern is what happens between now and 2006 when the new MedicareAdvantage Program comes into effect under this bill. That program will include Medicare+Choice or Medicare HMOs, and a new option that will be available through this bill of a PPO, which is a more lightly managed insurance. Medicare HMOs are heavily managed with gatekeepers and a restricted number of providers, both doctors and hospitals to which you have access, but you get more benefits. PPOs have less restrictions, less management, and more choices. The fee-for-service has no restrictions, maximum choices, but higher costs.

What we wanted to do is put in an amendment that gave us a bridge of funding so these existing HMO plans can survive until we get to 2006, because there is a big concern. We have seen HMO plan after HMO plan go out of business because of inadequate funding. Through the work of Senator SCHUMER and several others in this Chamber, we have been pushing this issue in the Senate. We ran into a roadblock because of the unavailability of funds in the Senate bill. But there is money in the House bill, and the amendment Senator SCHUMER is going to offer here, as soon as I drop the mike, will mirror what the House bill does.

I will turn it over to my colleague from New York. This is a vitally important amendment. It is really important for us to come out of the conference with money for Medicare+Choice or Medicare HMO plans for the years 2004 and 2005, so when 2006 rolls around we will have a viable program, a robust program that this new MedicareAdvantage Program can intersect.

If we, on our side of the aisle, are concerned about competition and choices and if we want choices, then we have to fund those choices to get to 2006, when, candidly, there will be a lot more money for these programs to survive. I would like to see them survive in the interim.

The Senator from New York, as I said before, is leading the charge on this issue. The House, thankfully, has included it in their underlying bill. We hope we will be able to keep that in conference.

I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Madam President, I ask unanimous consent to set aside pending amendments and call up amendment No. 1040.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from New York [Mr. SCHUMER], for himself, Mr. SANTORUM, Mr. CORZINE, Mrs. CLINTON, Mr. LAUTENBERG, and Mr. KERRY, proposes an amendment numbered 1040.

Mr. SCHUMER. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for equitable reimbursement rates in 2004 and 2005 for Medicare+Choice organizations making the transition to MedicareAdvantage organizations)

On page 294, line 6, strike "or (C)" and insert "(C), or (D)".

On page 294, line 21, insert "(other than in 2004 and 2005)" after "multiplied".

On page 297, strike lines 5 through 9, and insert the following:

"(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(D) ANNUAL FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—For 2004 and 2005, the adjusted average per capita cost for the year, as determined under section 1876(a)(4) for the Medicare+Choice payment area for items and services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B and not enrolled in a Medicare+Choice plan under this part for the year, except that such amount shall be adjusted—

"(i) to exclude costs attributable to payment adjustments described in subsection (a)(5)(B)(ii), and

"(ii) to include an amount equal to the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 298, line 10, strike "subparagraph (B)" and insert "subparagraphs (B) and (E)".

On page 301, between lines 8 and 9, insert the following:

"(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 302, line 23, insert "(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)" after "medicare beneficiaries".

On page 303, line 9, insert "other than 2004 and 2005" after "for each year".

On page 349, between lines 4 and 5, insert the following:

(3) PAYMENT RATES BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—

(A) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1)(A), in the flush matter following clause (ii), by inserting "(other than in 2004 and 2005)" after "multiplied"; and

(ii) in paragraph (5), by inserting "other than 2004 and 2005" after "for each year".

(B) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(C) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting "(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)" after "medicare beneficiaries".

(D) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

"(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.".

Mr. SCHUMER. Madam President, I offer this amendment on behalf of myself and my colleague from Pennsylvania, as the lead sponsors of this amendment. I also ask Senators CORZINE, CLINTON, LAUTENBERG, and KERRY be added as cosponsors who support what we are doing here.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SCHUMER. Madam President, Senator SANTORUM has summed this up very well. We have a large number of senior citizens who have opted into a Medicare+Choice Program. The Medicare+Choice Program has been an experiment. Basically it said, let's let some providers, in this case HMOs, provide Medicare for senior citizens so they have an option to go into it.

What most of these programs have done, frankly, is they made a sort of deal with senior citizens. They say you have to go to the doctors and hospitals that are a part of our plan. In that way, we will reduce costs. Then we can provide prescription drug coverage or other types of coverage for you. It has been quite popular in a good number of places, in my State as well as many other States.

This program has had some trouble, there is no question about it. The reason is the cost of prescription drugs has gone way up. Health care costs have gone way up. As a result, many have pulled out of Medicare+Choice. Many seniors—not all but most of the seniors I know—went into it so they could get some prescription drug coverage.

I agree completely with Senator SANTORUM. We are, in 2006, going to provide all kinds of different help to private providers who will provide either prescription drug coverage or a whole Medicare+Choice-type situation.

But it absolutely makes no sense to let these programs go under, which they will because there is not enough money for them now, in 2004, 2005, until 2006 funding kicks in, and then whole new infrastructures would have to be set up.

In addition, the premiums have gotten so high because the costs have gotten high and we have been unable to put in the money that many of those providing Medicare+Choice have either pulled out entirely of large regions in this country or so many have pulled out there is not the competition we would like to see.

In Suffolk County, in my area, I think it is 80,000 senior citizens who were in Medicare+Choice; but where there were once 6 providers, there are now only 2.

In addition, and really galling to the seniors, with good reason—I completely agree with them—the premiums, the copayments on these programs have been large. They once were $10 or $20 or $30. Now, particularly in suburban areas, they are $140 to $170 a month. In fact, many of my constituents, with justification, cannot understand why Medicare+Choice is available in some areas with no copayments and no premiums, and in others the premium is so high that if you are a typical senior citizen on a fixed income, you can't afford it.

Our proposal does two things—and, again, Senator SANTORUM is exactly correct. No. 1, it provides the money so these programs can stay in effect until 2006. Once we get to 2006, they are taken care of because of the structure of this bill. But to have them collapse makes no sense.

Second, it provides some equity. Because costs are higher, for instance, in Suffolk and Nassau Counties, they should not be treated the same and given the same dollars as New York City.

Who is paying the higher costs in the end? The senior citizen who is having the same kind of expenses as a senior citizen in New York City.

We add just the formula and make it more flexible so high-cost areas get some reimbursement. This is a problem in the suburbs of New York, in the suburbs of Philadelphia, in the suburbs of Texas and California. It tends to be a suburban problem.

But make no mistake about it: Many of the senior citizens who live in these suburban communities are not wealthy. They are not middle class. They are struggling. They are on a fixed income. Medicare+Choice originally was a salvation to them. Now it is becoming a real burden.

I would add, I do not believe this is the fault of the HMOs providing the service. It is the Federal Government that has not put in enough money to make these things viable. We have corrected this in this proposal, but only in 2006, when it takes effect. Again, it makes no sense, no sense whatsoever, to let these HMOs that do Medicare+Choice fold and then have to start up again.

So this is an important amendment. Unfortunately, we cannot bring it to a vote because in the rules of the Senate, we would have to get 60 votes to adopt this, and that is too uphill a burden. But the good news is, it is in the House bill which has different rules.

I know Senator SANTORUM, as well as all my cosponsors, joins me in saying we want this program to be put in the final bill when it comes out of conference committee. We know there will be the kind of dollars that might be available, and this is an extremely high priority.

So I am offering this amendment to underscore that importance, to let our diligent leaders of the Finance Committee—Senator GRASSLEY and Senator BAUCUS—know how important it is to a good number of us, and to make sure it has its place at the table when the conference committee occurs.

I just want to make a few more points about Medicare+Choice Programs. These do not benefit well-to-do people. Let me give you some numbers. Among Medicare beneficiaries who have annual incomes between $10,000 and $20,000 and who do not have Medicaid or group health coverage, 40 percent are in Medicare+Choice. These are the very people who cannot afford the high cost of prescription medicines.

Medicare+Choice, when it came in, was a godsend to them. And I, for one, am on this side of the aisle, but I do not let any ideological blinders get in my way. If Medicare+Choice, a private program, is going to solve their problem, great, but let's provide it with the funds, particularly in more suburban, high-cost areas so it can actually work.

Here is another statistic. In addition, 52 percent of Hispanic and 40 percent of African-American Medicare beneficiaries who do not have Medicaid or group health depend on Medicare+Choice. So this is an area that affects typical Americans: hardworking retirees, who have not made a windfall, who made a decent living just by the sweat of their brow, and now they are retired and are on a fixed income, they need some kind of help that goes beyond Medicare because they have a large prescription drug bill or they need something else. Medicare+Choice becomes a health care safety net.

Again, it would be a shame if we did nothing. If we did not have this bill, most of the Medicare+Choice Programs would have faded away or made the premiums so high they would be out of the reach of all but very comfortable people. This amendment provides the bridge between now and 2006 when we know this will work.

I know there are many Senators who are enthusiastically for this approach. I want to add that Senator KERRY, who could not be here today, wanted me to let my colleagues know how enthusiastic a supporter he is.

I hope we will work this out in the conference because it is one of the most important things that are not in this bill, once you overcome the basic disagreement we have of Medicare versus private.

AMENDMENT NO. 1040 WITHDRAWN

So I am going to withdraw the amendment because, again, we do not want to put ourselves, because of the Senate rules, under a burden of having to get much more than a majority, a 60-percent vote. We have hope because it is in the House bill. We are going to work hard in conference to see that it is kept in the conference agreement. But at this point, Madam President, I ask unanimous consent to withdraw this amendment on behalf of Senator SANTORUM, myself, and the other cosponsors.

The PRESIDING OFFICER (Mrs. DOLE). The Senator has the right to withdraw the amendment, and the amendment is withdrawn.

Mr. SCHUMER. I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Madam President, I ask unanimous consent that I be allowed to yield to the Senator from New Mexico and then retain the floor after he offers his two amendments.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from New Mexico.

Mr. BINGAMAN. Madam President, I thank my colleague from Rhode Island very much for yielding to me.

Madam President, I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1065

Mr. BINGAMAN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN], for himself and Mr. DOMENICI, proposes an amendment numbered 1065.

Mr. BINGAMAN. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies)

On page 120, between lines 16 and 17, insert the following:

"(I) UPDATE OF ASSET OR RESOURCE TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section that are made on or after January 1, 2009, such determinations shall be made (to the extent a State, as of such date, has not already eliminated the application of an asset or resource test under section 1905(p)(1)(C)) in accordance with the following:

"(i) SELF-DECLARATION OF VALUE.—

"(I) IN GENERAL.—A State shall permit an individual applying for such subsidies to declare and certify by signature under penalty of perjury on the application form that the value of the individual's assets or resources (or the combined value of the individual's assets or resources and the assets or resources of the individual's spouse), as determined under section 1613 for purposes of the supplemental security income program, does not exceed $10,0000 ($20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse).

"(II) ANNUAL ADJUSTMENT.—Beginning on January 1, 2010, and for each subsequent year, the dollar amounts specified in subclause (I) for the preceding year shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

"(ii) METHODOLOGY FLEXIBILITY.—Nothing in clause (i) shall be construed as prohibiting a State in making eligibility determinations for premium and cost-sharing subsidies under this section from using asset or resource methodologies that are less restrictive than the methodologies used under 1613 for purposes of the supplemental security income program.

"(J) DEVELOPMENT OF MODEL DECLARATION FORM.—The Secretary shall—

"(i) develop a model, simplified application form for individuals to use in making a self-declaration of assets or resources in accordance with subparagraph (I)(i); and

"(ii) provide such form to States and, for purposes of outreach under section 1144, the Commissioner of Social Security.".

Mr. BINGAMAN. Madam President, just very briefly, let me state that this is the revised version of the amendment Senator DOMENICI and I had 2 days ago that would have eliminated the assets test. This keeps the assets test but reforms it very substantially.

I will explain this further when we get an opportunity to actually debate the amendment.

Madam President, I ask unanimous consent that the amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1066

Mr. BINGAMAN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 1066.

The amendment is as follows:

(Purpose: To permit the establishment of 2 new medigap plans for medicare beneficiaries enrolled for prescription drug coverage under part D)

On page 137, line 6, strike "Notwithstanding" and insert "Except as provided in paragraph (4) and notwithstanding".

On page 138, line 2, strike "or 'G'" and insert "'G', or a policy described in paragraph (4)".

On page 138, line 17, insert ", who seeks to enroll with the same issuer who was the issuer of the policy described in clause (ii) of such subparagraph in which the individual was enrolled (unless such issuer does not offer at least one of the policies described in paragraph (4))," after "section 1860D-2(b)(2)".

On page 140, between lines 13 and 14, insert the following:

"(4) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Prescription Drug and Medicare Improvement Act of 2003, with respect to policies issued to individuals who are enrolled in a Medicare Prescription Drug plan under part D or under a contract under section 1860D-3(e), the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that shall be consistent with the following:

"(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

"(i) The policy should provide coverage for benefits other than prescription drugs similar to the coverage for benefits other than prescription drugs provided under a medicare supplemental policy which had a benefit package classified as 'H' before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003.

"(ii) The policy should provide coverage for prescription drugs that—

"(I) compliments, but does not duplicate, the benefits available under part D; and

"(II) does not cover 100 percent of the deductible, copayments, coinsurance (including any cost-sharing applicable under the limitation on out-of-pocket expenditures), or any other cost-sharing applicable under part D.

"(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except that the reference to the benefit package classified as 'H' in clause (i) of such subparagraph is deemed to be a reference to the benefit package classified as 'J'.

(b) REPORT.—The Secretary shall enter into an arrangement with the National Association of Insurance Commissioners (in this section referred to as the "NAIC") under which, not later than 18 months after the date of enactment of this Act, the NAIC shall submit to Congress a report on the medicare supplemental policies described in section 1882(v)(4) of the Social Security Act, as added by subsection (a), that assesses the viability of the policies described in such section and, if viable, the details of those policies.

Mr. BINGAMAN. Madam President, just to indicate what this amendment does, this is an amendment related to Medigap and directs that a Medigap plan be developed to wrap around the prescription drug benefit that is currently in the bill.

Again, I will further explain this amendment and argue for it when we get the opportunity to do so.

I did need to have both of these amendments offered so that the Congressional Budget Office would do a score for them. Again, I thank my colleague from Rhode Island for yielding to me for that purpose.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Madam President, I rise today to discuss the historic legislation that is before this Chamber. A year ago, this body undertook a similar endeavor to bring a Medicare prescription drug benefit to the 40 million aged and disabled beneficiaries who are on the program today, as well as maintain the promise for the tens of millions of future beneficiaries who will be joining the rolls in the coming decades.

Despite the fact that a majority of Senators voted in favor of a $594 billion plan for a drug program offered by Senators GRAHAM, MILLER, and KENNEDY, procedural barriers prevented us from delivering a benefit to our elderly and disabled last year.

Since that time, Congress has passed another round of tax cuts at the President's behest, and the Nation's fiscal condition continues to deteriorate at an alarming rate. Just last week, the Congressional Budget Office announced that this administration is now on pace to shatter previous Federal budget deficit records. CBO's latest fiscal year 2003 budget deficit forecast now tops $400 billion, an increase of $100 billion over the CBO's deficit forecast offered just a month ago.

The current record budget deficit was $290 billion set in 1992. In just the first 8 months of fiscal year 2003, we have already posted a deficit of $291 billion.

Congress and the administration are now turning their attention to the long-neglected problem of a prescription drug benefit for Medicare. This year, we are faced with an arbitrary cap of $400 billion under which a drug benefit must fit. This cap is the result of the administration's insistence on dealing with the drug benefit after the tax cut and not before. Madam President, $400 billion was not sufficient when we sought to enact a meaningful prescription drug benefit last year, and I believe it is even less adequate this time.

The issue of Medicare prescription drugs is extremely important to me, and even more important to the constituents I represent.

In a State of slightly more than a million people, 14.5 percent of the population in Rhode Island is over the age of 65 years. This is a higher proportion of older persons than the national average of 12.4 percent. According to the Census Bureau estimates, the number of elderly is expected to increase to 18.8 percent of Rhode Island's population by the year 2025. Rhode Island also has one of the highest concentrations of persons age 85 and over. Consequently, seniors in my State tend to utilize higher degrees and greater levels of health care than their counterparts in other States.

My State is also unique in terms of its health insurance market. Being a small State, Rhode Island experienced a particularly tumultuous insurance cycle during the mid-1990s that resulted in basically one insurer remaining in the market. Being dominated by a single insurance company has resulted in artificially low reimbursement rates for providers in my State. In fact, I am told Medicare is often the highest payer, sometimes 30 to 40 percent higher than some of the private options.

This has created a tremendous burden on providers in my State who are struggling to keep up with the increasing cost of doing business while continuing to provide quality care to their patients.

As Senator GRASSLEY stated at the outset of this debate, his legislation contains a provision aimed at increasing the reimbursement rate for rural providers that fall below the national average. This will make certain rural patients are not denied access to doctors and quality care. However, I believe the same assurance must be given to all Medicare beneficiaries, regardless of where they live. I am constantly hearing from providers in my State who are struggling with the drastically increasing cost of doing business. I believe we must do more to recognize regional variations in the cost of providing health care services in this country to ensure all providers are equitably compensated for services under the Medicare Program and access to care for beneficiaries is assured.

I would like to take a few moments to outline the many concerns I have regarding this legislation. I commend the Senate Finance Committee and the leadership of Senator GRASSLEY and Senator BAUCUS for their efforts to move a package forward. This is a daunting challenge. They have invested their energy and their vision and their enthusiasm over many weeks. I commend them for that.

However, I believe the proposal before this body is deficient in many significant ways. Under the legislation, seniors below 100 percent of poverty and those between 100 and 135 percent of poverty would have much of their needs covered at minimal expense. This is one of the beneficial aspects of the legislation. I must commend the Senators for insisting upon this protection for low-income seniors. Seniors between 135 and 160 percent of poverty would face a variable deduction and coinsurance.

These are beneficial aspects. If we could do more along these lines to provide assurances to low-income seniors that their benefits would be taken care of, if we could close the gap in coverage and we could do many things, this legislation would be one that would be universally supported. But there are significant shortcomings as well as the beneficial aspects.

Our elderly and disabled beneficiaries need a comprehensive Medicare prescription drug benefit now, not 3 years from now. According to the Kaiser Family Foundation, a senior today pays an average of $999 in out-of-pocket drug costs. Under the Grassley-Baucus proposal, beginning in 2004, seniors would be entitled to the Bush administration's privately run discount card program. The Government-endorsed card would provide seniors with negotiated discounts on certain drugs.

Instead of taking the time and expense to implement and dismantle a temporary discount card, we should be dedicating ourselves to implementing today a meaningful comprehensive prescription drug benefit as expeditiously as possible. I recognize the proposal before us is highly complicated and relies on a private marketplace that does not even exist and will take time to put in place. Yet if the original Medicare program could be up and running within 11 months during an era when there were no computers to speak of, I see no reason why we can't phase in the basic elements of a prescription drug program starting immediately.

I greatly fear the beneficiaries of Medicare will never see this benefit take effect when 2006 rolls around. There are a number of very plausible scenarios such as increasing Federal budget deficits, competition with the never ending drumbeat for tax cuts, and the expiration of some of the 2001 and 2003 tax cuts, the lack of private companies willing to offer these new plans, technical problems, or any number of other potential stumbling blocks that could derail implementation of this benefit, leaving seniors with nothing more than the temporary discount card as a benefit. Indeed, the bill before us continues the temporary card more than 6 months after the benefit is supposed to start.

Given the fact that Medicare beneficiaries have already waited too long for Congress to enact a prescription drug benefit, we need to do all we can to deliver a Medicare prescription drug benefit as soon as possible. Yet an effort by Senator LAUTENBERG to move up the implementation date of the new Medicare Part D program to July 1, 2004 failed. I am extremely disappointed this amendment did not prevail, leaving seniors to wait even longer for us to deliver on this promise.

The current package relies entirely on the private sector to provide a Medicare prescription drug benefit to seniors. The new Medicare Part D program created by this legislation is a significant departure from the traditional Medicare Program structure. The expectation is that Medicare HMOs and PPOs will provide the complete range of health care services, including prescription drugs, under the new MedicareAdvantage option, while drug-only plans, which currently don't exist in the health insurance marketplace, will provide drug coverage to beneficiaries who remain in the traditional fee-for-service Medicare Program.

It is important to point out that most seniors have a favorable opinion of the existing Medicare Program and are satisfied with the coverage they receive through the traditional program. According to a recent Kaiser Family Foundation Harvard School of Public Health survey, 80 percent of seniors have a favorable impression of Medicare and 62 percent felt that the program is well run.

Seventy-two percent of people age 65 and over surveyed thought seniors should be able to continue to get their health insurance coverage through Medicare over private plans and 63 percent favored drug coverage through Medicare over private plans.

The only time a beneficiary would have access to the Medicare prescription drug fallback option under the traditional program is when no other private plans are available in their service area. However, once two drug-only plans enter the market in a particular area, this fallback option automatically disappears and a senior's choice is eliminated. He or she is forced to move to a different plan. I believe seniors should have true choice when making a decision about Medicare. They should be able to choose the Medicare prescription drug plan that best suits their needs, even if it is the Government-administrated option, which has a proven record of lower costs to taxpayers.

I support providing a level playing field for all Medicare prescription plans and was a proud cosponsor of Senator STABENOW's amendment that would have guaranteed the availability of the Medicare fallback plan as the standard option for seniors. This was not an amendment to force some outmoded Government-controlled health care system. It was an amendment about choice; indeed, a choice seniors overwhelmingly favor. Apparently we rejected that choice when we rejected the Stabenow amendment.

The Federal Government already serves as a direct provider of prescription drug benefits to millions of active-duty military personnel and veterans, so we do have a compelling Government model rather than a private sector model on which to base our expansion of Medicare.

Advocates for private sponsored prescription drug coverage under Medicare contend the private sector is more efficient and generally better suited to providing a prescription drug benefit to the elderly and disabled. I have also heard arguments that private plans are more cost-effective. However, as history has shown, the Medicare program has operated with significantly lower administrative costs than their private sector counterparts—2 to 3 percent versus 8 to 10 percent. Moreover, the Federal Government already has a long track record of providing prescription drug benefits to millions of active duty personnel and their families.

The Government also has a wealth of experience as a bulk purchaser of medications for our Nation's veterans. The TRICARE program provides comprehensive health and prescription drug coverage to 8.6 million military and their dependents. Similarly, almost 5 million of our veterans have access to prescription drug coverage for free for service-connected conditions and for a nominal $7 copay for a 30-day supply of medication for nonservice-connected ailments.

Federal health care programs have a proven track record of offering comprehensive, stable, and reliable benefits in a cost-effective manner. The facts certainly do not necessarily reflect the rhetoric when it comes to private plans.

Indeed the best model for, I think, pharmaceuticals is the Veteran's Administration and TRICARE programs, all of which are run by the Federal Government.

Under the Finance bill, premiums will vary based on geographic location and the level of benefits offered by the plan. The most recent CBO estimates indicate that the average premium for the standard prescription drug plan would be $35 in 2006 and will increase to $59 by 2013. However, private plans are free to provide a different package of benefits so long as the minimum benefit is "actuarially equivalent" to the standard benefit package set forth by the Government. Plans would also be free to charge beneficiaries a different premium to reflect these benefit packages. For beneficiaries on fixed incomes, these unpredictable premiums will be a great burden.

Beneficiaries will also face annual unpredictable increases in their deductible. The bill sets the deductible at $275 for 2006 and will increase in subsequent years based on the average annual per capita expenditures on covered drugs. I fear that some of the cost saving measures in this bill are "pennywise and pound foolish." We should be very clear that this legislation imposes a significant amount of cost-sharing on seniors, not only in terms of the $275 deductible, variable monthly premiums and 50 percent coinsurance under the prescription drug plan, but in other areas as well. Specifically, the Grassley-Baucus proposal increases the annual deductible beneficiaries currently pay under Medicare Part B to $125 in 2006 and it indexes future increases to inflation.

I am also deeply concerned with other provisions included in this legislation to offset the cost of the rural provider payments. In particular, it imposes for the first time a beneficiary coinsurance requirement of 20 percent for diagnostic lab tests to offset a portion of these rural provider payments. I have heard from literally hundreds of providers and beneficiaries from my State in opposition to this new cost burden. In essence, what this provision translates to is an $18.6 billion shift in cost onto beneficiaries over the next decade. From a regional standpoint, absolutely none of this funding will benefit providers in my State, nor will it ensure better access to care or improve quality of care to beneficiaries in my State. Yet the over 170,000 Medicare beneficiaries in Rhode Island will be forced to pay millions in additional costs. I believe it is extremely unfair and inappropriate to boost the payments of a select group of providers at the expense of beneficiaries. The purpose of the legislation is to bring new benefits—not impose new burdens—on our elderly and disabled.

The bill also reduces the reimbursement rate for certain cancer drugs administered in a physician's office. I fear that the cumulative effect of these provisions will be increasingly limited access to care for suburban and urban beneficiaries, either because they cannot afford the deductibles and coinsurance they are expected to pay, or because they are unable to find a physician who will take Medicare.

I am also skeptical of the new "Center for Medicare Choices" being created under this bill to administer parts C and D of Medicare. I don't understand why the new "Medicare Advantage" program under Part C and the prescription drug benefit program under part D are being separated from Medicare Parts A and B under the Center for Medicare and Medicaid Services.

Scarce Federal dollars that could be directed towards providing a more generous benefit to seniors are instead being used to create a new federal bureaucracy. I am also concerned that the time and effort needed to create this new agency will slow the implementation of a drug benefit plan for seniors.

When the Medicare program was originally created in 1965, it was done in response to the fact that elderly and disabled Americans were simply unable to get affordable health insurance coverage through the private market. While many aspects of our health care system have dramatically changed since then, I believe this same basic principle holds true today.

Should this legislation pass without significant changes, Medicare beneficiaries are going to be faced with a barrage of confusing and complicated options. If we expect seniors and the disabled to be informed consumers of health care, we need to be absolutely certain that we provided the resources necessary to educate them on their options. They are going to need assistance, at least initially, in sorting through all of the relevant information to determine which option is best suited for them, based on their overall health care needs. Indeed, one third of all seniors are probably better off it they do not participate in Part D, according to CBO.

While the Grassley-Baucus proposal does take some initial steps to bolster beneficiary education through the Medicare State Health Insurance Program (SHIPS) volunteers and through local Social Security Offices, this new program, with all its options, and new features, is going to be very confusing to the public. I believe we need to do more on education and outreach to assist beneficiaries with this new program if the program is going to be successful and effective.

For example, even today, only about half the seniors who are eligible for the various low-income assistance programs (QMB, SLMB, QI-1) enroll in those programs.

I believe we can and must do more to ensure that beneficiaries, particularly those in hard-to-reach rural and inner city communities, have access to information describing these new changes, the importance of the low-income benefit, and encouraging enrollment. I hope to work with the chairman and ranking member of the Finance Committee to make sure that all Medicare beneficiaries are well informed in terms of the parameters of the temporary discount card as well as the more comprehensive benefit.

Medicare beneficiaries who are eligible for Medicaid, known as the dual eligibles, have disproportionately high medical and long-term care needs. These seniors, including most vulnerable elderly in nursing homes, are ineligible for the drug benefit in this proposal. This population represents about 11 percent of older Americans covered by Medicare. While Medicare covers acute care and major medical expenses for this group, Medicaid picks up the cost of their prescription drugs. Since many of the dual eligibles suffer from chronic illnesses and have multiple health problems, their drug costs are extremely high. With the Gassley-Baucus proposal, the Federal Government shirks its responsibility as the primary payer by failing to assist these Medicare beneficiaries with their prescription drug costs. Indeed, it prohibits these seniors from receiving the drug benefit. It is also unclear how States' efforts to help this population will work with this proposal. Currently, States struggling with tight budgets are cutting back on care for Medicaid beneficiaries, and they are cutting optional benefits. Prescription drugs are one of Medicaid's optional benefits that States could choose to cut. The Grassley-Baucus proposal does nothing to help lift the States' burden and enable them to provide needed health care to their populations.

Under the Grassley-Baucus proposal, those low-income seniors who are not eligible for coverage through Medicaid, would as I mentioned, receive substantial Federal assistance. Unfortunately, their plan relies on state asset tests, which as Senator BINGAMAN has illustrated, can be extremely confusing and onerous for beneficiaries. Moreover, it is estimated that roughly half of all beneficiaries who would be eligible for assistance under the plan would be disqualified because of the asset test. Consequently, they would be forced to pay significantly higher deductibles, premiums and coinsurance.

So the laudable attempts to cushion the blow for low-income seniors could be undercut by maintaining this asset test.

For a vulnerable senior or disabled person struggling to get by on a fixed income, their options will not be much better than what they face now. If they are unable to afford prescription medications without coverage today, they are not going to be any better off under this plan. Low-income Medicare beneficiaries are still going to be in the unenviable position to having to choose between their medications and other basic costs, such as food and transportation.

The bill provides $250 million to reimburse local governments, hospitals and other providers for emergency health services furnished to undocumented aliens, but does not offer aid to help cover uncompensated care provided to the uninsured Americans in health care facilities around the country.

Over half of the estimated unauthorized immigrants in the United States live in five states—California, Texas, New York, Illinois and Florida. However, all States in the Union face substantial costs due to uncompensated care, regardless of immigration status.

In 2001, people who were uninsured during any part of the year receive $98.9 billion in care, of which $34.5 billion was uncompensated care. Last year, my State of Rhode Island provided more than $120 million in uncompensated care, and this is expected to grow higher this year due to the weak economy.

Local governments, hospitals, and providers throughout the United States are facing rising care costs, trying to provide services to the uninsured, which includes undocumented aliens but includes many others.

With the sluggish economy and rising deficits, States cannot alone continue to shoulder the burden placed on the health care system by the uninsured. A recent Institute of Medicine report entitled "A Shared Destiny" documents the impact of the uninsured and uncompensated care on communities.

The consequence of uninsurance for communities can include reduced health care services, closure of local health care institutions, increases in local cost of health care and health insurance, and poorer health for residents in general.

Federal reimbursements for health services provided to the uninsured are needed by all States. It would be more equitable to States to distribute funding based on uncompensated care determined by the number of uninsured individuals in a State as a percentage of the total number of uninsured U.S. residents rather than simply immigration status. Under the current provision, over 50 percent of the funding would go to three States, and seven States, including Montana, might not receive any funding.

Distributing funding based on the number of uninsured will help all of us. I hope Senators GRASSLEY and BAUCUS will work to explore ways in which we can address this extremely pressing issue for all States.

Another aspect of the legislation is a very serious one and one which troubles me significantly. It is the projection by CBO that 37 percent of Medicare eligibles who presently receive prescription drug coverage through an employer retirement plan will lose that coverage as a direct result of this legislation. Under this bill, over 4 million people will lose their existing prescription drug coverage.

This effect is particularly troublesome because many seniors with retiree coverage currently enjoy more generous benefits than would be provided to them under this legislation. We are all aware that some employers are already eliminating coverage or trimming back on the benefits offered to retirees. However, this legislation will likely accelerate this disturbing trend because employers see no reason to pay for a benefit the Government already provides.

I am deeply disappointed that the amendment offered by Senator ROCKEFELLER, which would have permitted drug spending by employers to count toward the out-of-pocket spending requirements of the drug benefit, was not approved. I believe the Senator's amendment would have gone a long way toward eliminating a problem of employers dropping retiree health insurance coverage.

I am also particularly concerned that legislation may have negative implications for State and local government retirees and their families. States across the Nation are suffering from staggering budget shortfalls. This legislation might present an enticing opportunity for States to slash some of their costs by shifting their retiree health insurance costs on to the Federal Government by substituting what they currently offer for what is being proposed under the Grassley-Baucus plan.

I know this would have serious implications for the over 35,000 retirees and their families currently in the Rhode Island State employees pension system as well as the almost 20,000 employees who will be expecting these benefits when they retire.

Over the past several days, my colleagues and I have brought forth amendments that would have addressed the many recognized shortcomings in the pending legislation. We have repeatedly attempted to modify the bill in a way that would have provided a stable, universal, and affordable Medicare prescription drug benefit to the almost 40 million elderly and disabled beneficiaries in America.

I fear that the product taking shape in this Chamber is only going to disappoint beneficiaries by delivering a hollow benefit that will not meet their real health care needs. Even with an additional $12 billion in resources, this body is choosing to experiment with the privatization of Medicare over providing enhanced benefits to seniors or eliminating the gap in coverage under this plan.

For these reasons, I am unable to support this legislation. I am deeply disheartened to be reaching this conclusion, but elderly and disabled Medicare beneficiaries deserve better than the proposal before this Chamber. I only wish we were seizing this historic opportunity to provide them with a benefit they need and deserve and can be sure they will get.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

AMENDMENT NO. 1040

Mrs. CLINTON. Madam President, I come to the floor in support of the amendment proposed and then withdrawn by my colleague, Senator SCHUMER, that would have helped Medicare+Choice programs continue to provide insurance for their beneficiaries. This is a serious problem in New York and, I have reason to believe, in many other parts of the country because, as costs have continued to rise, many health plans are being forced to drop people from their rolls. They are actually withdrawing from large regions of New York and elsewhere in the country, leaving people to scramble for alternatives. Even those who are continuing to provide coverage are raising their premiums drastically.

Like the rest of Medicare, Medicare+Choice plans are feeling the squeeze in a system caught between rapidly exploding costs and rapidly imploding finances. Here we are on the floor debating the future of Medicare and the structure of new benefits like prescription drugs, but while we debate the future of Medicare, we need to recognize that there are people right now in our States who depend on these plans today, and the plans, when they withdraw and then reenter from year to year, cause confusion and excess costs that fall directly on the backs of our seniors. So these seniors, who are already facing rising premiums, benefit cuts, and withdrawal of services, should not be forgotten in the context of the debate we are carrying on today which will actually try to encourage more seniors to move in to these kinds of private health insurance choices.

I hope that we do something not only about the future, but we start doing something about the present and take care of our seniors who were promised better benefits in these Medicare+Choice plans only to find the rug pulled out from under them, as the plans either raised premiums, sometimes 15, 20 percent, and withdrew from their region, leaving them without the coverage for which they thought they bargained.

I fear we are setting up many more of our seniors for this kind of disappointment, confusion, and disruption if we do not heed the lessons of what has already happened.

I thank the Chair for this attention, and I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Madam President, I do not think in my 19 years in the Senate we have faced a more important and decisive issue than what is before us right now. The action the Senate will take on this bill, I believe, will set us on one of two courses.

If the Senate passes S. 1, as it is now constituted, and then goes to conference with the House—and the House bill is even worse than this one—we will have set this country on a course, inexorably, I believe, toward the privatization of Medicare and the privatization of Social Security. That is why I believe this upcoming vote is such a momentous vote.

There are those who say: We can pass it—maybe it is better than nothing—and then we can come back sometime in the future and make it better and fix it. I am not certain that is a gamble I want to take with the future of Medicare and Social Security.

The proponents of this bill are claiming that it is going to provide prescription drug coverage for seniors. Obviously, that is something we all hear about when we go back to our respective States—we know it; we sense it; we feel it; we see it—that more of our elderly are cutting their pills in half. They are not taking the prescribed medicine. They wind up in the emergency room of the hospital.

Under Medicare, if one is in the hospital, they get their drugs paid for. But if they are outside and they need drugs to keep them healthy, to keep them out of the hospital, then there is no help. I hear this from our seniors all the time.

So we know the need is there and that we should address it. We have been talking about it for a number of years.

Quite frankly, I think the bill before us, S. 1, moves the focus from the elderly and their situation and their need for an affordable, reliable prescription drug benefit, to a special interest: What is best for the drug companies? What can we do to make sure that they can continue to make the high profits they are making; to continue to be able to advertise and push these drugs on people who may demand drugs for which they could use cheaper alternatives?

The focus of this bill is a special interest focus to help the drug companies.

I have gotten over 700 phone calls in my office. Only four of them were for this bill. Seven hundred phone calls from the elderly, and only four in favor of it. I cannot believe I am the only person getting these kinds of phone calls. Funny, I have not gotten one phone call from a drug company. They are very happy and very satisfied with this bill.

So why do we find ourselves in this situation? Well, it is really only a matter of priorities. This administration and Congress had no qualms about passing enormous tax cuts amounting to $93,000 a year for millionaires and above, but now we have problems coming up with adequate funds for our Nation's seniors. This bill will not provide significant relief to the millions of seniors who need it.

Let's put it in perspective. During the last 3 years, this Congress has passed, and the President has signed, $1.6 trillion in tax cuts. That is assuming we do not continue the cuts that are already scheduled to sunset. If we do not sunset these tax cuts, it is going to amount to a lot more than that.

At the same time, we are told by CBO that seniors will have about $1.8 trillion in drug costs over the next 10 years. So do we have the picture? We have just passed $1.6 trillion in tax cuts, half of which benefit the wealthiest 1 percent in our country. Keep that figure in mind, $1.6 trillion. That is with the sunset provisions. Now, if we do not sunset them, it is going to be trillions more than that.

CBO says over the next 10 years our seniors are going to need drugs costing about $1.8 trillion. We do not have the money for that. Why? Because $1.6 trillion has already gone out for the tax cuts. After breaking the bank on these tax breaks for the wealthy, we are left with table scraps for our seniors. It is all due to a bad budget that many of us did not support. I did not vote for this budget. It was a bad budget.

We are going to see more about how bad this budget is when our appropriations bills hit the floor on education, health, and job training. We are going to see how bad this budget really was then.

Some examples of how bad I believe the provisions of this bill are: A senior living on $15,000 per year—that is just right over 160 percent of the Federal poverty level—with $1,000 in annual drug costs will actually lose money if enrolled in this program. My colleagues heard me right. If a senior is making $15,000 a year, and they have $1,000 in annual drug costs, if they join this plan, they pay more in than they get out. In fact, it is estimated that at least 35 percent, more than a third of all Medicare beneficiaries, will lose money if they enroll in this plan.

A married couple with a combined income of $20,000, again just slightly over the 160 percent of poverty level, if they had individual drug costs of $1,500 each—that is $3,000 a year in drug costs—they would save less than $400, barely 12 percent of their total drug costs.

Even seniors with high drug costs will only get modest assistance. In fact, a senior under Medicare will have to have drug costs approaching $9,000 per year before this plan will even cover a half of their expenses.

When we add together what a senior has to pay in premiums, deductibles, and cost sharing, then they have this coverage gap, the donut hole, where they do not get 50 percent coverage until they hit $9,000 in drug costs and then they get a 50/50 split—$9,000 in drug costs before they even get 50 percent.

As I said, the plan has a donut hole, a gap, the coverage of the size of Texas, maybe Alaska. What this means for seniors is that they will pay 100 percent of their drug bill even while they are continuing to pay premiums, but they will not receive any drug coverage.

Now, there is an eruption coming. When this bill passes and it gets out there and seniors finally get in this in a couple of years, there is an eruption coming because there are going to be seniors out there saying: Wait a minute, I am paying into this thing and I do not get anything back because I fall in this gap? Wait until my colleagues start hearing from their constituents on that one.

Under this gap, once a senior's total drug costs reach $4,500, they are on their own until their catastrophic kicks in at $5,800, if I am not mistaken. But they still have to continue to pay premiums. Even though they pay for everything, they still pay the premiums. They are paying something, but they are getting nothing. That leaves a senior citizen with another $1,300 in out-of-pocket drug spending each year if they hit that gap.

That is what we call the Swiss cheese model of drug coverage. It is full of holes, and woe to you if you fall in one of them.

This bill provides too little to middle-class seniors. We tried to fix the problem. Senator BOXER offered an amendment to fill in this unfair coverage gap. The Republicans said: No, we cannot afford it.

Oh, we can afford $1.6 trillion to the wealthiest in this country, but we cannot afford to close the coverage gap. Priorities, my friends, priorities. That is what this debate is about, priorities.

The second flaw in the bill is it is a bureaucratic maze. Congress is trying to cram through one of the most significant changes in social policy in decades in 2 weeks. I am beginning to think it is because the leaders of this effort do not want seniors and the rest of the people in this country to see what is in the bill until it is too late. This is a complex, daunting, bureaucratic nightmare of a bill, and it will be for seniors.

This weekend the New York Times headlined in red "Criticism of drug benefit is simple: It's bewildering. High level of complexity causes concern."

> With both houses of Congress poised to pass a Medicare drug bill next week, lawmakers are increasingly anxious about the complexity of the legislation and its reliance on new and largely untested arrangements to deliver drug benefits to the elderly.
>
> This complexity, they say, may be daunting and confusing to beneficiaries, and even to insurance companies, which are supposed to manage the new benefits. Many lawmakers say they have just begun to examine the bill's intricate details and the web of political compromises behind those provisions.
>
> Senator Larry E. Craig, Republican of Idaho, lamented the bill's "high level of complexity and prescriptiveness." Senator Hillary Rodham Clinton, Democrat of New York, said it would create "a Medicare maze, a whole new bureaucracy."

Yes, it is bewildering. It is complex. If you think reading the bill is complex, 654 pages, I bet there are not a handful in this room who know what is in the bill—maybe a few in the committee, not many more. If you think that is bewildering, wait until the seniors start getting hit with this.

There is a reason why over the last several years when we put in Medicare+Choice for Medicare 89 percent of seniors chose to stay in traditional Medicare. Why? They want a simple, straightforward, understandable, reliable, guaranteed benefit, one in which they get coverage for the drugs they need, one they can sign up for and it does not put you in and put you out and put you in and put you out, year after year, but it is there solidly and one that is affordable.

What they are going to get under this plan is a series of befuddling and bewildering steps just to obtain substandard drug coverage.

Let's take an example. A senior citizen, we will call him Bob, next year is going to receive a drug card. Well, la-di-da, he will get a drug card. He might already have three or four drug cards in his wallet. In fact, I had an individual in Iowa a few weeks ago who took out his wallet and he already had five prescription drug cards: One from AARP, one from the State, one from a drug company, and a couple more I did not recognize. He said: Not a one is worth a hoot.

Millions of drug cards are out there now from CVS, State programs, other private organizations, AARP. If discount cards provided anything, if they amounted to anything, they would not need a drug benefit under Medicare. There are millions of them out there. Seniors will tell you they are not worth the paper they are printed on.

The reality is for the next 2 years, seniors like Bob will be left with virtually nothing. He gets a card. If Bob were low income, next year he will receive a debit card worth $600. Consider this. Bob gets a debit card worth $600, but what happens when Bob is going to the drugstore and he is getting his prescription drugs. It is now July and he goes to the pharmacist for his refill and the pharmacist says, sorry, you are out of money. The $600 is used up. What does he do then? He goes back and he sees his friend Fred, and Fred says, Well, I am still going to the drugstore and I am getting mine free. Bob wonders why he does not get his. Wait until that hits next year. Wait until your constituents start calling you up because their debit card has run out of money and it is July or August or September.

Now he has the card for a couple of years. After 2 years of having the card, it expires. It is done for. Now Bob is going to be forced to wade through hundreds of pages of health plan documents to choose which plan he wants. I decided to look at some of the plans that are out there and here are three of them. Here is Care First, Blue Cross Inc. Anyone want to try wading through this? Anyone want to read that and understand what is in there? I am a lawyer, probably not very good, but I have trouble reading that.

Here is another one from the Kaiser Foundation Health Plan of the Mid-Atlantic States. Bob will have to wade through this one, too, to figure out what he wants.

Here is one from MDIPA. This is a little smaller than the others but still pretty daunting.

In a couple of years, Bob will get a couple of these and he will be told to decide which he wants. He has to read through them and figure it out. What is he going to do, hire an accountant; hire a lawyer to figure out which plan is best for him? The plans could have different benefits, different rules, different prices, and different drugs.

Once Bob makes his choice, he could find out some of the drugs he needs are not actually covered by the plan. So he either has to change drugs or what, change plans? No. Bob cannot do that. He can do that at the end of a year. But if he finds out his drugs are not covered, he cannot switch. He has to wait until the end of the year. If Bob chooses one of the new PPO plans, the preferred provider plans, he might even have to change doctors to become part of it because they will list only certain doctors.

If that is not enough, once Bob chooses a plan and he is in it, his monthly premiums may skyrocket past $35 a month at any point in time. I have said to some people, That cannot be right; surely they cannot do that. But it is in the bill. It is in the 654-page bill. If you belong to a plan, any time that plan wants to raise the premium, you have to pay it. You cannot get out of the plan. You have to stay in it. So you have signed up for a plan. It says it will charge $35 a month. After a couple of months, the plan figures out it is not making enough money and now the premiums will be $45 a month. Why, you can write your Senator and tell your Senator how unfair this is. Guess what. Your Senator cannot do a darn thing about it. Nowhere in this bill does it guarantee seniors will not have to pay different monthly premiums.

Senator DASCHLE offered an amendment to try to fix this significant problem so seniors would be guaranteed some protection from fluctuating monthly premiums but, again, the Republicans said no. So we are supposed to vote for a bill that cannot even tell seniors what they are getting and how much it is going to cost them. In fact, Senator LOTT, who was quoted in the New York Times this week, said:

> You are going to make a huge change in an entitlement program and you don't even know how it would work, if it would work.

At least we have one Republican over there who recognizes this as a bureaucratic maze. At least the amendment of Senator DASCHLE would have given seniors some peace of mind that what they bargained for is what they were going to get.

So we are back to Bob. Now, Bob is in the plan. His premiums might skyrocket. He might find that the prescription drug coverage is unaffordable. Now Bob is down at the coffee shop with his friends. None of them make very much money, but their income levels vary a little bit. They are all basically the same. They are retired, they worked hard all their lives, and they are spending a little time watching their grandkids grow. None of them are wealthy. They weren't born with silver spoons in their mouths. They don't have a lot of stock. They are just getting by.

You know, you see them on Main Street all the time. You see them in our towns, all over our States—average, middle class elderly Americans—

and they are down at the coffee shop. They start talking. Bob finds out that all of his friends pay different amounts for their prescription drugs. Bob's friend George is paying a $50 deductible. Bob says, "How can this be?"

Well, George earns just a little less than Bob. He earns $14,000 a year. So he pays a $50 deductible. He pays a lower premium and 10 percent copay for most of his drugs.

Their other friend Joe makes a bit less money a year. He is getting around $12,000 or so a year. He pays no deductible, no premium, and a 5 percent copay for his drugs.

Bob is sitting there and he is astounded. He doesn't make much more than they do. He makes $15,000 a year. He is struggling to make ends meet at that, and he is still stuck paying 50 percent copays, large deductibles, and large premiums.

Think about how you are going to hear from your seniors who gather at the local McDonald's in the morning to have their coffee and they start talking about this. One gets drugs practically free. Someone making just a few hundred dollars more pays the full premium, the full deductible, 50 percent copays. Try explaining that to your elderly citizens when this hits the streets.

Seniors are going to know immediately that this is not fair. This is the first time in Medicare's history that we are means-testing the program, where seniors are treated differently under Medicare. I believe there are serious consequences to creating this welfare class in Medicare, and that is what we are doing. We are creating a welfare class under Medicare.

It will be incredibly confusing for seniors to have four tiers of differing benefits. Seniors will not know where they fall in these income classes. Think of it, there are four. You have 75 to 100 percent of the poverty level; you have another class from 100 to 135 percent of the Federal poverty level. You have another class from 135 to 160 percent of the Federal poverty level. And now you have another class above 160 percent of the poverty level. There are four different classes.

How does Bob know where he fits? He is going to have to go through some tests. He is going to have to fill out some forms and submit the forms so people know how much money he makes.

I had some of those forms here. Here they are right here. Here is a set of forms right now for the Commonwealth of Pennsylvania. It is 16 pages long. It is what a person has to fill out in the Commonwealth of Pennsylvania to show they are poor, if I can use that word, that they are low-income, that they need some assistance, some benefits. This is the kind of paperwork they fill out.

Here is all the information about you: where you live, what you do, what you have done in your lifetime. Any cash on hand? Any savings accounts? Any checking accounts? Any certificates of deposit? Any stocks or bonds? A boat? Do you have a Christmas or vacation club?

Does anyone own or is anyone buying a car, truck, or motorcycle? You have to fill it in—the year, make, and model.

Do you have a life insurance policy? Do you own a burial space or burial plot? This is what the elderly are going to have to start filling out. And guess who gets it. Where do they take this?

Let's say Bob's friend George—how much did I say George is making? He is making about $14,000 a year. He has to prove that. He has to prove it by filling this out.

Who does he give it to? The IRS? No. Does he give it to his Senator? No. How about his Congressman? No, he doesn't give it to the Congressman either. He gives it to his pharmacist and his doctor.

So, now, our pharmacists all over America are going to have to keep all this stuff on file. Now they are going to have to look through it to make sure that George didn't make a mistake somewhere in filling this out. Think what is going to happen to elderly all over America who now say: Wait a minute, I don't necessarily want my pharmacist to know all my business. The pharmacists are going to say: I don't want all this paperwork. Wait until that hits the streets. More paperwork for our pharmacists, more paperwork for our elderly. And they aren't going to know how to fill this out.

Not only that—assets. What if George, let's say, or George and Betty, husband and wife, fall just slightly below the $19,000 level in both incomes. So they go to fill out this paperwork to get a cut in their drug coverage, to get a better benefit. But then they hit that page on assets. What kind of assets do you have?

I know people are going to laugh about this, but this is true. Betty is going to have to have her wedding ring appraised by somebody. How much is it worth? How about family heirlooms? Let's say George and Betty had some furniture that their grandparents passed down. It is now an antique, worth some money. How much is it worth?

I said the other day, it seems to me this portion of the bill is going to be a boon to the pawnshop artists around America. They are all going to be called out to assess things and determine how much they are worth. Who is going to pay that bill? That is in the bill. You may think I am joking. It is in the bill, an asset test, and it includes things such as jewelry and furniture and, yes, even a burial plot. We are forcing this humiliating process on seniors, to prove they are poor, by filling out this complicated paperwork—an assets test.

Finally, after all of this trouble, if Bob and his friends' health plan does not make enough money off of them, they will just pull out of the market, leaving them right back where they started. We have seen this happen time and time again with Medicare HMOs all over the country. It could happen over and over and over again as the new private, drug-only HMOs come in and pull out.

The Federal fallback may be available one year but not the next. So seniors will be bounced from one plan to another plan, maybe back to Medicare, maybe to another plan. There is nothing to stop it. And if a plan is in there, and it is not making money, they are out of it.

So I guess I could ask, by now are you confused? Is it a little tough to follow what all is going to happen? Imagine how our seniors are going to feel. Senator CLINTON prepared this chart. I looked it over, and it really does kind of give you the complexity of this bill we are talking about. I will not go through it all except to say that seniors starting here, in private plan "one," with a $40-a-month premium, $275 deductible, 47 percent coinsurance, no limitations on doctors—well, let's say you join this plan and then find out the drugs you need are not offered there. You file a grievance. It goes to a hearing to see whether the drug is covered. Then, let's say it is a private plan, and it doesn't make enough money, and they drop out. Then you fall back into the Federal fall back and you start all over.

It is a maze. That is what we are asking our seniors to get involved in. Keep in mind that over one-third of all seniors will have to navigate this maze—just to lose money. They have to go through this just to lose money. One-third will go through this maze, and they will pay more in than they get out.

I suspect very strongly that this whole thing was developed by people who want the system to fail. They want it to fail. This bill is an example of ideology over fact, placing all the bets on private health plans to provide the drug benefit to seniors. It is especially bad for seniors in rural States where private plans have shown no interest in participating in the Medicare Program. This private-sector worship is derived from the belief that the free market will take care of everything: The free market is the answer to everything; if only it is just put on the free market.

Well, private enterprise or the free market does very well, thank you, when you are doing automobiles or airplanes or wicker baskets or widgets, clothes, glasses, watches, television sets, computers, and a host of other things. That is where the free market works. But the free market, the private sector, by its very nature, leaves those people behind who are not profitable, people such as those with disabilities, mental illnesses, and the elderly.

The free market did not break down the barriers to people with disabilities in our country. It was this Congress and a President and the Americans with Disabilities Act that said: No more; we are going to provide opportunities and openness in our country to people with disabilities. It was not the free market because people with disabilities simply are not profitable.

Why do you think we have health care coverage now under Medicare and private health care plans for physical illnesses but not for mental illnesses, for which we have been trying for a long time to get parity? People with mental illness are not profitable. And why do we have Medicare? Because a long time ago the private insurance companies found out that the elderly were not very profitable either. And I speak about this from personal knowledge.

When I was a senior in high school, in the small town of Cumming, IA, population 150, my mother had passed away some years before. We were a bunch of bachelors living in a house. My father was 74 years old. It was 1958. He worked most of his life in the coal mines, and he had then what they call miner's lung, also known as black lung. He had a couple of injuries. He was not in very good shape. He had no stocks. He had no bonds. He owned no property. He did not own anything.

His total income—total income—per year was less than $1,500 because, thank God, during World War II, he had worked for a while and got covered under Social Security. See, before that he had worked all his life, and there was no Social Security. But, fortunately, during World War II he worked a little bit, and got covered by Social Security, so he was getting about $1,200 or $1,300 a year. Actually, he got a little more than that because he had kids under the age of 18, me being one, and Social Security gave him a little extra, $35 a month.

So here was my dad. He was 74. He was in bad shape. He had no assets, no money. There was no Medicare out there, folks. There was nothing. Could my dad afford to see a doctor? No way. And my father did not see a doctor. But every year, like clockwork, in the middle of the winter, my dad would get sick. It happened every year. He would get sick. He had this bad lung problem. He would catch a cold, and he could not get over it. He would get pneumonia, and we would get a neighbor, with a car, and rush him to Des Moines to the hospital. They would put him in a tent, dry him out, get his lungs down, and cure his pneumonia. They would send him home after a couple weeks.

How did we afford to do that? We did not have anything. I will tell you how we afforded it. Thank God for the Sisters of Mercy at a Catholic hospital in Des Moines, IA, who gave us charity because he did not have anything. That is the only way that my father got health care.

Now, why didn't some insurance company rush out to cover him at a price he could afford? Keep in mind, he was making less than $1,500 a year. He was not profitable. He was 74. He had black lung disease. He had a couple of other illnesses and injuries. My father was not profitable to an insurance company.

I can remember like it was yesterday when I came home from leave from the Navy. This was later on in 1966. I came home on leave from the Navy to see my father, who was now nearing his 80th year of life. I remember when he showed me his Medicare card and said: Now I can go see a doctor. I can go to the hospital if I have to. And I don't have to take charity anymore.

I often wonder, what would my father's later years have been like, what would it have been like if he had had Medicare earlier on? How much better his life would have been, how much healthier he would have been, how much more he would have enjoyed in his elder years if he had had decent health care.

So I don't want anyone lecturing to me about how wonderful the private market is for health care for the elderly. Go tell it to somebody else, but don't tell it to me because I lived through this. That is why when someone tells me that the private sector is somehow going to take care of the elderly, I say: Wait a second, maybe the elderly who have a lot of money, but how about those at the bottom?

That is why I say what we are doing here is setting up a welfare class. Once again, people like my father will have to fill out paperwork and beg, ask to be put in a system they can afford. I guess we haven't learned anything around here. We haven't learned a thing. Maybe we have too many people here who didn't go through what I went through. I don't know. I don't know everybody's situation. I would like to think if people went through with their fathers what I went through with mine, they might have a different perspective on Medicare.

There is no reasonable rationale for relying on private health plans for prescription drugs for the elderly, even in monetary terms and costs. We know administrative costs are much lower in Medicare. We have a history. The administrative costs in Medicare are between 2 and 3 percent a year; in private health care plans, 15 percent per year administrative costs. We also know that over the last 30 years, Medicare spending has grown at a slower rate than private health care plan spending: 9.6 percent compared to 11.1 percent.

Here is a story that appeared in the Washington Post recently. It is entitled "Bush Pushes for Expanded Private Role in Medicare." It reads:

> President Bush yesterday renewed his call for market competition to play a large role in Medicare's future, as the Senate wrestled over how far to go in encouraging private health plans to deliver care and prescription drug coverage to older Americans.
>
> Bush disparaged a core tradition of Medicare in which the federal government has determined what medical services are covered and how much government pays doctors and hospitals to provide them. He said Medicare would be more effective if "health plans compete for their business and give them the coverage they need, not the coverage that a Washington bureaucrat thinks they need.

Well, with all due respect, President Bush never lived through what I lived through. His father never had to rely on charity for health care like my father did. So he can disparage Medicare because no one in his family ever gave a hoot about Medicare. They didn't need it. He has turned a cold shoulder of indifference to those who rely on Medicare.

But not only that, the President ignores history. He says the private sector can do it better. Wait a second. We have a history. We have facts. We don't have to rely upon rhetoric. We have facts. Administrative costs in Medicare, 2 to 3 percent; private health care plans, 15 percent. OK, which is more efficient? In the last 30 years, Medicare spending has grown at a slower rate than private health care plan spending has grown. So what is he talking about? What is the President talking about when he says the private health care plans can do it better?

We have a history. We have facts. We have data. That private sector, when it comes to the elderly, does not do it better.

When it comes to this private plan program, it means there is going to be less money available to actually help seniors get prescription drugs. Billions will be wasted on advertising, marketing, glossy brochures, higher payments to private plans, billions of dollars that should be going directly to seniors. And how about CEO salaries? We haven't talked about that. All these private health care plans, they pay a lot of money for their CEOs. That is fine, if they are in the private sector. But that is money that is going to be siphoned off. Last year, the drug companies in America spent more money on advertising than they did on research. Wait until this plan gets out there.

I say to every senior citizen listening to me give this talk: Get prepared. You are going to get a lot of mail in your mailbox. You are going to get a lot of brochures for this drug and that drug and this plan and that plan. You are going to get inundated with advertisements, and you are going to see them on TV. You think you see a lot now. You wait, you will see more. Why? Because now they have all this money.

I understand we are about to have an amendment that is going to provide $6 billion to the private companies to entice them into providing these plans. If they are so doggone good, why do we have to do this? "Senate GOP Eyes Billions to Encourage Private Plans, Employers." I am told it is going to be $6 billion. We haven't seen it yet. Whether it is $6 billion, $5 billion, $4.5 billion, I don't know. Whatever it is, it is too much.

I mean if President Bush is right and the private sector can do it better, why do we have to bribe them? Why do we have to bribe them with taxpayers' money, $6 billion, come on and get it? Talk about hogs feeding at the trough. This is it, folks. Six billion dollars, I am told. Well, maybe $5.5 billion. I don't know what it is. But they are going to give it to entice them into this program. Why are we robbing seniors to cushion the pockets of private plans with billions of dollars of a subsidy? "President Bush Pushes for Expanded Private Role in Medicare."

Well, you kind of see it all coming together. The President, Republicans are pushing for all these tax breaks for their wealthy friends. And now they reward the drug companies. No cost containment at all. Let the drug companies keep boosting their prices year after year after year. And guess what. We will just keep raising the premiums on seniors. Now we get the private plans in with their expensive CEOs, their expense accounts, and we are going to bribe them with $6 billion. What a deal.

Tom Scully, the Bush administration's top Medicare official, called Medicare "an unbelievable disaster" and "a dumb system" during a recent meeting in Pennsylvania.

The third-ranking Republican in the Senate, Senator SANTORUM from Pennsylvania, said:

> I believe the standard benefit, the traditional Medicare program has to be phased out.

Senator ROBERT BENNETT of Utah, on March 1:

> Medicare is a disaster. Medicare will have to be overhauled. Let's create a whole new system.

Of course, we all remember the immortal words of our former House Speaker, Newt Gingrich. He didn't want to kill Medicare, he just wanted to let it "wither on the vine."

So let's get this straight. Seniors are telling us not to privatize Medicare: 89 percent have already voted to keep traditional Medicare. They tell us they want a less expensive, more reliable, straightforward, simple benefit, guaranteed to be there.

The facts tell us that privatizing Medicare doesn't work. We have the facts. So why did the administration, in this bill and the House bill, insist on this privatization? Because it is the first step toward total privatization of Medicare and, I believe, the first step toward privatizing Social Security.

Senator STABENOW offered an amendment I supported which would have guaranteed a Government fallback in every area of the country, so that seniors could choose traditional Medicare regardless of what private plans are offered. As we said on the Senate floor that day, this bill offers two private plans. Senator STABENOW wanted to say: OK, we will give them more choice and offer a Medicare plan. Let them all compete. The Republicans said no. They want only to have two choices for seniors between two private plans. But they don't want to let seniors be able to choose Medicare, which they have already shown.

As the Senator from Michigan stated time and time again on the Senate floor, 89 percent have already chosen Medicare. Yet somehow we are turning a deaf ear to them.

It seems to me we have a lot of talk around here about choice, but they don't want to let Medicare be one of those choices for seniors. The only choice in the bill is for HMOs and private plans. They will be the ones choosing your premiums. They will be the ones choosing your options. They will be the ones choosing your benefits. Well, you tell that to my seniors back in Iowa who have never had a private option.

The Republicans say they want to provide seniors with choice. They claim seniors should get the same type of benefits we in Congress get. Well, all right. Let me tell you what I have for drug coverage. I pay 25 percent for my drugs. That is it. I go to the drugstore and I pay 25 percent. What a nice deal; simple, straightforward. Seniors won't have coverage anywhere nearly as generous in their plan. Look at it this way. If this plan provides $400 billion over 10 years, which is what it does, CBO has estimated that senior drug costs over the same period of time will be $1.8 trillion.

Figure that out. We are providing $400 billion. The estimated drug costs are going to be $1.8 trillion, and that is probably on the lower side. That means we are leaving the seniors to cover 78 percent of the tab for drugs. I get 25 percent; seniors have to pay 78 percent. You are going to tell me that is fair? Again, there is a storm coming, when the seniors in this country find out what is in this bill and how it affects them.

So why the insistence on privatizing Medicare? Well, I think the answer is clear. Congress is choosing a special interest over seniors' interests by following ideology over facts. I said earlier today there are three reasons we are passing this bill. The first reason is because the drug companies want it. The second reason is because the drug companies want it. You guessed it, yes. The third reason is because the drug companies want it.

You might think, from my comments, that I have it in for the drug companies. Nothing could be further from the truth. I have fought for years on the floor of the Senate for more money for research—the kind of basic research that is done through the NIH, done in coordination with drug companies, taking some of that basic research and investing their own money in these drugs and bringing them to the marketplace. Some of them have been wonderful. We are making new strides in drug development every day. I have a lot of respect for our drug manufacturers who have brought a lot of these drugs to market. However, that does not mean my esteem for the drug companies would compel me to vote for a bill that will continue to allow them to make the kind of profits they make on the backs of our senior citizens who are on fixed incomes.

No, in this one case, in this area—this is where Medicare ought to provide the drug benefit. It is where Medicare—just like we do in the Veterans' Administration—ought to be the one bargaining for the prices for our elderly. Let me and the others who can afford health plans, and pay generously for them, pay the drug companies, not the elderly.

So, again, drug companies stand to gain billions of dollars from this drug benefit—trillions.

Mr. DURBIN. Will the Senator yield for a question?

Mr. HARKIN. Without losing my right to the floor, yes.

Mr. DURBIN. I, like you, have been in the House and Senate. Can you ever recall a bill involving an industry like the pharmaceutical industry, such a grand bill involving a national program, involving that industry, where that industry has been so silent during the course of the entire preparation and deliberation of the bill? I ask the Senator from Iowa, in his vast experience and with his great insight, what does he make of the silence of the pharmaceutical industry about S. 1, the pending bill?

Mr. HARKIN. Well, the Senator asks an insightful question. Earlier, I had stated—and the Senator may not have been in the Chamber—my office has received over 700 phone calls. Only four have been in favor of this bill. I have not received one phone call from a drug company.

Now, the Senator understands when we have legislation that impacts powerful industries in this country, and if it impacts them negatively, they are all out here. Our phones are ringing off the hook; lobbyists are in our offices; the private jets are parked at Dulles. They are all over the place.

So it says to me that this bill must be a great benefit to the drug companies because I haven't heard one peep from them. I have found in my experience, I tell the Senator, in the House and in the Senate that when you see a large industry silent on a bill that impacts them so greatly, you can only come to one assumption: They must love it.

Mr. DURBIN. Will the Senator yield for a further question?

Mr. HARKIN. I will.

Mr. DURBIN. I ask the Senator, if he has had the time to read the 654 pages of S. 1, has the Senator heard from staff or anyone during the course of the days and days of debate about this S. 1, the prescription drug proposal, that it contains anything that is going to reduce the excessive increase in the cost of prescription drugs for American families and American seniors?

Mr. HARKIN. I thank the Senator again for a very insightful question. I asked my staff—and I have good staff, and they do a lot of work on health care—to look at this 654-page bill.

I said: What in there will help keep the cost of drugs down? Anything at all?

Nothing. Zero. There is nothing in the bill that is going to help keep the cost of drugs down. In fact, I say to the Senator, I think just the opposite is going to be true because this bill will allow plans to increase premiums any time they want. So you signed up for a plan, and your premium is $35 a month. The plan is not making much money. The drug company jacks up the price of the drugs a little bit. That means the plan is not making much money, but the plan can increase the premium. The drug companies are always left harmless. They can just keep jacking up the prices.

Mr. DURBIN. If the Senator, through the Chair, will yield for one more question.

(Mr. SMITH assumed the Chair.)

Mr. HARKIN. I yield for a question.

Mr. DURBIN. I am aware of Senator HARKIN's background as a Vietnam veteran and a naval aviator. The Senator is undoubtedly aware that the Veterans' Administration, which is trying its best to provide medical care for the millions of veterans in our country, has negotiated with the drug companies to bring down the cost of drugs for veterans as much as 50 percent.

Mr. HARKIN. That is right.

Mr. DURBIN. Since we have established there is no effort in this bill to bring down the cost of prescription drugs for Medicare recipients in our country, we hear from the other side of the aisle that any effort to bring down the cost of drugs is tampering with the free market.

I ask the Senator from Iowa for his objective appraisal. Does he think the Veterans' Administration is guilty of socialistic, communistic, Bolshevik behavior, tampering with the market to bring down the cost of prescription drugs for the millions of veterans who desperately need their care? I think I know the answer to the question.

Mr. HARKIN. I think the Senator knows the answer to that question. He and I have both fought hard in this Chamber for veterans benefits. I yield to no one in my support of those who have put on the uniform of this country to defend our flag, to defend our way of life, and I know the Senator from Illinois will take a back seat to no one also in that effort. We fought hard to get a veterans drug benefit that had cost containment. That is what it does.

Today, I am proud to say—I am proud—because of what we fought for here, the veterans in this country today get the cheapest prices on drugs of anyone in our country. I am proud of that fact, and they deserve it. Has it ruined the drug companies? Of course not. They are selling more drugs. Maybe they take a little bit less profit, but they are selling more drugs because now people can afford to buy them. That is what we need today. We need that kind of system Medicare could provide in dealing with the drug companies for big purchasing, bargain down the prices so the elderly can get the same price on drugs as our veterans.

I ask rhetorically a question of the Senator from Illinois.

Mr. BYRD. Will the Senator yield?

Mr. HARKIN. Does the Senator from Illinois think the drug companies are losing money on every bottle of pills a veteran buys? I can see him shaking his head. Obviously not. Veterans get their bottle of pills cheaper than anyone else. I bet my bottom dollar the drug companies are not losing a penny on any one of them. They are making money. They are just not making as much money as they are, say, if I went in and bought them.

I yield for a question without losing my right to the floor.

Mr. BYRD. Mr. President, I do not have a question except as to what the status of the legislation is at this point.

Mr. REID. Will my friend from Iowa yield so I can respond to the Senator from West Virginia?

Mr. HARKIN. I yield, without losing my right to the floor, to the assistant minority leader.

Mr. REID. I say to my friend from West Virginia, the distinguished Senator, we are trying to get some votes lined up shortly. It is my understanding Senator BYRD wishes to speak for 10 or 15 minutes on the Durbin amendment.

Mr. BYRD. I would.

Mr. REID. Senator DORGAN wishes to speak for how long on the Durbin amendment?

Mr. DORGAN. Five minutes.

Mr. REID. Does Senator STABENOW wish to speak on the Durbin amendment?

Ms. STABENOW. Five minutes.

Mr. REID. And then Senator LINDSEY GRAHAM is here to speak on what?

Mr. GRAHAM of South Carolina. To call up my amendment, 2 minutes.

Mr. REID. Of course, the Senator from Iowa has the floor. How much longer does the Senator expect to speak?

Mr. HARKIN. I do not think I will be much more than a half an hour.

Mr. REID. That kind of defeats that theory.

Mr. HARKIN. I may not be that long. I think I can wrap up in a half an hour.

Mr. REID. So much for my ideas.

Mr. HARKIN. Mr. President, as I said earlier in response to the questions asked by my friend from Illinois, it is clear S. 1, the 654 pages, is a sham, a ruse, a bewildering, complex bill that is going to cause a lot of consternation for a lot of our elderly.

Again, to the Senator from Illinois, I say, our Government, instead of using our power and influence to negotiate for better drug prices and better drug coverage on behalf of American seniors, is choosing to nurture special interest groups and big campaign donors. Why is it other industrialized nations are spending between 30 and 50 percent less on drugs than the United States? To me it is a matter of priorities.

I end my comments by saying again, before this bill came, the Republicans took care of their friends, giving the wealthiest in this country nearly $1 trillion in tax breaks. Not only did we find the money to give every millionaire $93,000 in tax cuts, we made these tax cuts retroactive to January 1 of this year.

Less than a month later, here we are, and the Republicans tell us we do not have enough money to get seniors on a fixed income real help with their prescription drug costs. Instead, next year they get a card. If you are low income, you get a $600 debit card. And then 2 years from now—actually 3 years from now in 2006—we start this class business. Some are in this class, some in another class, and some in another class. Try to figure it out.

Our job in Congress should be to use our votes to provide security for seniors, not hand out profitable favors for special interest groups.

If we are going to live up to our promise to seniors—our promise to seniors—I ask, how many Senators in this body in the last couple of years have signed pledges not to privatize Medicare, not to privatize Social Security? Our senior citizens, I know in my State and I am sure around the country, have asked us to sign those pledges. I wonder how many here have signed them not to privatize Medicare and not to privatize Social Security.

If we are going to live up to those promises we made and those documents we signed and put their interests ahead of the special interests, the only vote on this bill is a resounding no, unless this Senate, in its wisdom, adopts the amendment offered by the Senator from Illinois, Mr. DURBIN, because the Durbin amendment will work.

The Senator from Illinois has developed a comprehensive and thoughtful alternative that truly gives what our seniors want and need: comprehensive coverage with the option of staying in Medicare.

Let's take a look at the key differences between S. 1 and the Durbin amendment.

Under S. 1, seniors have to pay a $275 deductible every year. Under the Durbin amendment, there is no deductible. Under S. 1, the bill before us, seniors pay a premium not set by law but set by insurance companies, which can be raised at any time. Under the Durbin amendment, seniors will know what premium they will pay because it will be set by law. Under the bill before us, even after the deductible, seniors will still have to pay 50 percent of their drug costs, the result of which means more than one-third of seniors will actually lose money if they participate.

I have a chart that illustrates the so-called savings for seniors under the proposed drug benefit. Let's say you are a senior citizen and you are making over $14,369 a year—let's say you make $15,000 a year. Your total drug costs are $500. Your monthly drug costs about $42. Your share is $389.50. Your premium is $420. Your total out-of-pocket expenses for that year are $809.50. That means you lose $310 on your drugs. You pay in but you lose.

Let's say your total costs are $1,000 a year. Your out-of-pocket expenses are $1,057.52. You lose $58. It is not until you reach just about $1,200 a year in drug costs that you break even. If your drug costs are less than that, you lose. Try telling that to senior citizens in your State.

Let's face it, if you have an income of $15,000 a year and you live up in some of our northern States and you have a high heating bill in the wintertime, maybe you have other extraneous expenses, maybe you have to rent a place, you are not a homeowner and you have to pay rent, you have to eat, you have to buy clothes, and you are paying $500 a year in drug costs, and yet you are going to lose money? Wait until that hits the streets.

Under the Durbin amendment, seniors will pay only 30 percent of their drug costs, getting much closer to what I pay now—25 percent to 30 percent. That is it. They will know in advance they are only going to pay 30 percent.

Under the bill before us, seniors will actually lose coverage for a period of time, even while they continue to pay their premium. That is that donut. When the drug costs reach $4,500, seniors stop getting any benefits until they reach $5,800. That is $1,300 they pay out of pocket, but they continue to pay their premiums.

Under the Durbin amendment, there is no donut hole, no coverage gap.

Most importantly, the bill before us will create mass confusion for seniors who stay in traditional Medicare because for the first time they will have to negotiate private plans and deal with the possibility, if not the likelihood, that plans will come into and pull out of States year after year. The result of this volatility will be a completely unpredictable system, where seniors not only will not know what plan they will be in from year to year, but they may have to switch drugs every year as plans with different formularies come in and out of the system.

Think about the confusion that is going to cause.

The Durbin amendment opens Medicare to private competition, but it includes a real and dependable prescription drug benefit delivered by Medicare. Basically, they have stated we will let them compete with Medicare and we will provide those choices to the elderly, but the Durbin amendment is real and dependable. The Durbin amendment makes other improvements on the underlying bill, but the bottom line for seniors is simple. The Durbin amendment delivers what the bill does not, a meaningful, dependable, reliable prescription drug benefit to all seniors in all States at all times.

Now, some might say, yes, but the Durbin amendment sunsets at the end of 2009. Well, before any of my Republican colleagues start screaming bloody murder and start casting aspersions about how this may be a gimmick and a hoax, let's remember this is exactly the same thing they did, with the support of the President, to shoehorn almost a trillion dollars in tax cuts for the wealthy into a $350 billion price tag.

I always say if it is good enough for the wealthy, it ought to be good enough for our seniors, too. Let them have the same deal.

Again this is about priorities. Earlier this year the President and the Republican Congress made it clear their top priority was tax breaks to those least deserving and least in need. That is the result of their first effort. I am sure there will be more before the year is out. I already hear them over in the House talking about it. It netted each millionaire in this country a $93,000 tax cut this year.

What the Durbin amendment says to our seniors is they are also our priority. Instead of bleeding our Treasury dry by giving every tax receipt back to the richest in the Nation, the Durbin amendment says before we get too far ahead of ourselves on tax breaks for the wealthy or anything else, we are going to get seniors the help they need.

Some will come and argue his plan is too expensive, that it is not sustainable. All I can say is, this plan has roughly the same short- and long-term costs as the tax breaks we passed.

All I ask is, what are the priorities of my colleagues? As luck would have it, both the tax breaks for the wealthy and under the Durbin amendment would sunset at roughly the same time. So in the not too distant future, the new Congress and new President can again set their priorities and decide which should be continued. Should we continue the tax breaks for the wealthy or should we continue a reliable prescription drug benefit under Medicare for the elderly? That is a choice a future Congress could make.

We should not foist upon our elderly a misguided, complex, befuddling, bewildering—and these are not my words; these are words used by others—system of prescription drug coverage that will not meet their needs, that will cost them more money, that will actually cost some of them more than what they get out of it. That is what we are doing. That is what we are going to foist upon the elderly of this country, unless we adopt the Durbin amendment. If we do, then this Senator can wholeheartedly support this bill and vote for it. If not, then I will not be a part of a sham, of a ruse, to tell our elderly they are going to get something when they are not, to hold out a false hope when in fact they are not going to get the benefits they have asked us to give to them.

This Senator's priority is with the elderly. Let's deal with them first. Let's meet their needs first. Then if we have something left over, let's think about tax breaks for the wealthy. Let's not do it the other way around.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. SUNUNU. Mr. President, I ask unanimous consent the following Members be recognized to speak: Senator GRAHAM for 5 minutes, Senator BYRD for 10 minutes, Senator STABENOW for 5 minutes, Senator DOMENICI for 10 minutes, Senator DORGAN for 5 minutes, and Senator ENSIGN for 5 minutes.

Mr. REID. Mr. President, reserving the right to object, we had some votes tentatively scheduled after and that appears to have fallen by the wayside. I therefore ask that Senator BYRD be recognized for up to 15 minutes rather than 10 minutes, and Senator STABENOW for 10 minutes instead of 5 minutes, and I ask that the Senator from New Hampshire accept that modification to the unanimous consent request.

Mr. SUNUNU. Mr. President, I am happy to accommodate that request. In addition, I ask that Senator DOMENICI be recognized for 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from South Carolina.

AMENDMENT NO. 948, AS MODIFIED

Mr. GRAHAM of South Carolina. I ask unanimous consent the pending amendments be set aside so I can offer my amendment. I have a modified amendment at the desk that I call up, amendment No. 948.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the modified amendment.

The assistant legislative clerk read as follows:

The Senator from South Carolina [Mr. GRAHAM] proposes an amendment numbered 948, as modified.

The amendment is as follows:

(Purpose: To provide for the establishment of a National Bipartisan Commission on Medicare Reform)

At the appropriate place in title II, insert the following:

Subtitle —National Bipartisan Commission on Medicare Reform

SEC. 01. MEDICAREADVANTAGE GOAL; ESTABLISHMENT OF COMMISSION.

(a) Enrollment Goal.—It is the goal of this title that, not later than January 1, 2010, at least 15 percent of individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title should be enrolled in a MedicareAdvantage plan, as determined by the Center for Medicare Choices.

(b) Failure to Achieve Goal.—If the goal described in subsection (a) is not met by January 1, 2012, as determined by the Center for Medicare Choices, there shall be established a commission as described in section 2.

SEC. 02. NATIONAL BIPARTISAN COMMISSION ON MEDICARE REFORM.

(a) Establishment.—Upon a determination under section 01(b) that the enrollment goal has not been met, there shall be established a commission to be known as the National Bipartisan Commission on Medicare Reform (in this section referred to as the "Commission").

(b) Duties of the Commission.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under sections 1817 and 1841 of such Act (42 U.S.C. 1395i and 1395t), including—

(A) the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals; and

(B) the ability of the Federal Government to sustain the program into the future;

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals and trends in employment-related health care for retirees;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered under, and beneficiary contributions to, the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5) and (6) should be implemented;

(8) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program;

(9) make recommendations regarding a comprehensive approach to preserve the medicare program, including ways to increase the effectiveness of the MedicareAdvantage program and to increase MedicareAdvantage enrollment rates; and

(11) review and analyze such other matters as the Commission determines appropriate.

(c) Membership.—

(1) Number and appointment.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairperson of the Commission, shall be appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) Deadline for appointment.—Members of the Commission shall be appointed by not later than October 1, 2012.

(3) Terms of appointment.—The term of any member appointed under paragraph (1) shall be for the life of the Commission.

(4) Meetings.—The Commission shall meet at the call of the Chairperson or a majority of its members.

(5) Quorum.—A quorum for purposes of conducting the business of the Commission shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) Vacancies.—A vacancy in the membership of the Commission shall be filled, not later than 30 days after the Commission is given notice of the vacancy, in the same manner in which the original appointment was made. Such a vacancy shall not affect the power of the remaining members to carry out the duties of the Commission.

(7) Compensation.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) Expenses.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) Staff and Support Services.—

(1) Executive director.—

(A) Appointment.—The Chairperson shall appoint an executive director of the Commission.

(B) Compensation.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule under title 5, United States Code.

(2) Staff.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) Applicability of civil service laws.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) Experts and consultants.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) Physical facilities.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) Powers of Commission.—

(1) Hearings and other activities.—The Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties under this section.

(2) Studies by GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties under this section.

(3) Cost estimates by congressional budget office and office of the chief actuary of the centers for medicare & medicaid.—

(A) In general.—The Director of the Congressional Budget Office or the Chief Actuary of the Center for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties under this section.

(B) Reimbursements.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) Detail of federal employees.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties under this section. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) Technical assistance.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties under this section.

(6) Use of mails.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) Obtaining information.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties under this section, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairperson of the Commission, the head of each such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

(f) REPORT.—Not later than April 1, 2014, the Commission shall submit to the President and Congress a report and an implementation bill that shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive the approval of at least 11 members of the Commission.

(g) TERMINATION.—The Commission shall terminate on the date that is 30 days after the date on which the report and implementation bill is submitted under subsection (f).

SEC. 03. CONGRESSIONAL CONSIDERATION OF REFORM PROPOSALS.

(a) DEFINITIONS.—In this section:

(1) IMPLEMENTATION BILL.—The term "implementation bill" means only a bill that is introduced as provided under subsection (b), and contains the proposed legislation included in the report submitted to Congress under section 02(f), without modification.

(2) CALENDAR DAY.—The term "calendar day" means a calendar day other than 1 on which either House is not in session because of an adjournment of more than 3 days to a date certain.

(b) INTRODUCTION; REFERRAL; AND REPORT OR DISCHARGE.—

(1) INTRODUCTION.—On the first calendar day on which both Houses are in session immediately following the date on which the report is submitted to Congress under section 02(f), a single implementation bill shall be introduced (by request)—

(A) in the Senate by the Majority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate; and

(B) in the House of Representatives by the Speaker of the House of Representatives, for himself and the Minority Leader of the House of Representatives, or by Members of the House of Representatives designated by the Speaker and Minority Leader of the House of Representatives.

(2) REFERRAL.—The implementation bills introduced under paragraph (1) shall be referred to any appropriate committee of jurisdiction in the Senate and any appropriate committee of jurisdiction in the House of Representatives. A committee to which an implementation bill is referred under this paragraph may report such bill to the respective House without amendment.

(3) REPORT OR DISCHARGE.—If a committee to which an implementation bill is referred has not reported such bill by the end of the 15th calendar day after the date of the introduction of such bill, such committee shall be immediately discharged from further consideration of such bill, and upon being reported or discharged from the committee, such bill shall be placed on the appropriate calendar.

(c) FLOOR CONSIDERATION.—

(1) IN GENERAL.—When the committee to which an implementation bill is referred has reported, or has been discharged under subsection (b)(3), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the implementation bill, and all points of order against the implementation bill (and against consideration of the implementation bill) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the implementation bill is agreed to, the implementation bill shall remain the unfinished business of the respective House until disposed of.

(2) AMENDMENTS.—An implementation bill may not be amended in the Senate or the House of Representatives.

(3) DEBATE.—Debate on the implementation bill, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the resolution. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the implementation bill is not in order. A motion to reconsider the vote by which the implementation bill is agreed to or disagreed to is not in order.

(4) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on an implementation bill, and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the implementation bill shall occur.

(5) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to an implementation bill shall be decided without debate.

(d) COORDINATION WITH ACTION BY OTHER HOUSE.—If, before the passage by 1 House of an implementation bill of that House, that House receives from the other House an implementation bill, then the following procedures shall apply:

(1) NONREFERRAL.—The implementation bill of the other House shall not be referred to a committee.

(2) VOTE ON BILL OF OTHER HOUSE.—With respect to an implementation bill of the House receiving the implementation bill—

(A) the procedure in that House shall be the same as if no implementation bill had been received from the other House; but

(B) the vote on final passage shall be on the implementation bill of the other House.

(e) RULES OF SENATE AND HOUSE OF REPRESENTATIVES.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementation bill described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 04. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this subtitle for each of fiscal years 2012 through 2013.

Mr. GRAHAM of South Carolina. Mr. President, I offer this amendment with the hope we can negotiate a resolution and have it accepted as part of the package. The chairman of the committee has been very gracious in trying to bring that result about. Briefly, this amendment costs no money. The whole idea of reform in the bill is a new alternative traditional Medicare that will be created, called Medicare Advantage, to which people will gravitate, that allows preventive medicine practices that currently do not exist, bringing modernization to Medicare, making it more user friendly and cost effective. That is the goal of the bill, by creating a new option.

Estimates range from 2 to 43 percent participation. For those looking for reform, the only vehicle for reform in this bill I can find is the idea of Medicare Advantage, and that is somewhat minimal.

This amendment addresses the problem of "what if." What if in 2010, after 4 years of enactment of this bill, the traditional Medicare is the primary choice made? What if the Medicare Advantage Program does not receive 15-percent enrollment? If it has not achieved 15-percent enrollment, creating efficiency and modernization is going to be lost.

This is the last time maybe in a generation to look at traditional Medicare and not only improve it for the senior citizen but improve it for their grandchildren who are going to have to pay for it.

Traditional Medicare, as I understand this bill, is pretty much unaffected in terms of reforms. Having a prescription drug benefit can be a good idea because it emphasizes preventive medicine practices. Having prescription drugs reasonably available can keep people healthier longer and improve the quality of life and keep them out of the hospital and do a lot of good things. But Medicare is $13 trillion short of the money we need. This bill is going to be $4 trillion additional liability. This is a chance as a body to look at the structural problems that Medicare faces.

We are increasing the age limit to 67 for Social Security eligibility. It seems to me that is a good idea given the fact people are living longer. I would like to do that with Medicare. I don't think that is oppressive. I think that is fair to grandparents and grandchildren. I believe we should have a means test. If we have a prescription drug benefit, I believe you should be asked to participate based on your ability to participate because $3 out of $4 coming into Medicare Part B comes from the General Treasury. It is truly a subsidized entitlement. These are the type of reforms I would like to see happen. I don't think they are going to happen. And the Medicare Advantage Program is the only alternative that has a reform element to it.

My amendment says in 2010, after 4 years, if 15 percent of Medicare recipients are not enrolled in Medicare Advantage, if you cannot get 15 percent to pick Medicare Advantage—you get 2 years to reach 15 percent, January of 2012. If you have not achieved 15 percent by January 2012, it is a chance to have a fail-safe mechanism requiring a commission to be appointed. The President, the House, and the Senate would appoint nine members to this commission who would study and report back to Congress in a timely manner what would be needed at that point in time to save Medicare from bankruptcy to make sure it does not blow a hole in the budget and make sure it is efficiently run. This commission has 18 months to create a work product, legislation that comes back to the House and Senate, and we vote up or down on that legislation.

This amendment will force in the future reforms that may not be achieved if we do not have adequate participation in Medicare Advantage. It takes the issue away from Congress in the sense of the commission is required to look at it and bring it back to Congress for our input and our vote. I believe we need an element like this in this entitlement bill because if we do not have a way down the road to take a second look at this program, we are all going to suffer greatly in this Nation.

It costs no money. Hopefully, it will never have to happen. If we cannot get 15 percent of Medicare recipients to enroll in Medicare Advantage, there will be no way to reform this program. I hope we can find a resolution in a bipartisan fashion and this amendment will be accepted.

I yield the floor.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Mr. President, before we pat ourselves on the back, pop the champagne bottles, and fan out across America to tell seniors that their prescription drug worries are now an issue of the past, let's take a closer look at the Medicare proposal before us.

The more I read through this Medicare bill, the more I become convinced that history is once more repeating itself. I can recall a painful experience during my majority leadership when an outraged citizenry, composed mostly of seniors, forced Congress to repeal the ill-fated Medicare Catastrophic Coverage Act back in 1989. The year before, Congress was engaged in a Medicare debate eerily similar to the one we are having at this time. A bipartisan compromise was reached to make the most sweeping change in Medicare's then 23 years of existence.

Congress agreed to two key changes to the Medicare program—a prescription drug benefit and a "stop-loss" protection from catastrophic medical bills. Facing deficits as we do today, Congress, in its infinite wisdom, decided that beneficiaries should pay for the new benefits themselves, with the wealthiest paying the most. The new law included a complicated benefit that was too difficult to explain and a lengthy delay in the benefit's taking effect. In the end, seniors saw the bill, were confused as to what they were getting in exchange, and wanted no part of it. Hence, it was repealed in the next session. We are poised to make the same mistake again.

I foresee a great deal of confusion and dismay occurring around kitchen tables and in corporate boardrooms across America when people actually start to read beyond the newspaper headlines and see the fine print of this plan 3 years from now. Seniors may not know whether to laugh or weep. And if no one signs up for this new Medicare plan, it will fail and fail miserably.

What incentive do seniors have to sign up for a plan that is full of coverage holes, up-front costs, and confusing paperwork? What incentive do insurance companies have to enter an untried, untested, drug-only insurance market? How can an insurance company make a plan work when almost every single participating insuree makes a claim?

Many of the 335,000 Medicare beneficiaries in West Virginia are struggling just to make ends meet and pay for the prescription medicines that sustain them. In West Virginia, the average annual income of a Medicare beneficiary is a mere $10,800.

I have to wonder, what does this prescription drug proposal mean to a 75-year-old widow from West Virginia who lives off her late husband's pension of $21,000 a year, but has $5,700 per year out-of-pocket drug costs to treat her diabetes, high blood pressure, osteoporosis, and elevated cholesterol levels?

To take advantage of this new, so-called drug benefit, she would have to spend at least $420 in yearly premiums, a $275 deductible, and then she and Medicare would each pay 50 percent of her drug costs until the costs reach $4,500, after which she would pay the remainder of her $5,700 medical bill—about another $1,000 in other words. And she could very well have to spend more given that the deductible, premiums, and copay amount are not defined in this legislation. Does this sound confusing? I am confused just trying to describe it.

Ultimately, Medicare would pay about a mere $2,000 of this poor West Virginia widow's $5,700 drug costs, a benefit of only about 35 percent. What a flimsy benefit. It doesn't even come close to the approximately 70 percent prescription drug subsidy Members of Congress receive under the Federal Employees Health Benefit Program. We wouldn't dare design health benefits for ourselves in this way.

Under this legislation, seniors in similar situations in West Virginia and across the Nation would still be forced to resort to pill splitting and desperately foregoing the medicines their doctors have prescribed.

Let's slow down and take a better look at this legislation. President Bush says he wants the Senate to pass a bill before the July recess, and so we're now engaged in a headlong rush to do just that. Members have been sitting around for days just waiting for Congressional Budget Office staff, who have been working nonstop around the clock to produce, and in some cases, reproduce cost estimates that fall within the too small budget parameters that we have required for passage. This is no way to legislate on a program of such great importance to the citizens of this country. We need more time to explain this plan to our elderly citizens. Don't we need their feedback?

I doubt that our Nation's seniors will be excited about accepting a mere half-loaf benefit. Seniors will probably want no part of it. Just like they did almost 15 years ago, when I was majority leader they may revolt, and Members of Congress could be back here scratching their heads and scrambling to find a solution and save their seats.

Senator DURBIN and I and other Senators have offered a substitute Medicare amendment that actually makes sense, and I am proud to be a cosponsor of it. The Medicare benefit under the Durbin amendment has no deductible, a guaranteed $420 yearly premium, no gaps in coverage, and a catastrophic cap on drug spending at $5,000. The Durbin amendment would also allow seniors to receive their prescription drug benefit through the traditional Medicare program or through an available private plan if they desire. Seniors would receive their prescription drug benefit as soon as possible, rather than having to wait until 2006, after the next elections. Finally, the Durbin amendment would allow the Federal Government to use the leveraging power of millions of seniors to negotiate lower prices for prescription medications.

The same widow in West Virginia with $5,700 in drug costs, would only have to spend about $2,000 under the Durbin amendment plan versus the almost $4,000 she would have to pay under the Grassley-Baucus Medicare bill before us today. I think it is quite obvious which Medicare plan the elderly citizens from West Virginia would choose.

This legislation, as it stands, also does nothing to address the high cost of prescription drugs. We should do better for our seniors. And we can do better. I believe that we can improve this legislation through the adoption of the Durbin amendment. Let's not shortchange our seniors. They deserve our very best efforts.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I rise also to support and I am pleased to cosponsor the Durbin amendment. But first, I ask unanimous consent to set aside the pending amendment so I may offer three amendments.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENTS NOS. 1075, 1076, 1077

Ms. STABENOW. I send the amendments to the desk and ask the reading of the amendments be waived.

The PRESIDING OFFICER. Without objection, the clerk will report the amendments by number.

The assistant legislative clerk read as follows:

The Senator from Michigan [Ms. STABENOW], for herself and Mr. LEVIN, proposes en bloc amendments numbered 1075, 1076, 1077.

The amendments are as follows:

AMENDMENT NO. 1075

(Purpose: To permanently extend a moratorium on the treatment of a certain facility as an institution for mental diseases, and for other purposes)

On page 676, after line 22, add the following:

SEC. . EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking "until December 31, 2002", and

(2) by striking "Kent Community Hospital Complex in Michigan or."

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

AMENDMENT NO. 1076

(Purpose: To provide for the treatment of payments to certain comprehensive cancer centers)

On page 438, between lines 10 and 11, insert the following:

SEC. . COMPREHENSIVE CANCER CENTERS.

(a) IN GENERAL.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by striking "or" at the end of subclause (III);

(B) by striking the semicolon at the end of subclause (IV) and inserting ", or"; and

(C) by inserting after subclause (IV) the following:

"(IV) a hospital that is a nonprofit corporation, the sole member of which was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that specifies in its articles of incorporation that at least 50 percent of its total discharges must have a principal finding of neoplastic disease, as defined in subparagraph (E), and that is a freestanding facility licensed for less than 131 acute care beds;"; and

(2) in subparagraph (E), by striking "(II) and (III)" and inserting "(II), (III), and (IV)".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning after the date of enactment of this Act.

AMENDMENT NO. 1077

(Purpose: To provide for the redistribution of unused resident positions)

On page 438, between lines 10 and 11, insert the following:

SEC. . REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting "subject to subparagraph (I)," after "October 1, 1997,";

(2) in subparagraph (H)(i), by inserting "and subject to subparagraph (I)," after "subparagraphs (F) and (G),"; and

(3) by adding at the end the following new subparagraph:

"(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

"(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

"(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

"(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

"(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

"(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

"(ii) REDISTRIBUTION.—

"(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

"(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

"(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

"(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

"(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

"(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

"(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

"(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

"(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.".

(b) NO APPLICATION OF INCREASE TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: "The provisions of subsection (h)(4)(I) (determined without regard to clause (ii) thereof) shall apply with respect to the first sentence of this clause in the same manner as such provisions apply with respect to subparagraph (F) of such subsection.".

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(i)(II) of the Social Security Act (as added by subsection (a)).

AMENDMENT NO. 994

Ms. STABENOW. Mr. President, I believe this is an incredibly important vote. This amendment really is about providing seniors with what they are asking. The seniors of this country, and those who are disabled, deserve our best effort. As we come together we have been spending this time putting together prescription drug coverage for seniors, debating about how to lower prices, and the Durbin amendment—which I am pleased to cosponsor—does just that. I believe the Durbin amendment is our best effort. That is what seniors are asking for.

They are not asking for more insurance forms to wade through. Most of them are not asking for more choice. They are asking for prescription drug coverage.

I was talking to someone today at lunchtime who is on Medicare. He said to me, Whatever you do, please do not do anything to Medicare. It is simple; it is easy; it is dependable; they handle my secondary insurance.

He said, I actually have a 1-800 number I call and a real person answers the phone.

He was going on and on talking about how successful and how helpful Medicare has been for him.

I said, Boy, I would love to have you come to the floor and share this with my colleagues, because we keep hearing about how awful the traditional Medicare system is.

The conversation I had with the gentleman at noon reflects what I commonly hear at home. As I said before, the seniors of this country consider Medicare—and I wish we would consider Medicare—a great American success story.

Why is the Durbin amendment the best effort we can provide? Why is it the best we can give to our seniors?

First of all, working within the dollars that have been put aside in the budget resolution, this does not require any additional funds. But, by doing this, by putting the priority on our seniors and those receiving the health care, by making that the focus, that the priority, you can create a very different benefit if your priority is to start with: What do our seniors need? What do those who are disabled need? Let's start with a system that is designed for them.

When we do that, we can create a system that does not have any deductible, no deductible at all. We can create a system that guarantees what the premium will be. Not a suggested premium like we have in the underlying bill, but we can say it is $35 a month; it is guaranteed; it is in the law. Seniors will know what to count on and what to claim for.

We can do a better job on cost savings. Instead of saying we will cover 50 percent of the cost, we can cover 70 percent. That is a big difference—70 percent of the cost.

We can make sure there is no coverage gap. In fact, no one will lose their benefits, their help with their medical payments, as they move up with greater and greater bills. The higher the bill, the more they would continue to get help.

One of the reasons this can be done is because there is a real effort to get the best possible price for our seniors. The real issue in all of this debate—and the reason we have all this convoluted, complicated process that has been going on—is the pharmaceutical industry wants to make sure all the seniors are not in one plan where they can negotiate a big group discount as with any other insurance plan. We know the veterans of this country do not pay retail because the VA gets a group discount. Well, the Durbin amendment would give our seniors that group discount. And if you do that, you can lower prices. It is still a fair return, but you can lower prices, and use those savings to provide a better benefit, to make sure there is no deductible, to make sure there is no gap in coverage for our seniors.

We also can deal with a very important issue for many of us; that is the question of employer benefits. We want to make sure our employers do not have the incentive to drop benefits. There are many people in my great State of Michigan who I have worked with in our great auto industry, and other manufacturing industries, and others that have good benefits now. We are grateful to the employers in the industries involved, and they have a history of good benefits, good wages, and good employees, I might add. We are very proud of the work that goes on in Michigan.

Now that many of our Michiganites have retired, we want to make sure we provide incentives for employers to maintain those benefits. Those lifesaving benefits are absolutely critical. And we know that in the underlying bill, unfortunately, the projection is there will be an incentive for many employers to drop or reduce benefits, which is not acceptable.

What we have in this option, in this best offer that is in front of us, is the ability to count the employer benefits toward out-of-pocket spending, which is an encouragement for employers to continue to provide the benefits they currently provide to their retirees.

Under the Durbin amendment, you would have the option of a private plan. If you would like to go into an HMO or PPO, if that is a positive experience for you, you have that choice. But it also makes sure there is a Medicare choice always, that you have an opportunity to stay within Medicare.

Then one of the most important parts of this amendment is the fact that it would take effect as soon as possible. I think one of my concerns is with all of the talk and all the news reports about a new prescription drug benefit, it is not clear to our seniors that, in fact, no help in terms of a benefit is available until 2006. There is a discount card, yes, but nothing in terms of the bill taking full effect until 2006. So this amendment would say "as soon as possible." As soon as possible we want to make sure this takes effect.

The Durbin amendment puts forward our best effort. It is a better benefit. It is a defined benefit so there is dependability. It reduces prescription drug costs. It maintains choice for those who wish to have another choice other than traditional Medicare. It creates a reliable Medicare benefit fallback if you choose private insurance. If your private carrier drops you, such as happened to my mother with her Medicare+Choice plan, you would always be able to have Medicare as a permanent choice for you if that happens. We incentivize employers to maintain benefits. And, finally, the Medicare-delivered benefit can be implemented faster.

There is a lot of good work and good will among all of our colleagues to try to develop and pass a prescription drug benefit here in the Senate. I believe our seniors deserve the very best we can offer, something that is straightforward, is dependable, is reliable—a system that is based on what is best for them, not what is best for insurance companies or pharmaceutical companies or any other interest but what is best for them.

Medicare has been a great American success story. It works. It just needs to be updated. It just needs to be modernized to cover prescription drugs. I believe it also should be modernized to cover more preventive efforts and other kinds of improvements that will continue to strengthen Medicare and allow it to modernize and improve with the times.

We can do that. We can do that without going to a complicated, convoluted system that focuses more and more on efforts that ultimately could privatize Medicare.

I urge my colleagues to join in support of the Durbin amendment. Give our seniors what they are asking for.

I will share with my colleagues a chart I have used many times on this floor. Right now, 89 percent of the seniors of this country are in Medicare. They are asking—I am very confident they are asking—for the Durbin amendment. I encourage my colleagues to support it.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Nevada.

Mr. REID. Mr. President, I ask unanimous consent that if there is not a vote called following the statement by the Senator from Nevada, Mr. ENSIGN, Senator DURBIN be recognized for 15 minutes, Senator SMITH of Oregon for 5 minutes, and Senator NICKLES for 20 minutes to speak on this bill or any pending amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico has the floor.

Mr. DOMENICI. Mr. President, I rise today to speak about this legislation. Perhaps some will not recognize my speech at all because I know there is $12 billion to be resolved, and I understand it is going to be resolved. I am speaking as if we have finished our work and we are going to vote. I am here to tell the Senate and anybody interested why I am going to vote for this legislation.

First of all, we need prescription drugs for our senior citizens.

Secondly, we have a situation, of which I am absolutely positive. From what I have heard, if I were attending the meetings in the Democratic caucus, I would hear the Democratic Senators who are informed on the subject stand up and talk about how bad this bill is. I would hear them say that it does not do enough, that it does not take care of enough poor people, that it does not have enough choice, and that all the seniors who are currently on Medicare are expected leave and go somewhere else. That is not any good.

And just as sure as that is going on, and I have inquired before making this speech if that is the case, I go to our Republican caucuses, and I hear one Senator after another speak about the shortcomings of this bill. Some speak about it with a clear-cut: "I am not going to vote for it." But many speak of it in terms of: "I just want to let you know how bad I think it is. I don't want to talk you out of it, I just want to tell you how bad it is." One Senator after another, then another: "I just want to tell you how bad it is. It just won't work."

Then somebody else on this side begins speaking about it from fiscal policy, and they say: "It is going to cost too much. It is going to break us." And there are Senators in the other caucus saying: "We are not reforming the Medicare system, and it's going to go broke. We are just adding more debt to that system." Now again, I have not been there, but I asked.

Then I go to our caucus, and I hear the same thing: "The Medicare system is already somewhat bankrupt. It is not going to have sufficient money in a few years. We are going to have to start finding money for it somewhere. And this is going to add, some say, $4.5 trillion." That is what we have been hearing in our caucus. Some are saying: "No, I don't want you not to vote for it, but I just want to tell you about all these problems."

I want to tell you I am going to vote for it because I am a hope-filled Senator. I am hope filled about the future of the American economy and American prosperity. I am hope filled about American ingenuity. American breakthroughs, American science achievements, and American wellness achievements. I want to tell you about why I am hopeful.

First, we have mapped the human genome system during our lifetime. This means that we currently know where the aberrations in the human genome system are, and where all of the major diseases lie within the chromosome system of the human anatomy. That is an unheard of achievement.

Why do I speak of it while I try to talk about Medicare and prescription drugs? Because we are not living in a stagnant world. We are not living in a world that during the next 10 or 15 or 20 or 30 years that we are going to have just what we have today in terms of wellness, in terms of prescription drugs, in terms of curing illnesses. We are in the midst of the most gigantic breakthroughs in wellness. We are in the midst of breakthroughs in terms of finding cures to all kinds of human ailments and all kinds of drug breakthroughs which are going to cure people and make them well. There sits that breakthrough called the mapping of the human genome system.

At the same time we are passing this bill, science is far from stagnant. There is going on in science today something called nanoscience. Nanoscience involves the actual manipulation of atoms to create new systems and new products. While we are wondering if we are going to be able to afford this drug system we are currently putting in place, out there in all kinds of centers of higher learning, American scientists and scientists in the rest of the world are developing technology involving the manipulation of atoms to create new systems and new products.

I believe within 15 to 20 years there will be so many new products and things that will be manufactured and made that will add to the productivity of America. I mention it because it makes my vote tomorrow on this bill hope filled. I believe there are going to be productivity changes, there are going to be drug cures, there are going to be medicinal cures, there will be wellness cures. All of these things are going to happen because we are not going to be living in a stagnant system. We are going to deliver under this prescription drug bill the drugs our people need; principally with the money going to the poorest, who need the most help, and then moving it upwards so that those who are least in need will get the least help.

While we have Senators on each side finding fault with the proposal, which probably means it is pretty good, we also find them saying: "We can't afford it."

I am here to suggest we can afford it. As a matter of fact, I am here to say we can't afford not to do it. I am here to say with all the breakthroughs that are going to occur, we must put in place a system that is more apt to take advantage of those breakthroughs. I believe the distinguished leader of the Senate who has spoken on this subject is correct. If we have these HMOs and PPOs and these delivery systems, they are more apt to take advantage of the breakthroughs that are going to occur because of nanoscience, because of the genome, and then because there is also a huge new system called microtechnologies. Microtechnologies, believe it or not, are going to create all kinds of tiny little engines, engines that are going to be able to do all kinds of things that make products and solve problems and cure health problems.

The microtechnology system means that little tiny engines will be produced on a chip just like the chip that we now talk about. There will be engines on that chip. And, if you look at that chip with a microscope, you will actually see little engines working. Those engines may, indeed, be put in the human body to go after certain ailments and just take them on as little engines. And the illnesses will disappear or perhaps be ameliorated.

All of these things are going to happen. Nobody at the CBO, nobody at the other agencies who have evaluated whether we will be able to pay for this bill and whether we will be able to deliver on this bill, have figured in those kinds of gigantic breakthroughs that are going to occur in this American system. In fact, none of them are figuring the productivity breakthroughs that are going to occur, in this Senator's opinion, from nanoscience and microtechnology breakthroughs. Nor are they taking into consideration breakthroughs on the medicinal side that will result from our continuation of funding the NIH at about 10-percent growth a year.

I add one caveat. If I were voting on this bill and were asked, "What should you do in addition to this bill?" I would adopt a resolution that would require mandatory funding of the physical sciences at about 10 percent a year just like we did the NIH for the next 10 years. Then you would have the great instruments of breakthrough—the NIH, the National Institutes of Science, plus American ingenuity and business. You would have the physical sciences funded at a much higher rate than we are funding them so that nanoscience and the others I have spoken of can have their breakthrough day. So that we can, in fact, deliver what we plan to deliver under this bill.

I close where I started, by saying: For all intents and purposes, the bill is finished. It is probably not perfect, but no democracy can draw a perfect bill. It is probably better than those who are saying how bad it is, and it is probably slightly worse than those who are running around saying how great it is. But it is pretty good in terms of a delivery system that can get us started and that we can always change.

I don't fear the fact that we have a large group of Americans coming along, the generation that we are worried about, the baby boomers. I am not concerned about how we are going to pay for them and how we are going to take care of them. I believe the breakthroughs I have just discussed generally will be specific breakthroughs that will be occurring rapidly in large numbers, every year for the next 20 to 30 years. I believe that 20 years from now we will not recognize the prescription drugs being delivered today. We will not recognize what the drugs are being delivered to cure, and what they are curing because we will have made so many changes. And, almost all of these changes will be for the positive. By applying human ingenuity, human knowledge, human capacity to such basic research as the human genome or the mapping of the chromosomes and the aberrations on the chromosomes which create diseases, we are going to find cures so that we won't have to be paying the drug costs because we will have found the cures for the sicknesses.

I thought it would be a good 15 minutes, maybe 10, while we had a few lax moments, to at least let one Senator put some comments in the RECORD that sort of set the tone for what he will be thinking about when he votes on this rather celebrated bill. I will be thinking about all the people we are going to help today, tomorrow, and next year. But I will also be thinking about all the changes that are going to occur because of these great sciences that I have just spoken of. We won't recognize what we are taking care of in 10 years. We won't recognize what medicines we are delivering. We won't recognize what diseases we are curing. And, frankly, it is entirely possible that we won't recognize the hospital system that we have delivering hospital care to our people if, in fact, the genome system really works as some people think it will.

Some are saying within 20 to 40 years we won't even have hospitals like the ones we have. There will be different kinds of institutions that will be delivering health care because of the capacity of the genome system to deliver health care in a completely different way. I hope that these words at least are helpful. They are to this Senator. They make me feel that I have something to say beyond coming down here and reading a bunch of numbers, which I used to have to do ad nauseam when I was chairman of the Budget Committee, and try to make all kinds of predictions on how you are going to have enough money for this, that, or the other thing.

To tell you the truth, this program is a close call in terms of whether we are going to be able to pay for it. It might be a close call as to whether it is the best program we can put together. But I tell you, it is the right thing to do. We don't have anything like it today, and our people, in particular poor people, suffer because of it. We ought to fix this as soon as we can and then go to work keeping an environment in our economic system that is vibrant and healthy. We must do this so that our system can do the things that I have been discussing over the next 15 or 20 years as this prescription drug benefit delivers the prescription drugs we are talking about.

I understand my time has elapsed, and I yield the floor.

The PRESIDING OFFICER (Ms. COLLINS). Under the previous order, the Senator from North Dakota is recognized for 5 minutes.

Mr. DORGAN. Madam President, we are about to vote at some point in the coming hour or two on a series of amendments, one of which will be the Durbin amendment, called the MediSAVE amendment. I wanted to make a couple of comments about that amendment.

I regret there being a substantial difference between what is promised and what is delivered to senior citizens with respect to a prescription drug benefit in the Medicare Program. My colleague from New Mexico indicated this is not a perfect bill. It is not. It is not a terrible bill; that is certainly the case as well. It addresses an issue that almost every Senator says needs addressing, and that is adding a prescription drug benefit to the Medicare Program. But I confess, the more we have dealt with this, the clearer it is to me that we are creating the most complicated, byzantine system that we possibly could have created.

We had opportunities, and will continue to have them, to improve this bill. We have missed most of them in the last few days.

This is a horribly complicated proposal. The Durbin amendment is an amendment that provides substantially improved benefits, and I will describe all of them. These benefits are not in the underlying legislation. The average cost of prescription drugs for senior citizens in this country is about $2,300 a year.

I might say that senior citizens are about 12 percent of America's population and they consume one-third of the prescription drugs, because we know when people reach retirement age, that status of life, many of them need prescription drugs in order to deal with their health issues.

Miracle drugs provide no miracles for those who cannot afford to take them. So we understand when people reach their declining income years, we ought to put together a prescription drug plan, attach it to the Medicare Program, and give them the assurance that we did 40 years ago, that if they are sick, they can go to a hospital; they would have Medicare; and if they need prescription drugs now, give them the assurance that they will have that opportunity.

We all have talked to senior citizens, particularly women, I might say, who live on fixed incomes, alone, at an advanced age, and have a very minimal amount of income, and who tell us: I cannot afford to take the prescription drugs the doctor says I must take.

I have talked about the woman who came to me at a meeting one day and said, "I have heart disease and diabetes." She must have been in her eighties. "The doctor prescribes medicines and I have no opportunity to buy them because I cannot afford them."

The fact is, we can do something about that. Now, my colleague, Senator DURBIN from Illinois, offers an amendment that creates a more meaningful benefit to senior citizens, No. 1. If they spend $2,300 a year, on average, for prescription drugs, the underlying bill will give them the benefit of somewhere around $600.

I will say that again. If they spend $2,300, we are going to say you have prescription drug coverage now. But the fact is, it only covers $600. My colleague's amendment will double that to $1,200.

Second, it creates a defined benefit. Under the plan before us, the Grassley-Baucus plan, there is no guaranteed benefit for seniors. The premiums are left to the insurance companies. Well, figure out what you can do, describe what the premium is going to be, and tell us later, would you?

That is no way for the Congress to define a prescription drug benefit. My colleague offers an amendment that has a defined benefit and that is exactly what our responsibility is, to define the benefit.

The other issue my colleague addresses is reduced cost. I offered an amendment that did pass that talks about the reimportation from Canada of prescription drugs, offering consumers the same drug, made by the same company, put in the same bottle, at a lower price because we pay the highest prices for prescription drugs in the world. You can buy exactly the same drug in Canada for a substantial discount.

My colleague says, with this prescription drug plan attached to the Medicare Program, what we ought to do is instruct Health and Human Services to negotiate the same group purchasing arrangements that we have done in the VA. We know how that works. We know what that saves.

There isn't any reason it should not be in this legislation. My colleague's amendment maintains a choice. People still have the opportunity to go into a private plan someplace, but they can come back to this plan, which will be a Medicare attached plan with better benefits.

So what my colleague from Illinois is offering is something that is much better, provides better benefits, provides defined benefits, provides downward pressure on prices, and it seems to me it represents what everybody in this Chamber has promised at one time or another but which none will deliver unless we start passing an amendment of this type.

We have missed a lot of good opportunities in recent days to pass amendments that would have improved this bill. I guarantee you, if we don't make some improvements, by the year 2006, when this becomes available—it should have been 2004, but the last amendment was turned down—there will be a lot of disappointed people, because they expect prescription drug coverage. Instead, they are going to get a fraction of that. We can remedy that.

The first step, it seems to me, is to vote for the Durbin amendment, the MediSAVE amendment. There are other amendments we can support as well which will make this the kind of prescription drug benefit in Medicare that senior citizens have been promised by virtually all of us.

Let's not deliver much less than we have promised. We have all promised to do something about this because we understand the need and we understand the urgency. When you reach those declining income years of life and need prescription drugs, the miracle drugs to save your life and to maintain a decent life, we understand the need to provide the help to finance those drugs. Many seniors simply cannot do it. They go to the grocery store that has a pharmacy in the back, and they have to figure out the cost of their drugs before they decide how much food they can afford. We have all heard those stories time and again.

The question is, are we going to do this? If the answer is yes, the question is, are we going to do it right? If the answer is yes, then it is voting for the Durbin amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Who is to be recognized next?

The PRESIDING OFFICER. Under the agreement, Senator ENSIGN of Nevada is to be recognized next.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I ask that the time of the Senator from Nevada be reserved, and we now turn to Senator DURBIN who is under the consent agreement.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Illinois.

Mr. DURBIN. Madam President, I thank my colleague from Nevada. I say to my colleagues, the more they study S. 1, the more they get to know it, the more concerned they have to be. I agree with the premise that we are making a commitment for the first time to provide prescription drug help to senior citizens. This is historic. We are doing the right thing.

Then when you look at the way this has been written and try to put it in the context of your parents or grandparents making these decisions, you understand the complexity of it, the fact it does not provide the protection which a lot of people promised. Basically, when it gets down to it, this is fraught with danger and peril.

The seniors understand that. When you sit down with senior citizens and say let me tell you what we are doing, what we are offering, the first thing they say to you is: Senator, what are you doing to keep the cost of drugs from running off the chart? I know you say you are going to help me by paying a certain percentage. What good is that percentage, Senator? My Social Security payments are going up, enough to keep up with the cost of inflation. So if you are not going to contain the cost of prescription drugs, what good is this?

That is a hard question, isn't it? But it is the right question. When you take a look at S. 1, the bill before us, the honest answer is nothing. What this bill says is we will rely on HMOs and private insurance companies to offer a prescription drug benefit.

My friend from Florida was an insurance commissioner. Senator NELSON has told us time and again what it means to deal with some of these insurance companies. As much as his expertise might bring to this debate, the greatest experts on HMOs are senior citizens. Ask them about coverage by HMOs. They despise HMOs. They know what these insurance companies are going to do.

First, they are going to nail them with a premium much more than 35 bucks a month. There is a provision in this bill which makes insurance sense but does not make common sense. It says if you have a chance to enroll in this voluntary program at the monthly premium—and let's assume for discussion it is $35—and you turn it down because it is voluntary and say you do not want to enroll in it, and then a year later or 2 years later, you think, maybe you should enroll in it, there is a provision in this bill that says your monthly premium may not be $35, it may be $100.

It makes insurance sense because it is called adverse selection. You do not want sick people to pay premiums just when they get sick. Think about that senior on a limited income who has to make a calculation as to how much they are going to pay. Look at that senior, if you are talking about a $1,000 annual prescription drug bill—I am sitting there with my mother or my grandmother, and she says to me: Son, should I pay this $35 a month? I know it is a $275 deductible.

I say: Mom, your payments are less than 100 bucks a month. You are going to end up paying more. You are not going to get any help from this plan because the first $1,000 your monthly premium is going to be added on to the help from the Government. You will be paying more than $1,000 for $1,000 worth of drugs. It may not make sense to you, mom.

OK, maybe I will not sign up.

Then a year or two later she starts getting sick and needs prescription drugs desperately, and now that monthly premium is no longer $35; it is $100. It makes insurance sense, but it does not make common sense, and that is one of the wrinkles in this bill.

When you ask the seniors about S. 1, this Grassley-Baucus bill, they are worried about this $35 premium that may be $50 or may be $100, and these are people, I hate to remind my colleagues, who are living on $400 or $500 or $600 a month.

To a Member of the Senate, $35 is not something you consider a life-threatening decision. For a senior citizen on a fixed income, a widow living alone in a small rural town in downstate Illinois or Florida, it is a big deal. Seniors have told us: I do not like this idea of $35 a month if it is not even certain that is what the premium is going to be.

Then you say to them: Incidentally, you are going to have to deal, once again, with HMOs and private insurance companies for your prescription drugs, and they start bailing out saying: What are you doing to me, Senator? I do not trust these people. That is why almost 90 percent of the people on Medicare do not sign up for the Medicare HMO. They do not trust these HMOs. They know what they are going to do.

I sat in this Chamber and heard the debates where HMOs and insurance companies make life decisions for seniors time and again, and they come down on the side of protecting their bottom line, protecting their profit, rather than protecting the health of the seniors. The seniors know this. When the Republicans come forward and say trust the HMOs, they will take care of you on prescription drugs, they will bring the prices down, you know they are not going to mistreat you, seniors are skeptical, and they have a right to be.

Let me tell you, there is an alternative which I offered. Madam President, I say to my colleagues in the Senate, I hope they will take a look at it for two reasons: No. 1, if this plan turns out to crater and bomb and the senior citizens across America say, What have you done to me; this is not what we were bargaining for, you will at least be able to say: I voted for an alternative. Sadly, it didn't make it. I hope it does, but if it does not make it, I voted for the right alternative that did not have the problems of S. 1. That is what MediSAVE offers.

For my colleagues in the Senate, unless you are sure you want to go to the bank on S. 1, that you want to walk into a senior citizens meeting and try to explain this to your constituents who live in the State of Maine or the State of Florida or the State of Pennsylvania, then for goodness' sake, think twice about a simpler, more honest, and direct approach. Let me tell you what it is.

It has a guaranteed $35-a-month premium. S. 1 guarantees nothing. No deductible and a payment by the Government of 70 percent of the drug cost; not 50 percent—70 percent. Does that sound overly generous? My colleagues in the Senate, guess what. That is what we get. That is our benefit in the Senate.

Is this lavish, luxurious, too much, over the top? I do not hear a lot of Senators complaining about it, nor Members of the House of Representatives. If it is good enough for my colleagues, is it not good enough for your mother? Is it not good enough for your grandmother? That is what it boils down to. The Durbin amendment says we are going to give seniors across this Nation the same percentage break on prescription drugs that Members of Congress get.

Yesterday, by a vote of 93 to 3, we said that is fine. We all know what that is all about. There is this little process where the bill passes the House and passes the Senate, and then there is this mystery gathering called a conference committee, the waltz kings of the House and the Senate. They waltz nonchalantly into the committee room and close the door. And out of that committee room in a day or a week or a month pops a bill twice this size that no one has read. They say: I am afraid we do not have time to read it; we have to get moving. We have to get back home. We will let our staff take a look at it.

Two weeks from now somebody will take a close look at it. They will vote and leave. How many times have we seen that happen?

After the waltz kings have gone into the conference committee and done their work, I bet you dollars to doughnuts MARK DAYTON'S amendment, which said Members of Congress are bound by the same prescription drug benefit as senior citizens in America, will be gone—out. We will be back at 70-percent reimbursement on our prescription drugs and say to seniors: You know, 20 percent is really all we can afford, and I hope you understand.

The alternative is 70/30. If it is good enough for Members of Congress, it is good enough for your mom and your grandmother.

There is no coverage gap under the MediSAVE amendment, and there is no coverage gap under congressional health insurance, congressional prescription drug benefits.

We have an amendment offered by Senator BOXER, and I hope my colleagues will think twice about this. To think that one could spend $4,500 in a year and then have their protection cut off for prescription drugs is something people just rationalize and say: Gosh, we wish we had more money; we would make it work. Senator BOXER brings it to the real world. What if someone you love has been diagnosed with cancer? What if they are facing some of the most expensive drug therapy—chemotherapy, radiation therapy—imaginable to save their lives and they are forking out dollar after dollar to get through this illness that could claim their life and you are praying for them every day and guess what. Come October, after they have been on this drug therapy for 9 months, this prescription drug benefit under S. 1 disappears.

What are you supposed to do? Fork it over out of pocket, if you can. Is that an answer? MediSAVE, the alternative, says do not do that to people. Cover them completely. Make this a real insurance policy, not a game where if you are too sick we are going to nail you.

It also says let's negotiate the drug prices. That is what this is all about.

If we do not deal with the expensive drug prices in America, this is a fraud on the public. Think about it. We estimate over the next 10 years that seniors will spend $1.8 trillion on drugs. How much do we provide to help them—$400 billion. Do the math. It is less than 25 percent. But if we could bring down that cost from $1.8 trillion to a more manageable figure, that $400 billion goes further.

The Veterans' Administration has shown they can do it for our veterans. They brought down the price of prescription drugs in veterans hospitals by 50 percent. We can do the same thing for Medicare recipients if we care more about them than the profits of the drug companies. Trust me, the drug companies can bring those prices down and still continue to be the most profitable businesses in America.

These companies spend hundreds of millions of dollars a year showing people skipping through a field of wild flowers, saying, I no longer am sneezing; therefore, I need to have Claritin and Clarinex; and whatever the next generation of Claritin is going to be, please go to your doctor and beg for it.

They spend hundreds of millions of dollars on this marketing and then they say they cannot cut the cost of their drugs because it will cut into their research. Baloney. We know better. They spend more money on advertising than they do on research for new drugs, and that tells the story. They can bring down the cost of these drugs for seniors and families across America and have plenty of money left over for profit and plenty of money for research.

We say under this MediSAVE amendment this competition will reduce costs and make this drug benefit worth something to families and seniors across America.

I say to my friends, the last part of this is the most important part. Medicare will offer a drug benefit option. Those who stand back and say, Senator DURBIN, you have gone too far; Medicare is going to offer a prescription drug option; I ask them to please look back at 40 years of history and experience in America, where the Medicare Program has worked with doctors and hospitals in every city and town in America to provide the very best medical care for seniors. At the beginning of that debate, many people voted against it saying it was pure socialism, that was not the market at work, and they were right. It is not the market at work. It is the Government of this country representing the families of this country at work for them.

We believe the same should be true when it comes to prescription drugs. Medicare should offer an option. Let the Medicare administration, with no profit motive and low administrative overhead and the ability to bargain for a discounted formulary of drugs, compete with these private insurance companies, which my friends on the Republican side of the aisle insist are going to show the way in how to save money for seniors. If it is true, they will be ready to compete and the seniors can make the choice, but under this bill they cannot. There is no choice to be made.

Medicare does not offer a prescription drug option under this bill, and that tells the whole story.

The final point I will make to my colleagues is this: If they voted for Senator DAYTON'S amendment yesterday, 93 to 3, saying Members of Congress are going to pay the same thing as seniors across America and my colleagues think we are going to get by with knocking that out in conference and nonchalantly passing the bill and we get 70 percent reimbursement while seniors get 20 percent reimbursement, I am sorry, the cat is out of the bag. The press corps and the American people are watching every move. Do the right thing. Bring seniors up to the level of Members of Congress. Do it now. Vote for the MediSAVE amendment and then my colleagues can go home and I think honestly say to seniors we have given them a real prescription drug benefit.

The drug companies will not like it, the HMOs will not like it, but I guarantee that parents, grandparents, and seniors across this country are going to understand they finally have a benefit that was worth the wait.

I reserve the remainder of my time.

Mr. NELSON of Florida. Will the Senator yield?

Mr. DURBIN. I yield to the Senator from Florida for a question.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. I say to my colleague from Illinois, I think he has analyzed this about as well as anyone I have heard. We made promises to the senior citizens of this country that they would have a defined benefit that would cost a minimal amount with very little deductible, with no huge gap in the coverage, that would be a part of Medicare and that whatever it was to cost——

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DURBIN. I ask unanimous consent for an additional 3 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. ENSIGN. Reserving the right to object, we have been waiting about an hour and a half to speak and all I can say is we have been waiting quite a long time.

Mr. DURBIN. Two additional minutes, and I will ask unanimous consent that the Senator be given 2 additional minutes for his patience.

Mr. ENSIGN. I do not need any additional time. I just wanted to speak if I could.

Mr. DURBIN. Two minutes. Does the Senator object?

Mr. ENSIGN. Okay.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NELSON of Florida. So I compliment the Senator and ask him why, if that was the promise that was made to American seniors, are we not considering this as the major bill on the floor, the MediSAVE amendment, instead of the package we have on the floor?

Mr. DURBIN. I thank the Senator from Florida. The answer is obvious: Because the drug companies won the debate and the seniors lost it. The drug companies have no pressure whatsoever to reduce prices. Secondly, an ideology that said the private side, the insurance companies and the HMOs, are the only answer to America's future in health care overcame common sense.

Common sense has shown seniors, and the Senator knows it better than anybody in this Chamber, when the HMOs get their hands on benefits like this, seniors are going to lose out. That argument has won the day, and that is what is in S. 1.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Madam President, what is the pending business?

The PRESIDING OFFICER. The pending amendment is No. 1077, authored by the Senator from Michigan.

Mr. ENSIGN. I ask unanimous consent that the pending amendment be laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1024

Mr. ENSIGN. I call up amendment No. 1024.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Nevada [Mr. ENSIGN], for himself and Mrs. LINCOLN, proposes an amendment numbered 1024.

Mr. ENSIGN. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to repeal the medicare outpatient rehabilitation therapy caps)

At the appropriate place in title IV, insert the following:

SEC. . OUTPATIENT THERAPY CAP REPEAL.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395*l*) is amended by striking subsection (g).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2005.

Mr. ENSIGN. Madam President, there is a cap on the amount of therapy that can be given to seniors for physical therapy, occupational therapy and speech therapy, that is set to go into effect in July. There is a $1,590 cap that is set to go into effect. What we need to do is to repeal that cap and we need to do it for very good reasons.

First, the oldest and the sickest seniors will be in a situation where they have to pay 100 percent of the costs over the cap. MedPAC and independent analyses have found that one out of seven beneficiaries needing such therapies will exceed the cap. This arbitrary limitation would cause the greatest harm to the sickest and the most vulnerable of our beneficiaries. It would be those seniors who suffer from stroke, from Parkinson's disease or a similar condition that would likely exceed the therapy cap.

It would be the older, more vulnerable beneficiaries who will be most affected by this therapy cap. As beneficiaries continue to age and encounter multiple health problems, they are more likely to be the ones to exceed the cap. Unlike other requests for Medicare monies, this provision is truly a provision for the beneficiaries. It is the beneficiaries who will either bear the cost of the cap or not get care. It is a beneficiary cap on services.

In 1999, as part of the Balanced Budget Reconciliation Act, Congress passed a 2-year moratorium to prevent implementation of the caps. A year later, Congress passed an extension of that moratorium for 1 more year through 2002, and CMS has delayed implementation until July 1 of this year. So we need to act.

From a personal story, several years ago my grandmother had a total knee replacement. I visited her in the hospital when she was going through rehabilitation. Anybody who has had a total knee replacement understands it is one of the most painful surgeries you can have, as well as rehabilitation is painful. If the cap would have been in place at the time, she could have ended up being in a situation—at her income level, if she was a senior who could not afford to pay additional money—of not getting the care and rehabilitation needed for independent living. She is about 85 years old and lives on her own today because of the physical therapy.

There are many other people we will institutionalize if we do not repeal the cap. It is very important that truly needy seniors who are very sick get the rehabilitation they need for the occupational therapy, speech therapy, as well as physical therapy.

I urge our colleagues to look at this. I have talked to the chairman of the Finance Committee, and he is committed to making sure this cap does not go into effect this year. It truly would be harmful to many seniors in our population.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

AMENDMENT NO. 1073

Mr. SMITH. I ask unanimous consent to set aside the pending amendment and call up amendment No. 1073.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

The Senator from Oregon [Mr. SMITH], for himself and Mr. FEINGOLD, and Ms. CANTWELL, proposes an amendment numbered 1073.

Mr. SMITH. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow the Secretary to include in the definition of special medicare choice plans for special needs beneficiaries plans that disproportionately serve special needs or frail, elderly beneficiaries)

On page 379, strike lines 9 through 13, and insert:

"(A) IN GENERAL.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

"(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

"(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

Mr. SMITH. I come to the floor on behalf of myself and Senator FEINGOLD and ask unanimous consent to add Senator CANTWELL as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SMITH. Senator FEINGOLD and I have designed this amendment to help frail Medicare beneficiaries with special health care needs. This is truly one of those times when doing the compassionate thing is in harmony with what is cost-effective.

It is a fact that chronic illness is the highest cost, the fastest growing segment of health care. Seniors are disproportionately affected by multiple chronic conditions that require a wide array of services. More than half of all seniors have two or more chronic conditions.

Further, one in five Medicare beneficiaries has five or more chronic health conditions. These seniors account for two thirds of total Medicare expenditures.

They also see, on average, 14 different physicians annually and fill an average of 50 prescriptions per year.

These seniors require routine monitoring, treatment and coordination of care among multiple providers to prevent or delay a decline in their health.

And yet traditional Medicare does not include a care coordination benefit. However, a limited group of Medicare+Choice plans do.

"Specialized Medicare + Choice plans" focus on frail and chronically ill Medicare beneficiaries with special needs—such as nursing home residents, nursing home certifiable beneficiaries who live in the community, and low income seniors who are eligible for both Medicare and Medicaid.

These plans provide important services absent from original Medicare such as care coordination, disease management and supportive services.

The Prescription Drug and Medicare Improvement Act of 2003 takes an important step toward providing a "home" for such plans to transition into mainstream Medicare by creating a designation for "Specialized Medicare Advantage Plans for Special Needs Beneficiaries."

The amendment I am offering today would also allow the Secretary of HHS to permit plans that disproportionately serve special needs beneficiaries to offer specialized Medicare Advantage plans.

For example, under my amendment, health plans serving a large number of seniors whose poor health places them at risk for entering nursing homes could become a specialized Medicare+Choice provider. These are known as social HMO's or SHMO's.

The Social HMO demonstration is an example of one such program that assists frail elderly with special needs but serves a mix of well and frail seniors.

One of the four Social HMO demonstrations—Kaiser's Senior Advantage II—is in my home State of Oregon.

This program is extremely popular with the seniors it serves—those with the most complex medical needs—while saving the state of Oregon millions of dollars in Medicaid costs that would have been incurred had these seniors required nursing home care.

I have several letters of support for my amendment, and I ask unanimous consent that they be printed in the Record.

There being no objection, the material was ordered to be printed in the Record, as follows:

Kaiser Permanente,
Portland, OR, June 24, 2003.
Hon. Gordon Smith,
U.S. Senate, Russell Senate Office Building, Washington, DC.

Dear Senator Smith: I am writing to thank you for your support of Kaiser Permanente's Social HMO Demonstration program through an amendment to the Medicare Prescription Drug and Reform Act of 2003. The underlying bill would establish a special designation for newly anointed "Medicare Advantage" plans that exclusively serve beneficiaries with special needs such as nursing home residents and dually eligible (Medicare/Medicaid) beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that serve a disproportionate share of special needs beneficiaries.

Kaiser's "Social HMO demonstration, Senior Advantage II, is an example of a specialized M+C plan that disproportionately serves these types of beneficiaries, including those that qualify for nursing home care but live in the community. We currently serve, 4,400 Medicare beneficiaries. Seniors with multiple chronic conditions, like many of those served by Senior Advantage II, are at greater than average risk of unnecessary hospitalizations, adverse drug interactions related to multiple drug usage, and contradictory information from different providers. Those with five or more chronic diagnosed conditions also are more than four times as likely to have functional limitations than someone with only one condition. The average Senior Advantage II members has 13 diagnoses. Like other specialty M+C plans, Kaiser has developed a wide range of chronic care and geriatric programs to efficiently respond to the health care challenges of our special needs beneficiaries. About 30% of our members are eligible for our Expanded Benefit package that allows our frailest members, those who qualify for nursing home care, to remain independent and in the community. In fact, over three-quarters of respondents to a survey of Social HMO members indicated that the Expanded Care services were "important or very important" in helping them remain living at home.

Senior Advantage II has been making a difference in the lives of our most vulnerable Oregonians for two decades. The Kaiser Permanente SHMO also serves as model to integrate home and community-based care into the rest of the local organization and Kaiser nationwide. Your amendment would allow the Secretary to establish a new population-based designation for M+C plans like ours that recognizes their commitment to targeting and serving special needs beneficiaries.

Kaiser Permanente appreciates your continued support of our efforts to develop more effective programs of geriatric care and for your leadership on behalf of our nation's most vulnerable seniors.

Sincerely,

Eugene Scanzera,
Manager, Medicare Product Line, Kaiser Permanente Northwest Region.

Medicare Payment Coalition for Frail Beneficiaries,
Bloomington, MN, June 24, 2003.
Hon. Gordon Smith,
U.S. Senate, Russell Senate Office Building, Washington, DC.

Dear Senator Smith: On behalf of the Medicare Payment Coalition for Frail Beneficiaries, we offer our strong support for your amendment to the Medicare Prescription Drug and Reform Act of 2003. Your amendment would promote better care for frail elderly and seniors with complex medical conditions by establishing a special designation for certain Medicare Advantage plans serving this high-risk group.

Beneficiaries with multiple chronic conditions represent the most needy and costly group in Medicare. Those with five or more conditions see an average of 14 different physicians annually and have about 37 office visits each year. This segment of the Medicare population also is the most expensive, costing Medicare about 14 times as much as for beneficiaries who have only one chronic condition. To improve health outcomes for this vulnerable group of seniors and control Medicare costs over the long run, we need to establish a special approach for addressing the complex and ongoing nature of the problems faced by the highest-cost population.

Currently, there are only a few Medicare+Choice programs with the skill and expertise for serving special needs beneficiaries. Most of these programs operate under demonstration authority like Evercare, the Wisconsin Partnership Program, the Minnesota Senior Health Options Program and the Social HMO demonstration, although a few private plans offer plans targeted toward special needs beneficiaries. Care coordination, aggressive primary care interventions and specialized geriatric interventions used by these plans have led to improved outcomes and reduced use of expensive services such as inpatient hospital and nursing home care.

The Medicare Prescription Drug Act, as introduced, creates a designation for "specialized Medicare Advantage plans" for plans for exclusively serve special needs beneficiaries. Your amendment enhances this important provision by allowing the Secretary also to designate as specialized Medicare Advantages plans those that disproportionately serve special needs beneficiaries. This designation allows these plans to be recognized for intentionally targeting for service frail, chronically ill beneficiaries. This designation also could offer the Secretary greater flexibility in the administration of these plans. Historically, it has been difficult for specialized plans to transition from demonstration status to mainstream provider status because there is no mechanism for doing so. This legislation provides an important first step for this by establishing a population-based specialized plan designation and enabling an approach to managed care that simply cannot be implemented under traditional M+C arrangements.

Congress is on the verge of enacting the most profound changes to Medicare since its inception in 1965. Your amendment provides a framework for enhancing Medicare's responsive to our nation's most vulnerable and costly seniors. I extend our sincere thanks for your leadership in this important area.

Sincerely,

Richard J. Bringewatt,
Chair.

Mr. SMITH. Keeping seniors out of nursing homes by managing their health better while saving money is a win-win situation. Despite this, these specialized programs only exist in several States.

My amendment will further improve Medicare through the development of specialized programs that manage the care of Medicare's most medically complex and expensive beneficiaries more effectively, leading to improved quality of care and ultimately life for seniors with multiple conditions, while helping control Medicare costs.

It is not often that we see a proposal in the Senate that will simultaneously improve quality of health care while saving the government money, and I urge my colleagues to support this amendment. It is compassionate and it is cost effective.

AMENDMENT NO. 994

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, I rise in opposition to the Durbin amendment. I wish to make a couple of points to my colleagues about it.

No. 1, this is not a $400 billion amendment. I have been informed that the Congressional Budget Office scores this at $570 billion over 10 years. It attempts in the legislation to limit the cost by limiting the years—according to the Congressional Budget Office, effective in limiting the cost. So we are talking about $170 billion over budget allocation. That would obviously add an increasing amount of money to the unfunded liability and the Medicare Program.

One of the things we want to do, one of the reasons we were able to bring a bipartisan consensus, is to add a responsible benefit and focus the money we are going to put forward on Medicare prescription drugs to those who are the lowest income, the poorest of the poor.

We talked about that the other day; we talked about the assets test. One of the keys to this legislation is the greatest subsidies go to the lowest income.

If we take those above the Medicaid eligibility already covered by a prescription drug plan, under the plan before the Senate now the subsidy is 97.5 percent. So the Government picks up 97.5 percent of drug costs and the beneficiary 2.5 percent. That is a fairly generous subsidy for the poorest of the poor who are not otherwise covered. The very poor, Medicaid, who are already covered, are people at 75 percent of poverty up to 100 percent of poverty—obviously poor. Those who are slightly above the poverty level get a 95 percent subsidy. So for every $1 they spend 95 cents is picked up by the Federal Government. That is a very generous subsidy.

Some would argue—and I would be one—that we should have a generous subsidy. We can argue whether it is 90 or 95 or 85 or 99, but it should be a very high subsidy because these are very low income individuals who do not have assets, do not have any other way to pay for their prescriptions, and they are truly deciding whether to buy food or to take the medicine prescribed them. We do have a focus benefit on low-income.

The Senator from Illinois focuses in on those who are higher, above 160 percent of poverty, and says this program is inadequate for them. I make the argument that there are many who have said that for higher income individuals, given the fact that the vast majority of higher income individuals already have prescription drug coverage, well over 75 percent of people at 160 percent of poverty and above have existing prescription drug coverage, many provided through their employers, all of which are probably more generous than either this benefit or the one the Senator from Illinois is offering.

So what we are doing—and this is a big concern on both sides of the aisle—is our benefit plans are displacing private dollars with public dollars. The concern, at least on my part, and I think on others, is: Is that a wise thing to do? Should we be taking private plans and replacing them with public dollars? In some cases, and I would argue in most cases, under either formula—certainly under the one that is on the floor right now—probably the benefits are not as generous.

So there is an issue as to whether we should be doing this at all for higher incomes or whether we should have some sort of catastrophic benefit or some other benefit for higher income. That is what Senator ENSIGN is going to be putting forward in his plan with Senator HAGEL later on.

But I think the overwhelming sentiment among the American people is, yes, we should have a prescription drug benefit for those who have lower incomes, who can't afford it, and those who are high users of drugs because of chronic illness. But to spend a lot of additional tax dollars on higher income seniors, I think most Americans are saying that is probably not a wise expenditure of funds, to go to $570 billion or more when just a couple of years ago—less than that, I think it was a year ago—we were looking at $350 billion, or $300 billion. Now we are at $400 billion. There is no end as to how much we would like to subsidize, I am sure, from some people's perspective—everybody over the age of 65 in the Medicare Program. But I think the responsible thing to do is work within budget constraints and focus the resources on the poorest of the poor. That is what we have done.

The other criticism I have with this plan is it is a one-size-fits-all, Government-run plan. History has shown those are not necessarily the most efficient, the most cost-effective, and best-run kinds of plans.

The Senator from Illinois says we have this gap. We may have a gap, we may not, depending on how the insurer who bids on these plans structures the plan. The only thing fixed in the plan on the floor now is the deductible is $275 for those people who are at 160 percent of poverty and above; the deductible is fixed at $275.

Also fixed is the catastrophic insurance. What does that mean? That means where the Government comes in and pays 90 percent of all the costs of drug use. It comes in after the person has spent $3,700 out of pocket. So the plan does not kick in—the design between that is flexible, but the plan cannot kick in until you have spent $275, and your catastrophic benefit, that is where the Government comes in and pays 90 percent of the cost above a level of expenditures, out-of-pocket expenditures, which kicks in after you have spent $3,700. Beyond that, the plan can be structured to have all sorts of designs to provide prescription drug coverage.

The argument I would make is there are some people who would like some designs, other people would like other designs, and we should let people decide what plan fits their needs as opposed to a one-size-fits-all plan.

I see the Senator says there should be no deductible. I think most people would argue, when you have "no deductible" plans, you have very skewed utilization. In other words, you have people using this plan a lot more than if there were some constraint before you get your benefit. When it comes to deductibles and copayments, they are very effective in getting people to think twice as to whether they want to consume more because they have at least some stake in the consumption.

There is lots of evidence out there that suggests that people who do not pay anything for their drugs tend not to—the best way to put it—I guess—value them as much as people who do pay something: That sort of makes sense.

Mr. DURBIN. Will the Senator yield for a question?

Mr. SANTORUM. In one second. That makes sense. If you are not paying anything for something, you value it less than if you had to pay even $2 or $5 or some sort of copay.

That is important psychologically because you have better utilization, you have a better track record of people properly taking something because they have an investment, personal investment in this particular drug.

I am happy to yield for a question.

Mr. DURBIN. I ask the Senator if he would concede the point that both the underlying bill, S. 1, as well as the MediSAVE amendment require a percentage payment of prescription drug bills for every dollar spent: The underlying bill, 50 percent; the bill I proposed, 30 percent; even at catastrophic levels, 10 percent.

To say the individual is paying nothing overlooks the fact that there is a percentage requirement copay on every prescription drug for every senior under both plans.

Mr. SANTORUM. I see that you have a cost share of up to 70/30. I do not have that. I was just looking at the summary you provided, so I don't know whether there is no cost share for lower income or how the cost share works. All I know is it is up to 70/30. I do not know what that necessarily means.

I see there is no deductible, so I was commenting on those two.

If there is a cost share throughout, that is a positive thing. Maybe we would share the agreement there needs to be some sort of cost share, particularly for those who are not at poverty level. If you are at poverty level, then the cost share should be minimal because you don't want to use it as a great disincentive to the drugs prescribed to you. But if you have some income, you should have some responsibilities for putting forth some money for these drugs. That is ground we share.

As the Senator from Illinois suggests, there is cost sharing under our plan. It is a little bit more than the Senator's. But the Senator's plan is more expensive, a lot more expensive than the plan we have here.

The other problem I have is that it does not bring in any kind of private sector incentives, to try to reduce costs. One of the problems with the Medicare system today is it is a top-down, Government-run, one-size-fits-all plan, where the private sector, which administers this plan—Medicare administers it, but they do it through intermediaries which are really private sector entities.

The private sector, in a sense, administers the Medicare plan. But they are an intermediary. In other words, they are just folks who interface with the beneficiary and collect money and pay bills and do what Medicare just doesn't have the capacity to do. The problem with that is they do not have any risk in doing their job. In other words, all they do is a ministerial job. They get paid to provide a service as opposed to what we do in this plan, which is vitally important. We say to those who want to provide Medicare benefits, whether it is through the stand-alone drug benefit we are providing or through the Medicare Advantage Program, which is a PPO and HMO product which has the Medicare drug benefit integrated into the entire benefit which is inpatient and outpatient procedures, we want you to assume some of the risk.

Why is that important? What do I mean by risk? Insurance risk. The risk that if they do not manage the program well, they are going to lose money.

When that is done to insurance companies, they tend to behave differently, when they have no risk, if the plan is not run well. The risk is if they really do a bad job, they could lose the contract, and that happens on occasion. But there is no financial risk to them if they are not managing this benefit correctly.

Mr. DURBIN. Will the Senator yield for a question?

Mr. SANTORUM. Sure.

Mr. DURBIN. I thank the Senator for yielding. This is getting perilously close to a debate, which hardly ever happens on the floor of the Senate. I will gladly ask for time and yield to his questions so we can have an honest-to-goodness Senate debate. It will be a historic day.

My question is this: Is it not true that, although the Medicare agency does not provide the services but works through intermediaries, the Medicare agency attempts to control the costs by establishing what providers can be reimbursed, what hospitals and doctors can be reimbursed, as much as we are suggesting here that the drug companies would be told that they have to reduce costs for Medicare beneficiaries? Isn't that an analogy?

Mr. SANTORUM. The Senator from Illinois is correct. The way we control costs within the Medicare system is through price controls dictated by the Federal Government. There are a whole host of problems we run into all the time with the uneconomic decisions, in many cases, by CMS—which is the agency that runs Medicare—in reimbursing for services.

We have lots of places in this country where doctors will not provide services to Medicare recipients because the reimbursement does not match what their costs are. We talked to lots of hospitals and they will tell you, depending on the region—because it is different in different regions—this is a very convoluted price control system. They will tell you they are not getting the proper reimbursements for their services and they cannot afford to provide those services, or if it was not for private payers in certain regions of the country, these hospitals would be going under because of the reimbursement dictated, not by the market, not by what beneficiaries value, but by what is decided in Baltimore, MD, by a bunch of people sitting behind a desk who have no idea of what it costs in Coudersport, PA, to provide OB/GYN service, or gynecological services, in this case, because you don't have a private-sector service for Medicare recipients.

Nevertheless, the point is, you have an artificially imposed price control from a very far-removed entity. And I think at least most Members on this side of the aisle would like to see that change. We would like to see the system better reflect what the marketplace will bear as private insurance dictates. It is a much more flexible, much more dynamic system that takes into account what the beneficiary wants and what they value.

So I would argue that while I agree with the Senator from Illinois that this plan mirrors very closely the traditional Medicare plan—I do not disagree with him at all—I would argue the traditional Medicare plan is a command-and-control, top-down plan that does not work particularly well.

One of the reasons we are here today is that it takes an act of Congress to add a benefit. It should not take an act of Congress to add a benefit. We should have prescription drug coverage.

Had we had the Medicare Advantage Program in place 20 years ago, everybody in Medicare Advantage today would have a prescription drug benefit. Everybody would have it. They would have the ability to offer that benefit because they would be responding to what the consumer and the beneficiary wants. Just like today, Medicare+Choice—which is a Medicare HMO that was established 5, 6 years ago—has prescription drug benefits if you are in that program. Why? Because there are beneficiaries who want that.

Madam President, I understand the chairman of the committee would like the floor, so I will yield.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Let me say to the Senator from Pennsylvania, this is just for the purpose of a unanimous consent request. Then I will yield the floor.

Madam President, I ask unanimous consent that at 6:30 the Senate proceed to a vote in relation to Durbin amendment No. 994, to be followed by a vote in relation to the Clinton amendment No. 1000, with no second-degree amendments in order to the amendments prior to the votes, and with 2 minutes equally divided for debate prior to each vote after the first; further, that following those votes, the Senator from Iowa—me—be recognized to offer an amendment.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object, in relation to the time between now and 6:30, I ask my friend from Pennsylvania, how long do you intend to speak?

Mr. SANTORUM. Madam President, I would be happy to divide the time between now and 6:30 equally between the two sides.

Mr. REID. I think that would be appropriate. I ask that the consent request of my friend from Iowa be modified to divide the time between now and 6:30 equally between the majority and minority.

The PRESIDING OFFICER. Will the Senator from Iowa accept the modification?

Mr. GRASSLEY. Yes.

Mr. REID. With the time controlled by Senator DURBIN on our side.

Mr. GRASSLEY. And the Senator from Pennsylvania on our side.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. SANTORUM. Madam President, another concern I have—and it is not a concern with the bill; it is just the marketing of the bill—is to suggest that their plan will move forward immediately. One of the comments made was that the plan before us does not take effect until 2006, and their plan will take place as soon as possible.

Let me just suggest, we went to CMS, which is the organization within the Government that runs Medicare, and other experts in the field and asked: When is the soonest possible we can have this drug benefit in place? And they said: It would not be prudent to do so before 2006, to promise before 2006, because it is rather complicated to put together.

So the reason we put in 2006 is we want a backstop. The Durbin amendment has no backstop. It just says: As soon as possible. Who knows how long that will be? We have a backstop, focusing on getting this ready for 2006, which I think is actually beneficial, and, at the same time, it does not rush the process that potentially could do something that would be imprudent and, potentially, ineffective in moving forward a plan.

So I think 2006, given all the expertise we have in this town as to what would be the proper timeframe, is the right answer. It is a good balance between making sure there is a date certain and that it is fairly quick and, at the same time, not too quick as to cause problems.

The other thing we do—and this is not mentioned in the marketing of the MediSAVE amendment—we have a plan that does go into effect immediately, unlike the Durbin amendment, which will probably be years—at least a year or 2—before it goes into effect. And there would be no coverage for anybody under that amendment.

We will have coverage immediately, starting within a few months, according to CMS, again, the agency that runs Medicare. They anticipate, with the drug card—which accomplishes much of what the Senator from Illinois has suggested they want to accomplish, which is to get a group discount or volume discount through the Federal Government—we will do that immediately, not in a year or 2 years or 3 years or however long the Durbin amendment would take, but it will do it immediately.

Within a couple of months, we will have out to every Medicare-eligible beneficiary a discount card that can replace all the other discount cards that a lot of seniors already have. It will be a single discount card that will give a discount nationally where we will be able to negotiate with a variety of different pharmaceutical companies. So it is an opportunity for us to use the volume discount to be able to reduce drug costs for seniors.

In addition to that, if you are lower income, you will receive up to $600 in money to help defray the cost of your prescriptions—not 2 years from now, not 3 years from now, but immediately—really, a few months from now, hopefully as soon as the first of the year, or maybe even sooner than the first of the year. So it really does accomplish a lot of what the Durbin amendment attempts to do.

By the way, once we move into the full-blown plan in 2006, you are going to be contracting under the standalone benefit which goes with the traditional fee-for-service Medicare system as well as Medicare Advantage, which is the PPO and HMO options that will be available to seniors—none of that will be available, by the way, under the Durbin amendment—but what we will do is provide the opportunity for them to negotiate these discounts with pharmaceutical companies because they will be bidding in large regions, multi-State regions, with lots of people, lots of scrips that will be filled. So they will be able to use their purchasing power to get a lot of these volume discounts.

Now, will they be as big as the Federal Government? No. But when you are looking at these kinds of volumes, there is only so much volume discount you can get. At some level you don't get any more discount. It sort of caps out. We think the prescription business will be big enough that they will get substantial discounts and accomplish exactly what the Senator from Illinois hopes to accomplish in his legislation.

It looks like the Senator from Illinois is ready to go, so I reserve the remainder of our time.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from Pennsylvania.

I say to the Senator, again, I am prepared, at any point, if the Senator would like to ask a question and debate, let's try it. Let's see how the Senate works in real debate. But I really appreciate the Senator from Pennsylvania coming to the floor.

I say to the Senator, you were the first voice in opposition to this amendment. I have been coming here day after day after day. I suspected there was some opposition here—don't get me wrong—but I am glad the Senator came forward to speak his mind about this amendment.

And I congratulate you on your choice of words. Those who oppose an amendment involving Medicare use words such as "top-down," "command-and-control," conjuring images of commissars, Bolshevik 7-year, 10-year plans—this kind of mighty hand of government pressing down on the poor, the poor peasant, the poor American citizen.

The sad reality is, the seniors of America don't agree with you. They like Medicare. They even like it in Pennsylvania. Do you know what we find when we say to seniors: "We give you a choice. You don't have to stay in Medicare. You can go to a private HMO"? Eighty-nine percent of them stay in Medicare—the "top-down, command-and-control" system.

Now, why do they stay there?

Mr. SANTORUM. I say to the Senator from Illinois, I believe the number is 12 percent of Medicare beneficiaries participate in the Medicare+Choice Program. So it is 88 percent.

Mr. DURBIN. I am sorry I said 89. I stand corrected.

Mr. SANTORUM. If the Senator will yield further, I would also ask the Senator if he knows that Medicare+Choice is not available in most communities because they are only available in most urbanized areas.

Mr. DURBIN. I will concede the point because I can remember so well when these Medicare HMO choice plans came rolling into Illinois and so many other States and realized they couldn't make the money off seniors they planned to and pulled the rug out from under them. They called my office and they said: What happened to this Medicare HMO we were supposed to turn to? We can't trust them. They are not there. We are sticking with Medicare.

So my point to the Senator from Pennsylvania is that we are dealing here with a Medicare option which most seniors don't view as an ugly, reprehensible, big government option. They view it instead as something they are comfortable with, that America for 40 years has lived with, and has been a dramatic success since the days when President Lyndon Johnson came forward and said: There is no reason, since your mother and father, once retired, now have a little Social Security check, why they shouldn't have health care. So we are going to create Medicare. In the 1960s, we did it. It worked.

What is the proof of its value and effectiveness? The fact that seniors are living longer. It is an indication to me that this Government-run Medicare Program has worked. It pains my friends from the conservative side of the aisle to concede the fact that a Government program works, but Medicare does work. And because it has worked, seniors trust it. But my Republican friends didn't like it to start with—at least their predecessors in the Senate—and they don't care much for it today. So they are trying to find a way to move us away from this command-and-control, top-down program, and they have decided they will use prescription drugs as their stalking horse for the elimination of Medicare. That is a sad outcome.

Now they are even talking about $6 billion with which they are going to subsidize private insurance companies, a Federal subsidy to create an alternative to Medicare as part of this bill.

The goal for some—I won't ascribe this to the Senator from Pennsylvania because I don't know if this is his own philosophy—is to get rid of Medicare. They believe it is outmoded and old-fashioned. I do not. I believe Medicare offers something to seniors which the private sector cannot offer: A nonprofit, low-administrative-cost system which treats seniors the same from one edge of America to the other and basically says: We will try to keep costs under control because we speak for tens of millions of seniors.

The same approach can work effectively when it comes to prescription drugs. The MediSAVE plan, which I offer with the support of major senior citizen organizations and organized labor, says just that. If you want a private insurance company to compete, God bless you, bring them in. Give them their best opportunity. If they can beat the socks off Medicare in a region of the country, that is to the benefit of seniors. But for goodness' sake, why are those who are in favor of the private sector so afraid of Medicare as an option, the top-down, command-and-control, bureaucratic government? That happens to be what we have lived with successfully for 40 years in America under the Medicare system.

Despite all the pejorative adjectives applied, seniors don't see it that way. They trust Medicare. Some Senators may not trust it, but seniors trust it. We ought to trust them to make a choice. What is wrong with their making a choice?

Frankly, you have to be honest about this bill. There is no guarantee in here about a $35 monthly premium. Seniors could face a much larger premium, and they know it. There is no guarantee that the private HMO company offering prescription drugs is going to be around in 2 years. It could be gone. And that infuriates seniors as well. They had the rug pulled out from under them with the Medicare HMOs. They don't want the same thing happening with prescription HMOs. That is why most of them are likely to gravitate toward the Medicare style plan. That is a dagger to the heart of styptic-hearted conservatives who want to see Medicare go away. But it is a fact.

Ask your seniors in Pennsylvania, in Illinois, even in Tennessee. They will tell you they like Medicare: Please, don't give up on it. That is why I think this alternative is so important.

Frankly, what we are saying to them is, we are going to have an issue which my friend from Pennsylvania has not addressed. We are going to have an effort by Medicare and others to bring prescription drug costs down. It has worked for the Veterans' Administration, and we have 25 times as many seniors under Medicare as we have veterans.

So let us give that bargaining power to Medicare and to the private insurance companies. And who is going to win? The winners will be seniors and their families.

Mr. SANTORUM. Will the Senator from Illinois yield for a question?

Mr. DURBIN. I am happy to yield.

Mr. SANTORUM. I want to ask you, first on the Medicare+Choice plan. You say it has failed. Are you aware that the Senator from New York, Mr. SCHUMER, offered an amendment today? I encourage you to read his statement. He talked about how the Medicare+Choice plan has been dramatically underfunded. I have a letter here from July 12 of last year signed by 11 Democrats, including Senators CLINTON, SCHUMER, LIEBERMAN, CORZINE, and WYDEN, talking about how the Medicare fee-for-service plan has grown by at least 10 percent, and yet the Medicare+Choice plan has been locked in by law and growing at only 2 percent. That is the reason a lot of the Medicare+Choice plans had to leave. Are you aware of all that information?

Mr. DURBIN. I am not. I thank the Senator for bringing to it my attention. Let me make it clear: Some Medicare HMO choice plans are good. Seniors want them, and they should have the option to turn to them. In my State, though—I don't know if it happened in Pennsylvania—some of these insurance plans came in and decided they couldn't make enough money, and they cut and ran.

Mr. SANTORUM. If the Senator will continue to yield, I would suggest you look at the statement of the Senator from New York today. I ask unanimous consent that the letter to which I referred be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

UNITED STATES SENATE,
Washington, DC, July 12, 2002.

Hon. TOM DASCHLE,
Majority Leader, Hart Senate Office Building, Washington, DC.

DEAR MAJORITY LEADER DASCHLE: We are writing to express our continued support for the Medicare+Choice (M+C) program. Currently approximately 5 million Medicare beneficiaries are enrolled in M+C plans across the country and many of them live in the states we represent. For these seniors, M+C represents a vital link to high quality, affordable health coverage.

Unfortunately, a serious funding crisis is threatening the Medicare+Choice option. Many participants live in areas where funding for their M+C health benefits has increased by only two or three percent annually since 1998 while health care costs have risen by at least ten percent. These increases are inadequate and they threaten the viability of the program in most areas. We believe Congress should assign a high priority to adequately funding the Medicare+Choice program.

We understand the difficult task you face in balancing so many competing demands in the health care areas. However, we believe that M+C plays an important role in the overall soundness of the health care system, and we would like to see it continue without disruption for the seniors we represent. We hope you will consider our support for M+C as you work on Medicare legislation this year.

Sincerely,

Joseph Lieberman, Jon Corzine, Barbara Boxer, Chris Dodd, Max Cleland, Dianne Feinstein, Ron Wydem, Charles Schumer, ———, Jean Carnahan, Hillary Rodham Clinton.

Mr. SANTORUM. Take a look at this letter. It is very clear that the reason these plans left was that we set the growth rate for Medicare HMOs at one-fifth the growth rate of the traditional Medicare Program, and obviously they couldn't continue because health care costs continued to go up. Remember, they were the only ones providing prescription drugs. So while Medicare was going up 10 percent without prescription drugs, HMOs were going up probably 10 percent or more because they were offering prescription drugs. So they said: We just can't continue, under this artificial ceiling, to continue. What we are trying to do with this plan is to put that choice back to seniors.

Mr. DURBIN. Reclaiming my time, you don't put it back in that situation. You eliminate Medicare as a competitor to these private insurance companies. The Medicare agency itself cannot offer this prescription drug plan other than through a private agency with which they contract.

What I am saying to the Senator from Pennsylvania is: Take a look at the Veterans' Administration. The Veterans' Administration is a good indication of what can happen when a Federal agency such as the Veterans' Administration wants to bring down costs; it bargains on behalf of the people it represents and lowers prescription drug costs.

Under this bill, S. 1, as I understand it, you have to have two private insurance companies offering in a region or there is a Medicare fallback, which turns out to be a plan that they contract out to some private provider.

Mr. SANTORUM. If the Senator from Illinois will yield for a question.

Mr. DURBIN. I am happy to yield.

Mr. SANTORUM. Does your plan have the benefit actually administered by the CMS or do they, like the traditional Medicare plan, contract through an intermediary to provide the benefit?

Mr. DURBIN. This is a Medicare delivered benefit through the Medicare agency.

Mr. SANTORUM. So there is no intermediary. The plan is actually run—unlike the current Medicare plan, it is going to be run by the Federal Government without an intermediary?

Mr. DURBIN. If the Senator will allow me to consult with the expert.

Mr. SANTORUM. I am happy to.

Mr. DURBIN. I guess the difference is, we don't divide it into 10 regions when it comes to Medicare.

Mr. SANTORUM. It is provided through an intermediary, which is the exact same delivery mechanism of the fallback plan in this bill.

Mr. DURBIN. The difference is this: The difference is negotiating lower costs for prescription drugs. And in this situation, it is my belief that this underlying bill does not. The reason the Stabenow amendment was defeated the other day, the reason there is opposition here, is, once you put Medicare in the picture on a national basis, bargaining for lower prescription drug prices, you are more likely to succeed and the drug companies are more likely to have to reduce their costs.

I think that is why the pharmaceutical companies don't particularly care for my approach and the reason many people have opposed it here. But from where I am standing, if my interest is in the senior citizens of America having the lowest prescription drug prices and our giving a helping hand as much as we can, rather than the bottom line profits of prescription drug companies, I think this is a much more advisable approach.

I reserve the remainder of my time.

Ms. MIKULSKI. Mr. President, I rise in strong support of amendment No. 994 from my colleague from Illinois, Senator DURBIN. The MediSAVE amendment would provide a vastly superior Medicare prescription drug benefit to our seniors. But I am also disheartened. This is not the bill we are debating. I wish it were.

The MediSAVE amendment meets all of the principles I laid out for a Medicare prescription drug plan. In an earlier statement, I outlined the principles that I would use to grade any Medicare prescription drug plan. I think the MediSAVE plan gets an A. I commend Senator DURBIN for his hard work on this plan.

I have five principles for a prescription drug benefit.

1. The cornerstone must be Medicare. I am opposed to the privatization of Medicare. Any prescription drug benefit that relies on the private sector must be in addition to, not in lieu of, traditional Medicare. Seniors must not be forced to leave the Medicare system they trust to get the prescription drugs they need.

2. Voluntary. No one should be coerced or forced into a private program or forced to give up coverage they currently have.

3. Affordable. The benefit must be affordable. That means a reasonable premium and copayment.

4. Universal and portable. The benefits must be available to all seniors, regardless of where they live. And all seniors must have the same benefit, and be able to take it anywhere they go.

5. Meaningful. The benefit must cover the drugs your doctor says you need—not what an insurance executive thinks you should get.

How would the MediSAVE plan benefit seniors?

MediSAVE would create a more meaningful benefit. It would have no deductible for drug coverage. It would have a guaranteed premium of $35 per month. Rather than having to pay 50 percent of their drug costs covered, under this plan seniors would have to pay 30 percent of those costs. That adds up to a big savings for seniors, many of whom live on a fixed income. MediSAVE would also take into account the amounts that employers contribute toward retirees' drug costs which will help millions of seniors keep the employer-sponsored health care they earned. But most importantly, MediSAVE would deliver the prescription drug benefit through the Medicare that seniors trust.

I believe the Durbin amendment is a great improvement over the bill we are debating. I urge all my colleagues in supporting this amendment.

Mr. JOHNSON. Mr. President, today I join several of my colleagues to urge Members of the Senate to vote in strong support of the "Medicare Savings Alternative that's Voluntary and Equitable," or MediSAVE amendment. I thank Senator DURBIN for working hard to create an amendment which will make this Medicare prescription drug package a meaningful benefit for seniors across this country.

I have been troubled over the course of this debate on many fronts. There are numerous holes in S. 1 that many of my colleagues have tried to fill. Many of my colleagues have offered targeted amendments to address this bill's specific flaws. So far, we have tried to put some reasonable limitations on the premium levels that can be charged to beneficiaries. We have tried to eliminate the coverage gap that will hit seniors hard in the fall of 2006. We have tried to extend the fallback period to two years to provide more stability to seniors living in areas where managed care is just not likely to work. We have attempted to ensure that the 37 percent of employers that are estimated to drop their retiree coverage would not do so. And all of these attempts have been unfruitful, due to the resistance of Members on the other side of the aisle.

We have tried to make this a better bill, and while we have had success on a few cost containment amendments, we have come up short on many of these other critically important provisions. Seniors in my home State will be scratching their heads in 2006, wondering where their affordable, comprehensive Medicare prescription drug benefit is. This is why I am a cosponsor and supporter of the MediSAVE amendment. This amendment will provide seniors with a real benefit, one that allows seniors to get their drug coverage through traditional Medicare, not forcing them into plans to get it. It has no deductibles, limited cost sharing and no coverage gap. It addresses a blatant omission in this bill to deal with the skyrocketing costs of prescription drugs in the U.S. It allows the Federal Government to utilize its bargaining power to purchase prescription drugs at reasonable prices, rather than providing a blank check to drug manufacturers as is planned under the current bill.

Let's try and make this the best bill possible. This amendment may require us to allot some additional funds down the road, but aren't our seniors worth it? Isn't the security of average seniors, those who have worked hard all their lives to make this country what it is today equally, if not more important than big tax cuts for the elite? I urge my colleagues to support this important amendment today.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SANTORUM. A couple of points, Mr. President. The Senator from Illinois said people prefer having the Government run this program and administer this program. I know the Senator doesn't like top-down command and control, but it is what it is. It is a one-size-fits-all Government benefit.

A survey was just done a few days ago that said voters trust private plans over Government to provide health benefits by a margin of 54 to 34, when it comes to providing medical and pharmaceutical benefits. So the American people are used to dealing with private sector entities when it comes to health insurance, and they are very comfortable to have them provide services. And, in fact, arguably even the Medicare system that the Senator from Illinois has put forward is going to be run—the drug benefit is going to be administered by a private sector entity. It will be a company that will be contracting through a Medicare agency to provide these services. The difference is—this is the real key difference between what we want to do and what the Senator from Illinois wants to do, one of them—that we want to have these private sector entities that we were contracting with to bear some of the risk of insurance.

Again, I repeat that the importance of having these private sector entities bear some of the risk of insurance is, if they are bearing the risk, and if they don't administer this program effectively, it is going to cost them money. So they are going to probably do a little better job of administering that program than if they are simply being paid a fee to write checks or collect fees. So we believe having a shared risk with the private sector and the public sector getting together to use the best of the private sector, which is to be able to have good beneficiary relationships and to go out and try to solicit—remember, if you are a private sector contractor, you have competition. You have to treat your beneficiaries well or they can go to the other player. Your ability to sign up beneficiaries will be diminished if you are not providing quality services.

Under the Senator's plan, there is one administrator, no incentive to save money, no incentive to be customer friendly. It doesn't matter because they have no place else to go. You can take it or leave it. If you have competition and you allow people to go somewhere else, they have an obligation not only to be better at providing services but they have an obligation, if they want to keep these beneficiaries in their program, to provide good services, quality services, to be responsive—not be open, as a lot of these organizations are, from 8:30 to 4:30, and if you have a problem, you have to call on Monday morning.

A lot of these ministerial organizations, again, have no risk involved. The beneficiary has no place else to go. They have no incentive to save money. So why not just basically save money on their side, cut back on what it costs to administer this program, and get paid the same fee. They can save a little money that way, and they have no chance of losing anybody.

I think having some incentive to provide quality services and to try to save money because they have some stake in it is a very important component of delivering better services for the consumer and a better product for the taxpayer. We keep coming back to this, and we seem to overlook it.

Millions of Americans are paying their hard-earned tax dollars for this benefit. We have an obligation to make sure the money is effectively spent. I think we have an obligation to put into place systems that are more efficient than the current system—more efficient not from the standpoint of how much it costs the Government in administrative costs. That is one of the things I hear, that this is much more administratively effective than it is for these other private plans. Well, if all you do is pay bills, and you don't worry about how much is being used, you don't worry about the quality or about anything else, all you are doing is writing checks in Baltimore or writing checks to companies like Blue Cross plans who are the intermediary, then it is pretty cheap. But if what you are doing is trying to coordinate care to try to make sure that quality is imbued through the system, if you are trying to actually provide a quality service, it is probably going to cost a little bit more. I think most people believe that is a good tradeoff, plus you have the competitive angle, which I argue could actually save money.

So while I respect the Senator from Illinois and the fact that he has put forth his amendment, it is, in fact, a straight extension virtually of the traditional Medicare delivery services. It is not $400 billion; it is $570 billion. It is $170 billion more than what we all have agreed upon in the budget to provide for a prescription drug benefit.

The American public has been very clear about this. Yes, they want prescription drug benefits for seniors, but they want those benefits focused on those who are lower income, who cannot afford it, and those who are high users of prescription drugs because of disease or chronic illness. So what we have done in this bill is to do that. They also want a fiscally responsible alternative. They want a fiscally responsible plan. In fact, in surveys over the past several years, they were asked a simple question: Are you for a $400 billion Medicare prescription drug plan or are you for an $800 billion Medicare prescription drug plan? Overwhelmingly, believe it or not, they are for a $400 million plan. The American public realizes there is not just an endless pot of money that is going to be available to provide benefits for anybody, and they want something fiscally responsible.

There are many on this side of the aisle who would argue that what we have even in the underlying bill is not fiscally responsible; it is too much money, too much of a subsidy to too many people. But we brought this bill forward to find a bipartisan compromise. Part of that was to make sure there is—and there is—a $389 billion drug benefit in this bill. There is a few billion dollars to help these PPOs get set up and organized—literally, I think, seven. So there is 380-some-billion-dollars for the drug benefit, which is one objective we want to accomplish.

The other objective this side of the aisle would particularly like to see is to have choices for seniors—the private-public partnership which we believe are so important to improve quality and efficiency for the taxpayer. We are spending only $7 billion on that. That is a paltry sum compared to this big expansion of the drug benefit. We think that is important. The Senator from Illinois would disagree with that. It is a very different point of view.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I say to my friend, thank you for expressing your point of view. You are the first person to speak on it in opposition. I hope you don't carry the day, but you might.

It is interesting that some are fiscal conservatives and deficit hawks when it comes to prescription drug benefits, but where were these voices during the tax cut debate? We were sunsetting tax cuts right and left, creating the biggest deficit in the history of the United States, and I didn't hear a word from the deficit hawks.

When it comes to helping senior citizens paying for drugs, we have to be responsible. This amendment is responsible. It is sunsetted. We have a report from CBO which says that. The $570 billion does not take into account the fact that this is sunsetted in 2010. It works within the $400 billion.

The second issue raised here is that there are people—and I think my friend from Pennsylvania is perilously close to this coalition—who don't care much for Medicare. They don't think it is a very good program. Well, the vote is in on Medicare, and it is 88 to 12. Eighty-eight percent of the people who had a chance to move out of Medicare didn't do it. They stayed. I hope you will vote for the MediSAVE amendment.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. Mr. President, I ask unanimous consent that I be recognized for 30 seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE HELD AT THE DESK

Mr. STEVENS. Mr. President, I have a resolution at the desk. I ask that it be held at the desk so that I might be able to clear it this evening. It pertains to my great friend who is now 86. He was the first person to pick up the news of the World War II attack on Pearl Harbor. He is now getting along in years. We are going to honor him on Friday night, and I would like to have this resolution adopted by that time.

I thank the Chair.

Mr. REID. Mr. President, have the yeas and nays been ordered on the Durbin amendment?

The PRESIDING OFFICER. They have not.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

Mr. SANTORUM. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. There is a pending request for the yeas and nays.

There is not a sufficient second.

Mr. SANTORUM. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 994. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL), the Senator from Illinois (Mr. FITZGERALD), and the Senator from Arizona (Mr. McCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. McCAIN) would vote "yea".

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY), the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 56, as follows:

[Rollcall Vote No. 245 Leg.]

YEAS—39

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Clinton
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Graham (FL)
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—56

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Conrad
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Feinstein
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Lott
Lugar
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—5

Campbell
Fitzgerald
Kerry
Lieberman
McCain

The amendment (No. 994) was rejected.

AMENDMENT NO. 1000

The PRESIDING OFFICER. There are 2 minutes evenly divided before the next vote.

The Senator from New York.

Mrs. CLINTON. This amendment is critical to the functioning of the plan now under consideration. If we are going to move toward creating a marketplace for drugs, then we need information about which drugs work better for the money they cost. Last December, we found out through a study by the National Heart, Lung and Blood Institute that the newer drugs such as calcium channel blockers and ACE inhibitors which cost 30 to 40 percent more than diuretics were not as effective for treating high blood pressure. There is much information about this.

My amendment is very simple. It asks NIH to do studies comparing drugs to give that information to physicians and to consumers so they can make good decisions in the marketplace. It also asks that we synthesize the literature out there, make it available over the Internet. If we are going to have a marketplace for drugs, the information about which drugs are more effective should not be the sole property of the great companies. Physicians, clinicians, consumers, and patients need that information. This will help us do that.

I hope you will support this amendment. It does not have any cost attached to it. It is about getting information to the people who will make the decisions about which drugs should be used when it comes to making these choices we are trying to provide for people.

Mr. ENZI. Mr. President, I rise in opposition to amendment No. 1000, offered by Senator CLINTON. This amendment would give the Federal Government new funding to manage comparative effectiveness studies of pharmaceuticals. While this may sound good on the surface, this amendment would end up as a tool for health care rationing by bureaucrats in Washington.

Comparative effectiveness analysis in the private sector can provide useful information. However, giving the Federal Government the power to make national determinations based on one or two comparative studies is dangerous, because these decisions would affect tens of millions of patients who rely on the Government for their health insurance.

This amendment would get the Federal Government even further into the business of making medical decisions. It would promote one-size-fits-all medicine.

Studies conducted under this amendment may be misused by the Centers for Medicare and Medicaid Services or other bureaucracies by encouraging broad and simplistic decisions about which patients should have access to new medicines.

Even worse, these comparative effectiveness studies might become a rigid benchmark adopted by payers across the health care system. Private insurers already look to Medicare for decisions on medical procedures and technologies, and doctors are already concerned about the way Medicare conducts those determinations.

Private insurers copy many of Medicare's limitations on the procedures and therapies from which physicians choose in determining the best course of treatment for their senior patients. If we extend this level of bureaucratic control to drugs and biotechnology, the Government's decisions about medical access would end up being imposed on many more patients than just Medicare beneficiaries.

In considering this amendment, we need to keep in mind that innovations in health care are usually incremental. This applies to drug developments, where "next-generation" advances yield incremental benefits compared to existing treatments.

Government studies on comparative effectiveness may fail to recognize or value fully these advances. If we had a Medicare drug benefit in place today that only paid for so-called "breakthroughs" in pharmaceuticals, we may not have reaped the benefits of many antibiotics, antivirial drugs, non-steroidal anti-inflammatory agents, and "beta blockers" for controlling high blood pressure.

Finally, centralized comparative analysis runs the risk of overlooking the value of specific medicines for individual patients. Prescription medicines to treat a specific disease or condition are different from one another. That is why patients and doctors need choice.

Population-based comparative effectiveness determinations such as those proposed in this amendment may fail to recognize important differences in the way individuals and sub-populations respond to different drugs and drug combinations. As a result, such studies can discourage access to new medicines that can benefit many patients with diseases and conditions such as hypertension, diabetes, heart disease and mental illness.

Comparative effectiveness studies are not dangerous, and we ought to encourage more and better studies on the relative merits of various drugs for various people. What concerns me is how this amendment would put the Government in control of these studies.

If one branch of the Government is conducting these broad studies, and another branch of the Government is paying for the drugs that your loved one needs, it is just a matter of time before the results of the broad studies are imposed upon the freedom that your family doctor has to choose the best drug therapy for your loved one.

Coming from Wyoming, I am used to fighting against one-size-fits-all solutions from the Federal Government. I certainly cannot support an amendment that would impose such an approach on something as important as healthcare for seniors who rely on pharmaceuticals to make their lives better.

I urge my colleagues to vote against this amendment.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Mr. President, I appreciate the intent of the amendment. However, I have significant concerns and must oppose it. The research provided by this amendment is unnecessary. It duplicates, in fact, existing authority in the HHS.

More importantly, this amendment contains two damaging provisions. It directs the Food and Drug Administration to include information coming from these studies in approved product labeling, effectively taking the sole authority of the FDA to regulate prescription drug labeling and giving it to other, nonexpert sources.

This amendment also changes the fundamental research mission of the National Institutes of Health.

Further, these changes have not been considered by the Health, Education, Labor, and Pensions Committee, which has jurisdiction over these programs.

This amendment is unnecessary. I urge my colleagues to defeat it.

Mrs. CLINTON. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL), the Senator from Illinois (Mr. FITZGERALD), and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote "yea".

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea".

The PRESIDING OFFICER (Mr. SUNUNU). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 43, nays 52, as follows:

[Rollcall Vote No. 246 Leg.]

YEAS—43

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—52

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Lott
Lugar
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—5

Campbell
Fitzgerald
Kerry
Lieberman
McCain

The amendment (No. 1000) was rejected.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I believe there is a unanimous consent request that the next amendment be the Grassley-Baucus amendment. I think they are working on that. I ask unanimous consent to make a statement on the bill for not to exceed 20 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. Mr. President, first I want to make a couple comments on the bill, then talk about a couple amendments we will be working on. I wish to compliment first Senator FRIST and Senator GRASSLEY, Senator BAUCUS for getting us here. I also compliment President Bush because he has been pushing for us to expand Medicare to include prescription drugs. I happen to share that goal so I compliment him because here we are.

I believe in the next 24, maybe 28 hours, we will eventually pass a Medicare bill that will provide prescription drugs. That is our objective. That is a good one. I hope we will be successful.

I also hope we will pass a bill that is affordable. I am not sure the bill before us now meets that definition. I want to talk about what is in the bill and maybe some of the challenges we have confronting us, but again I want to compliment the chairman of the Finance Committee.

This year we did have a markup in the committee, and we did report out a bill. I didn't vote for it. I will explain why I didn't vote for it. But I hope to vote for a bill either on the floor of the Senate or as the bill comes out of conference.

At least we had a markup. I am on the Finance Committee. The Democrats were in control of the Senate last year. We didn't have a markup in the Finance Committee. We basically had a markup on the floor of the Senate. We spent some time on it, several weeks, but we didn't pass a bill. It didn't become law. It was very frustrating. We didn't do the normal process.

This year I don't quite agree with the final outcome as it came out of committee, but at least we had a chance. We had a bill. We had a markup. We considered dozens of amendments. We reported out a bill.

Now, the Senate has been on this bill for 2 weeks. We have considered a lot of amendments. We will consider more both tonight and tomorrow. So my compliments to the leader and to the chairman of the committee for getting the bill to where we are.

Let me talk a little bit about the current status of Medicare. Medicare has big challenges confronting it today. It is a very popular program, but it is a program that really can and could and should be improved. It is a very expensive program. The cost of Medicare has more than doubled since 1990. In 1990 we were spending $100 billion. Today we are spending over $200 billion. But that doesn't show the liabilities that we already have in the system.

Medicare has a shortfall of $13.3 trillion. By "shortfall" I mean benefits that have been promised that are not funded, not paid for. That is an enormous sum of unfunded liability. The total unfunded liability of Social Security is $4.6 trillion. The total debt held by the public is $3.6 trillion. So we are looking at Medicare's shortfall actually exceeding or tripling the total amount of debt held by the public.

I heard many colleagues, when we talked about raising the debt limit, say we should not do this. What we are doing on Medicare and the bills we are considering right now will increase the unfunded liability in Medicare probably by $4 or $5 or $6 trillion, greater than the total Social Security shortfall and far greater than the debt held by the public. This is an enormous expansion of benefits we are saying we will pay for. People need to know it.

Is it affordable? Just to pay for the Medicare shortfall today according to the 2004 budget of the U.S. Government it says to pay the actuarial deficiency as a percent of discounted payroll tax base—we would have to increase Medicare taxes 5.3 percent on top of the 2.9 we are already paying just to pay for this $13.3 trillion. We would have to more than double the tax. Actually, it would be, in effect, almost tripling the Medicare tax which is presently 2.9 percent on all payroll, not just on the Social Security base of $80,000-some. This is on all payroll. You would have to increase it an additional 5.23 percent, according to Government submissions and budget submissions, to cover the 75-year projections.

Social Security would only have to be raised 1.87 percent. So, again, it shows that at least actuarially, Medicare is in much worse shape, about three times worse shape as Social Security. And that is without us passing additional benefits on top of it. So I want my colleagues to be aware of that. This is a very unstable house, and we are getting ready to build another deck on top of it. That is the reason I am raising some of these concerns.

I want our colleagues to be aware. Maybe we will do it anyway. Maybe it is the popular thing to do. But at least I don't want it to go without saying: Wait a minute, did anybody not pay attention to the fact that these are enormous liabilities. They are going to be very expensive and somebody is going to have to pay the bill sometime. In the past, we paid for Medicare with the payroll tax. That has had some limiting effect. When trust funds were drawn down, people said: We have to do something. So there would either be a tax increase or there might be some reforms.

We passed Medicare reforms in 1997. We spent a lot of the last few years maybe undoing some of those reforms, but it did save money. Now we are getting ready to expand Medicare at a greater percentage than it has ever been expanded since its creation in 1965.

Again, I favor making significant improvements in Medicare. I find the system to be very obsolete in the benefits it provides. It has serious shortfalls. Medicare doesn't provide prescription drugs. It should. Medicare doesn't have preventive care, ordinary, routine checkups in many areas. It should. A good health plan certainly would do that.

It has a hospital deductible of $840. That is way too high. Then it has a different deductible for doctors. They should be a combined deductible, and it should be much lower than $800 and $900 combined.

It is a system that leaves a lot to be desired. It doesn't have catastrophic coverage. So if a person gets really sick and they are in the hospital for a long time, after a certain number of days Medicare doesn't pay it. That doesn't make sense. You really should have insurance to pay for something you can't afford to pay for, and this system doesn't do that.

As a matter of fact, a lot of our health care system, in my opinion, is broken because we end up insuring for relatively almost first-dollar costs, and we don't insure in some cases for the really expensive things or at least that is the way Medicare is. That is not a good example. We should change that. You should insure for those events that you can't afford. You shouldn't be insuring for ordinary, routine things that obviously individuals can pay for.

I make the analogy to automobiles. You should insure for the accidents, the collisions, for something very serious, something very expensive. You should not insure to fill the car up with gasoline or to change the oil.

In health care costs, I am afraid we insure for almost everything, and that greatly increases the cost. My major complaint with the bill before us is that I want to improve and expand and modernize Medicare. I want to improve Medicare. My mother is on Medicare. I want her to have a better health care system. I want her to have a health care system that is comparable to what we have for Federal employees. I would like for senior citizens to have a good base plan and then be able to choose any of a variety of other plans they wish to have—keep what they want or they can choose something better. They can have an integrated benefit system.

Unfortunately, I am not sure that is what we are going to pass probably tomorrow night. The bill we have before us—the reason I voted against it in Finance Committee, and I may vote against it on the floor of the Senate, is because I find the bill very expensive and very light on reforms. It doesn't make as many reforms as I would like and it is expensive on the subjects. I have mentioned we would have to increase payroll taxes by 5.23 percent just to make up for the shortfall. That doesn't include the drug benefit. I have been told by tax estimators that you would have to add another .7 or .8 percent to pay for the drug benefit we are adding.

I am concerned that the drug benefit we are adding will be much more expensive than anybody estimates. The budget resolution says it was $400 billion. I compliment the chairman and the House, who are staying with the $400 billion estimate, but I would project that many years from now, it will not be a $400 billion expansion; it will be much closer to $800 billion by the end of 10 years.

I am making this prediction and I mean it. This is not just a guess. Maybe it is a little more than a guess, but I think ultimately you will see a few things happen, and I will talk about the basic benefit we are offering and why I think the cost will exceed our estimates.

In the first place, the subsidies are very large indeed. For people below 160 percent of poverty, the Federal Government is going to pay almost all the drug expense. For individuals in this income category, as estimated by CMS—they estimate usage—drug usage is $3,200 for people below poverty, and then a little less than $3,000 for incremental levels above that. But the beneficiaries at the lower income levels pay very little. The Government pays almost all of it. I have heard some people say, wait a minute, you want to change that. I am questioning, is this affordable? For income levels in this category, the lowest income, the poorest of our seniors, an individual would pay $82 and the Federal Government would pay $3,214. An individual pays 2 percent and the Federal Government pays 97½ percent. That is a very high ratio.

The next level is not much different. The individual would pay 5 percent and the Federal Government pays 95 percent. The next level up—and this is with an income up to about 150 percent of poverty. For a couple, the income is about $19,576. So the Federal Government would pay 90 percent and the individual would pay 10 percent. Those are very generous subsidies.

Looking at the estimate, I would guess that if the Federal Government is going to pay 97 or 95 or 90 percent, you will have drug utilization go up maybe well beyond these figures.

These figures come from CMS, and they say those are figures for people with insurance, but I would guess the people who are on this level—Medicaid eligibles, and many States have a lot of restrictions on the number of prescription drugs they can have. In many States you are limited to three a month. If the Government is paying 97½ percent, and there is not a limitation of three or so many a month and it doesn't have the limitations of the States because the States are requiring cost sharing of 30, 40, or 50 percent, my guess is it will go up dramatically.

I think in all levels utilization will go up dramatically. Maybe I am wrong. I am concerned about it at least for these lower income levels, the income levels below 160 percent of poverty. The bill we have before us is probably too generous, but maybe not affordable. I hope I am proven wrong. But I have been in business. I took over management of a company when the company had a health care plan where the company paid 100 percent of health care premiums and costs. That really wasn't sustainable. I think a lot of other businesses found out, wait a minute, that is not affordable. Most businesses started putting in 80/20 ratios, where the beneficiary paid 20 percent, or 10 percent. I don't mind lower income people having to pay a smaller copay; I am fine with that. But I think we are starting out so generous that it will encourage overutilization, and costs will explode. Once you start out with a percentage like that, it is hard—I can see starting at 80 percent and maybe going to 90, but I don't see going from 97 percent to 90 percent. A future Congress may be forced to make those decisions. It may not be affordable or sustainable. The demands may be so great that it is not sustainable.

Is this a good deal for seniors? Certainly, people on the low end, below the 100 percent of poverty level, with an income of $9,600 and, for a couple, $13,000, the copay is $82 and they will receive almost $3,300. Under present law, according to CMS, they pay $734. So the amount they pay goes down almost 80-some-odd percent. This is a great deal for low-income if we can afford it. The next level would pay $150. Currently, they are paying almost $1,200. Again, they are only paying about one-eighth of what they were paying previously and getting a very nice return. This is 136 to 150 percent of poverty—that would be for individuals with incomes, and for a couple it would be up to $19,500. They would pay only $343. Presently, they are paying $1,300. So it is a big improvement for them, and they are receiving about $3,000 in benefits.

So there is a very good and generous benefit—maybe the most generous benefit anybody could propose is for incomes below 160 percent of poverty. Above that, it is not such a good benefit. I have heard some colleagues complain it is not so good for individuals with incomes above 100 percent of poverty, with incomes of about $15,400 or, for a couple, of about $21,000. Above that level, the formula changes. Then they have to pay a premium of $35 a month. Then they have a deductible of $275 a month. Then they receive a drug benefit after they get through the deductible of 50 percent up to $4,500. Then above $4,500, for the next $1,300, they would have to pay 100 percent. Above that level, they get 90 percent.

Well, that is not a great drug benefit. It is not great. It is OK, maybe, but it is not as good as a lot of plans. Looking at a lot of plans people now have, at levels like this, an individual for this plan today would be paying, under the new bill, $1,600. The individual today is only paying about $1,162. They would pay about an extra $500 for maybe a similar benefit, and it is estimated they would receive a total of about $3,000. Actually, if you look at the upper income—above $21,000 for a couple—in every category they pay more under the proposal we have before us than they are under current law. So it is not a real good deal for them. It is voluntary. Maybe they will drop out. If they drop out—it depends on the health status, but if they are healthy, it may make things worse for the taxpayers. They may not help subsidize others who are less healthy. It is a very generous benefit for lower income, below 160 percent of poverty, and it is not such a good deal for upper income.

A lot of people above 160 percent of poverty have drug coverage. A lot of people below that have health care. Below 160 percent, you cannot beat this deal. Above it, you can beat it. A lot of people have better., You say what do you mean? They might have a union plan. We had amendments to make sure those were made whole. We wanted to subsidize them to make sure they didn't lose a dollar. The CBO estimated that 37 percent of the people who have private health care coverage are going to drop them and go into this Government plan. They have health care through their employer, and their employer is going to say if Uncle Sam is going to do this, why don't you get your health care and drug benefits through Uncle Sam instead of through the employer.

A lot of employers are struggling to pay for retirees' health care benefits, so they would welcome this. So you will see a lot of companies dumping or dropping their health care coverage, even though it may well be more generous than what we have proposed before us, the bill before us in the Senate. Likewise, many States have drug programs, many of which may be more generous, not necessarily for low-income, but they have a plan, or some system, or other type of entity that we will be picking up. States were making a contribution, maybe it is a combination of State and Federal, to Medicaid. They are dropping it. Where the States were making a contribution in the past, we will be assuming that contribution. This is a big federalization, frankly, of the benefit that is provided in the public sector and private sector.

Seventy-seven percent of seniors today have some type of drug insurance. This is going to preempt most of that and say the Federal Government is going to take it over and, in some cases, not do as good as the private sector has done, maybe not even as good as most of the public sector.

Is it affordable? The estimates are it is $400 billion. I already mentioned I am concerned, at least on the levels where the Federal Government subsidies are 97 percent or 95 percent or 90 percent, that utilization will exceed expectations. If the Government is going to pay most of the cost of the drugs, my guess is people are going to say: Give me more of those drugs.

There is not a restriction that is going to say you can go to one doctor, go to this specialist for whatever ails you, you can go to another specialist for whatever ails you, and, frankly, if the Government is going to be picking up 95 percent of the drug care costs, people are going to say: Give me some of those. They are going to see the ads on TV. They may see Celebrex—it has a great rhyme to it—or see some other ad that looks good, and they say: Doctor, give me some of that. And if Uncle Sam is going to be paying 97 percent of the cost, why not? That makes your patient happy. Maybe it will work, maybe it will not.

My guess is we are going to see, where the third party or Government is paying 90-some-percent of drug care costs, that utilization will soar and that will greatly drive up the cost.

I think in the drug benefit formula where we have basically a formula above 160 percent of poverty where the Government says you pay your $35 a month and you pay your deductible of $275 and then Government will match you 50 percent up to the first $4,500, a lot of people who might have a drug annual expense in the neighborhood of $1,200 or $1,300 may say: I do not get my money back until I use or consume $1,300 worth of drugs, and I am paying a monthly premium; therefore, I am going to start taking advantage of it. If Uncle Sam is going to be paying 50 percent, I want more. So their utilization may go up and may go up dramatically. So that could increase costs.

Then we have this so-called doughnut amounts above $4,500 to where presently individuals would have to consume or pay for 100 percent up to $5,813. A lot of people are going to say we need to fill that up.

I ask unanimous consent for an additional 8 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. Mr. President, they are going to say we get 50 percent up to $4,500, and then it stops and we go to catastrophic, let's fill that in. The estimates were by some, if you filled that in, it would cost you another $200 billion. My guess is we are not going to do it this year, but we will do it sometime probably in the next 3 or 4 years. That will cost a bunch of money.

Then people are going to be complaining: This is really not a good deal. You get 90-percent subsidy over here but 50-percent subsidy over here. We need to make that 60, 70 percent. Frankly, that 60 percent is not high enough. Let's move that category up to 200 percent of poverty. Let's move it up higher.

When you make those kinds of incremental changes, and I know many of the advocates want to do that—they stated that. I acknowledge it, and everybody around here should acknowledge that is their desire—I expect they will be successful.

There are a lot of people who will say this is not near as good a deal as I have right now, and they are going to lobby Congress: We need a greater share; we need a greater match. Why not go 50/50? Can't we go 60/40, 80/20? Can't we fill in the doughnut and insure that whole amount?

When you make a few of those changes, you have a bill that is not going to cost $400 billion, it is going to cost $800 billion. In that last year, the line will be going straight up. I am concerned about that situation. I am concerned about the expense of it.

People say: What do we do to make it more affordable? Did we make some of the changes that would help make it more affordable? Did we make some of the reforms, some of which are not easy?

I have been an advocate for increasing the eligibility age, making Medicare the same age as recipients of Social Security. Right now with Social Security, you do not receive Social Security at age 65, you receive full retirement Social Security at 65 and 10 months. By the year 2022, you have to be 67 to receive Social Security.

I happen to think because people are living a lot longer and because Medicare has such enormous financial problems, we should make the Medicare-eligibility age concurrent with Social Security. Basically, by the year 2022, one would have to be 67 before receiving Medicare. I know that is not an easy vote, but, frankly, this Senate voted for it just a few years ago. We voted for it, I believe, with 62 votes. We passed it. We can, could, and should pass it again. It will save our kids a lot of Medicare taxes. That is one reform. I doubt we are going to offer that amendment, but it has been proposed and discussed, and I think it should be seriously considered.

Another amendment will be offered by Senator FEINSTEIN, myself, and Senator CHAFEE tomorrow that basically means testing Part B premiums. I will talk about Part B premiums, and it gets too confusing for a lot of people. We subsidize Medicare. Most people think we pay for Medicare just with the payroll tax.

The payroll tax, I already mentioned, is very deficient. As a matter of fact, it is 2.9 percent of all income, not capped. If somebody has an income of $1 million a year—Michael Jordan, I think, makes a little more than that—if they make an income of $1 million, they pay $29,000 a year into Medicare. Yet we are still going broke. The actuaries say we have to add another 5.2 percent on top. We have to have 8.1 percent to pay for the liabilities we currently have. That is without a drug benefit. If we add a drug benefit, we would probably need to add 1 percent on top of that.

Now we are talking about real money; we are talking about 8 or 9 percent of the liabilities in Medicare. We need to make reforms. One would be to means test Part B premiums. Payroll tax pays a lot of money, but general revenue pays a lot of money into Medicare.

To give an example, this year general revenue, not the payroll tax, general revenue coming from all taxpayers in the year 2003 will put in about $81 billion. In the year 2013, it will be $189 billion. So it more than doubles in the next 10 years, and it does not keep up.

That general revenue portion is the individual recipient pays one-fourth of Part B. This is what pays the doctors. The recipient pays one-fourth of it, and the taxpayer or the general revenue fund pays three-fourths of it. What that means is we are asking our kids to pay for three-fourths of our doctors visits.

At least for those with upper incomes we should not be asking our kids, who are maybe making $20,000 or $15,000 or $30,000, to be paying part of the doctor bills for at least the wealthier seniors. Not all seniors are low income. So the amendment we will be considering probably tomorrow evening says instead of having a 25-percent copay for beneficiaries on Part B, if your income is very high, it will be 50 percent; if it is much higher, it will be 100 percent.

I believe the levels are if an individual has an income of $75,000 and $100,000 for a couple, their percentage would increase from 25 percent to 50 percent. Likewise, for a couple, if an individual had an income of $100,000 or the couple had an income of $200,000, they would have to pay 100 percent of the premium. So we would not be subsidizing them. That would take a lot of pressure off the system.

The most recent trustee report states that SMI, that is Part B revenues, in 2002 were equivalent to about 7.8 percent of personal Federal income tax collected that year. If such taxes remain at their current level relative to the national economy, then Part B general revenue financing in the year 2077, 75 years from now, would represent roughly 32 percent of total income taxes. Now, that is staggering. About a third of all income taxes would have to be paid just to pay the Part B subsidies that we now have in the system. That is not sustainable.

My point is, we have to have a Medicare system that provides better benefits. Yes, I agree. We also have to have a Medicare system that is sustainable for future generations, for our kids and grandkids. We want to have a system they can afford.

I mention these as two reforms, and there is one other one I am going to mention. The primary reform that is in the underlying bill provides for a private sector health care plan—most of the time we call it a PPO, preferred provider organization—similar to many of the health care plans that are all across America providing an integrated structural benefit. They do not just provide drugs. They provide all health care benefits. They provide the hospital and the doctor, access to specialists and drugs. That is what is in most people's health care plans today.

That is not Medicare. We would like to update and upgrade Medicare to bring it into the 21st century so it has comparable benefits, so it can have an integrated management system, so that individuals who are in the system say, yes, they control your drugs and they control your visit to the hospital and the specialist, and you have really good quality care.

We do not have that in Medicare today. The real reform and what many of us are hoping we can do is improve Medicare so people can have preventive health care, so they can have more screenings, catastrophic, and prescription drugs all as one part of a package like Federal employees, like other health care, like a lot of the union plans that are out there today. We do not have that in Medicare today. So we are trying to make that a viable alternative to the present system.

So if some individual wants to stay in the present system, they can, but if they would like to choose a better, more modern system, more integrated system, they can do that.

I very much hope to see that the PPO model will actually become a reality that is a real viable alternative. CBO estimates that in the underlying bill only 2 percent would participate in the new PPOs. That is a failure. CMS, the Center for Medicare and Medicaid, estimates it might be as high as 42 or 43 percent. I would like for that to be the case. I think that may be overly optimistic.

I think we need to work to improve this section of the bill. I know that Senator GRASSLEY and Senator BAUCUS have an amendment to maybe make a small step in that direction, and I compliment them for it. For the life of me, I think if this is the only reform in the bill that we have, and we do not even have competitive bidding until the year 2009, that is not real reform.

I hope to be or expect to be a conferee on this bill, and I am going to work to try and see that we have real competition as a viable alternative to improve quality Medicare for all seniors. They should at least have that option. I do not see it in the bill we have right now, but I want to work to make that happen. That is one key we are hanging on for reform in the bill that is before us. We do not have Part B means testing. We do not have eligibility age. We did not make the tough decisions to help save Medicare and make it more affordable for future generations. What we are doing is basically spending a lot of general revenue money to provide benefits that frankly are long overdue.

I hope we would make some of these improvements in conference or maybe on the floor. We are going to try and make one or two of these tomorrow, and I hope that they would pass to make this a better bill.

I want to support this package. I want to pass Medicare. I want to improve Medicare for all seniors. I am afraid right now the bill is heavy on subsidies and short on reform, short on improvements, short on making real structural and substantial savings that will save the system for future generations. I want to save it for seniors today, and I want to save it for future generations tomorrow.

I will work with my colleagues both in the House and the Senate and the conference to try to achieve that objective.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. McCONNELL. Mr. President, I begin by complimenting the distinguished Senator from Oklahoma for his remarks and his very important contribution to this debate. He is one of the most knowledgeable members of our conference on this subject. I thank him for the fine work he has been doing on this important bill.

Of course, Chairman GRASSLEY and the ranking member, Senator BAUCUS, have been doggedly pursuing this important legislation, not to mention our leader, the majority leader, the only physician in the Senate. He has had this as a top priority for the last 4 or 5 years, really for all of his term in the Senate. These individuals, along with Senator KYL and Senator LOTT, have made an important contribution in getting this legislation to the stage that we find it today.

For almost 40 years, since Medicare was created, we have debated how to help our most frail citizens acquire the miraculous but expensive prescription drugs that they need. After all the talking for decades, today we are finally acting to provide to our seniors, the poor and the fragile of our society, the financial aid and means to acquire these wonder drugs.

As we move deeper into this debate to provide Medicare assistance to those citizens most likely to need these miracle drugs but least able to afford them, some will ask, what took us so long? The question is really not rhetorical. The reason it has taken so long is the same reason why I suggest today that this Medicare debate has not been easy, nor do I believe it is preordained that a quality Medicare prescription drug and reform bill will pass this body.

The reason we have difficult work to do is because there is a riddle to Medicare drug benefits. The riddle of Medicare drug benefits is this: How can Congress take the fastest growing Federal entitlement, with the largest long-term funding gap, and add an expensive but needed new benefit without overwhelming the fiscal solvency of the program or imposing a crushing payroll tax burden? Simply put, how can we add prescription drugs to Medicare today yet still preserve Medicare tomorrow?

Yes, it is possible, and the President has solved the riddle of Medicare. To understand how, we can look to another riddle from ancient Greek mythology. Legend holds that the ancient city of Thebes suffered from a creature called a sphinx: part woman, part lion, and part bird. This creature would devour any who failed to solve the riddle of the sphinx.

The riddle asked: What animal walks in the morning on four feet, in the afternoon on two feet, and in the evening on three feet? The answer is, of course, man, said the legendary Oedipus. In childhood, he creeps on his hands and knees; in manhood, he walks upright; and in old age, he walks with the aid of a cane.

Oedipus first considered man in all stages of life, but only by considering the common cane did Oedipus find the answer. Thus, he solved the riddle, destroyed the sphinx, and ended his people's suffering.

I suggest a similar approach to the riddle of Medicare. We must consider Medicare as it relates to our people in all stages of life—yes, as seniors, but also as working adults and as children. The key is to consider the common cane, the ageless symbol of age, the cane. When the Government buys this quad cane through Medicare, it pays $44 for this cane. When the Government buys the same cane through the Veterans Affairs Department, it pays $15. Let's run that by us one more time. Two different departments of the Government: Medicare buys the cane and pays $44. Veterans Affairs buys the cane and pays $15. The same cane, same Government, same patient but different Government program—$44 versus $15.

Solve this and we solve the riddle of Medicare. Solve this and Medicare prescription drugs will not come at the expense of Medicare preservation.

The General Accounting Office has documented how Medicare habitually overpays compared not just to what the private sector pays for medical goods but what other parts of the Government pay for medical goods. Medicare pays $12 for a catheter that most Federal Employees Health Benefits Plans pay only $1. Medicare pays $9 for an infection drainage bag while Blue Cross/Blue Shield typically pays $2.25. Yet overpaying is only part of the problem. Fraud and abuse costs Medicare as much as $12 billion per year. Over 10 years that would equal almost one-third of the $400 billion we dedicate to Medicare in this bill we are considering.

Paperwork and redtape also waste Medicare dollars. With 110,000 pages of regulations, hospitals hire literally armies of clerks to handle everything but medical care. Some doctors are forced to spend as much time on Medicare patients' paperwork as they do caring for the Medicare patient.

Medicare's regulatory burden is so great that the world-renowned Mayo Clinic requested not to be named Medicare Center for Excellence because the paperwork and redtape linked to such a distinction exceeded the benefit of any additional funds, as well as the honor itself.

These are the aspects of Medicare that so many want to change yet so many seem to ignore.

If we provide these drugs without fixing how we continuously overpay for this cane, we will fail to fix Medicare. Medicare prescription drugs for our parents will come as Medicare preservation for our children. There is an answer to the riddle. In a word, it is reform. That is what the President's plan is all about and the key to the work we began earlier this week: Provide prescription drugs for our parents and ensure preservation for our children.

The President has sent us the right plan at the right price. It will strengthen and modernize the entire Medicare system.

As we continue to work on this modified version of the President's plan we must keep in mind that while the President likes what we have done so far, he wants us to do more. That is a good goal for all. This is not a political game. This is for real. This is not about the next election; it is about the next generation. This is not just about prescription drugs; this is also about preservation.

Yes, this is about our parents and grandparents, but this is also about our children and grandchildren. If we keep in mind all of our people and all that is at stake, I am confident we will produce a bill we can all be proud of and that the President can sign. That challenge continues today.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. HARKIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 991

Mr. HARKIN. Mr. President, last week, I believe it was Friday, a number of amendments were laid down, one of them being an amendment that I offered. It is cosponsored by Senator SMITH of Oregon. It has been sitting there all week. I have not had much of a chance to say anything about it.

I thought, since there is a lull on the floor, I might take an opportunity to talk about that amendment and what it does, just so, when it comes up for a vote, I will not have to take a lot of time then to talk about it.

The amendment, I would say at the outset, is exactly the same as President Bush requested in his 2004 budget but for one small change. President Bush's budget requested $350 million a year for 5 years, under Medicaid, to get people with disabilities out of institutions and nursing homes and into community living.

The problem is that the cost of this to the States is very high for the first year. You can understand and appreciate, taking people out of an institution, out of a nursing home, means the State has to find housing; it has to find, perhaps, qualified personnel to help, maybe attendant services. So there are a lot of preliminary things a State has to do in order to provide for this transition from an institution to community-based living. Many States simply cannot afford it.

The good news is that States want to do this because it has been shown, in the States that have done this already, they save a lot of money. It is much cheaper to have a person with a disability in a community-based or home-based setting than in an institution or a nursing home—much cheaper. In fact, in a couple or three States that have already done this, we have had savings of over $40 million or $50 million a year to those States.

Again, the hurdle is that first year, getting people out of these institutions and into community-based living. What the President had requested in his budget was $350 million over 5 years as an enticement to States to do this. What the Federal Government would do is it would provide 100 percent of the funds per Medicaid beneficiary for that first year. After the first year, then the State would go back to the Federal/State Medicaid match that the State had before. So, let's say a State had a 60/40 Federal/State match on Medicaid right now. During the first year, the State would have to come up with no money; the Federal Government would take 100 percent, would provide 100 percent. The State could use that money, then, that extra money, to set up community-based living systems for people and institutions and nursing homes. After that first year, then the State would go back to the 60/40 split it had before.

That is what this amendment is. It is called "Money Follows The Person," and that is what President Bush called it in his proposed budget also.

What our amendment would do would be to provide, in the 5-year program, $300 million in the first year and then $350 million in each of the following 4 years. Then that would be the end of it. It would be 2004 to 2008.

Again, it has been 13 years since the Americans With Disabilities Act was passed. We will celebrate that on July 26 this year. In the Americans With Disabilities Act, we as a Congress, as a country, said no to segregation of people with disabilities. The Americans With Disabilities Act said: We are going to integrate people with disabilities into our society. No longer are we going to exclude and segregate them. However, our Medicaid Program today, 13 years later, still says yes to segregation.

Here is what I mean by that. Recent data indicates that 70 percent of Medicaid funds are spent on institutional care and only 30 percent to pay for community services. The thrust of our Medicaid spending today is for institution-based care. Our Medicaid system kind of flies in the face of the Americans With Disabilities Act in which we as a country committed ourselves to desegregate people with disabilities, fully integrating them in our society.

I have been trying for the last 10 years to get this change made. It is a bipartisan effort. I am not the first to do this. Others have tried it also. I do commend President Bush for putting it in his budget proposal for this year. It is the right thing to do, and I commend the President for doing that.

Now, again, I want to make it clear, this amendment is about choice. No one will be moved out of an institution who does not choose to be moved. This is not mandatory. Under this amendment, a State will be required to ensure that individuals and their representatives have the necessary information to make an informed choice as to whether they want to live in community-based situations or whether they would prefer to remain in an institution.

Now, again, regarding the offset, our amendment is fully offset by a Medicare secondary payer provision that is supported by the Department of Justice and was included in the House bill.

Mr. President, I have a letter, dated June 17, from William E. Moschella, Assistant Attorney General. It is to the chairman of the House Committee on Energy and Commerce, Congressman TAUZIN. The letter states:

> This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act—

Which we are about now—

> set forth in Title III, Section 301, which would protect the integrity of the Medicare Trustee Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services in numerous court cases.

So the Department of Justice, speaking for the administration, is in favor of this offset.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from William E. Moschella, Assistant Attorney General.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. DEPARTMENT OF JUSTICE, OFFICE OF LEGISLATIVE AFFAIRS, OFFICE OF THE ASSISTANT ATTORNEY GENERAL,
Washington, DC, June 17, 2003.

Hon. W.J. (BILLY) TAUZIN,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act, set forth in Title III, Section 301, which would protect the integrity of the Medicare Trust Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services ("HHS") in numerous court cases.

Congress enacted the Medicare Secondary Payer ("MSP") statute in 1980 to protect the fiscal integrity of the Medicare program by making Medicare a secondary, rather than a primary, payer of health benefits. To ensure that Medicare would be secondary, Congress precluded it from making payment when a primary plan has already made payment or can reasonably be expected to pay promptly. Congress recognized, however, that in contested cases, payments under such plans would be delayed. To protect providers, suppliers, and beneficiaries, Congress authorized Medicare to make a "conditional" payment when prompt resolution of a claim cannot reasonably be expected. The Medicare Trust Fund must be reimbursed, however, once the primary insurer's obligation to pay is demonstrated.

Some recent court decisions have held, however, that Medicare has no right to reimbursement unless the primary insurer could reasonably have been expected to make prompt payment at the outset. *See, e.g., Thompson v. Goetzmann*, 315 F.3d 457 (5th Cir. 2002). These rulings make the statute's reimbursement mechanism inoperative in some jurisdictions. Section 301 of this legislation would end this costly litigation and provide clear legislative guidance regarding Medicare's status as a secondary payer of health benefits. The technical changes in Section 301 make clear that Medicare may make a conditional payment when the primary plan has not made or is not reasonably expected to make prompt payment.

The technical amendments of Section 301 clarify other provisions of the MSP statute, as well. They make clear that a primary plan may not extinguish its obligations under the MSP statute by paying the wrong party (i.e., by paying the Medicare beneficiary or the provider instead of reimbursing the Medicare Trust Fund. The Section clarifies that a primary plan's responsibility to make payment with respect to the same item or service paid for by Medicare may be demonstrated, among other ways, by a judgment, or a payment conditioned upon the recipient's compromise, waiver or release of items or services included in the claim against the primary plan or its insurer; no finding or admission of liability is required. In addition, Section 301 makes clear that an entity will be deemed to have a "self-insured plan" if it carries its own risk, in whole or in part. Finally, the Section makes clear that the Medicare program may seek reimbursement from a primary plan, from any or all of the entities responsible for or required to make payment under a primary plan, and additionally from any entity that has received payment from the proceeds of a primary plan's payment. These provisions of Section 301 will resolve contentious litigation and are designed to protect the fiscal integrity of the Medicare program.

We hope that this information is helpful. The Office of Management and Budget has advised that there is no objection to this report from the standpoint of the Administration's program. Please let us know if we may be of additional assistance.

Sincerely,

WILLIAM E. MOSCHELLA,
Assistant Attorney General.

Mr. HARKIN. So again, we have an amendment that is exactly what the President had in his 2004 budget request. We have an offset supported also by the administration. So this is truly a bipartisan effort.

This amendment Senator SMITH and I have offered is widely supported by older Americans and people with disabilities. AARP, the Consortium of Citizens with Disabilities, ADAPT, the National Council on Independent Living, the National Council on the Aging, and the National Association of Area Agencies on Aging all support this amendment.

Both parts of this amendment—the Money Follows Program and the offsets—are about fairness and justice. If this amendment is adopted, private insurers will pay their fair share of Medicare costs and people with disabilities will have the opportunity to live in their own communities.

I will just talk about a constituent of mine, Ken Kendall. Ken was injured in an accident and has a serious spinal cord injury. When he lost his health insurance, he was forced to go on Medicaid, and his only choice was a nursing home almost 2 hours from his friends and family.

Ken recently wrote to me that he went to dinner and a movie for his 30th birthday. No big deal, except he had not been to dinner and a movie in the 2 years since he went into a nursing home. He said: "I was almost in tears. I felt like I had a real life again."

This amendment would give people like Ken a real life again, and not just on their birthdays. Individuals with disabilities should not have to continue waiting to enjoy the opportunities all other Americans take for granted.

So again, that is the essence of the amendment.

AMENDMENT NO. 991, AS MODIFIED

Mr. President, I ask unanimous consent that the amendment be modified with the modification I send to the desk. This is a modification to amendment No. 991.

The PRESIDING OFFICER. Is there objection?

Without objection, the amendment is so modified.

The amendment (No. 991), as modified, is as follows:

At the appropriate place, insert the following:

TITLE —MEDICAID DEMONSTRATION PROJECTS

SEC. 01. SHORT TITLE.

This title may be cited as the "Money Follows the Person Act of 2003".

SEC. 02. FINDINGS.

Congress makes the following findings:

(1) In his budget for fiscal year 2004, President George W. Bush proposes a "Money Follows the Person" rebalancing initiative under the medicaid program to help States rebalance their long-term services support systems more evenly between institutional and community-based services.

(2) The President, by proposing this initiative, and Congress, recognize that States have not fully developed the systems needed to create a more equitable balance between institutional and community-based services spending under the medicaid program.

(3) While a few States have been successful at achieving this balance, nationally, approximately 70 percent of the medicaid funding spent for long-term services is devoted to nursing facilities and intermediate care facilities for the mentally retarded. Only 30 percent of such funding is spent for community-based services.

(4) As a result, there are often long waiting lists for community-based services and supports.

(5) In the Americans with Disabilities Act of 1990, Congress found that individuals with disabilities continue to encounter various forms of discrimination, including segregation, and that discrimination persists in such critical areas as institutionalization.

(6) In 1999, the Supreme Court held in *Olmstead v. LC* (527 U.S. 581 (1999)) that needless institutionalization is discrimination under the Americans with Disabilities Act of 1990, noting that institutional placement of people who can be served in the community "perpetuates unwarranted assumptions that persons so isolated are unworthy of participating in community life." (Id. at 600). The Court further found that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." (Id. at 601).

(7) Additional resources would be helpful for assisting States in rebalancing their long-term services support system and complying with the *Olmstead* decision.

SEC. 03. AUTHORITY TO CONDUCT MEDICAID DEMONSTRATION PROJECTS.

(a) DEFINITIONS.—In this section:

(1) COMMUNITY-BASED SERVICES AND SUPPORTS.—The term "community-based services and supports" means, with respect to a State, any items or services that are an allowable expenditure for medical assistance under the State medicaid program, or under a waiver of such program and that the State determines would allow an individual to live in the community.

(2) INDIVIDUAL'S REPRESENTATIVE; REPRESENTATIVE.—The terms "individual's representative" and "representative" mean a parent, family member, guardian, advocate, or authorized representative of an individual.

(3) MEDICAID LONG-TERM CARE FACILITY.—The term "medicaid long-term care facility" means a hospital, nursing facility, or intermediate care facility for the mentally retarded, as such terms are defined for purposes of the medicaid program.

(4) MEDICAID PROGRAM.—The term "medicaid program" means the State medical assistance program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(5) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(6) STATE.—The term "State" has the meaning given such term for purposes of the medicaid program.

(b) STATE APPLICATION.—A State may apply to the Secretary for approval to conduct a demonstration project under which the State shall provide community-based services and supports to individuals—

(1) who are eligible for medical assistance under the medicaid program;

(2) who are residing in a medicaid long-term care facility and who have resided in such facility for at least 90 days; and

(3) with respect to whom there has been a determination that but for the provision of community-based services and supports, the individuals would continue to require the level of care provided in a medicaid long-term care facility.

(c) REQUIREMENTS.—A State is not eligible to conduct a demonstration project under this section unless the State certifies the following:

(1) With respect to any individual provided community-based services and supports under the demonstration project, the State shall continue to provide community-based services and supports to the individual under the medicaid program (and at the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) reimbursement rate), for as long as the individual remains eligible for medical assistance under the State medicaid program and continues to require such services and supports, beginning with the month that begins after the 12-month period in which the individual is provided such services and supports under the demonstration project.

(2) The State shall allow an individual participating in the demonstration project (or, as appropriate, the individual's representative) to choose the setting in which the individual desires to receives the community-based services and supports provided under the project.

(3) The State shall identify and educate individuals residing in a medicaid long-term care facility who are eligible to participate in the demonstration project (and, as appropriate the individual's representative) about the opportunity for the individual to receive community-based services and supports under the demonstration project.

(4) The State shall ensure that each individual identified in accordance with paragraph (3) (and, as appropriate, the individual's representative), has the opportunity, information, and tools to make an informed choice regarding whether to transition to the community through participation in the demonstration project or to remain in the medicaid long-term care facility.

(5) The State shall maintain an adequate quality improvement system so that individuals participating in the demonstration project receive adequate services and supports.

(6) The State shall conduct a process for public participation in the design and development of the demonstration project and such process shall include the participation of individuals with disabilities, elderly individuals, or individuals with chronic conditions who are part of the target populations to be served by the demonstration project, and the representatives of such individuals.

(7) The Federal funds paid to a State pursuant to this section shall only supplement, and shall not supplant, the level of State funds expended for providing community-based services and supports for individuals under the State medicaid program as of the date the State application to conduct a demonstration project under this section is approved.

(d) APPROVAL OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall conduct a competitive application process with respect to applications submitted under subsection (b) (taking into consideration the preferences provided under paragraph (2)) that meet the requirements of subsection (c). In determining whether to approve such an application, the Secretary may waive the requirement of—

(A) section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations;

(B) section 1902(a)(10)(B) of such Act (42 U.S.C. 1396a(a)(10)(B)) with respect to comparability; and

(C) section 1902(a)(10)(C)(i)(III) of such Act (42 U.S.C. 1396a(a)(10)(C)(i)(III)) with respect to income and resource limitations.

(2) PREFERENCE FOR CERTAIN APPLICATIONS.—In approving applications to conduct demonstration projects under this section, the Secretary shall give preference to approving applications that indicate that the State shall do the following:

(A) Design and implement enduring improvements in community-based long-term services support systems within the State to enable individuals with disabilities to live and participate in community life, particularly with respect to those practices that will ensure the successful transition of such individuals from medicaid long-term care facilities into the community.

(B) Design and implement a long-term services support system in the State that prevents individuals from entering medicaid long-term care facilities in order to gain access to community-based services and supports.

(C) Engage in systemic reform activities within the State to rebalance expenditures for long-term services under the State medicaid program through administrative actions that reduce reliance on institutional forms of service and build up more community capacity.

(D) Address the needs of populations that have been underserved with respect to the availability of community services or involve individuals or entities that have not previously participated in the efforts of the State to increase access to community-based services.

(E) Actively engage in collaboration between public housing agencies, the State medicaid agency, independent living centers, and other agencies and entities in order to coordinate strategies for obtaining community integrated housing and supportive services for an individual who participates in the demonstration project, both with respect to the period during which such individual participates in the project and after the individual's participation in the project concludes, in order to enable the individual to continue to reside in the community.

(F) Develop and implement policies and procedures that allow the State medicaid agency to administratively transfer or integrate funds from the State budget accounts that are obligated for expenditures for medicaid long-term care facilities to other accounts for obligation for the provision of community-based services and supports (including accounts related to the provision of such services under a waiver approved under section 1915 of the Social Security Act (42 U.S.C. 1396n)) when an individual transitions from residing in such a facility to residing in the community.

(e) Payments to States.—

(1) In general.—The Secretary shall pay to each State with a demonstration project approved under this section an amount for each quarter occurring during the period described in paragraph (2) equal to 100 percent of the State's expenditures in the quarter for providing community-based services and supports to individuals participating in the demonstration project.

(2) Period described.—The period described in this paragraph is the 12-month period that begins on the date on which an individual first receives community-based services and supports under the demonstration project in a setting that is not a medicaid long-term care facility and is selected by the individual.

(f) Reports.—

(1) In general.—Each State conducting a demonstration project under this section shall submit a report to the Secretary that, in addition to such other requirements as the Secretary may require, includes information regarding—

(A) the types of community-based services and supports provided under the demonstration project;

(B) the number of individuals served under the project;

(C) the expenditures for, and savings resulting from, conducting the project; and

(D) to the extent applicable, the changes in State's long-term services system developed in accordance with the provisions of subsection (d)(2).

(2) Uniform data format.—In requiring information under this subsection, the Secretary shall develop a uniform data format to be used by States in the collection and submission of data in the State report required under paragraph (1).

(g) Evaluations.—The Secretary shall use an amount, not to exceed one-half of 1 percent of the amount appropriated under subsection (h) for each fiscal year, to provide, directly or through contract—

(1) for the evaluation of the demonstration projects conducted under this section;

(2) technical assistance to States concerning the development or implementation of such projects; and

(3) for the collection of the data described in subsection (f)(1).

(h) Funding.—

(1) In general.—There is appropriated to carry out this section—

(A) $300,000,000 for fiscal year 2004; and

(B) $350,000,000 for each of fiscal years 2005 through 2008.

(2) Availability.—Funds appropriated under paragraph (1) for a fiscal year shall remain available until expended, but not later than September 30, 2008.

SEC. 04. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

Mr. HARKIN. Mr. President, all this modification does is it changes the first year, but it leaves everything else the same. This was $350 million each of the 5 years. This is now $300 million in the first year, and $350 million for each of the 4 years thereafter.

So again, as I said, 13 years ago we passed the Americans with Disabilities Act. We said no to segregation of people with disabilities. Ever since that time, Medicaid still continues to segregate people. When 70 percent of their money goes for institutional care, and only 30 percent goes for community-based care, it is time to break that down and give people with disabilities the right to exercise their own choice about where they want to live. And that, really, is the essence of the amendment.

I hope Senators will support the amendment overwhelmingly since, as I said, it was in the President's 2004 budget and the offset we have used is also fully supported by the administration.

With that, Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I ask unanimous consent to set the pending amendment aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1087

(Purpose: To permit the offering to consumer-driven health plans under MedicareAdvantage)

Mr. GRASSLEY. I rise to offer an amendment for Senator Craig. I send the amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. Grassley], for Mr. Craig, proposes an amendment numbered 1087.

(The amendment is printed in today's Record under "Text of Amendments.")

Mr. GRASSLEY. I am doing this for Senator CRAIG. I am going to yield the floor because Senator CRAIG is going to discuss his amendment tomorrow.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 992 WITHDRAWN

Mr. BAUCUS. On behalf of the Senator from Michigan, Ms. STABENOW, I ask unanimous consent amendment No. 992 be withdrawn.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENTS NOS. 941, 961, 983 EN BLOC

Mr. GRASSLEY. Mr. President, I call up amendments Nos. 941, 961, and 983 en bloc.

The PRESIDING OFFICER. The clerk will report the amendments.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for Mr. WYDEN, proposes an amendment numbered 941.

The Senator from Iowa [Mr. GRASSLEY], for Mrs. MURRAY, proposes an amendment numbered 961.

The Senator from Iowa [Mr. GRASSLEY], for Mr. SPECTER, proposes an amendment numbered 983.

The amendments are as follows:

AMENDMENT NO. 941

(Purpose: To provide for a study by MedPAC on Medicare payments and efficiencies in the health care system)

At the end of title IV, add the following:

SEC. . MEDPAC STUDY ON MEDICARE PAYMENTS AND EFFICIENCIES IN THE HEALTH CARE SYSTEM.

Not later than 18 months after the date of enactment of this Act, the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall provide Congress with recommendations to recognize and reward, within payment methodologies for physicians and hospitals established under the medicare program under title XVIII of the Social Security Act, efficiencies, and the lower utilization of services created by the practice of medicine in historically efficient and low-cost areas. Measures of efficiency recognized in accordance with the preceding sentence shall include—

(1) shorter hospital stays than the national average;

(2) fewer physician visits than the national average;

(3) fewer laboratory tests than the national average;

(4) a greater utilization of hospice services than the national average; and

(5) the efficacy of disease management and preventive health services.

AMENDMENT NO. 961

(Purpose: To fund the blended capitation rate for purposes of determining benchmarks under the MedicareAdvantage program)

At the end of subtitle A of title II, add the following:

SEC. . IMPROVEMENTS IN MEDICAREADVANTAGE BENCHMARK DETERMINATIONS.

(a) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting "who are enrolled in a MedicareAdvantage plan" after "the average number of medicare beneficiaries".

(b) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(B) by adding at the end the following new subparagraph:

"(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

AMENDMENT NO. 983

(Purpose: To provide medicare beneficiaries with information on advance directives)

On page 676, after line 22, insert the following:

SEC. . PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b–2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking "The notice" and inserting "(1) The notice"; and

(3) by adding at the end the following:

"(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

"(B) In this section:

"(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

"(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.".

AMENDMENTS NOS. 941, 967, AS MODIFIED; 961, 974, 983, AND 1010, EN BLOC

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the following amendments be agreed to en bloc and the motion to reconsider be laid upon the table en bloc: Amendments Nos. 941, 967, as modified; 961, 974, 983, and 1010.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments (Nos. 941, 961, 974, 983, and 1010) were agreed to.

The amendment (No. 967), as modified, was agreed to as follows:

(Purpose: To provide improved payment for certain mammography services)

At the end of subtitle B of title IV, add the following:

SEC. . IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 13951(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2015.

The PRESIDING OFFICER. The Senator from Montana.

AMENDMENTS NOS. 1088, 1089, 1090, AND 1091, EN BLOC

Mr. BAUCUS. Mr. President, on behalf of Senator MIKULSKI, I send four amendments to the desk and ask unanimous consent that the pending amendments be set aside so that the amendments might be offered. I don't know whether it is permissible to get consent to offer all four or we have to do it individually?

I send to the desk the four amendments en bloc and ask that the pending amendments be set aside. The amendments, for the purposes of consent, are to provide equal or equitable treatment for children's hospitals. Another is on the same subject. The third is to permit direct payment under the Medicare Program for clinical social worker services provided to residents of skilled nursing facilities. And the fourth is to extend certain municipal health service demonstration projects.

The PRESIDING OFFICER. Without objection, the clerk will report the amendments by number.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Ms. MIKULSKI, proposes amendments Nos. 1088 through 1091 en bloc.

The amendments are as follows:

AMENDMENT NO. 1088

(Purpose: To provide equitable treatment for children's hospitals)

At the end of subtitle B of title IV, add the following:

SEC. . EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and for which the PPS amount is less than the pre-BBA amount the amount of payment under this subsection shall be increased by the amount of such difference. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

AMENDMENT NO. 1089

(Purpose: To provide equitable treatment for certain children's hospitals)

At the end of subtitle B of title IV, add the following:

SEC. . EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

AMENDMENT NO. 1090

(Purpose: To permit direct payment under the medicare program for clinical social worker services provided to residents of skilled nursing facilities)

At the end of subtitle A of title IV, add the following:

SEC. . PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "clinical social worker services," after "qualified psychologist services,".

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking "and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.

AMENDMENT NO. 1091

(Purpose: To extend certain municipal health service demonstration projects)

At the end of title VI, add the following:

SEC. . EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking "December 31, 2004, but only with respect to" and all that follows and inserting "December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.".

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that at 9:15 tomorrow morning, the Senate proceed to a vote in relation to Harkin amendment No. 991, to be followed by a vote in relationship to the Edwards amendment No. 1052; provided further that there be 2 minutes equally divided before each vote and that no second-degree amendments be in order to the amendments prior to the vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. COLEMAN). Without objection, it is so ordered.

AMENDMENT NO. 1092

(Purpose: To evaluate alternative payment and delivery systems)

Mr. GRASSLEY. Mr. President, I send an amendment to the desk for myself and Senator BAUCUS and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for himself and Mr. BAUCUS, proposes an amendment numbered 1092.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in Today's RECORD under "Text of Amendments.")

Mr. GRASSLEY. This is an amendment I have worked out with Senator BAUCUS after considerable consultation with many colleagues on both sides of the aisle. The amendment has two parts. First, it would permit the Secretary, starting in 2009, to designate an alternative payment system for PPOs in a limited number of regions that the Secretary has determined to be highly competitive. This alternate payment system would permit the Secretary to set the Federal contribution for participation plans solely based on the bids they submit to the Secretary. The Secretary would still be required to choose the three plans with the lowest credible bids to participate. The Federal contribution would be set for the three plans participating by the second lowest bid submitted.

The second thing the amendment would do is authorize the Secretary, also starting in 2009, to establish a number of projects in the fee-for-service Medicare Program. These projects would be designed to provide enhanced services or benefits to improve the quality of care provided to Medicare beneficiaries, to improve the health care delivery system under the Medicare Program, and lower expenditures in that program. The enhanced services or benefits would include preventive services, chronic care coordination, disease management services, or other services the Secretary determines will advance the purposes of these projects.

The total cost of this amendment would be $12 billion starting in the year 2009 and would be equally divided between the alternative payment system and the fee-for-service projects.

Mr. President, this amendment represents a very reasonable compromise on the question of how to introduce into the Medicare Advantage Program a more competitive payment system.

I thank everyone, and most especially Senator BAUCUS, for working so hard and in a cooperative spirit to develop this amendment now before the Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, first, I thank my good friend and colleague, the chairman of the committee, Senator GRASSLEY, for his Job-like patience, as we have worked extremely hard with various Senators to try to come up with—and I think we have—a compromise, balanced solution as to how we spend the newly discovered $12 billion.

I have a couple of points. The intent of this amendment and the language of this amendment accomplish a couple of purposes: No. 1, to evenly divide the $12 billion—$6 billion and $6 billion—to be available to be potentially used by PPOs in areas designated by the Secretary, and the other $6 billion to be spent in additional Medicare Programs for disease management, chronic care, and other ways to help particularly address the lack of coordination services for the chronically ill and those seniors who particularly need disease management.

The amendment also has a couple other provisions, and to maintain the balance, maintain the symmetry is so important. I will remind my colleagues that in an attempt to get prescription drug benefits to seniors—something we all want to do—we are faced with two competing ideas. One is competition and the other is traditional Medicare. So the underlying bill is an attempt to work those two concepts together. This amendment follows on that tradition. It follows the same spirit, the same symmetry.

I mentioned the $6 billion and $6 billion. In addition, the amendment provides the authority to continue in the applicable number of years—beginning in 2009 through 2013—and the $12 billion is not available until then anyway. That is the problem we have. It doesn't start until 2009. But it is $6 billion available for potential PPO use and $6 billion for disease management, starting in 2009, for a 5-year period. In addition, the authority for both under this amendment continues into the future beyond the 5-year period.

In addition, the language is written so it is an absolutely clear, ironclad guarantee that after the 5-year period no further dollars will be spent on either side, either the $6 billion available for PPOs or the $6 billion to be available for disease management, et cetera. It is very important to maintain that symmetry and balance in order to accomplish the spirit of cooperation so that we get this program started, get the prescription drug program that we want delivered and on its way.

This is not perfect, but I can tell you that many hours have been devoted by many Senators on both sides of the aisle to come up with this solution, which does achieve that balance.

I urge Senators to support this. This is going to break the logjam. This is the key amendment which has been topic A. Many Senators are wondering about this as they are thinking about other amendments they may or may not offer.

I hope with the passage of this amendment we will be able to take up other amendments Senators have tomorrow and debate them and finally, hopefully, by sometime tomorrow and Thursday—perhaps at a late time on Thursday—pass this legislation and send it to conference.

I yield the floor.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, I rise to speak in support of this amendment, which is a product of about 48 hours of discussion and negotiation, in terms of packaging. I really speak in support of both of the parts of this amendment to which the managers have just spoken.

In the next couple days—hopefully maybe tomorrow night or the next morning—we will indeed have a historic vote to provide America's seniors with coverage they simply don't have today, don't have access to today—prescription drugs, preventive care, and chronic disease management. That is in the underlying bill.

Seniors will have the opportunity, for the first time, to choose the sort of coverage that best suits their individual needs. At the same time, they will have access to a benefit they don't have today, and that is in the underlying bill.

I support the amendment just introduced because it makes the bill even better for two reasons. No. 1—and this is where about $6 billion is spent—it strengthens the competitive model.

Ultimately, I believe—and I think the majority of people in this body believe—the only way we are going to be able to increase quality over the long term, in 10, 20, or 30 years, at the same time we have this unprecedented increase in the number of seniors in this country, a doubling in the number of seniors over the next 30 years, is to take advantage of the dynamism of the private sector where we can obtain the efficiencies that a command-and-control type plan, a Government-type plan simply cannot capture. It is the only way. Half of this amendment concentrates just on that—about $6 billion—to make those competitive, private sector dynamic, marketplace principles, yes, regulated by Government, work.

The other half of the amendment, the other $6 billion, also does something which we stress in the underlying bill, but through this amendment we will spend an additional $6 billion in supporting and investing in what we call preventive medicine, chronic disease management, coordinated chronic disease management we know how to address, but we have insufficiently invested in to maximize the care, the health care security our seniors deserve.

I will refer to a couple charts to explain why I am so excited about both aspects of this bill. I will first take the half of the bill that has to do with chronic disease management, and it links with what I prefaced in my remarks; that is, doubling the number of seniors. The challenge is going to be to sustain this long term; that is, Medicare long term.

If we look at overall numbers of beneficiaries in Medicare today, we know there are about 40 million beneficiaries, and this chart shows the percentage of beneficiaries. As we look at the total amount of moneys being spent today by those beneficiaries, those patients, those seniors, those individuals with disabilities who are a part of Medicare, we find that 6 percent, or about 1 in 20, account for 50 percent of all the money that is expended in Medicare today.

Since we know that health care is expensive, what we need to do, I believe, to make sure we get the best value for each health care dollar, each tax dollar that is paid to Government or that is paid for by the beneficiary, is to make sure this money is spent effectively and efficiently.

How do we do that? We ought to spend a lot of time focusing on this 50 percent, which is really 1 out of every 20 people. So in this body of 100 people, there would be six—just these six desks around me—accounting for 50 percent of all the expenditures. So why don't we figure out why these six people are so expensive?

Who are these six people? In this next chart, I will show you who they are because once we identify them and give them the very best coordinated care possible, I believe that number will reduce over time.

On this next chart, these "CCs" stand for chronic conditions. By "chronic condition," I mean heart failure, diabetes, chronic obstructive pulmonary disease, or emphysema.

What we find if we look at all Medicare expenditures—say this pie chart is all the money we spend on Medicare—most of the expenses are on individuals who have five chronic care conditions, and then those who have four chronic care conditions is about 13 percent; three chronic care conditions about 10 percent; two chronic conditions, say heart failure and diabetes, 7 percent.

By concentrating on people with chronic conditions, and if we give them coordinated care, seamless care, if we give them prescription drugs, which this bill does for the first time, if we help them with maybe a nurse calling once a week to help manage their care, use resources appropriately, over the long haul, this program will be sustainable.

I walked through these two charts because all of us know that Medicare is expensive, and we know that over time we need to fund whatever program we do, so let's concentrate our policy on where the expenses are, these six individuals, if we use this body as an example, and those are the people who have chronic care conditions.

Thus, this amendment, $6 billion of $12 billion, is being spent, focused like a laser beam on people with chronic care conditions. That is what the amendment does.

The underlying bill does that by setting up these PPOs, Medicare Advantage and Medicare+Choice, which gives seamless coordinated care built in a competitive marketplace. The underlying bill does that, but what this amendment does is focus an additional $6 billion on people with chronic conditions.

Also, part of that money is to improve preventive care, and we all know it is a lot cheaper to figure out who is going to get sick from heart disease and treat them accordingly than waiting until they get sick and are hospitalized and they develop what is called end stage cardiomyopathy. To me it is exciting.

I mentioned diabetes because diabetes is one of the conditions that I think best demonstrates how modern medicine today can, if properly managed, both have better outcome and lower cost. Today there are about 17 million Americans who suffer from diabetes. Another 16 million adults are at risk for developing the condition, and over the past decade, the number of diagnosed cases of diabetes has risen sharply.

Just in the last several weeks, the American-Diabetes-Association-sponsored study indicated that one-third, one out of every three children born in the United States this year will develop diabetes in their lifetime—one out of every three. So if you are a parent and listening to me now, and you have three children, one of those statistically will develop diabetes over their lifetime. It is huge. The National Health Interview Survey projects that 45 to 50 million Americans will have diabetes by 2050.

If we ineffectively manage diabetes, if we do not have access to the latest drugs, the appropriate management, the cost of managing and treating diabetes is huge. According to the American Diabetes Association, $91.9 billion was spent last year just in direct medical expenses for diabetics. Today, more than $1 in every $7 spent on health care in the United States is spent on behalf of diabetic patients.

I mention all of this because we know that health care costs for diabetes, if not managed in a coordinated system, are huge, and based on the statistics I just said with this dramatic increase in diabetes will increase over time.

How do we address it? We address it through an integrated health care model where you look at diet, you look at exercise, you look at drugs, you look at the appropriate testing to monitor blood sugars, and you have coordinated care. That is what we do in this Medicare PPO, Medicare Advantage model, and diabetes would fall into one of these chronic conditions. And we are going to be investing another $6 billion through this amendment in the overall management of conditions like diabetes.

The other—and I will close in a minute or so—the other $6 billion of this amendment, the other half of this amendment, is invested in increasing the competitive model.

I commented on this briefly, but what this allows us to do is to take advantage of what we know is in the marketplace today. We know that command and control and price controls run out of Washington, DC, do not work. We have tried it. We have seen it in Medicare in the past, and it resulted in a system that, yes, has been good for seniors, but it has not stayed abreast with the great advances we have seen in health care delivery or the new technology today. So we need a more responsive system, one that takes advantage of new innovation, new technology in the marketplace, that captures those dynamics of market-based competition. It is the private sector working in partnership with the public sector.

I will close by saying that I feel strongly that this amendment will incrementally, greatly improve health care for our seniors today. It will be debated, I am sure, over the course of the evening tonight and early in the morning. It is a product of a lot of working together, Democrats and Republicans, over the last 48 hours to put together the very best ideas for improving competition and market-based fundamentals and, at the same time, focusing on preventive medicine, prevention of disease, management of those chronic conditions, where many of the challenges exist in Medicare today.

We are nearing a historic vote to provide America's current and future seniors comprehensive health care coverage. Friday, we will pass legislation to improve and strengthen Medicare. The transformed program will offer modern and innovative coverage for procedures ranging from physical exams to hospital visits. And most significantly, the updated Medicare system will, for the first time, offer seniors prescription drug coverage. As a doctor who has served thousands of Medicare patients, I am committed to ensuring health care security for our seniors. Prescription drugs must be a part of that security.

The bipartisan bill offers seniors more choice and flexibility. Seniors will be able to stay with traditional Medicare, or they will have the option of being covered under Medicare Advantage. Medicare Advantage will offer better benefits and up-to-date medical care, including: preventive care; disease management; and protection from catastrophic costs. It will also, of course, offer comprehensive prescription drug coverage.

Seniors all across the country, including in rural areas, will have a Medicare plan that offers them similar types of benefits 8 million current and retired Federal employees now enjoy. Medicare Advantage is designed to combine the best of the Government and private sector and provide security, choice, quality, safety, flexibility and innovation. Chronic health problems especially will be tackled with more resources and better results.

The amendment will significantly strengthen the bill in this regard. Most importantly, it allows the Secretary of Health and Human Services additional flexibility to institute a true competitive bidding model for PPOs and other Medicare Advantage coordinated health plans. It does this by allowing payments to plans without regard to a benchmark linked to current payments under the Medicare+Choice or Medicare FFS system.

The second part of the amendment will devote up to $6 billion additional funds, beginning in 2009, for the Secretary to conduct broad demonstration projects that will likely lead to improvements in the disease management, chronic care management, and preventive care provided to seniors who choose to remain in the traditional Medicare program. This is great progress for seniors. We are modernizing Medicare to keep pace with modern medicine and tackle chronic disease.

Diabetes is a good example of how modern medicine, through prescription drugs, is offering both therapeutic benefits today as part of an integrated care regimen and promises effective treatments and new types of health care delivery in the future.

Approximately 17 million Americans—6% of the population—now suffer from diabetes. Another 16 million adults are at risk for developing the condition. Over the past decade, the number of diagnosed cases of diabetes has risen sharply. A recent American Diabetes Association sponsored study indicated that one third of children born in the United States in the year 2000 will develop diabetes in their lifetimes. The National Health Interview Survey projects that 45 to 50 million Americans will have diabetic by 2050.

Undiagnosed and improperly treated, diabetes can cause a host of complications, including: kidney failure; heart disease; and loss of limb. Medical expenditures for persons with diabetes are four times as high as their non-diabetic counterparts, in large part, because of these complications. According to the American Diabetes Association, $91.9 billion dollars was spent last year just in direct medical expenses for diabetics. Today, more than one in every seven dollars spent on healthcare in the United States is spent on behalf of diabetic patients.

Indeed, the healthcare costs for diabetes threaten to add a significant financial burden to Medicare. But the good news is there is much we can do to prevent the illness. We know that patient education, weight control, exercise and treatment can significantly reduce the incidence of adult onset diabetes.

Meanwhile, since 1995, five new classes of medicine have been introduced to treat diabetes. These medicines, coupled with health management and coordinated care programs, are powerful tools to increase a patient's health status and reduce complications due to the illness.

For example, one comprehensive disease management program treated approximately 7,000 diabetic patients and produced savings of $50 to $100 per diabetic patient, per month. Pharmaceutical costs increased under the program, but total health care spending declined.

Why? Because of fewer emergency room visits, substantially fewer inpatient hospitalizations and reduced lengths of stay. At the same time, (HEDIS) measures of the quality of care these patients received significantly improved.

In other words, a modern, coordinated health approach to diabetes which included prescription drugs, led to reduced costs and improved outcomes. And diabetes is only one of many chronic conditions for which prescription drugs help clinicians optimize care and improve the quality of life for patients. This amendment will go far in advancing life saving prescription drug approaches.

This is an exciting week for the Senate and for the American people. We have built on years of research, discussion, and debate. We now have a bill that reflects broad bipartisan support. Thanks to the leadership of my colleagues in the Senate, and the commitment of President Bush, America's seniors will finally receive the health coverage they need and the security they deserve.

Medicine has come a long way since 1965. Now, so too, will Medicare.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

AMENDMENT NO. 1093 TO AMENDMENT NO. 1092

(Purpose: To evaluate alternative payment and delivery systems)

Mr. KYL. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arizona [Mr. KYL] proposes an amendment numbered 1093 to amendment No. 1092.

Mr. KYL. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under "Text of Amendments.")

Mr. KYL. Mr. President, this is a second-degree amendment to the Baucus-Grassley amendment. I will explain it in just a moment, but while the majority leader is still in the Chamber, let me compliment him, not only for the fine presentation he just made based upon his personal knowledge of how the medical health care system in this country works but also for his leadership and the enormous amount of time and effort he has put into crafting this legislation and working with Members to try to resolve the many disputes that have arisen. I think without the patience he has shown in dealing with all of the Members, we would not be to this point that we are today, literally on the brink of passing, in the Senate, very historic legislation. So I compliment the majority leader and personally thank him for his patience in dealing with some of my concerns about the bill and the good work he has done in working with those problems.

I also want to thank Chairman GRASSLEY, who has shown a lot of patience and has worked hard in a very bipartisan way to put together a plan that could pass this body. I know that people on both sides of the aisle would prefer that it be closer to their particular points of view, but the chairman was always cognizant of the fact that in order to get a bill passed, it had to be done in a bipartisan way. So I compliment the chairman and ranking member for working in that fashion.

I also want to compliment and tell my colleagues a little bit about the efforts of the Secretary of HHS, Tommy Thompson. He, too, has become very personally involved in this effort and has worked very hard to effect the President's goals and plans in ensuring that we can strengthen, protect, improve and preserve Medicare. I appreciate his strong role as well.

I say all of that to make it clear that the amendment I offer is in the spirit of this bipartisan work, hopefully my work will be deemed to be cooperative with our leadership, although there is one element of the amendment Chairman GRASSLEY and Senator BAUCUS have laid down that I disagree with and this is what I am proposing to amend.

What I would like to do is explain the history of this and then come to my amendment. The amendment is very simple. It strikes a sunset provision, but that does not mean anything unless one knows the context, so let me speak for a moment about that context.

When the President first proposed this year that we legislate to add a new prescription drug benefit to Medicare, he said we should do it in the context of a real effort to strengthen Medicare so that we can preserve and protect it for the future. It has served our seniors well, but we are now in the 21st century and two things basically have occurred.

First, we now know that medicines, prescription drugs, are used as the preferred treatment for many illnesses and diseases, which was not the case back in 1965 when Medicare was first created. So all of us have become convinced that we need to add a prescription drug benefit to Medicare. This was the President's first great goal.

The second thing he said was, there is no way we can sustain the current promised benefits under Medicare if we do not create some new opportunities for Medicare beneficiaries, if we do not really strengthen the Medicare system we have. Among the things we can do to ensure that it will continue to work is to provide some choices for seniors, and so what he proposed was those people who would like to keep the existing Medicare, with a new prescription drug benefit, would be able to do that. But, especially for those younger seniors, people who have been in the workplace and are familiar with a PPO, or preferred provider, insurance plan or perhaps an HMO or Medicare+Choice kind of plan, we would provide that alternative as well so that the senior could choose. The idea was that a lot of the people that will be coming into the senior market, being used to an employer-provided plan, might like to keep that kind of plan rather than go into traditional Medicare. So we want to provide a choice, and it will be up to the senior to decide. So that is the direction that we sat down to work in as we developed this legislation.

I would have preferred that in creating this private market alternative, or the preferred provider organization—which we will hear referred to as PPOs—to the traditional Government Medicare system, we had made it much more like the FEHBP, the Federal Employees Health Benefits Program. That is a medical insurance plan that most of the people who are in this Chamber today have. It serves about 10 million Federal employees including family members and retirees. This is also the health plan for Members of Congress.

I would like to tell my seniors, if it is good enough for Members of Congress, then the seniors ought to take a look at it. It is a pretty good program. In fact, it is a very good program. I would have liked to have made this new Medicare Program alternative very much in the mold of the FEHBP, especially in the way that the preferred provider organizations work, bid, and are paid. We could have done that.

The way it works in the FEHBP is we do not have any limit on what kind of a bid the PPOs have to have. If they meet the basic criteria, providing the care we have mandated by statute, they can bid and provide the service and they can try to sell it to us. The federal government's share of the cost is determined by the use of a weighted average of all the health plans' costs.

If it is a good deal, federal employees and Members of Congress will sign up. If it is not a good deal, we will not. Generally, we do not tell the PPOs how much they can bid or how much they can charge. If they bid too much and charge too much, nobody is going to buy it. So they all have pretty reasonable bids and pretty reasonable costs, but theoretically they could bid themselves out of the market. It is up to them.

These insurance actuaries are pretty smart. They know how they can meet all of the requirements that they have. They have to be sure they cover the benefits they have promised. They have to provide those. They have to make a little profit, of course. They have to make sure the premiums are low enough so that people will sign up and, of course, most importantly in the beginning, they have to win the bid. If they do not win the bid, if they are so high that nobody will sign up, well, then, there is no reason for them to be in the game in the first place.

They look at all of those things, and they figure out how much they can afford to bid, what the premiums will be, and so on. It is a pretty good plan, and I wish we could have been able to offer that to our seniors. But instead, the determination was made by Chairman GRASSLEY and others that we would take the key component of the President's plan with respect to the PPOs and write that up into the legislation, draft it up, and that section of the legislation says we are going to limit the number of bids because we really want to control the cost, and so we are going to say only the three lowest bids are going to succeed, and then the President proposed to pay the PPOs at the middle bid of the three bids.

So the insurance companies that bid have to figure out, how much is it going to cost us to provide care to each senior, and that is what they bid, but they have to be sure the bid is low enough that they win because only the three lowest ones will be accepted.

That is what President Bush proposed, and it is deemed to be a way of both providing a lower cost to the Government kind of care but a quality care because obviously people are not going to sign up and utilize it if they do not think it provides quality care.

There are a lot of things about the way PPOs operate that ensure good quality care. This is a good idea. The President proposed it, and that was the original idea in drafting this.

But then a very arbitrary thing happened. The people in this building know that everything we do has to be under the rules of the CBO, the Congressional Budget Office. Everything has to be scored by CBO. That is to say, we send it to CBO, and they tell us how much it is going to cost in their mind. When we said we were going to allocate $400 billion over 10 years to this new prescription drug benefit, we had to make sure that the CBO score fit within the $400 billion.

Well, CBO came along and they said this competitive bidding system was going to cost a lot more money—it was over a $100 billion—it was way more than Chairman GRASSLEY and Senator BAUCUS wanted to allocate to the preferred provider organization part of the system.

So they said, we have to do something that does not cost anything or does not cost very much. So they decided to solve the problem CBO had created by simply writing in, in effect, a limitation that said this will not cost anything because we are going to set it at the very same level as traditional Medicare payments. There is a complicated formula. I am not going to get into all the details, but essentially it is the higher of the Medicare+Choice payment rate or the traditional fee-for-service Medicare reimbursement level.

The bottom line is, they said we are going to cap the amount the PPOs could be reimbursed. If you want the contract, you can bid anything you want to bid, but you can't be reimbursed over a certain amount, and that amount is defined in statute. By definition, therefore, the score did not cost very much and therefore it could fit within this $400 billion. So they thought that might solve the problem.

But the problem with this is, it will not work. A lot of people realize it won't work, but we still have to comply with the CBO score, they say. I will get to a solution in a moment.

How do we know it won't work? CBO, the same organization that did the score, says all of 2 percent of seniors will sign up for this PPO alternative. Two percent. Why? Because this arbitrary capped rate is not going to be enough to provide the coverage for them that we promise. So why would they want to sign up with a PPO when they can get the coverage under traditional Medicare?

When I am eligible for Medicare, that is what I would do. I would not sign up if a plan cannot deliver the goods. CBO says only 2 percent will sign up. As a result, obviously, we have to find an alternative.

Let's go back to this question that CBO raised by its scoring and whether or not an arbitrary limit will actually work. CBO says it won't; only 2 percent are going to sign up.

Why do they say that? First, we have the experience of Medicare reimbursement over the last many, many years. Sadly, the government has a cap on what it pays the doctors and hospitals and other health care providers, too. We do that by statute. We say we are only going to pay you X amount if you do certain things and you cannot go above that.

What happens? After a while, there is so much upward pressure on that amount because it does not begin to keep track with inflation, especially health care inflation. Pretty soon the doctors are saying, we not only cannot make any money getting reimbursed at this low level, but we cannot pay our nurses, we cannot keep our doors open, there is no way we can stay in practice providing services to our senior citizens if you are going to pay this ridiculously low amount. In fact, a lot of doctors have retired, gotten out of the business, discouraged their kids from going into medicine, and we see real shortages, especially in certain specialties. There are other factors that lead to that as well, but this is a big one.

So every year or two, Congress, responding to that pressure, says: My goodness, we have to change that reimbursement level. It is too low. So then we have these big fits and starts where we hold it down for a while and then all of a sudden we raise it up to the level necessary to compensate the hospitals and the doctors and nurses to take care of our senior citizens. We did this for the physicians just a few months ago because they were getting cut significantly in the reimbursement rate and CBO said we paid $54 billion to fix the physician problem for basically one year. That is one-eighth of the amount of this entire bill, over a 10-year period, just to make sure that the cut did not go into effect last year for the doctors so they could stay in business.

We find there is supposed to be another cut in physician reimbursement levels this year, and again we are most likely going to have to make an adjustment.

The problem is artificial government controls, price controls, do not work. They do not work in Medicare any better than in rent control or the gasoline price controls we had in the 1970's or any other price controls. Free market countries like the United States have learned that lesson. Socialist countries have not. I would have thought we would have learned the lesson. But that is the way the Medicare system works. It is the perfect exhibit A if you want evidence of the fact these controls in providing health care services do not work. Just look at the reimbursement providers in Medicare today.

I mentioned it is a lot like rent control. There is always the inexorable pressure. Is it any wonder when you finally remove the rent controls that in some places the rents actually go up? The owners get enough to refurbish the place to keep it up and people are willing to rent the places that look a lot nicer and better than back when there were rent controls. Sometimes the prices do go up. That is the price of quality health care.

We should never get into the situation in this Congress where we are going to shortchange our seniors by trying to put artificial caps on what we pay the people who take care of them. It will not work.

There is no such thing as a free lunch. If you want quality health care, you are going to have to pay for it one way or another. It may work to have a price control for a little while, but it does not work for very long. We found that out, and that is why every couple of years we have to make the big adjustments.

So why would we think the price controls would work with the new preferred provider organizations that we are trying to establish as a credible alternative to traditional Medicare? A lot of people will find the benefits of those PPOs to their liking. Why do we think the price controls will allow them to work? CBO says it will not happen; only 2 percent will sign up. Clearly, we had to find a way out of this dilemma.

The bottom line is, under CBO's rationale, either nobody bids because they cannot get reimbursed or we have to do the constant adjustment. There is no adjustment provided for in this legislation. Or there is a modest adjustment, but not an adjustment that will take care of this problem.

What do we do to solve the problem? We do not want to create the PPO option and then destroy its effectiveness before it can even work. I am very worried, to digress a moment, we will create some expectations on the part of our seniors that we cannot satisfy. That will be fundamentally wrong. It would be very wrong to suggest that we are going to do something for our seniors that, in fact, we are not doing. I, for one, am simply not going to be part of that. We cannot promise seniors an option that, in fact, we know, in advance will not work.

What is the solution? Obviously, the solution is to go back to the way we were going to do this in the first place, back to the President's proposal, and not have the arbitrary cap. Simply allow competitive bidding. Let the market decide what the right levels are. These people are smart. They will find the right level. It may be, in some areas, some time, below the Medicare reimbursement. That is what the Centers for Medicare and Medicaid Services, the organization that oversees these programs, believes. It may be the same. It may be more. It will be different from region to region and year to year. Let the market decide that.

Now, there was not enough money in the $400 billion to do this. So what happened was Chairman GRASSLEY and Senator BAUCUS were able to conclude that about $12 billion was available in the bill to be allocated for some purpose.

Very candidly, many Democrats did not want to do what I am suggesting. So they said you can only have half of the $12 billion to try to make your plan work. We want to use the other half to do something we want to do. What they want to do in the bill is perfectly reasonable, and I don't have any objection to the Grassley-Baucus amendment in that regard. In fact, I don't have any objection to most of the Grassley-Baucus amendment. I think it is a good amendment except for one thing.

What the amendment does for the $6 billion I spoke of, it says, starting in the year 2009, the Secretary of HHS can use competitive bidding that does not have this arbitrary payment cap on it, up to spending $6 billion if you have to spend it. The CBO scoring would suggest you could probably cover one or two of the 10 regions of the country if there were going to be 10 regions during one of the bidding cycles. It does not give us much of a chance to do this, but at least it establishes the principle.

The Secretary will at least have one chance, in one region, during one bidding period, to say at least in this situation we are going to eliminate our caps and see what happens.

Theoretically, if the bids come in below that cap, he still has the $6 billion to do that in another region. It is like somebody guaranteeing a loan. If the loans get paid off, then the person who guaranteed it never has to pay off. This is like $6 billion to guarantee the loan. This is $6 billion to see that the preferred provider organizations get paid, if in fact their bids exceed the Medicare cap level. It may exceed it; it may not.

Chances are, if it does not happen until 2009, which is the way the amendment is written, it will exceed it because of this pressure that inevitably builds when you have price controls keeping the prices down. So for 4 years the prices are going to be tamped down and finally then in the fifth year we get to go out to bids, and my guess is they probably will be higher and the proponents of the competitive bidding will say: See, we told you it would cost a lot of money. Of course. It might. If you tamp down something that the market would cause to rise a little bit every year and you tamp it down for 5 years and don't have some opportunity to adjust it, then naturally if you take the cap off it is going to rise. So CBO is probably correct, it probably will cost some money. That is the inevitable result of lifting the price control after you have kept things tamped down for too long.

The alternative, of course, is that there may not be any PPOs bidding because they cannot provide the services we have promised to seniors. But there is a little bit of an opportunity here to provide this unrestricted opportunity for bidding. That is what the amendment originally said that was drafted. I was originally going to be a cosponsor of the Grassley-Baucus amendment because even though it did not reestablish the competitive bidding process very much, there is a little sliver in there and at least we could go to conference, to the conference committee between the House and Senate, and argue that we had established the principle and we wanted to make sure that principle could continue on.

But, again, a funny thing happened. There were objections on the Democratic side to this process extending beyond the 5 years that it was in effect. What they said was you have to spend the $6 billion in that 5-year period. There will not be any money after that.

I said that's OK.

But then they said: And the authority to do this has to sunset at that moment, after 5 years. You cannot have the authority to do this, regardless of the cost, later on.

Later they said: Well, as long as it is cost neutral, but as I pointed out that is probably a false promise because of the price controls keeping the prices tamped down. So my amendment eliminates that sunset clause. It says: No, if this is a good idea, let it continue.

Ironically, if the CMS is correct, then it is not going to cost any more. And if CBO is correct, it is going to cost more and, as a result of that, we are going to have to have some alternative to the competitive bidding process with the price caps on it because there are not going to be any PPOs to offer the health care benefits. If, in fact, they cannot make it work under the money that is then available, there has to be an alternative available. That is why this should not sunset. It is why the authority to do this should continue on.

As to this point I just want to say I cannot imagine, after all the work that has gone into this—people have looked at how complex this is—we would think that we are smart enough in the

Senate to know exactly what the price of this insurance contract ought to be for every Medicare beneficiary 10 years down the road. How do we know that? We cannot possibly know that. How do we know what a fair price for a Mercury automobile is going to be in 10 years? A price that is just exactly fair, that lets, say, Ford Motor Company make some money, just low enough to entice us to buy the car. We don't know that. That is why we have a free market. You charge whatever you want to charge and if it is a good deal, people will buy it; if it is not, they will not.

It is the same thing here. We are not smart enough to fix these prices and we are playing with the quality of health care of our senior citizens.

My fear is we are going to keep this ratcheted down so much that we will have an experience like we had not so long ago with the HMOs of this country, where they were squeezing the benefits and patients got pretty angry about it. They said, we don't want to have to go to a doctor we don't know, we don't want to have them tell us they can't see us for 6 weeks. We don't want them to say it would be nice to have a MRI or CAT scan but all we can give you is a X-ray. That is where the call for the Patients' Bill of Rights came in, and I supported it because I don't think patients should get squeezed down in their health care just because we are trying to save money.

Of course we want to save money. We are talking about taxpayer money here. But the whole concept of the preferred provider option, the private sector option, was to be able to save money in the long run for the Medicare system. That is why the President proposed it and why we, especially on the Republican side, said this is something we need to do to strengthen Medicare. We need to provide an option that will enable us to keep the costs of this under control as Medicare goes into the future. And for the reasons the majority leader articulated so well a moment ago, we believe these preferred provider organizations will be able to do that. So they can balance good quality care with efficiencies and effectiveness at cost control as well. That was the whole idea for it.

But we cannot get into a situation where we tie both hands behind their back and then tell them to go out and serve our senior citizens. We say: You can go do that but you can't get paid any more than X, and X doesn't go up unless we cause it to go up.

That is the reason for the fix that I proposed. It was in the amendment originally but then it was determined that this had to be sunsetted. My amendment eliminates the sunset, allows the authorization for the pure competitive bidding to continue on. That is as simple as it is and is the primary reason why I did it.

Let me note a couple of other items. Some people, especially my friends on the Democratic side, have said, wait a minute here, this has to be balanced. And I said I agree. The drug benefit, according to CBO, right now in the bill, the underlying bill, is $402 billion over 10 years. It slightly exceeds the $400 billion. In the same bill we are spending $7.8 billion over 10 years on the PPOs and Medicare+Choice, which are the HMOs.

So it is $402 billion on the drug benefit, $7.8 billion on the PPOs and HMOs. I think we could afford to put a little bit more money toward ensuring that the PPOs can be successful here, that they will bid and provide these services to our senior citizens.

Another point: When we put these price controls on the providers, as we do today under Medicare, as I said, there is no free lunch. Somebody has to pay. What happens is that the private sector health insurance in our society is subsidizing Medicare. The hospitals and the doctors and all the other providers have to make it up somewhere and that is where they make it up. This raises the cost of private insurance. A lot of people find that very hard to pay. In fact, it takes some people out of the private insurance markets. So, ironically, one of the reasons not as many Americans are insured as should be is because the premiums are too high because the private sector has to subsidize the care that we are providing on the Government side of the equation through Medicare and Medicaid.

This price cap is going to further that subsidization, ironically at a time when millions of retirees are going to be leaving the private market because their employer will no longer want to provide a benefit that the Government is providing for at a taxpayer subsidy. So there is going to be a lot smaller private sector market to subsidize a lot bigger amount, which will cause more people to lose their insurance because of the higher cost of premiums. It does not make sense to underfund Medicare.

The final problem: Remember at the very beginning I mentioned the FEHBP, the Federal Employees Health Benefits Program. It is interesting that throughout the history of the FEHBP we have not had any of the problems I have been talking about here. Congress has rarely had to do anything to modify the FEHBP system. It works very well. Yet every year or so we have had to modify the reimbursement to Medicare providers in response to what we did through the Balanced Budget Act of 1997. We have had to do it ever since because we are not smart enough to know what every doctor in this country and every hospital ought to get paid to take care of us. Yet that is what we tried to say in the statute. So we have to keep changing it. Why would we want to not go with a system that we know has worked very well? We can do that by allowing this open bidding and allow the free market to work.

I think for all of these reasons it would be very wise for us to remove the sunset on the Grassley-Baucus amendment and let this process work, even a little bit, and show our colleagues in the House of Representatives and, frankly, all the country that we are committed to this principle of the free market ensuring the best deal for the American taxpayers but also the best deal for our senior citizens.

I am just going to close with this thought: Medicare is a mandatory system in the United States of America. There is essentially no option. When you are 65 years old, it is Medicare or no care. A doctor cannot take care of you outside of Medicare after you turn 65. There is only one exception, and that is if the doctor says: I will not treat any Medicare patients for a period of 2 years.

Now, we do not want to force our doctors into doing that. We want them to stay in Medicare, taking care of Medicare patients. But the only way a doctor can treat people outside of Medicare is to swear—there is a formal process for doing it—that he will not treat any Medicare patients for 2 years. We do not want them to do that, but that is the only way. You would have to find such a doctor. If your condition is diabetes, and that doctor is an orthopedic surgeon, you probably will not have too good of luck.

So most seniors do not have the option of searching around trying to find a doctor who works outside of Medicare because most of them do not do it. Fortunately, most of them stay in Medicare. But this is the only circumstance under which you can find a doctor outside of Medicare.

Since we are saying—literally mandating—that our moms and dads—pretty soon some of us—have to take the Government program for our health care after we turn 65—and nothing is more important to us than our health and our family's health—my mom's health—it bothers me a lot that we are setting up a system to take care of my mother that we know in advance is bound not to work. It promises a benefit it cannot deliver. But because of the scoring problem, we have to do it that way.

There is a better alternative: to take the time to do it right, to make the personal commitment to do it right, to understand there is no such thing as a free lunch—that I want to deliver the best quality care for my mother as I can because she does not have an option.

If she had an option to go into some other system, as they do in Great Britain, then I would not be quite as concerned.

But we are forcing everybody into a system, and then we are saying—as we tie its hands behind its back—now you make sure you can go out and serve, when CBO says only 2 percent of the people will sign up for that. So that means everybody is going to continue on with traditional Medicare.

Now, maybe that works for them, but we know there are going to be some huge problems not too far down the road with traditional Medicare. Are we going to be able to deliver the benefits we promised? If you look at the numbers, we are going to have big tax increases or we are going to have to go deeply into debt in order to do that.

There is an alternative, and that is this option I have been talking about. Because we are playing with real people's lives, and because the ultimate value here is the quality of medical care we are going to ensure our senior citizens get—because it is the only way they can get medical care—we have the highest obligation to give this matter our most serious attention and not simply rush it through because we want to finish the bill before the July Fourth recess—although I certainly understand the Secretary and our leadership's desire to try to do that to get the bill in conference—but to take enough time and to give it enough thought to do it right.

This is forever, in a sense. It is for a long, long time. And for those friends of mine who say, "Oh, don't worry about it; we are going to make a lot of changes in this," how many changes have we made in some of the sort of "sacred cow" laws in the United States—things that everybody supports and so nobody wants to even suggest to change: Social Security, Endangered Species Act, Medicare itself?

It is easy to demagog these issues, and, as a result, Members are not very keen to make changes with them; you are accused of trying to destroy the program or whatever it might be. So I think my colleagues who say, "Oh, don't worry; we'll fix it later," miscalculate the courage they are going to have later when they realize it has to be fixed.

The time to do it is now. The time to get it right is now. The President is right, this was the way to do it. And so, to support the President's program, I am offering this amendment to get back to what that program was. I hope my colleagues will support me in this because nothing less than quality health care for my mother and the rest of the senior citizens in this country is at stake.

Mr. President, I appreciate your patience, and I yield the floor.

Mr. ALEXANDER. Mr. President, I wish to voice my support for the inclusion of disease management as a permanent part of the Medicare fee-for-service program. I consider disease management a way to reform the fee-for-service program. I am concerned about the long-term fiscal viability of the Medicare program. As we add a much needed drug benefit to the Medicare program, we must do so in a way that seniors can afford and that our country can afford. Consistent with a letter I signed to the President, I continue to look for ways that we can take this opportunity to reform the current program and ensure we keep the program strong for future beneficiaries.

I understand that the Medicare bill we are debating incorporates disease management as part of the new Medicare Advantage Program, so that private plans offer these services to beneficiaries and that there are several demonstrations to test out a variety of care management techniques in the traditional, fee-for-service program. That is a positive step in the right direction. But I think we need to go further.

I believe strongly that seniors will get better care in a private plan option under this bill, and I encourage them to do so. But I also know there will be seniors that choose to stay in traditional, fee-for-service Medicare. And these will likely be older seniors, the ones that do suffer from multiple chronic conditions and are in the most need for efficient management of their health care. I ask you, can we afford to allow these beneficiaries' health to worsen and to subsequently bear the enormous costs of their care? We cannot. I believe that adding disease management to the traditional-fee-for-service program is a way to reform the system, and to help bring down costs for these seniors. Disease management can reform the system to improve the long-term sustainability of Medicare.

Last week the House Ways and Means and Energy and Commerce Committees both voted in support of legislation that would incorporate disease management into all of Medicare—both private plans and the traditional, fee-for-service programs. I ask that as we move into conference, I hope we can accept the House language that phases in disease management as a permanent part of the Medicare fee-for-service program.

Without a doubt, it is critical to the health of seniors and to the pockets of taxpayers that we implement effective reforms such as disease management in Medicare now—to more rationally and effectively manage care for beneficiaries with chronic conditions, and to ensure the fiscal sustainability of the Medicare Program.

Mr. SMITH. Mr. President, I rise today with my colleague from North Dakota in support of critical drug coverage for beneficiaries who contend with the debilitating effects of multiple sclerosis.

This amendment would provide transitional coverage for the four FDA-approved therapies in the 2-year interim until 2006, when the prescription drug plan will take effect.

Approximately 400,000 Americans have MS. In my home State of Oregon, it is estimated that there are 5,800 people living with MS.

Currently, Medicare covers only one of the four FDA-approved MS therapies and only when administered by a physician. This amendment would cover all four MS therapies, including when they are administered by the patients themselves, providing better coverage and better care for Americans with multiple sclerosis.

While these therapies do not cure MS, they can slow its course, and have provided great benefit to MS patients. It is critical that MS patients have access to all approved drugs because some MS patients do not respond well to, or cannot tolerate, the one MS therapy that is currently covered.

Currently, many Medicare beneficiaries with MS are forced to take the less effective therapy, to pay the costs out of pocket or forgo treatment.

Equally, this amendment is important to rural Medicare beneficiaries with MS. By administering drugs themselves, rural beneficiaries can avoid the costs and hassles of traveling long distances to health care facilities to receive their MS therapy.

In the spirit of providing all Medicare beneficiaries with increased choice, MS patients need and deserve the full range of treatment choices currently available and self-administration helps ensure access to needed medications.

I urge my colleagues on both sides of the aisle to join me in support of this amendment and to provide adequate and comprehensive drug coverage for MS patients.

ADEQUACY OF MEDICARE PAYMENTS TO PHYSICIANS

Mr. SPECTER. Mr. President, I have sought recognition today to engage the distinguished chairman of the Finance Committee in a colloquy regarding concerns about the adequacy of Medicare payments to physicians.

Each year, Medicare payments to physicians are adjusted through use of a "payment update formula" that is based on the Medicare Economic Index, MEI, and the sustainable growth rate, SGR. This formula has a number of flaws that create inaccurate and inappropriate payment updates that do not reflect the actual costs of providing medical services to the growing number of Medicare patients.

As discussed above, the formula has resulted in numerous payment cuts to Medicare physicians. Earlier this year, Congress passed legislation as part of the fiscal year 2003 omnibus appropriations bill, H.J. Res. 2, that avoided an impending 4.4-percent cut in the Medicare conversion factor. This was accomplished by adding 1 million previously missed Medicare beneficiaries to the mix and recalculating the appropriate formulas. Although this change resulted in a welcomed 1.6-percent increase in the Medicare conversion factor for 2003, the Centers for Medicare and Medicaid Services', CMS, preliminary Medicare conversion factor figure predicts a 4.2-percent reduction for 2004. The reason for this latest reduction stems from the fact that the current formula that originally resulted in the need to fix the 2003 conversion factor cut, is flawed. The latest scheduled round of payment cuts will make Pennsylvania's Medicare practice climate untenable.

In its March 2003 report, the Medicare Payment Advisory Commission, MedPac, stated that if "Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary in 2004." We owe it to America's physicians to fix the system so that they can continue to provide Medicare beneficiaries with the vital care they need.

With 17 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania's physicians have already suffered a $128.6 million hit, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $553 million or $17,396 per physician for the period 2003–2005. They simply cannot afford these payment cuts. I know you have worked very hard in preparing a bipartisan Medicare bill that represents a good solid beginning to improving our Nation's health care system. However, I firmly believe this is an issue that Congress must address.

Mr. GRASSLEY. Mr. President, I thank my colleague from Pennsylvania for raising this important issue. He is correct that I have been working with the physician community, as well as the U.S. House of Representatives, to obtain a fuller understanding regarding the adequacy of the current physician formula under Medicare. We have learned that Medicare's current payment formula for physicians is problematic, and I agree that this issue should be addressed. We will continue our discussion, and objectively evaluate proposals that will update the payment formula for physicians.

Mr. SPECTER. I thank the chairman for his willingness to work with me on this issue as the Prescription Drug and Medicare Improvement Act moves forward.

The PRESIDING OFFICER. The Senator from Missouri.

MORNING BUSINESS

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

SALUTE TO THE 129TH MOBILE PUBLIC AFFAIRS DETACHMENT

Mr. DASCHLE. Mr. President, on July 12, the 5th U.S. Army will demobilize the 129th Mobile Public Affairs Detachment of the South Dakota National Guard. This unit, headquartered in Rapid City, was among more than 20 Guard and Reserve units from my State called to active duty in support of Operation Enduring Freedom/Noble Eagle and Operation Iraqi Freedom.

Today, these soldiers and their service become a part of South Dakota's military heritage. Like those who served in the two World Wars, in Korea, in Vietnam and numerous other places, this new generation has answered the call. They have offered to make every sacrifice, including life itself, to protect our freedom and security. We must never forget them or the honor with which they served.

This unit participated in a mobilization with few precedents in South Dakota history. Nearly 2,000 Guard and Reserve troops were called to active duty in our State, by far the largest mobilization since World War II. At the time the fighting began, units from more than 20 communities had been called up, from Elk Point in the South to Lemmon in the North, from Watertown in the East to Custer in the West. Indeed, our State's mobilization rate ranked among the highest of all the States on a per-capita basis.

These soldiers were proud to serve, and their communities are proud of them. Across the State, thousands of citizens pitched in to participate in send-off parades, to lend a hand for families who suddenly had to get by without a mom or dad, and even to assist with financial hardships caused by the mobilization. This mobilization was a statewide effort, in many ways.

In addition to the service of this particular unit, I want to acknowledge the sacrifices and dedication of the families who stayed home. They are the unsung heroes of any mobilization. They motivate and inspire those who are far from home, and they, too, deserve our gratitude.

Today, I join these families and the State of South Dakota in celebrating the courage, commitment, and success of the members of the 129th Mobile Public Affairs Detachment, and I honor their participation in this historic event in our Nation's history. Welcome home. Thanks to all of you for your courage, your sacrifice, and your noble commitment to this country and its ideals.

NATIONAL PEACE ESSAY CONTEST

Mr. DASCHLE. Mr. President, I am honored today to present to my colleagues in the Senate an essay by Collette N. Roberts of Rapid City, SD. Collette is a student at St. Thomas More High School, and she has been awarded first place in the 16th annual National Peace Essay Contest for South Dakota. "Justification of War: the Anglo-Zulu and Kosovo Wars" examines the Anglo-Zulu war of the late 19th century as a paradigm for understanding Kosovo's struggle against the military campaign of Slobodan Milosevic's Serbia. Collette has tackled a vitally important subject with insight and maturity. I can only hope that she continues to share her wisdom with the world, and I commend her essay to my colleagues' attention. I ask unanimous consent that Collette Roberts's essay be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JUSTIFICATION OF WAR: THE ANGLO-ZULU AND KOSOVO WARS

(By Collette N. Roberts)

". . . this has never been and never can be one territory under two masters" (Judah, 2000, p. 4). The line in the poem by Anne Pennington and Peter Levi holds the ring of truth. Many wars have been waged over a piece of land such as the Anglo-Zulu and Kosovo Wars. The circumstances surrounding these wars are similar, but are justified only in part. In both wars, one side had reached the last resort: either defend their homeland or face subjugation. Both were waged by legitimate authorities; however, nothing justifies the genocide of a race and the slaughter of innocent civilians. Upon examination, the justness of the Anglo-Zulu and Kosovo Wars and NATO involvement in Kosovo is subjective, contingent upon the motives and actions of each party.

The eighteenth and nineteenth centuries mark the imperialistic age for Great Britain. By the 1870s, most of South Africa had succumbed to British rule. Zululand, however, one of the last independent African states in the region, presented challenge to an advancing white frontier (The Diagram Group, 1997, p. 105). Not only did the independent state disrupt Britain's confederation plans for the region, but also prevented sugar farmers from using the spacious tracts of land within the boundaries of Zululand. Furthermore, as long as the Zulu remained independent, they could not be sued for cheap labor. Zululand became a dollar sign in the eyes of the British. When the Zulu defied British subjugation, war inevitably ensued (Gump, 1949, p. 3).

British military forces, commanded by Frederick Thesiger (better known as Lord Chlemsford), began the invasion of Zululand in 1879. The Zulu, under the rule of King Cetshwayo, rose to defend their homeland. The first major battle occurred at Islandhlwana. Losses were heavy to both armies; but the Zulu, underestimated by the British, claimed victory. To justify his actions, Dabulamanzi, a Zulu general, said, "It is the whites who have come to fight with me in my own country and not I that do to fight with them" (Gump, 1994, p. 54).

Despite the intensity and valor with which the Zulu fought, the battle oNdini marked the end of the Anglo-Zulu War. Poorly provisioned and outgunned, the Zulu military system was broken. Between six and ten thousand Zulu men died defending their homeland (Knight, 1995, p. 270). Following the war, the British began decentralizing the Zulu royal house. Zululand was carved into thirteen regions, each headed by British sympathizers. Finally subjugated, young Zulu men soon found themselves traveling outside Zululand in search of work. The system of migrant labor, as in other parts of south Africa, had at last taken hold of Zululand. The economic seeds of apartheid, the racist system of black oppression, had been sown (Knight, 1995, p. 272).

Those, like the Zulu, who are invaded by a conquering power are faced with only two choices: subjugation or war (Gump, 1994, p. 3). Though the chances for success were poor for the Zulu, war was the only chance to defend their homeland and preserve their way of life. When the British could not easily lay their hands on what they wanted, they believed they had reached the last resort, and therefore initiated war. These attitudes are common throughout all imperialistic societies. Britain justified its actions through claims to “savage” Zulu; to expose them to a “new and better way of living” (Gump, 1994, p. 14). However, war, from the imperialistic standpoint, should not be the final option when a piece of land and the promise of a profit are found to be superior to human life.

The Anglo-Zulu War is not the only conflict in history that has occurred over a piece of land. For centuries, opposition has brewed between the Serbs and Albanians of the Balkans. The source of conflict is Kosovo, a province of Serbia, sharing borders with Albania (Andryszewski, 2000, p. 9). The claim of the area is bitterly disputed between the Serbs and the Albanians. Serbs hold that, despite the ethnic shift only a few generations ago, the people of Kosovo have been primarily Serbian. The Albanians, on the other hand, argue that their ancestors, the ancient Illyrians and the Dardanians, habituated the region prior to the Slavic invasions of the sixth and seventh centuries. Therefore, they believe, Albanians have the right to what they call “first possession.” The truth concerning the claim of Kosovo is unclear. However, as in most cases, the truth is not what matters, but rather is what the people believe the truth to be (Judah, 2000, p. 2).

In April, 1987, a politician from Belgrade delivered a speech glorifying the Serbian nation. Because of high tensions between the Albanians and the Serbs, biased speechmaking had been against certain unspoken “rules” in Yugoslavia. However, by the end of the year, he became the most powerful politician in Serbia (Andryszewski, 2000, p. 18). In 1991, Milosevic began his war in Bosnia for a “Greater Serbia.” By the time the Dayton Peace Agreement had been approved and signed, hundreds of thousands of Muslims and Croats had fallen victim to the program of “ethnic cleansing,” driven from their homes, tortured, raped, and murdered (Andryszewski, 2000, p. 20). Despite the declaration of peace, Milosevic's ambitions for a “Greater Serbia” had not been eliminated. His ambitions soon turned toward Kosovo.

Kosovo remained under the harsh rule of Serbia. In 1997, the Kosovo Liberation Army (KLA), a small guerrilla force, began to wage a war against Serbian authorities. Alone, the KLA's chances for a sweeping victory were slim. However, the worthy cause of self-defense justifies their actions. The occasional skirmishes between the KLA and Serbian authorities culminated in the Serbian massacre in Drenica where dozens of ethnic Albanian civilians were slaughtered (Andryszewski, 2000, p. 30). Despite NATO threats of airstrikes to end the fighting, the violence between the Albanians and Serbs continued to escalate. In January, 1999, Serbs massacred forty-five ethnic Albanians in the Kosovar village of Racak. NATO, acting as a peace-keeper gave the Serbs and Kosovar Albanians an ultimatum: make peace or face NATO military action. The Albanians were willing to make peace, but all agreements proved futile when Milosevic refused to sign (Andryszewski, 2000, p. 33).

Far from any kind of last resort, Milosevic, wielding the power of a legitimate authority, instigated a massive Serb military attack on Kosovo. Kosovar Albanians, both military and civilian, were his paramount targets. A campaign of ethnic cleansing, echoing that of Bosnia, was launched on the Kosovar Albanians. Homes were burned, women were raped, and men were slaughtered; mass graves, freshly dug, could be seen from the air (Andryszewski, 2000, p. 48). Milosevic justified his unjust actions through his call for a “Greater Serbia.” Again, the desire for a piece of land was put before the sanctity of human life.

When peace became impossible and violence continued, NATO was left with the last resort. As promised, NATO took military action to halt the Serbian offensive and its mass genocide of the Albanians. A reasonable chance for success was existent. Furthermore, there was the belief that the consequences of these aggressive actions would be better than the situation that would exist had these actions not been implemented. In March 1999, NATO airplanes and cruise missiles began bombing Serbian military targets. Ultimately, through the joint efforts of the KLA and NATO, Serbia withdrew from Kosovo seventy-eight days later and signed NATO peace agreements. By the time peace had been achieved, 900,000 Albanians had been removed from their homes in Kosovo (Andryszewski, 2000, p. 54). Another ten thousand lay dead—murdered by Serbs during their ethnic cleansing of Kosovo (Andryzsewski, 2000, p. 57).

Critics may argue that the decision to bomb Serbia may not have been the most effective course of action. Regrettably, serious mistakes were made and the bombings killed civilians, both Serb and Albanian. Furthermore, a bomb hit the Chinese embassy in Belgrade, killing three and wounding nearly two dozen (Andryszewski, 2000, p. 50). Despite these tragic events, had NATO not put pressure on Serbia to end its campaign of ethnic cleansing, the number of genocide victims would have only increased.

As demonstrated, one territory cannot serve two masters. The Anglo-Zulu and Kosovo Wars were waged because two parties tried to control one piece of land. Each party had reasons for taking part in the fight. Many factors come into play that do or do not justify these reasons. The Zulus and Albanians were justified by reaching the last resort and defense of their homeland. Though neither of these parties had any reasonable chance of victory, the justness of their cause is in no way lessened. NATO military action was justified in its attempts to check the violence. Britain and Milosevic, though legitimate authorities, valued land over human life. Their motives were unjust. Justice is blind, but will forever be weighed by our motives and actions.

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LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred on September 22, 2000. A man looking to “waste some faggots” entered a gay bar in Roanoke, VA, and opened fire, killing Danny Overstreet, and injuring six others. Overstreet, sitting at a table closest to the gunman, dropped when a shot hit him in the chest. The 43-year-old gay man died within minutes, despite efforts to help him. The other six victims eventually recovered. A witness told police that the gunman—a vocal antigay advocate—had asked directions earlier in the evening to gay bars in the Roanoke area.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

SUPREME COURT AFFIRMATIVE ACTION DECISION

Mr. KENNEDY. Mr. President, on Monday, in a landmark decision, the Supreme Court made clear that colleges and universities can adopt admissions policies that take students' racial and ethnic background into account to achieve a diverse student body. The Court's decision is a resounding vindication for the fundamental principle that affirmative action can be used in education to promote opportunity for all, and encourage interaction among students of diverse backgrounds.

Our diversity is our greatest strength, and this decision recognizes the broad benefits of diversity in higher education. A diverse student body benefits all students at our colleges and universities and helps prepare students for our increasingly diverse workforce and our diverse society.

As the opinion of Justice O'Connor states, “Major American businesses have made clear that the skills needed in today's increasingly global marketplace can only be developed through exposure to widely diverse people, cultures, ideas and viewpoints." High-ranking military leaders, too, have stated that affirmative action is necessary for promoting a "qualified, racially diverse officer corps," to enable the Armed Forces to protect national security.

The Court's decision supports the paramount importance of education as a gateway to equal opportunity, reaffirming once again the Court's historic decision nearly 50 years ago in Brown v. Board of Education. Few areas are as vital to sustaining our democracy as education. Our institutions of higher education, like our public schools, are indispensable in broadening the minds of young adults, and training them for leadership.

As the Court stated in Brown, and emphasized again in Monday's opinion, "Education is the very foundation of good citizenship." The Nation is becoming increasingly diverse, and it is important for all our institutions to reflect that rich diversity.

The Court stated: "In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity. Access to education must be inclusive of talented and qualified individuals of every race and ethnicity, so that all members of our heterogeneous society may participate in the education institutions that provide the training and education necessary to succeed in America."

The Supreme Court has made clear that a well-crafted affirmative action admissions program like that of the University of Michigan Law School is constitutional. It is flexible and allows for individualized review of each applicant, and it is not a quota. The Court also made clear that States do not have to promote diversity only by relying on percentage plan programs which guarantee college admission to all students above a certain class-rank in every high school graduating class in the State.

As the Court recognized, such programs do not work for graduate and professional schools. In fact, percentage plans can prevent colleges and universities from making the individualized assessment of applicants that is necessary to assemble a diverse student body.

Our country has made extraordinary progress over the past half century toward equality of opportunity in all aspects of our society, and affirmative action has been an indispensable part of that success. But we all know that we have to do more to make the promise of Brown a reality. Even with affirmative action, vast inequities remain in access to higher education especially for African-Americans and Latinos.

We know that civil rights is still the unfinished business in America. Half a century after Brown, our schools remain starkly divided along racial and ethnic lines, and minority children are too often relegated to inadequate schools. We have to do more to see that minority children are not forced to think of an institution like the University of Michigan as an impossible dream. This decision by the Supreme Court is another major step by the Court to make that dream possible, and it is difficult to believe that either this Congress or this President would approve a Supreme Court nominee who would reverse that decision.

Mr. FEINGOLD. Mr. President, it has been nearly 50 years since the Supreme Court ruled segregation in schools unconstitutional in Brown v. Board of Education of Topeka, Kansas. Then-Chief Justice Earl Warren said: "We conclude that in the field of public education the doctrine of 'separate but equal' has no place. Separate educational facilities are inherently unequal."

This week, the tenet of equality that lies at the foundation of the Brown decision was reaffirmed and strengthened. In fact, it is becoming more and more infused into our Nation's increasingly diverse identity.

This week, the U.S. Supreme Court reaffirmed the principle that diversity is a compelling national interest and that race can be a factor in higher education admissions decisions. The Court upheld the admissions policy at the University of Michigan Law School in Grutter v. Bollinger.

Justice Sandra Day O'Connor, on behalf of the 5-to-4 majority and citing Brown, wrote: "This Court has long recognized that education . . . is the very foundation of good citizenship."

Justice O'Connor and the Supreme Court found the use of race in the Michigan Law School admissions policy consistent with the aspirations of the 1954 Supreme Court in deciding Brown. O'Connor stated for the Court:

> In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity. All members of our heterogeneous society must have confidence in the openness and integrity of the educational institutions with which the law interacts . . . Access to legal education (and thus, the legal profession) must be inclusive of talented and qualified individuals of every race and ethnicity, so that all members of our heterogenous society may participate in the educational institutions that provide the training and education necessary to succeed in America.

The Court's decision keeps this country on a path toward the day when our children and our children's children will not be able to envision a pre-Brown v. Board America. In fact, Justice O'Connor cites the Brown opinion in writing the Grutter decision. Justice O'Connor's words reflect a powerful American value that is really a strength of our Nation—diversity. It is in the best interest of all Americans to seek diversity in all segments of our society, including educational institutions, the military, and the workplace. To fail to do so, in fact, would be to misrepresent our national identity.

I am heartened, by the large number of amicus briefs filed in support of affirmative action. These briefs showed the Court the deep importance of diversity to so many people and institutions across the Nation. I am pleased to have had the opportunity to join Senator KENNEDY and several of our colleagues in signing one such brief, urging the court to uphold the Bakke decision and support Michigan's admission policies.

One of the greatest strengths of our Nation is its guarantee of equal educational opportunities for all students. Our Nation's colleges and universities are the envy of the world for their rigorous courses of study and high-caliber professors, but also for their enriching environment of students from a range of racial, ethnic, and social and economic backgrounds representing every part of America, if not the world. I am proud that the Court has affirmed the importance of campus diversity and deemed it a constitutionally permissible governmental interest.

In the Grutter case, the Court decisively allowed race and ethnicity to be considered in combination with other factors in an admissions decision. I don't believe that the decision striking down the specific point system used in the undergraduate admissions policy will be a serious impediment to the implementation of race-sensitive admissions policies at colleges and universities.

In the 50 years since the walls of segregation began to crumble, we have traveled many miles on the road toward guaranteeing civil rights to all Americans. But this week's decision affirming diversity as a compelling national interest—and thus declaring affirmative action constitutional and viable—confirms our Nation's progress in ways unmeasurable by miles or years. The Court's decision is more than a victory. It is a milestone. It is a testament to the strength of Brown and our Constitution's equal protection guarantees.

* * *

HONORING AMERICAN AND KOREAN VETERANS OF THE KOREAN WAR

Ms. MURKOWSKI. Mr. President, today marks the 53rd anniversary of the official beginning of the Korean war.

Korea has often been called the forgotten war, but for the thousands of Alaskans who are veterans of that war it is hardly forgotten. The memory is with them daily.

The heroic American and Korean veterans of that war fought under the most adverse circumstances to free the people of the Republic of Korea from the yoke of Communism.

These veterans learned the hard way the lesson that is engraved on the Korean war Memorial here in Washington, "Freedom is not free."

While today marks the beginning of the Korean war, this anniversary does not mark the beginning of the war between freedom and Communism in that troubled country. From the moment that the Korean peninsula was divided in 1945, that battle had begun.

While Korea was one of the first examples of Imperial Japan's lust for land when it became a Japanese possession in the wake of the Russo-Japanese War at the beginning of the twentieth century, it was a side show in World War II. The U.S. had no plan for what to do with Korea when the war was over.

Although we had had U.S. representatives—governmental, business and missionary—in Korea from 1882 until the outbreak of the war, we made no plans for what would happen when at war's end, we might return to Korea.

The United States remained committed to the December 1945 decision of the Allied foreign ministers in Moscow that a trusteeship under four powers, including China, should be established with a view toward Korea's eventual independence. As a result, we were slow to draw-up long-range alternative plans for South Korea.

We had made no decisions on how to govern Korea, or to assist Korea in governing itself. We had not made plans for the defense of the country, nor for its economic development. We didn't even have a plan for how we might accept a Japanese surrender on the peninsula.

The most convenient way to deal with the surrender issue was to allow the Soviets to accept the surrender in the north and for U.S. forces to take the surrender in the south. Such a division of Korea, which to modern eyes, seems so normal on our maps, was totally foreign to the long history of Korea. Further, the division, which was drawn on a large-scale map in the Pentagon and had no rational basis on the actual terrain, did not represent any known political division of the peninsula. When it took place, it left freedom loving Koreans in the north and communist insurgents in the south.

The Korean war did not begin with the full scale invasion of the Republic of Korea on June 25, 1950. It had been underway as an insurgency in the south since, at least, 1946. One of the first tasks facing the United States was to train and replace existing Japanese police and security forces. The United States, with insufficient forces in-country to deal with the insurgency problem, acted quickly to stem the insurgency by creating a Korean defense force to combat it.

This Korean Constabulary, consisting of Korean veterans of the various armies who had fought World War II in the area, was led by U.S. officers and fought under U.S. orders. The Constabulary had an initial force of 2,000 men in 1946, but built up to approximately 26,000 over the next two years.

It was equipped with the very little military materiel left behind by U.S. forces as they withdrew. The young American officers, mostly reservists, with few regulars had little in the way of education, language or experience for their task, but they had good will and a devotion to duty which they infused in their Korean troops. In contrast, the army that the North Koreans were forming north of the divide was well equipped with Soviet equipment and led by well trained and well indoctrinated communist zealots.

While all out invasion would wait until 1950, substantial insurgency and guerrilla warfare was a constant theme in the southern half of the peninsula from 1946 to 1948. When the Republic of Korea was founded in August of 1948, the Korean Constabulary became the Korean Army and brought with it a level of devotion to country and duty which has been, since that time, the envy of most of the world's fighting forces.

Today is a time, therefore, not just to remember the heroic men and women who served from 1950 to 1953, but to honor the heroic Koreans and Americans who defended Korean freedom in the days before 1950.

CIVIL LIBERTIES IN HONG KONG

Mr. FEINGOLD. Mr. President, 8 months ago I took the floor in this Chamber to call attention to some disturbing trends with regard to democracy and civil liberties in Hong Kong. I said that Hong Kong's rulers, at the behest of Beijing, were set upon a path that risked destroying the spirit and vitality that make Hong Kong unique. I urged those who care about Hong Kong, and about freedom, to speak out and alert Hong Kong authorities to the error of their ways. Many did so.

Today, I regret to report, Hong Kong is one step closer to becoming just another Chinese city. Hong Kong's Legislative Council is expected to vote into law next month antisubversion legislation that would significantly erode the barriers that insulate Hong Kong's residents from the antidemocratic legal concepts and practices of the People's Republic of China.

As I said here last October, China's leaders pressured their hand-picked Chief Executive in Hong Kong, Tung Chee-Hwa, to introduce this legislation last year. Hong Kong authorities maintained that they had no choice but to comply, since Article 23 of the Basic Law that became Hong Kong's constitution after the territory reverted from British to Chinese control in 1997 required Hong Kong to adopt laws to protect national security. Many Hong Kong legal experts disagreed. But be that as it may, the same Basic Law says the territory will move toward electing its legislature and executive by universal suffrage. At present, only one-third of the legislators were chosen by direct popular vote, and only 800 of Hong Kong's 7 million residents were allowed to cast ballots in Tung Chee-Hwa's reelection as Chief Executive last year. The Government has yet to announce any plans to expand suffrage.

The sequence of these steps is important. Pushing through legislation curtailing civil liberties to comply with Article 23 before establishing a democratic legislature per Article 68 violates the most fundamental tenet of popular rule—that governmental authority is derived from the consent of the governed. The Hong Kong authorities invited public comments on the legislation, both in its initial outline form and later detailed drafts. But despite serious objections from journalists, lawyers, chambers of commerce, human rights activists, religious groups, and other interested parties, the bill on which the Legislative Council is expected to vote next month reflects only minor revisions from the Government's original draft. Without a legislature accountable to the citizenry, the people were free to speak their views, but the Government was free to ignore them.

As a result, most of the concerns I raised about the legislative proposal last October remain unaddressed:

Definitions of offenses such as "subversion," "sedition" and "secession" are extremely vague, permitting security officials to prosecute people arbitrarily, as they do on the Mainland.

Merely "handling" publications the authorities consider to be "seditious" would be a criminal offense, as would "intimidating" the Government in Beijing or acting to "disestablish" the "basic system" of China—meaning the political monopoly of the Communist Party—or endangering China's "stability."

"Inciting" subversion, even if only through speech, would be criminalized. In China, workers have been given long prison sentences for "inciting subversion" for simply demanding to be paid. Others have received 10-year terms for criticizing the Government on the Internet.

Hong Kong affiliates of organizations that Beijing decides threaten national security may be banned. This provision is likely to be used to ban Falun Gong, and conceivably it could be applied to the Roman Catholic Church if it does not renounce its ties to Rome. Hong Kong groups that monitor human rights and labor conditions in China have also been labeled "hostile foreign elements" by Mainland authorities and thus could be targeted.

Police will be permitted to enter and search private residences and seize property without a warrant.

Journalists and others could be prosecuted for the unauthorized disclosure of official secrets or information related to Hong Kong affairs that are the responsibility of the Central Government. Recall that for 5 months, Mainland authorities treated information about SARS as an official secret, and the world learned about the epidemic only after it spread to Hong Kong. Disclosing that information was clearly in the public's interest. But this bill does not allow a public interest defense, nor is there any counterbalancing right-to-know or freedom-of-information legislation. If this bill becomes law, how long will it take us to find out about China's next epidemic?

These proposed revisions to Hong Kong's laws, demanded by Beijing, run counter to China's commitment in the 1984 Sino-British Declaration to preserve Hong Kong's civil liberties for at least 50 years following the handover. They would significantly undermine such internationally recognized basic human rights as freedom of expression, freedom of association, and freedom of conscience, and potentially threaten freedom of religion and the right to due process as well.

Hong Kong's democratic politicians, activists, attorneys, journalists, and other professionals are understandably alarmed about this legislation. To hear some of them tell it, passage of this bill will mean the end of Hong Kong as we know it. In reality, I suspect most Hong Kong residents would wake up on July 10 to find life in their city essentially unchanged. The effects of this legislation will appear only gradually and incrementally. The first to feel the impact will probably be groups on the margins of Hong Kong society, such as Falun Gong practitioners. Perhaps most Hong Kongers will say nothing, because they are not Falun Gong practitioners. But over time, they will come to find themselves living in a poorer place, and the world will be poorer as a result.

If this legislation passes in its present form, it promises to make Hong Kong poorer in more ways than one. Last December, the American Chamber of Commerce in Hong Kong wrote the Government to express its concern about the bill's potential impact on the free flow of information, which it said was essential for the operation of Hong Kong's markets and for maintaining its competitiveness as a business location. The letter came a few weeks after a senior analyst at Bank of China International resigned after China's Premier criticized one of his reports. The British Chamber of Commerce warned Hong Kong could become "a much less favorable location for international business" if investors could not obtain free and unfettered information. Some analysts have suggested that investment on the Chinese Mainland could suffer as well, since foreign firms operating in China often rely on their Hong Kong offices for uncensored information about the Mainland.

Through the United States-Hong Kong Policy Act of 1992, Congress made support for human rights and democratization in Hong Kong a fundamental principle of United States foreign policy. As a concrete expression of support for Hong Kong's continued autonomy, the act stipulated that Hong Kong would continue to receive the same treatment under most United States laws after the handover as it had before. However, it allowed the President to suspend that provision on a case by case basis, whenever he determined that Hong Kong was no longer sufficiently autonomous to justify being treated differently from the rest of China under a particular law. This is not a decision the President should take lightly. However, if the proposed legislation compromises the independence of Hong Kong's judicial system or the integrity of its financial markets, as some analysts fear, the President would have no choice but to review specific United States statutes to evaluate whether separate treatment for Hong Kong can still be justified.

I hope we never get to that point. I hope that Hong Kong's freedom and its creativity can be preserved and that its people will be given more say in how they are governed, not less. For that reason, I urge those in the Hong Kong Government and Legislative Council who care about Hong Kong's future—and I am sure most of them do—to turn back from the course they are on before it is too late.

CBO COST ESTIMATE

Mr. SHELBY. Mr. President, I ask unanimous consent that the Congressional Budget Office cost estimate for S. 498, the Joseph A. De Laine Congressional Gold Medal bill, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 19, 2003.

Hon. RICHARD C. SHELBY,
Chairman, Committee on Banking, Housing, and Urban Affairs, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed estimate for S. 498, a bill to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the nation.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Matthew Pickford.

Sincerely,
DOUGLAS HOLTZ-EAKIN,
Director.

Enclosure

S. 498—A bill to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the nation

S. 709 would authorize the President to award posthumously a gold medal to Joseph De Laine Jr. to honor Reverend Joseph Anthony De Laine on behalf of the Congress for his civil rights contributions to the nation. The legislation would authorize the U.S. Mint to spend up to $30,000 to produce the gold medal. To help recover the costs of the medal, S. 498 would authorize the Mint to strike and sell bronze duplicates of the medal at a price that covers production costs for both the medal and the duplicates.

Based on the costs of recent medals produced by the Mint, CBO estimates that the bill would not significantly increase direct spending from the U.S. Mint Public Enterprise Fund. We estimate that the gold medal would cost about $25,000 to produce in fiscal years 2003 and 2004, including around $5,000 for the cost of the gold and around $20,000 for the costs to design, engrave, and manufacture the medal. CBO expects that the Mint would recoup little of its costs by selling bronze duplicates to the public.

S. 498 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would not affect the budgets of state, local, or tribal governments.

The CBO staff contact for this estimate is Matthew Pickford. This estimate was approved by Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

TRIBUTE TO JANINE LOUISE JOHNSON

Mr. HARKIN. Mr. President, it is with great sadness that I pay tribute to Janine Johnson, who for over 12 years served the Senate, its Members and staff as an assistant counsel in the Office of Legislative Counsel. Janine died on May 29, 2003 at the far too young age of 37.

In reality, there is little my words can add to the memorial Janine herself built through her outstanding legal skills, extraordinary dedication and uncommon kindness and personal grace. She will be remembered for her positive impact on the laws she helped so much to enact and for the example and fond memories she has left her colleagues and friends.

Janine came to work in the Senate Office of Legislative Counsel with an already full set of accomplishments: First in her high school class of 333 in Winchester, Massachusetts; National Merit Scholar; cum laude graduate of both Harvard College and Harvard Law School; a federal circuit court clerkship with Judge Cecil F. Poole on the United States Court of Appeals for the Ninth Circuit; member of the Massachusetts Bar.

We are fortunate that Janine built on that record by bringing her excellent qualifications and talent to the Senate. Beginning in February of 1991, she drafted many bills and amendments for committees and individual members and their staffs. Her work, which was primarily in the areas of the environment, public works, agriculture, nutrition and natural resources, contributed to a long list of enacted legislation.

In addition to numerous environmental and public works laws, including the Water Resources Development Acts of 1996 and 2000, and the Transportation Equity Act for the 21st Century of 1998, Janine contributed greatly to writing the Federal Agriculture Improvement and Reform Act of 1996 and the Farm Security and Rural Investment Act of 2002. And though her efforts helped better our Nation, and even other parts of the world, only a very few people have any idea or appreciation of Janine's work.

That is just the way Janine would have it. She was a private person who did not seek the limelight. Instead, she quietly went about doing excellent work as the consummate professional she was. She was meticulous, detail-oriented and precise, as one would want someone drafting important legislation to be, with an uncanny ability to take concepts and ideas and shape them into exact language carefully crafted to fit into the federal statutory scheme. To cite an example, Janine was the lead legislative counsel in drafting the nutrition title of the 2002 farm bill. Especially in a bill as extensive and complex as the farm bill, it is the rule that drafting errors are to be expected. To this day, not one error has been found in the drafting of the 2002 farm bill's nutrition title.

Janine willingly put in the extra hours so often required to produce such high-quality work while meeting the demanding time constraints of the legislative process. She was a very patient and stabilizing force in what are frequently pressurized circumstances—someone who also took pride in cultivating and maintaining good relations with both sides of the aisle and all sides of the various issues she worked on.

In short, Janine Johnson exemplified the fine professional qualities that are characteristic of the Senate Office of Legislative Counsel. She distinguished herself by setting a high standard within an office known for its high standards.

Janine's death is a terrible loss, and yet as we consider her very substantial and lasting accomplishments and contributions—and more importantly the memories of her that live on—it is fitting to recall the words of John Donne:

> Death be not proud, though some have called thee
> Mighty and dreadfull, for, thou art not so,
> For, those, whom thou think'st, thou dost overthrow,
> Die not, poore death, nor yet canst thou kill me.

I offer my condolences and kind wishes to Janine's family, friends and colleagues as they mourn her passing.

CONTROL OF STATE AND LOCAL POLITICAL INSTITUTIONS

Mr. ALEXANDER. Mr. President, I recently had the opportunity to read a book cowritten by a friend and law school classmate of mine, Professor Ross Sandler. The book, "Democracy by Decree," cowritten by Professor David Schoenbrod, is a fascinating discussion of an issue that has bedeviled our democracy since the 1960's: the control of State and local political institutions by the Federal courts.

When I served as Governor of Tennessee, I had the opportunity to attend many meetings with my fellow Governors. I learned that at that time, the prisons in virtually every State were under the control not of the Governor but of the Federal courts, whose decrees governed almost all aspects of prison management. Many of these decrees had lasted for years and years, and most would continue in force past the time I left the Governor's mansion.

Under our Federal system, the enforcement of criminal laws had been left to the States. With all of these decrees in force, however, instead of elected officials controlling a central aspect of law enforcement, a small group of lawyers and judges in each State could and would dictate penal policy by controlling the decrees. Nearly all these cases started out with the salutary purpose of protecting the constitutional rights of prison inmates to be free of prison brutality. They ended up going much further than the Constitution required or even permitted. Federal judges in some States were deciding how hot the coffee had to be in the prison commissary or how often the windows had to be washed. Judicial decrees of this nature had lasted so long that no one quite knew how to terminate them, and prison officials even got used to them. Not only had prison officials become comfortable with judicial management, they sometimes even colluded with litigants to force elected officials to provide a greater percentage of government resources to the penal system, even when the Constitution did not so require.

When the situation of judicial abuse over the management of prisons came to the attention of Congress, this body responded effectively by enacting the Prison Litigation Reform Act, codified at section 3626 of title 18 of the U.S. Code. This law, largely developed by Chairman HATCH, Senator SPECTER, former Senator Abraham, and others, limits the period of time Federal judges could impose decrees managing State and local prisons. Under the act, a judicial decree governing prison conditions cannot remain in effect for more than 2 years, unless the issuing court reviews the conditions at the prison and affirmatively determines that the decree is still needed to remedy a current violation of law or the Constitution. The burden of proving the need for the continuation of the decree remains, as in the original suit, with the plaintiffs. The 2-year time limit applies equally to consent decrees and to decrees entered after trial.

I believe the Prison Litigation Reform Act has been effective at restoring control of State and local penal facilities to the democratic branches of the States. According to Professor Sandler, many of the 20 and 25-year-old decrees governing prison conditions have been terminated or modified. This very fact demonstrates that the constitutional shortcomings that had initially prompted many of the lawsuits had been fixed, but there was no effective mechanism for allowing political actors to resume control over these institutions. At the same time, however, there has been no evident impact on the ability of the Federal courts to protect prison inmates from current or ongoing violations of the law or the Constitution.

What the Prison Litigation Reform Act accomplished so successfully and in a carefully balanced way should serve as a model for Congress to emulate in other areas of Federal law. Federal courts, prodded by activists and plaintiffs' lawyers, have taken control through negotiated consent decrees of multiple State and local social programs. The same problems that bedeviled Governors, State legislators, and prison administrators before the Prison Litigation Reform Act now confronts those democratically responsible actors who seek to manage foster care, special education, mental health services, Food Stamps, and welfare programs. In many States and local communities, any number of these programs is under direct judicial supervision. As was the case with prison decrees, many of the orders governing these myriad social programs have been in place for many years, binding elected officials to obligations imposed for a different set of circumstances, with no requirement that the court review the underlying facts to determine if continued judicial oversight is warranted or appropriate.

As a former law clerk to one of this Nation's most eminent Federal judges, I know that judicial oversight can often be a crucial tool, sometimes the only tool, with which to vindicate people's constitutional or legal rights. I know that Federal judges did not seek to usurp the prerogatives of Governors, mayors, and legislators. Over time and often incrementally, however, they did so.

Judges, in fact, were and are often reluctant to intrude into the operations of government programs. When they seek to encourage a negotiated resolution, however, they empower plaintiffs' lawyers and government lawyers to negotiate and decide the outcome. Often, the parties to the negotiation find that they can make common cause, particularly in finding non-democratic means for improving programs and prying more money and authority from Governors, mayors, and legislators. Working behind closed doors, and unaccountable to the people, the lawyers and the activists negotiate elaborate decrees of hundreds of pages, often encrusted with horse trades that often have little or nothing to do with the law or the alleged violations but a lot to do with long-term agendas of the parties to the negotiations. Only a small cadre of people is involved behind these closed doors. And at the end of the process, these self-interested negotiators present the judge with a decree that reflects the "consent" of all parties but bypasses the democratic process. These decrees are put into effect, and often no one ever reviews whether the legal bases on which they may be founded remain viable. Instead, they remain in effect for years and years, tying the hands of elected officials, even if there is no violation of law to remedy.

Building on the proven model of the Prison Litigation Reform Act, Congress can and should limit the harm that institutional reform decrees do to local democracy without precluding judges from vindicating legal and constitutional rights when necessary. Congress ought to consider legislation in different areas to limit judicial decrees in institutional reform cases to correcting only actually proven systemic violations of federal law or the Constitution. Further, Congress ought to allow courts to consider and make modifications of consent decrees in institutional reform cases any time a public official with an interest in the case has a good and compelling reason to seek changes. Finally, Congress should compel termination of decrees after a fixed time, unless plaintiffs demonstrate that current violations of law necessitating the continuation of the decree exist.

Reform by Congress of the general procedures governing judicial decrees in cases seeking reform of State and local government institutions along the lines suggested by Professor Sandler in his book will strengthen our State and local democratic institutions while ensuring the continued protection of constitutional and legal rights. I hope to look for opportunities to pursue and effectuate some of the proposals I have outlined above as the Senate considers relevant authorizing legislation. I hope many of my colleagues will join me in this effort.

ADDITIONAL STATEMENTS

IN HONOR OF THE NATIONAL UNDERGROUND RAILROAD FAMILY REUNION FESTIVAL AND ITS SPONSORS

• Mr. CORZINE. Mr. President, I rise to pay tribute to the Harriet Tubman Historical Society and the National Underground Railroad Family Reunion Festival. The William Still Underground Railroad Foundation, Inc. sponsors this national festival. Celebrating the rich history of those that sought their freedom and the freedom of others by following the North Star, the festival reunites families from throughout the country—particularly descendants of the many men and women who bravely constituted the Underground Railroad.

Descendants of William Still, who is considered by many to be the father of the Underground Railroad, have gathered to preserve their family's legacy for the past 133 years. They unite in celebration and in honor of Still and other pioneering gentlemen and gentlewomen who fought against the oppressive forces of slavery. William Still was a freeborn black who became a prominent abolitionist, writer, and businessman. Working tirelessly to free the enslaved and to destroy the very institution of slavery, William Still led perhaps the most dramatic system of protest our young Nation had ever seen.

As the birthplace of William Still and other notable abolitionists, New Jersey played a significant role in the success of the Underground Railroad. Offering an excellent cover of dense forests and heavy wilderness, our State provided various routes for Underground conductors. After crossing the Delaware River under the cloak of darkness, escaping slaves would travel from Camden to Burlington, and then on to Bordentown. Runaways also came to Bordentown through the towns of Swedesboro and Woodbury. This path to freedom then ran north through the woodlands of Princeton and on to New Brunswick, a hub in the railroad that also received fugitives traveling from Trenton. Conductors then bore their travelers across the Raritan River—a perilous but pivotal crossing. From Rahway these exhausted and terrified slaves and their devoted guides traveled to Jersey City and into New York. These newly emancipated men, women, and children then continued their journey north, to Canada and to freedom. The Underground Railroad carried the hopes and dreams of hundreds of thousands. Many Americans risked their own lives and the lives of their loved ones in order to defend the beliefs that all are created equal and that liberty is a universal right.

Families and communities throughout New Jersey were vital to the liberation of countless slaves. The National Family Reunion Festival, sponsored by the Still family, seeks to provide a forum for generations, not only to preserve their due sense of pride, but to pass on the stories of their forebears' bravery to younger generations. The Still family boasts a proud American heritage that dates back 360 years. Fittingly, the Stills have spearheaded this year's 3-day festival. It is the first of its kind—a unique blend of history and culture, the past and the present, a commemoration of the historical fight against the enslavement of men and women and finally a celebration of the unity we seek and strive to create in our Nation every day. The National Underground Railroad Family Reunion Festival will bring together descendants of conductors, abolitionists, stationmasters, and fugitives along with those who joyously recognize the incredible courage with which the railroad ran and the invaluable justice for which it ran.

Mr. President, I invite you and my colleagues to join me in commending The William Still Underground Railroad Foundation, Inc. and the Harriet Tubman Historical Society for their spectacular efforts that honor the valorous deeds of abolitionists and keep the history and legacies of our great Nation alive.•

THE CENTENNIAL CELEBRATION OF COWETA, OKLAHOMA

• Mr. NICKLES. Mr. President, I am pleased to inform my colleagues in the Senate today that the city of Coweta, in my home State of Oklahoma, is celebrating the centennial of its founding.

Coweta has a rich and proud history. From its beginning as a Native American settlement town to being one of the fastest growing cities in one of the fastest growing counties in Oklahoma, Coweta is truly a great place to live, work, and raise a family. It is a place where values like faith, family, and community are lived daily by its residents. The spirit and character of Oklahoma are alive and well in Coweta.

It is my honor and privilege of help recognize and celebrate this occasion. Generations of residents have made Coweta a renewable place during its first 100 hundred years. Current and future generations will continue to make Coweta a special place for many years to come.

Congratulations to Coweta for celebrating this centennial.•

TRIBUTE TO STEPHEN CABELL

• Mr. BUNNING. Mr. President, I rise today to honor and pay tribute to Mr. Stephen Cabell of Owensboro, KY. Earlier this year, Stephen was named a Presidential Scholar in the Arts.

The Presidential Scholars in the Arts Program is administered by the U.S.

Department of Education to honor some of our Nation's most artistic and creative high school seniors. Each year, the National Foundation for Advancement in the Arts recommends a small number of exceptionally gifted students to this program. This year, only 16 students from across the country were named a Presidential Scholar in the Arts. This honor rewards individuals who excel in various disciplines of the arts, including music, theater, dance, and visual arts. Stephen was awarded this honor in recognition of his musical composition genius.

Stephen Cabell was born in Owensboro, KY. During his freshman year of high school he was accepted into the Interlochen Arts Academy in Michigan, a prestigious high school known for its contribution to the fine arts. While attending Interlochen, he studied horn, piano, and music composition. Stephen continues his love of music during his free time, when he tutors students in music theory, researches composers, and collects musical scores. He is the son of Steve and Mary Cabell of Owensboro, who I know are very proud of Stephen and his talent and commitment to music and perfection.

Since he was 8 years old, Stephen has been composing musical pieces. During his career he has won numerous awards. Stephen is a recipient of the Morton Gould Young Composers Award from the American Society of Composers, Authors, and Publishers, ASCAP, as well as the Neil Robert Memorial Scholarship from the Interlochen Arts Academy. Groups such as the Owensboro Symphony Orchestra, Imani Winds, and the Interlochen Academy regularly perform his music. Most recently, Stephen performed one of his pieces at the John F. Kennedy Center for the Performing Arts in an event designed to showcase the talents of all 16 Presidential Scholars. In the fall, Stephen plans to study composition at the Curtis Institute of Music.

Stephen Cabell has repeatedly proven his genius in the field of musical composition. I would like to congratulate him again on being named a Presidential Scholar in the Arts, a tremendous honor indeed. I thank the Senate for allowing me to recognize Stephen and his accomplishments. He is a true source of pride for Kentucky.●

TRIBUTE TO DANNY PIPER

● Mr. HARKIN. Mr. President, I want to put into the CONGRESSIONAL RECORD a statement I made last year shortly after we lost a great friend of mine and a true American success story, Danny Piper.

Danny Piper came into my life 13 years ago. I was the Chairman of the Disability Policy Subcommittee here in the Senate, and was the sponsor of the Americans with Disabilities Act. We were having a series of hearings leading up to the hopeful passage of this bill. Danny became the first person with Downs Syndrome to testify before a congressional committee. I can't remember exactly how this came about, but I am sure that Marietta Lane, Paul Marchand, and Bobby Silverstein had something to do with finding Danny and getting him and Sylvia and Larry to Washington.

I can remember that day like it was yesterday. Danny was cool, composed, and very confident as a witness. I spoke with him later, and asked if appearing before the Senate was like being in his high school play. "Not so bad," Danny replied.

I followed Danny from then on. I was so proud when he got his high school certificate, then got his first job. In fact, I spent one of my "workdays" at the store with Danny. He showed me the "ropes." He showed me the correct way to stock shelves. He made sure I knew how to load the cardboard box machine so I wouldn't get hurt. We went to lunch together, and it was a day I will always cherish.

Evey once in a while I would run into Dan in one place or another. He always hailed me as "Hi, big guy." Once, I was visiting a school in Ankeny during the summer, and I was to meet with some teachers and administrators. To my surprise, when I entered the room, there stood Dan. So he gave me his usual, "Hi, big guy" routine. One of the older persons there said, "This is Senator HARKIN." Dan just sort of shrugged, and said, "Yeah, yeah, I know . . . big guy". This memory still makes me smile.

Dan was always a part of all my campaigns, always there for my announcements and always there for the victory parties. But perhaps my most cherished moment with Dan was this spring. Dan set another first, I believe, when he introduced me at my announcement for reelection before a bank of TV cameras and a couple of hundred people. Sylvia told me how hard he practiced for this, and I could tell. He was poised, but a little nervous as he forgot to introduce my wife, Ruth. I told Dan it was no big deal, I still forget to do that sometimes myself. But he gave that introduction without missing a beat. He had it down pat. I was so proud and honored that Dan would do that for me.

Sylvia and Larry, their family were pioneers in every sense of the word. Long before it was even grudgingly accepted, they made sure Dan was fully integrated in with his peers in school, made sure he was not "sent away" like my brother was so many years ago, to an institution where everyone was "just like him." Dan was a pioneer, also, challenging a system that wanted to deny him his individuality, deny him his personal hopes and dreams, deny him his independence, deny him his human right to meet challenges and set goals for himself.

When we visited Dan in the hospital, I was so certain that he was going to make it. He had that same positive upbeat attitude I have always known. He was looking forward to helping me again this fall, as he had always helped me.

Well, Dan, a tragic accident has meant that you will not be with us physically. But the most powerful thing about you, Dan, was your spirit, and that will always be with us who were touched by your life. Your spirit commands us to lead on, break down barriers that separate us, provide that ladder or ramp of opportunity for all. We will enact MICASSA into law, Dan, and your example of overcoming challenges and meeting goals compels us not to fall in this endeavor.

Thank you, Dan, for all the help you gave us during your brief life. You helped us to be more understanding, more generous and more caring toward one another. That is a great legacy. In whatever lies ahead, you will be often on my mind, and always in my heart.●

RON MICHAELSON: 29 YEARS AT THE ILLINOIS STATE BOARD OF ELECTIONS

● Mr. DURBIN. Mr. President, I rise today to pay tribute to my friend Dr. Ronald D. Michaelson. Ron Michaelson will retire in June after 29 years of outstanding service to Illinois as the executive director of the Illinois State Board of Elections. I want to salute his dedication to public service and briefly share his story with you today.

Dr. Michaelson grew up in Chicago. He received a bachelor of arts degree from Wheaton College in 1963, a master of arts degree in political science from Northwestern University in 1965, and a Ph.D. in government from Southern Illinois University in 1970.

Dr. Michaelson went on to devote his life to public service. He began his professional career working in State government as an assistant to former Illinois Governor Richard Ogilvie. He then spent several years teaching at Sangamon State University. His interest in the political arena remained, however, and in 1974 he returned to that arena to head the newly created State board of elections. The board was formed to interpret election laws and coordinate procedures for holding elections, and Dr. Michaelson became the board's first and so far only executive director.

Dr. Michaelson's drive and ambition helped him administer and supervise the agency in a fair and bipartisan manner. He devoted himself and his 65 staff members to creating one of the most respected campaign disclosure systems in the Nation—one that requires candidates to report disclosure statements electronically, making them easily accessible to those interested in a candidate's campaign donations. Dr. Michaelson's success in creating a fair and effective system of campaign disclosure in the tough political environment of Illinois provided a heartening and instructive example for the cause of political openness nationwide.

In addition to his teaching and his work in government, Dr. Michaelson has authored numerous articles that have been published in leading state and national journals. He is the past national chairman of the Council on Governmental Ethics Laws and speaks frequently at conferences in the areas of election administration and campaign finance. He currently serves as an appointee to the advisory committee of the Federal Election Commission and teaches as an adjunct professor of public affairs at the University of Illinois at Springfield.

Dr. Michaelson's dedication to public service will continue beyond his retirement this month. He intends to assist the State board of elections on a part-time basis with the implementation of the recently enacted Help America Vote Act.

In a time of considerable cynicism about public officials, Ron Michaelson's career stands as a shining example of the finest tradition of honorable service to the public: an example of integrity, fairness, hard work, and high standards. I am truly pleased to honor Dr. Michaelson on his retirement from the Illinois State Board of Elections and to thank him for his service to the state of Illinois and for the example he has set in the course of that service. I know my fellow Senators will join me in congratulating Dr. Michaelson on his remarkable career.•

TRIBUTE TO REBECCA WILLIAMS

• Mr. BUNNING. Mr. President, I rise today to honor and pay tribute to Ms. Rebecca Williams of Henderson, KY. Rebecca was recently awarded a James Madison Memorial fellowship.

The James Madison fellowship, in its 12th year of competition, supports the further study of American history by college graduates who aspire to become teachers of American history, American government, and social studies in the Nation's secondary schools. Named in honor of the fourth President of the United States, the fellowship will fund up to $24,000 of Ms. William's course of study toward a master's degree.

The award recognizes promising and distinguished teachers and encourages the strengthening of their knowledge of the origins and development of American government and history. Ultimately, the award acknowledges educators who will provide outstanding tutelage to students across the country.

Ms. Williams is a teacher at Bryan Station High School in Lexington, KY. She is one of 56 recipients of the fellowship, selected from applicants from across the United States. Ms. Williams has distinguished herself as an exceptional and aspiring educator. Her dedication to the field of American history and to the education of Kentucky's youth is remarkable.

Ms. Williams is a tribute to Kentucky, and I am proud of her achievements. I thank the Senate for allowing me to recognize Ms. Williams's wonderful accomplishments. She is Kentucky at its finest.•

TRIBUTE TO THE EDUCATION ASSOCIATION OF McCRACKEN COUNTY

• Mr. BUNNING. Mr. President, I rise to honor and pay tribute to the McCracken County Education Association for the high ideals which they have taught through example to the children of their county school system. The McCracken County Education Association of McCracken County, KY, generously took the initiative not only to raise $10,089 and donate it to Habitat for Humanity but also to give their time and effort in the construction of a home in Paducah.

The initiative involved all 12 of McCracken County's public schools and the children that attend them. Each teacher was asked to raise $35 from their own classroom while the central office and each school contributed $350. The ways in which the money was raised are just as admirable for their originality and civic mindedness as they are for their charity. One teacher added a brick to a miniature house structure for every dollar her students contributed, while one school of only 350 students held a bake sale and raised approximately $5,000. Overall and throughout, the raising of funds was marked with a spirit of cooperation and team spirit. On June 6 the funds were presented to Habitat for Humanity of Paducah/McCracken County and on the 14th the teachers, administrators, and staff of McCracken County Education Association assembled at 1920 Broad St. in Paducah, KY, to donate time and labor in the construction of a house.

The altruism and generosity of the McCracken County Education Association ought to be highly commended and imitated by all who have seen its shining example. Such interest in the well-being of our neighbors combines the virtues of justice and compassion and enriches the society in which it exists.

While it is true that the McCracken County Education Association's concern for their neighbors and for a society in which all have shelter is truly virtuous, it is also true that the work they did was just as, if not more, valuable for the reason that they are the educators of America's future. The children whom the McCracken County Education Association included in this fundraiser event learned more than just what books might have taught them in school. They learned that an active interest in the well-being of others is important. They learned that though they are children who are still in the process of learning, their voices will be heard if they work together with order and with the good of society at heart. It is not only these children who stand to learn something from this notable example of generosity and civic responsibility but all of us here today.

My Senate colleagues and all others would do well to imitate the concern and initiative of the McCracken County Education Association. I thank the Senate for allowing me to laud the praises of the McCracken County Education Association.•

BIRTHDAY TRIBUTE FOR MR. WILLARD ELDREDGE

• Mr. CRAPO. Mr. President, I would like to take a moment to extend a heartfelt birthday greeting to Mr. Willard Eldredge who turns 80 years old today. On July 5, his friends and family will gather in Idaho Falls to honor this great man on the occasion of his birthday. Mr. Eldredge has touched many lives over the years, and I am one of the fortunate ones to have benefited from his influence. You see, I was involved in Boy Scouts, and eventually became an Eagle Scout. Mr. Eldredge was a Scout pack leader of mine many years ago. He taught me and other young men the values, work ethic, and commitment that it took to succeed in Scouts and in life. He served as a role model for me, and taught me lessons about honor, duty, honesty, and patriotism that I have carried with me throughout my life. It is now my honor to wish my former mentor a wonderful, and very happy 80th birthday.•

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 2:52 p.m., a message from the House of Representatives, delivered by

Mr. Hays, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 923. An act to amend the Small Business Investment Act of 1958 to allow certain premier certified lenders to elect to maintain an alternative loss reserve.

H.R. 1416. An act to make technical corrections to the Homeland Security Act of 2002.

H.R. 1460. An act to amend title 38, United States Code, to improve education and entrepreneurship benefits, housing, and certain other benefits for veterans, and for other purposes.

H.R. 1772. An act to improve small business advocacy, and for other purposes.

H.R. 2555. An act making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 923. An act to amend the Small Business Investment Act of 1958 to allow certain premier certified lenders to elect to maintain an alternative loss reserve; to the Committee on Small Business and Entrepreneurship.

H.R. 1416. An act to make technical corrections to the Homeland Security Act of 2002; to the Committee on Governmental Affairs.

H.R. 1460. An act to amend title 38, United States Code, to improve education and entrepreneurship benefits, housing, and certain other benefits for veterans, and for other purposes.

H.R. 1772. An act to improve small business advocacy, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 2555. An act making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes; to the Committee on Appropriations.

MEASURES PLACED ON THE CALENDAR

The following bill was read the second time, and placed on the calendar:

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

MEASURE HELD AT THE DESK

The following resolution was ordered held at the desk by unanimous consent:

S. Res. 186. A Resolution commending August Hiebert for his Service to the Alaska Communications Industry.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2899. A communication from the Chairman, Navy Sea Cadet Corps, transmitting, pursuant to law, the 2002 Audit and Annual Report; to the Committee on the Judiciary.

EC–2900. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Flufenacet acetamid; Pesticide Tolerance" (FRL7313–9) received on June 24, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2901. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Extension of Tolerances for Emergency Exemptions (Multiple Chemicals" (FRL7311–5) received on June 24, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2902. A communication from the Director, Regulations Management, Veterans Benefits Administration, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled "Accelerated Payments Under the Montgomery GI Bill—Active Duty Program" (RIN2900–AL22) received on June 24, 2002; to the Committee on Veterans' Affairs.

EC–2903. A communication from the Under Secretary for Health, Department of Veterans Affairs, transmitting, pursuant to law, the 2002 Annual Report entitled "VA Research: Discovery, Innovation, Leadership"; to the Committee on Veterans' Affairs.

EC–2904. A communication from the White House Liaison, Department of Health and Human Services, transmitting, pursuant to law, the report of vacancy and the designation of acting officer for the position of Assistant Secretary for Legislation; to the Committee on Health, Education, Labor, and Pensions.

EC–2905. A communication from the White House Liaison, Department of Health and Human Services, transmitting, pursuant to law, the report of vacancy and the designation of acting officer for the position of Inspector General; to the Committee on Health, Education, Labor, and Pensions.

EC–2906. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Amendment of Regulations on Aluminum in Large and Small Volume Parenterals Used in Total Parenteral Nutrition; Delay of Effective Date" (Doc. No. 02N–0241) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2907. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Labeling for Oral and Rectal Over-the-Counter Drug Products Containing Aspirin and Nonaspirin Salicylates; Reye's Syndrome Warning" (RIN0910–AA01) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2908. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Ingrown Toenail Relief Drug Products for Over-the-Counter Human Use" (RIN0910–AA01) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2909. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Antidiarrheal Drug Products for Over-the-Counter Human Use; Final Monograph" (RIN0910–AA01) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2910. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Public Information Regulations" (Doc. No. 99N–2637) received on June 24, 2003; to the Committee on Health, Education, Labor, and Pensions.

EC–2911. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Suspension of Community Eligibility" (Doc. No. FEMA–7809) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2912. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Changes in Flood Elevation Determinations" (44 CFR Part 65) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2913. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Final Flood Elevation Determinations" (44 CFR Part 67) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2914. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Final Flood Elevation Determinations" (44 CFR Part 67) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2915. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Changes in Flood Elevation Determinations" (Doc. No. FEMA–B–7436) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2916. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Changes in Flood Elevation Determinations" (Doc. No. FEMA–B–7539) received on June 24, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2917. A communication from the Chairman of the Board of Governors of the Federal Reserve System, transmitting, pursuant to law, the Annual Report on the Profitability of the Credit Card Operations of Depository Institutions for 2002; to the Committee on Banking, Housing, and Urban Affairs.

EC–2918. A communication from the General Counsel, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a nomination confirmed for the position of Assistant Secretary for Congressional and Intergovernmental Relations; to the Committee on Banking, Housing, and Urban Affairs.

EC–2919. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad to Canada; to the Committee on Foreign Relations.

EC-2920. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC-2921. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC-2922. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles or defense services sold commercially under contract in the amount of $50,000,000 or more to Israel; to the Committee on Foreign Relations.

EC-2923. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC-2924. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad and the export of defense articles or defense services in the amount of $50,000,000 or more to South Korea; to the Committee on Foreign Relations.

EC-2925. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense services, technical data and defense articles sold commercially under a contract in the amount of $50,000,000 or more to South Korea; to the Committee on Foreign Relations.

EC-2926. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $100,000,000 or more to Japan; to the Committee on Foreign Relations.

EC-2927. A communication from the Assistant Secretary for Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $100,000,000 or more to Belgium, Canada, Denmark, France, Germany, Ireland, Italy, Norway and the United Kingdom; to the Committee on Foreign Relations.

EC-2928. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to law, the report of the text of agreements and background statements of international agreements other than treaties; to the Committee on Foreign Relations.

EC-2929. A communication from the Under Secretary of Defense, Acquisition, Technology and Logistics, transmitting, pursuant to law, a report concerning the amount of funds for information technology and software used to support Department of Defense weapon systems; to the Committee on Armed Services.

EC-2930. A communication from the Director, Strategic and Tactical Systems, Office of Under Secretary of Defense, Acquisition, Technology and Logistics, transmitting, pursuant to law, the report of funds for four new Foreign Comparative Testing projects; to the Committee on Armed Services.

EC-2931. A communication from the Director, Admissions Liaison, Department of the Air Force, transmitting, the report of separation action; to the Committee on Armed Services.

EC-2932. A communication from the Director, Admissions Liaison, Department of the Air Force, transmitting, the report of separation action; to the Committee on Armed Services.

EC-2933. A communication from the Under Secretary of Defense, Acquisition, Technology and Logistics, transmitting, pursuant to law, the Annual Report on the Department of Defense Mentor-Protege Program; to the Committee on Armed Services.

EC-2934. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Implementation Plans; Federally Enforceable State Operating Permit Program; Allegheny County, Pennsylvania" (FRL7511-7) received on June 24, 2003; to the Committee on Environment and Public Works.

EC-2935. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Implementation Plans; State of Colorado: Credible Evidence" (FRL7512-7) received on June 24, 2003; to the Committee on Environment and Public Works.

EC-2936. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Implementation Plans; Utah; SIP Renumbering" (FRL7501-5) received on June 24, 2003; to the Committee on Environment and Public Works.

EC-2937. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Implementation Plans and Designation of Areas for Quality Planning Purposes 1-Hour Ozone Standard for San Diego, California" (FRL7515-4) received on June 24, 2003; to the Committee on Environment and Public Works.

EC-2938. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Finding of Substantial Inadequacy of Implementation Plan; Call for California State Implementation Plan Revision" (FRL7518-4) received on June 24, 2003; to the Committee on Environment and Public Works.

EC-2939. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Interim Final Determination that the State of California has Corrected Deficiencies and Stay and Deferral of Sanctions; San Joaquin Valley Ozone Nonattainment Area" (FRL7517-9) received on June 24, 2003; to the Committee on Environment and Public Works.

EC-2940. A communication from the Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of the Drinking Water State Revolving Fund Program; to the Committee on Environment and Public Works.

EC-2941. A communication from the Comptroller General of the United States, General Accounting Office, transmitting, pursuant to law, a report on the forum to develop a more comprehensive key national indicator system; to the Committee on Governmental Affairs.

EC-2942. A communication from the Administrator, General Service Administration, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC-2943. A communication from the Chairman, National Science Board, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC-2944. A communication from the Chairman, Federal Maritime Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC-2945. A communication from the Secretary of Veterans Affairs, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC-2946. A communication from the Chair, Equal Employment Opportunity Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC-2947. A communication from the Chief Executive Officer, Corporation for National and Community Service, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC-2948. A communication from the Chairman, Congressional Award, transmitting, pursuant to law, the fiscal year 2002 report to Congress; to the Committee on Governmental Affairs.

EC-2949. A communication from the CFO and Plan Administrator, First South Farm Credit Retirement Committee, transmitting, pursuant to law, the Annual Pension Plan Report for calendar year 2002; to the Committee on Governmental Affairs.

EC-2950. A communication from the District of Columbia Auditor, transmitting, a report entitled "The Department of Mental Health Failed to Implement A Vocational Rehabilitation Program for the District's Mental Health Consumers"; to the Committee on Governmental Affairs.

EC-2951. A communication from the Assistant Administrator, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Atlantic Highly Migratory Species; incidental Catch Requirements of Bluefin Tuna" (RIN0648–AO75) received on June 24, 2003; to the Committee on Governmental Affairs.

EC–2952. A communication from the Deputy Associate Administrator, Office of Acquisition Policy, General Service Administration, transmitting, pursuant to law, the report of a rule entitled "Federal Acquisition Regulation" (FAC 2001–14) received on June 24, 2003; to the Committee on Governmental Affairs.

EC–2953. A communication from the General Counsel of the Department of Commerce, transmitting, a draft of proposed legislation entitled "Fishery Conservation and Management Amendments of 2003"; to the Committee on Commerce, Science, and Transportation.

EC–2954. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: SOCATA Group AEROSPATIALE Models MD 892A–150, MS 892E–150, MS 893A, MS 893E, MS 894A, MS 894E, Rallye 150ST Airplanes" ((RIN2120–AA64)(2003–0245)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2955. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Hartzell Propeller Inc. Model HC–C2Y (KR) 1BF/F8477–4 Propellers" ((RIN2120–AA64)(2003–0242)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2956. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Dornier Model 328 100 and 300 Series Airplanes" ((RIN2120–AA64)(2003–0243)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2957. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: McDonnell Douglas Model MD 90 Airplanes" ((RIN2120–AA64)(2003–0240)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2958. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Fokker Odel F28 Mark 0070 and 0100 Series Airplanes" ((RIN2120–AA64)(2003–0241)) received on June 19 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–2959. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Moundridge, KS; Correction" ((RIN2120–AA66)(2003–0102)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2960. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Cabelier, ND" ((RIN2120–AA66)(2003–0101)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. SHELBY, from the Committee on Banking, Housing, and Urban Affairs, without amendment:

S. 1334. An original bill to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes (Rept. No. 108–79).

By Mr. SHELBY, from the Committee on Banking, Housing, and Urban Affairs, with an amendment:

S. 498. A bill to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the Nation.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. GREGG for the Committee on Health, Education, Labor, and Pensions.

*David Hall, of Massachusetts, to be a Member of the Board of Directors of the Legal Services Corporation for a term expiring July 13, 2005.

*Lilian R. BeVier, of Virginia, to be a Member of the Board of Directors of the Legal Services Corporation for a term expiring July 13, 2004.

Mr. GREGG. Mr. President, for the Committee on Health, Education, Labor, and Pensions I report favorably the following nomination list which was printed in the Record on the date indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that this nomination lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

*Public Health Service nominations beginning Thomas D. Matte and ending Ronald R. Pinheiro, which nominations were received by the Senate and appeared in the Congressional Record on June 3, 2003.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. VOINOVICH:

S. 1326. A bill to establish the position of Assistant Secretary of Commerce for Manufacturing in the Department of Commerce; to the Committee on Commerce, Science, and Transportation.

By Mr. CORZINE:

S. 1327. A bill to reduce unsolicited commercial electronic mail and to protect children from sexually oriented advertisements; to the Committee on Commerce, Science, and Transportation.

By Mr. HATCH (for himself and Mrs. Clinton):

S. 1328. A bill to provide for an evaluation by the Institute of Medicine of the National Academy of Sciences of leading health care performance measures and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

By Mr. LOTT (for himself and Mr. Kerry):

S. 1329. A bill to amend title 49, United States Code, to require the Secretary of Transportation to carry out a grant program to provide financial assistance for local rail line relocations projects; to the Committee on Commerce, Science, and Transportation.

By Ms. MURKOWSKI:

S. 1330. A bill to establish the Kenai Mountains-Turnagain Arm National Heritage Area in the State of Alaska, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SANTORUM (for himself, Mr. Conrad, and Mr. Breaux):

S. 1331. A bill to clarify the treatment of tax attributes under section 108 of the Internal Revenue Code of 1986 for taxpayers which file consolidated returns; to the Committee on Finance.

By Mr. HATCH:

S. 1332. A bill to amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the Medicare program, and for other purposes; to the Committee on Finance.

By Mr. GRASSLEY (for himself, Mr. Bingaman, Mr. Bunning, Mr. Daschle, Mr. Rockefeller, Mr. Baucus, Ms. Snowe, Mr. Thomas, Mr. Smith, Mr. Conrad, Mr. Graham of Florida, Mr. Kerry, Mr. Breaux, Mrs. Lincoln, and Mr. Jeffords):

S. 1333. A bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain expenses of rural letter carriers; to the Committee on Finance.

By Mr. SHELBY:

S. 1334. An original bill to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes; from the Committee on Banking, Housing, and Urban Affairs; placed on the calendar.

By Mr. GRASSLEY (for himself, Mr. Graham of Florida, Ms. Mikulski, and Mr. Breaux):

S. 1335. A bill to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs; to the Committee on Finance.

By Mr. BROWNBACK (for himself and Mr. Kennedy):

S. 1336. A bill to allow North Koreans to apply for refugee status or asylum; to the Committee on the Judiciary.

By Mr. SMITH:

S. 1337. A bill to establish an incentive program to promote effective safety belt laws and increase safety belt use; to the Committee on Commerce, Science, and Transportation.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. ENSIGN (for Mr. CAMPBELL (for himself, Mr. ENSIGN, Mr. KYL, Mr. BURNS, Mr. ALLARD, Mr. CRAPO, and Mr. CRAIG)):

S. Res. 183. A resolution commemorating 50 years of adjudication under the McCarran Amendment of rights to the use of water; to the Committee on Energy and Natural Resources.

By Mr. KYL (for himself, Ms. MIKULSKI, Mr. BROWNBACK, Mr. MCCAIN, and Mr. ALLEN):

S. Res. 184. A resolution calling on the Government of the People's Republic of China immediately and unconditionally to release Dr. Yang Jianli, and for other purposes; to the Committee on Foreign Relations.

By Ms. MURKOWSKI (for herself, Mr. STEVENS, and Mr. INOUYE):

S. Res. 185. A resolution expressing the sense of the Senate with respect to raising awareness and encouraging education about safety on the Internet and supporting the goals and ideals of National Internet Safety Month; considered and agreed to.

By Mr. STEVENS (for himself and Ms. MURKOWSKI):

S. Res. 186. A resolution commending August Hiebert for his service to the Alaska Communications Industry; ordered held at the desk.

ADDITIONAL COSPONSORS

S. 470

At the request of Mr. SARBANES, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 470, a bill to extend the authority for the construction of a memorial to Martin Luther King, Jr.

S. 501

At the request of Mr. GRASSLEY, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 501, a bill to provide a grant program for gifted and talented students, and for other purposes.

S. 517

At the request of Mr. DAYTON, his name was added as a cosponsor of S. 517, a bill to amend title 38, United States Code, to provide improved benefits for veterans who are former prisoners of war.

S. 518

At the request of Ms. COLLINS, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 518, a bill to increase the supply of pancreatic islet cells for research, to provide better coordination of Federal efforts and information on islet cell transplantation, and to collect the data necessary to move islet cell transplantation from an experimental procedure to a standard therapy.

S. 595

At the request of Mr. BREAUX, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 595, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financings to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 610

At the request of Mr. VOINOVICH, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 610, a bill to amend the provisions of title 5, United States Code, to provide for workforce flexibilities and certain Federal personnel provisions relating to the National Aeronautics and Space Administration, and for other purposes.

S. 640

At the request of Mr. LEAHY, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 640, a bill to amend subchapter III of chapter 83 and chapter 84 of title 5, United States Code, to include Federal prosecutors within the definition of a law enforcement officer, and for other purposes.

S. 664

At the request of Mr. BAUCUS, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 664, a bill to amend the Internal Revenue Code of 1986 to permanently extend the research credit, to increase the rates of the alternative incremental credit, and to provide an alternative simplified credit for qualified research expenses.

S. 678

At the request of Mr. AKAKA, the names of the Senator from Nebraska (Mr. HAGEL) and the Senator from Ohio (Mr. VOINOVICH) were added as cosponsors of S. 678, a bill to amend chapter 10 of title 39, United States Code, to include postmasters and postmasters organizations in the process for the development and planning of certain policies, schedules, and programs, and for other purposes.

S. 752

At the request of Mr. BINGAMAN, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 752, a bill to amend the Internal Revenue Code of 1986 to treat distributions from publicly traded partnerships as qualifying income of regulated investment companies, and for other purposes.

S. 765

At the request of Mr. VOINOVICH, the name of the Senator from Tennessee (Mr. ALEXANDER) was added as a cosponsor of S. 765, a bill to amend the Ethics in Government Act of 1978 (5 U.S.C. App.) to streamline the financial disclosure process for executive branch employees.

S. 811

At the request of Mr. ALLARD, the name of the Senator from Colorado (Mr. CAMPBELL) was added as a cosponsor of S. 811, a bill to support certain housing proposals in the fiscal year 2003 budget for the Federal Government, including the downpayment assistance initiative under the HOME Investment Partnership Act, and for other purposes.

S. 854

At the request of Mr. COLEMAN, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 854, a bill to authorize a comprehensive program of support for victims of torture, and for other purposes.

S. 875

At the request of Mr. KERRY, the names of the Senator from Vermont (Mr. JEFFORDS) and the Senator from Colorado (Mr. CAMPBELL) were added as cosponsors of S. 875, a bill to amend the Internal Revenue Code of 1986 to allow an income tax credit for the provision of homeownership and community development, and for other purposes.

S. 888

At the request of Mr. GREGG, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 888, a bill to reauthorize the Museum and Library Services Act, and for other purposes.

S. 939

At the request of Mr. HAGEL, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 939, a bill to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding of such part, to provide an exception to the local maintenance of effort requirements, and for other purposes.

S. 973

At the request of Mr. NICKLES, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 973, a bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period for the depreciation of certain restaurant buildings.

S. 1032

At the request of Mr. SARBANES, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1032, a bill to provide for alternative transportation in certain federally owned or managed areas that are open to the general public.

S. 1046

At the request of Mr. HOLLINGS, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1091

At the request of Mr. DURBIN, the names of the Senator from Michigan

(Ms. STABENOW) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 1091, a bill to provide funding for student loan repayment for public attorneys.

S. 1109

At the request of Mr. TALENT, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of S. 1109, a bill to provide $50,000,000,000 in new transportation infrastructure funding through Federal bonding to empower States and local governments to complete significant infrastructure projects across all modes of transportation, including roads, rail, transit, aviation, and water, and for other purposes.

S. 1129

At the request of Mrs. FEINSTEIN, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1195

At the request of Mr. DAYTON, his name was added as a cosponsor of S. 1195, a bill to amend title XIX of the Social Security Act to clarify that inpatient drug prices charged to certain public hospitals are included in the best price exemptions for the medicaid drug rebate program.

S. 1201

At the request of Mr. GRAHAM of South Carolina, the name of the Senator from Indiana (Mr. LUGAR) was added as a cosponsor of S. 1201, a bill to promote healthy lifestyles and prevent unhealthy, risky behaviors among teenage youth.

S. 1218

At the request of Mr. HOLLINGS, the names of the Senator from New Jersey (Mr. LAUTENBERG), the Senator from Washington (Ms. CANTWELL) and the Senator from Florida (Mr. NELSON) were added as cosponsors of S. 1218, a bill to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program.

S. 1248

At the request of Mr. GREGG, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1252

At the request of Mr. DAYTON, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 1252, a bill to provide benefits to domestic partners of Federal employees.

S. 1289

At the request of Mr. GRAHAM of Florida, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 1289, a bill to name the Department of Veterans Affairs Medical Center in Minneapolis, Minnesota, after Paul Wellstone.

S. 1293

At the request of Mr. HATCH, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 1293, a bill to criminalize the sending of predatory and abusive e-mail.

S. 1303

At the request of Mr. BROWNBACK, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1303, a bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration services, and chemotherapy support services.

S. 1315

At the request of Mr. CRAIG, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 1315, a bill to amend the Federal Land Policy and Management Act of 1976 to provide owners of non-Federal lands with a reliable method of receiving compensation for damages resulting from the spread of wildfire from nearby forested National Forest System lands or Bureau of Land Management lands, when those forested Federal lands are not maintained in the forest health status known as condition class 1.

S. 1325

At the request of Mr. BURNS, the name of the Senator from Kansas (Mr. BROWNBACK) was added as a cosponsor of S. 1325, a bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies.

S. CON. RES. 25

At the request of Mr. VOINOVICH, the names of the Senator from Minnesota (Mr. COLEMAN) and the Senator from New York (Mrs. CLINTON) were added as cosponsors of S. Con. Res. 25, a concurrent resolution recognizing and honoring America's Jewish community on the occasion of its 350th anniversary, supporting the designation of an "American Jewish History Month", and for other purposes.

S. CON. RES. 40

At the request of Mrs. CLINTON, the names of the Senator from Oregon (Mr. SMITH), the Senator from Texas (Mrs. HUTCHISON), the Senator from North Dakota (Mr. CONRAD), the Senator from North Dakota (Mr. DORGAN), the Senator from Minnesota (Mr. DAYTON) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as "National Purple Heart Recognition Day".

S. RES. 160

At the request of Mr. AKAKA, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. Res. 160, a resolution to express the sense of the Senate that the Federal Government should actively pursue a unified approach to strengthen and promote the national policy on aquaculture.

AMENDMENT NO. 936

At the request of Mr. NELSON of Florida, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of amendment No. 936 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 938

At the request of Mr. NELSON of Florida, the name of the Senator from Louisiana (Mr. BREAUX) was added as a cosponsor of amendment No. 938 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 956

At the request of Mr. REID, his name was added as a cosponsor of amendment No. 956 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 967

At the request of Mr. HARKIN, the names of the Senator from North Dakota (Mr. DORGAN), the Senator from New York (Mr. SCHUMER), the Senator from Washington (Mrs. MURRAY), the Senator from Maryland (Ms. MIKULSKI) and the Senator from Oregon (Mr. SMITH) were added as cosponsors of amendment No. 967 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 972

At the request of Mr. BINGAMAN, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 972

At the request of Mr. SMITH, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 972

At the request of Mr. HOLLINGS, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 972

At the request of Mr. HATCH, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 972

At the request of Mr. BOND, his name was added as a cosponsor of amendment No. 972 proposed to S. 1, supra.

AMENDMENT NO. 991

At the request of Mr. HARKIN, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of amendment No. 991 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 994

At the request of Mr. DURBIN, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of amendment No. 994 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 994

At the request of Mr. SARBANES, his name was added as a cosponsor of amendment No. 994 proposed to S. 1, supra.

AMENDMENT NO. 994

At the request of Ms. MIKULSKI, her name was added as a cosponsor of amendment No. 994 proposed to S. 1, supra.

AMENDMENT NO. 1000

At the request of Mrs. CLINTON, the names of the Senator from Connecticut (Mr. LIEBERMAN) and the Senator from Florida (Mr. GRAHAM) were added as cosponsors of amendment No. 1000 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1003

At the request of Mr. BROWNBACK, the names of the Senator from Alaska (Mr. STEVENS) and the Senator from Alaska (Ms. MURKOWSKI) were added as cosponsors of amendment No. 1003 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1021

At the request of Mr. CONRAD, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of amendment No. 1021 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1022

At the request of Mr. BROWNBACK, the name of the Senator from Virginia (Mr. ALLEN) was added as a cosponsor of amendment No. 1022 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1024

At the request of Mr. ENSIGN, the names of the Senator from Maryland (Ms. MIKULSKI) and the Senator from Minnesota (Mr. DAYTON) were added as cosponsors of amendment No. 1024 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 1040

At the request of Mr. SCHUMER, the names of the Senator from Pennsylvania (Mr. SANTORUM) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of amendment No. 1040 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. VOINOVICH:

S. 1326. A bill to establish the position of Assistant Secretary of Commerce for Manufacturing in the Department of Commerce; to the Committee on Commerce, Science, and Transportation.

Mr. VOINOVICH. Mr. President, I rise today to ask my colleagues' support for legislation I have introduced creating the new position of Assistant Secretary for Manufacturing in the Department of Commerce.

In America we are blessed with ingenuity, gumption, and a can-do spirit that is recognized around the world. At the turn of the last century we helped lead the world into the Industrial age. American inventors gave electricity and air travel to the world.

As we enter the 21st century, American manufacturing has as much potential as it has ever had at any time in our Nation's history. Accomplishments in the high-tech industry have been rapidly integrated into manufacturing to make our factories and our workers more productive, reduce costs, and save time.

At the same time, substantial new trade, training, energy, labor, and foreign competition challenges have arisen. Helping our manufacturing interests deal with these challenges is something that private sector organizations such as the National Association Manufacturers have done well for years. It only stands to reason that we focus resources in the Government sector in support of manufacturing as well.

I am concerned about the slow economic recovery and our Nation's declining position in the global marketplace, particularly for manufacturing, which is the backbone of our economy, both in Ohio and the Nation. There is a genuine panic by the manufacturing community over their future and the jobs created from manufacturing. They feel they are under siege from environmental regulations, rising health care costs, litigation, escalating natural gas costs, and the prospect of dramatically higher electricity costs if energy reform legislation is not passed.

First, health care costs continue to rise. Nationwide, we have seen double-digit increases in health care premiums over the last 2 years alone. In Ohio, the business community tells me they are seeing 20 to 50 percent increases in their health care costs. These increases raise labor costs, decreasing capital that otherwise would be available to make investments, and, ultimately, negatively impact our global competitiveness. In addition, these costs are being passed on to employees, limiting their take-home pay and increasing the number of uninsured.

Second, high natural gas prices are also having a detrimental effect on industry in Ohio and across the Nation. Many industries cannot compete internationally because of these high prices. Over the last 10 years, the average price for natural gas has been less than $3.00 per million cubic feet (Mcf). This year, companies in Ohio have been paying almost $10.00 per Mcf, more than a threefold increase. These price spikes are felt the hardest by Ohio's agriculture, chemical, and manufacturing industries. In order to be competitive, we cannot afford to hamper American companies in this manner.

Additionally, I have heard from companies in both the manufacturing and the chemical sectors that they cannot survive with these high prices. In particular, two chemical companies in Ohio have informed me that they are considering moving their operations not only out of Ohio, but outside of the United States because of these high costs. At the same time, suppliers of these companies are considering temporary shutdowns because they cannot afford to operate. Ohio's companies have not been able to budget and plan sufficiently because these prices have been so unpredictable this year.

As natural gas prices continue to rise, the President's National Energy Policy Task Force projects that over

1,300 new power plants will need to be built to satisfy America's energy needs over the next 20 years. As a result of the emissions limits and regulatory uncertainty triggered by the Clean Air Act, the Department of Energy currently predicts that over 90 percent of these new plants will be powered by natural gas. Further, analysis by EIA and the EPA shows that a large percentage of coal-fired plants are likely to be replaced by natural gas-fired plants in the near future.

Third, manufacturers need reliable transportation infrastructure to bring in supplies and ship out their products. We are a "just in time" economy and we are falling behind in our national investment in highways and bridges. According to the U.S. Department of Transportation, for each $1 billion of Federal spending on highway construction, 47,500 jobs are created annually. Furthermore, the Department estimates that every dollar invested in our highways yields $5.70 in economic benefits due to reduced delays, improved safety and reduced vehicle operating cost. Clearly, transportation investment in needed "ready-to-go" projects could go a long way in getting the economy back on track.

Finally, manufacturing companies are distressed by the surge in foreign competition, particularly from China. As a matter of fact, if a vote were taken today among Ohio manufacturers, many would oppose normal trade relations with China.

These are only a few of the challenges facing American manufacturers. Their profitability and survivability is impacted by virtually every policy and/or agency within the Federal Government. Moreover, the fact that there has been limited coordination of Government policies and agencies that impact manufacturing has contributed to a prolonged, steady decline of what I believe is the most critical sector of our economy.

According to USA Today, U.S. manufacturers laid off 95,000 workers in April—the 33rd consecutive month of decline and the largest drop in 15 months. Since July 2000, manufacturing has lost 2.6 million jobs. My own State of Ohio has lost 154,500 manufacturing jobs, over a 15-percent decline. New orders for manufactured goods in April decreased by $9.4 billion, or 2.9 percent, to $320 billion. This was the largest percent decline since November 2001. Shipments decreased by $7.1 billion or 2.2 percent to $320.6 billion. This was the largest percent decline since February 2002.

According to the National Association of Manufacturers, "If the U.S. manufacturing base continues to shrink at its present rate and the critical mass is lost, the manufacturing innovation process will shift to other global centers. Once that happens, a decline in U.S. living standards in the future is virtually assured."

Unfortunately, up to now, there has been no senior level policymaker responsible for examining prospective and existing Government policies to determine their potential impact on manufacturing. This is more than an unfortunate oversight; it is a potential economic disaster. Government policies are often developed without regard to their impact on manufacturing. Too many Government decisionmakers view manufacturing as a "dying sector" that is better transferred overseas so Americans can focus on the more profitable service sector. What these people fail to realize is that manufacturing is the foundation of the service sector.

There is no retail industry without manufactured products to sell. There is no transportation industry without manufactured products to transport. There is no repair industry without manufactured products to repair. Even services such as accounting, financial management, banking, and information technology sell their services to manufacturers and could not remain profitable without a vibrant manufacturing sector.

Manufacturing growth spawns more additional economic activity and jobs than any other economic sector. Every $1 of final demand for manufactured goods generates an additional 67 cents in other manufactured products, and 76 cents in products and services from nonmanufacturing sectors.

In fact, manufacturers are responsible for almost two-thirds of all private sector Research & Development—$127 billion in 2002. In addition, spillovers from R&D benefit other manufacturing and nonmanufacturing firms.

Manufacturing productivity gains are historically higher than those of any other economic sector. For example, over the past two decades, manufacturing averaged twice the annual productivity gains of the rest of the private sector. These gains enable Americans to do more with less, increase our ability to compete, and facilitate higher wages for all employees.

Manufacturing salaries and benefits average $54,000, which is higher than the average for the total private sector. Two factors in particular attract workers to manufacturing: one, higher pay and benefits, and, two, opportunities for advanced education and training.

Manufacturing has been an important contributor to regional economic growth and tax receipts at all levels of government. During the 1990s, manufacturing corporations paid 30 to 34 percent of all corporate taxes collected by State and local governments, as well as Social Security and payroll taxes, excise taxes, import and tariff duties, environmental taxes and license taxes.

Furthermore, manufacturing is a secure foundation for future economic prosperity. Capital investments in factories and equipment tend to anchor businesses more securely to a community, a State or a nation. When a corporation owns property in a community, they are more likely to be an active participant in helping improve the quality of life, stability, and economic vitality of that community.

Our competitors recognize this and are moving rapidly to claim the manufacturing preeminence that once characterized the U.S. economy. While America's industrial leadership is being squeezed by rising health care costs, runaway litigation, excessive regulation and some of the highest taxes on investment in the industrialized world, our foreign competitors are taking a larger market share with less expensive products that make it difficult to raise prices. The result is a dramatic decline in manufacturing cashflow that forces firms to cut back on R&D and capital investment, and to reduce employment. The U.S. manufacturing base is receding—and with it the all-important innovation that is the seedbed of our industrial strength and competitive edge.

Unfortunately, while many countries support their manufacturing sector with favorable government policies, tax incentives, and even financial subsidies, the United States does not even coordinate government initiatives that might impact our own manufacturers. Within the U.S. Government, however, we do have Cabinet level Departments to represent the interests of agriculture, transportation, and energy. These three sectors combined do not generate as much economic activity, nor employ as many individuals as manufacturing. Nevertheless, there is no senior level policymaker anywhere in the Federal Government whose sole responsibility is the health and growth of manufacturing. Is it any wonder we are losing market share to foreign competition?

The bill I am introducing today will help rectify this unfortunate situation. It will establish an Assistant Secretary in the Commerce Department who will: one, represent and advocate for the interests of the manufacturing sector; two, aid in the development of policies that promote the expansion of the manufacturing sector; three, review policies that may adversely impact the manufacturing sector; and, four, assist the manufacturing sector in other ways as the Secretary of Commerce shall prescribe.

The new Assistant Secretary of Commerce for Manufacturing will also submit to Congress an annual report that contains: one, an overview of the state of the manufacturing sector in the United States; two, forecast of the future state of the manufacturing sector in the United States; and, three, an analysis of current and significant laws, regulations, and policies that adversely impact the manufacturing sector in the United States.

It is a small step forward but an important one. I look forward to working with my colleagues to enact this important legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1326

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ASSISTANT SECRETARY OF COMMERCE FOR MANUFACTURING.

(a) ESTABLISHMENT.—There is in the Department of Commerce the position of Assistant Secretary of Commerce for Manufacturing. The Assistant Secretary shall be appointed by the President by and with the advice and consent of the Senate.

(b) DUTIES.—The Assistant Secretary of Commerce for Manufacturing shall—

(1) represent and advocate for the interests of the manufacturing sector;

(2) aid in the development of policies that promote the expansion of the manufacturing sector;

(3) review policies that may adversely impact the manufacturing sector; and

(4) perform such other duties as the Secretary of Commerce shall prescribe.

(c) REPORTING REQUIREMENTS.—The Assistant Secretary of Commerce for Manufacturing shall submit to Congress an annual report that contains the following:

(1) An overview of the state of the manufacturing sector in the United States.

(2) A forecast of the future state of the manufacturing sector in the United States.

(3) An analysis of current and significant laws, regulations, and policies that adversely impact the manufacturing sector in the United States.

(d) COMPENSATION.—Section 5314 of title 5, United States Code, relating to Level IV of the Executive Schedule, is amended by inserting before "and Assistant" in the item relating to the Assistant Secretaries of Commerce the following: "Assistant Secretary of Commerce for Manufacturing,".

By Mr. CORZINE:

S. 1327. A bill to reduce unsolicited commercial electronic mail and to protect children from sexually oriented advertisements; to the Committee on Commerce, Science, and Transportation.

Mr. CORZINE. Mr. President, today I am introducing legislation, the Restrict and Eliminate the Delivery of Unsolicited Commercial Electronic Mail, REDUCE, Spam Act, to curb the influx of unwanted junk e-mail, or "spam," that is clogging our inboxes and wasting the time and money of American consumers and businesses.

The flood of spam is growing so fast that it will soon account for more than half of all e-mail sent in the United States. Spam already accounts for nearly 40 percent of e-mail traffic, and costs U.S. businesses $10 billion annually in lost productivity and additional equipment, software and manpower costs necessary to manage this burden. Microsoft Inc. estimates that more than 80 percent of the more than 2.5 billion e-mail messages sent each day to Hotmail users are spam. And data suggests that the problem is only growing.

The problem of spam goes well beyond inconvenience and cost. The Federal Trade Commission examined a random sample of 1000 spam messages and, in a report issued on April 30, 2003, found staggering evidence of fraud. According to the report, 33 percent of the messages sampled contained false routing information; 22 percent contained false information in the subject line; 40 percent contained false statements in the text; and a full 66 percent contained false information of some sort. Most alarmingly, in the case of spam touting business or investment opportunities, 96 percent contained some sort of fraudulent information.

In addition, pornographic spam is a growing problem for parents trying to shield their children from such images. The FTC report found that 17 percent of spam advertising pornographic websites included adult images in the body of the message. This is not acceptable when our children are using email more and more each day.

Unfortunately, it is very difficult to track down those who send spam. Often, spammers use multiple e-mail addresses or disguise routing information to avoid being identified. Finding spammers can take not just real expertise, but persistence, time, energy and commitment.

To attack the problem of spam, my proposal adopts a two-prong approach championed by the leading thinker about cyberlaw, Professor Lawrence Lessig of Stanford Law School. Congresswoman ZOE LOFGREN also has introduced similar legislation in the House of Representatives. The approach is simple: first, anyone sending bulk unsolicited commercial e-mail would have to include on each e-mail a simple prefix—either ADV: or ADV:ADLT. Second, anyone who finds a spam-source who has failed to properly label unsolicited commercial e-mail would be eligible for a monetary reward from the FTC.

The first part of this proposal would enable Internet Service Providers, ISPs, employers and individual users to filter spam from business and personal email. This would give people the ability to tell their Internet service provider to block ADV e-mail, or they could automatically filter such e-mail into a spam folder on their own computer. This approach would enable far more effective filtering than currently possible.

The second part of my proposal would require the FTC to pay a bounty to anyone who tracks down a spammer who has failed properly to label unsolicited commercial e-mail. The proposal would invite anyone across the world who uses the Internet to hunt down these law-violating spammers. The FTC would then fine them and pay a portion of that fine as a reward to the bounty hunter who found them. The FTC could use the remainder of the fine to track down and prosecute other spammers.

Creating incentives for private individuals to help track down spammers is likely to substantially strengthen the enforcement of anti-spam laws. And with proper enforcement, spammers would soon learn that neglecting to label spam does not pay. In the end, that will mean that more spammers will label their spam or give up and stop spamming altogether. Either way, we will have fixed, or at least started to fix, the problem.

Professor Lessig is so convinced that this approach will substantially reduce spam that he has pledged to resign from his job at Stanford if it does not. While I will not hold him to that warranty, I do share his enthusiasm about this innovative approach, which is likely to be much more effective than relying exclusively on government investigators to identify spammers.

Having said that, I recognize that any domestic anti-spam legislation potentially is subject to evasion by spammers who relocate overseas in order to continue sending spam. To respond to that possibility, my bill also orders the Administration to study the possibility of an international agreement to reduce spam. This is an issue that affects us globally, and, in my view, we should consider a coordinated response.

In addition to these primary provisions, my bill would require marketers to establish a valid return e-mail address to which an e-mail recipient can write to "opt-out" of receiving further e-mails, and would prohibit marketers from sending any further e-mails after a person opts-out. The bill also would prohibit spam with false or misleading routing information or deceptive subject headings, and would authorize the Federal Trade Commission to collect civil fines against marketers who violate these requirements. Furthermore, my proposal would give Internet Service Providers the right to bring civil actions against marketers who violate these requirements and disrupt their networks, and, finally, the proposal would establish criminal penalties for fraudulent spam.

I know that the Commerce Committee recently ordered reported legislation to deal with the problem of spam, and I am hopeful that bill will come before the full Senate before long. When it does, it is my intention to work with my colleagues to see if some of the concepts in the REDUCE Spam Act, such as the establishment of individual rewards for bounty hunters, and a report on a possible international agreement on spam, can be incorporated into the broader package, to ensure that any legislation sent to the President will actually be effective in reducing spam.

I ask unanimous consent that the text of the legislation be printed in the RECORD at this point, along with a related article by Professor Lawrence Lessig.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1327

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Restrict and Eliminate the Delivery of Unsolicited Commercial Electronic Mail or Spam Act of 2003" or the "REDUCE Spam Act of 2003".

SEC. 2. DEFINITIONS.

In this Act:

(1) COMMERCIAL ELECTRONIC MAIL MESSAGE.—

(A) IN GENERAL.—The term "commercial electronic mail message" means any electronic mail message the primary purpose of which is the commercial advertisement or promotion of a commercial product or service (including content on an Internet website operated for a commercial purpose).

(B) REFERENCE TO COMPANY OR WEBSITE.—The inclusion of a reference to a commercial entity or a link to the website of a commercial entity in an electronic mail message does not, by itself, cause such message to be treated as a commercial electronic mail message for purposes of this Act if the contents or circumstances of the message indicate a primary purpose other than commercial advertisement or promotion of a commercial product or service.

(2) COMMISSION.—The term "Commission" means the Federal Trade Commission.

(3) ELECTRONIC MAIL ADDRESS.—

(A) IN GENERAL.—The term "electronic mail address" means a destination (commonly expressed as a string of characters) to which an electronic mail message can be sent or delivered.

(B) INCLUSION.—In the case of the Internet, the term "electronic mail address" may include an electronic mail address consisting of a user name or mailbox (commonly referred to as the "local part") and a reference to an Internet domain (commonly referred to as the "domain part").

(4) FTC ACT.—The term "FTC Act" means the Federal Trade Commission Act (15 U.S.C. 41 et seq.).

(5) HEADER INFORMATION.—The term "header information" means the source, destination, and routing information attached to an electronic mail message, including the originating domain name and originating electronic mail address.

(6) INITIATE.—The term "initiate", when used with respect to a commercial electronic mail message, means to originate such message or to procure the transmission of such message, either directly or through an agent, but shall not include actions that constitute routine conveyance of such message by a provider of Internet access service. For purposes of this Act, more than 1 person may be considered to have initiated the same commercial electronic mail message.

(7) INTERNET.—The term "Internet" has the meaning given that term in section 231(e)(3) of the Communications Act of 1934 (47 U.S.C. 231(e)(3)).

(8) INTERNET ACCESS SERVICE.—The term "Internet access service" has the meaning given that term in section 231(e)(4) of the Communications Act of 1934 (47 U.S.C. 231(e)(4)).

(9) PRE-EXISTING BUSINESS RELATIONSHIP.—

(A) IN GENERAL.—The term "pre-existing business relationship", when used with respect to a commercial electronic mail message, means that either—

(i) within the 5-year period ending upon receipt of a commercial electronic mail message, there has been a business transaction between the sender and the recipient, including a transaction involving the provision, free of charge, of information, goods, or services requested by the recipient and the recipient was, at the time of such transaction or thereafter, provided a clear and conspicuous notice of an opportunity not to receive further commercial electronic mail messages from the sender and has not exercised such opportunity; or

(ii) the recipient has given the sender permission to initiate commercial electronic mail messages to the electronic mail address of the recipient and has not subsequently revoked such permission.

(B) APPLICABILITY.—If a sender operates through separate lines of business or divisions and holds itself out to the recipient as that particular line of business or division, then such line of business or division shall be treated as the sender for purposes of subparagraph (A).

(10) RECIPIENT.—The term "recipient", when used with respect to a commercial electronic mail message, means the addressee of such message.

(11) SENDER.—The term "sender", when used with respect to a commercial electronic mail message, means the person who initiates such message. The term "sender" does not include a provider of Internet access service whose role with respect to electronic mail messages is limited to handling, transmitting, retransmitting, or relaying such messages.

(12) UNSOLICITED COMMERCIAL ELECTRONIC MAIL MESSAGE.—The term "unsolicited commercial electronic mail message" means any commercial electronic mail message that—

(A) is not a transactional or relationship message; and

(B) is sent to a recipient without the recipient's prior affirmative or implied consent.

SEC. 3. COMMERCIAL ELECTRONIC MAIL CONTAINING FRAUDULENT HEADER OR ROUTING INFORMATION.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1351. Unsolicited commercial electronic mail containing fraudulent header information

"(a) Any person who initiates the transmission of any unsolicited commercial electronic mail message, with knowledge and intent that the message contains or is accompanied by header information that is false or materially misleading, shall be fined or imprisoned for not more than 1 year, or both, under this title.

"(b) For purposes of this section, the terms 'unsolicited commercial electronic mail message' and 'header information' have the meanings given such terms in section 2 of the REDUCE Spam Act of 2003.".

(b) CONFORMING AMENDMENT.—The chapter analysis at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1351. Unsolicited commercial electronic mail.".

SEC. 4. REQUIREMENTS FOR UNSOLICITED COMMERCIAL ELECTRONIC MAIL.

(a) SUBJECT LINE REQUIREMENTS.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message to an electronic mail address within the United States, unless the subject line includes—

(1) except in the case of an unsolicited commercial electronic mail message described in paragraph (2)—

(A) an identification that complies with the standards adopted by the Internet Engineering Task Force for identification of unsolicited commercial electronic mail messages; or

(B) in the case of the absence of such standards, "ADV:" as the first four characters; or

(2) in the case of an unsolicited commercial electronic mail message that contains material that may only be viewed, purchased, rented, leased, or held in possession by an individual 18 years of age and older—

(A) an identification that complies with the standards adopted by the Internet Engineering Task Force for identification of adult-oriented unsolicited commercial electronic mail messages; or

(B) in the case of the absence of such standards, "ADV:ADLT" as the first eight characters.

(b) RETURN ADDRESS REQUIREMENTS.—

(1) ESTABLISHMENT.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message to an electronic mail address within the United States, unless the sender establishes a valid sender-operated return electronic mail address where the recipient may notify the sender not to send any further commercial electronic mail messages.

(2) INCLUDED STATEMENT.—All unsolicited commercial electronic mail messages subject to this subsection shall include a statement informing the recipient of the valid return electronic mail address referred to in paragraph (1).

(3) PROHIBITION OF SENDING AFTER OBJECTION.—Upon notification or confirmation by a recipient of the recipient's request not to receive any further unsolicited commercial electronic mail messages, it shall be unlawful for a person, or anyone acting on that person's behalf, to send any unsolicited commercial electronic mail message to that recipient. Such a request shall be deemed to terminate a pre-existing business relationship for purposes of determining whether subsequent messages are unsolicited commercial electronic mail messages.

(c) HEADER AND SUBJECT HEADING REQUIREMENTS.—

(1) FALSE OR MISLEADING HEADER INFORMATION.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message that such person knows, or reasonably should know, contains or is accompanied by header information that is false or materially misleading.

(2) DECEPTIVE SUBJECT HEADINGS.—It shall be unlawful for any person to initiate the transmission of an unsolicited commercial electronic mail message with a subject heading that such person knows, or reasonably should know, is likely to mislead a recipient, acting reasonably under the circumstances, about a material fact regarding the contents or subject matter of the message.

(d) AFFIRMATIVE DEFENSE.—A person who violates subsection (a) or (b) shall not be liable if—

(1)(A) the person has established and implemented, with due care, reasonable practices and procedures to effectively prevent such violations; and

(B) the violation occurred despite good faith efforts to maintain compliance with such practices and procedures; or

(2) within the 2-day period ending upon the initiation of the transmission of the unsolicited commercial electronic mail message in violation of subsection (a) or (b), such person initiated the transmission of such message, or one substantially similar to it, to less than 1,000 electronic mail addresses.

SEC. 5. ENFORCEMENT.

(a) In General.—Section 4 shall be enforced by the Commission under the FTC Act. For purposes of such Commission enforcement, a violation of this Act shall be treated as a violation of a rule under section 18 (15 U.S.C. 57a) of the FTC Act prohibiting an unfair or deceptive act or practice.

(b) Rulemaking.—Not later than 30 days after the date of enactment of this Act, the Commission shall institute a rulemaking proceeding concerning enforcement of this Act. The rules adopted by the Commission shall prevent violations of section 4 in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the FTC Act were incorporated into and made a part of this section, except that the rules shall also include—

(1) procedures to minimize the burden of submitting a complaint to the Commission concerning a violation of section 4, including procedures to allow the electronic submission of complaints to the Commission;

(2) civil penalties for violations of section 4 in an amount sufficient to effectively deter future violations, a description of the type of evidence needed to collect such penalties, and procedures to collect such penalties if the Commission determines that a violation of section 4 has occurred;

(3) procedures for the Commission to grant a reward of not less than 20 percent of the total civil penalty collected to the first person that—

(A) identifies the person in violation of section 4; and

(B) supplies information that leads to the successful collection of a civil penalty by the Commission;

(4) a provision that enables the Commission to keep the remainder of the civil penalty collected and use the funds toward the prosecution of further claims, including for necessary staff or resources; and

(5) civil penalties for knowingly submitting a false complaint to the Commission.

(c) Regulations.—Not later than 180 days after the date of enactment of this Act, the Commission shall conclude the rulemaking proceeding initiated under subsection (b) and shall prescribe implementing regulations.

SEC. 6. PRIVATE RIGHT OF ACTION.

(a) Action Authorized.—A recipient of an unsolicited commercial electronic mail message, or a provider of Internet access service, adversely affected by a violation of section 4 may bring a civil action in any district court of the United States with jurisdiction over the defendant to—

(1) enjoin further violation by the defendant; or

(2) recover damages in an amount equal to—

(A) actual monetary loss incurred by the recipient or provider of Internet access service as a result of such violation; or

(B) at the discretion of the court, the amount determined under subsection (b).

(b) Statutory Damages.—

(1) In general.—For purposes of subsection (a)(2)(B), the amount determined under this subsection is the amount calculated by multiplying the number of willful, knowing, or negligent violations by an amount, in the discretion of the court, of up to $10.

(2) Per-violation penalty.—In determining the per-violation penalty under this subsection, the court shall take into account the degree of culpability, any history of prior such conduct, ability to pay, the extent of economic gain resulting from the violation, and such other matters as justice may require.

(c) Attorney Fees.—In any action brought pursuant to subsection (a), the court may, in its discretion, require an undertaking for the payment of the costs of such action, and assess reasonable costs, including reasonable attorneys' fees, against any party.

SEC. 7. INTERNET ACCESS SERVICE PROVIDERS.

Nothing in this Act shall be construed—

(1) to enlarge or diminish the application of chapter 121 of title 18, relating to when a provider of Internet access service may disclose customer communications or records;

(2) to require a provider of Internet access service to block, transmit, route, relay, handle, or store certain types of electronic mail messages;

(3) to prevent or limit, in any way, a provider of Internet access service from adopting a policy regarding commercial electronic mail messages, including a policy of declining to transmit certain types of commercial electronic mail messages, or from enforcing such policy through technical means, through contract, or pursuant to any other provision of Federal, State, or local criminal or civil law; or

(4) to render lawful any such policy that is unlawful under any other provision of law.

SEC. 8. EFFECT ON OTHER LAWS.

Nothing in this Act shall be construed to impair the enforcement of section 223 or 231 of the Communications Act of 1934 (47 U.S.C. 223 or 231), chapter 71 (relating to obscenity) or 110 (relating to sexual exploitation of children) of title 18, United States Code, or any other Federal criminal statute.

SEC. 9. FTC STUDY.

Not later than 24 months after the date of enactment of this Act, the Commission, in consultation with appropriate agencies, shall submit a report to Congress that provides a detailed analysis of the effectiveness and enforcement of the provisions of this Act and the need, if any, for Congress to modify such provisions.

SEC. 10. STUDY OF POSSIBLE INTERNATIONAL AGREEMENT.

Not later than 6 months after the date of enactment of this Act, the President shall—

(1) conduct a study in consultation with the Internet Engineering Task Force on the possibility of an international agreement to reduce spam; and

(2) issue a report to Congress setting forth the findings of the study required by paragraph (1).

SEC. 11. EFFECTIVE DATE.

The provisions of this Act shall take effect 180 days after the date of enactment of this Act, except that subsections (b) and (c) of section 5 shall take effect upon the date of enactment of this Act.

[From the Philadelphia Inquirer, May 4, 2003]

How to Unspam the Internet

(By Lawrence Lessig)

The Internet is choking on spam. Billions of unsolicited commercial messages—constituting almost 50 percent of all e-mail traffic—fill the in-boxes of increasingly impatient Internet users. These messages offer to sell everything from human growth hormones to pornography. And increasingly the offers to sell pornography are themselves pornographic.

So far, Congress has done nothing about this burden on the Internet. Many states have passed laws that have tried. Virginia just passed the most extreme of these laws, making it a felony to send spam with a fraudulent return address. Other states are considering the same.

Yet all of these regulations suffer from a similar flaw: Spamsters know the laws will never be enforced. The cost of bringing a lawsuit is extraordinarily high. Most of us have better things to do than sue spamsters. Thus, despite a patchwork of regulation that in theory should be restricting spam, the practice of spam continues to increase at an astonishing rate.

But last week, U.S. Rep. Zoe Lofgren (D., Calif.) introduced a bill that, if properly implemented by the Federal Trade Commission, would actually work. I am so confident she is right that I've offered to resign my job if her proposal does not significantly reduce the burden of spam.

The Restrict and Eliminate Delivery of Unsolicited Commercial E-mail (REDUCE) Spam Act has two important parts. First, anyone sending bulk unsolicited commercial e-mail must include on each e-mail a simple tag—either ADV: or ADV:ADLT. Second, anyone who finds a spamster who fails properly to label unsolicited commercial e-mail will be paid a bounty by the FTC.

The first part of the proposal would enable simple filters to block unwanted spam. Users could tell their Internet service provider to block ADV e-mail, or they could automatically filter such e-mail into a spam folder on their own computer. These simple filters would replace the extraordinarily sophisticated filters companies have been developing to identify and block spam.

These complex filters, though ingenious, are necessarily one step behind. Spamsters will always find a way to trick them. The filters will be changed to respond, but the spamsters will in turn change their spam to find a way around the filters. Thus the filters will never block all spam, but they will always block a certain number of messages that are not spam.

But part one of the Lofgren legislation would never work if it weren't for part two: A spamster bounty. Lofgren's proposal would require the FTC to pay a bounty to anyone who tracks down a spamster who has failed properly to label unsolicited commercial e-mail. This proposal would invite savvy 18-year-olds from across the world to hunt down these law-violating spamsters. The FTC would then fine them, after paying a reward to the bounty hunter who found them.

The bounty would assure that the spam law was enforced. Properly enforced, the law would teach most spamsters that failing to label spam doesn't pay. The spamsters in turn would decide either to label their spam or give up and get a real job. Either way, the burden of spam would be reduced.

No doubt no solution would eliminate 100 percent of spam. Much is foreign; American laws would not easily reach those spamsters. But the question lawmakers should ask is what is the smallest, least burdensome regulation that would have the most significant effect. If Lofgren's proposal were passed, the vast majority of spamsters would have to change their ways. Technologists could then target their filters on the spamsters that remain.

What about free speech? Don't spamsters have First Amendments rights?

Of course they do. And many of the laws proposed right now go too far in censoring speech. Threatening a felony for a bad return address, as the Virginia law does, is a dangerous precedent. Laws that ban spam altogether are much worse.

But Lofgren's proposal simply requires a proper label so consumers can choose whether they want to receive the speech or not. And most important, by reducing the clutter of unsolicited and unwanted spam, the law would improve the opportunity for other speech—including political speech—to get through.

More fundamentally, free speech is threatened just as much by bad filters as by bad laws. A well-crafted law—narrow in its scope, and moderate in its regulation—can in turn eliminate the demand for bad filters. Lofgren's proposal would have just this effect. Congress should act to follow Lofgren's lead. In Internet time, not Washington time.

By Mr. HATCH (for himself and Mrs. CLINTON):

S. 1328. A bill to provide for an evaluation by the Institute of Medicine of the National Academy of Sciences of leading health care performance measures and options to implement policies that align performance with payment under the Medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

Mr. HATCH. Mr. President, I rise today to address an issue of importance to all Americans, the quality and safety of health care in the United States.

Numerous studies have identified serious shortcomings in the quality and safety of health care. However, addressing these shortcomings and improving health care outcomes in a complex health care system requires long-range strategies and specific goals.

The Medicare program, as one of the largest purchasers of health care, is ideally situated to take a leadership role in encouraging quality improvement. Currently, however, Medicare's payment methods and regulations provide few incentives to pursue innovative quality improvement strategies and to reward those who achieve exemplary performance.

Traditional Medicare pays most physicians according to a fee schedule and pays hospitals according to a DRG-based payment system. Medicare+Choice plans are paid a capitated rate and, in turn, pay physicians using a range of approaches, from salary to capitation to fee-for-service, none of which directly reward enhanced quality.

Attempts to adjust Medicare payments to reward performance improvements in safety and quality have been hampered, in part, by the lack of measures and data for assessing performance. Although the Centers for Medicare and Medicaid Services recently began an initiative to develop voluntary consensus performance measures for 10 clinical conditions for hospitals, standardized measures of quality for hospitals and providers do not otherwise exist.

As the Senate considers a new Medicare prescription drug benefit and additional measures to reform the Medicare program, it is more important than ever that we consider also measures to ensure that these new benefits are provided as safely and effectively as possible.

That is why I am today introducing a bill charging the Institute of Medicine with performing a study to evaluate leading health care performance measures and options to implement policies that align performance with payment in Medicare.

We have learned much about health care quality in the last several years. The Institute of Medicine, in its studies entitled "To Err Is Human," and "Crossing the Quality Chasm," has identified the health care safety and quality shortcomings that exist and the need for improvement. In a recent study performed at the request of Congress, "Leadership by Example," the Institute of Medicine identified the leadership role that Government can take in improving health care quality in government sponsored health care programs and those in the private sector.

The bill that I am introducing today, and the study that will result, represents the next step toward improving health care quality and safety in the United States. It is an important step and one that we must take in order to ensure that Medicare beneficiaries receive the highest quality health care services available. I urge my colleagues to join me in supporting this legislation.

Mrs. CLINTON. Mr. President, I am pleased to join my friend from Utah, Senator HATCH, today in introducing a bill that will commission a study from IOM to identify performance measures and payment incentives that reward high quality providers in Medicare.

Currently Medicare pays the same amount for good care as it does for poor quality care. It's easy to assume that the dollars that go to Medicare all yield high quality care, but the evidence is otherwise.

Take heart disease, the leading cause of death in the U.S. Cholesterol management after a heart attack can mean the difference between disability and an active lifestyle. Yet we don't have adequate data that show us whether most Medicare beneficiaries are getting this clinically appropriate care. And the only data that we do have, from NCQA, The State of Health Care Quality 2002, tells us that in 2001 almost one-quarter, 23 percent, of Medicare beneficiaries in health plans did not have their cholesterol managed after a heart attack.

In New York, between 14 and 22 percent of diabetic beneficiaries in health plans did not get a blood sugar control test in 2001.

When Medicare and Medicare enrollees pay the same amount to providers that give excellent care as it does to those who provide mediocre care, that may unintentionally create incentives for providers to skimp or cut corners on quality. We debate endlessly over ways to control costs in Medicare, but we have not taken one of the simple steps that will, almost certainly, drive quality up and assure that we are getting good value for the dollars we spend.

Medicare should be a leader in national efforts to improve quality. Medicare, with its $250 billion of purchasing power, 40 million enrollees, programs data, and professional experience can bring more resources to bear on these quality problems than any other purchaser.

The study we are proposing today would be the first step down this path. It would cost relatively little but yield great rewards as a guide to how to measure and pay for quality in the future. The study would develop measures to assess quality, including outcome measures. It would tell us what payment incentives have worked in the private sector. And it would identify approaches to use incentives to improve quality that can be implemented across all of Medicare.

So I am pleased that we are making this effort today, and hope that it is just the first step of many more that we will take down the path of improving Medicare for patients and consumers.

By Ms. MURKOWSKI:

S. 1330. A bill to establish the Kenai Mountains-Turnagain Arm National Heritage Area in the State of Alaska, and for other purposes; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, the Kenai Mountains-Turnagain Arm National Heritage Area is one of the best examples for preserving the heritage of one of this Nation's first pioneer areas. This legislation will create a national heritage corridor that covers an area from Seward to Anchorage.

This national heritage corridor will protect the natural and cultural resources of a well established region. The Kenai Mountains-Turnagain Arm National Heritage Area will follow along a corridor that was established by pioneering Alaskans. This route will partially follow two nationally recognized treasures—the Iditarod Trail and the Seward Highway National Scenic Byway. It will honor Native traders, gold rush stampeders and the route of the Alaska Railroad. One of the biggest gold discoveries along this route was the Bear Creek gold find near Hope in 1895. The route of the Alaska Railroad was finished in 1923.

Unlike many others, this national heritage corridor will not be managed by the Federal Government, but instead, by a group of local community leaders. The preservation of historic areas depends largely upon the community and its support, and clearly, no one entity can provide the adequate management, protection and preservation for these extensive resources. In fact, over the past five years, a group of local community leaders has been working hard for this national heritage designation. They have been successful in garnering support from communities throughout this entire route. These local folks have extensive knowledge of the resources; they are personally acquainted with the area; they understand the ruggedness and the beauty of the land, and certainly appreciate the potential economic value this designation would bring to the area.

The preservation of history and heritage depends upon the mutual support and assistance from public and private groups. This national heritage designation has been a vision of many people from Seward to Anchorage, and comprises lands in the Kenai Mountains and the upper Turnagain Arm region. An 11-member board will be established and charged with seeing the vision become a reality. This non-profit board will be tasked with coordinating and supporting the protection of trail resources; interpreting the trail, and identifying the cultural landscapes of the Kenai Mountains-Turnagain Arm historic transportation corridor. A plan will also be developed for the management of the heritage corridor, and will complement existing Federal, State, borough and local plans. To ensure even greater support of this designation, there will be opportunities provided to the public for their full participation as the plan is being developed.

The purposes of designating this national treasure are to: Enable all people to envision and experience the heritage and impacts of transportation routes used first by indigenous people, followed by pioneers to the Nation's first frontier;

Encourage economic viability in the affected communities.

This national heritage corridor is significant for a whole host of reasons: Allow citizens to help preserve the heritage of the pioneers; protect and honor the history of Native traders, gold seekers and pioneers; decisions and management will be made by local citizens; support of several historical associations, the cities of Seward, Girdwood, Hope and Anchorage; an 11-member non-profit local board will plan and operate the heritage corridor; increase public awareness and appreciation for the natural, historical and cultural resources, and modern resource development of the heritage corridor; restore historic buildings and structures that are located within the boundaries of the heritage corridor; and, no additional lands will be acquired by the Federal Government or by the local management group.

Rarely ever do we have such an opportunity when whole communities, Federal, State and local governments agree on and support such a national designation. Through adequate funding from the Department of the Interior, interpretation signs and technical assistance to conduct local planning will help to preserve and protect natural, historical, landscape and cultural resource values for current and future generations of the Kenai Mountains-Turnagain Arm National Heritage Area.

And, finally, with the passage of this bill, visitors to the area can enjoy the shore lines of Turnagain Arm and watch the world's second largest tidal range move 30 foot tides in and out. A traveler through the mountain passes of the heritage area can view evidence of retreating glaciers and avalanches. Visitors will be amazed at the abundant wildlife that make their home in the area. The history of early settlers will be preserved for current and future generations.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1330

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Kenai Mountains-Turnagain Arm National Heritage Area Act".

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) The Kenai Mountains-Turnagain Arm transportation corridor is a major gateway to Alaska and includes a range of transportation routes used first by indigenous people who were followed by pioneers who settled the Nation's last frontier;

(2) the natural history and scenic splendor of the region are equally outstanding; vistas of nature's power include evidence of earthquake subsidence, recent avalanches, retreating glaciers and tidal action along Turnagain Arm, which has the world's second greatest tidal range;

(3) the cultural landscape formed by indigenous people and then by settlement, transportation and modern resource development in this rugged and often treacherous natural setting stands as powerful testimony to the human fortitude, perseverance, and resourcefulness that is America's proudest heritage from the people who settled the frontier;

(4) there is a national interest in recognizing, preserving, promoting, and interpreting these resources;

(5) the Kenai Mountains-Turnagain Arm region is geographically and culturally cohesive because it is defined by a corridor of historic routes—trail, water, railroad, and roadways through a distinct landscape of mountains, lakes, and fjords;

(6) national significance of separate elements of the region include, but are not limited to, the Iditarod National Historic Trail, the Seward Highway National Scenic Byway, and the Alaska Railroad National Scenic Railroad;

(7) national heritage area designation provides for the interpretation of these routes, as well as the national historic districts and numerous historic routes in the region as part of the whole picture of human history in the wider transportation corridor including early Native trade routes, connections by waterway, mining trail, and other routes;

(8) national heritage area designation also provides communities within the region with the motivation and means for "grass roots" regional coordination and partnerships with each other and with borough, State, and Federal agencies; and

(9) national heritage area designation is supported by the Kenai Peninsula Historical Association, the Seward Historical Commission, the Seward City Council, the Hope and Sunrise Historical Society, the Hope Chamber of Commerce, the Alaska Association for Historic Preservation, the Cooper Landing Community Club, the Alaska Wilderness Recreation and Tourism Association, Anchorage Historic Properties, the Anchorage Convention and Visitors Bureau, the Cook Inlet Historical Society, the Moose Pass Sportsman's Club, the Alaska Historical Commission, the Girdwood Board of Supervisors, the Kenai River Special Management Area Advisory Board, the Bird/Indian Community Council, the Kenai Peninsula Borough Trails Commission, the Alaska Division of Parks and Recreation, the Kenai Peninsula Borough, the Kenai Peninsula Tourism Marketing Council, and the Anchorage Municipal Assembly.

(b) PURPOSES.—The purposes of this Act are—

(1) to recognize, preserve, and interpret the historic and modern resource development and cultural landscapes of the Kenai Mountains-Turnagain Arm historic transportation corridor, and to promote and facilitate the public enjoyment of these resources; and

(2) to foster, through financial and technical assistance, the development of cooperative planning and partnership among the communities and borough, State, and Federal Government entities.

SEC. 3. DEFINITIONS.

In this Act:

(1) HERITAGE AREA.—The term "Heritage Area" means the Kenai Mountains-Turnagain Arm National Heritage Area established by section 4(a) of this Act.

(2) MANAGEMENT ENTITY.—The term "management entity" means the 11 member Board of Directors of the Kenai Mountains-Turnagain Arm National Heritage Corridor Communities Association.

(3) MANAGEMENT PLAN.—The term "management plan" means the management plan for the Heritage Area.

(4) SECRETARY.—The term "Secretary" means the Secretary of the Interior.

SEC. 4. KENAI MOUNTAINS-TURNAGAIN ARM NATIONAL HERITAGE AREA.

(a) ESTABLISHMENT.—There is established the Kenai Mountains-Turnagain Arm National Heritage Area.

(b) BOUNDARIES.—The Heritage Area shall comprise the lands in the Kenai Mountains and upper Turnagain Arm region generally depicted on the map entitled "Kenai Peninsula/Turnagain Arm National Heritage Corridor", numbered "Map #KMTA-1, and dated "August 1999". The map shall be on file and available for public inspection in the offices of the Alaska Regional Office of the National Park Service and in the offices of the Alaska State Heritage Preservation Officer.

SEC. 5. MANAGEMENT ENTITY.

(a) The Secretary shall enter into a cooperative agreement with the management entity, to carry out the purposes of this Act. The cooperative agreement shall include information relating to the objectives and management of the Heritage Area, including the following:

(1) A discussion of the goals and objectives of the Heritage Area;

(2) An explanation of the proposed approach to conservation and interpretation of the Heritage Area;

(3) A general outline of the protection measures, to which the management entity commits.

(b) Nothing in this Act authorizes the management entity to assume any management authorities or responsibilities on Federal lands.

(c) Representatives of other organizations shall be invited and encouraged to participate with the management entity and in the development and implementation of the management plan, including but not limited to: The State Division of Parks and Outdoor Recreation; the State Division of Mining, Land and Water; the Forest Service; the State Historic Preservation Office; the Kenai Peninsula Borough; the Municipality of Anchorage; the Alaska Railroad; the Alaska Department of Transportation; and the National Park Service.

(d) Representation of ex-officio members in the non-profit corporation shall be established under the bylaws of the management entity.

SEC. 6. AUTHORITIES AND DUTIES OF MANAGEMENT ENTITY.

(a) MANAGEMENT PLAN.—

(1) IN GENERAL.—Not later than 3 years after the Secretary enters into a cooperative agreement with the management entity, the management entity shall develop a management plan for the Heritage Area, taking into consideration existing Federal, State, borough, and local plans.

(2) CONTENTS.—The management plan shall include, but not be limited to—

(A) comprehensive recommendations for conservation, funding, management, and development of the Heritage Area;

(B) a description of agreements on actions to be carried out by Government and private organizations to protect the resources of the Heritage Area;

(C) a list of specific and potential sources of funding to protect, manage, and develop the Heritage Area;

(D) an inventory of the resources contained in the Heritage Area; and

(E) a description of the role and participation of other Federal, State, and local agencies that have jurisdiction on lands within the Heritage Area.

(b) PRIORITIES.—The management entity shall give priority to the implementation of actions, goals, and policies set forth in the cooperative agreement with the Secretary and the heritage plan, including assisting communities within the region in—

(1) carrying out programs which recognize important resource values in the Heritage Area;

(2) encouraging economic viability in the affected communities;

(3) establishing and maintaining interpretive exhibits in the Heritage Area;

(4) improving and interpreting heritage trails;

(5) increasing public awareness and appreciation for the natural, historical, and cultural resources and modern resource development of the Heritage Area;

(6) restoring historic buildings and structures that are located within the boundaries of the Heritage Area; and

(7) ensuring that clear, consistent, and appropriate signs identifying public access points and sites of interest are placed throughout the Heritage Area.

(c) PUBLIC MEETINGS.—The management entity shall conduct 2 or more public meetings each year regarding the initiation and implementation of the management plan for the Heritage Area. The management entity shall place a notice of each such meeting in a newspaper of general circulation in the Heritage Area and shall make the minutes of the meeting available to the public.

SEC. 7. DUTIES OF THE SECRETARY.

(a) The Secretary, in consultation with the Governor of Alaska, or his designee, is authorized to enter into a cooperative agreement with the management entity. The cooperative agreement shall be prepared with public participation.

(b) In accordance with the terms and conditions of the cooperative agreement and upon the request of the management entity, and subject to the availability of funds, the Secretary may provide administrative, technical, financial, design, development, and operations assistance to carry out the purposes of this Act.

SEC. 8. SAVINGS PROVISIONS.

(a) REGULATORY AUTHORITY.—Nothing in this Act shall be construed to grant powers of zoning or management of land use to the management entity of the Heritage Area.

(b) EFFECT ON AUTHORITY OF GOVERNMENTS.—Nothing in this Act shall be construed to modify, enlarge, or diminish any authority of the Federal, State, or local governments to manage or regulate any use of land as provided for by law or regulation.

(c) EFFECT ON BUSINESS.—Nothing in this Act shall be construed to obstruct or limit business activity on private development or resource development activities.

SEC. 9. PROHIBITION ON THE ACQUISITION OR REAL PROPERTY.

The management entity may not use funds appropriated to carry out the purposes of this Act to acquire real property or interest in real property.

SEC. 10. AUTHORIZATION OF APPROPRIATIONS.

(a) FIRST YEAR.—For the first year $350,000 is authorized to be appropriated to carry out the purposes of this Act, and is made available upon the Secretary and the management entity completing a cooperative agreement.

(b) IN GENERAL.—There is authorized to be appropriated not more than $1,000,000 to carry out the purposes of this Act for any fiscal year after the first year. Not more than $10,000,000, in the aggregate, may be appropriated for the Heritage Area.

(c) MATCHING FUNDS.—Federal funding provided under this Act shall be matched at least 25 percent by other funds or in-kind services.

(d) SUNSET PROVISION.—The Secretary may not make any grant or provide any assistance under this Act beyond 15 years from the date that the Secretary and management entity complete a cooperative agreement.

By Mr. SANTORUM (for himself, Mr. CONRAD, and Mr. BREAUX):

S. 1331. A bill to clarify the treatment of tax attributes under section 108 of the Internal Revenue Code of 1986 for taxpayers which file consolidated returns; to the Committee on Finance.

Mr. SANTORUM. Mr. President, today I am introducing a bill along with Senator CONRAD that would close a gaping loophole in the Internal Revenue Code. This loophole involves the treatment of companies whose debt is cancelled in a bankruptcy proceeding. Under existing law, these companies are not required to immediately pay tax on their income from debt cancellation. They are, however, required to reduce their net operating losses, NOLs, and other tax attributes. These attribute reductions have the effect of allowing bankrupt companies to defer, but not permanently avoid, paying tax on income from debt cancellation.

It has come to my attention that MCI/WorldCom and certain other bankrupt companies are attempting to circumvent these rules. In plain English, MCI/WorldCom—the group of corporations that has perpetrated the greatest business fraud—is trying to relieve itself of $35 billion of debt and yet emerge from bankruptcy with an NOL that is estimated to range from $10 to $15 billion. Such an NOL will, post-bankruptcy, eliminate federal income tax of $3.5 billion to $5.25 billion on MCI/WorldCom's first $10 to $15 billion of income.

Plainly, if this tax loophole is not eliminated, MCI/WorldCom will not pay taxes for the foreseeable future. By attempting to utilize this loophole, MCI/WorldCom is demonstrating that it is not, in fact, a new company—instead, it is the same reckless company that we have come to know. The legislation I am introducing today will assure that MCI/WorldCom doesn't get away with this outrageous behavior. It will also prevent other companies from imitating this approach.

Such results would be bad tax policy for two reasons. First, they would clearly be contrary to the policy objectives that Congress intended to achieve when it enacted the current tax attribute reduction rules. Second, equivalent taxpayers would be treated differently under Section 108 based on their corporate structure and borrowing practices—factors that, form a tax policy standpoint, do not justify any difference in treatment.

Based on rulings and court cases, I believe this bill reflects the current tax position of the Treasury Department with respect to NOLs. Although it is also clear that aggressive taxpayers and their lawyers have utilized this tax loophole. The approach to this provision is contrary to United Dominion Industries, Inc. v. United States, 532 U.S. 822 (2001). Although not dealing directly with Section 108, the case is clear that the only NOL of a consolidated group is the group's entire NOL. I am introducing this bill with an effective date of today to provide notice to MCI/WorldCom, and all similarly situated taxpayers, that this Congress will not stand for this.

I encourage my colleagues to support closing this loophole to avoid such abuse in the future. I ask unanimous consent to have the Business Week story from May 12, 2003, "Why This Tax Loophole For Losers Should End," and the text of the bill be printed in the RECORD.

S. 1331

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CLARIFICATION OF THE TREATMENT OF TAX ATTRIBUTES.

(a) IN GENERAL.—Section 108(b) of the Internal Revenue Code of 1986 (relating to reduction of tax attributes) is amended by adding at the end the following new paragraph:

"(6) AFFILIATED GROUPS.—If the taxpayer is a member of an affiliated group of corporations which files a consolidated return under section 1501, the tax attributes described in paragraph (1) shall be the aggregate tax attributes of such group. The Secretary shall prescribe such regulations as may be necessary under section 1502 to carry out the purposes of this paragraph.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness occurring after June 25, 2003, except that discharges of indebtedness under any plan of reorganization in a case under title 11, United States Code, shall be deemed to occur on the date such plan is confirmed.

There being no objection, the additional material ordered to be printed in the RECORD, as follows:

[From Business Week, May 12, 2003]

WHY THIS TAX LOOPHOLE FOR LOSERS SHOULD END

(By David Henry)

Is there no end to the ugly superlatives that fallen telecom giant WorldCom Inc. is amassing? First, its top execs reigned over the greatest alleged accounting fraud in history. Then, the company filed the largest corporate bankruptcy. Now, it is lining up to collect what could be one of the biggest single corporate tax breaks of all time.

To the fury of its competitors, WorldCom is angling to snare a $2.5 billion benefit from Uncle Sam. How? By exploiting a provision in the Internal Revenue Service code so it can hanging onto previous losses of at least $6.6 billion and enjoy years of tax-free earnings. What's more, the ploy would protect new management against any takeover for at least two years. And, WorldCom could use the losses to offset even income it picks up by taking over other companies. "WorldCom is in an enviable position," says Robert Willens, tax accounting analyst at Lehman Brothers Inc. "It will have a copious tax losses and can be a powerful acquirer."

WorldCom's new owners—the holders of its $41 billion of bad debt—are driving a truck through a loophole that needs to be closed pronto. It was left open by Congress when the lawmakers overhauled IRS rules to stamp out a notorious trade in corporate tax losses. At one time, owners of loss-making businesses could sell their companies along with their accumulated tax loss—often their only asssit—to profitable companies. Now, tax losses are snuffed out when company ownership changes hands.

So, WorldCom is going through hoops to avoid that fate. Pending a final vote by creditors later this year, the company is changing its bylaws to prohibit anyone from building a stake of more than 4.75 percent in the company. They have to keep bidders at bay for at least two years, otherwise the IRS would argue that control of WorldCom has changed hands and that the tax losses—which, assuming a 38 percent tax rate, could give a $2.5 billion boost to earnings—should be wiped out. "It is the perfect poison pill," says Carl M. Jenks, tax expert at law firm Jones Day.

The perverse tactic is increasingly popular. The former Williams Communication Group put a similar 5 percent ownership limit in place last fall when it became WilTil Communications Group Inc. after a bankruptcy reorganization. The bankruptcy judge overseeing UAL Corp. agreed on Feb. 24 to a similar restriction on UAL securities in order to preserve its $4 billion of tax losses. "We will generally recommend that any company with net operating losses worth anything adopt these restrictions," says Douglas W. Killip, a tax lawyer at Akin Gump Strauss Hauer & Field.

For WorldCom's rivals, the tax break is salt on a wound. William P. Barr, a former U.S. attorney general and now general counsel of Verizon Communications, fumes that WorldCom is trying to "compound its fraud by escaping the payment of taxes." WorldCom's bankruptcy reorganization will eliminate the cost of servicing some $30 billion of debt. That, the company projects, will help it to make $2 billion before taxes next year. By using the tax losses, it will be able to keep about $780 million in cash it would otherwise owe the government. In fact, it won't be liable for any tax at least until the accumulated losses are worked through. And, because it racked up the $6.6 billion in losses just through 2001, WorldCom could have billions more to play with once the numbers for 2002 are finally worked out.

What's more, the poison pill is likely to deter any company from buying WorldCom and dumping some of the obsolete assets still clogging the telecom industry. That will slow any recovery in capital spending and hurt WorldCom's competitors. "It is bad when business decisions are motivated by tax reasons and not based on sound economics," says Anthony Sabino, bankruptcy law professor at St. John's University.

Rivals are likely to push the IRS to find a way to stop WorldCom from utilizing the losses, observers say. But their chances of success are slim because the IRS never issued regulations that could have nullified the ploy. And the courts generally rule against the agency when it attempts to write rules retroactively, Willens says.

Still, it's time to close the stable door before any more horses bolt. Besides, Uncle Sam could use the money right now.

By Mr. HATCH:

S. 1332. A bill to amend title XVIII of the Social Security Act to provide regulatory relief, appeals process reforms, contracting flexibility, and education improvements under the Medicare program, and for other purposes; to the Committee on Finance.

Mr. HATCH. Mr. President, there is no question that our need to improve the Medicare program by adding prescription drug coverage for beneficiaries is extremely important, as this debate indicates.

But, our discussions would not be complete if we neglected another major Medicare improvement which is also long overdue, and that is the need to improve the climate in which providers strive to provide high quality services to patients.

Medicare's anticipated regulations—three times longer than the U.S. tax code—prevent providers from delivering health care efficiently and beneficiaries from receiving the care they need.

Complex Federal regulations and reams of paperwork require physicians to spend hours each day filling out government forms rather than caring for their patients. The array of Federal Medicare rules with which physicians must comply is overwhelming. Doctors are required to complete claims forms, advance beneficiary notices, certify medical necessity, file enrollment forms, and comply with code documentation guidelines. Indeed, these rules and mandates are not only extensive, they are constantly changing and they may be interpreted differently in different regions of the country.

The complexity of the rules and the variation in their interpretation has prompted outcries from all centers of our country. In fact, I have heard loud and clear from the physicians in my home State of Utah about the severity of the problem.

Leon Sorensen, Executive Vice President of the Utah Medical Association, recently wrote to me and said:

> "The Utah Medical Association has long been concerned about the unnecessary burdens placed upon physicians by the voluminous regulations of Medicare. Not only does compliance with these regulations take physicians' time away from patients, but also the regulations contribute to the high cost of medical care while contributing little of value. They discourage physicians from participating fully in Medicare. They are often punitive in nature rather than an educational. They use tactics that would not be tolerated by businesses or government if applied to them.
>
> An example is the practice of extrapolating a small sample of billing errors over the physician's entire practice, making the physician liable for payback of thousands of dollars of "overpaid" claims when demonstrated over billings may amount only to a few dollars. If this process were used by the IRS in a tax audit, the public outcry would be deafening.
>
> Medicare also requires that alleged "overpayments" to physicians by repaid within 60 days, even if a physician chooses to appeal Medicare's allegations. When assessed a Medicare overpayment, the only way physicians can appeal is to subject their practices to another audit, using a "statistically valid random sample." Statistical sample audits can shut down a physician's practice for days, preventing physicians from treating patients. Physicians are forced to settle with Medicare rather than be subjected to such unfair scrutiny.
>
> Any defense against this kind of administrative abuse is extremely costly, time consuming and often ineffective.

Indeed, failure to follow Medicare's complex rules—or just the perception of such failure—can result in an audit of a physician's billing records, withholding of payments and crippling of a physician's practice.

And, physicians are not the only individuals affected by these rules. Medicare beneficiaries are affected—both directly and indirectly—by Medicare's onerous rules and burdensome paperwork. Both patients and providers are confused by obscure paperwork and apparently conflicting rules. Physicians have difficulty understanding how to bill for their services and beneficiaries find it difficult to understand the forms and billing information that they receive. Indeed, the administrative costs associated with managing this paperwork and the fear of harsh consequences in response to clerical errors has led some providers to consider whether they should continue to participate in the Medicare program.

The problem has not escaped the attention of the administration and addressing it is a priority for President Bush and it should be for Congress also. Secretary Thompson has said, "Patients and providers alike are fed up with voluminous and complex paperwork. Rules are constantly changing. Complexity is overloading the system, criminalizing honest mistakes and driving doctors, nurses, and other health care professionals out of the program."

Congress has considered legislation over the past few years to provide relief from this regulatory burden. Former Senator Frank Murkowski should be given great credit for drafting S. 452, the "Medicare Education and Regulatory Fairness Act of 2001"—legislation that he introduced in the Senate on March 5, 2001 but which never came to a vote.

The legislation that I am introducing today, the "Medicare Education Regulatory Reform and Contracting Improvement Act of 2003," MERCI, builds on that initiative. It will improve the Medicare program for beneficiaries and providers alike by clarifying regulations, rewarding quality and by enhancing services. I am introducing this legislation today because the need for Medicare regulatory reform remains. In fact, the need for Medicare regulatory reform has never been greater. In addition, the regulatory reform that I am proposing in MERCI fits hand in glove with the reforms that we have proposed in S. 1, the "Prescription Drug and Medicare Improvement Act of 2003." The reformed Medicare program must include reformed regulations if it is to provide efficient service to beneficiaries.

Let me take a moment to review a few of the important provisions in this bill. The educational provisions of the MERCI Act are designed to decrease Medicare billing and claims payment errors by improving education and training programs for Medicare providers. It includes also provisions that will improve communication between the Department of Health and Human Services and Medicare providers. Furthermore, the bill will improve communication with Medicare beneficiaries by providing for central toll-free telephone services to require free, appropriate referrals to individuals seeking information or assistance with Medicare.

The MERCI Act includes regulatory reform provisions that are designed to reduce waste, fraud and abuse in Medicare; provisions that are just and fair for beneficiaries, contractors, and providers. Among other things, the bill eliminates retroactive application of regulatory changes and expedites the appeals processes for beneficiaries, providers, and suppliers of Medicare services.

Finally, the MERCI Act will improve Medicare contracting; increasing competition, improving service and reducing costs by providing for a competitive bidding process for Medicare contractors that takes into account performance quality, price and other factors that are important to beneficiaries.

Medicare beneficiaries and Medicare providers have been suffering from burdensome and confusing regulations for too long. It is time that they received some mercy. The time for Medicare regulatory reform has come and the bill that I am introducing today provides that mercy. MERCI, the "Medicare Education, Regulatory Reform and Contracting Improvement Act of 2003" takes a common sense approach to providing relief for the Medicare beneficiaries and providers who have been suffering this burden for so long.

I believe that MERCI will improve the delivery of health care services to Medicare beneficiaries by enhancing the efficiency of the Medicare program for all concerned.

Finally, I would be remiss if I did not thank Chairman GRASSLEY and Senator BAUCUS for working with me to include the MERCI legislative language in S. 1, the "Prescription Drug and Medicare Improvement Act of 2003." Senators GRASSLEY and BAUCUS have worked for many years to reform Medicare's complex regulations, as have I, and their agreement to include this language is appreciated greatly.

And so, it is with a great appreciation for my colleagues who have worked with me on this legislation and for those who have worked on similar legislation in the past, that I urge my colleagues in the Senate today to join me in addressing the needs of Medicare beneficiaries and providers by supporting this legislation.

By Mr. GRASSLEY (for himself, Mr. BINGAMAN, Mr. BUNNING, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. BAUCUS, Ms. SNOWE, Mr. THOMAS, Mr. SMITH, Mr. CONRAD, Mr. GRAHAM of Florida, Mr. KERRY, Mr. BREAUX, Mrs. LINCOLN, and Mr. JEFFORDS):

S. 1333. A bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain expenses of rural letter carriers; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, the U.S. Postal Service provides a vital and important communication link for the Nation and the citizens of my home State of Iowa. Rural Letter Carriers play a special role and have a proud history as an important link in assuring the delivery of our mail. Rural letter carriers first delivered the mail with their own horses and buggies, later with their own motorcycles, and now in their own cars and trucks. They are responsible for maintenance and operation of their vehicles in all types of weather and road conditions. In the winter, snow and ice is their enemy, while in the spring, the melting snow and ice causes potholes and washboard roads. In spite of these quite adverse conditions, rural letter carriers daily drive over 3 million miles and serve 24 million American families on over 66,000 routes.

Although the mission of rural carriers has not changed since the horse and buggy days, the amount of mail they deliver has changed dramatically. As the Nation's mail volume has increased throughout the years, the Postal Service is now delivering more than 200 billion pieces of mail a year. The average carrier delivers about 2,300 pieces of mail a day to about 500 addresses.

Most recently, e-commerce has changed the type of mail rural letter carriers deliver. This fact was confirmed in a GAO study entitled "U.S. Postal Service: Challenges to Sustaining Performance Improvements Remain Formidable on the Brink of the 21st Century," dated October 21, 1999. As this report explains, the Postal Service expects declines in its core business, which is essentially letter mail, in the coming years. The growth of e-mail on the Internet, electronic communications, and electronic commerce has the potential to substantially affect the Postal Service's mail volume.

First-Class mail has always been the bread and butter of the Postal Service's revenue, but the amount of revenue from First-Class letters is declining. E-commerce is providing the Postal Service with another opportunity to increase another part of its business. That is because what individuals and companies order over the Internet must be delivered, sometimes by the Postal Service and often by rural letter carriers. Currently, the Postal Service had about 33 percent of the parcel business. Rural letter carriers are now delivering larger volumes of business mail, parcels, and priority mail packages. But, more parcel business means more cargo capacity is necessary in postal delivery vehicles, especially in those owned and operated by rural letter carriers.

When delivering greeting cards or bills, or packages ordered over the Internet, rural letter carriers use vehicles they currently purchase, operate and maintain. In exchange, they receive a reimbursement from the Postal Service. This reimbursement is called an Equipment Maintenance Allowance, EMA. Congress recognizes that providing a personal vehicle to deliver the U.S. Mail is not typical vehicle use. So, when a rural letter carrier is ready to sell such a vehicle, it's going to have little trade-in value because of the typically high mileage, extraordinary wear and tear, and the fact that it is probably right-hand drive. Therefore, Congress intended to exempt the EMA allowance from taxation in 1988 through a specific provision for rural mail carriers in the Technical and Miscellaneous Revenue Act of 1988.

That provision allowed an employee of the U.S. Postal Service who was involved in the collection and delivery of mail on a rural route, to compute their business use mileage deduction as 150 percent of the standard mileage rate for all business use mileage. As an alternative, rural letter carrier taxpayers could elect to utilize the actual expense method, business portion of actual operation and maintenance of the vehicle, plus depreciation. If EMA exceeded the allowable vehicle expense deductions, the excess was subject to tax. If EMA fell short of the allowable vehicle expenses, a deduction was allowed only to the extent that the sum of the shortfall and all other miscellaneous itemized deductions exceeded two percent of the taxpayer's adjusted gross income.

The Taxpayer Relief Act of 1997 further simplified the tax returns of rural letter carriers. That Act permitted the EMA income and expenses "to wash," so that neither income nor expenses would have to be reported on a rural letter carrier's return. That simplified taxes for approximately 120,000 taxpayers, but the provision eliminated the option of filing the actual expense method for employee business vehicle expenses. The lack of this option, combined with the dramatic changes the Internet is having on the mail, specifically on rural letter carriers and their vehicles, is a problem I believe Congress must address.

The mail mix is changing and already Postal Service management has, understandably, encouraged rural letter carriers to purchase larger right-hand drive vehicles, such as Sports Utility Vehicles, SUVs, to handle the increase in parcel loads. Large SUVs are much more expensive than traditional vehicles. So without the ability to use the actual expense method and depreciation, rural letter carriers must use their salaries to cover vehicle expenses. Additionally, the Postal Service has placed 11,000 postal vehicles on rural routes, which means those carriers receive no EMA.

These developments have created a situation that is contrary to the historical Congressional intent of using reimbursement to fund the government service of delivering mail, and also has created an inequitable tax situation for rural letter carriers. If actual business expenses exceed the EMA, a deduction for those expenses should be allowed. To correct this inequity, I am introducing a bill today that reinstates the ability of a rural letter carrier to choose between using the actual expense method for computing the deduction allowable for business use of a vehicle, or using the current practice of deducting the reimbursed EMA expenses.

Rural letter carriers perform a necessary and valuable service and face many changes and challenges in this new Internet era. We must make sure that these public servants receive fair and equitable tax treatment as they perform their essential role in fulfilling the Postal Service's mandate of binding the Nation together.

I urge my colleagues to join Senators BINGAMAN, DASCHLE, BUNNING, ROCKEFELLER, SNOWE, THOMAS, SMITH of Oregon, CONRAD, GRAHAM of Florida, KERRY, BREAUX, LINCOLN and myself in sponsoring this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1333

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CERTAIN EXPENSES OF RURAL LETTER CARRIERS.

(a) IN GENERAL.—Section 162(o) of the Internal Revenue Code of 1986 (relating to treatment of certain reimbursed expenses of rural mail carriers) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following:

"(2) SPECIAL RULE WHERE EXPENSES EXCEED REIMBURSEMENTS.—Notwithstanding paragraph (1)(A), if the expenses incurred by an employee for the use of a vehicle in performing services described in paragraph (1) exceed the qualified reimbursements for such expenses, such excess shall be taken into account in computing the miscellaneous itemized deductions of the employee under section 67.".

(b) CONFORMING AMENDMENT.—The heading for section 162(o) of the Internal Revenue Code of 1986 is amended by striking "REIMBURSED".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

Mr. BINGAMAN. Mr. President, I join Senator GRASSLEY, the chairman of the Finance Committee, and several of our colleagues in introducing legislation that will allow rural letter carriers to deduct their actual expenses when they use their own vehicle to deliver the mail. This Tax Code correction will reduce the out-of-pocket costs currently incurred by our Nation's rural letter carriers, giving them comparable tax treatment enjoyed by others using their vehicles in their line of business.

For many years, rural letter carriers were allowed to calculate their deductible expenses by using either a special formula or keeping track of their costs. In 1997, Congress simplified the tax treatment for letter carriers, but disallowed them the ability to use the actual expense method—business portion of actual operation and maintenance of the vehicle, plus depreciation—for calculating their costs. Unfortunately, this has resulted in many letter carriers being unable to account for their real expenses when using their own vehicle to deliver the mail. This problem is worse in more rugged parts of our country where road conditions and severe weather can require letter carriers to use an SUV or four-wheel-drive vehicle that are more expensive to maintain. This legislation will ensure that these mail carriers are fully reimbursed for the costs associated with the operation of their vehicles.

Although the Internet has made the world seem smaller, purchased goods must still be delivered. The benefits of Internet purchases in remote locations is limited if the purchased item cannot be delivered. For this reason, in rural States, such as New Mexico, these letter carriers play an important role in delivering the majority of the State's mail and parcels. On a daily basis across the Nation, rural letter carriers drive over 3 million miles delivering mail and parcels to over 30 million families. We need to be sure that we have not created a tax impediment for these dedicated individuals. I look forward to working with the chairman and my colleagues to get this legislation passed this year.

I ask unanimous consent that the text of the bill be printed in the RECORD immediately following the statement of Senator GRASSLEY on the introduction of this legislation.

By Mr. GRASSLEY (for himself, Mr. GRAHAM of Florida, Ms. MIKULSKI, and Mr. BREAUX):

S. 1335. A bill to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, I rise today to introduce the Long-Term Care and Retirement Security Act. This legislation, which I sponsored in the 106th and 107th Congress with my distinguished colleague from Florida, Senator BOB GRAHAM, would ease the tremendous cost of long-term care.

The bill that Senator GRAHAM and I are re-introducing today would allow individuals a tax deduction for the cost of long-term care insurance premiums. Increasingly, Americans are interested in private long-term care insurance to pay for nursing home stays, assisted living, home health aides, and other services. However, most people find the policies unaffordable. The younger the person, the lower the insurance premium, yet most people aren't ready to buy a policy until retirement. A deduction would encourage more people to buy long-term insurance.

Our proposal would also give individuals or their care givers a $3,000 tax credit to help cover their long-term care expenses. This would apply to those who have been certified by a doctor as needing help with at least three activities of daily living, such as eating, bathing, or dressing. This credit would help care givers pay for medical supplies, nursing care and any other expenses incurred while caring for family members with disabilities.

One family that would benefit from this legislation is the Gardner family of Waterloo, IA. Ruth Gardner is a 70-year-old mother of nine who suffers from a degenerative tissue disorder, Scleroderma, atrial fibrillation, congestive heart failure and is a breast cancer survivor. For the last 3 years her nine children, their spouses and numerous grandchildren have worked tirelessly to fulfill Ms. Gardner's wish of spending her last months with dignity and respect at home.

While Ms. Gardner's wish may seem small, the task of managing her care is not. Each week family members meet to organize their schedules in an effort to provide over 20 hours of daily care for Ms. Gardner. Working relentlessly, and at a considerable cost, the Gardner family manages to provide around-the-clock care while balancing both work and their family lives. All this effort comes at a great cost, both emotionally and financially. The Gardners have been able to locate some funding to help support the care for Ms. Gardner; however, the family continues to bear considerable costs. These costs include weekly nursing visits that cost $102 per visit, emergency response service at $30 a month, daily hospice service at $32 an hour and not to mention the hours and hours of personal time donated by the family.

The Long-Term Care and Retirement Security Act would help the 22 million family caregivers like the Gardners. A $3,000 tax credit would help to pay for Ms. Gardner's monthly hospice care, weekly nurse visits or help to hire a nurse to cover some of the time that the family currently donates. This legislation would also help the increasing number of families placed in the difficult situation by allowing them to purchase long-term care insurance. Had this legislation been enacted earlier, long-term care insurance would have been an affordable option for Ms. Gardner, alleviating the difficult situation that her family currently faces.

As it has in the past, the bill that Senator GRAHAM and I are introducing today has been endorsed by both the AARP and the Health Insurance Association of America. A companion bill sponsored by Representatives NANCY JOHNSON, Karen Thurman and EARL POMEROY is pending in the House of Representatives.

An aging nation has no time to waste in preparing for long-term care, and the need to help people afford long-term care is more pressing than ever. I look forward to working with Senator GRAHAM and our colleagues in the Senate to get our bill passed into law as soon as possible.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1335

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Long-Term Care and Retirement Security Act of 2003".

SEC. 2. TREATMENT OF PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 223 as section 224 and by inserting after section 222 the following new section:

"SEC. 223. PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount of eligible long-term care premiums (as defined in section 213(d)(10)) paid during the taxable year for coverage for the taxpayer and the taxpayer's spouse and dependents under a qualified long-term care insurance contract (as defined in section 7702B(b)).

"(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the applicable percentage shall be determined in accordance with the following table based on the number of years of continuous coverage (as of the close of the taxable year) of the individual under any qualified long-term care insurance contracts (as defined in section 7702B(b)):

"If the number of years of continuous coverage is—	**The applicable percentage is—**
Less than 1	60
At least 1 but less than 2	70
At least 2 but less than 3	80
At least 3 but less than 4	90
At least 4	100.

"(2) SPECIAL RULES FOR INDIVIDUALS WHO HAVE ATTAINED AGE 55.—In the case of an individual who has attained age 55 as of the close of the taxable year, the following table shall be substituted for the table in paragraph (1):

"If the number of years of continuous coverage is—	**The applicable percentage is—**
Less than 1	70
At least 1 but less than 2	85
At least 2	100.

"(3) ONLY COVERAGE AFTER 2003 TAKEN INTO ACCOUNT.—Only coverage for periods after December 31, 2003, shall be taken into account under this subsection.

"(4) CONTINUOUS COVERAGE.—An individual shall not fail to be treated as having continuous coverage if the aggregate breaks in coverage during any 1-year period are less than 60 days.

"(c) COORDINATION WITH OTHER DEDUCTIONS.—Any amount paid by a taxpayer for any qualified long-term care insurance contract to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a).".

(b) LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end ", except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract".

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by an employer to accident and health plans) is amended by striking subsection (c).

(c) CONFORMING AMENDMENTS.—

(1) Section 62(a) of the Internal Revenue Code of 1986 is amended by inserting after paragraph (18) the following new paragraph:

"(19) PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—The deduction allowed by section 223.".

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

"Sec. 223. Premiums on qualified long-term care insurance contracts.

"Sec. 224. Cross reference.".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2003.

(2) CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2004.

SEC. 3. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25B the following new section:

"SEC. 25C. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

"(a) ALLOWANCE OF CREDIT.—

"(1) IN GENERAL.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable credit amount multiplied by the number of applicable individuals with respect to whom the taxpayer is an eligible caregiver for the taxable year.

"(2) APPLICABLE CREDIT AMOUNT.—For purposes of paragraph (1), the applicable credit amount shall be determined in accordance with the following table:

“For taxable years beginning in calendar year—	The applicable credit amount is—
2004	$1,000
2005	1,500
2006	2,000
2007	2,500
2008 or thereafter	3,000.

“(b) Limitation Based on Adjusted Gross Income.—

“(1) In general.—The amount of the credit allowable under subsection (a) shall be reduced (but not below zero) by $100 for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted gross income exceeds the threshold amount. For purposes of the preceding sentence, the term ‘modified adjusted gross income’ means adjusted gross income increased by any amount excluded from gross income under section 911, 931, or 933.

“(2) Threshold amount.—For purposes of paragraph (1), the term ‘threshold amount’ means—

“(A) $150,000 in the case of a joint return, and

“(B) $75,000 in any other case.

“(3) Indexing.—In the case of any taxable year beginning in a calendar year after 2004, each dollar amount contained in paragraph (2) shall be increased by an amount equal to the product of—

“(A) such dollar amount, and

“(B) the medical care cost adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins, determined by substituting ‘2003’ for ‘1996’ in subclause (II) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

“(c) Definitions.—For purposes of this section—

“(1) Applicable individual.—

“(A) In general.—The term ‘applicable individual’ means, with respect to any taxable year, any individual who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in subparagraph (B) for a period—

“(i) which is at least 180 consecutive days, and

“(ii) a portion of which occurs within the taxable year.

Notwithstanding the preceding sentence, a certification shall not be treated as valid unless it is made within the 39½ month period ending on such due date (or such other period as the Secretary prescribes).

“(B) Individuals with long-term care needs.—An individual is described in this subparagraph if the individual meets any of the following requirements:

“(i) The individual is at least 6 years of age and—

“(I) is unable to perform (without substantial assistance from another individual) at least 3 activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

“(II) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least 1 activity of daily living (as so defined), or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

“(ii) The individual is at least 2 but not 6 years of age and is unable due to a loss of functional capacity to perform (without substantial assistance from another individual) at least 2 of the following activities: eating, transferring, or mobility.

“(iii) The individual is under 2 years of age and requires specific durable medical equipment by reason of a severe health condition or requires a skilled practitioner trained to address the individual's condition to be available if the individual's parents or guardians are absent.

“(2) Eligible caregiver.—

“(A) In general.—A taxpayer shall be treated as an eligible caregiver for any taxable year with respect to the following individuals:

“(i) The taxpayer.

“(ii) The taxpayer's spouse.

“(iii) An individual with respect to whom the taxpayer is allowed a deduction under section 151(c) for the taxable year.

“(iv) An individual who would be described in clause (iii) for the taxable year if section 151(c)(1)(A) were applied by substituting for the exemption amount an amount equal to the sum of the exemption amount, the standard deduction under section 63(c)(2)(C), and any additional standard deduction under section 63(c)(3) which would be applicable to the individual if clause (iii) applied.

“(v) An individual who would be described in clause (iii) for the taxable year if—

“(I) the requirements of clause (iv) are met with respect to the individual, and

“(II) the requirements of subparagraph (B) are met with respect to the individual in lieu of the support test of section 152(a).

“(B) Residency test.—The requirements of this subparagraph are met if an individual has as his principal place of abode the home of the taxpayer and—

“(i) in the case of an individual who is an ancestor or descendant of the taxpayer or the taxpayer's spouse, is a member of the taxpayer's household for over half the taxable year, or

“(ii) in the case of any other individual, is a member of the taxpayer's household for the entire taxable year.

“(C) Special rules where more than 1 eligible caregiver.—

“(i) In general.—If more than 1 individual is an eligible caregiver with respect to the same applicable individual for taxable years ending with or within the same calendar year, a taxpayer shall be treated as the eligible caregiver if each such individual (other than the taxpayer) files a written declaration (in such form and manner as the Secretary may prescribe) that such individual will not claim such applicable individual for the credit under this section.

“(ii) No agreement.—If each individual required under clause (i) to file a written declaration under clause (i) does not do so, the individual with the highest modified adjusted gross income (as defined in section 32(c)(5)) shall be treated as the eligible caregiver.

“(iii) Married individuals filing separately.—In the case of married individuals filing separately, the determination under this subparagraph as to whether the husband or wife is the eligible caregiver shall be made under the rules of clause (ii) (whether or not one of them has filed a written declaration under clause (i)).

“(d) Identification Requirement.—No credit shall be allowed under this section to a taxpayer with respect to any applicable individual unless the taxpayer includes the name and taxpayer identification number of such individual, and the identification number of the physician certifying such individual, on the return of tax for the taxable year.

“(e) Taxable Year Must Be Full Taxable Year.—Except in the case of a taxable year closed by reason of the death of the taxpayer, no credit shall be allowable under this section in the case of a taxable year covering a period of less than 12 months.”.

(b) Conforming Amendments.—

(1) Section 6213(g)(2) of the Internal Revenue Code of 1986 is amended by striking “and” at the end of subparagraph (L), by striking the period at the end of subparagraph (M) and inserting “, and”, and by inserting after subparagraph (M) the following new subparagraph:

“(N) an omission of a correct TIN or physician identification required under section 25C(d) (relating to credit for taxpayers with long-term care needs) to be included on a return.”.

(2) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25B the following new item:

“Sec. 25C. Credit for taxpayers with long-term care needs.”.

(c) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

SEC. 4. ADDITIONAL CONSUMER PROTECTIONS FOR LONG-TERM CARE INSURANCE.

(a) Additional Protections Applicable to Long-Term Care Insurance.—Subparagraphs (A) and (B) of section 7702B(g)(2) of the Internal Revenue Code of 1986 (relating to requirements of model regulation and Act) are amended to read as follows:

“(A) In general.—The requirements of this paragraph are met with respect to any contract if such contract meets—

“(i) Model regulation.—The following requirements of the model regulation:

“(I) Section 6A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 6A.

“(II) Section 6B (relating to prohibitions on limitations and exclusions).

“(III) Section 6C (relating to extension of benefits).

“(IV) Section 6D (relating to continuation or conversion of coverage).

“(V) Section 6E (relating to discontinuance and replacement of policies).

“(VI) Section 7 (relating to unintentional lapse).

“(VII) Section 8 (relating to disclosure), other than section 8F thereof.

“(VIII) Section 11 (relating to prohibitions against post-claims underwriting).

“(IX) Section 12 (relating to minimum standards).

“(X) Section 13 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

“(XI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

“(XII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

"(ii) MODEL ACT.—The following requirements of the model Act:

"(I) Section 6C (relating to preexisting conditions).

"(II) Section 6D (relating to prior hospitalization).

"(III) The provisions of section 8 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

"(B) DEFINITIONS.—For purposes of this paragraph—

"(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of September 2000).

"(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

"(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.".

(b) EXCISE TAX.—Paragraph (1) of section 4980C(c) of the Internal Revenue Code of 1986 (relating to requirements of model provisions) is amended to read as follows:

"(1) REQUIREMENTS OF MODEL PROVISIONS.—

"(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

"(i) Section 9 (relating to required disclosure of rating practices to consumer).

"(ii) Section 14 (relating to application forms and replacement coverage).

"(iii) Section 15 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

"(iv) Section 22 (relating to filing requirements for marketing).

"(v) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C, except that—

"(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

"(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

"(vi) Section 24 (relating to suitability).

"(vii) Section 29 (relating to standard format outline of coverage).

"(viii) Section 30 (relating to requirement to deliver shopper's guide).

The requirements referred to in clause (vi) shall not include those portions of the personal worksheet described in Appendix B relating to consumer protection requirements not imposed by section 4980C or 7702B.

"(B) MODEL ACT.—The following requirements of the model Act must be met:

"(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

"(ii) Section 6G (relating to outline of coverage).

"(iii) Section 6H (relating to requirements for certificates under group plans).

"(iv) Section 6I (relating to policy summary).

"(v) Section 6J (relating to monthly reports on accelerated death benefits).

"(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(g)(2)(B).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to policies issued more than 1 year after the date of the enactment of this Act.

Mr. GRAHAM of Florida. Mr. President, there has been a renewed interest in health issues, particularly the plight of the uninsured. That issue presents lawmakers with significant challenges, particularly finding the right mixes of programs to provide health care coverage to the vastly different populations that make up this group.

There is an equally daunting health care issue facing our country, but it is one that has received far less attention. That issue is the increasing need for long-term care. Over 13 million people in the United States need help with basic activities of daily living such as eating, getting in and out of bed, getting around inside, dressing, bathing and using the toilet. While many Americans believe that long-term care is an issue primarily affecting seniors, the reality is that 5.2 million adults between the ages of 18 to 64 and over 450,000 children need long-term care services. These numbers are expected to double as the baby boom generation begins to retire.

Most long-term is provided at home or in the community by informal caregivers. However, in situations where individuals must enter nursing homes or other institutional facilities, costs are paid largely out-of-pocket. Such a financing structure jeopardizes the retirement security of many Americans who have worked hard their entire lives.

In order to help families address their long-term care needs, Senator GRASSLEY and I are re-introducing the "Long-Term Care and Retirement Security Act." This legislation provides two important tools to help Americans and their families meet their immediate and future long-term care needs—an above-the-line income tax deduction for the purchase of long-term care insurance and a caregiver tax credit.

First, the bill provides an above-the-line deduction for long-term care premiums to make long-term care insurance more affordable for a greater number of Americans. Today, such premiums are deductible, but the availability of the deduction is severely limited. First, the current deduction is available only for the thirty percent of taxpayers who itemize their deductions. That leaves the remaining seventy percent of taxpayers with absolutely no benefit. Second, the deduction is limited to an amount, which in addition to other medical expenses exceeds 7.5 percent of the taxpayers adjusted gross income. This AGI limit further decreases the utilization of the current deduction.

The Graham-Grassley legislation removes these restrictions and makes the deduction for long-term care premiums available to all taxpayers.

In order to provide sufficient incentives for families to maintain long-term care coverage, the deduction allowed under this bill increases the longer the policy is maintained. The deduction starts at 60 percent for premiums paid during the first year of coverage and gradually increases each year thereafter until the deduction reaches 100 percent after at least 4 years of continuous coverage. This schedule is accelerated for those age 55 or older. For them, the deduction starts at 70 percent for the first year and increases to 100 percent with at least two years of continuous coverage.

Second, the bill provides an income tax credit for taxpayers with long-term care needs. The credit is phased in over 4 years, starting at $1,000 for 2003 and eventually reaching $3,000. To target assistance to those most in need, the credit phases out for married couples with income above $150,000, $75,000 for single taxpayers.

In addition to the deduction and tax credit, our bill allows employers to offer long-term care insurance under cafeteria plans and include long-term care services as reimbursable costs under flexible spending arrangements. The bill also updates the requirements that long-term care policies must meet in order to qualify for the income tax deduction. These updated requirements reflect the most recent model regulations and code issued by the National Association of Insurance Commissioners.

I urge my colleagues to join Senator GRASSLEY and me in cosponsoring this legislation.

By Mr. BROWNBACK (for himself and Mr. KENNEDY):

S. 1336. A bill to allow North Koreans to apply for refugee status or asylum; to the Committee on the Judiciary.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1336

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PURPOSE.

The purpose of this Act is to ensure that North Koreans are not barred from eligibility for refugee status or asylum in the United States on account of any legal right to citizenship they may enjoy under the Constitution of the Republic of Korea. This Act is not intended in any way to prejudice whatever rights to citizenship North Koreans may enjoy under the Constitution of the Republic of Korea.

SEC. 2. TREATMENT OF NATIONALS OF THE DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA.

For purposes of eligibility for refugee status under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157), or for asylum under section 208 of such Act (8 U.S.C. 1158), a national of the Democratic People's Republic of Korea shall not be considered a national of the Republic of Korea.

By Mr. SMITH:

S. 1337. A bill to establish an incentive program to promote effective safety belt laws and increase safety belt use; to the Committee on Commerce, Science, and Transportation.

Mr. SMITH of Oregon. Mr. President, I rise today to introduce the Safe, Efficient, Automobile Travel to Better Ensure Lives in Transit, SEAT BELT, Act of 2003.

This bill will establish an incentive grant program that rewards States that have enacted or will enact primary seat belt laws. The bill also gives a premium to those States that increase seat belt usage.

According to the National Highway Traffic Safety Administration, NHTSA, motor vehicle crashes are responsible for 95 percent of all transportation-related deaths and 99 percent of all transportation-related injuries. It is estimated that in 2002, 42,850 people were killed in vehicle crashes and roughly 3 million more were injured. Motor vehicle crashes are ranked as the leading cause of death for Americans ages 1 to 34.

In addition to the thousands of transportation-related deaths and injuries, the economic costs associated with vehicle crashes constitute a serious public health problem and significant fiscal burden to the Nation. The total annual economic cost to the U.S. economy of all motor vehicle crashes is an astonishing $230.6 billion, or 2.3 percent of the U.S. gross domestic product. This translates into an average of $820 for every person living in the United States.

Increasing seat belt usage is a guaranteed and proven way to lower the number of transportation-related deaths and costs associated with vehicle crashes. In 2002, 59 percent of vehicle occupants killed were not restrained by seat belts or child safety seats. Safety experts agree that the best short-term and most immediate way to reduce traffic crash fatalities and serious injuries is to increase seat belt use.

Experience in the United States and other countries has shown that sound laws coupled with high-visibility enforcement are the keys to high seat belt use. Currently, the effectiveness of most State seat belt laws is reduced by secondary enforcement provisions that preclude law enforcement from stopping an unbelted motorist unless another traffic law violation is also observed.

Primary enforcement seat belt laws are significantly correlated with higher seat belt usage levels. States with primary enforcement laws have an average of 80 percent belt usage, compared to just 69 percent in States having secondary enforcement laws. Currently, only 19 jurisdictions have primary seat belt laws. Nearly 4000 lives would be saved each year if seat belt use were to increase from the national average of 75 percent to 90 percent.

The SEAT BELT Act creates two grant programs to encourage seat belt use. The first grant program rewards States that have or will have primary seat belt enforcement. Forty percent of the available funds for this program will be applied to the first grant category.

Every State that enacts a primary seat belt law or currently has one will receive two times their Section 402 allotment. Those States that enact a primary seat belt law sooner will receive their incentive grant sooner. Any funds not obligated by the end of FY 2008 will be made available to States qualified to receive funds under the second grant category.

The second grant program would reward States that increase their seat belt usage. Sixty percent of the available funds for this program will be applied to the second grant category. The Secretary of Transportation shall carry out this program which is designed to maximize the effectiveness of the awarded funds and the fairness of the distribution of such funds; increase the national seat belt usage rate as expeditiously as possible; reward States that maintain a seat belt usage rate above 85 percent, as determined by NHTSA; and reward States that demonstrate an increase in their seat belt usage rates.

The SEAT BELT Act will ensure that funds are distributed fairly by rewarding the 19 jurisdictions, including my home state of Oregon, which took an early lead to enact a primary seat belt law. The Act also provides sufficient financial incentives to persuade the States that have not enacted a primary seat belt law to do so. And lastly, the Act provides continuing incentives to States to encourage them to have high seat belt usage rates and rewards them for their persistence in striving towards higher usage rates.

I urge my colleagues to cosponsor this important legislation and ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1337

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Safe, Efficient Automobile Travel to Better Ensure Lives in Transit (SEATBELT) Act of 2003".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) According to the National Highway Traffic Safety Administration (NHTSA), motor vehicle crashes are responsible for 95 percent of all transportation-related deaths and 99 percent of all transportation-related injuries.

(2) Motor vehicle crashes are the leading cause of death for Americans between the ages of 1 and 34.

(3) It is estimated that, in 2002, 42,850 people were killed and approximately 3,000,000 people were injured in vehicle crashes.

(4) NHTSA estimates that if safety belt use were to increase from 75 percent to 90 percent, nearly 4,000 lives would be saved each year.

SEC. 3. SAFETY BELT INCENTIVE GRANTS.

(a) REQUIREMENTS FOR GRANT PROGRAMS.—

(1) IN GENERAL.—Chapter 4 of title 23, United States Code, is amended by adding at the end the following new section:

"§ 412. Safety belt incentive grants

"(a) PRIMARY ENFORCEMENT SAFETY BELT USE LAW INCENTIVE GRANTS.—

"(1) ELIGIBILITY.—The Secretary shall make a grant to each State that, as determined by the Secretary, has in effect a primary enforcement safety belt use law.

"(2) AMOUNT OF GRANT.—The amount of a grant for which a State qualifies under this subsection shall equal the amount of funds allocated to the State under section 402 of this title for fiscal year 2003 multiplied by 2.

"(3) DISTRIBUTION OF FUNDS.—Funds awarded to a State under this subsection shall be distributed over a 2-year period.

"(4) FUNDS AVAILABLE FOR GRANT PROGRAM.—Forty percent of the funds made available to carry out the occupant protection programs under section 405 of this title in a fiscal year shall be available for grants under this subsection during such fiscal year.

"(5) DISPOSITION OF UNUSED FUNDS.—Any funds available for grants under this subsection that have not been awarded by the end of fiscal year 2008 shall be made available for the safety belt usage grant program under subsection (b).

"(b) SAFETY BELT USAGE AWARD GRANTS.—

"(1) IN GENERAL.—The Secretary shall carry out a program for making safety belt usage award grants to eligible States. The program shall be designed to—

"(A) maximize the effectiveness of the awarded funds and the fairness of the distribution of such funds;

"(B) increase the national seat belt usage rate as expeditiously as possible;

"(C) reward States that maintain a seat belt usage rate above 85 percent (as determined by the National Highway Traffic Safety Administration); and

"(D) reward States that demonstrate an increase in their seat belt usage rates.

"(2) FUNDS AVAILABLE FOR GRANT PROGRAM.—Sixty percent of the funds made available to carry out the occupant protection programs under section 405 of this title in a fiscal year shall be available for grants under this subsection during such fiscal year.

"(c) USE OF FUNDS.—Grants awarded under this section may be used to carry out activities under this title.

"(d) DEFINITIONS.—In this section:

"(1) PASSENGER MOTOR VEHICLE.—The term 'passenger motor vehicle' has the meaning given the term in section 405(f)(5) of this title.

"(2) PRIMARY ENFORCEMENT SAFETY BELT USE LAW.—The term 'primary enforcement safety belt use law' means a law that meets the criteria for such laws published by the Secretary in a rule relating to the grant program under this section.

"(3) SAFETY BELT.—The term 'safety belt' has the meaning given the term in section 405(f)(6) of this title.".

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of that chapter is amended by inserting after the item relating to section 411 the following new item:

"412. Safety belt incentive grants.".

(b) INTERIM FINAL RULE.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Transportation shall publish an interim final rule listing the criteria for awarding grants pursuant to section 412 of title 23, United States Code, as added by subsection (a), including the criteria to be used by the Secretary in determining whether a law is a primary enforcement safety belt use law for purposes of such section.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 183—COMMEMORATING 50 YEARS OF ADJUDICATION UNDER THE McCARRAN AMENDMENT OF RIGHTS TO THE USE OF WATER

Mr. ENSIGN (for Mr. CAMPBELL (for himself, Mr. ENSIGN, Mr. KYL, Mr. BURNS, Mr. ALLARD, Mr. CRAPO, and Mr. CRAIG)) submitted the following resolution; which was referred to the Committee on Energy and Natural Resources:

S. RES. 183

Whereas section 208 of the Department of Justice Appropriation Act, 1953 (commonly known as the McCarran Amendment) (43 U.S.C. 666) waived the sovereign immunity of the United States so that it could be joined in comprehensive State general adjudications of the rights to use water;

Whereas in United States v. District Court for Eagle County, 401 U.S. 520, 524 (1971), the Supreme Court confirmed that the McCarran Amendment was "an all-inclusive statute concerning 'the adjudication of rights to the use of water of a river system' which . . . has no exceptions and . . . includes appropriative rights, riparian rights, and reserved rights";

Whereas in Colorado River Water Conservation District v. United States, 424 U.S. 800, 819 (1976), the Supreme Court concluded that the concern over "avoiding the generation of additional litigation through permitting inconsistent dispositions of property . . . Is heightened with respect to water rights, the relationships among which are highly interdependent" and that the "consent to jurisdiction given by the McCarran Amendment bespeaks a policy that recognizes the availability of comprehensive state systems for adjudication of water rights as the means of achieving these goals";

Whereas since the passage of the McCarran Amendment, Federal and non-Federal users, along with numerous Western States, have invested millions of dollars in water right adjudications in those States to establish rights to the use of water that will determine priority of use during times of scarcity;

Whereas State water laws in the West have evolved to accommodate instream values such as recreation and environmental needs, while continuing to recognize and protect traditional consumptive uses for the West's cities and farms;

Whereas Federal claims for water have been recognized under both Federal and State laws within State general adjudications, thus enhancing the protection of Federal interests, as well as the certainty and reliability of non-Federal interests, in water in the West;

Whereas the significance of the McCarran Amendment, in providing States with the ability to determine the extent of federal claims to water resources, has become increasingly apparent as many of the Western States are experiencing a severe and sustained drought, where water supplies for all purposes are severely restricted; and

Whereas now more than ever there is a pressing need to recognize and support the availability of comprehensive systems for quantification of rights to use water in those Western States for all beneficial purposes: Now, therefore, be it

Resolved, that the Senate—

(1) reaffirms the policies and principles of the McCarran Amendment that have been recognized by Supreme Court decisions and recognizes that, as a matter of practice, the United States should adhere and defer to State water law; and

(2) commends Western States that maintain comprehensive systems for the quantification of rights to use water for all beneficial purposes, including environmental protection and enhancement.

Mr. CAMPBELL. Mr. President, I rise to submit a Resolution commemorating 50 years of adjudicating water rights under the McCarran Amendment and commending Western States' management of water.

Rather than simply go into the Resolution itself, I would like to put the Amendment in its proper historical context.

Unlike the Eastern United States, the history of the West, its settlement, and even its founding, is closely linked to the Federal Government. We should remember that Lewis and Clark and so many other courageous explorers who mapped the Western territories were funded by the United States government. We should also be mindful that much of what we know as the West was purchased or otherwise acquired by the United States Government including the Louisiana Purchase of 1803 and the 1848 Treaty of Guadalupe Hidalgo.

However, just because the Federal Government might have acquired the Western territories didn't mean that people wanted to move there. The West was a rough place, harsh land and harsher winters were enough to keep most folks back East. Again, the United States took action to promote Westward expansion by implementing laws like the Homestead Act to encourage people to relocate.

Eventually, the dream of discovering gold and mining precious metals was the catalyst that got people moving West, and eventual completion of the trans-continental railroad provided the means. Each Western territory developed into a distinct State, based on the makeup of its constituents, diverse as the Mormons of Utah to the Spanish and Mexican-Americans of New Mexico and to the Great Plains Indians and other Tribes.

No matter the reason why people moved West, they all needed water, as precious and scarce a resource then as it is today. New industries and cities to sprout up that needed water to survive and a way to manage it.

Water law out West is as distinct from the East as are the histories of the two great regions of our Nation. In the West, water is a rare commodity, and is therefore regarded as a property right under the law sold apart from the land.

Since water was such a scarce resource, each State managed water based on its particular resources, geography, population, and municipal and industrial needs. Yet, Western States all recognized and favored water adjudication systems according to the doctrines of prior appropriation and beneficial use.

State management of water worked rather smoothly for decades. Then after World War II, during the new Deal's expansive programs, the Federal government sought to realign and trump the established States' interest in water to some degree. On one hand, the Federal Government believed it to be acting in its own interest since Uncle Sam owned much of the West. The United States still owns thirty-seven percent of my State of Colorado.

The United States rode roughshod over State interests, often completely ignoring private property rights and resisting cooperative agreements to manage water. The States fought Federal arm twisting as best as they could, but couldn't do much against the U.S. as sovereign. The Federal bullying got so bad that in 1951, a Readers Digest article criticized the U.S.'s strong arm tactics in the famous Santa Margarita water conflict stating that, "the lack of moral sensitivity in our Government has put into jeopardy thousands of our small landowners; their property, homes, savings and their future."

Thankfully, Senator PATRICK McCARRAN of Nevada along with other likeminded Senators, successfully defended States' interests and got a very simply provision passed into law. In short, the law that we are celebrating today waives the United States' sovereign immunity so that it could be joined in general state adjudications of rights to use water.

Although a simple concept, the McCarran Amendment effectively leveled the playing field, requiring Uncle Sam to work within the State system he implicitly helped to establish.

The breadth of the McCarran Amendment has been defined by U.S. Supreme Court cases. The Court concluded that although the amendment itself might be short in length, its effect was far reaching. The High Court stated that McCarran was "an all inclusive statute concerning the adjudication of 'the rights to the use of water of a river system'" which "has no exceptions" and "includes appropriat[ive] rights, riparian rights, and reserved rights."

It is undeniable that the history of the West is linked to the Federal Government. Since the Federal Government maintains vast landholdings, the future of the West will also be linked to Uncle Sam. Similarly, the management of property and natural resources, of which water is both, has been and shall remain a State function.

The purpose of the McCarran Amendment was to prevent federal bullying of private and state interests in managing water, and to recognize water as a State resource. McCarran encourages the Federal Government to work together with the States.

I am submitting this resolution today at a time when much of the West is still under or will likely experience severe drought conditions. The Federal Government must remember the history of the McCarran amendment and look to the States in adjudicating water.

SENATE RESOLUTION 184—CALLING ON THE GOVERNMENT OF THE PEOPLE'S REPUBLIC OF CHINA IMMEDIATELY AND UNCONDITIONALLY TO RELEASE DR. YANG JIANLI, AND FOR OTHER PURPOSES

Mr. KYL (for himself, Ms. MIKULSKI, Mr. BROWNBACK, Mr. MCCAIN, and Mr. ALLEN) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 184

Whereas, according to the Department of State's 2002 Country Reports on Human Rights Practices in China, the Government of the People's Republic of China has "continued to commit numerous and serious [human rights] abuses," including "instances of . . . arbitrary arrest and detention, lengthy incommunicado detention, and denial of due process";

Whereas according to the report, "the country's criminal procedures were not in compliance with international standards," the "lack of due process in the judicial system remained a serious problem," and "authorities routinely violated legal protections in the cases of political dissidents";

Whereas Dr. Yang Jianli, an internationally renowned scholar, pro-democracy activist, and president of the Foundation for China in the 21st Century, is an alien lawfully admitted for permanent residence in the United States who has been detained incommunicado by the Government of the People's Republic of China since April 26, 2002;

Whereas according to the United Nations Commission on Human Rights Resolution 1997/38 of April 11, 1997, "prolonged incommunicado detention may . . . itself constitute a form of cruel, inhuman, or degrading treatment," which is prohibited by international law;

Whereas Dr. Yang Jianli has been deprived of his basic human rights by being denied access to legal counsel and contact with his wife and two children (who are United States citizens), and has also been denied his right to trial within a reasonable time or to release pending trial;

Whereas, on June 3, 2003, the United Nations Working Group on Arbitrary Detention expressed the opinion that "[t]he non-observance of Mr. Yang Jianli's right to a fair trial is of such gravity as to give his deprivation of liberty an arbitrary character. Therefore, his arrest and detention is arbitrary being in contravention of Article 9 of the Universal Declaration of Human Rights and Article 9 of the International Covenant on Civil and Political Rights."; and

Whereas the arbitrary imprisonment of United States citizens and permanent resident aliens by the Government of the People's Republic of China and the continuing violations by the Government of their fundamental human rights demands a forceful response by Congress and the President of the United States: Now, therefore, be it

Resolved,

SECTION 1. CONDEMNATION OF THE TREATMENT BY THE GOVERNMENT OF CHINA OF DR. YANG JIANLI.

The Senate—

(1) condemns and deplores the incommunicado detention of Dr. Yang Jianli, and calls for his immediate and unconditional release;

(2) condemns and deplores the lack of due process afforded to Dr. Yang; and

(3) strongly urges the Government of the People's Republic of China to consider the implications for the broader relationship between the United States and the People's Republic of China of detaining permanent resident aliens of the United States without providing them access to legal counsel or family members.

SEC. 2. SENSE OF THE SENATE.

It is the sense of the Senate that the United States should—

(1) make the immediate release of Dr. Yang Jianli by the Government of the People's Republic of China a top priority of United States foreign policy;

(2) continue to make every effort to assist Dr. Yang Jianli and his family while discussions of his release are ongoing;

(3) ensure that the Government of the People's Republic of China understands that the detention of United States citizens and permanent resident aliens, and the infliction of human rights violations on these groups, is not in the interests of the Government of the People's Republic of China because it will reduce the opportunities for cooperation between the United States and the People's Republic of China;

(4) reiterate its deep concern regarding the continued imprisonment of Dr. Yang Jianli and other United States citizens and permanent resident aliens whose human rights are being violated; and

(5) engage in discussions with the Government of the People's Republic of China regarding the legal status and immediate humanitarian needs of these United States citizens and permanent resident aliens.

Mr. KYL. Mr. President, I rise today to submit a resolution calling on the government of the People's Republic of China to release Dr. Yang Jianli, an internationally renowned scholar and pro-democracy activist, who has been detained in China since April 2002 without access to legal counsel, contact with his family, or a trial. Dr. Yang, a U.S. permanent resident, is a mathematician and economist who lives in Massachusetts. He heads the Foundation for China in the 21st Century, a group that advocates democratization in China.

On June 3, the U.N.'s Working Group on Arbitrary Detention condemned China's detention of Dr. Yang, finding that the Chinese government has violated his rights as a citizen of China and as a resident of the U.S. The panel declared that, "The nonobservance of Dr. Yang's right to a fair trial is of such gravity as to give his deprivation of liberty an arbitrary character. Therefore, his arrest and detention is arbitrary being in contravention of Article 9 of the Universal Declaration on Human Rights and Article 9 of the International Covenant on Civil and Political Rights."

In recognition of the U.N. working group's conclusions, as well as the Chinese government's blatant rejection of them, the State Department officially called for Dr. Yang's release, stating, "We are particularly disturbed now by China's public rejection of an accepted international process and the findings of the independent and impartial panel of jurists, so we are urging China to comply fully with international obligations that it has assumed, and we urge that Dr. Yang be released and allowed to return to his wife and children in Boston."

The resolution that I am submitting with my colleagues goes hand-in-hand with the State Department's support for Dr. Yang. It expresses the sense of the Senate that the U.S. should: (1) make the immediate release of Dr. Yang Jianli a top foreign policy priority; (2) make clear to the Chinese government that the detention of U.S. citizens and permanent residents is not in its best interests; and (3) express the deep concern of the U.S. regarding the imprisonment of Dr. Yang and other U.S. citizens and permanent residents, as well as discuss their legal status and humanitarian needs.

I would like to note that a similar resolution—submitted by Representatives COX and FRANK—is expected to be considered today by the House of Representatives.

As I have stated repeatedly, if China wants to become a productive and respected member of the international community, it must begin to adhere to accepted norms of behavior. China's leaders seem to be oblivious to the understanding that all people deserve certain basic freedoms and that violation of such fundamental rights is an appropriate concern of the United States and the world at large. We should make clear that the Chinese government's continued detention of Yang Jianli and others—in violation of these international norms—will adversely impact our bilateral relations. Without such pressure, the behavior of China's leaders is unlikely to change, and the voices of those who have devoted their lives to the cause of freedom—like Yang Jianli—will continue to be silenced.

I hope that my colleagues in the Senate will join me in strongly supporting this resolution and in calling for Dr. Yang Jianli's release.

Ms. MIKULSKI. Mr. President, I rise to join Senator Kyl in submitting a resolution calling for the immediate release of Dr. Yang Jianli. Dr. Yang Jianli. Dr. Yang is a democracy activist who has since been held incommunicado in China for more than a year. Dr. Yang is being held in violation of his human rights and international law. He should be freed now.

Dr. Yang Jianli is a scholar and important democracy activist in his home State of Massachusetts where he is founder and president of the Foundation for China in the 21st Century. Jianli is a permanent United States resident who continues to work for democracy in his native China.

Dr. Yang was taken into custody when he returned to China on April 26, 2002. He has been held incommunicado since then. His family in Massachusetts and Maryland are understandably concerned about his welfare.

The U.S. Department of State has called for China to release Dr. Yang. So has the United Nations Working Group on Arbitrary Detention. The Chinese government refuses to admit to detaining this man illegally. However, the U.N. Working Group on Arbitrary Detention says, "The non-observance of Dr. Yang's right to a fair trial is of such gravity as to give his deprivation of liberty an arbitrary character. Therefore, his arrest and detention is arbitrary being in contravention of Article 9 of the Universal Declaration of Human rights and Article 9 of the International Covenant of Civil and Political Rights." In other words, the Chinese government never bothered to charge Yang Jianli with a crime—they just locked him up and threw away the key.

We can assist by increasing the pressure of the Chinese government and support the U.N. petition on Dr. Yang's behalf. Being deprived of his basic human rights of access to legal counsel and contact with his wife and children is wrong. When China wanted most-favored-nation trade status, we heard a lot of lip service to human rights and democracy. Dr. Yang Jianli's case shows the true face of China's government. They locked him up because he wanted to speak out about democracy and human rights.

I strongly urge the Chinese government to respond to the continual requests for Yang's freedom by the United States government and human rights groups around the world. The House is taking up a similar resolution today. I hope that the Senate will act quickly to add our voices in calling for freedom for Yang Jianli.

Mr. BROWNBACK. Mr. President, after more than a year of suffering abuse and incommunicado detention, I urge this body to call for the immediate and unconditional release of Chinese democracy activist, Dr. Yang Jianli.

Dr. Yang, a permanent resident of the United States, a respected scholar, a pro-democracy advocate, president of the Foundation for China in the 21st Century, as well as a loving husband and father, is now a prisoner and victim of shameless abuse by the Chinese government.

Following his participation in the 1989 Tiananmen Square pro-democracy student protests, Dr. Yang was added to an unofficial blacklist of expatriate Chinese dissidents. Upon his return to the country in 2002, Dr. Yang was detained and has been denied access to his family, legal counsel and due process.

The resolution submitted today in the Senate coupled with H. Res. 199, strongly calls for the release of Dr. Yang Jianli and condemns the People's Republic of China for ongoing deplorable human rights abuses. Clearly, it is not in their interest to deny human rights to any United States citizen or U.S. permanent resident alien.

Let this also be an additional chance to voice our regret and deep concern for the continual abuse of the people in China. Dr. Yang Jianli understands this better than most. He has devoted his life to the cause of democracy and freedom for the people for China and has been, once again, silenced.

China must know and the world must know that denial of basic human rights will no longer be tolerated. Dr. Yang is just one of the many, who suffer daily under the harsh rule of those who refuse to embrace democracy. We must let his story and his voice be heard for the millions of others who can not speak out. Let us continue to pressure the People's Republic of China and let us continue to stand for what is right and just around the world.

SENATE RESOLUTION 185—EXPRESSING THE SENSE OF THE SENATE WITH RESPECT TO RAISING AWARENESS AND ENCOURAGING EDUCATION ABOUT SAFETY ON THE INTERNET AND SUPPORTING THE GOALS AND IDEALS OF NATIONAL INTERNET SAFETY MONTH

Ms. MURKOWSKI (for herself, Mr. Stevens, and Mr. Inouye) submitted the following resolution; which was considered and agreed to:

S. Res. 185

Whereas, in the United States, 48 million children between the ages of 5 and 17 use computers;

Whereas 5 to 17 year-olds in the United States currently spend 5 billion hours on-line annually;

Whereas 70 million youth under the age of 18 worldwide are on-line;

Whereas the majority of teenagers' on-line use occurs after school, at home, when working parents are not at home;

Whereas 90 percent of those age 15 to 24 use the Internet, with almost half of them using it once a day or more;

Whereas approximately 3 out of 4 young people have access to the Internet at home, and nearly 1 in 3 has access from their own bedroom;

Whereas 9 out of 10 children between ages 8 and 16 have viewed pornography on the Internet, with most being accessed unintentionally when, often in the process of doing homework, a child used a seemingly innocent sounding word in an Internet search for information or pictures;

Whereas 62 percent of parents of teenagers are unaware that their children have accessed objectionable websites;

Whereas 89 percent of sexual solicitations were made in either chat rooms or Instant Messages;

Whereas 30 percent of the girls responding to a Girl Scout research study reported that they had been sexually harassed in a chat room, but only 7 percent told a parent about the harassment, most fearing their parents would overreact and ban computer usage altogether;

Whereas, in 1996, the Federal Bureau of Investigation was involved in 113 cases involving Internet crimes against children, but in 2001, the FBI opened 1,541 cases against suspects of Internet crimes involving child pornography or abuse; and

Whereas June as National Internet Safety Month will provide national awareness of the dangers of the Internet while offering education about how to be safe, responsible, and accountable on the Internet: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) National Internet Safety Month provides an opportunity to educate the people of the United States on the dangers of the Internet and the importance of being safe and responsible on-line;

(2) national and community organizations should be recognized and applauded for their work in promoting awareness of the dangers of the Internet and for providing information on developing the critical thinking and decision-making skills to be safe on-line; and

(3) Internet safety organizations, law enforcement, educators, and volunteers should increase their efforts to raise the awareness of on-line safety.

SENATE RESOLUTION 186—COMMENDING AUGUST HIEBERT FOR HIS SERVICE TO THE ALASKA COMMUNICATIONS INDUSTRY

Mr. STEVENS (for himself and Ms. Murkowski) submitted the following resolution; which was ordered held at the desk:

S. Res. 186

Whereas Augie Hiebert came to Alaska in 1939 and built the first successful commercial radio station;

Whereas on Dec. 7, 1941, Augie Hiebert picked up the first report of the raid on Pearl Harbor from his radio station in Fairbanks, Alaska giving military leaders the first word of the attack that began World War II;

Whereas in 1953, Augie Hiebert founded Alaska's first television station;

Whereas Augie Hiebert established Alaska's first FM radio station and was named president of the Alaska Broadcasting system, overseeing the affiliation of nine stations that serve all major Alaska communities;

Whereas Augie Hiebert helped establish Alaska's first satellite earth station activated in 1970;

Whereas Augie Hiebert led in the development of the Territory and State of Alaska, working for over a half century to pioneer modern radio and television on behalf of the broadcast industry;

Whereas Augie Hiebert has been a pillar of the Alaska community as president of the Anchorage Chamber of Commerce and the Association of the U.S. Army in Alaska, and as director of the Alaska Educational Broadcasting Committee, the CBS Television Network Affiliates Association, the Civil Air Patrol, and the Pioneers of Alaska: Now, therefore, be it

Resolved, That it is the sense of the Senate that Augie Hiebert is commended for his service to the communications industry in Alaska and the world and for bringing the best that broadcasting has to offer to the people of Alaska.

AMENDMENTS SUBMITTED AND PROPOSED

SA 1044. Mr. BAYH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table.

SA 1045. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1046. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1047. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1048. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1049. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1050. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1051. Mr. ENZI (for himself, Mrs. Lincoln, Mr. Pryor, and Ms. Murkowski) proposed an amendment to the bill S. 1, supra.

SA 1052. Mr. EDWARDS (for himself and Mr. Harkin) proposed an amendment to the bill S. 1, supra.

SA 1053. Mr. AKAKA submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1054. Mr. FEINGOLD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1055. Mrs. HUTCHISON (for herself, Mr. Kennedy, Mr. Durbin, Mr. Kerry, and Mr. Lautenberg) submitted an amendment intended to be proposed to amendment SA 1004 proposed by Mrs. HUTCHISON to the bill S. 1, supra; which was ordered to lie on the table.

SA 1056. Mr. SHELBY (for himself, Ms. Stabenow, Mr. Sessions, Mr. Cochran, Mr. Lott, and Mrs. Murray) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1057. Mrs. DOLE (for herself and Mr. Edwards) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1058. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1059. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1060. Mr. BAUCUS (for Mrs. Feinstein (for himself, Mr. Nickles, Mr. Chafee, and Mr. Graham, of South Carolina)) proposed an amendment to the bill S. 1, supra.

SA 1061. Mr. BAUCUS (for Mr. Akaka (for himself and Mr. Inouye)) proposed an amendment to the bill S. 1, supra.

SA 1062. Mr. REID (for Mrs. Boxer) proposed an amendment to amendment SA 974 proposed by Mr. GRASSLEY (for himself, Mr. Leahy, Ms. Cantwell, Mr. Durbin, and Mr. Kohl) to the bill S. 1, supra.

SA 1063. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1064. Ms. SNOWE (for herself, Mr. Rockefeller, and Mr. Smith) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1065. Mr. BINGAMAN (for himself, Mr. Domenici, Ms. Mikulski, and Mrs. Lincoln) proposed an amendment to the bill S. 1, supra.

SA 1066. Mr. BINGAMAN proposed an amendment to the bill S. 1 , supra.

SA 1067. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1068. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1069. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1070. Mr. SCHUMER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1071. Mr. ROCKEFELLER (for himself and Mr. Smith) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1072. Mr. ROCKEFELLER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1073. Mr. SMITH (for himself, Mr. Feingold, and Ms. Cantwell) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1074. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1075. Ms. STABENOW (for herself and Mr. Levin) proposed an amendment to the bill S. 1, supra.

SA 1076. Ms. STABENOW (for herself and Mr. Levin) proposed an amendment to the bill S. 1, supra.

SA 1077. Ms. STABENOW (for herself and Mr. Levin) proposed an amendment to the bill S. 1, supra.

SA 1078. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1079. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1080. Mr. DeWINE (for himself and Mr. Durbin) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1081. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1082. Mr. CONRAD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1083. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1084. Mr. VOINOVICH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1085. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1086. Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1087. Mr. GRASSLEY (for Mr. Craig) proposed an amendment to the bill S. 1, supra.

SA 1088. Mr. BAUCUS (for Ms. Mikulski) proposed an amendment to the bill S. 1, supra.

SA 1089. Mr. BAUCUS (for Ms. Mikulski) proposed an amendment to the bill S. 1, supra.

SA 1090. Mr. BAUCUS (for Ms. Mikulski) proposed an amendment to the bill S. 1, supra.

SA 1091. Mr. BAUCUS (for Ms. Mikulski) proposed an amendment to the bill S. 1, supra.

SA 1092. Mr. GRASSLEY (for himself and Mr. Baucus) proposed an amendment to the bill S. 1, supra.

SA 1093. Mr. KYL proposed an amendment to amendment SA 1092 proposed by Mr. Grassley (for himself and Mr. Baucus) to the bill S. 1, supra.

TEXT OF AMENDMENTS

SA 1044. Mr. BAYH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. . URBAN HEALTH PROVIDER ADJUSTMENT.

(a) In General.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in subsection (b) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r-4(f)).

(b) Hospital Described.—A hospital is described in this subsection if the hospital—

(1) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(2) is located in Marion County, Indiana.

(c) Limitation.—The payment adjustment described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r-4(g)(1)(A)).

SA 1045. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) Demonstration Project.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), the amount of payment for a device of brachytherapy furnished under the demonstration project shall be equal to the hospital's charges for each device furnished, adjusted to cost.

(b) Specification of Groups for Brachytherapy Devices.—The Secretary shall create additional groups of covered OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.

(c) Duration.—The Secretary shall conduct the demonstration project under this section for the 3-year period beginning on the date that is 90 days after the date of enactment of this Act.

(d) Report.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project conducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.

(f) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration project under this section.

(2) Budget neutrality.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration project under this section was not implemented.

SA 1046. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtile B of title IV, add the following:

SEC. . DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) Demonstration Project.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) Definitions.—In this section:

(1) Surgical First Assisting Services.—The term "surgical first assisting services" means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) Certified Registered Nurse First Assistant.—The term "certified registered nurse first assistant" means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) Payment Rates.—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) for the same services if furnished by a physician.

(d) Demonstration Project Sites.—The project established under this section shall be conducted in 5 States selected by the Secretary.

(e) Duration.—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) Report.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the project under this section.

(2) Budget neutrality.—In conducting the project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the project under this section was not implemented.

(i) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SA 1047. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes: which was ordered to lie on the table: as follows:

On page 78, line 15, insert before the period the following: "and all succeeding years. Once such a determination is made with respect to an area, the Administrator shall ensure that a contract of the type entered into under the preceding sentence remains in effect for such area for each such succeeding year and beneficiaries receiving the standard prescription drug coverage under such a contract may elect to remain enrolled in such coverage under a such contract regardless of whether the access required under subsection (d)(1) is going to be provided in the area in the year".

SA 1048. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 79, between line 22 and 23, insert the following:

"(F) Permanent fallback in certain areas.—

"(i) In general.—Notwithstanding paragraph (1), in the case of an applicable area, the Administrator shall enter into a contract under paragraph (1)(B) with respect to the area for each year after the year in which the area meets the definition of an applicable area. Eligible beneficiaries residing in such area may elect to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D-6(e)) under such contract in a year regardless of whether the access required under subsection (d)(1) is going to be provided in the area in that year.

"(ii) Applicable area.—For purposes of this subparagraph, the term 'applicable area' means an area—

"(I) that was designated under paragraph (1)(B) for a year;

"(II) in which the access required under subsection (d)(1) was met with respect to a year subsequent to the year described in subclause (I); and

"(III) that was designated under paragraph (1)(B) for a year subsequent to the year described in subclause (II).

SA 1049. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 39, strike line 23 through page 40, line 2, and insert the following:

"(E) RESTRICTIONS ON REMOVING DRUGS FROM FORMULARY.—An eligible entity may not remove a drug from the formulary under the plan—

"(i) during the 2-year contract for the plan; and

"(ii) unless the entity has provided appropriate notice to beneficiaries, physicians, and pharmacists that the drug will be removed at the beginning of the subsequent 2-year contract for the plan.

SA 1050. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 79, between line 22 and 23, insert the following:

"(F) PERMANENT FALLBACK FOR CERTAIN BENEFICIARIES.—

"(i) IN GENERAL.—Notwithstanding paragraph (1), the Administrator shall enter into a contract under paragraph (1)(B) for each area for each year. Applicable eligible beneficiaries residing in such area may elect to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract in a year regardless of whether the access required under subsection (d)(1) is going to be provided in the area in that year. Other eligible beneficiaries residing in such area may elect to receive such coverage under such contract only if the area has been designated under paragraph (1)(B) for the year.

"(ii) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subparagraph, the term 'applicable eligible beneficiary' means an individual who—

"(I) is enrolled under this part;

"(II) was covered under a group health plan; and

"(III) involuntarily lost such coverage such that the beneficiary was eligible for a special open enrollment period under section 1860D–2(b)(3).

SA 1051. Mr. ENZI (for himself, Mrs. LINCOLN, Mr. PRYOR, and Ms. MURKOWSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 37, between lines 20 and 21, insert the following:

"(C) CONVENIENT ACCESS TO PHARMACIES.—In this section, the term 'convenient access' means access that is no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TriCare retail pharmacy program. Such rules shall include adequate emergency access for enrolled beneficiaries.

On page 48, between lines 4 and 5, insert the following:

"(4) TYING OF CONTRACTS.—No eligible entity with a contract under this part, or its agent, may require a pharmacy to participate in a medicare prescription drug plan as a condition of participating in nonmedicare programs or networks, or require a pharmacy to participate in a nonmedicare program or network as a condition of participating in a medicare prescription drug plan.

SA 1052. Mr. EDWARDS (for himself and Mr. HARKIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end, add the following:

TITLE —DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. 01. DIRECT-TO-CONSUMER ADVERTISING.

Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by inserting at the end the following:

REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including, if available, effectiveness in comparison to other drugs for substantially the same condition or conditions); and

(ii) information relating to side effects and contraindications;

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided that*, nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

"(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

"(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

"(A) the Secretary provides the person written notice of the violation; and

"(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

"(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

"(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

"(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

"(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).".

SEC. 03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. 04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

SA 1053. Mr. AKAKA submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements to the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r-4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).".

SA 1054. Mr. FEINGOLD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title I, add the following:

SEC. 133. OFFICE OF THE MEDICARE BENEFICIARY ADVOCATE.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish within the Department of Health and Human Services, an Office of the Medicare Beneficiary Advocate (in this section referred to as the "Office").

(b) DUTIES.—The Office shall carry out the following activities:

(1) Establishing a toll-free telephone number for medicare beneficiaries to use to obtain information on the medicare program, and particularly with respect to the benefits provided under part D of title XVIII of the Social Security Act and the Medicare Prescription Drug plans and MedicareAdvantage plans offering such benefits. The Office shall ensure that the toll-free telephone number accommodates beneficiaries with disabilities and limited-English proficiency.

(2) Establishing an Internet website with easily accessible information regarding Medicare Prescription Drug plans and MedicareAdvantage plans and the benefits offered under such plans. The website shall—

(A) be updated regularly to reflect changes in services and benefits, including with respect to the plans offered in a region and the associated monthly premiums, benefits offered, formularies, and contact information for such plans, and to ensure that there are no broken links or errors;

(B) have printer-friendly, downloadable fact sheets on the medicare coverage options and benefits;

(C) be easy to navigate, with large print and easily recognizable links; and

(D) provide links to the websites of the eligible entities participating in part D of title XVIII.

(3) Providing regional publications to medicare beneficiaries that include regional contacts for information, and that inform the beneficiaries of the prescription drug benefit options under title XVIII of the Social Security Act, including with respect to—

(A) monthly premiums;

(B) formularies; and

(C) the scope of the benefits offered.

(4) Conducting outreach to medicare beneficiaries to inform the beneficiaries of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(5) Working with local benefits administrators, ombudsmen, local benefits specialists, and advocacy groups to ensure that medicare beneficiaries are aware of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(c) FUNDING.—

(1) ESTABLISHMENT.—Of the amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures, $2,000,000 may be used to establish the Office in accordance with this section.

(2) OPERATION.—With respect to each fiscal year occurring after the fiscal year in which the Office is established under this section, the Secretary may use, out of amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures for such fiscal year, such sums as may be necessary to operate the Office in that fiscal year.

SA 1055. Mrs. HUTCHISON (for herself, Mr. KENNEDY, Mr. DURBIN, Mr. KERRY, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 1004 proposed by Mrs. HUTCHISON to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

In lieu of the matter proposed to be added, add the following:

SEC. . REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking "and" after the semicolon at the end;

(2) in subclause (VII)—

(A) by striking "on or after October 1, 2002" and inserting "during fiscal year 2003"; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subclause:

"(VIII) during fiscal year 2004, 'c' is equal to 1.41; and

"(IX) on or after October 1, 2005, 'c' is equal to 1.47.".

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking "1999 or" and inserting "1999,"; and

(2) by inserting ", or the Prescription Drug and Medicare Improvement Act of 2003" after "2000".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

At the end of subtitle B of title IV, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against

any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1056. Mr. SHELBY (for himself, Ms. Stabenow, Mr. Sessions, Mr. Cochran, Mr. Lott, and Mrs. Murray) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) In General.—The last sentence of section 1886(d)(1)(B) is amended by inserting ", and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)" before the period at the end.

(b) Treatment of Proposed Revision.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) Effective Date.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

SA 1057. Mrs. DOLE (for herself and Mr. Edwards) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) Payments to Hospitals.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(b) Budget Neutral.—The Secretary shall adjust the area wage index referred to in subsection (a) in a manner which assures that the appropriate payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than those which would have be made in the year if this section did not apply.

(c) Payments to Skilled Nursing Facilities and Home Health Agencies.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395(j)(o)) under the medicare program under title XVIII of such Act (42 U.S.C 1395 et seq.). Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(d) Application.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This provision must be implemented in a budget neutral manner, using a methodology that maintains the current SNF and home health expenditure levels.

SA 1058. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title VI, insert the following:

SEC. . RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) Definitions.—In this section:

(1) Clerical error.—The term "clerical error" means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) Trust fund.—The term "Trust Fund" means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) Correction of Trust Fund Holdings.—

(1) In general.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) Obligations issued and redeemed.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) Appropriation.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

SA 1059. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title I, add the following:

SEC. . REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES.

(a) Review.—

(1) In general.—The Secretary shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

(2) Specific matters reviewed.—In conducting the review under paragraph (1), the Secretary shall—

(A) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

(B) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

(b) Report.—

(1) In general.—Not later than the date that is 18 months after the date of enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a)(1), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

(2) Contents.—The report submitted under paragraph (1) shall contain—

(A) a detailed description of the plans of the Secretary to implement the provisions of this Act in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

(B) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

SA 1060. Mr. BAUCUS (for Mrs. Feinstein (for herself, Mr. Nickles, Mr. Chafee, and Mr. Graham of South Carolina) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of title IV, insert:

Subtitle D—Part B Premium

SEC. . INCOME-RELATED INCREASE IN MEDICARE PART B PREMIUM.

(a) In General.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

‘‘(h) Increase in Premium for High-Income Beneficiaries.—

‘‘(1) Amount of increase.—

‘‘(A) In general.—Except as provided in paragraph (4), if the modified adjusted gross income of an individual for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) exceeds the threshold amount, the amount of the premium under subsection (a) for the individual for the calendar year shall, in lieu of the amount otherwise determined under subsection (a), be equal to the applicable percentage of an amount equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for the calendar year.

‘‘(B) Applicable percentage.—The term ‘applicable percentage’ means the percentage determined in accordance with the following tables:

‘‘(i) Individuals not filing joint returns.—

“If the modified adjusted gross income exceeds the threshold amount by:	**The applicable percentage is:**
Not more than $25,000	50 percent
More than $25,000	100 percent.

‘‘(ii) Individuals filing joint returns.—

“If the modified adjusted gross income exceeds the threshold amount by:	**The applicable percentage is:**
Not more than $50,000	50 percent
More than $50,000	100 percent.

‘‘(C) Definition of threshold amount.—For purposes of this subsection, the term ‘threshold amount’ means—

‘‘(i) except as provided in clause (ii), $75,000; and

‘‘(ii) $150,000 in the case of a taxpayer filing a joint return.

‘‘(D) Inflation adjustment for threshold amount.—

‘‘(i) In general.—In the case of any calendar year beginning after 2006, the dollar amount in clause (i) of subparagraph (C) shall be increased by an amount equal to—

‘‘(I) such dollar amount, multiplied by

‘‘(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding calendar year exceeds such average for the 12-month period ending with June 2005.

‘‘(ii) Joint returns.—The dollar amount described in clause (ii) of subparagraph (C) for any calendar year after 2006 shall be increased to an amount equal to twice the amount in effect under clause (i) of subparagraph (C) (after application of this subparagraph).

‘‘(iii) Rounding.—If any dollar amount after being increased under clause (i) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

‘‘(E) Definition of modified adjusted gross income.—For purposes of this subsection, the term ‘modified adjusted gross income’ means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

‘‘(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

‘‘(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

‘‘(F) Joint return.—For purposes of this subsection, the term ‘joint return’ has the meaning given such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

‘‘(2) Determination of modified adjusted gross income.—The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

‘‘(A) Notice.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year. In providing such notice, the Secretary shall use the most recent poverty line available as of the date the notice is sent.

‘‘(B) Calculation based on information provided by beneficiary.—If, during the 60-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with appropriate information (as determined by the Secretary) on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

‘‘(C) Calculation based on notice amount if no information is provided by the beneficiary or if the Secretary determines that the provided information in not appropriate.—The amount initially determined by the Secretary under this paragraph with respect to an individual shall be the amount included in the notice provided to the individual under subparagraph (A) if—

‘‘(i) the individual does not provide the Secretary with information under subparagraph (B); or

‘‘(ii) the Secretary determines that the information provided by the individual to the Secretary under such subparagraph in not appropriate.

‘‘(3) Adjustments.—

‘‘(A) In general.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (2), the Secretary shall increase or decrease the amount of the individual's monthly premium under this part (as the case may be) for months during the following calendar year by an amount equal to $\frac{1}{12}$ of the difference between—

‘‘(i) the total amount of all monthly premiums paid by the individual under this part during the previous calendar year; and

‘‘(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (2) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

‘‘(B) Interest.—

‘‘(i) Increase.—In the case of an individual for whom the amount initially determined by the Secretary under paragraph (2) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (2), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by an amount of interest equal to the sum of the amounts determined under clause (ii) for each of the months described in such clause.

‘‘(ii) Computation.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (2) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (2) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

‘‘(iii) Exception.—Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (2) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

‘‘(C) Steps to recover amounts due from previously enrolled beneficiaries.—In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this part for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium under this part for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

‘‘(D) Deceased beneficiary.—In the case of a deceased individual for whom the amount of the monthly premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

‘‘(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

‘‘(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

‘‘(4) Waiver by secretary.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

"(5) TRANSFER TO PART B TRUST FUND.—

"(A) IN GENERAL.—The Secretary shall transfer amounts received pursuant to this subsection to the Federal Supplementary Medical Insurance Trust Fund.

"(B) DISREGARD.—In applying section 1844(a), amounts attributable to subparagraph (A) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B) thereof."

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting "or section subsection (h)" after "subsections (b) and (e)";

(B) in subsection (a)(3) of section 1839(a), by inserting "or subsection (h)" after "subsection (e)";

(C) in subsection (b), inserting "(and as increased under subsection (h))" after "subsection (a) or (e)"; and

(D) in subsection (f), by striking "if an individual" and inserting the following: "if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))".

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting "or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted," before "he may".

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

"(19) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

"(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Centers for Medicare & Medicaid Services return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the adjusted gross income of such taxpayer,

"(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

"(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

"(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

"(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act."

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3)(A) of section 6103(p) of such Code is amended by striking "or (18)" each place it appears and inserting "(18), or (19)".

(B) Paragraph (4) of section 6103(p) of such Code is amended by striking "or (16)" and inserting "(16), or (19)".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 2006.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(19) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 2002.

SA 1061. Mr. BAUCUS (for Mr. AKAKA (for himself and Mr. INOUYE)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).".

SA 1062. Mr. REID (for Mrs. BOXER) proposed an amendment to amendment SA 974 proposed by Mr. GRASSLEY (for himself, Mr. LEAHY, Ms. CANTWELL, Mr. DURBIN, and Mr. KOHL) the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of the amendment add the following:

"SEC. . NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

"(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

"(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

"(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

"(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A).

SA 1063. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. . MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

SA 1064. Ms. SNOWE (for herself, Mr. ROCKEFELLER, and Mr. SMITH) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . MEDICARE COVERAGE OF ALL ANTICANCER ORAL DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking "chemotherapeutic agent for a given indication," and all that follows and inserting "agent for a medically accepted indication (as defined in subsection (t)(2)(B));".

(b) CONFORMING AMENDMENT.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended by striking "therapeutic".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to drugs furnished during the period that begins on January 1, 2004 and ends on January

1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this subsection had never been enacted.

SA 1065. Mr. BINGAMAN (for himself, Mr. DOMENICI, Ms. MIKULSKI, and Mrs. LINCOLN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 120, between lines 16 and 17, insert the following:

"(I) UPDATE OF ASSET OR RESOURCE TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section that are made on or after January 1, 2009, such determinations shall be made (to the extent a State, as of such date, has not already eliminated the application of an asset or resource test under section 1905(p)(1)(C)) in accordance with the following:

"(i) SELF-DECLARATION OF VALUE.—

"(I) IN GENERAL.—A State shall permit an individual applying for such subsidies to declare and certify by signature under penalty of perjury on the application form that the value of the individual's assets or resources (or the combined value of the individual's assets or resources and the assets or resources of the individual's spouse), as determined under section 1613 for purposes of the supplemental security income program, does not exceed $10,0000 ($20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse).

"(II) ANNUAL ADJUSTMENT.—Beginning on January 1, 2010, and for each subsequent year, the dollar amounts specified in subclause (I) for the preceding year shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

"(ii) METHODOLOGY FLEXIBILITY.—Nothing in clause (i) shall be construed as prohibiting a State in making eligibility determinations for premium and cost-sharing subsidies under this section from using asset or resource methodologies that are less restrictive than the methodologies used under 1613 for purposes of the supplemental security income program.

"(J) DEVELOPMENT OF MODEL DECLARATION FORM.—The Secretary shall—

"(i) develop a model, simplified application form for individuals to use in making a self-declaration of assets or resources in accordance with subparagraph (I)(i); and

"(ii) provide such form to States and, for purposes of outreach under section 1144, the Commissioner of Social Security.".

SA 1066. Mr. BINGAMAN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 137, line 6, strike "Notwithstanding" and insert "Except as provided in paragraph (4) and notwithstanding".

On page 138, line 2, strike "or 'G' " and insert " 'G', or a policy described in paragraph (4)".

On page 138, line 17, insert ", who seeks to enroll with the same issuer who was the issuer of the policy described in clause (ii) of such subparagraph in which the individual was enrolled (unless such issuer does not offer at least one of the policies described in paragraph (4))," after "section 1860D–2(b)(2)".

On page 140, between lines 13 and 14, insert the following:

"(4) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Prescription Drug and Medicare Improvement Act of 2003, with respect to policies issued to individuals who are enrolled in a Medicare Prescription Drug plan under part D or under a contract under section 1860D–3(e), the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that shall be consistent with the following:

"(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

"(i) The policy should provide coverage for benefits other than prescription drugs similar to the coverage for benefits other than prescription drugs provided under a medicare supplemental policy which had a benefit package classified as 'H' before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003.

"(ii) The policy should provide coverage for prescription drugs that—

"(I) compliments, but does not duplicate, the benefits available under part D; and

"(II) does not cover 100 percent of the deductible, copayments, coinsurance (including any cost-sharing applicable under the limitation on out-of-pocket expenditures), or any other cost-sharing applicable under part D.

"(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except that the reference to the benefit package classified as 'H' in clause (i) of such subparagraph is deemed to be a reference to the benefit package classified as 'J'.

(b) REPORT.—The Secretary shall enter into an arrangement with the National Association of Insurance Commissioners (in this section referred to as the "NAIC") under which, not later than 18 months after the date of enactment of this Act, the NAIC shall submit to Congress a report on the medicare supplemental policies described in section 1882(v)(4) of the Social Security Act, as added by subsection (a), that assesses the viability of the policies described in such section and, if viable, the details of those policies.

SA 1067. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, after line 18, add the following:

SEC. . MEDICARE COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C.1395x) is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (U), by striking "and" at the end;

(ii) in subparagraph (V)(iii), by adding "and" at the end; and

(iii) by adding at the end the following new subparagraph:

"(W) kidney disease education services (as defined in subsection (ww));"; and

(B) by adding at the end the following new subsection:

"Kidney Disease Education Services

"(ww)(1) The term 'kidney disease education services' means educational services that are—

"(A) furnished to an individual with kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

"(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

"(C) designed—

"(i) to provide comprehensive information regarding—

"(I) the management of comorbidities;

"(II) the prevention of uremic complications; and

"(III) each option for renal replacement therapy (including peritoneal dialysis, hemodialysis (including vascular access options), and transplantation); and

"(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy.

"(2) The term 'qualified person' means—

"(A) a physician (as described in subsection (r)(1));

"(B) an individual who—

"(i) is—

"(I) a registered nurse;

"(II) a registered dietitian or nutrition professional (as defined in subsection (vv)(2));

"(III) a clinical social worker (as defined in subsection (hh)(1));

"(IV) a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)); or

"(V) a transplant coordinator; and

"(ii) meets such requirements related to experience and other qualifications that the Secretary finds necessary and appropriate for furnishing the services described in paragraph (1); or

"(C) a renal dialysis facility subject to the requirements of section 1881(b)(1) with personnel who—

"(i) provide the services described in paragraph (1); and

"(ii) meet the requirements of subparagraph (A) or (B).

"(3) The Secretary shall develop the requirements under paragraph (2)(B)(ii) after consulting with physicians, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons.

"(4) In promulgating regulations to carry out this subsection, the Secretary shall ensure that such regulations ensure that each beneficiary who is entitled to kidney disease education services under this title receives such services in a timely manner that ensures that the beneficiary receives the maximum benefit of those services.

"(5) The Secretary shall monitor the implementation of this subsection to ensure that beneficiaries who are eligible for kidney disease education services receive such services in the manner described in paragraph (4).".

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ", (2)(W)", after "(2)(S)".

(3) PAYMENT TO RENAL DIALYSIS FACILITIES.—Section 1881(b) of such Act (42 U.S.C. 1395rr(b)), as amended by section 433(b)(5), is further amended by adding at the end the following new paragraph:

"(13) For purposes of paragraph (7), the single composite weighted formulas determined under such paragraph shall not take into account the amount of payment for kidney disease education services (as defined in section 1861(ww)). Instead, payment for such services shall be made to the renal dialysis facility on an assignment-related basis under section 1848.".

(4) ANNUAL REPORT TO CONGRESS.—Not later than April 1, 2004, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the number of medicare beneficiaries who are entitled to kidney disease education services (as defined in section 1861(ww) of the Social Security Act, as added by paragraph (1)) under title XVIII of such Act and who receive such services, together with such recommendations for legislative and administrative action as the Secretary determines to be appropriate to fulfill the legislative intent that resulted in the enactment of that subsection.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date that is 6 months after the date of enactment of this Act.

SA 1068. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, after line 18, add the following:

SEC. . MEDICARE COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V)(iii), by adding "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) diabetes screening tests and services (as defined in subsection (ww));".

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Diabetes Screening Tests and Services

"(ww)(1) The term 'diabetes screening tests' means diagnostic testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

"(A) a fasting plasma glucose test; and

"(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

"(2) For purposes of paragraph (1), the term 'individual at risk for diabetes' means an individual who has any, a combination of, or all of the following risk factors for diabetes:

"(A) A family history of diabetes.

"(B) Overweight defined as a body mass index greater than or equal to 25 kg/m^2.

"(C) Habitual physical inactivity.

"(D) Belonging to a high-risk ethnic or racial group.

"(E) Previous identification of an elevated impaired fasting glucose.

"(F) Identification of impaired glucose tolerance.

"(G) Hypertension.

"(H) Dyslipidemia.

"(I) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

"(J) Polycystic ovary syndrome.

"(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.".

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) in subparagraph (H), by striking "and" at the end;

(2) in subparagraph (I), by striking the semicolon at the end and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(J) in the case of a diabetes screening test or service (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(3).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

SA 1069. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 499, after line 20, insert the following:

SEC. . ELIMINATION OF COST-SHARING FOR BONE MASS MEASUREMENTS.

(a) ELIMINATION OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1)(N) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(N)) is amended—

(A) by inserting "other than bone mass measurement described in section 1861(s)(15)" after "(as defined in section 1848(j)(3))"; and

(B) by adding after the comma at the end the following: "and in the case of such services consisting of such a bone mass measurement, the amounts paid shall be 100 percent of such payment basis,".

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after "1861(s)(10)(A)" the following: ", with respect to bone mass measurement (as defined in section 1861(rr)),".

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395*l*(b)), as amended by section 432(b), is further amended—

(1) by striking "and" before "(5)"; and

(2) by inserting before the period at the end the following: ", and (6) such deductible shall not apply with respect to bone mass measurement (as defined in section 1861(rr))".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2004.

SA 1070. Mr. SCHUMER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 120, strike lines 3 through 16, and insert the following:

"(H) NONAPPLICATION TO DUAL ELIGIBLE INDIVIDUALS.—In the case of an individual who is a dual eligible individual—

"(i) the subsidies provided under this section shall not apply; and

"(ii) such individuals may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with the State medicaid program under title XIX.

On page 122, line 1, strike "and territorial residents".

Beginning on page 149, strike line 22 and all that follows through page 152, line 3, and insert the following:

"(e) DEFINITIONS.—For purposes of this section, the".

On page 152, strike lines 8 through 11, and insert the following:

(2) EXEMPTION FROM FUNDING LIMITATION FOR THE COMMONWEALTH OF PUERTO RICO AND THE TERRITORIES.—

(A) IN GENERAL.—Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

"(3) CERTAIN PAYMENTS DISREGARDED.—The limitations under subsection (f) and the previous provisions of this subsection shall be applied without regard to any payments made for medical assistance for covered drugs (as defined in section 1860D(a)(2)) under title XIX for dual eligible individuals (as defined in section 1860D–19(a)(4)(E) or for any payments made in carrying out section 1935.".

(B) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

SA 1071. Mr. ROCKEFELLER (for himself and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . MEDICARE COVERAGE OF ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking "prescribed for use as an anticancer chemotherapeutic agent" and all that follows and inserting "prescribed for use as—

"(i) an antineoplastic agent for a medically accepted anticancer indication (as defined in subsection (t)(2)(B)), excluding (except as provided in subparagraph (T)) drugs for chemotherapy-induced nausea; or "(ii) an oral alternative to IV-administered medications, but only if the Secretary determines such coverage does not result, as estimated by the Secretary, in expenditures made under this title during any 5-year period that are greater than the expenditures that would have been made under this title during such period if such coverage was not provided.".

(b) Conforming Amendment.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended to read as follows:

"(iv) oral drugs described in section 1861(s)(2)(Q); and".

(c) Effective Date.—The amendments made by this section shall apply only with respect to drugs furnished during the period that begins on or after the date that is 90 days after the date of the enactment of this Act and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this section had never been enacted.

SA 1072. Mr. ROCKEFELLER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . MEDICARE COVERAGE OF ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS; PUBLIC DISCLOSURE OF MARKET-BASED DRUG PRICING INFORMATION.

(a) Medicare Coverage of All Antineoplastic and Certain Other Drugs.—

(1) In general.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking "prescribed for use as an anticancer chemotherapeutic agent" and all that follows and inserting "prescribed for use as—

"(i) an antineoplastic agent for a medically accepted anticancer indication (as defined in subsection (t)(2)(B)), excluding (except as provided in subparagraph (T)) drugs for chemotherapy-induced nausea; or

"(ii) an oral alternative to IV-administered medications, but only if the Secretary determines such coverage does not result, as estimated by the Secretary, in expenditures made under this title during any 5-year period that are greater than the expenditures that would have been made under this title during such period if such coverage was not provided.".

(2) Conforming amendment.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended to read as follows:

"(iv) oral drugs described in section 1861(s)(2)(Q); and".

(3) Effective date.—The amendments made by this subsection shall apply only with respect to drugs furnished during the period that begins on or after the date that is 90 days after the date of the enactment of this Act and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this subsection had never been enacted.

(b) Public Disclosure of Market-Based Drug Pricing Information.—

(1) In general.—Section 1927(b)(3)(D) (42 U.S.C. 1396r–8(b)(3)(D)) is amended to read as follows:

"(D) Public availability of information.—

"(i) Timely availability of information.—Notwithstanding any other provision of law, with respect to a manufacturer with an agreement in effect under this section, not later than 30 days after the date the Secretary receives from such manufacturer the information required to be reported under this paragraph (or verifies such information with a wholesaler), the Secretary shall make the information described in clause (ii), including the identity of the manufacturer to which the information applies, publicly available through the Internet or other means of communication.

"(ii) Information described.—The information described in this clause is the following:

"(I) Average manufacturer's price.—The average manufacturer price (as defined in subsection (k)(1)) for each of the manufacturer's covered outpatient drugs.

"(II) Best price.—With respect to single source drugs and innovator multiple source drugs, the manufacturer's best price (as defined in subsection (c)(1)(C)) for each of the manufacturer's covered outpatient drugs.

"(III) Base average manufacturer price and initial average manufacturer price for newly marketed drugs used to determine an additional rebate for single source and innovator multiple source drugs.—The average manufacturer price described in subparagraphs (A)(ii)(II) (without regard to the percentage increase determined under that subparagraph) and (B) of subsection (c)(2) for each dosage form and strength of a single source drug or an innovator multiple source drug used to determine, with respect to a rebate period, an additional rebate for such dosage form and strength for such a drug.

"(iii) Nondisclosure of certain information.—Notwithstanding any other provision of law, information disclosed by manufacturers (or verified with wholesalers) under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A) may not be disclosed except—

"(I) as the Secretary determines to be necessary to carry out this section;

"(II) to permit the Comptroller General to review the information provided; or

"(III) to permit the Director of the Congressional Budget Office to review the information provided. .

"(iv) Rule of construction.—Nothing in this subparagraph shall be construed as affecting any requirement applicable to the Secretary of Veterans Affairs regarding the confidentiality of information required to be disclosed to the Secretary of Veterans Affairs by a manufacturer under section 8126 of title 38, United States Code.".

(2) Effective date; implementation.—

(A) Effective date.—The amendments made by paragraph (1) take effect upon the date of enactment of this Act and apply to the most recent reported price information under section 1927(b)(3) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)) as of such date, and all such information reported under such section after such date.

(B) Additional period for implementation.—Notwithstanding the 30-day requirement for the public availability of market-based drug pricing information under section 1927(b)(3)(D)(i) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)(i)), with respect to the initial public availability of such information, the Secretary of Health and Human Services shall have up to 90 days from the date of the enactment of this Act in which to make such information so available.

(3) Authorization of appropriations.—There are authorized to be appropriated to carry out section 1927(b)(3)(D) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)), as amended by this subsection, such sums as may be necessary to carry out such section. Amounts appropriated pursuant to this subsection shall be in addition to amounts otherwise appropriated to carry out title XIX of such Act (42 U.S.C. 1396 et seq.).

SA 1073. Mr. SMITH (for himself, Mr. Feingold, and Ms. Cantwell) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 379, strike lines 9 through 13, and insert:

"(A) In General.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

"(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

"(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

SA 1074. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title IV, add the following:

SEC. . IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) In General.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting "consistent with subsection (j)" after "the Secretary shall ensure"; and

(B) by adding at the end the following new subsection:

"(j) National Coverage Determination Process.—

"(1) Timeframe for decisions on requests for national coverage determinations.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

"(2) Process for public comment in national coverage determinations.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

"(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

"(B) provide a 30-day period for public comment on such draft;

"(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

"(D) include in such final decision summaries of the public comments received and responses thereto;

"(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

"(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C).

"(3) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term 'national coverage determination' has the meaning given such term in section 1869(f)(1)(B).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

SA 1075. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 676, after line 22, add the following:

SEC. . EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking "until December 31, 2002", and

(2) by striking "Kent Community Hospital Complex in Michigan or."

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SA 1076. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 438, between lines 10 and 11, insert the following:

SEC. . COMPREHENSIVE CANCER CENTERS.

(a) IN GENERAL.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by striking "or" at the end of subclause (III);

(B) by striking the semicolon at the end of subclause (IV) and inserting ", or"; and

(C) by inserting after subclause (IV) the following:

"(IV) a hospital that is a nonprofit corporation, the sole member of which was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that specifies in its articles of incorporation that at least 50 percent of its total discharges must have a principal finding of neoplastic disease, as defined in subparagraph (E), and that is a freestanding facility licensed for less than 131 acute care beds;"; and

(2) in subparagraph (E), by striking "(II) and (III)" and inserting "(II), (III), and (IV)".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning after the date of enactment of this Act.

SA 1077. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 438, between lines 10 and 11, insert the following:

SEC. . REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting "subject to subparagraph (I)," after "October 1, 1997,";

(2) in subparagraph (H)(i), by inserting "and subject to subparagraph (I)," after "subparagraphs (F) and (G),"; and

(3) by adding at the end the following new subparagraph:

"(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

"(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

"(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

"(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

"(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

"(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

"(ii) REDISTRIBUTION.—

"(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

"(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

"(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

"(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

"(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

"(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

"(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

"(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

"(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.".

(b) NO APPLICATION OF INCREASE TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: "The provisions of subsection (h)(4)(I) (determined without regard to clause (ii) thereof) shall apply with respect to the first sentence of this clause in the same manner as such provisions apply with respect to subparagraph (F) of such subsection.".

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(i)(II) of the Social Security Act (as added by subsection (a)).

SA 1078. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . REVISION OF ALTERNATIVE GUIDELINES FOR GEOGRAPHIC RECLASSIFICATION OF CERTAIN DISPROPORTIONATELY LARGE HOSPITALS.

Section 4409(b) of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) is amended—

(1) in paragraph (1)—

(A) by inserting "(A)" after "(1)";

(B) by adding "or" after the semicolon at the end; and

(C) by adding at the end the following new subparagraph:

"(B) beginning with fiscal year 2003, the hospital is the only hospital located in such an Area";

(2) in paragraph (2), by inserting "in the case of a hospital described in paragraph (1)(A)," before "not less than 40 percent"; and

(3) in paragraph (3), by inserting "for fiscal years before 2003," before "the hospital submitted an application".

SA 1079. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . RECLASSIFICATION OF CERTAIN RURAL COUNTIES FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) In General.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal years 2003, 2004, and 2005, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), a hospital located in a rural county in a State that is adjacent to 1 or more urban areas is deemed to be located in the urban metropolitan statistical area from which the greatest number of hospital employees commute, if—

(1) the rural county is surrounded by urban metropolitan statistical areas; and

(2) the hospital would be reclassified as being located in an adjacent urban metropolitan statistical area for purposes of determining the wage index and the standardized amount applicable to the hospital but for a requirement that the hospital have a wage index that is 106 percent of its applicable rural wage index.

(b) Treatment as Decision of Medicare Geographic Classification Review Board.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(c) Process for Applications To Ensure that Provisions Apply Beginning October 1, 2003.—The Secretary of Health and Human Services shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) Adjustments To Ensure Budget Neutrality.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary of Health and Human Services shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or less than those that would otherwise be made if this section had not been enacted.

SA 1080. Mr. DEWINE (for himself and Mr. DURBIN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements to the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS.

(a) Comprehensive Coverage of Immunosuppressive Drugs Under the Medicare Program.—

(1) In General.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended by striking ", to an individual who receives" and all that follows before the semicolon at the end and inserting "to an individual who has received an organ transplant".

(2) Effective Date.—The amendment made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(b) Provision of Appropriate Coverage of Immunosuppressive Drugs Under the Medicare Program for Organ Transplant Recipients.—

(1) Continued entitlement to immunosuppressive drugs.—

(A) Kidney transplant recipients.—Section 226A(b)(2) (42 U.S.C. 426–1(b)(2)) is amended by inserting "(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))" after "shall end".

(B) Other transplant recipients.—The flush matter following paragraph (2)(C)(ii)(II) of section 226(b) (42 U.S.C. 426(b)) is amended by striking "of this subsection)" and inserting "of this subsection and except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))".

(C) Application.—Section 1836 (42 U.S.C. 1395o) is amended—

(i) by striking "Every individual who" and inserting "(a) In General.—Every individual who"; and

(ii) by adding at the end the following new subsection:

"(b) Special Rules Applicable to Individuals Only Eligible for Coverage of Immunosuppressive Drugs.—

"(1) In general.—In the case of an individual whose eligibility for benefits under this title has ended except for the coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2), the following rules shall apply:

"(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

"(B) The individual shall be responsible for the full amount of the premium under section 1839 in order to receive such coverage.

"(C) The provision of such drugs shall be subject to the application of—

"(i) the deductible under section 1833(b); and

"(ii) the coinsurance amount applicable for such drugs (as determined under this part).

"(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

"(2) Establishment of procedures in order to implement coverage.—The Secretary shall establish procedures for—

"(A) identifying beneficiaries that are entitled to coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2); and

"(B) distinguishing such beneficiaries from beneficiaries that are enrolled under this part for the complete package of benefits under this part.".

(D) Technical amendment.—Subsection (c) of section 226A (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) Extension of secondary payer requirements for ESRD beneficiaries.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: "With regard to immunosuppressive drugs furnished on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, this subparagraph shall be applied without regard to any time limitation.".

(3) Effective date.—The amendments made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(c) Plans Required to Maintain Coverage of Immunosuppressive Drugs.—

(1) Application to certain health insurance coverage.—

(A) In general.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

"SEC. 2707. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

"A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such requirement shall be deemed to be incorporated into this section.".

(B) Conforming amendment.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting "(other than section 2707)" after "requirements of such subparts".

(2) Application to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

"SEC. 714. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

"A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such requirement shall be deemed to be incorporated into this section.".

(B) CONFORMING AMENDMENTS.—

(i) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking "section 711" and inserting "sections 711 and 714".

(ii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

"Sec. 714. Coverage of immunosuppressive drugs.".

(3) APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(A) in the table of sections, by inserting after the item relating to section 9812 the following new item:

"Sec. 9813. Coverage of immunosuppressive drugs.";

and

(B) by inserting after section 9812 the following:

"SEC. 9813. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

"A group health plan shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such requirement shall be deemed to be incorporated into this section.".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2004.

SA 1081. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 476, between lines 5 and 6, insert the following:

(10) EXEMPTION FOR CERTAIN INHALATION DRUGS AND BIOLOGICALS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) (7) and (9), is amended by adding at the end the following new paragraph:

"(10)(A) Notwithstanding the preceding provisions of this subsection, in the case of existing inhalation drugs and biologicals furnished on or after January 1, 2004, and before January 1, 2011, the payment rate for such drugs and biologicals shall be 95 percent of the average wholesale price (as in effect on June 30, 2003).

"(B) During the period described in subparagraph (A), the Secretary may not make any increased or separate payments under paragraph (8) with respect to existing inhalation drugs and biologicals.

"(C) For purposes of this paragraph, the term 'existing inhalation drugs and biologicals' means inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) that are first available for payment under this part on or before June 30, 2003.".

SA 1082. Mr. CONRAD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . ACCELERATING THE RATE OF REDUCTION OF BENEFICIARY COPAYMENT LIABILITY UNDER THE MEDICARE HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.

Section 1833(t)(8)(C)(ii) (42 U.S.C. 1395l(t)(8)(C)(ii)) is amended—

(1) in subclause (V), by striking "and thereafter" and inserting "through 2008"; and

(2) by adding at the end the following new subclauses:

"(VI) For procedures performed in 2009, 36 percent.

"(VII) For procedures performed in 2010 and 2011, 34 percent.

"(VIII) For procedures performed in 2012, 32 percent.

"(IX) For procedures performed in 2013 and thereafter, 30 percent.".

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1083. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Stearns County, Minnesota, such county is deemed to be located in the Minneapolis-St. Paul, Minnesota-Wisconsin, Metropolitan Statistical Area.

(b) BUDGET NEUTRALITY.—The Secretary shall adjust the area wage index referred to in subsection (a) in a manner which assures that the appropriate payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than those which would have be made in the year if this section did not apply.

SA 1084. Mr. VOINOVICH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 152, between lines 7 and 8, and insert the following:

"(g) STATE OPTION TO PAY MEDICARE PART D PRICE FOR COVERED OUTPATIENT DRUGS FOR DUAL ELIGIBLE INDIVIDUALS.—Notwithstanding any provision of title XVIII, or section 1927(c)(1)(C)(i), with respect to a State that provides medical assistance for a covered drug (as such term is defined in section 1860D(a)(2)) for a dual eligible individual enrolled under the State plan under this title (or under a waiver of such plan) that is also a covered outpatient drug (as defined for purposes of in section 1927) included on the State formulary established under section 1927, if the price the State would pay for the drug under this title exceeds the price that an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan would pay for the drug under title XVIII, the State may elect to pay the price that applies under title XVIII. An election by a State under the preceding sentence shall have no effect on the terms of a rebate agreement entered into under section 1927 which would otherwise apply to the provision of medical assistance for the covered outpatient drug.".

SA 1085. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating "tolerance" corridors for variations around the update target trend.

SA 1086. Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 37, strike lines 4 and 5 and insert "reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.".

On page 165, strike lines 4 and 5 and insert "into account reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.".

SA 1087. Mr. GRASSLEY (for Mr. CRAIG) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title II, add the following:

SEC. . ESTABLISHMENT OF MEDICAREADVANTAGE CONSUMER-DRIVEN HEALTH PLAN OPTION.

(a) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.), amended by section 205, is amended by inserting after section 1858A the following new section:

"CONSUMER-DRIVEN HEALTH PLAN OPTION

"SEC. 1858B. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—Beginning on January 1, 2006, there is established a consumer-driven health plan program under which consumer-driven health plans offered by consumer-driven health plan sponsors are offered to MedicareAdvantage eligible individuals in preferred provider regions.

"(2) DEFINITIONS.—

"(A) CONSUMER-DRIVEN HEALTH PLAN SPONSOR.—The term 'consumer-driven health plan sponsor' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to consumer-driven health plan sponsors.

"(B) CONSUMER-DRIVEN HEALTH PLAN.—The term 'consumer-driven health plan' means a MedicareAdvantage plan that—

"(i) provides 100 percent coverage for preventive benefits (as defined by the Secretary);

"(ii) includes a personal care account from which enrollees must pay out-of-pocket costs until the deductible is met; and

"(iii) has a high deductible (as determined by the Secretary).

"(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' has the meaning given that term under section 1858(a)(2)(C).

"(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

"(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to consumer-driven health plans offered by a consumer-driven health plan sponsor.

"(2) SERVICE AREA.—The service area of a consumer-driven health plan shall be a preferred provider region.

"(3) AVAILABILITY.—Each preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

"(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

"(5) ASSURING ACCESS TO SERVICES IN CONSUMER-DRIVEN HEALTH PLANS.—The requirements of section 1858(a)(5) shall apply to consumer-driven health plans.

"(6) PERSONAL CARE ACCOUNTS.—

‘‘(A) ESTABLISHMENT.—Each consumer-driven health plan shall establish a personal care account on behalf of each enrollee from which such enrollee shall be required to pay out-of-pockets costs until the deductible described in subsection (a)(2)(B)(iii) is met.

‘‘(B) ROLLOVER.—Subject to subparagraph (C), any amounts remaining in a personal care account at the end of a year shall be credited to such an account for the subsequent year.

‘‘(C) CHANGES OF ELECTION.—If, after electing a consumer-driven health plan, a beneficiary elects a plan under this part that is not a consumer-driven health plan during a subsequent year or elects to receive benefits under the original medicare fee-for-service program option (whether or not as a result of circumstances described in section 1851(e)(4)), any amounts remaining in the account as of the date of such election shall be credited to the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 in such proportion as the Secretary determines is appropriate.

‘‘(c) PAYMENTS TO CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

‘‘(1) PAYMENTS TO ORGANIZATIONS.—

‘‘(A) MONTHLY PAYMENTS.—

‘‘(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsections (e) and (i), and section 1859(e)(4), the Secretary shall make, to each consumer-driven health plan sponsor, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

‘‘(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

‘‘(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

‘‘(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a consumer-driven health plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

‘‘(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

‘‘(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

‘‘(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

‘‘(2) APPLICATION OF PREFERRED PROVIDER BENCHMARKS.—The benchmark amounts calculated under section 1858(c)(2) shall apply with respect to consumer-driven health plans.

‘‘(3) APPLICATION OF PREFERRED PROVIDER PAYMENT FACTORS.—The provisions of section 1858(c)(3) shall apply with respect to consumer driven health plans.

‘‘(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

‘‘(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii).

‘‘(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The preferred provider regional benchmark calculated under section 1858(c)(4)(B) shall apply with respect to consumer-drive health plans amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii).

‘‘(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

‘‘(i) the payment amount under subparagraph (D); and

‘‘(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

‘‘(D) DETERMINATION OF PAYMENT AMOUNT.—

‘‘(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a consumer-driven health plan sponsor for a consumer-driven health plan as follows:

‘‘(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

‘‘(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

‘‘(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in section 1858(c)(3)(A)(ii).

‘‘(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

‘‘(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to consumer-driven health plan sponsors in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

‘‘(5) PAYMENTS FROM TRUST FUND.—The payment to a consumer-driven health plan sponsor under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

‘‘(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect consumer-driven health plan sponsors.

‘‘(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to consumer-driven health plan sponsors.

‘‘(d) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLANS; PREMIUMS.—

‘‘(1) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

‘‘(A) IN GENERAL.—For the requirements on submissions by consumer-driven health plans, see section 1854(a)(1).

‘‘(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

‘‘(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan must reasonably and equitably reflect the cost of benefits provided under that plan.

‘‘(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the consumer-driven health plan sponsor with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

‘‘(E) NO LIMIT ON NUMBER OF PLANS IN A REGION.—The Secretary may not limit the number of consumer-driven health plans offered in a preferred provider region.

‘‘(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a consumer-driven health plan offered by a consumer-driven health plan sponsor shall be equal to the sum of the following:

‘‘(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

‘‘(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

‘‘(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

‘‘(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to consumer-driven health plan sponsors.

‘‘(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a consumer-driven health plan sponsor to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

"(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

"(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

"(A) IN GENERAL.—For 2007 and 2008, the consumer-driven health plan sponsor offering a consumer-driven health plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

"(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

"(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

"(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

"(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a consumer-driven health plan may not exceed an amount determined appropriate by the Administrator.

"(2) ADJUSTMENT OF PAYMENT.—

"(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the consumer-driven health plan sponsor offering the plan.

"(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

"(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

"(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

"(II) 10 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

"(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

"(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

"(ii) 10 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

"(3) ESTABLISHMENT OF RISK CORRIDORS.—

"(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each consumer-driven health plan. The risk corridor for a plan for a year shall be equal to a range as follows:

"(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 5 percent of such target amount.

"(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 10 percent of such target amount.

"(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (i)(II).

"(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (ii)(II).

"(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a consumer-driven health plan offered by a consumer-driven health plan sponsor in a year, an amount equal to the sum of—

"(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

"(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

"(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A consumer-driven health plan sponsor that offers a consumer-driven health plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

"(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

"(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a consumer-driven health plan sponsor and a consumer-driven health plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

"(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—A consumer-driven health plan sponsor shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a consumer-driven health plan.

"(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to consumer-driven health plan sponsors.

"(h) CONTRACTS WITH CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—The provisions of section 1857 shall apply to a consumer-driven health plan offered by a consumer-driven health plan sponsor under this section.

"(i) BUDGET NEUTRALITY.—Notwithstanding any other provision of this section, in conducting the program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under this title do not exceed the amount the Secretary would have paid if this section had not been enacted.".

(b) CONSUMER-DRIVEN HEALTH PLAN TERMINOLOGY DEFINED.—Section 1859(a) (42 U.S.C. 1395w–29(a)), as amended by section 211(b), is amended by adding at the end the following new paragraph:

"(4) CONSUMER-DRIVEN HEALTH PLAN SPONSOR; CONSUMER-DRIVEN HEALTH PLAN.—The terms 'consumer-driven health plan sponsor' and 'consumer-driven health plan' have the meaning given such terms in section 1858B(a)(2).".

SA 1088. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and for which the PPS amount is less than the pre-BBA amount the amount of payment under this subsection shall be increased by the amount of such difference. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

SA 1089. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

SA 1090. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "clinical social worker services," after "qualified psychologist services,".

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking "and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.

SA 1091. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of title VI, add the following:

SEC. . EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking "December 31, 2004, but only with respect to" and all that follows and inserting "December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.".

SA 1092. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle C of title II, add the following:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

"(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

"(1) ANNUAL DETERMINATION AND DESIGNATION.—

"(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D–11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

"(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

"(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

"(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

"(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

"(iii) Whether the Secretary expects that MedicareAdvantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

"(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

"(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

"(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

"(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

"(3) SUBMISSION OF BIDS.—

"(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

"(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

"(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

"(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

"(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

"(5) FUNDING LIMITATION.—

"(A) IN GENERAL.—

"(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period or year, as applicable, may not exceed the applicable amount (as defined in clause (ii)).

"(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term 'applicable amount' means—

"(I) for the period beginning on January 1, 2009, and ending on September 30, 2013, the total amount that would have been expended under this title during the period if this subsection had not been enacted plus $6,000,000,000; and

"(II) for fiscal year 2014 and any subsequent fiscal year, the total amount that would have been expended under this title during the year if this subsection had not been enacted.

"(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

"(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

"(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

"(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

"(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

“(6) Limitation of judicial review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

“(7) Secretary reports.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

“(A) a detailed description of—

“(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(iii) amounts remaining within the funding limitation specified in paragraph (5); and

“(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

“(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

“(8) Biennial GAO reports.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

“(A) an evaluation of—

“(i) the quality of care provided to beneficiaries enrolled in a MedicareAdvantage preferred provider plan in a highly competitive region;

“(ii) the satisfaction of beneficiaries with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.”.

(b) Conforming Amendment.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

“(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.”.

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) Establishment.—

(1) Review and report on results of existing demonstrations.—

(A) Review.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) Report.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) Projects.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) Enhanced benefits or services.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) Project Sites and Duration.—

(1) In general.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that the region or regions are designated as such a highly competitive region.

(2) Rule of construction.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) Biennial GAO Reports.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) Funding.—

(1) In general.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) Limitation.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) Monitoring and reports.—

(A) Ongoing monitoring by the Secretary to ensure funding limitation is not violated.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) Reports.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(4) APPLICATION OF LIMITATION.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) AUTHORITY.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

SA 1093. Mr. KYL proposed an amendment to amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

In lieu of the matter proposed to be inserted, insert the following:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

"(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

"(1) ANNUAL DETERMINATION AND DESIGNATION.—

"(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D-11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

"(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

"(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

"(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

"(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

"(iii) Whether the Secretary expects that MedicareAdvantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

"(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

"(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

"(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

"(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

"(3) SUBMISSION OF BIDS.—

"(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

"(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

"(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

"(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

"(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

"(5) FUNDING LIMITATION.—

"(A) IN GENERAL.—

"(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period beginning on January 1, 2009, and ending on September 30, 2013, may not exceed the applicable amount (as defined in clause (ii)).

"(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term 'applicable amount' means the total amount that would have been expended under this title during the period described in clause (i) if this subsection had not been enacted plus $6,000,000,000.

"(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

"(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

"(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

"(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

"(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

"(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

"(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

"(A) a detailed description of—

"(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

"(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

"(iii) amounts remaining within the funding limitation specified in paragraph (5); and

"(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

"(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

"(8) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

"(A) an evaluation of—

"(i) the quality of care provided to beneficiaries enrolled in a MedicareAdvantage preferred provider plan in a highly competitive region;

"(ii) the satisfaction of beneficiaries with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.”.

(b) Conforming Amendment.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

“(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.”.

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) Establishment.—

(1) Review and report on results of existing demonstrations.—

(A) Review.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) Report.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) Projects.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) Enhanced benefits or services.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) Project Sites and Duration.—

(1) In general.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that the region or regions are designated as such a highly competitive region.

(2) Rule of construction.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) Biennial GAO Reports.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) Funding.—

(1) In general.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) Limitation.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) Monitoring and reports.—

(A) Ongoing monitoring by the Secretary to ensure funding limitation is not violated.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) Reports.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(4) Application of Limitation.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) Authority.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, June 26, 2003, at 11:00 a.m. in Room 485 of the Russell Senate Office Building to conduct a Business Meeting on pending Committee matters.

Those wishing additional information may contact the Indian Affairs Committee at 224-2251.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, June 25, 2003, at 9:30 a.m., in open session to consider the nomination of Lieutenant General John P. Abizaid, USA, for appointment to the grade of General and to be commander, United States Central Command.

The PRESIDING OFFICER. Without objection, is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate, on Wednesday, June 25 at 10:00 a.m. to consider pending calendar business.

On Wednesday, June 25, at 10:00 a.m., the Committee will hold a Business Meeting in Room SD-366 to consider the following items on the Agenda:

Agenda Item #3: S. 470—A bill to extend the authority for the construction of a memorial to Martin Luther King, Jr.

Agenda Item #4: S. 490—A bill to direct the Secretary of Agriculture to convey certain land in the Lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California.

Agenda Item #6: S. 546—A bill to provide for the protection of paleontological resources on Federal lands, and for other purposes.

Agenda Item #7: S. 643—A bill to authorize the Secretary of the Interior, in cooperation with the University of New Mexico, to construct and occupy a portion of the Hibben Center for Archaeological Research at the University of New Mexico.

Agenda Item #8: S. 651—A bill to amend the National Trails System Act to clarify Federal authority relating to land acquisition from willing sellers for the majority of the trails in the System, and for other purposes.

Agenda Item #9: S. 677—A bill to revise the boundary of the Black Canyon of the Gunnison National Park and Gunnison Gorge National Conservation Area in the State of Colorado, and for other purposes.

Agenda Item #10: S. 924—A bill to authorize the exchange of lands between an Alaska Native Village Corporation and the Department of the Interior, and for other purposes.

Agenda Item #13: S. 1076—A bill to authorize construction of an education center at or near the Vietnam Veterans Memorial.

Agenda Item #14: H.R. 255—To authorize the Secretary of the Interior to grant an easement to facilitate access to the Lewis and Clark Interpretative Center in Nebraska City, Nebraska.

Agenda Item #15: H.R. 1577—To designate the visitor center in Organ Pipe National Monument in Arizona as the "Kris Eggle Visitor Center", and for other purposes.

In addition, the Committee may turn to any other measures that are ready for consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 25, 2003 at 9:30 a.m. to hold a hearing on The African Growth and Opportunity Act.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 25, 2003 at 2:00 p.m. to hold a hearing on Constitutionalism, Human Rights and the Rule of Law in the Nation of Iraq.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 25, 2003, at 2:30 p.m. to hold a hearing on The Successor States to Pre-1991 Yugoslavia: Progress & Challenges.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Wednesday, June 25, 2003, at 9:30 a.m. to consider the nomination of the Joshua B. Bolton to be Director of the Office of Management and Budget.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet in Executive Session during the session of the Senate on Wednesday, June 25, 2003. The following agenda will be considered:

Agenda

S. 1248, Individuals with Disabilities Education Improvement Act of 2003.

Any nominees that have been cleared for action.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a hearing on "Oversight Hearing: Lessons Learned—The Inspector General's Report on the 9/11 Detainees" on Wednesday, June 25, 2003, at 10:00 a.m. in the Dirksen Senate Office Building Room 226.

Tentative Witness List

Panel I: The Honorable Glenn A. Fine, Inspector General, Department of Justice, Washington, DC.

Panel II: Harley G. Lappin, Director, Federal Bureau of Prisons, Department of Justice, Washington, DC; Michael E. Rolince, Assistant Director in Charge, Washington Field Office, Federal Bureau of Investigation, Washington, DC; and David Nahmias, Counsel to the Assistant Attorney General, Criminal Division, Department of Justice, Washington, DC.

THE PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a hearing on "Department of Justice and Judicial Nominations" on Wednesday, June 25, 2003, at 2:00 p.m. in the Dirksen Senate Office Building Room 215 [Finance Committee Hearing Room].

Revised Tentative Agenda

Panel I: Senators.

Panel II: Allyson K. Duncan to be United States Circuit Judge for the Fourth Circuit.

Panel III: Robert C. Brack to be United States District Judge for the District of New Mexico; Samuel Der-Yeghiayan to be United States District Judge for the Northern District of Illinois; Louise W. Flanagan to be United States District Judge for the Eastern District of North Carolina; Lonny R. Suko to be United States District Judge for the Eastern District of Washington; and Earl Leroy Yeakel III to be United States District Judge for the Western District of Texas.

Panel IV: Karen P. Tandy to be Administrator of the Drug Enforcement Administration, United States Department of Justice; and Christopher A. Wray to be Assistant Attorney General for the Criminal Division, United States Department of Justice.

THE PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS, AND PROPERTY RIGHTS

SUBCOMMITTEE ON NEAR EASTERN AND SOUTH ASIAN AFFAIRS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on the Constitution, Civil Rights and Property Rights and the Senate Foreign Relations Subcommittee on Near Eastern and South Asian Affairs be authorized to meet to conduct a joint hearing on "Constitutionalism, Human

Rights and the Rule of Law in Iraq," on Wednesday, June 25, 2003, at 2:00 p.m. in SD226.

Tentative Witness List

Panel I: Mr. Sermid Al-Sarraf, Iraqi Jurists Association, Los Angeles, CA; Dr. Khaled Abou El Fadl, Professor of Law, The Omar and Azmeralda Alfi Distinguished Fellow in Islamic Law, UCLA School of Law, Los Angeles, CA; Mr. Bernard Haykel, Assistant Professor of Middle Eastern Studies and History, New York University, New York, NY; Dr. Kenneth M. Pollack, Director of Research, Saban Center for Middle East Policy, Brookings Institution, Washington, DC; and Ms. Zainab Salbi, President and Founder, Women for Women International, Washington, DC.

Panel II: Mr. Naoyuki Agawa, Former Professor of Constitutional Law, Keio University, Minister and Director of the Japan Information and Culture Center, Embassy of Japan, Washington, DC; Mr. A. E. Dick Howard, White Burkett Miller Professor of Law and Public Affairs, Roy L. and Rosamond Woodruff Morgan Research Professor, University of Virginia School of Law, Charlottesville, VA; Dr. Donald P. Kommers, Joseph and Elizabeth Robbie Professor of Government and International Studies, University of Notre Dame, Professor of Law, Notre Dame Law School, Notre Dame, IN; Mr. Neil J. Kritz, Director, Rule of Law Program, U.S. Institute of Peace, Washington, DC; and Mr. John C. Yoo, Professor of Law, Boalt Hall School of Law, University of California at Berkeley, Visiting Fellow, American Enterprise Institute, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON ECONOMIC POLICY

Mr. SANTORUM. Mr. President, I ask unanimous consent that the subcommittee on economic policy of the committee on banking, housing, and urban affairs be authorized to meet during the session of the Senate on June 25, 2003, at 2:00 p.m. to conduct a hearing on "Jumpstarting the Economy: Rural America."

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON FISHERIES, WILDLIFE AND WATER

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Subcommittee on Fisheries, Wildlife, and Water be authorized to meet on Wednesday, June 25th at 9:30 am to examine the consulting process required by Section 7 of the Endangered Species Act.

The hearing will take place in SD 406 (Hearing Room).

SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS

Mr. SANTORUM. Mr. President, I ask unanimous consent that the subcommittee on public lands and forests of the committee on energy and natural resources be authorized to meet during the session of the Senate on Wednesday, June 25, at 2:30 p.m. in room SD-366. The purpose of this oversight hearing is to gain an understanding of the grazing programs of the Bureau of Land Management and the United States Forest Service. The subcommittee will receive testimony on grazing permit renewal, BLM's potential changes to grazing regulations, range monitoring, drought and other grazing issues.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. THOMAS. Mr. President, I ask unanimous consent that an intern, Samantha Muirhead, be granted privilege of the floor.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. REED. Mr. President, I ask unanimous consent that Dr. Susan Dimock, a fellow in my office, be granted floor privileges for the duration of the debate on S. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that Jennifer Crow, an American Political Science Association fellow in the office of Senator CANTWELL, be given floor privileges during consideration of S. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE PLACED ON THE CALENDAR—S. 1323

Mr. TALENT. Mr. President, I understand S. 1323 is at the desk and is due for its second reading.

The PRESIDING OFFICER. The Senator is correct.

The clerk will read the bill by title for the second time.

The legislative clerk read as follows:

A bill (S. 1323) to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

Mr. TALENT. I object to further proceedings on the measure at this time.

The PRESIDING OFFICER. Objection is heard. The bill will be placed on the calendar.

THE CALENDAR

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed en bloc to the immediate consideration of the following post office naming bills: Calendar No. 150, S. 867; Calendar No. 152, S. 1207; Calendar No. 153, H.R. 825; Calendar No. 154, H.R. 917; Calendar No. 155, H.R. 925; Calendar No. 156, H.R. 981; Calendar No. 157, H.R. 985; Calendar No. 158, H.R. 1055; Calendar No. 159, H.R. 1368; Calendar No. 160, H.R. 1465; Calendar No. 161, H.R. 1596; Calendar No. 162, H.R. 1609; Calendar No. 163, H.R. 1740; and Calendar No. 164, H.R. 2030.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. TALENT. Mr. President, I further ask unanimous consent that the bills be read a third time and passed, the motions to reconsider be laid upon the table, and that any statements relating to the bills be printed in the RECORD, with the above occurring en bloc.

The PRESIDING OFFICER. Without objection, it is so ordered.

RONALD REAGAN POST OFFICE BUILDING

The bill (S. 867) to designate the facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, as the "Ronald Reagan Post Office Building," was considered, ordered to be engrossed for a third reading, read the third time, and passed, as follows:

S. 867

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DESIGNATION OF RONALD REAGAN POST OFFICE BUILDING.

(a) IN GENERAL.—The facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, shall be known and designated as the "Ronald Reagan Post Office Building".

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility referred to in subsection (a) shall be deemed to be a reference to the Ronald Reagan Post Office Building.

WALT DISNEY POST OFFICE BUILDING

The bill (S. 1207) to redesignate the facility of the United States Postal Service located at 120 East Ritchie Avenue in Marceline, Missouri, as the "Walt Disney Post Office Building," was considered, ordered to be engrossed for a third reading, read the third time, and passed, as follows:

S. 1207

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. WALT DISNEY POST OFFICE BUILDING.

(a) REDESIGNATION.—The facility of the United States Postal Service located at 120 East Ritchie Avenue in Marceline, Missouri, and known as the Marceline Main Office, shall be known and designated as the "Walt Disney Post Office Building".

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility referred to in subsection (a) shall be deemed to be a reference to the Walt Disney Post Office Building.

MICHAEL J. HEALY POST OFFICE BUILDING

The bill (H.R. 825) to redesignate the facility of the United States Postal

Service located at 7401 West 100th Place in Bridgeview, Illinois, as the "Michael J. Healy Post Office Building" was considered, ordered to a third reading, read the third time, and passed.

FLOYD SPENCE POST OFFICE BUILDING

This bill (H.R. 917) to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the "Floyd Spence Post Office Building," was considered, ordered to a third reading, read the third time, and passed.

CESAR CHAVEZ POST OFFICE

This bill (H.R. 925) to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the "Cesar Chavez Post Office," was considered, ordered to a third reading, read the third time, and passed.

JAMES R. MERRY POST OFFICE

This bill (H.R. 981) to designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the "James R. Merry Post Office" was considered, ordered to a third reading, read the third time, and passed.

DELBERT L. LATTA POST OFFICE BUILDING

This bill (H.R. 985) to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the "Delbert L. Latta Post Office Building," was considered, ordered to a third reading, read the third time, and passed.

DR. ROSWELL N. BECK POST OFFICE BUILDING

This bill (H.R. 1055) to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the "Dr. Roswell N. Beck Post Office Building," was considered, ordered to a third reading, read the third time, and passed.

NORMAN D. SHUMWAY POST OFFICE BUILDING

The bill (H.R. 1368) to designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the "Norman D. Shumway Post Office Building" was considered, ordered to a third reading, read the third time, and passed.

GENERAL CHARLES GABRIEL POST OFFICE

The bill (H.R. 1465) to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the "General Charles Gabriel Post Office" was considered, ordered to a third reading, read the third time, and passed.

TIMOTHY MICHAEL GAFFNEY POST OFFICE BUILDING

The bill (H.R. 1596) to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the "Timothy Michael Gaffney Postal Office Building" was considered, ordered to a third reading, read the third time, and passed.

ADMIRAL DONALD DAVIS POST OFFICE BUILDING

The bill (H.R. 1609) to redesignate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the "Admiral Donald Davis Post Office Building" was considered, ordered to a third reading, read the third time, and passed.

DR. CAESAR A. W. CLARK, SR. POST OFFICE BUILDING

The bill (H.R. 1740) to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the "Dr. Caesar A. W. Clark, Sr. Post Office Building" was considered, ordered to a third reading, read the third time, and passed.

PATSY TAKEMOTO MINK POST OFFICE BUILDING

The bill (H.R. 2030) to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building" was considered, ordered to a third reading, read the third time, and passed.

SAFETY ON THE INTERNET

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 185 which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 185) expressing the sense of the Senate with respect to raising awareness and encouraging education about safety on the Internet.

There being no objection, the Senate proceeded to consider the resolution.

Ms. MURKOWSKI. Mr. President, I rise in support of this resolution expressing the sense of the Senate with respect to raising awareness and encouraging education about safety on the Internet and supporting the goals and ideals of National Internet Safety Month.

The Internet has become one of the most significant advances in the twentieth century and, as a result, it affects people's lives in a positive manner each day. However, this technology is fraught with dangers that need to be brought to the attention of all Americans.

Never before has the problem of online predatory behavior been more of a concern. Consider the pervasiveness of Internet access by children and the rapid increase in Internet crime and predatory behavior. Never before have powerful educational solutions—like Internet safety curricula for grades kindergarten through 12, youth empowerment Internet safety campaigns and community-based Internet safety awareness presentations with the formation of community action teams, such as what I-Safe America, a nonprofit Internet safety foundation, does—been more critical and readily at hand. It is imperative that every community in every state be apprised of the increase in Internet-based criminal activity so that all Americans may learn about the Internet safety strategies which will enable them to keep their children safe from victimization. Consider the facts: Worldwide, 70 million youth under the age of 18 are online. This is considered to be a conservative estimate since it is projected that there are two million new Internet users per month in America alone. The Family/PC Survey in 2000 reported that 1 in 4 kids participate in real-time online chats. The Pew Study reported in the Journal of the American Medical Association in June 2001 that 13 million youth use Instant Messaging and that 89 percent of sexual solicitations were made in either chat rooms or Instant Messages. One in five teenagers who are online note that they have received unwanted sexual solicitations, according to the Crimes Against Children Research Center in a study completed in 2000.

It's important to note that while it's reported that 90 percent of teens and young adults ages 15 to 24 go online and half of them go online once a day or more, three out of four young people have access at home and nearly one in three has access from their own bedroom, according to the Kaiser Family Foundation. According to a 1999 Arbitron New Media study, the majority of teenagers' online use occurs at home, right after school, when working parents are not at home. Thirty percent of the girls responding to a 2002 Girl Scout Research Institute study, "The Net Effect: Girls and New

Media," said they had been sexually harassed in a chat room, but only seven percent told a parent about the harassment, most fearing their parents would overreact and ban computer usage altogether.

From a parental perspective, 75 percent of parents say that they know where their children spend time online. The truth about kids' Internet habits, according to WebSense, USA Today, and the National Foster Parent Association show that 58 percent of teens say they have accessed an objectionable website. A 2000 Time/CNN poll indicated that 43 percent of children say they do not have rules about Internet use in their homes. Also, 62 percent of parents of teenagers are unaware that their children have accessed objectionable websites, according to a Yankelovich Partners Study. According to the London School of Economics, 9 out of 10 children between the ages of 8 and 16 have viewed pornography on the Internet. In most cases, sex websites were accessed unintentionally when a child, often in the process of doing homework, used a seemingly innocent sounding word to search for information or pictures.

Most disturbing, however, are the patterns of Internet crimes against children. In 1996, the Federal Bureau of Investigation was involved in 113 cases involving Internet crimes against children. In 2001, the FBI opened 1,541 cases against people suspected of using the Internet to commit crimes involving child pornography or abuse. The U.S. Customs Service now places the number of websites offering child pornography at more than 100,000. Moreover, there was a 345 percent increase in the production of these sites just between February 2001 and July 2001, according to a recent study. The FBI notes that child pornography and the sexual exploitation of children through online means is the most significant crime problem it confronts.

Now is the time for America to focus its attention on supporting Internet safety, especially now that children are now on summer vacation and will subsequently spend more time online. Recent Internet crime trends indicate a call to action as it pertains to national Internet safety awareness at all levels.

Mr. TALENT. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and any statements relating to this matter be printed in the Record.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 185) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. Res. 185

Whereas, in the United States, 48 million children between the ages of 5 and 17 use computers;

Whereas 5 to 17 year-olds in the United States currently spend 5 billion hours on-line annually;

Whereas 70 million youth under the age of 18 worldwide are on-line;

Whereas the majority of teenagers' on-line use occurs after school, at home, when working parents are not at home;

Whereas 90 percent of those age 15 to 24 use the Internet, with almost half of them using it once a day or more;

Whereas approximately 3 out of 4 young people have access to the Internet at home, and nearly 1 in 3 has access from their own bedroom;

Whereas 9 out of 10 children between ages 8 and 16 have viewed pornography on the Internet, with most being accessed unintentionally when, often in the process of doing homework, a child used a seemingly innocent sounding word in an Internet search for information or pictures;

Whereas 62 percent of parents of teenagers are unaware that their children have accessed objectionable websites;

Whereas 89 percent of sexual solicitations were made in either chat rooms or Instant Messages;

Whereas 30 percent of the girls responding to a Girl Scout research study reported that they had been sexually harassed in a chat room, but only 7 percent told a parent about the harassment, most fearing their parents would overreact and ban computer usage altogether;

Whereas, in 1996, the Federal Bureau of Investigation was involved in 113 cases involving Internet crimes against children, but in 2001, the FBI opened 1,541 cases against suspects of Internet crimes involving child pornography or abuse; and

Whereas June as National Internet Safety Month will provide national awareness of the dangers of the Internet while offering education about how to be safe, responsible, and accountable on the Internet: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) National Internet Safety Month provides an opportunity to educate the people of the United States on the dangers of the Internet and the importance of being safe and responsible on-line;

(2) national and community organizations should be recognized and applauded for their work in promoting awareness of the dangers of the Internet and for providing information on developing the critical thinking and decision-making skills to be safe on-line; and

(3) Internet safety organizations, law enforcement, educators, and volunteers should increase their efforts to raise the awareness of on-line safety.

ENVIRONMENTAL POLICY AND CONFLICT RESOLUTION ADVANCEMENT ACT OF 2003

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 64, S. 163.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 163) to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. TALENT. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the Record.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 163) was read the third time and passed, as follows:

S. 163

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Environmental Policy and Conflict Resolution Advancement Act of 2003".

SEC. 2. ENVIRONMENTAL DISPUTE RESOLUTION FUND.

Section 13 of the Morris K. Udall Scholarship and Excellence in National Environmental and Native American Public Policy Act of 1992 (20 U.S.C. 5609) is amended by striking subsection (b) and inserting the following:

"(b) Environmental Dispute Resolution Fund.—There is authorized to be appropriated to the Environmental Dispute Resolution Fund established by section 10 $4,000,000 for each of fiscal years 2004 through 2008, of which—

"(1) $3,000,000 shall be used to pay operations costs (including not more than $1,000 for official reception and representation expenses); and

"(2) $1,000,000 shall be used for grants or other appropriate arrangements to pay the costs of services provided in a neutral manner relating to, and to support the participation of non-Federal entities (such as State and local governments, tribal governments, nongovernmental organizations, and individuals) in, environmental conflict resolution proceedings involving Federal agencies.".

RECOGNITION OF JOSEPH A. DE LAINE

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 167, S. 498.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 498) to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine in recognition of his contributions to the Nation.

There being no objection, the Senate proceeded to consider the bill.

Mr. TALENT. Mr. President, I ask unanimous consent that the committee amendment be agreed to, the bill, as amended, be read three times, passed, the motion to reconsider be laid upon the table, and any statements relating thereto be printed in the Record with no intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendment was agreed to.

The bill (S. 498), as amended, was read the third time and passed, as follows:

S. 498

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FINDINGS.

Congress finds that—

(1) the Reverend Joseph Armstrong De Laine, one of the true heroes of the civil rights struggle, led a crusade to break down barriers in education in South Carolina;

(2) the efforts of Reverend De Laine led to the desegregation of public schools in the United States, but forever scarred his own life;

(3) in 1949, Joseph De Laine, a minister and principal, organized African-American parents in Summerton, South Carolina, to petition the school board for a bus for black students, who had to walk up to 10 miles through corn and cotton fields to attend a segregated school, while the white children in the school district rode to and from school in nice, clean buses;

(4) in 1950, these same parents sued to end public school segregation in Briggs v. Elliott, 1 of 5 cases that collectively led to the landmark 1954 Supreme Court decision of Brown v. Board of Education;

(5) because of his participation in the desegregation movement, Reverend De Laine was subjected to repeated acts of domestic terror, in which—

(A) he, along with 2 sisters and a niece, lost their jobs;

(B) he fought off an angry mob;

(C) he received frequent death threats; and

(D) his church and his home were burned to the ground;

(6) in October 1955, after Reverend De Laine relocated to Florence County in South Carolina, shots were fired at the De Laine home, and because Reverend De Laine fired back to mark the car, he was charged with assault and battery with intent to kill;

(7) the shooting incident drove him from South Carolina to Buffalo, New York, where he organized an African Methodist Episcopal Church;

(8) believing that he would not be treated fairly by the South Carolina judicial system if he returned to South Carolina, Reverend De Laine told the Federal Bureau of Investigation, "I am not running from justice but injustice", and it was not until 2000 (26 years after his death and 45 years after the incident) that Reverend De Laine was cleared of all charges relating to the October 1955 incident;

(9) Reverend De Laine was a humble and fearless man who showed the Nation that all people, regardless of the color of their skin, deserve a first-rate education, a lesson from which the Nation has benefited immeasurably; and

(10) Reverend De Laine deserves rightful recognition for the suffering that he and his family endured to teach the Nation one of the great civil rights lessons of the last century.

SEC. 2. CONGRESSIONAL GOLD MEDAL.

(a) PRESENTATION AUTHORIZED.—The President is authorized, on behalf of Congress, to award a gold medal of appropriate design to Joseph De Laine, Jr. to honor his father, Reverend Joseph Armstrong De Laine (posthumously), for his contributions to the Nation.

(b) DESIGN AND STRIKING.—For the purposes of the award referred to in subsection (a), the Secretary of the Treasury (hereafter in this Act referred to as the "Secretary") shall strike a gold medal with suitable emblems, devices, and inscriptions, to be determined by the Secretary.

SEC. 3. DUPLICATE MEDALS.

The Secretary may strike and sell duplicates in bronze of the gold medal struck pursuant to section 2, under such regulations as the Secretary may prescribe, and at a price sufficient to cover the costs thereof, including labor, materials, dies, use of machinery, and overhead expenses, and the cost of the gold medal.

SEC. 4. STATUS AS NATIONAL MEDALS.

The medals struck pursuant to this Act are national medals for purposes of chapter 51 of title 31, United States Code.

SEC. 5. FUNDING.

(a) AUTHORITY TO USE FUND AMOUNTS.—There is authorized to be charged against the United States Mint Public Enterprise Fund an amount not to exceed $30,000 to pay for the cost of the medals authorized by this Act.

(b) PROCEEDS OF SALE.—Amounts received from the sale of duplicate bronze medals under section 3 shall be deposited in the United States Mint Public Enterprise Fund.

ORDERS FOR TOMORROW

Mr. TALENT. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:15 a.m. Thursday, June 26. I further ask that following the prayer and the pledge, the morning hour be deemed to have expired, the Journal of the proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of S. 1, the prescription drug benefit bill, as provided under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. TALENT. Mr. President, tomorrow the Senate will resume consideration of S. 1, the prescription drug benefit bill. Under the previous agreement, the Senate will begin with two back-to-back rollcall votes upon returning to the bill. The voting sequence will be as follows:

The first vote will be in relation to the Harkin amendment No. 991. The second vote will be in relation to the Edwards amendment No. 1052.

Again, the first vote of tomorrow's session will occur at 9:15 a.m. For the remainder of the day, we will continue to process amendments to S. 1. Members can expect rollcall votes throughout the day and late into the evening tomorrow as the Senate progresses toward completion of this landmark legislation.

ADJOURNMENT UNTIL 9:15 A.M. TOMORROW

Mr. TALENT. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 10:50 p.m., adjourned until Thursday, June 26, 2003, at 9:15 a.m.

NOMINATIONS

Executive nominations received by the Senate June 25, 2003:

CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD

RIXIO ENRIQUE MEDINA, OF OKLAHOMA, TO BE A MEMBER OF THE CHEMICAL SAFETY AND HAZARD INVESTIGATION BOARD FOR A TERM OF FIVE YEARS, VICE ANDREA KIDD TAYLOR, TERM EXPIRING.

DEPARTMENT OF COMMERCE

JULIE L. MYERS, OF KANSAS, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE MICHAEL J. GARCIA.

DEPARTMENT OF STATE

JEFFREY A. MARCUS, OF TEXAS, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO BELGIUM.

DEPARTMENT OF JUSTICE

DEBORAH ANN SPAGNOLI, OF CALIFORNIA, TO BE A COMMISSIONER OF THE UNITED STATES PAROLE COMMISSION FOR A TERM OF SIX YEARS, VICE JOHN R. SIMPSON, TERM EXPIRED.

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

REAR ADM. (SELECT) ERIC T. OLSON, 6412

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. VICTOR E. RENUART JR., 0278

IN THE NAVY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CHAD F ACEY, 4207
MICKEY S BATSON, 5421
WILLIAM R BERTRAM, 3254
JOSEPH D BOOGREN, 1129
DAVID B CARSON, 0391
DARYL S DAVIS, 2823
ERIC S DIETZ, 8294
DAVID L FLAKE, 2656
SHELLIE FOUNTAIN JR., 1624
ROBERT J GIBSON JR., 2107
DONNA A HULSE, 0625
ALBERT C KINNEY III, 5289
DEBRA A LANKHORST, 3452
GARY A RICHARDS, 1323
TIMOTHY G ROHRER, 6017
STEPHEN K SAULS, 6101
VINCENT H SCOTT, 0800
FRANK A SHAUL, 3998

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CONRADO K ALEJO, 8696
GEORGE M BAIN, 5279
JEFFREY S BAKER, 5416
JAMES C BEENE, 3078
MICHAEL P BETTS, 1765
DONALD A BUZARD, 1406
ANTONIO J CARDOSO, 8232
ALLEN CRISP, 2931
KNARVELL DAILEY, 5669
JAMES V DANIELS, 8931
EDWARD A FLINT, 1590
LEONARD M FRIDDLE, 9984
ALAN D FULLERTON, 1614
ANGELITO R GALICINAO, 8289
SHELDON GERINGER, 0994
DONALD GRIFFIN, 4372
RHONDA K HARDERS, 4949
JEFFREY K HAYHURST, 6322
DOUGLAS J HOLDERMAN, 4888
CHRISTOPHER L HULL, 6958
EDWARD J JOHNSON, 6286
RICHARD D JONES, 3843
DONALD H KELLER JR., 5379
LINDSAY C LECUYER, 5106
PATRICIA R LOONAM, 4782
MARK C LOOSE, 5336
JON B LUNDQUIST, 8310
RICHARD D MCCLELLAN, 0196

JIMMY R MCLAUGHLIN, 4721
DWAINE D MEAGHER, 2912
SYLVESTER MOORE, 0139
WILLIAM K NESMITH, 7945
ROBERT S NEVILLE, 3754
ROBERT E NOVOTNY, 9678
GARY E PERKINS, 9364
SEAN R PRASSER, 9354
THOMAS L PRICE, 3291
TERRY W PULLIAM, 0498
DALE C RAMSEY, 4031
JEFFREY S RANDALL, 6294
STEPHEN R SKAW, 7250
DANIEL SPAGONE, 1311
RUSTIN E STOBER, 9284
JOHN D THOMAS, 6371
PETER H THOMAS, 3701
JAMES H TRAVERS, 8468
RICHARD C VALENTINE, 1467
CARL B WEICKSEL, 0058

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

BARBARA M BURGETT, 4365
ROBERT A DEWS JR., 0785
ELLEN H EMERSON, 1664
ROBERT J FINK, 0026
KIM D HILL, 1990
ELIZABETH S HOSTETLER, 9806
DONNA M KASPAR, 1735
KATHLEEN A KEELY, 8700
CATHY M KIMMEL, 9415
LESA J KIRSCH, 4270
CARL K KLOTZSCHE, 5484
WILLIAM R KRONZER, 4852
JOHN D NELL, 5883
CAROLYN R OWENS, 6658
MARY E SMITH, 0727
KRISTIN B STRONG, 8435
CRAIG D UNION, 3164
MARGARET M WARD, 6154
ROBERT C WEITZMAN, 4254

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ROBERT J ALLEN, 7459
RICKY D BALCOM, 1466
KYLE B BECKMAN, 2041
JOSEPH F BEVERLY, 6855
JAMES S BIGGS, 1490
THOMAS R CROWELL, 5892
BRIAN F EGGLESTON, 0218
MARK R H ELLIOTT, 9979
JAMES M ELLIS, 8052
MICHAEL A ELSBERG, 9663
ALLEN W HAMMERQUIST, 2133
HOWARD D HART, 4024
JUAN J HOGAN, 3032
DAVID R HUNT, 5108
MARK M JAREK, 7398
JAMES A KNORTZ, 4205
MICHAEL T LENTS, 3641
MICHAEL L MARAVILLA, 0430
FRANCIS M MOLINARI, 9942
LAURAN W RYE, 2158
MICHAEL W STUDEMAN, 3795
BLAKE D WARD, 2263
HAROLD E WILLIAMS, 9232

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ERIC J BUCH, 4009
RAYMOND E CHARTIER JR., 6883
TIMOTHY C GALLAUDET, 5764
JOHN V GURLEY, 8839
JAMES R JARVIS, 1415
GREG M JIMENEZ, 3419
PETER M KLEIN, 5856
PAUL E MATTHEWS, 4994
BRUCE J MORRIS, 4849
WILLIAM H NISLEY II, 4071
PAUL S OOSTERLING, 8046
DEAN A SADANAGA, 4737
EUGENE P TRAMM, 5012
ERIC J TREHUBENKO, 8042
ROBIN D TYNER, 3410

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

LEE K ALLRED, 7603
TRACY A BARKHIMER, 6113
MARTIN R BEAULIEU, 2376
JOSEPH G DACQUISTO, 2611
DANA S DEWEY, 3930
SHAWN P HENDRICKS, 4065
ERIC D HOLMBERG, 3152
JOHN M HOOD, 6604
RICHARD W KAMMANN JR., 3034
STEVEN J LABOWS, 0821
RALPH D LEE, 4131
JOHN S LEMMON, 1949
MATTHEW A LETOURNEAU, 6897
THOMAS C POPP, 5693
SCOTT D PORTER, 0299
JAMES K REINING, 4176
PATRICK W SMITH, 4557
DAVID M SWENSON, 2813
JACK H WATERS, 7276
PETER M WATERS, 4094
DONALD L ZWICK, 7159

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ALLAN D ANDREW, 2725
MICHAEL A BALLOU, 3358
JOHN H BITTING III, 8537
LAWRENCE J BRACHFELD, 8676
WILLIAM J BROUGHAM, 6568
ALVARO F CUELLAR, 5088
JOHN D DANNECKER, 9567
PHILLIP E DAWSON III, 6069
STEVEN M DEBUS, 1808
JAY F DILL, 8139
DILIP B GHATE, 4103
PATRICIA A GILL, 8176
DAVID A GOGGINS, 5210
WILLIAM C GREENE, 9041
DONALD R HARDER, 4443
THOMAS W HEATTER, 9612
SCOTT D HELLER, 2024
PAUL A HERBERT, 4293
TODD A HOOKS, 0755
MICHAEL C LADNER, 3654
DOUGLAS M LEMON, 0490
JOSEPH D MAUSER, 9128
JAMES E MELVIN, 3975
MARSHALL G MILLETT, 6623
BRIAN P MURPHY, 3862
F S NESSLER, 6391
SEAN P OMALLEY, 8105
WILLIAM G PLOTT, 9919
MARTIN RODRIGUEZ, 2817
ELTON G SAYWARD JR., 6600
ZACHARY M SCRUTON, 7723
DOUGLAS W SMALL, 3880
FRANCIS E SPENCER III, 0294
HENRY W STEVENS III, 1442
BRIAN S TAIT, 6961
VINH X TRAN, 5774
RONALD R VANCOURT, 0392
MARK R VANDROFF, 2337
RANDOLPH R WEEKLY, 9935
STEPHEN F WILLIAMSON, 0454
JOHNNY R WOLFE JR., 4924

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

ANGELA D ALBERGOTTIE, 9549
JOYCE M BERNARD, 8341
AMY D BURIN, 1291
KATHLEEN M CREIGHTON, 3795
BRUCE R DEMELLO, 6972
PETER R FALK, 7416
CARRIE A HASBROUCK, 7935
WINNIE L HUSKEY, 8740
SANDRA M JAMSHIDI, 5712
DOREEN M JONES, 5416
MICHAEL G LARIOS, 4266
SCOTT A MARGULIS, 0017
BRANDEE L MURPHY, 6455
LAWRENCE A PEMBERTON, 4784
SUZANNE PROSE, 3870
KATHLEEN M SAYLOR, 9059
JOSEPH B SPEGELE, 0843

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CHARLES J CHAN, 3624
BART L GROSSMAN, 4276
KENNETH W JALALI, 9628
JOHN L LARSON, 7792
GREGORY A MUNNING, 5297
KENNETH W PARNELL, 3848
KURT B REINHOLT, 1387
GEORGE S ROBINSON, 9768
ROBERT J STAILEY, 6642
RICK T TAYLOR, 8939
DANIEL VANORDEN, 0728
MARK S WASSIL, 6914
MATTHEW A WEBBER, 9387

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

CHRISTOPHER A ADAMS, 5187
CHARLES N ALBRECHT, 8060
WILLIAM T ALEX, 3704
TOMAS A ALKSNINIS, 9762
DAVID W ALLDRIDGE, 8598
GLENN R ALLEN, 8908
THOMAS R AMBLAD, 8683
CRAIG A ANDERSON, 0701
MARK A ANDERSON, 0766
BRUCE A APGAR, 4024
DANIEL D ARENSMEYER, 7872
RAYMOND A ART, 4310
SCOTT W ASKINS, 4568
RUSSELL B AUSLEY, 9339
STUART P BAKER, 7874
BARRY BAKOS, 7576
JAY C BALLARD, 1675
JOHN S BANIGAN, 8436
MICHAEL P BARATTA, 2706
TIMOTHY S BARBIER, 6152
ERIC T BARKDULL, 2917
USHER L BARNUM JR., 3240
BENJAMIN K BARRETT, 8070
GREGORY L BARRINGER, 5661
JEFFREY B BARTA, 0929
KENNETH G BECK, 8267
MARK W BEDDOES, 9865
ALAN E BELL, 1035
TODD A BELTZ, 6646
MARK B BENJAMIN, 5266
AUGUSTUS P BENNETT, 8241
MICHAEL L BENO, 2938
JAMES H BENTON, 4147
PAUL R BERNADO, 7436
WILLIE D BILLINGSLEA, 4876
RANDY B BLACKMON, 6305
DAVID I BLAIR, 8033
ANTHONY R BLANKENSHIP, 2051
BRETT F BONIFAY, 1215
DAVID C BORAH, 8862
BRIAN K BORING, 9338
DAVID L BOSSERT, 6128
DAVID W BOUVE, 1671
MORDAUNT P BRABNER, 8857
ALBERT A BRADY, 5315
RANDY L BRATCHER, 2972
WILLIAM J BREITFELDER, 1029
KEVIN S BRENNAN, 0149
MICHAEL J BRESLAUER, 7504
BARRY D BROCKWAY, 9159
JOHN S BRUCE, 1956
DAN W BRUNE, 0907
CHRISTOPHER W BRUNETT, 2300
MARK R BRUNNER, 7101
ROBERT B BURGIO, 8773
ERIK A BURIAN, 5780
CHRISTOPHER T BURKETT, 4019
MICHAEL P BURNS, 6423
RONALD S BUSH, 7845
CHRISTOPHER J BUSHNELL, 3702
SHAN M BYRNE, 0098
ROBERT A H CADY, 7356
JAMES S CAMPBELL, 7648
GEORGE S CAPEN, 3568
LESLIE T CARDENAS, 7564
STEVEN M CARLISLE, 8270
JOHN A CARTER, 8137
DANIEL L CHEEVER, 3913
JOHN W CHEWNING, 0665
CHRISTOPHER W CHOPE, 3297
CHRISTIAN E CHRISTENSON, 7690
BRIAN K CHRISTIANSON, 5070
ARTHUR E CIMILUCA JR., 2861
STEVEN J CINCOTTA, 5375
KEVIN M CLAFFY, 4403
ANTHONY J CLAPP, 4467
BRYAN L CLARK, 4429
ROBERT E CLARK, 1972
JOHN S COFFEY, 5823
MATTHEW J COLBURN, 4749
MICHAEL J COLMAN, 3335
CLAYTON L CONLEY, 1021
BLAKE L CONVERSE, 4188
CHARLES B COOPER II, 9109
MATTHEW F COUGHLIN, 2585
STEPHEN J COUGHLIN, 1838
JOHN R CRAIG, 6692
MICHAEL L CROCKETT, 9220
MICHAEL S CRUDEN, 1275
THOMAS CURRAN, 6780
REX L CURTIN, 1973
RANDY C DARROW, 4167
REEVES A DAVES, 2198
YVETTE M DAVIDS, 0043
ANDREW N DAVIS, 2052
DUANE T DAVIS, 4153
JACK E DAVIS, 0103
JAMES P DAVIS, 7739
GARY L DEAL, 9242
STEVEN E DEAL, 8010
THOMAS L DEARBORN, 5971
JEFFREY E DEBOLT, 0437
BRUCE A DEFIBAUGH, 9544
ALBERT E DEMPSEY III, 9097
RONALD M DENNIS, 9080
DON E DIZON, 5980
RICHARD E DODSON JR., 6791
MICHAEL P DONNELLY, 3485
MICHAEL P DORAN, 0358
CHAD O DORR, 0761
FRANK J DOWD, 8031
PAUL T DRUGGAN, 7043
SHAWN P DUFFY, 6491
SCOTT E DUGAN, 7066
ROBERT B DUMONT III, 6642
JOHN T DYE JR., 9690
RANDELL W DYKES, 0213
JOHN P ECKARDT, 8188
BRIAN P ECKERLE, 4396

HENRY B EDWARDS III, 6621
JASON C EHRET, 7684
GERALD L ELLIOTT II, 6947
JAMES A EMMERT, 7176
DARREL W ENGWELL JR., 2529
ROMMEL M ESTEVES, 6308
NEWMAN J EVANS III, 5751
BRIAN G FALKE, 1884
ANDREW L FEINBERG, 2693
MICHAEL S FEYEDELEM, 2816
WILLIAM C FILAN, 4025
STEPHEN M FIMPLE, 8383
STEVEN C FINCO, 8251
CHRISTOPHER M FITZGERALD, 2587
EDWARD M FLANAGAN, 3241
TODD J FLANNERY, 0429
ANDREW FLEMING, 7649
CHRISTOPHER J FLETCHER, 3138
DAVID K FLICK, 3605
ROBERT L FLOYD, 1197
THOMAS D FOHR, 5783
DURANTE A FOOTMAN, 0297
BRETT C FOSTER, 5387
JOSEPH P FRANSON JR., 2307
TYLER L FRAUTSCHI, 4771
BRIAN W FRAZIER, 4099
MICHAEL S FULGHAM, 8559
FREDERICK E GAGHAN JR., 1793
THOMAS D GAJEWSKI, 9683
SCOTT R GALLAGHER, 7945
ROBERT D GAMBERG, 2063
HARRY L GANTEAUME, 4815
EDWARD G GANUN, 7356
DANIEL L GARCIA, 2572
MICHAEL C GARD, 4761
PETER A GARVIN, 1814
JOSEPH E GELARDI, 8863
GREGORY J GIBSON, 6368
JASON A GILBERT, 2735
CHARLES W GILL, 4897
JEFFREY W GILLETTE, 9264
CRAIG S GIVENS, 9906
DONALD J GLATT, 2667
THOMAS C GOMEZ, 3434
MARK R GONZALES, 8602
JUAN C GONZALEZ, 1807
CURTIS J GOODNIGHT, 6933
BENJAMIN B GOODWIN, 3341
ANDREW M GORZELA, 1875
FREDERICK J GOSEBRINK II, 1689
MICHAEL V GOSHGARIAN, 0524
SCOTT C GOVER, 3613
JEFFREY C GRAF, 2148
CHRISTOPHER E GRAY, 4365
CHRISTOPHER S GRAY, 1786
BRIAN C GRIMM, 0739
PAUL F GRONEMEYER, 3045
TIMOTHY J GROUT, 2810
WESLEY R GUINN, 2557
JOHN E GUMBLETON, 3017
STEVEN J HADDAD, 1741
PAUL C HAEBLER, 2345
MARK L HAGENLOCHER, 0037
ROBERT A HALL JR., 6311
PATRICK M HALLER, 7520
WILLIAM K HALVERSON, 2639
TIMOTHY W HANSEN, 8496
MICHAEL S HARBER, 5489
MICHAEL V HARBER, 3785
ROGER D HARDY, 4178
DANIEL P HARMON, 1943
MICHAEL S HARRINGTON, 1760
GREGORY M HARRIS, 4414
MITCHELL R HAYES, 2266
JURGEN HEITMANN, 9985
EDWIN M HENDERSON, 9926
GARY M HERBERT, 3287
JOHN W HERMAN, 4602
EDMUND B HERNANDEZ, 3579
PATRICK D HERRING, 2348
EDWARD L HERRINGTON, 6209
ALAN L HERRMANN, 8175
CHRISTOPHER E HICKS, 7061
GRANT R HIGHLAND, 5527
MATTHEW B HOGAN, 4130
ALVIN HOLSEY, 9576
WILLIAM D HOPPER, 1213
KENNETH M HOUCK, 2941
REGINALD M HOWARD, 1767
PATRICK N HUETE, 2264
GREGORY C HUFFMAN, 4891
EDWARD C HUTT, 5504
JAMES A IMANIAN, 1077
WILLIAM T IPOCK II, 8257
ROGER G ISOM, 9474
RHETT R JAEHN, 3163
ANDREW D JAMES, 9717
BRIAN S JAMES, 5751
JEFFREY W JAMES, 1498
ROBERT W JANSSEN, 6819
ANDREW C JARRETT, 7466
JOKER L JENKINS, 4205
BRADLEY T JENSEN, 6428
JON J JERGE, 1150
MARK A JOHNSON, 4524
ERNEST R JONES JR., 9714
JAMES T JONES, 8435
SARA A JOYNER, 7535
MARK A JOYNT, 3592
JOEL D JUNGEMANN, 4412
KURT A KASTNER, 7524
SUSANNE G KECK, 6646
GREGORY J KEITHLEY, 1852
SCOTT K KELLY, 3650
JOHN E KENNINGTON, 7490
ANDREW M KENNY JR., 3221
DABNEY R KERN, 3378
WILLIAM E KERN, 6745
IAN J KERR, 6865
JARED A KEYS, 1922
BRADLEY J KIDWELL, 8413
DOUGLAS P KIEM, 0435
KEVIN G KING, 9967
KEVIN E KINSLOW, 1733
GREGORY S KIRKWOOD, 0844
DAVID R KLAIN, 8963
JOHN J KLEIN, 7906
JOSEPH G KLEIN II, 1190
JAMES F KOELTZOW, 3931
WILLIAM S KOYAMA, 6326
NEAL D KRAFT, 0972
CARY J H KRAUSE, 1318
SCOTT C KRAVERATH, 5711
KEVIN F KROPP, 5877
THOMAS A KUBISTA, 7978
TIMOTHY C KUEHHAS, 0367
GLENN P KUFFEL JR., 6004
ERIC G KUKANICH, 7507
CARL A LAHTI, 0987
DENNIS A LAZAR JR., 5735
RICKY A LEE, 3702
DAVID T LEMLY, 9106
TODD L LENNON, 3694
ZIGMOND V LESZCZYNSKI, 4515
MICHAEL W LEUPOLD, 8982
RANDALL K LEWIS, 8859
STUART W LEWIS, 5029
MARK F LIGHT, 6959
STEVEN W LIGLER, 2528
PAUL J LING III, 9325
JAMES M LINS, 5260
DAVID J LOBDELL, 1851
PAUL J LOMMEL, 5810
JAMES P LOPER, 3029
STEPHEN E LORENTZEN, 3089
MARK LOTZE, 2207
WALLACE G LOVELY, 1667
JON E LUX, 7540
PAUL J LYONS, 1845
JOHN L MACMICHAEL JR., 0821
MARK P MAGLIN, 2950
GREGORY M MAGUIRE, 9275
JAMES A MANN, 7507
JEFFREY S MANNING, 1159
TIMOTHY J MARICLE, 0461
JEFFREY P MARSHALL, 7447
GREGG W MARTIN, 0170
MATTHEW J MARTIN II, 9047
MICHAEL W MARTIN, 3359
RANDALL H MARTIN, 8358
VINCENT R MARTINEZ, 5088
PETER W MATISOO, 1107
STEVEN P MCALEARNEY, 0268
MICHAEL W MCCALLUM, 3885
ANDREW C MCCUE, 2875
LARRY A MCELVAIN JR., 3184
TIM MCGARVEY, 2405
JAMES L MCREYNOLDS, 2735
PETER A MEHL, 5532
DARRYL C MELTON, 1769
JEFFREY P MENNE, 6513
MARK V METZGER, 9455
GEORGE D MICHAELS, 0173
MARIO MIFSUD, 4285
JOHN L MIHELICH III, 5233
ANDREW W MILES, 1206
JEFFERY S MILLER, 5321
MATTHEW C MILLER, 7451
RANDALL B MILLER, 3064
RICHARD M MILLER JR., 2998
ERIC J MITCHELL, 3799
GREGORY H MOLINARI, 9944
MASON K MOLPUS, 6078
BRIAN T MOORE, 6610
CHARLES C MOORE II, 9995
H C D MORAN, 8976
MICHAEL S MORENO, 5563
BRIAN L MORGAN, 0179
SEAN T MORIARTY, 2243
KURUSH F MORRIS, 6285
TERRY S MORRIS, 2199
GERALD M MOST, 8103
RICHARD P MOUNTAIN, 3401
SCOTT E MULVANIA, 7587
CHRISTOPHER P MURDOCH, 8663
MARK E MUZII, 9254
JEFFREY S MYERS, 1190
RICHARD D NELSON, 3949
JOHN R NETTLETON, 0831
ROBERT A NEWSON, 3821
TROY M NICHOLS, 4489
THAD E NISBETT, 1850
NORBERTO M D NOBREGA, 8181
RONALD J NOVAK, 6813
MARK T NOWICKI, 0748
HEIDI C OCHS, 9208
RICHARD M ODOM II, 6196
WILLIAM A OEFELEIN, 5484
STEVEN B OKUN, 1140
MICHAEL F OTT JR., 7295
GREGORY B OWENS, 3665
MARCELL S PADILLA, 2493
EUGENE F PALUSO II, 6657
SCOTT W PAPPANO, 5931
WILLIAM J PARKER III, 3462
VERNON J PARKS JR., 4410
PETER J PASQUALE, 8011
BENJAMIN J I PEARSON, 9485
GREGORY S PEKARI JR., 1336
ROBERT A PEREBOOM, 1517
DOUGLAS G PERRY, 1753
ERIC S PFISTER, 0710
CATHERINE K PHILLIPS, 6592
DUANE A PHILLIPS, 2221
PATRICK M PICKARD, 1340
WILLIAM S PIESESKI, 7831
IAN R POLLITT, 6864
PATRICK J PORTER, 6044
GANDOLFO A PRISINZANO, 0694
ERIC W PURDY, 4232
VINCENT J QUIDACHAY, 0860
FRANK N QUILES, 8219
KEVIN J QUINN, 0886
JOHN L RADKA, 4147
CHARLES E RADOSTA, 2794
CHRISTOPHER M RANKIN, 2913
KEVIN H RASCH, 6409
KENDALL M RASMUSSEN, 7647
STEVEN R RASMUSSEN, 2694
JOHN J REESE, 2098
JAMES C RENTFROW, 3002
KENNETH J REYNARD, 5282
JOHN E RIES, 6865
ROBERT M RIGGS, 6555
JR W J RILEY, 9091
DANIEL J RIVERA, 7233
JAMES L ROBBINS, 9335
DAVID A ROBERTS, 7683
WILBUR L J ROBERTS, 1365
CHRISTOPHER ROBINSON, 4334
CHRISTOPHER A RODEMAN, 9088
JAMES R ROGERS II, 5907
GREGORY R ROMERO, 2472
AARON L RONDEAU, 6243
MARC A RZEPCZYNSKI, 0063
BENJAMIN D SALERNO, 7198
MARK E SANDERS, 8552
LEONARD D SANTIAGO, 5995
MICHAEL T SCARRY, 6936
PAUL J SCHLISE, 6783
TIMOTHY L SCHORR, 1769
JAMES C SEALS JR., 4298
TODD J SENIFF, 1629
CURTIS A SETH, 6453
PATRICK J SHAFFER, 3260
JOHN E SHASSBERGER, 5989
DANIEL P SHAW, 3358
MICHAEL D SHEAHAN, 2490
JOHN M SHEEHAN, 8333
JOE C SHIPLEY, 6510
ERIC S SHIREY, 0197
KARIN A SHUEY, 1800
DANIEL A SHULTZ, 9370
PHILLIP T SICARD, 6015
OTTO F SIEBER, 8414
JAMES W SIGLER, 5221
RICHARD A SKIFF JR., 1124
KATHY L SLOAN, 9315
BRENT E SMITH, 7750
FRED W SMITH JR., 3203
JED C SMITH, 4008
THOMAS B SMITH II, 9913
TIMOTHY J SMITH, 9569
VICTOR S SMITH, 4224
JAMES B SNELL, 7780
MICHAEL C SPARKS, 8768
WESLEY W SPENCE, 3837
JAMES L SPENCER IV, 6025
MARK F SPRINGER, 3775
RAY A STAPF, 2035
STEPHEN P STARBOARD, 7644
MARC A STERN, 1578
MARK L STEVENS, 3342
JONATHAN R STEVENSON, 5124
WILLIAM R STEVENSON, 9236
JOHN L STOFAN, 9733
JERRY K STOKES, 2816
RICK J STONER, 7194
DAVID A STRACENER, 9368
SHRI J STROUD, 8232
ORLANDO A SUAREZ, 5371
KEVIN W SUTTON, 1261
PAUL TANKS JR., 8569
RANDALL D TASHJIAN, 5529
JAMES L TAYLOR JR., 9814
MICHAEL J TESAR, 1347
FREDERICK N TEUSCHER JR., 4839
CHRISTOPHER P THOMAS, 1643
MARK A THOMAS, 9609
JOHN J THOMPSON, 2677
JOSEPH M THOMPSON, 4680
THOMAS L THOMPSON, 2160
DAVID L TIDWELL, 0074
RYAN C TILLOTSON, 8072
JOHN V TOLLIVER, 5114
JOHN D TOUGAS, 1079
KARL W TRAHAN JR., 5571
TIMOTHY R TRAMPENAU, 4042
MARC G TRANCHEMONTAGNE, 5851
BRADDOCK W TREADWAY, 9112
JOHN C TREUTLER, 2352
WILLIAM M TRIPLETT, 5906
WADE D TURVOLD, 9482
RONALD B TUTTLE JR., 5721
KIERAN S TWOMEY, 9206
PATRICK J TWOMEY, 0731

MURRAY J TYNCH III, 1357
MATTHEW S TYSLER, 2534
ROY C UNDERSANDER, 0717
MAURICE R VARGAS, 6318
DAVID J VARNES, 8121
LAWRENCE R VASQUEZ, 1688
HENRY L VELARDE, 5727
ERIC H VENEMA, 6068
DEAN M VESELY, 0573
THOMAS K VINSON, 2818
DANIEL E VOTH, 2417
MARK D WADDELL, 5039
GREGORY J WALLS, 8547
COLIN S WALSH, 2476
DENNIS J WALSH JR., 6794
HOWARD C WARNER III, 1652
JAMES P WATERS III, 8850
ROBERT WEBBER JR., 6493
JAMES R WICKMAN, 8694
STEVEN J WIEMAN, 0889
DOUGLAS E WILCOX, 7146
JEFFREY B WILLIAMS, 8298
MARK T WILLIAMS, 0223
RICHARD C WILLIAMS JR., 0983
STEVEN M WILLIAMS, 0311
CRAIG L WILSON, 1562
JAMES A WINSHIP, 5264
JEFFREY S WINTER, 4575
PETER J WINTER, 4248
NEIL W WOODWARD III, 9384
RAYMOND B WORTHINGTON, 6066
ERIC K WRIGHT, 5680
BRIAN F WYSOCKI, 9206
ELIZABETH A YEOMANS, 7479
EUGENE S YOUNG, 4115
ROBERT E YOUNG, 4476
RICHARD J ZINS, 5660

FOREIGN SERVICE

THE FOLLOWING-NAMED PERSONS OF THE AGENCIES INDICATED FOR APPOINTMENT AS FOREIGN SERVICE OFFICERS OF THE CLASS STATED, AND ALSO FOR THE OTHER APPOINTMENTS INDICATED HEREWITH:

FOR APPOINTMENT AS FOREIGN SERVICE OFFICERS OF CLASS TWO, CONSULAR OFFICER AND SECRETARY IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF COMMERCE

JAMES M. CUNNINGHAM, OF CALIFORNIA
RICK A. DELAMBERT, OF CALIFORNIA
JAMES C. RIGASSIO, OF NEW JERSEY
JOHN E. SIMMONS, OF CALIFORNIA

FOR APPOINTMENT AS FOREIGN SERVICE OFFICERS OF CLASS THREE, CONSULAR OFFICER AND SECRETARY IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF COMMERCE

MITCHEL I. AUERBACH, OF FLORIDA
REBECCA M. BALOGH, OF VIRGINIA
ISABELLA G. CASCARANO, OF THE DISTRICT OF COLUMBIA
WILLIAM B. CZAJKOWSKI, OF ILLINOIS
ANGELA R. DAWKINS, OF VIRGINIA
ROBERT J. DONOVAN, OF THE DISTRICT OF COLUMBIA
STEPHEN R. JACQUES, OF VIRGINIA
WILLIAM S. LAWTON, OF WASHINGTON
GREGORY J. O'CONNOR, OF VIRGINIA
ALYCE CAMILLE RICHARDSON, OF FLORIDA
PAMELA R. WARD, OF OREGON
JENNIFER ANNE WOODS, OF VIRGINIA

THE FOLLOWING-NAMED MEMBERS OF THE FOREIGN SERVICE OF THE DEPARTMENT OF STATE AND COMMERCE TO BE CONSULAR OFFICERS AND/OR SECRETARIES IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA, AS INDICATED:

CONSULAR OFFICERS AND SECRETARIES IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF COMMERCE

DOUGLAS J. WALLACE, OF MARYLAND

DEPARTMENT OF STATE

ORY S. ABRAMOWICZ, OF ILLINOIS
VALERIE T. ADAMCYK, OF NEW YORK
PETER JAMES ANTHES, OF VIRGINIA
JOHN M. BARRETT, OF CALIFORNIA
SALLY P. BEHRHORST, OF CALIFORNIA
MANU BHALLA, OF NEW HAMPSHIRE
THOMAS EDWARD BROWN JR., OF MARYLAND
JOSEPH J. CALLAHAN IV, OF FLORIDA
MICHAEL R. CARPENTER, OF MICHIGAN
MICHAEL CARVER, OF TEXAS
BENJAMIN CHIANG, OF VIRGINIA
JASON JOHN CHIODI, OF VIRGINIA
LEWIS ANDREW CLARK, OF VIRGINIA
MARY GARDNER COPPOLA, OF THE DISTRICT OF COLUMBIA
RODNEY DEVI CUNNINGHAM, OF NEW YORK
FRANK DEPARIS, OF VIRGINIA
SONIA M. DESAI, OF CALIFORNIA
DANIEL SCOTT DUANE, OF NEW YORK
JENNIFER W. EADIE, OF VIRGINIA
MEGAN ALLISON ELLIS, OF CALIFORNIA
SHANNON BELL FARRELL, OF WISCONSIN
TIMOTHY J. FINGARSON, OF NORTH DAKOTA
DONALD LOREN FRERICHS, OF TEXAS
ANGELA LOUISE GEMZA, OF MINNESOTA
SARAH GORDON, OF NEW YORK
C. COLIN GUEST, OF VIRGINIA
JASON KAMATA HACKWORTH, OF WASHINGTON
SCOTT WILLIAM HANSEN, OF COLORADO
RONALD E. HAWKINS JR., OF MARYLAND
RICH HEATON, OF COLORADO
CHRISTINE BINH-AN PHAM HENNING, OF MICHIGAN
DEBORAH ANN HICK, OF FLORIDA
ERIK JONATHAN HOLMGREN, OF ILLINOIS
BRADLEY A. HURST, OF CALIFORNIA
SUZANNE MARY INZERILLO, OF ILLINOIS
KENNETH JONES, OF NEW JERSEY
PAUL A. KIRSCHBAUM, OF VIRGINIA
ELIZABETH J. KONICK, OF NEW YORK
COURTNEY ALLISON KRAMER, OF THE DISTRICT OF COLUMBIA
JAMIE TYLER LA MORE, OF ARIZONA
MICHAEL D. LAMPEL, OF ILLINOIS
MEGAN E. LARSON-KONE, OF MARYLAND
SARA MARGARET LUTHER, OF COLORADO
THOMAS H. LYONS, OF TENNESSEE
PETER K. MALECHA, OF WASHINGTON
JOHN RUSH MARBURG, OF MARYLAND
ELIZABETH KATHLEEN MARTIN, OF ILLINOIS
MARISSA M. MARTIN, OF FLORIDA
ANDREW MCCLEARN, OF COLORADO
JASON MCINERNEY, OF CALIFORNIA
ANTHONY LUIS MIRANDA, OF WASHINGTON
GONS GUTIERREZ NACHMAN, OF FLORIDA
ARI NATHAN, OF CALIFORNIA
JAMES PATRICK NEEL, OF NEVADA
PETER NEISULER, OF THE DISTRICT OF COLUMBIA
TIMOTHY D. NELSON, OF CALIFORNIA
AMY LORENE NICODEMUS, OF NEW JERSEY
JONATHAN R. PECCIA, OF ILLINOIS
CAROLINE L. PRICE, OF GEORGIA
JUDITH RAVIN, OF NEW JERSEY
SIMEON RASAY RAYA JR., OF NEW JERSEY
ANTHONY FERRER RENZULLI, OF THE DISTRICT OF COLUMBIA
FREDERIC JORGE ROCAFORT-PABON, OF FLORIDA
JACQUELYN BURKE ROSHOLT, OF MINNESOTA
KIRK HARRIS SAMSON, OF WISCONSIN
JANET NICOLE SANDERS, OF GEORGIA
SATRAJIT SARDAR, OF TEXAS
GABRIELLE HAYES SARRANO, OF VIRGINIA
ERIN A. SAWYER, OF CALIFORNIA
VERONICA SCARBOROUGH, OF VIRGINIA
ELIZABETH GRACE NICHOLS SCHLACHTER, OF CALIFORNIA
LAURA KATHRYN SCHEIBE, OF SOUTH DAKOTA
JON M. SELLE, OF TEXAS
MICHAEL T. SESTAK, OF NEW YORK
GEOFFREY C. SIEBENGARTNER, OF NEW YORK
JESSICA LEIGH SIMON, OF OREGON
DAVID WALKER SIMPSON, OF TEXAS
CHRISTOPHER MAGNUS SMITH, OF MARYLAND
ALEXANDER W. SOKOLOFF, OF FLORIDA
ROBERT J. TATE, OF WASHINGTON
ADAM RICHARD VOGELZANG, OF MARYLAND
MARGARET C. WHITE, OF VIRGINIA
THOMAS WISE, OF MINNESOTA

THE FOLLOWING-NAMED CAREER MEMBER OF FOREIGN SERVICE OF THE DEPARTMENT OF STATE FOR PROMOTION IN THE SENIOR FOREIGN SERVICE TO THE CLASS INDICATED:

CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF STATE

HOWARD M. KRAWITZ, OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES—*Wednesday, June 25, 2003*

The House met at 10 a.m. and was called to order by the Speaker pro tempore (Mr. TERRY).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
June 25, 2003.

I hereby appoint the Honorable LEE TERRY to act as Speaker pro tempore on this day.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

PRAYER

The Reverend Michael J. Greer, Pastor, Good Shepherd Catholic Church, Miami, Florida, offered the following prayer:

O gracious God, extend Your guidance and inspiration over this legislative body. May they find the ways and means to extend assistance to those in need, appropriate, equitably, and build up foreign relations to promote trust in a spirit of collaboration. Deliver the United States from violence and those things that divide so that we may be more faithful to the words we so often say, one Nation under God.

And as we are so fortunate to be able to speak and to act freely, yet responsibly, may they encourage that right here and everywhere so as to promote liberty and justice for all.

And so bless these Members, and as they receive suggestions from their constituents, so may they also receive the support they need from the people they represent and work for and be assured of Your providential care in their lives and for this Nation. Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Nebraska (Mr. BEREUTER) come forward and lead the House in the Pledge of Allegiance.

Mr. BEREUTER led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

WELCOMING THE REVEREND MICHAEL J. GREER

(Mr. LINCOLN DIAZ-BALART of Florida asked and was given permission to address the House for 1 minute.)

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, it is my distinct pleasure and truly an honor this morning to welcome to the United States House of Representatives my friend, Father Michael Greer. Michael Greer is truly a wonderful human being and our community in South Florida is so very privileged that he lives and works with us.

Father Greer has been a teacher of theology. He possesses extraordinary academic credentials, with degrees in theological and liturgical studies from various institutions of higher learning, including the University of Notre Dame in South Bend, Indiana, Father Greer's hometown. Father Greer has taught at the St. Vincent De Paul Seminary and Florida International University. But most of all Michael Greer has become known and beloved in our community by and through his work as the pastor of the Good Shepherd Catholic Church in Miami for the last 16 years.

The Good Shepherd community has flourished during Father Greer's years there. Love, compassion and mercy toward our fellow human beings are not only practiced at Good Shepherd, their presence there is perceived by our entire diverse community.

Michael Greer does not only believe in diversity, he lives it each day in his work, including his constant visits to the sick and his masses, in English, Spanish and Creole.

Good Shepherd now has a wonderful school, also. We are privileged today to have the presence as well of the school's distinguished principal, Dr. Maria Elena Lopez.

Mr. Speaker, the Congress of the United States is honored today by the visit of a humble and great man, Father Michael Greer of Miami.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain 10 one-minutes per side.

WAR CRIMES IN BELGIUM

(Mr. PITTS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PITTS. Mr. Speaker, should the United States allow its military and political leaders like General Tommy Franks, Colin Powell and Vice President CHENEY to be tried for war crimes in Belgium? Some bureaucrats in Belgium would like to think so. Trying to be a player on the world stage, it adopted a universal jurisdiction law supposedly giving Belgian courts jurisdiction over war crimes committed anywhere in the world. Defense Secretary Rumsfeld did the right thing by saying we would not spend taxpayer money to support the new NATO headquarters in a country that could prosecute our soldiers and leaders. Maybe it is time that we even think of moving the NATO headquarters to a more friendly country.

Belgium should not turn its legal system into a platform for divisive politicized lawsuits against her own NATO allies. No civilian or military leader could go to Brussels without fear of harassment from Belgium's courts enforcing spurious charges against them. The bureaucrats in Brussels and around the world who think they can wield unlimited global judicial power without being elected by anyone should be stopped.

IN SUPPORT OF DEBT RELIEF

(Mrs. MALONEY asked and was given permission to address the House for 1 minute.)

Mrs. MALONEY. Mr. Speaker, I rise to urge my colleagues to support legislation I have introduced with the gentleman from Iowa (Mr. LEACH), H.R. 2482, the Iraqi Freedom from Debt Act. This bill will require the United States to negotiate in the International Monetary Fund and World Bank for these institutions to relieve the debt owed them by Iraq. This legislation also includes a sense of Congress that France and Russia and all other creditors should relieve the debts owed by Iraq.

While estimates of Iraq's debt range from one hundred billion to several hundred billion, the combined debt owed the IMF and World Bank is just $150 million. These institutions have the resources to relieve this debt, setting an important precedent for the rest of the world.

The case for debt relief in Iraq is especially compelling, given the fact that much of the debt can be characterized as odious. Odious debt is recognized as debt that is taken on by a country for

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

the personal benefit of corrupt leaders or for the oppression of a people.

By taking the lead on debt relief, the U.S. has an opportunity to boost the Iraqi economy and to prove to the world that a major reason for U.S. action in Iraq was to benefit the Iraqi people.

I urge my colleagues to support this legislation.

U.S.-EU SUMMIT IMPORTANT

(Mr. BEREUTER asked and was given permission to address the House for 1 minute.)

Mr. BEREUTER. Mr. Speaker, today this city is the site of the annual U.S.-EU summit. Leaders of the European Union are here meeting with President Bush and members of his administration in order to strengthen transatlantic relations and to work on a common agenda which seeks solutions to issues within this relationship.

A balanced and well-defined U.S.-EU relationship is critical to global peace and stability. Although the difficult debate over Iraq presented yet another challenge to the relationship between the United States and Europe, it remains clear to this Member that a strong, mature transatlantic relationship is critical to the long-term economic, political and security interests of both the United States and Europe. And one of the central ingredients to a successful partnership with Europe is a stable and integrated European Union. It is important that the EU has evolved to become, along with NATO, one of the two critical international organizations to achieve these objectives.

Summits such as the one today along with legislative exchanges can serve to reinvigorate transatlantic relations in order that we, the United States and the Europeans, can together meet the global challenges we face.

MEDICARE PRESCRIPTION DRUGS

(Ms. SOLIS asked and was given permission to address the House for 1 minute.)

Ms. SOLIS. Mr. Speaker, I rise today to urge my colleagues on the other side of the aisle to bring to this House an affordable and guaranteed Medicare prescription drug benefit to seniors. So far, my Republican colleagues have proposed a bill that does nothing to lower the cost of prescription drugs and actually raises seniors' Medicare part B deductible at a rate of eight times higher than their Social Security cost of living increase, which was just 1.5 percent.

Perhaps they are not hearing the same message that I hear when I go home and talk to my constituents. In the cities that I represent in East Los Angeles and in the San Gabriel Valley, seniors are telling me that they want an affordable and guaranteed drug benefit, just like the Democratic plan. They do not want a voucher program that dismantles Medicare as they know it. They simply want their medicine, and they want a choice to be able to keep their doctor.

Thirty-eight years ago this program was created. So many people in our district, the district that I represent, feel that this is their safety net and here we are attempting to try to privatize it. That is the wrong thing to do while people right now are struggling to make ends meet. Vote down this proposition that is being put forward by the Republican Party.

REMEMBERING ARMY SPECIALIST ORENTHIAL J. SMITH

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Mr. Speaker, I rise today in sadness to report the third death that has touched the Second District of South Carolina during Operation Iraqi Freedom. Twenty-one-year-old Specialist Orenthial J. Smith paid the ultimate sacrifice in the war against terrorism when he was killed during an ambush on his convoy south of Baghdad on Sunday. He was born in Barnwell, South Carolina, and lived in nearby Martin in Allendale County.

O.J. joined the United States Army shortly after graduating from high school with the intent on making the military his lifelong career. Stationed in Dexheim, Germany, with the 123rd Maintenance Support Battalion, Specialist Smith was a leader with a great potential. While in Germany, he graduated ninth out of 127 from a leadership development course.

I ask all of my colleagues to join me in extending to O.J.'s family our most sincere thanks for their son's sacrifice and commitment to bringing liberty and freedom to the oppressed people of Iraq while protecting the American public in the war against terrorism.

In conclusion, may God bless our troops.

WAS AMERICA MISLED ON IRAQ'S WEAPONS OF MASS DESTRUCTION?

(Mr. KUCINICH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KUCINICH. Mr. Speaker, today the House will consider an amendment to H.R. 2417 which will direct the Inspector General of the Central Intelligence Agency to conduct an audit of all telephone records and electronic communications between the CIA and the Office of the Vice President that relate to so-called weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom. I have introduced this amendment to obtain the Vice President's records in response to a June 5 article in the Washington Post which reported that the Vice President made multiple visits to the CIA by which some analysts felt pressured to make their assessments on Iraq fit with Bush administration policy objectives.

This administration has repeatedly claimed they had evidence which proved that Iraq had vast stockpiles of weapons of mass destruction that posed an imminent threat to the United States. Americans remember that this administration cited their evidence of Iraq's weapons as reason to go to war.

It has been over 3 months since the start of the war. No such weapons have been found. Has there been a massive intelligence failure on the part of all our intelligence agencies? Or has this administration deliberately misled this Nation to war? Either way, there needs to be an investigation.

My amendment would uncover the role the Vice President may have played to achieve a political translation of CIA intelligence about alleged stockpiles of weapons of mass destruction in order to suit the Bush administration's campaign to push this country to war.

MEDICARE PRESCRIPTION DRUGS

(Mr. PENCE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PENCE. Only in Washington, Mr. Speaker, could Congress be prepared to add a whole new entitlement to Medicare which may cost children like my today 10-year-old daughter Charlotte $7 trillion and Democrats are holding up tombstones to say Medicare is being phased out. It is astonishing to a conservative like me.

Today, Mr. Speaker, I informed our leadership that I cannot support the creation of a new Federal entitlement in the form of a universal drug benefit in Medicare, which is not to say that I am not ready today to help those at or near the level of poverty that are struggling with that terrible choice between food and rent and prescription drugs.

□ 1015

Let us focus resources at the point of the need and not answer the scare tactics of the other side and end up playing their game and creating an all new massive Federal entitlement that kids like my little Charlotte will have to pay for for generations.

THE REPUBLICANS' PRESCRIPTION DRUG BENEFIT

(Mr. DEFAZIO asked and was given permission to address the House for 1 minute.)

Mr. DEFAZIO. How can the Republicans spend $400 billion on a prescription drug benefit that will impose costs without benefits on many seniors and a totally inadequate benefit for those most in need? We start with the premise that, first and foremost, the plan is designed to protect and enhance the profits of the pharmaceutical industry and the private insurance industry. Yes, seniors will be pushed into a confusing maze of PPO, HMO, discount card, private insurance plans, no limit on premiums, no limit on profits, and no required benefits. Very expensive. The pharmaceutical industry will prevent the reimportation of their manufactured U.S. drugs from Canada, and they are going to protect the obscene prices they get for their drugs.

This plan will do a great job protecting the profits of the pharmaceutical industry and the insurance industry but pitifully little for our Nation's seniors, those so much in need. But so it should be. The insurance and pharmaceutical industries are the number one and number two campaign contributors to the Republican Party.

MEDICARE REFORM

(Mr. BURNS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BURNS. Mr. Speaker, the debate rages over health care in this country. I rise in support of improved health care for our Nation's seniors, and I think it has to be done through Medicare. I believe that Congress can truly improve the seniors' standard of living through preventative care and alternative treatment. The proposed Medicare reform legislation will move us in the right direction. I am encouraged by the prospects of shifting Medicare from a system that manages seniors when they are already sick into a system that is designed to prevent them from becoming sick in the first place. Preventative care is a part of the Medicare reform. Preventative care is truly the best form of care that we can and we should provide for our America's seniors.

PRESCRIPTION DRUGS

(Mr. EMANUEL asked and was given permission to address the House for 1 minute.)

Mr. EMANUEL. Mr. Speaker, what is missing from the debate about Medicare this week is how to make medications more affordable at affordable prices and more accessible to all Americans of all ages. And this is not a partisan problem. It is an American problem.

We have a bipartisan bill to use market forces to reduce prices, allow generics to come to market to compete against name-brand drugs, which would save $60 billion over the next 10 years. Another piece of our legislation uses market forces to allow consumers, businesses, Federal Government through Medicare to buy drugs in 27 countries, be they Germany, France, England, Italy, Canada, where prices are 40 to 50 percent cheaper.

I have the full confidence through our market forces we can make medications cheaper, and I have the confidence and hope my colleagues have the confidence in market forces that they are able to do that.

The third component would be to allow the NIH to recoup a 10 percent royalty on any drug developed with taxpayer resources. In the private sector, 30 percent is normally recouped on a rate of return. Ten percent for NIH funded research, all the cancer drugs, all the AIDS drugs on the market are developed with taxpayer return.

We should no longer consider taxpayer research dumb money. We should recoup that money because the NIH is the largest venture capital fund out there, use market forces to reduce prices, make medications for all Americans more affordable.

THE PRESCRIPTION DRUG PROGRAM

(Mr. SMITH of Michigan asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Michigan. Mr. Speaker, on the prescription drug program that we are about to vote on this week, I am not an expert on health care or prescriptions; but I have observed over the years what happens when government takes over some of these programs. The big change of course was when we amended the Social Security bill in 1965 to add Medicare. We estimated at that time that the cost of Medicare by 1990 would be $9 billion. It was $70 billion projected 2003 to be $26 billion, but the actual cost today is $265 billion. This bill we are estimating at $400 billion. I suggest that is a very low estimate, and the second 10 years is the greater challenge because of retirements.

To seniors, the danger is they are going to start out with choice on whether seniors keep their current Medicare and other insurance; but eventually as government goes broke and needs the money, there is the tendency to force everybody in the program to moderate the cost of the program. Industry is promoting this system because eventually they are going to reduce their prescription drug coverage to the retirees that they are now paying for. After that comes rationing. I think there are a lot of disadvantages for seniors in this bill, Mr. Speaker.

HOLDING THE ADMINISTRATION ACCOUNTABLE

(Mr. ETHERIDGE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. ETHERIDGE. Mr. Speaker, I rise today to call on Congress to support accountability in education reform. Last year, Congress passed President Bush's "no child left behind" education reform bill. The legislation authorized billions of dollars in new funding to support administration's reform effort that seeks to ensure accountability from our schools, but who will hold the administration accountable?

The fact is that this administration is shortchanging our schools nearly $20 billion under the No Child Left Behind. While our schools' struggle to meet tough new standards and local budgets is stretched to the limit in this bad economy, the administration has failed its responsibility to provide leadership and resources for our schools. Congress must hold the administration accountable. I have introduced legislation to do just that. H.R. 2366 requires full funding of the No Child Left Behind act or suspends its punitive measures. Without full funding, No Child Left Behind will become a massive unfunded mandate that will require cuts in vital services and increased property taxes or both. Similar legislation has been introduced in the other body, and I urge my colleagues to join me in this effort to hold the administration accountable to our children, to our schools, and to our taxpayers.

PRESCRIPTION DRUGS

(Mr. STEARNS asked and was given permission to address the House for 1 minute.)

Mr. STEARNS. Mr. Speaker, this Congress has an unprecedented opportunity to give America's seniors an up-to-date Medicare system that includes more choices and better benefits like prescription drug coverage. Health care is being transformed by new drug therapies and active prevention. Yet in the current system, Medicare must pay for those treatments out of their own pocket or go without them. One third of the seniors on Medicare have no drug coverage at all, and that is about 900,000 American seniors.

Our seniors should have choices so affordable health care plans compete for their business and at the same time give them the coverage that they need. Medicare recipients who are happy with their current benefits will be able to stay in the current system with an added prescription drug benefit. So our program is voluntary. Those who want enhanced services, like more coverage for preventative care, will have that choice; and seniors who like managed care plans will have that option as well. This is a plan we Republicans passed out of committee, and this is a plan we will pass very soon here in Congress.

HONORING OUR ARMED FORCES IN THE KOREAN WAR

(Ms. LORETTA SANCHEZ of California asked and was given permission to address the House for 1 minute.)

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I rise today to pay tribute to the brave men and women who served in the Armed Forces and fought for the freedom of the Korean people. This week marks the 50th anniversary of the signing of the cease-fire agreement that ended the fighting of the Korean War. A peace treaty was never signed, leaving strained relations on the Korean peninsula until today. Armed Forces from over 20 countries came together to fight in what is often called the "forgotten war." Casualties in the United States Armed Forces totalled 54,260 dead, with 8,176 listed as missing in action or as prisoners of war.

I would also like to recognize Orange County resident Martin Markley, who recently received a Bronze Star for combat valor after surviving a bloody battle in Korea over 50 years ago, and I want to give my thanks to those veterans who helped defend for the Korean people; and I want to extend my sympathy to those who lost loved ones during that war. They have not been forgotten and their memory will always be remembered.

PARLIAMENTARY INQUIRY

Mr. KINGSTON. Mr. Speaker, parliamentary inquiry. May I use the name of a Senator, a sitting Senator in attributing a quote to him or her?

The SPEAKER pro tempore (Mr. TERRY). During 1-minutes, the gentleman may not refer to or quote Senate proceedings, but may refer to statments made generally with attribution.

SADDAM HUSSEIN AND WEAPONS OF MASS DESTRUCTION

(Mr. KINGSTON asked and was given permission to address the House for 1 minute.)

Mr. KINGSTON. Mr. Speaker, today we are going to be working on the intelligence bill, probably voting on it later this week; and we are going to be hearing a lot from the left in this Chamber that we have not located weapons of mass destruction in Iraq and somehow the President is at fault. I just wanted to remind my colleagues what some of their Democrat Members in the other body said.

Here is a Member from Indiana, October 3, 2002: "Saddam Hussein possesses chemical, biological weapons and, if events are allowed to run their own course, will some day possess nuclear weapons."

Here is another Senator from California, a woman. My colleagues get the choice which of the two: "I believe that Saddam Hussein rules by terror and has squirreled away stores of biological and chemical weapons." That was October 10, 2002.

Here is a Senator from West Virginia, one with a very common name: "The people of the United States and the rest of the world are at risk as long as Saddam Hussein has weapons of mass destruction," March 18, 2003.

And here is another one from a Senator from Maryland: "Over the last 12 years he's ignored U.N. resolutions and embargoes and has illegal chemical and biological weapons . . ." That was March 18, 2003.

Many, many leading Democrat liberals were in support of our going into Iraq in the name of weapons of mass destruction. I just want our colleagues to keep that in mind as we debate this bill today.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair reminds the gentleman from Georgia that he is not allowed to make such references to members of the other body.

MEDICARE ON THE HIT LIST

(Mr. DAVIS of Illinois asked and was given permission to address the House for 1 minute.)

Mr. DAVIS of Illinois. Mr. Speaker, down-size, out-source, privatize, erode, dismount, turn back the clock, all buzz words which characterize the thought and actions of many of our Republican colleagues. And now Medicare is on the hit list. And our seniors are being told that they are going to get a prescription drug plan. Yes, we need a plan, but we do not need one that dismantles Medicare. We do not need one that turns back the clock. We do not need one that skyjacks our seniors and prices them out of the market. They want real government for all people, including our seniors.

CHILD TAX CREDIT

(Ms. SCHAKOWSKY asked and was given permission to address the House for 1 minute.)

Ms. SCHAKOWSKY. It is obvious that the Republicans cannot do two important things at one time. Remember the 12 million children whose tax credit was dumped from the tax bill to make room for millionaires, including 1 million children of families in the military?

Mr. Speaker, yesterday the Republican leader announced that they were just too busy. He said, We have a problem with simple logistics. That is why we cannot take care of the 12 million children.

He was referring to how busy the Republicans are steamrolling through a bill that turns Medicare into a voucher program, throws money at HMOs, lets drug companies continue to gouge, and leaves seniors with thousands of dollars in drug bills. The majority leader, the President, and everybody in this body knows that we could resolve the child tax credit issue in a matter of hours. All that has to happen is for the Republican leadership to stop holding these children hostage, demanding a ransom of $82 billion unpaid-for tax package. All it takes is for the House to accept the Senate bill, as a majority of the House voted to do. All it would take would be for President Bush to interrupt his whirlwind fund-raising tour long enough to demand immediate enactment of the Senate bill. Surely we can find a couple of hours here so that 12 million children are not left behind.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote is objected to under clause 6 of rule XX.

Record votes on postponed questions will be taken later today.

□ 1030

ABRAHAM LINCOLN BICENTENNIAL COMMISSION

Mr. SOUDER. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 858) to extend the Abraham Lincoln Bicentennial Commission, and for other purposes.

The Clerk read as follows:

S. 858

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ABRAHAM LINCOLN BICENTENNIAL COMMISSION.

(a) DUTIES.—Section 4 of the Abraham Lincoln Bicentennial Commission Act (36 U.S.C. note prec. 101; Public Law 106-173) is amended—

(1) in paragraph (1)(D), by striking "redesignation" and inserting "rededication"; and

(2) by adding at the end the following:

"(3) To recommend to Congress a plan to carry out the activities recommended under paragraph (2).

"(4) To carry out other related activities in support of the duties carried out under paragraphs (1) through (3).".

(b) EXTENSION.—Section 8 of such Act (36 U.S.C. note prec. 101; Public Law 106-173) is amended—

(1) in subsection (a), by striking "The" and inserting "In addition to the interim report required under subsection (b), the";

(2) in subsection (b)—

(A) in the subsection heading, by striking "FINAL REPORT.—" and inserting "REQUIRED INTERIM REPORT.—";

(B) by striking the first sentence and inserting: "Not later than June 24, 2004, the Commission shall submit an interim report to Congress."; and

(C) in the second sentence, by striking "final"; and

(3) by adding at the end the following:

"(c) FINAL REPORT.—Not later than April 30, 2010, the Commission shall submit a final report to Congress. The final report shall contain final statements, recommendations, and information described under subsection (b)(1), (2), and (3).".

The SPEAKER pro tempore (Mr. TERRY). Pursuant to the rule, the gentleman from Indiana (Mr. SOUDER) and the gentleman from Illinois (Mr. DAVIS) each will control 20 minutes.

The Chair recognizes the gentleman from Indiana (Mr. SOUDER).

Mr. SOUDER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, as a member of the Advisory Commission of the Abraham Lincoln Bicentennial Commission, I am proud the House is considering this legislation. This commission was established by Congress through the Abraham Lincoln Bicentennial Commission Act in 2000 through the 106th Congress.

The commission works to honor President Lincoln's momentous legacy by educating the general public on his unequaled contributions to our great Nation. It can be a universally celebrated event of racial reconciliation. It can be a time and an example for unifying America, increasingly diverse with many different populations, about the importance of having a united Nation and a united America.

This bicentennial can also highlight the unique American experience of being able to rise up from growing up in a log cabin, people of diverse backgrounds being able to rise to the very top of positions of power in America.

I am pleased that this bill will extend the commission until 2010, which will allow it to continue its valuable work through the upcoming celebration of the 200th anniversary of President Lincoln's birth in 2009.

I am pleased the other body has already passed this bill that honors perhaps our Nation's most extraordinary and cherished President. I congratulate the accomplished members of the commission for their work. We look forward to the commission's final report that will be due to Congress on April 30, 2010, if this bill is passed.

Mr. Speaker, therefore, I urge all Members to support the passage of S. 858, and I thank the Senator from Illinois (Mr. DURBIN) for introducing this important measure.

Mr. Speaker, I reserve the balance of my time.

Mr. DAVIS of Illinois. Mr. Speaker, I yield myself such time as I might consume.

Mr. Speaker, President Abraham Lincoln is considered by many to be the most outstanding President this country has ever had. As a matter of fact, many have suggested that he was courageous, often misunderstood, renowned in his ability to see situations and then move on them. So I am pleased to join with my colleague from Indiana in consideration of Senate bill 858, a bill to extend the Abraham Lincoln Bicentennial Commission.

The Abraham Lincoln Bicentennial Commission was established by Congress in 2000 to plan the national observances of the 200th anniversary of Abraham Lincoln's birthday in 2009. Fifteen Americans were named by the White House, the House of Representatives and the Senate to work together to propose and craft programs of celebration and education.

S. 858 would extend the authorization for the Abraham Lincoln Bicentennial Commission through the bicentennial year of 2009. Under current law, the commission would pass out of existence in 2004, 5 years before the event it is supposed to commemorate. In addition to the requirement that the commission submit an interim report in June of 2004, S. 858 also requires that a final report be issued in 2010 after the conclusion of bicentennial festivities.

Obviously, Mr. Speaker, this legislation has tremendous support, and I would urge its passage.

Mr. Speaker, I reserve the balance of my time.

Mr. SOUDER. Mr. Speaker, I yield as much time as he may consume to the gentleman from Illinois (Mr. LAHOOD), the distinguished sponsor of the original legislation that established the Abraham Lincoln Bicentennial Commission, as well as a cochair of the commission, without whose work this would not have occurred.

Mr. LAHOOD. Mr. Speaker, I want to thank my friend from Indiana for his comments.

I rise in support of the Senate bill 858, a bill to continue the important work of the Abraham Lincoln Bicentennial Commission. I encourage all of our colleagues to join with me in voting for this fitting tribute to our greatest President. I want to thank Senator DURBIN for getting this through the United States Senate, and I want to thank the majority leader's office for scheduling this for consideration today.

It is my honor to serve as cochair of the Abraham Lincoln Bicentennial Commission along with Senator DURBIN of Illinois and Mr. Harold Holzer of New York, a noted Lincoln scholar.

Created by Congress, the commission has 15 members and is charged with planning and organizing the national celebration of Lincoln's 200th birthday on February 12, 2009. Current plans for the bicentennial include a joint session of Congress, educational initiatives throughout the country, a new Lincoln penny, film projects and much more.

In celebrating Lincoln's birthday, we honor not just the memory of one man but also the promise of America's freedom. The ongoing struggle against tyranny abroad and the continued fight for racial justice at home both find their inspiration in the life and work of Abraham Lincoln.

Last year, the commission appointed an executive director and moved into offices in the Library of Congress. We have held meetings in Illinois, Kentucky and Washington and will travel to Indiana next year and will also be in Vermont this year.

Through our Web site, www.lincolnbicentennial.gov, we have already received countless suggestions from the public about how best to celebrate this important national event.

This year, the commission celebrated Lincoln's birthday by gathering together our distinguished advisory committee. Made up of scholars, business people and artists, we asked for their help in planning for the bicentennial. That evening nearly 500 people and many more watching C-SPAN witnessed "Lincoln Seen and Heard" in which the acclaimed actor Sam Waterston gave a dramatic performance of Lincoln's speeches, while Harold Holzer provided the accompanying images and narration.

Through events like this, we hope to raise the profile of the commission and prepare the public for the important occasion of Lincoln's 200th birthday, which we hope to celebrate nationwide and around the world.

It is vital that this important commission be allowed to continue its work through the actual bicentennial celebration. This bill would simply extend the life of the commission through the bicentennial year and require a final report so that future generations will have a record of how we celebrated the life of the foremost champion of human liberty.

Therefore, as the representative of the same District that sent Abraham Lincoln to Congress and as cochair of the Abraham Lincoln Bicentennial Commission, I urge my colleagues to support S. 858. I thank the gentleman from Indiana for the time.

Mr. DAVIS of Illinois. Mr. Speaker, it is my pleasure to yield such time as he might consume to the gentleman from Illinois (Mr. JACKSON), a Lincoln scholar, a civil war era buff, and a great historian who has studied and written extensively about this period.

Mr. JACKSON of Illinois. Mr. Speaker, let me begin by thanking the distinguished gentleman from Illinois for the very kind and generous and very thoughtful introduction.

Mr. Speaker, I rise today in strong support of this bill to extend the Abraham Lincoln Bicentennial Commission. I might also add, Mr. Speaker, that the gentleman from Illinois (Mr. LAHOOD) is to be congratulated for his foresight in the creation of this legislation and the appropriate ways that a commission might study the ways in which this Nation might honor, I believe, our most revered President.

I was recently appointed by the distinguished Democratic leader to the 15-member commission which has the esteemed responsibility of studying and recommending to Congress ways to appropriately honor President Lincoln in 2009, the bicentennial of his birth. I think it is very important to interpret the 16th President's life and work.

President Lincoln was an anti-slavery advocate in a Republican Party that sprang to live on an anti-slavery platform. His election in 1860 added fuel to the fire of disunion over slavery and its spread west, a disunion that triggered the American Civil War. While Lincoln was gradualist in his approach to ending slavery, he never wavered on a position that he knew would lead to its end. Slavery would not be allowed to spread into the western territories.

Initially seven, and ultimately eleven, southern States seceded from the Union rather than live under the rule of what many Democrats of that era referred to and called the black Republican Party.

Lincoln valued the Union above all, but he knew that the result of saving the Union was emancipation for the slaves. If the Union had not been preserved, slavery would not have been ended. Strategically, Lincoln understood that the Union was a common ground issue around which he could rally the American people while slavery was divisive.

By holding his coalition together around the issue of the Union, enough unionists eventually saw the connection between preserving the Union and ending slavery. Clarity on that connection helped Lincoln ease into emancipation in the middle of the war when it gave the North a huge boost. This cleared the way for the 13th, the 14th and the 15th amendments to the Constitution of the United States.

President Lincoln said 140 years ago this November in Gettysburg that government of the people, by the people, and for the people shall not perish from the face of the Earth. To Lincoln, the people meant every American, not just a select few. His policy and ultimate sacrifice for this noble belief are instructive for every American, especially public servants.

I am deeply honored to be among those who will shape a national celebration of his legacy.

Mr. SOUDER. Mr. Speaker, I yield myself such time as I may consume.

One of the other things I would like to add to the record about the extraordinary President Abraham Lincoln are that he gave two of the most outstanding speeches of all time in American history, the Gettysburg Address and the Second Inaugural.

In the book Lincoln at Gettysburg by the gifted writer Gary Wills, he points out an extraordinary point that the gentleman from Illinois (Mr. JACKSON) just referenced, and that is that the President did not directly address the biggest issues of the day. He indirectly tried to build a coalition to unite our Nation.

As Gary Wills points out, the Gettysburg Address does not mention Gettysburg, nor slavery, nor, more surprising, the Union or the South or the Emancipation Proclamation. Wills refers to it as a transcendental declaration. He laid the groundwork behind uniting America in a union where we would stand together, and in the opening phrase, taking out a few words of it and putting it down in its core form, we are engaged in testing whether any free Nation can survive, and that is what his message of the Gettysburg Address was.

His Second Inaugural speech, which many feel was his greatest speech, also subject to a second book by Stephen White, he pointed out that that was a brilliant theological address, stunned Congress, stunned the press of the United States because it was very short. Here they were very near the end of the Civil War, at a time when people wanted an address from their President, celebrating victory or talking about how things were going to work, and he made a seemingly impersonal address.

Nine straight Presidents did not serve a second term. He was the first President in 10 to serve a second term. Yet in his Second Inaugural he never said anything about that. He made it sound like it was kind of an accident he was there, because what his purpose was was to give a theological address on why both sides argued in the name of God, both sides thought that they were trying to do that, some people thought it was fatalistic, but he actually laid a theological argument out as to why we fought a Civil War, why it was important that we fought that Civil War and God's role in human history.

He may have been raised as a simple country boy, but he wrote and personally edited, and we can see all the notes as he worked through the speeches, two of the most powerful and enduring documents in world history. In the Hoosier State, with all due respect to the gentleman from Illinois (Mr. DAVIS), the gentleman from Illinois (Mr. JACKSON) and the gentleman from Illinois (Mr. LAHOOD), we have an expression, Abraham Lincoln grew up in Indiana. He is our most famous Hoosier. We say Indiana made Lincoln. Lincoln made Illinois.

Lincoln epitomizes the American dream, that he grew up in a log cabin in Kentucky where he was born and the first few years of his life. Then he moved to Indiana as a very young boy, grew up in multiple log cabins there in Indiana. He largely educated himself, moved to Illinois, taught himself the law, ran for office, losing more than he won. He participated in arguably the most famous of all American debates, the Lincoln-Douglas debates. He eventually rose as a compromise candidate for President, was trounced on the first ballot but came out as a compromise President, but almost every American will agree it is a classic example of the right man in the right place at the right time.

This is important for the rest of the world because Abraham Lincoln epitomizes the American dream. The four of us who spoke here, the gentleman from Illinois (Mr. DAVIS) and the gentleman from Illinois (Mr. JACKSON) and the gentleman from Illinois (Mr. LAHOOD) and myself, all come from different backgrounds. None of us were probably born in a log cabin, and our Speaker, who is a super Lincoln fan, who has turned his conference room into the Lincoln Room with paintings and statuary and other things of Abraham Lincoln, he himself grew up in small town Illinois. He would have liked to have been born in a log cabin, but he was not.

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But he grew up in Illinois and prides himself on rising up like others in the American Dream.

Abraham Lincoln is an example to us of racial reconciliation, of united nations, of rising up in the American Dream; and that is important in understanding why, like during the 10 years of this commission, we continue to develop at the grass roots level, the same way this commission has started to do, innovative ideas, bubbling up in community after community of how we can recognize those things that unite us as a Nation and to build on that so we do not come apart at the seams like we have seen in many nations around the world.

Mr. Speaker, I do not have any other colleagues who want to speak on this, but I want to thank, again, the Senator from Illinois in the other body, the gentleman from Illinois (Mr. LAHOOD), the gentleman from Illinois (Mr. DAVIS), and the gentleman from Illinois (Mr. JACKSON) for supporting this, and I urge all Members to support its passage.

Mr. Speaker, I yield back the balance of my time.

Mr. DAVIS of Illinois. Mr. Speaker, I yield myself such time as I may consume, and though I do not have any additional speakers, I will close by simply saying that I grew up an Abraham Lincoln fan as a little boy. My mother, who did not have much formal education, nor did my father, they were both Abraham Lincoln fans and they told us stories about Abraham Lincoln. This obviously whetted my appetite, and I became an Abraham Lincoln guy who read everything that I could get my hands on about Lincoln.

It is obvious from all of the comments that we have heard that Indiana, Illinois, and I guess we have to add Kentucky, have great memories and great fondness for the legacy of Abraham Lincoln, who would probably be considered a great communicator. We did not talk so much about people being communicators then. Now we talk about communication skills and abilities; but I guess he could communicate so much in just a few words, in things like the Lincoln Gettysburg Address and other comments that he made.

The one quote that I often like to suggest that Lincoln made was about education. He said that "education makes a man easy to lead, but difficult to drive; easy to govern, but impossible to enslave." So as we put resources into budgets for education, I always try to remember Abraham Lincoln.

Ms. SLAUGHTER. Mr. Speaker, I rise in strong support of S. 858, a bill to extend the Abraham Lincoln Bicentennial Commission.

History recognizes Abraham Lincoln as one of this Nation's greatest and most visionary Presidents. Born in rural Kentucky, Lincoln rose from humble roots to the highest office in the land. He was renowned as a masterful orator and legislator. He led our country through its greatest internal crisis, our Civil War, with a decisiveness balanced with humanity. In 1863, Lincoln issued the revolutionary Emancipation Proclamation, freeing all slaves in the South. And he professed himself committed to rebuilding our Nation into a strong, united entity through a generous, practical reconstruction program in the South.

Tragically, Lincoln never had the opportunity to act upon his vision for Reconstruction. Just 5 days after Lee's surrender at Appomattox, Lincoln was shot at nearby Ford's Theater. He died of his wounds the next morning. An outpouring of grief swept across the Nation, with thousands meeting his funeral train at every stop.

Abraham Lincoln embodied the principles and qualities our Nation values most highly. He was scrupulously honest, forthright, and moral. In all matters of governance, he made decisions based on his desire to do the greatest good for the largest number of people. He was utterly committed to the fair treatment of all Americans and to healing the wounds of our internal divisions.

As a Member of Congress, I strive to emulate Lincoln's example. In doing so, I am deeply proud to say that I am deeply proud to say that I am carrying on a family heritage. I can trace my own ancestry back to Lincoln himself; our families lived in the same part of Kentucky. His portrait hangs in my office as a constant reminder of his noble spirit and eloquent example.

The Abraham Lincoln Bicentennial Commission was established in 2000 to inform the public about the impact Abraham Lincoln had on the development of our Nation and to identify the best possible ways to honor his accomplishments. The Commission has already done a great deal of excellent work and looks forward to doing much more. Under the original legislation, however, the Commission is scheduled to expire this year—3 years before the actual Lincoln Bicentennial in 2003. This legislation would extend the Commission's life through the bicentennial it was established to celebrate.

Just last month, I was deeply honored to be appointed to the Commission's advisory board. It will be my privilege to work with my fellow board members and the Commission to educate our Nation about my kinsman and role model.

I urge my colleagues to join me in supporting S. 858 and honoring the legacy of Abraham Lincoln. Without his leadership, our Nation would not be the strong, unified United States we are today.

Mr. EVANS. Mr. Speaker, as Representative for the 17th Congressional District in Illinois, a district encompassing Springfield, Illinois, where Abraham Lincoln got his political start, I pledge my support for the Abraham Lincoln Bicentennial Commission.

Abraham Lincoln first came to Illinois in March of 1830, and like so many of us he came to love the beautiful state, its good people, and its bountiful opportunities. Abraham Lincoln was a patriotic man and a courageous leader. He led our Nation through one of the darkest times in its history, and helped to shape it into the great country that it is today.

The Abraham Lincoln Bicentennial Commission is dedicated to preserving and honoring the legacy of Abraham Lincoln. It will provide education to the American public about President Lincoln's accomplishments, as well as striving to honor his works.

I encourage everyone to visit Illinois and see the many sites commemorating President Lincoln, not only in Springfield, but throughout the state. It is important to continue to urge Americans to learn about the history of our Nation and the people who have made it so great. Abraham Lincoln is one of the most important figures who contributed to this rich history of which we are so proud.

Mr. EMANUEL. Mr. Speaker, I rise today in strong support of Senator RICHARD J. DURBIN's bill, S. 858, to extend the Abraham Lincoln Bicentennial Commission and to inform the American public about his selfless dedication and sacrifice to our country.

It is my privilege to represent Illinois in the House of Representatives just as Abraham Lincoln did more than a century and a half ago. I am honored to share this association with one of our nation's greatest lawyers, legislators, and Presidents.

Toward the end of this decade, on February 12, 2009, we will recognize the 200th anniversary of President Lincoln's birth. Passage of this bill authorizes the Bicentennial Commission to explore the best possible ways to honor his lasting accomplishments.

Our state slogan, "Land of Lincoln" reflects how proud Illinoisans are of his enduring contribution to America's unity and strength. His home in Springfield, Illinois is a National Historic Site administered by the National Park Service, and his tomb in Oak Ridge Cemetery, also in Springfield, is among the most visited sites in our state.

Mr. Speaker, I thank Senator DURBIN for introducing this legislation to make certain that a hero to all in my home state of Illinois and throughout the nation is honored appropriately. I strongly encourage all of my colleagues to vote for S. 858, authorizing the Abraham Lincoln Bicentennial Commission to help preserve the memory of his noble vision, statesmanship and humanity forever in American history.

Mr. DAVIS of Illinois. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from Indiana (Mr. SOUDER) that the House suspend the rules and pass the Senate bill, S. 858.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. SOUDER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

TEMPORARY AUTHORITY FOR CONGRESSIONAL HUNGER CENTER TO AWARD BILL EMERSON AND MICKEY LELAND HUNGER FELLOWSHIPS

Mr. GOODLATTE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2474) to require that funds made available for fiscal years 2003 and 2004 for the Bill Emerson and Mickey Leland Hunger Fellowships be administered through the Congressional Hunger Center, as amended.

The Clerk read as follows:

H.R. 2474

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TEMPORARY AUTHORITY FOR CONGRESSIONAL HUNGER CENTER TO AWARD BILL EMERSON AND MICKEY LELAND HUNGER FELLOWSHIPS.

Notwithstanding the Congressional Hunger Fellows Act of 2002 (section 4404 of Public Law 107–171; 2 U.S.C. 1161), funds appropriated for fiscal years 2003 and 2004 for the purpose of providing the Bill Emerson and Mickey Leland Hunger Fellowships shall be made available to the Congressional Hunger Center for the purpose of awarding the fellowships, except that any such funds provided in excess of $3,000,000 in fiscal year 2003 or $3,000,000 in fiscal year 2004 shall be appropriated to the Congressional Hunger Fellows Trust Fund established by such Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia (Mr. GOODLATTE) and the gentleman from Texas (Mr. STENHOLM) each will control 20 minutes.

The Chair recognizes the gentleman from Virginia (Mr. GOODLATTE).

Mr. GOODLATTE. Mr. Speaker, I yield myself such time as I may consume, and I rise in support of H.R. 2474, a bill that provides for the continuation, for 2003 and 2004, of a fellowship program honoring our colleagues, the Honorable Bill Emerson and the Honorable Mickey Leland.

Last year, Congress authorized the Congressional Hunger Fellows Program as a part of the Farm Security and Rural Investment Act of 2002. This provision was included in both the Committee on Agriculture bill and the law as a memorial to the Honorable Bill Emerson, a former member of the Committee on Agriculture, and the Honorable Mickey Leland. The purpose of the fellowships is to develop and train future leaders of the United States in humanitarian service.

The law establishes an independent agency in the legislative branch of the U.S. Government, creates a board of trustees to supervise and direct the program, establishes a Congressional Hunger Fellows trust fund in the Department of the Treasury that will provide funds from the interest to help run the program, and authorizes $18 million for the fund.

While the necessary process to establish a congressional Hunger Fellows Program has begun, the process is not complete. H.R. 2474 allows the current process to continue utilizing the Congressional Hunger Center just until the program authorized by the farm bill is completed. These fellowships provide a way to continue the legacy established by our former colleagues Bill Emerson and Mickey Leland and move towards achieving the valued goal of training future leaders of the United States in humanitarian service, goals I know Members share with me.

Mr. Speaker, I want to thank my colleague, the wife of the late Congressman Bill Emerson, the gentlewoman from Missouri (Mrs. EMERSON), and his successor, for introducing this legislation; and I urge my colleagues to support H.R. 2474.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield myself such times as I may consume.

Mr. Speaker, I rise in support of H.R. 2474, which requires that funds made available for the Bill Emerson National Hunger Fellowship and the Mickey Leland International Hunger Fellowships are to be awarded through the Congressional Hunger Center. This piece of legislation is needed to ensure that funds already appropriated to provide hunger fellowships in the fiscal year 2003 are able to be used for that purpose. In addition, it will ensure that funds made available in fiscal year 2004 are also available for these fellowships.

In the farm bill, we created the Congressional Fellows Hunger Act of 2002, which authorizes $18 million to a trust to be used as an endowment to provide domestic and international hunger fellowships. The program is overseen by a board of trustees, which only recently was appointed. Because of the time needed to establish the program as envisioned by the authorizing language, the funds provided for the fellowships in the fiscal year 2003 agricultural appropriations act are not available. This bill will allow those funds to be used by the Congressional Hunger Center for hunger fellowships.

The Congressional Hunger Center was formed in 1993 with a mandate to lead, speak, and act on behalf of the poor, the hungry, and the victims of humanitarian emergencies both on a domestic and international level. The Congressional Hunger Center, through its leadership development programs and its education, research, and advocacy programs has, as of 2002, graduated over 500 antihunger leaders who address hunger at the community, national, and international levels.

The fellowships originally awarded by the Congressional Hunger Center and codified in the Congressional Fellows Hunger Act of 2002 were designed, as we have heard, to honor the memories of Bill Emerson and Mickey Leland, who, during their careers in public service, were deeply interested in helping those in need by their words and by their actions. Bill Emerson, the distinguished late Representative from the eighth district of Missouri, and George T. Mickey Leland, the distinguished late Representative from the 18th district of Texas demonstrated their commitment to solving the problem of hunger in a bipartisan manner.

Providing the $3 million in funding to the Congressional Hunger Center for fiscal years 2003 and 2004 will ensure that the spirit of these two leaders will live on through the fellowships by making sure that there will be a future generation of leaders who will pursue careers in humanitarian service related to hunger.

Mr. Speaker, I reserve the balance of my time.

Mr. GOODLATTE. Mr. Speaker, I yield myself such time as I may consume to thank the gentleman from Texas for his support and leadership on this legislation.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from Missouri (Mrs. EMERSON), who has carried on the fight against hunger here in the United States and around the world that her late husband, Bill Emerson, was so well noted for. I thank her for that work.

Mrs. EMERSON. Mr. Speaker, I thank the gentleman from Virginia (Mr. GOODLATTE) for yielding me this time and for the graciousness which he has shown, as well as that of the gentleman from Texas (Mr. STENHOLM), in allowing us to make the corrections on the legislation that will permit the Hunger Fellows to proceed with the remarkable work that they do.

I also want to thank the gentleman from Illinois (Mr. HYDE), because this bill also goes through IR, and I want to thank Kevin Kramp and Lynn Gallagher from the Committee on Agriculture, and Frank Record from the Committee on International Relations, because without their great assistance we would not be here today.

I also want to thank both the gentleman from Virginia (Mr. GOODLATTE) and the gentleman from Texas (Mr. STENHOLM) for the wonderful words they had to say about my late husband, Bill Emerson, and the commitment he had throughout his lifetime to prevent hunger wherever it is found.

Mr. Speaker, passage of this bill is critical for the future of the Bill Emerson and Mickey Leland Hunger Fellowships. The funding for the 24 Bill Emerson National Hunger Fellows and the 50 Mickey Leland International Hunger Fellows will expire, as my colleagues have said, unless this legislation passes.

These 39 Fellows fight hunger and poverty worldwide. They each earn just $10,000 helping nutritionally vulnerable populations in urban and rural communities get food. For example, the Emerson Fellows assist low-income communities in getting access to fresh fruits and vegetables, as well as helping to do the same for Federal nutrition programs for school-aged children and the elderly. The Leland Fellows work with national and international agencies and faith-based groups to get school lunches to over 300 million children overseas.

In their work, the Fellows are constantly faced with things that we do not normally see on a daily basis, threats of terrorism, crime, AIDS, and, most recently, SARS, while helping the communities in which they are living formulate solutions to ending hunger and poverty.

For the past 3 years, many may know that agricultural appropriations and private foundations have funded the Emerson-Leland Fellows through the Congressional Hunger Center. As my colleagues have mentioned, the farm bill did authorize an endowment for the Congressional Hunger Fellows program, which incorporated the current Fellows program operated by the Congressional Hunger Center. But because operating funds for the endowment are not yet in place, the Congressional Hunger Center is left without operating funds to recruit for their future classes. This legislation will allow the program to continue while we establish the endowment.

So, again, I want to thank the chairman, the gentleman from Virginia (Mr. GOODLATTE), the gentleman from Texas (Mr. STENHOLM), the gentleman from Illinois (Mr. HYDE), and my good colleague, the gentleman from Massachusetts (Mr. McGOVERN), who helps cochair the Congressional Hunger Center, for all the work that they do in helping a problem that should not exist but, sadly, it does, and, hopefully, one day soon, we will find a means to make certain that no person on Earth goes hungry.

Mr. STENHOLM. Mr. Speaker, I yield such time as he may consume to the gentleman from Massachusetts (Mr. McGOVERN).

Mr. McGOVERN. Mr. Speaker, I thank the distinguished gentleman from Texas for yielding me this time, and I also applaud his incredible work on behalf of the hungry around the world and here in the United States. I also want to thank the chairman of the committee, the gentleman from Virginia, for bringing this bill so quickly to the House floor for consideration.

Mr. Speaker, I rise in support of H.R. 2474, authorizing the Bill Emerson and Mickey Leland Hunger Fellowships and urge its swift passage by this House. I want to acknowledge the leadership of my friend and colleague, the gentlewoman from Missouri (Mrs. EMERSON), and to thank her for her many contributions to ending hunger here at home and abroad. She has honored the memory of her husband and our former colleague, Bill Emerson, in whose honor the National Hunger Fellowships at the Congressional Hunger Center are named.

I have had the privilege of working closely with the gentlewoman from Missouri over the past few years, first when we helped create the Global Food for Education Initiative, known as the George McGovern-Robert Dole International Food for Education and Child Nutrition Program, and now when we serve together as the cochairs of the Congressional Hunger Center. I admire her leadership and determination, and I hope to learn a great deal more from her about how best to end hunger, honor America's farmers, and contribute to increasing food security for all nations.

Mr. Speaker, H.R. 2474 will correct a simple error in last year's farm bill reauthorization that authorized funding for the Bill Emerson and Mickey Leland Hunger Fellowships, but inadvertently channeled the monies to the Congressional Hunger Center's endowment rather than through the Center's program budget. Passage of H.R. 2474 will ensure that the two fellowship programs are administered and funded through the Congressional Hunger Center for fiscal year 2003 and fiscal year 2004.

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This adjustment will allow for the endowment to have enough time to build so it may sustain funding for the Congressional Hunger Center over the long term without interrupting the Bill Emerson and Mickey Leland Hunger Fellowships program in the short term. I also thank the gentlewoman from Missouri (Mrs. EMERSON), the gentleman from Texas (Chairman BONILLA), and the gentlewoman from Ohio (Ms. KAPTUR), the ranking member on the subcommittee for agricultural appropriations, for including the appropriate allocations for these hunger fellowships in the fiscal year 2004 agriculture appropriations bill. I also would like to express my appreciation to Jim Dyer, the majority staff director for the Committee on Appropriations, for his help and support on this matter.

Mr. Speaker, today I have had the privilege of meeting the newest class of Mickey Leland International Hunger Fellows who are in Washington for their initial orientation. The Congressional Hunger Center received 155 applicants for these fellowships, which were narrowed to 50 finalists, and 15 young men and women were chosen to receive these fellowships.

The Leland Fellows will work for 2 years on hunger issues, including a 1-year field placement in countries throughout South Asia, sub-Saharan Africa and Latin America. The class of 2003–2005 will work in Thailand, Uganda, Malawi, Ethiopia, the Philippines, Indonesia, Guatemala, Bangladesh, Mexico, Mauritania, and in East Africa. Their field placements include national and international nongovernmental organizations, private commercial organizations, and bilateral and multilateral agencies. They will spend their second year in the headquarters of the organizations that sponsor their field placements where they will focus on policy-making to address the root causes of hunger.

I know that our friend and former colleague, Mickey Leland, is looking down on these dedicated young people and is proud that the work they are doing in his name will create future leaders in the fight on hunger and poverty.

The Bill Emerson National Hunger fellows Program annually selects around 20 participants who work for 6 months in rural and urban community-based organizations across the country involved in fighting hunger at the local level. Their 6 months is spent in national nonprofit organizations engaged at the national level in antihunger and antipoverty work. This year, 24 men and women will represent the 10th class of Emerson Fellows.

Together, these two hunger fellowship programs, administered and coordinated by the Congressional Hunger Center, are having a significant impact on the fight to end hunger in America and around the world.

Mr. Speaker, I would like to acknowledge the gentleman from Virginia (Mr. WOLF) and our former colleague Tony Hall, who were instrumental in establishing the center 10 years ago. Congress can take great pride in the support for the Congressional Hunger Center and the Bill Emerson and Mickey Leland Hunger Fellowship programs. I urge my colleagues to support H.R. 2474.

Mr. STENHOLM. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this is a good bill. It is a good program. It has the kind of leadership and oversight from the gentleman from Massachusetts (Mr. McGOVERN) and the gentlewoman from Missouri (Mrs. EMERSON) that we in Congress appreciate very much. I urge support of the bill. I thank the chairman for his leadership in this endeavor.

Mr. WOLF. Mr. Speaker, I rise in support of H.R. 2474. The Congressional Hunger Center was established 10 years ago with a mission of fighting hunger by developing leaders. They have been doing that ever since.

When I think of the Congressional Hunger Center, I think of my good friend Ambassador Tony Hall. It was Tony who first got me involved in fighting hunger. In 1984, he persistently encouraged me to travel to the Horn of Africa to witness the devastation of the famine. As many of you know, that experience changed my life.

Many of the Congressional Hunger Center fellows are having similar experiences right now. There are Bill Emerson fellows who are having life-changing experiences in 12 locations across the country and Leland International Fellows in 15 locations throughout the world. The combination of the life-changing practical and the policy experiences will equip these young people to be active leaders on hunger issues wherever they may go.

One of the program's most committed international fellows is Robert Oliver Davila. Robert was a Peace Corps volunteer in Africa for three years. He joined the first class of international fellows after being a manager at the Worcester County Food Bank. Robert visited schools all over Ethiopia helping them implement the World Food Programme Global School Lunch Program. Robert monitored and evaluated the impact of the program on the lives of children, families and communities. Robert is now working with the Global School Feeding Support Unit in the Strategy and Policy Division of the World Food Programme.

Sarah Boron, from Dennison University in Ohio, helped develop a model to assess food and farm issues at Food for Lane County in Eugene, Oregon. Sarah is now helping local groups form food policy councils through the Community Food Security Coalition.

Many of us who have supported the Congressional Hunger Center over the years have maintained a vision of self-sufficiency for the organization in the future. As some of you know, Congress has been providing the bulk of the Hunger Center's operating budget each year through annual appropriations. Last year, the dream of self-sufficiency came closer to being a reality.

In the 2002 Farm Bill, Congress authorized an endowment to move the Hunger Center's fellows programs toward self-sufficiency. Unfortunately, when the appropriations committee provided funding for the newly authorized endowment, the Congressional Hunger Center was not able to access any funds for operating the fellows program.

H.R. 2474 will allow the Congressional Hunger Center to access the funds it needs to operate the fellows program, equipping people like Roger and Sarah to become leaders in fighting hunger. Equally important, this legislation does not detract from the vision of an endowment that allows the fellows program to operate self-sufficiently.

In closing Mr. Speaker, I encourage all my colleagues to support this legislation, which makes the technical corrections necessary to allow the Congressional Hunger Center fellows program to continue uninterrupted, growing leaders to fight hunger around the world.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H.R. 2474 requesting that funds be made available for fiscal years 2003 and 2004 for the Bill Emerson and Mickey Leland Hunger Fellowships to be administered through the Congressional Hunger Center.

The Bill Emerson and Mickey Leland Fellowships provide an opportunity for young people to invest their time, energy, and dedication to the cause of fighting hunger around the world. The fellowship was established in memory of the outstanding contributions of the Honorable Bill Emerson and the Honorable Mickey Leland both of whom were former members of Congress.

Each year approximately twenty participants are selected to participate in the highly selective Emerson and Leland Fellowship program. The fellows spend the first six months of their internship working on local level hunger issues, primarily through community food banks and local advocacy initiatives. The fellows then spend another six months in Washington, D.C. working with national organizations involved in the anti-hunger and poverty movement. This unique and challenging opportunity embodies the ideals and legacy of both Mr. Leland and Mr. Emerson.

Mickey Leland in addition to serving as a respected representative of the 18th Congressional District in Texas, Mr. Leland also served as a renowned yet humble humanitarian bringing both national and international attention to several causes including hunger and famine. With a "heart as big as Texas", Mickey Leland served as an active voice for social change. I am proud to follow him as a representative of the 18th District. And Bill Emerson over the span of five decades, contributed significantly to the strengthening of U.S. public policy and the process to achieve common sense solutions to legitimate real world problems, namely hunger. Thus the Emerson/Leland Fellowships provide an opportunity for young people to continue in the footsteps of these revered statesmen.

Therefore, it is in the spirit of the work of both Mickey Leland and Bill Emerson that this Congress would like to administer funds secured from the 2003 and 2004 fiscal years for the Emerson/Leland Fellowship through the Congressional Hunger Center. The Congressional Hunger Center is a unique non-profit, anti-hunger leadership organization. The mission of the center is to train and develop individuals who feel they can serve in either a domestic and/or international capacity to become leaders in the fight against hunger and effectively bridge the gap between service and public policy. The Congressional Hunger Center serves as a lasting tribute to all those who work to eradicate hunger but especially Mickey Leland, who was one of the Center's founding members. As such, it seems only natural that the Emerson/Leland Fellowship Program receives its funding through the Congressional Hunger Center.

Mickey Leland once said: "I cannot get used to hunger and desperate poverty in our plentiful land. There is no reason for it, there is no excuse for it, and it is time that we as a nation put an end to it." And while we cannot easily put an end to hunger, we can certainly do our part both individually and collectively to take an active role in helping to increase awareness and action around global hunger.

Therefore, I stand in full support of H.R. 2474 and hope that my Congressional colleagues will also express their support for this resolution as well.

Mr. STENHOLM. Mr. Speaker, I yield back the balance of my time.

Mr. GOODLATTE. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from Virginia (Mr. GOODLATTE) that the House suspend the rules and pass the bill, H.R. 2474, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. GOODLATTE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

GENERAL LEAVE

Mr. GOODLATTE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 2474, the bill just considered, and on S. 858, the bill considered immediately previously.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

RECOGNIZING IMPORTANT SERVICE PROVIDED BY FOREIGN AGRICULTURAL SERVICE ON OCCASION OF ITS 50TH ANNIVERSARY

Mr. GOODLATTE. Mr. Speaker, I move to suspend the rules and pass the joint resolution (H.J. Res. 49) recognizing the important service to the Nation provided by the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary.

The Clerk read as follows:

H.J. RES. 49

Whereas, during the terms of President Dwight David Eisenhower and the era of Secretary of Agriculture Ezra Taft Benson, it became apparent that the development of external markets was needed to ensure the financial viability of the agricultural sector of the United States;

Whereas the Foreign Agricultural Service of the Department of Agriculture was established on March 10, 1953, to develop and expand markets for, and improve the competitive position of, United States agricultural commodities and products;

Whereas the Foreign Agricultural Service has represented agricultural interests of the United States during a period of great expansion of United States agricultural exports from less than $3,000,000,000 in 1953 to over $50,000,000,000 in 2002;

Whereas the number of organizations engaged in the public and private partnership established by the Foreign Agricultural Service to promote United States agricultural exports has grown significantly, with market development and expansion occurring in nearly every global marketplace; and

Whereas March 10, 2003, was the 50th anniversary of the establishment of the Foreign Agricultural Service: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That Congress recognizes the Foreign Agricultural Service of the Department of Agriculture and its employees and partners for—

(1) cooperating with, and leading, the United States agricultural community in developing and expanding export markets for United States agricultural commodities and products;

(2) identifying the private partners capable of carrying out the mission of the Foreign Agricultural Service;

(3) identifying and expanding markets for United States agricultural commodities and products;

(4) introducing innovative and creative ways of expanding the markets for United States agricultural commodities and products;

(5) providing international food assistance to feed the hungry worldwide;

(6) addressing unfair barriers to United States agricultural exports;

(7) implementing strict procedures governing the use and evaluation of programs and funds of the Foreign Agricultural Service; and

(8) overseeing the efficient and effective use of Federal funds to carry out programs of the Foreign Agricultural Service.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia (Mr. GOODLATTE) and the gentleman from Texas (Mr. STENHOLM) each will control 20 minutes.

The Chair recognizes the gentleman from Virginia (Mr. GOODLATTE).

Mr. GOODLATTE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of House Joint Resolution 49. The gentleman from Texas (Mr. STENHOLM) and I introduced this resolution to recognize the important service of the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary.

USDA's Foreign Agricultural Service was established to develop and expand markets for United States agricultural commodities and products. Our farmers and ranchers are the most productive in the world and produce much more than we in the United States can consume. Therefore, a vibrant export market is very important to the success of U.S. agriculture.

FAS has contributed to that success; and as of 2002, the United States agricultural exports exceed imports by more than $12 billion. Our exports have grown significantly over the history of the FAS and now exceed $50 billion per year.

The FAS fosters the public and private partnership that is needed to promote United States agricultural exports and to develop and expand markets around the world. At this important time when free trade negotiations are ongoing, both in the WTO and through bilateral negotiations, the FAS is essential to represent United States agriculture and ensure that the challenges facing our agricultural producers are thoroughly addressed.

Another responsibility of the FAS is to provide food aid to needy people in developing countries and to help those countries to eventually become trading partners of the United States and buy our agricultural products. The FAS and its employees provide a significant service to the farmers and ranchers here at home so they can compete in worldwide markets. I congratulate them on their achievements and look forward to working closely with the FAS as the committee continues its work to expand markets for United States agriculture.

I thank the members of the Committee on Agriculture for their support of this resolution. I also appreciate the support of the Committee on International Relations on this matter. The gentleman from Illinois (Mr. HYDE) has been very cooperative in helping to expedite House Joint Resolution 49. I also thank the gentleman from Texas (Mr. STENHOLM). I urge Members to support this resolution.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of the resolution to recognize the role of the Foreign Agricultural Service in expanding export opportunities for America's farmers and ranchers and working to increase food security around the globe.

When FAS began its work, exports accounted for less than 10 percent of agricultural sales. Last year, 49 percent of the wheat and 54 percent of the cotton harvested in the United States was exported. By the year 2012, 98 percent of the world's population will live outside of the United States, and American agriculture will depend even more on export markets.

The men and women of the Foreign Agricultural Service have worked hard to identify and focus on the potential of growing markets such as Mexico and China where the economies are expected to grow by 5 and 7 percent respectively.

The U.S. agricultural producers are taking advantage of new trading opportunities. Between 1992 and 2002, U.S. agricultural exports to Mexico grew from $3.8 billion to $7.3 billion per year. And in China from .5 billion to $2 billion. At the same period, exports to Canada have grown from $4.9 billion to 8.7, making it our largest export market for agriculture. And all of these markets, particularly China, have a tremendous potential opportunity for U.S. producers.

The success of the programs administered by the FAS is also reflected by the increases in funding that were included for many of these programs in last year's farm bill. These include an additional $650 million for the Market Access Program, $308 million for Food for Progress, $100 million for the International Food for Education Program, and $67 million for the Foreign Market Development Program.

Rural communities depend on export for one-third of their jobs. Over the past 5 years, United States agricultural exports have averaged over $53 billion per year, and our agricultural trade surplus has averaged over $13 billion. This is compared to the overall trade deficit of the United States of over $500 billion. Each $1 billion in exports supports 15,000 American jobs. This means U.S. agricultural exports are supporting over 800,000 jobs, 50,000 in my home State of Texas alone. Many of these jobs are on farms or ranches, but even more of them are in transportation, storage, marketing, trade services, and food processing.

As a representative of some of the rural communities that benefit from such jobs, I thank the men and women of the Foreign Agricultural Service for their hard work, and I congratulate the agency on its service to rural America.

Mr. Speaker, I reserve the balance of my time.

Mr. GOODLATTE. Mr. Speaker, I have no request for time; I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield such time as he may consume to the gentleman from Massachusetts (Mr. MCGOVERN).

Mr. MCGOVERN. Mr. Speaker, I thank the gentleman from Texas (Mr. STENHOLM) for yielding me this time, and I thank him for his leadership on this bill, as well as the chairman of the committee.

Mr. Speaker, I rise in support of H.J. Res. 49 recognizing the 50th anniversary of the Foreign Agricultural Service at the Department of Agriculture. I have had the privilege of working with many of the FAS staff in Washington and in our embassies around the world, and on one special program in particular, the Global Food for Education Initiative, or the GFEI.

In July 2000, President Clinton announced at the Okinawa G–8 summit that the United States would initiate a $300 million pilot program, the Global Food for Education Initiative, to provide hungry children with a daily nutritious meal in a school setting. The twin goals of the program were to reduce hunger among children and increase the number of children, especially girls, attending school. The GFEI was modeled around a series of successful FAS school feeding programs that use section 416(b) surplus commodities and that were implemented by U.S. private voluntary organizations and the World Food Program.

FAS faced a monumental task to initiate the GFEI pilot program on a very tight timeline in an accountable and effective manner. They came through with flying colors. In December 2000, the President announced that the GFEI would carry out 48 projects in 39 countries and reach about 9 million children in Asia, Africa, Latin America, and the Caribbean.

In February 2003, USDA published the first evaluation of the GFEI. This report documents the marked success of these school feeding projects. Hunger was reduced, parents and community organizations were empowered, and school attendance increased, especially among girls.

I do not believe this level of success would have been achieved without the diligent leadership of Mary Chambliss, Robin Tilsworth, Babette Gainor, and the rest of the FAS staff. Their belief in this program and their commitment to accountability and oversight ensured that the project lived up to the promise of the initial proposal. I encourage my colleagues to visit the FAS Web site and review the GFEI report.

I have seen these projects in action in Indonesia and Colombia, and I have had the privilege of meeting the FAS staff based at our embassies who help carry out these programs in the field.

Mr. Speaker, there are 300 million hungry children worldwide. Most do not get a chance to go to school. For the children involved in the GFEI, these school meals are often the only food that child will receive, and that meal and school may be the only stable factors in their precarious and uncertain lives.

In last year's farm bill, the GFEI became permanent when the George McGovern-Robert Dole International Food for Education and Child Nutrition Program was established. It received $100 million for fiscal year 2003, a reduction from the pilot program, but an allocation which I hope will increase in the future.

Every single Member of the other body called upon the President to keep the McGovern-Dole Program in the capable hands of the FAS, a resounding endorsement if ever I heard one.

Mr. Speaker, I commend the FAS and its staff for their commitment to use our farmers' productivity to help end world hunger. I congratulate them on a half century of fine work, and I urge my colleagues to pass this resolution.

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Mr. STENHOLM. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. GOODLATTE. Mr. Speaker, I yield myself such time as I may consume.

This recognition of the Foreign Agricultural Service is well deserved. The work that they conduct around the world in promoting American agriculture is vitally important. It is even more important following the passage of the Trade Promotion Authority in the last Congress.

I urge my colleagues to support the resolution.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from Virginia (Mr. GOODLATTE) that the House suspend the rules and pass the joint resolution, H.J. Res. 49.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. GOODLATTE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

GENERAL LEAVE

Mr. GOODLATTE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on H.J. Res. 49, the joint resolution just considered.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

AWARDING A CONGRESSIONAL GOLD MEDAL TO PRIME MINISTER TONY BLAIR

Mr. KING of New York. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1511) to award a congressional gold medal to Prime Minister Tony Blair.

The Clerk read as follows:

H.R. 1511

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FINDING.

The Congress finds that Prime Minister Tony Blair of the United Kingdom has clearly demonstrated, during a very trying and historic time for our 2 countries, that he is a staunch and steadfast ally of the United States of America.

SEC. 2. CONGRESSIONAL GOLD MEDAL.

(a) PRESENTATION AUTHORIZED.—The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appropriate arrangements for the presentation, on behalf of the Congress, of a gold medal of appropriate design, to Prime Minister Tony Blair, in recognition of his outstanding and enduring contributions to maintaining the security of all freedom-loving nations.

(b) DESIGN AND STRIKING.—For purposes of the presentation referred to in subsection (a), the Secretary of the Treasury (referred to in this Act as the "Secretary") shall strike a gold medal with suitable emblems, devices, and inscriptions to be determined by the Secretary.

SEC. 3. DUPLICATE MEDALS.

The Secretary may strike and sell duplicates in bronze of the gold medal struck pursuant to section 2 under such regulations as the Secretary may prescribe, at a price sufficient to cover the cost thereof, including labor, materials, dies, use of machinery, and overhead expenses, and the cost of the gold medal.

SEC. 4. STATUS OF MEDALS.

(a) NATIONAL MEDALS.—The medals struck pursuant to this Act are national medals for purposes of chapter 51 of title 31, United States Code.

(b) NUMISMATIC ITEMS.—For purposes of section 5134 of title 31, United States Code, all medals struck under this Act shall be considered to be numismatic items.

SEC. 5. AUTHORITY TO USE FUND AMOUNTS; PROCEEDS OF SALE.

(a) AUTHORITY TO USE FUND AMOUNTS.—There is authorized to be charged against the United States Mint Public Enterprise Fund such amounts as may be necessary to pay for the costs of the medals struck pursuant to this Act.

(b) PROCEEDS OF SALE.—Amounts received from the sale of duplicate bronze medals authorized under section 3 shall be deposited into the United States Mint Public Enterprise Fund.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. KING) and the gentleman from Massachusetts (Mr. FRANK) each will control 20 minutes.

The Chair recognizes the gentleman from New York (Mr. KING).

GENERAL LEAVE

Mr. KING of New York. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert extraneous material thereon.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. KING of New York. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, it is a distinct privilege today to be able to move this bill awarding a Congressional Gold Medal to British Prime Minister Tony Blair. Throughout our history, there has probably been no country that the United States has had a closer relationship with than Great Britain. Certainly we share certain immutable, transcendent values. Throughout our history we have stood together in a number of noble causes, probably dramatically manifested during World War II when Prime Minister Churchill and President Roosevelt stood together to defeat the forces of fascism and Naziism. But there is probably no British Prime Minister who has been there when America needs him more than Tony Blair.

Certainly during the Clinton administration, it was Prime Minister Blair who stood shoulder to shoulder with President Clinton in the war in Kosovo against Serb aggression, against the dictator Milosevic. But nothing more illustrated the unique relationship between the United States and Britain and the immense courage and dedication of Tony Blair than what happened after our Nation was attacked on September 11, 2001. The first foreign leader to come to this country to express his regrets while the smoke was still there, while the flames were still burning, visited the World Trade Center, visited New York and came here to our Nation's capital was British Prime Minister Tony Blair.

When President Bush addressed a joint session of Congress on September 20, 2001, just 9 days after the brutal attack on the World Trade Center, it was Prime Minister Blair who sat here in the gallery expressing his solidarity with the United States. On that evening, President Bush said, "Once again we are joined together in a great cause and we are so honored the British Prime Minister has crossed an ocean to show his unity of purpose with America. Thank you for coming, friend."

Indeed, Tony Blair has been a friend of the United States but, just as important as that, he has been a friend and supporter of democratic values. He realizes the unique nature and relationship of the bonds between the United States and Britain and indeed between the United States and Europe. He has been a strong friend of the United States. Certainly in the recent war against Iraq, it was Tony Blair who resisted pressure both from the media, his own party and his own parliament to stand up and be with the United States.

For all those reasons, and I am sure this debate will go on for a while, probably longer than we anticipated it would today, I stand in support of this legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. FRANK of Massachusetts. Mr. Speaker, I am pleased to yield 5 minutes to the gentlewoman from New York (Mrs. MALONEY), the ranking member of the subcommittee, who is the cosponsor of this resolution.

Mrs. MALONEY. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise in support of this legislation that awards the Congressional Gold Medal, the highest honor Congress can award, to Prime Minister Tony Blair. Past recipients include Presidents George Washington and Harry Truman; heroic figures such as Charles Lindbergh, Rosa Parks, and Mother Teresa; and Prime Minister Winston Churchill, who led England through the dark hours of World War II.

Mr. Speaker, just as Prime Minister Churchill stood with President Roosevelt to defeat the Nazis, Prime Minister Blair has offered steadfast support for the United States since the terror attacks of 9/11. The American people will never forget that the Prime Minister traveled across an ocean to be in the gallery of the House in a sign of solidarity with our country as President Bush addressed our Nation after the terrorist attacks.

More recently, prior to the war in Iraq, the Prime Minister and his U.N. envoy, Sir Jeremy Greenstock, worked tirelessly to exhaust every diplomatic channel to build consensus in the United Nations. It was Prime Minister Blair who tried to bridge differences with our traditional European allies up until the wee hours before the war began. Additionally, Prime Minister Blair pushed our own administration to use its political capital to fully engage in the Middle East peace process.

While that effort continues to face very substantial obstacles, most notably the unceasing suicide attacks against Israel citizens, the Prime Minister deserves credit for putting Mideast Peace on the table as does the Administration for its efforts to implement the "road map."

While the Prime Minister has demonstrated considerable political courage in recent months, his stand with our country should not be surprising.

As a political leader in Britain the Prime Minister has spent this life leading the Labour Party out of oblivion and into its current dominant position in the Parliament.

At age 30 he was elected to Parliament. Later as a member of John Smith's shadow cabinet he worked to transform Labour into a party tough on crime and while still committed to its social causes.

After being elected Labour leader in 1994, Blair moved the party to the political center and redrafted the party constitution in his image of "New Labour"—much life President Clinton successfully moved the Democratic party to a position where it has won the popular vote in the last three Presidential elections.

As leader of the Labor Party, the British people rewarded the Prime Minister with a landslide victory in 1997, ending 18 years of conservative rule. At 43, Blair became the youngest Prime Minister since 1812. As Prime Minister, he has continued to change his country for the better. He has taken on the right to hereditary positions in the House of Lords, allowed the de-evolution of Scotland and Wales, and implemented a massive investment program in the areas of health care and education.

For the Prime Minister, education is the best economic policy and his government has followed this commitment.

I have great admiration for the Prime Minister's commitment to governing from the middle ground rather than trying to divide his country by playing to extreme groups on either side of the political spectrum.

Mr. Speaker, Congress could find no more deserving recipient of this high honor than Prime Minister Blair. In fighting terrorism, standing with the U.S. against Saddam and with the U.S. for Middle East peace, he has truly shown what it means for Britain to be our staunchest ally.

A recent Washington Post article well characterized Prime Minister Blair's current standing in the world. "After the terrorist attacks of September 11, he has found himself playing a pivotal role in reshaping international relations and winning points for standing on principle, even from some of his most vehement critics."

I recognize that some of my colleagues had strong reservations about the war in Iraq and I respect their opinions, but I urge that all Members stand and support this award in recognition of Tony Blair the man, as a leader of an inclusive political movement that has benefited all Britons.

Mr. Speaker, the deaths of six more British soldiers in Iraq this week remind us of the common sacrifice our troops are making serving side by side around the world. This is just one more example of the special relationship between the United States and the United Kingdom. I urge my colleagues to support this legislation in recognition of the man who has contributed so much to upholding this common bond.

I would like to note that this bill passed the Senate unanimously with 78 cosponsors and that we have 290 Members of the House that have cosponsored this important legislation. I thank the gentleman from Massachusetts (Mr. FRANK), the gentleman from New York (Mr. KING), the gentlewoman from Florida (Ms. GINNY BROWN-WAITE) and all who have worked to pass and to get this bill to the floor. I urge my colleagues to support it.

Mr. KING of New York. Mr. Speaker, I yield myself such time as I may consume. Let me at the outset commend the ranking member the gentlewoman from New York (Mrs. MALONEY) for the tremendous assistance she has given me on this as she has on so many other issues that come before our subcommittee and also the work that she does for the State of New York.

Mr. Speaker, one thing I should bring out is that on a personal level, I had the privilege of working with Prime Minister Blair several years ago on the Irish peace process. I saw firsthand at that time the sense of vision that he had, the sense of daring he had and the courage he had to do the right thing and the fact that he was the first British Prime Minister in history to be able to bring a settlement, to bring an agreement involving all the parties in the north of Ireland. To work with the Republic of Ireland and also to work closely with the United States is just one more demonstration of his courage and his ability to stand up and do what is right.

Mr. Speaker, I reserve the balance of my time.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. MCDERMOTT).

Mr. MCDERMOTT. Mr. Speaker, I oppose the awarding of this gold medal now. We have awarded gold medals to many people in our history since 1776, but on only one occasion have we ever awarded a Congressional Medal of Honor to a sitting head of state: Nelson Mandela, when he was 80 years old and in his last months in office. I suppose it is possible that these are the last months in office for Prime Minister Blair, but that is not clear just at the moment.

At this moment he is fighting for his political future against accusations that he misled the public about British intelligence findings on Iraq. Mr. Blair's Foreign Secretary, Jack Straw, was brought up before the Foreign Affairs Select Committee in the House of Commons yesterday. He was asked, among other things, why Mr. Blair's influential January dossier on Iraq's capabilities was so reliant on the uncredited 12-year-old writings of an American graduate student. Today Alastair Campbell, his doctor of spin, will be up there and he will be answering accusations that it was he who inserted in a dossier the astonishing information that Iraq not only possessed fully developed, operational chemical and biological weapons but was capable of delivering them within 45 minutes of a command order. Foreign Secretary Straw said yesterday there were substantial errors. He said that lessons have been learned, but he blamed the demands of the media. That very media, of course, made sure that the false papers issued by Prime Minister Blair's government deceived others around the world as well as the Britons. The influential information and errors may have even influenced Members of this body.

If this award to Mr. Blair is appropriate, it is either too late or too soon. If the medal had been awarded when it was first introduced, before these deceptions were discovered, it would have had smooth sailing. If it were brought up later, perhaps Mr. Blair will have cleared his name. At this moment, however, we are prejudging and perhaps trying to influence the outcome of some very serious investigations going on in Britain. We are trying to prop up Mr. Blair. The White House has sent up another one of those rubber stamp bills. I do not dispute that he needs propping up. His job rating at home is minus 13 which means his disapproval exceeds his approval by 13 points. What I dispute is whether the Congressional Medal of Honor should become a prop in the strategy of the British Prime Minister to regain his people's trust.

I ask the Members of this body to consider carefully whether they wish to risk cheapening the Congressional Medal of Honor by awarding it to an embattled politician. Let us not rush to judgment. Let us revisit this resolution another day. Even Winston Churchill was not awarded a Congressional Medal of Honor at any point in his tumultuous political career, though there were times when it would have come in quite handy. His medal was posthumous. With all due respect, Prime Minister Blair is not Winston Churchill.

Mr. KING of New York. Mr. Speaker, I yield myself such time as I may consume.

Without getting into all of the merits or demerits of the gentleman's statement, I would note that if there is one person in the world who does not care what his poll ratings are, it is Prime Minister Blair. The fact that his disapproval numbers may be high is exactly one of the reasons why he has demonstrated courage. He stands up for what is right. He is not concerned about the naysayers. He is not concerned about the tides of public opinion as they may be that day.

I would just again remind my colleagues that when the United States was at its darkest moment on September 11, 2001, the one leader who stood with us more than anyone else was Prime Minister Blair. He continues to stand with us. He can be proud of his record and we can be proud of our record if we do indeed award him this honor.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Michigan (Mrs. MILLER).

Mrs. MILLER of Michigan. Mr. Speaker, since September 11 our Nation has faced very trying times. For the first time in decades we have been threatened on our very own soil. We have seen American lives and the lives of others tragically lost. Proud symbols of the American dream and our prosperity have also been lost.

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But thankfully the American spirit was not. We have seen heroes rise from the dust where the World Trade Center towers once stood. American willpower and determination have united a Nation precisely when evildoers sought to divide us. We are resilient, proud, and since that fateful day, determined as ever. One nation, the United Kingdom, has stood proudly with us, shoulder to shoulder and shown solidarity and support as we vowed to end terrorism worldwide. The United States has no better friend than the United Kingdom and its leader, Prime Minister Tony Blair. Since day one, he has been a steadfast supporter of America in the war on terrorism and the ensuing campaigns in Afghanistan and Iraq.

In recognition of his unconditional support of our Nation, I strongly encourage my colleagues to join me in passing legislation to award Tony Blair the Congressional Gold Medal. There are no words to express America's deep-felt appreciation towards Mr. Blair; and while this award esteems a well-deserved honor to Mr. Blair, it hardly scratches the surface at how grateful we are for his support and the support of his country. The Congressional Gold Medal has a long history of recognizing military leaders, from its first recipient, George Washington, to Mother Teresa, Prime Minister Winston Churchill and current leaders like then-General Colin Powell and now Secretary of State.

Prime Minister Blair has certainly demonstrated the bravery, the dedication and conviction to join this elite group of awardees. Moreover, he has shown himself to be a true friend; and for that I commend him, and I look forward to voting "yes" on H.R. 1511.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield myself such time as I may consume.

I am genuinely moved by the breadth of spirit of my colleagues in the great praise they are heaping on this man of the left who presides proudly over a socialized health system and does so much else to show that government has an important positive role in our life, and I appreciate this kind of bipartisanship. Perhaps it will develop a certain trans-Atlantic quality and some of what they so vigorously praise in England might creep into their views about maybe doing something for the American people along the lines of what Mr. Blair does domestically for the British people.

Mr. Speaker, I yield 4 minutes to the gentleman from Pennsylvania (Mr. HOEFFEL), who has been a leader in trying to formulate an appropriate American approach to some important questions.

Mr. HOEFFEL. Mr. Speaker, I thank the gentleman for yielding me this time.

I am pleased to rise in support of this resolution today, awarding the Congressional Gold Medal to a great leader of a great country who is and has been a great ally of ours. But it is true that Prime Minister Blair, as President Bush, both have a credibility problem regarding weapons of mass destruction. And it is interesting to see how England is dealing with this problem. They are dealing with it forthrightly, openly. The Parliament has held hearings. Two members of the British Cabinet who resigned in protest have testified. The Prime Minister has subjected himself to questions and they are dealing with this, I believe from a far, it seems to be a very open process, a very forthright process; and the public in England will get the information they need to make a judgment about whether their intelligence was on the mark, whether the intelligence was given to their leaders based upon what they thought the leaders might want to hear. Was the intelligence misused by the British leadership? Was it inaccurate? And I think they have dealt with it very forthrightly.

Unfortunately, Mr. Speaker, that is not happening in this country. We are not seeing the administration stepping forward to deal with the growing credibility gap that has arisen because we cannot find the weapons of mass destruction. We know that Saddam Hussein had weapons of mass destruction and he used them in the past against his own people in a very murderous way, no question about it; but we cannot find them now. We may find them next week, and I hope we do because our credibility is on the line; but we need a full accounting of how we have dealt with this issue. We need to know where those weapons are. We need to maintain safe custody of them. We need to dismantle them. If they are buried in the desert or given to another country, we need to know what is going on and make sure that they cannot be used by anybody else in the future that has evil intent.

But we also need a full accounting of our intelligence operation. What were our leaders told? I know what I was told, Mr. Speaker. I was told publicly and privately by the leading senior advisors to the President, with great certainty I was told that Saddam Hussein last fall had weapons of mass destruction, at the very time it turns out that the Defense Intelligence Agency was circulating a memo that there was no credible evidence that Saddam Hussein then had weapons of mass destruction.

That is not the public comments nor the private assurances that Members of Congress or the American public were being given at the time of the President's Rose Garden speech September 26, 2002, and several other statements made. Was the President told what the intelligence agencies thought he wanted to hear? Did the President demand just one side of the story? We need an accounting of what has happened. Our credibility is at stake. If we are ever again to embrace the notion of preemptive use of military force which may be necessary in an age of terror when we are dealing with an adversary who does not have a country to defend or a capital city to defend, if we are ever going to use a preemptive strategy again, we must know our intelligence is accurate; otherwise, the doctrine of preemption is unusable.

If we are going to keep this country safe, we have to know what happened. We have to know how well or how poorly our intelligence operation functioned. We need an accounting. We are not getting it from the international relations committee, which last week refused to call for documents. We are not getting it on the floor with the intelligence bill because amendments to have an investigation have been ruled out of order. We have got a document dump at the intelligence committee. I am going to go over and look at those documents, but I do not think that is enough. We need to have an accounting. We need to know what happened.

Mr. KING of New York. Mr. Speaker, I yield myself such time as I may consume.

It is really interesting listening to how certain people on the other side who are trying to turn this into a debate of weapons of mass destruction are raising the issue of credibility when their statements themselves seem to be at least lacking some credibility, to put it mildly. I would just emphasize we are talking about what was known and what was not known.

Let us go back to last September when Vice President Gore said based at the time he was Vice President, he had absolutely no doubt that Iraq had an advanced program of weapons of mass destruction and those weapons were hidden throughout Iraq. That was Vice President Gore based on his access to intelligence. Just last month, President Clinton said he does not in any way fault President Bush on the issue of weapons of mass destruction because that is exactly what he was told when he was President of the United States. Just last Friday in the New York Times, Kenneth Pollack who was probably leading spokesman in the Clinton administration on the issue of Iraq said there was absolutely no doubt among any of the intelligence agencies in the world nor in the United States nor in the Clinton and Bush administrations that there were indeed weapons of mass destruction in Iraq.

And it really is ironic that we have to look to a British foreign minister to stand with our government and give the United States the presumption of the doubt over Saddam Hussein when certain Members of the opposition party do not show that same level of support that Prime Minister Blair is showing, which I think is very significant; and it also demonstrates more than ever why Americans have such a high opinion of Prime Minister Blair.

I would also say to the gentleman from Massachusetts, who was heaping praise on the Republicans for trying to set up this trans-Atlantic relationship with the British and was hoping that perhaps this may manifest itself here on the floor, I would also remind the gentleman and ask him if he supports the fact that Tony Blair is bringing the Labor Party from the left to the right and is certainly being criticized by those in the left in Britain. I wonder if he will also share that in his party and move his party more toward the center.

Mr. FRANK of Massachusetts. Mr. Speaker, will the gentleman yield?

Mr. KING of New York. I yield to the gentleman from Massachusetts.

Mr. FRANK of Massachusetts. Mr. Speaker, I very much agree with many of the specifics, but the gentleman misstates British politics when he says he has moved them from left to the right. Blair would himself repudiate that. What he has done is to move them from a position that he thought was too far to the left to a more mainstream position, but still very much on the left, still very much socialized medicine. So, yes, I think that the direction that the Labor Party has moved in, which is very much a reasonable and responsible position on the left, is a good one; but to characterize that as having moved to the right, I think Mr. Blair would give back his gold medal if the price of accepting it was to become a rightist in the gentleman's mind.

Mr. KING of New York. Mr. Speaker, reclaiming my time, I would say that the same critics in Britain who are criticizing Tony Blair's policy on the war would in fact be saying that he is moving his party to the right. So really I was quoting the equivalent critics in the British Parliament who are equivalent to those in this House. Those who oppose Blair's policy on Iraq, very similar to those on the other side who are opposing President Bush's policy on Iraq, are the same ones who are saying that he is moving his party toward the right. So I was just really quoting some of the ideological kinsmen of some of the opponents here today.

Mr. FRANK of Massachusetts. Mr. Speaker, will the gentleman yield?

Mr. KING of New York. I yield to the gentleman from Massachusetts.

Mr. FRANK of Massachusetts. Mr. Speaker, the gentleman once again misstates British politics because two of his sharpest critics were people who were in his government supporting his moves on domestic policy, supporting his repositioning towards New Labor. Two, Robin Cook and Claire Short, they resigned from the government specifically over Iraq. So the notion that criticism of his position on Iraq is also criticism of his movement towards the New Labor position is simply factually incorrect.

Mr. KING of New York. Reclaiming my time, it is very accurate. In fact, anyone who knows Claire Short, and I have known her for over 20 years, can say she was in the far left of the Labor Party. She was in the Blair cabinet very reluctantly, and she was one of those who was critical not just of his war policy but also of his domestic policies.

Mr. FRANK of Massachusetts. What about Robin Cook? Who was the foreign minister and who resigned only over misuse of intelligence and not over anything domestic.

Mr. KING of New York. Mr. Speaker, reclaiming my time, actually this has turned into the House of Commons. This is great. But reclaiming my time, I would say that the overwhelming, absolutely categorically overwhelming majority of those in the Labor Party who are opposed to Tony Blair resent also the fact that he is moving the party towards the center.

Mr. FRANK of Massachusetts. Would that also be true of the British public, which was opposed to his going to the war?

Mr. KING of New York. Reclaiming my time, the beauty of Tony Blair is unlike certain politicians he does not follow the polls. The fact is he stands up for what is right. In the fullness of time he will be vindicated.

Mr. Speaker, I reserve the balance of my time.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 4 minutes to the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. Mr. Speaker, I thank the gentleman for yielding me this time.

I want to begin first by agreeing with the gentleman from New York (Mr. KING) that Tony Blair has been historically courageous in Northern Ireland in helping to reconcile two sides that for 500 years have not been able to see eye to eye, and he deserves enormous historic credit for that. And on the issue of Iraq, but for Tony Blair, but for Tony Blair's insistence, President Bush would have never gone to the United Nations. It was he, Tony Blair, who made the precondition to his support that the United States would go to the United Nations in order to secure a vote, and for that he deserves enormous credit.

But at the same time in England, Great Britain, the Parliament right now, there is an ongoing investigation of the information that was used as to justification for the war in Iraq; and it is to the credit of the Parliament, it is to the credit of Tony Blair, that he is accepting the responsibility of the examination of the information which was used with regard to the weapons of mass destruction that was produced by the intelligence community in Great Britain and in the United States as a rationale for the war. It is to the credit of Tony Blair that he is accepting that examination.

In our country, just the opposite is the case. There are essentially three options that the American people, the

British people are now presented with. One, that the intelligence was correct, that the weapons of mass destruction existed, and that the weapons of mass destruction are now in the hands of al Qaeda, Baathist separatist activity groups, other terrorist groups, or in Syria. All of those options are horrific and not a consequence that we thought would be a result of this war.

Secondly, that the intelligence was plain wrong right from the beginning. There was never any information and that they botched it right from the beginning. That is horrible.

Or, third, that the intelligence was correct; but they were told, the intelligence community, to change the information, to change the information. They were told deliberately to alter it in order to argue that there were weapons of mass destruction, that Vice President CHENEY did visit the CIA, did try to influence the intelligence community to change the information, to leave out key documents. In Britain they are now looking at that very issue. They are being told that the information with regard to the uranium from Africa was not correct, that the academic paper that was used rather than real intelligence was wrong and should not have been relied upon. We need the same kind of examination in our country.

There is now sufficient evidence that is being produced that there has been a compromise of the total intelligence package that the Congress should have had but, more importantly, that the American people should have had as the basis of their judgment.

I voted for the resolution last October. I voted for it, and I believe that the American people and this Congress deserve all of the information. We need a blue ribbon commission to examine all of the intelligence that was used. England is doing it right now. Tony Blair is accepting that examination. We should have the courage in our own country to give all of the information to the American public. The intelligence in this country is right now not complete with regard to what our government knew before we voted on the floor of this Congress.

Mr. KING of New York. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would suggest to the gentleman that there was another option left out and that is the option that Vice President Gore spoke about last September, that the weapons are there, the weapons are hidden, and we will find them.

Mr. FRANK of Massachusetts. Mr. Speaker, will the gentleman yield for one question?

Mr. KING of New York. I yield to the gentleman from Massachusetts.

Mr. FRANK of Massachusetts. Can we anticipate a gold medal for Vice President Gore too? Are you going to give a gold medal to Al Gore too, anybody who helps you out?

Mr. KING of New York. Reclaiming my time, I would say to the ranking member if he wants to introduce that legislation and obtain 290 signatures, certainly we will give it consideration at that time. We are very open-minded. We are very liberal on this side of the aisle.

Mr. Speaker, I yield such time as he may consume to the gentleman from Ohio (Mr. OXLEY), the chairman of the full committee.

Mr. OXLEY. Mr. Speaker, Members should speak for themselves about being liberal on this side of the aisle.

Let me try to draw the debate back to what we had initially anticipated, which was to honor Tony Blair with a Congressional Gold Medal and discuss exactly why we were able to secure 290 co-sponsors for this legislation. It is because Tony Blair represents all that is good.

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It is because of that that the gentlewoman from Florida (Ms. BROWN-WAITE), a distinguished member of our committee, introduced this legislation and worked very hard, along with our friend, the gentlewoman from New York (Mrs. MALONEY) to gather 290 signatures, and under the leadership of the gentleman from New York (Mr. KING), the chairman of the subcommittee, that we are here today. That means that this House will go on record as supporting, with a strong bipartisan vote, exactly what Tony Blair means to the process and what he means to our country.

We have had a special relationship with Great Britain for so many years, after we got the initial argument out of the way some 200 plus years ago, and since that time have worked harmoniously with Great Britain, no matter who was in charge over here, or who was in charge over there. And here we have a situation where the Prime Minister of the Labor Party is being supported by a Republican Congress and a Republican President, because of what he brings to our relationship and what he means to all of us.

I think all of us were thrilled when almost a week after the terrible events of September 11, 2001, when President Bush spoke to the Nation from this very spot and said, America has no truer friend than Great Britain. And then, looking up to Tony Blair in the gallery right up behind me, and said, "Thank you for coming, friend," meaning not just the Prime Minister, but all of his countrymen. That is the special relationship that we enjoy through good times and bad with Great Britain.

My family on my dad's side was from England, and I have a great deal of respect for their traditions, and I certainly have a great deal of respect for their current leadership.

So despite all of the arguments about weapons of mass destruction, despite all of the differences that we displayed over Iraq, it was Great Britain in the presence of Tony Blair who came to our defense. It was Tony Blair who made a special trip over to the United States to bring us condolences and talk about unification and working together with Great Britain, and yes, it was Tony Blair who defied public opinion, who did not stick his finger up in the wind and see which way the wind was blowing, to say that he was going to do something right and support the United States in our efforts against the brutal dictator, Saddam Hussein.

For that and many, many other reasons, he deserves these accolades, and he deserves this Congressional Gold Medal. I urge all of my colleagues to support this meaningful tribute to a great world leader, Tony Blair.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield myself the remainder of my time.

Tony Blair is an embattled politician, as many people are. He will be facing an election within some period of years from his right wing, and he will be defending the positions that he holds. He is a strong defender of a continuation of socialized medicine. He believes that global warming should be addressed by international treaty. I support the British position on allowing gay and lesbian people to serve in the military. So there is a great deal about Tony Blair's record which seems admirable, and I am glad to see my Republican colleagues setting aside what might be some minor differences to them to intervene in a British election by basically giving him this big boost. I am not sure that their fellow conservatives in England are quite so happy.

I do want to say, though, that I differ with those who suggested that somehow we should not have used this to debate the question of whether or not Americans ought to know whether intelligence was misused or how it was misused. I agree there would be better places to debate it. Unfortunately, the Republican leadership has consistently done everything possible to keep that debate off the floor. The intelligence authorization will be coming up, and that would have been a good time to debate it. Our colleague, the gentlewoman from California (Mrs. TAUSCHER), had an amendment that would have allowed a debate on whether or not to have a select committee. We cannot have that debate today at the regular ordered time because the Republican leadership ordered the Committee on Rules to kill it.

So yes, I will agree; I saw this and said, let us use this as a chance to at least have some debate on this issue, since the Republican leadership will not allow it. In fact, what I most admire about Tony Blair right now is that as the Prime Minister and the head of the House of Commons, he has not even tried to use his control to shut off a debate. Unlike the Republican administration and the Republican leadership here, Tony Blair is allowing the British people and the British political system to have a thorough debate about the extent to which there was misuse of evidence on weapons of mass destruction, and I envy the British. I do not just envy them the Gold Medal, I envy them the fact that democracy is functioning in England today on this critical question of whether and to what extent intelligence was misused in a way that is not being allowed to happen in America.

Now, the gentleman from New York managing this bill referred to the article by Kenneth Pollack. I will submit Mr. Pollack's article for the RECORD, because he said I am sure there were weapons of mass destruction, and he goes on in that article to be very critical of this administration's misuse of the evidence. It is a very interesting article, and I appreciate once again the gentleman citing it, because he talks about very important questions about the misuse of intelligence, the exaggeration, the manipulation. This is an administration that argued, in part, that the weapons of mass destruction were a major reason to go to war, and that a Rosanna Danna Banana "nevermind" is not an appropriate response in a democracy.

That is what we are getting. We are getting from them bait and switch: Let us go to war because of weapons of mass destruction, and now it is because, well, he was a terrible man. Yes, he was a terrible man. Terrible people are killing people in the Congo. Terrible people run Liberia. Terrible people run Burma. If, in fact, we are going to become the ones that go to the rescue of people misused and abused by their government, there are a lot more that we can go to.

Weapons of mass destruction was the critical argument used to justify a war, and it now appears that they were grossly exaggerated. The very article by Kenneth Pollack, that the gentleman from New York cited is in fact harshly critical of this administration for its misuse of that.

So thanking Tony Blair because he came to the President's defense at a tough time is a reasonable thing to do. Going to Tony Blair's defense in a tough time for him, that is a reasonable thing to do. Certainly politicians are not unused to helping each other out in tough times and reciprocating.

But let us look at the contrast. I wish, in addition to the Gold Medal for Tony Blair, we were doing something for the American people. I would just propose to my friends on the other side, given your admiration for Tony Blair, a simple proposition: Let us duplicate here in the United States the procedures that are now being undertaken in the British Parliament, let us give the American people the same exposure to an open debate and investigation that the British people are giving. Let us do something for the American people while we give Tony Blair the Gold Medal, and thus show respect for democracy in our own country.

(By Kenneth M. Pollack)

WASHINGTON.—Where are Iraq's weapons of mass destruction? It's a good question, and unfortunately we don't yet have a good answer. There is hope that the capture of Abid Hamid Mahmoud al-Tikriti, Saddam Hussein's closest aide, will provide the first solid clues. In any event, the mystery will be solved in good time; the search for Iraq's nonconventional weapons program has only just begun.

In the meantime, accusations are mounting that the Bush administration made up the whole Iraqi weapons threat to justify an invasion. That is just not the case—America and its allies had plenty of evidence before the war, and before President Bush took office, indicating that Iraq was retaining its illegal weapons programs.

As for allegations that some in the administration may have used slanted intelligence claims in making their case against Saddam Hussein, they seem to have merit and demand further investigation. But if the truth was stretched, it seems to have been done primarily to justify the timing of an invasion, not the merits of one.

The fact that the sites we suspected of containing hidden weapons before the war turned out to have nothing in them is not very significant. American intelligence agencies never claimed to know exactly where or how the Iraqis were hiding what they had—not in 1995, not in 1999 and not six months ago. It is very possible that the "missing" facilities, weaponized agents, precursor materials and even stored munitions all could still be hidden in places we never would have thought to look. This is exactly why, before the war, so few former weapons inspectors had confidence that a new round of United Nations inspections would find the items they were convinced Iraq was hiding.

At the heart of the mystery lies the fact that the Iraqis do not seem to have deployed any stocks of munitions filled with nonconventional weapons. Why did Saddam Hussein not hit coalition troops with a barrage of chemical and biological weapons rather than allow his regime to fall? Why did we not find them in ammunition dumps, ready to be fired?

Actually, there are many possible explanations. Saddam Hussein may have underestimated the likelihood of war and not filled any chemical weapons before the invasion. He may have been killed or gravely wounded in the "decapitation" strike on the eve of the invasion and unable to give the orders. Or he may have just been surprised by the extremely rapid pace of the coalition's ground advance and the sudden collapse of the Republican Guard divisions surrounding Baghdad. It is also possible that Iraq did not have the capacity to make the weapons, but given the prewar evidence, this is still the least likely explanation.

The one potentially important discovery made so far by American troops—two tractor-trailers found in April and May that fit the descriptions of mobile germ-warfare labs given by Iraqi defectors over the years—might well point to a likely explanation for at least part of the mystery: Iraq may have decided to keep only a chemical and biological warfare production capability rather than large stockpiles of the munitions themselves. This would square with the fact that several dozen chemical warfare factories were rebuilt after the first gulf war to produce civilian pharmaceuticals, but were widely believed to be dual-use plants capable of quickly being converted back to chemical warfare production.

In truth, this was always the most likely scenario. Chemical and biological warfare munitions, especially the crude varieties that Iraq developed during the Iran-Iraq War, are dangerous to store and handle and they deteriorate quickly. But they can be manufactured and put in warheads relatively rapidly—meaning that there is little reason to have thousands of filled rounds sitting around where they might be found by international inspectors. It would have been logical for Iraq to retain only some means of production, which could be hidden with relative ease and then used to churn out the munitions whenever Saddam Hussein gave the word.

Still, no matter what the trailers turn out to be, the failure so far to find weapons of mass destruction in no ways invalidates the prewar intelligence data indicating that Iraq had the clandestine capacity to build them. There has long been an extremely strong case—based on evidence that largely predates the Bush administration—that Iraq maintained programs in weapons of mass destruction. It was this evidence, along with reports showing the clear failure of United Nations efforts to impede Iraq's progress, that led the Clinton administration to declare a policy of "regime change" for Iraq in 1998.

In 1995, for example, United Nations inspectors found Russian-made ballistic-missile gyroscopes at the bottom of the Tigris River; Jordanian officials intercepted others being smuggled into Iraq that same year. In July 1998, international inspectors discovered an Iraqi document that showed Baghdad had lied about the number of chemical bombs it had dropped during the Iran-Iraq War, leaving some 6,000 such weapons unaccounted for. Iraq simply refused to concede that the document even existed.

These episodes, and others like them, explain why many former Clinton administration officials, including myself (I was on the staff of the National Security Council in the 90's), agreed with the Bush administration that a war would likely be necessary to prevent Iraq from acquiring nuclear and other weapons. We may not have agreed with the Bush team's timing or tactics, but none of us doubted the fundamental intelligence basis of its concerns about the Iraqi threat.

As for the estimates the Bush administration presented regarding Iraq's holdings of weapons-related materials, they came from unchallenged evidence gathered by United Nations inspectors (in many cases, from records of the companies that sold the materials to Iraq in the first place). For instance, Iraq admitted importing 200 to 250 tons of precursor agents for VX nerve gas; it claimed to have destroyed these chemicals but never proved that it had done so. Even Hans Blix, the last head weapons inspector and a leading skeptic of the need for an invasion, admitted that the Iraqis refused to provide a credible accounting for these materials.

And it wasn't just the United States that was concerned about Iraq's efforts. By 2002, British, Israeli and German intelligence services had also concluded that Iraq was probably far enough along in its nuclear weapons program that it would be able to put together one or more bombs at some point in the second half of this decade. The Germans were actually the most fearful of all—in 2001 they leaked their estimate that Iraq might be able to develop its first workable nuclear device in 2004.

Nor was it just government agencies that were alarmed. In the summer of 2002 I attended a meeting with more than a dozen former weapons inspectors from half a dozen countries, along with another dozen experts on Iraq's weapons programs. Those present were asked whether they believed Iraq had a clandestine centrifuge lab operating somewhere; everyone did. Several even said they believed the Iraqis had a covert calutron program going as well. (Centrifuge and calutron operations allow a country to enrich uranium and produce the fissile material for a nuclear bomb.)

At no point before the war did the French, the Russians, the Chinese or any other country with an intelligence operation capable of collecting information in Iraq say it doubted that Baghdad was maintaining a clandestine weapons capability. All that these countries ever disagreed with the United States on was what to do about it.

Which raises the real crux of the slanted-intelligence debate: the timing of the war. Why was it necessary to put aside all of our other foreign policy priorities to go to war with Iraq in the spring of 2003? It was always the hardest part of the Bush administration's argument to square with the evidence. And, distressingly, there seems to be more than a little truth to claims that some members of the administration skewed, exaggerated and even distorted raw intelligence to coax the American people and reluctant allies into going to war against Iraq this year.

Before the war, some administration officials clearly tended to emphasize in public only the most dire aspects of the intelligence agencies' predictions. For example, of greatest importance were the estimates of how close Iraq was to obtaining a nuclear weapon. The major Western intelligence services essentially agreed that Iraq could acquire one or more nuclear bombs within about four to six years. However, all also indicated that it was possible Baghdad might be able to do so in as few as one or two years if, and only if, it were able to acquire fissile materials on the black market.

This latter prospect was not very likely. The Iraqis has been trying to buy fissile material since the 1970's and had never been able to do so. Nevertheless, some Bush administration officials chose to stress that one-to-two-year possibility rather than the more likely four-to-six year scenario. Needless to say, if the public felt Iraq was still several years away from acquiring a nuclear weapon rather than just a matter of months, there probably would have been much less support for war this spring.

Moreover, before the war I heard many complaints from friends still in government that some Bush officials were mounting a ruthless campaign over intelligence estimates. I was told that when government analysts wrote cautious assessments of Iraq's capabilities, they were grilled and forced to go to unusual lengths to defend their judgments and some were chastised for failing to come to more alarming conclusions. None of this is illegal, but it was perceived as an attempt to browbeat analysts into either changing their estimates for shutting up and ceding the field to their more hawkish colleagues.

More damning than the claims of my former colleagues has been some of the investigative reporting done since the war. Particularly troubling are reports that the administration knew its contention that Iraq tried to purchase uranium from Niger was based on forged documents. If true, it would be a serious indictment of the administration's handling of the war.

As important as this debate is, what may ultimately turn out to be the biggest concern over the Iraqi weapons program is the question of whose hands it is now in. If we do confirm that those two trailers are mobile biological warfare labs, we are faced with a tremendous problem. If the defectors' reports about the rates at which such mobile labs were supposedly constructed are correct, there are probably 22 more trailers still out there. Where are they? Syria? Iran? Jordan? Still somewhere in Iraq? Or have they found their way into the hands of those most covetous—Osama bin Laden and his confederates?

Nor can we allow our consideration of weapons of mass destruction and politicized intelligence to be a distraction from the most important task at hand: rebuilding Iraq. History may forgive the United States if we don't find the arsenal we thought we would. No one will forgive us if we botch the reconstruction and leave Iraq a worse mess than we found it.

Mr. KING of New York. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. GOSS), the chairman of the Permanent Select Committee on Intelligence.

Mr. GOSS. Mr. Speaker, I thank the distinguished gentleman for yielding me this time.

Mr. Speaker, I rise this morning to celebrate the purpose of the Medal, which is the great leadership of Tony Blair. The world needs civilized leaders. The world is a scary place. There are a lot of things going on, and all that is necessary for evil to triumph is for good men to do nothing. Good men are not infallible. Mistakes can be made. But good men acting on good judgment, doing the best they can with what they have is what we are celebrating here today.

Tony Blair as Prime Minister has been a great friend to our country, which has a special relationship, of course, with the United Kingdom, of which we are very proud, and an especially strong relationship in the area of intelligence. He has been a great friend with President Clinton when he was President of our country, and with President Bush. Who is currently the President of our country.

I think that friendship has gone through a lot of activity in the past several years, and Tony Blair has been there standing strong. He is a proud person to be associated with, in my view. I am pleased that the gentlewoman from Florida (Ms. BROWN-WAITE), the gentleman from New York (Chairman KING), the gentlewoman from New York (Mrs. MALONEY) and others have had the good sense to bring this forward at this time, and I thank them for doing it, and I urge strong support.

Mr. KING of New York. Mr. Speaker, I yield myself such time as I may consume.

As I said at the outset, it is a great honor for me personally to be able to stand here and move this legislation today. I must say that I am sure some of my Irish ancestors are appreciating the improbability of this moment that I would be making such an impassioned defense for a British Prime Minister.

The fact is, Tony Blair transcends national politics. He transcends pettiness and partisanship, and that is what we have tried to do here. Yes, obviously, there are differences between Members on this side of the aisle and certain policies of Tony Blair. We are not talking about his policies per se; we are talking about his courage, we are talking about his unique sense of dedication to democratic values and the fact that he is such a close ally of the United States, and that does transcend whatever differences there may be, and that should also transcend whatever differences we might have in recognizing the greatness of an individual and realizing the uniqueness of a very special relationship.

But, if I could just add in closing, because I know there is going to be a record of this and we have gone over different debates, I would just thank the gentleman from Massachusetts for introducing the full column by Mr. Pollack. I would stand by that, and I would say that anyone reading that, any balanced person reading that would see that as an affirmation that weapons of mass destruction did indeed exist, and also honest differences as far as nuclear weapons. It is all there. I will allow the public to look at that, to read it, and come to their judgment. It certainly went far beyond as far as being reasoned, as far as being rational, some of the overheated rhetoric that has been coming forth from others here. And that to me is the type of debate we should be having, an intelligent debate.

Also, I would say there is a difference between a parliamentary system and the system that we have. Indeed we fought a revolution in 1776 to establish our type of government.

But in conclusion, let us get back to the main point. Tony Blair is a unique world leader, an outstanding world leader, a long and dear and absolutely loyal friend of the United States. For that, Mr. Speaker, he deserves this Gold Medal as much as any world leader ever has. I stand with him. I would hope that the overwhelming majority of this Congress would stand with him, stand with the United States Senate in acknowledging the uniqueness and the unique loyalty and sense of courage that Tony Blair has demonstrated.

Mr. FRANK of Massachusetts. Mr. Speaker, will the gentleman yield?

Mr. KING of New York. I yield to the gentleman from Massachusetts.

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Mr. FRANK of Massachusetts. I would be willing to stand with the Senate on this if we could stand with them on the child tax credit. Can we make some kind of deal here on standing with the Senate?

Mr. KING of New York. Reclaiming my time, I would say that when Tony Blair is here, that if we can arrange a private meeting with the ranking member from Massachusetts, I am sure he can impart unique wisdom to the Prime Minister of Great Britain, and that would really mean that the Prime Minister has earned his gold medal.

Mr. PAUL. Mr. Speaker, I rise in strong opposition to this legislation for a number of reasons. First, to force the American people to pay tens of thousands of dollars to give a gold medal to a foreign leader is immoral and unconstitutional. I will continue in my uncompromising opposition to appropriations not authorized within the enumerated powers of the Constitution—a Constitution that each member of Congress swore to uphold.

Second, though these gold medals are an unconstitutional appropriation of American tax dollars, at least in the past we have awarded them to great humanitarians and leaders like Mother Theresa, President Reagan, Pope John Paul II, and others. These medals have generally been proposed to recognize a life of service and leadership, and not for political reasons—as evidenced by the overwhelming bipartisan support for awarding President Reagan, a Republican, a gold medal. That these awards have generally gone to these types of otherwise deserving individuals is why I have many times offered to contribute $100 of my own money, to be matched by other Members, to finance these medals.

I sense that this current proposal is different, however. No one is claiming that British Prime Minister Tony Blair has given a lifetime of humanitarian service like Mother Theresa, or demonstrated the historical leadership of a Ronald Reagan. No one suggests that British Prime Minister, leading the avowedly socialist Labour Party, has embraced American values such as freedom and limited governments and imported those to Great Britain—as Margaret Thatcher had attempted before him. No, Tony Blair is being proposed for his medal for one reason: he provided political support when international allies were sought in advance of America's attack on Iraq. Does this overtly political justification for awarding this medal not cheapen both the medal itself and the achievements of those who have been awarded it previously?

I find it particularly odd that this Republican-controlled Congress would nominate one such as Tony Blair to receive this award. His political party is socialist: Britain under Blair has a system of socialized medicine and government intervention in all aspects of the commercial and personal lives of its citizens. Socialism is an enemy of freedom and liberty—as the 20th century taught us so well. It is the philosophical basis of a century of mass-murder and impoverishment.

In May, a British television poll found that Prime Minister Blair is the most unpopular man in Great Britain. A brief look at his rules leaves little question why this is so. He has eroded Britain's constitutional base—recently abolishing the ancient position of Lord Chancellor without any debate. He has overseen a massive expansion of government with the creation of costly "assemblies" in Wales and Scotland. He has also overseen changes in Britain's voting system that many have claimed has opened the door to widespread voting fraud. In short, he is no Margaret Thatcher and certainly no Winston Churchill. Yet today Congress is voting to give him its highest honor.

Mr. Speaker, it is very easy to be generous with the people's money. I believe the politicization of this medal, as we are seeing here today, really makes my own point on such matters: Congress should not be spending the people's money for appropriations not authorized within the enumerated powers of the Constitution. When it does so, it charts a dangerous course away from the rule of law and away from liberty. I urge a "no" vote on this unfortunate bill.

Mr. EMANUEL. Mr. Speaker, I rise today in strong support of H.R. 1511, to award the Congressional Gold Medal to Tony Blair, Prime Minister of Great Britain.

The Congressional Gold Medal is the highest honor Congress can bestow to civilians and foreign leaders in recognition of their outstanding and enduring contributions to the United States. It is fitting that we consider Prime Minister Blair for this award in the wake of a challenging and historic period for our two nations.

Upon the terrorist attacks of September 11, Prime Minister Blair was the first leader to rush to America's side to provide assistance. His expression of solidarity assured us that we were not alone in the world as a victim of terrorism, and that attacks on our soil were also as assault on the sovereignty of Great Britain, which lost more of its own citizens in the World Trade Center than any other foreign nation. In a very difficult time for our country, Mr. Blair has courageously demonstrated that the U.K. is our staunchest and most steadfast ally by helping us lead the coalition of democratic nations in the defense of our mutual security from terrorism and the proliferation of weapons of mass destruction.

Together with Great Britain we have made progress toward dismantling the global network of state sponsored terrorism. However, despite considerable public opposition and political fallout in his own country, Prime Minister Blair never wavered from his commitment to the United States and the international coalition to determine whether the existence of weapons of mass destruction in Iraq presented an imminent threat to its neighbors and our troops based on the Middle East. Under the Prime Minister's leadership, Great Britain contributed troops and meaningful support for Operations Enduring Freedom and Iraqi Freedom. As British troops fought shoulder to shoulder with American troops in Iraq, Mr. Blair made it clear all along that the U.K. shared our values and principles for the mission, particularly when he said, "We go to liberate not conquer . . . and the only flag which will be flown in that ancient land is their own."

Mr. Speaker, I applaud Prime Minister Tony Blair's extraordinary leadership and his nation's enduring commitment to our mutual support of liberty and democracy. I am proud to support H.R. 1511 to authorize the President, on behalf of Congress, to award the Gold Medal to Prime Minister Blair. I also wish to thank the people of Great Britain, the members of the royal armed forces, and their families for their shared commitment and many sacrifices for the preservation of democracy and liberty in a world allied against terror.

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, it is with great disappointment that I cannot be present today to speak and vote in favor of H.R. 1511, a bill to award Prime Minister Tony Blair the Congressional Gold Medal. I introduced this legislation on March 31 and have since been working with my colleagues to obtain the necessary 290 cosponsors for floor action. I would like to commend Chairman OXLEY and the Financial Services Committee, as well as Rep. RICHARD BAKER and Rep. CAROLYN MALONEY for their tireless efforts in getting this bill to the floor today.

As we emerge successfully from Operation Iraqi Freedom, it is important to remember that we did not fight this war alone. The brave men and women of the British military have fought and died, side by side, with our American soldiers. Just yesterday, 6 British soldiers were killed in an attack north of Basra. Great Britain, under the leadership of Tony Blair, has paid the ultimate sacrifice.

Prime Minister Blair has ignored political expediency and risked his own career to stand up for what he knows is right. Operation Iraqi Freedom has freed millions of Iraqis from the oppression of Saddam Hussein's brutal dictatorship. The Operation has ousted a regime bent on securing and then distributing weapons of mass destruction to those who would use them against the United States, our friends, and the people of Iraq. Despite attempts by many of our "allies" to thwart this noble effort, Prime Minister Blair and Great Britain have remained strong and active players in Operation Iraqi Freedom.

I am deeply honored to play a role in awarding Prime Minister Tony Blair the Congressional Gold Medal and I thank my colleagues in the House of Representatives for joining me.

Mr. SCHIFF. Mr. Speaker, I rise today to commend British Prime Minister Tony Blair.

I am proud to be a consponsor of this legislation to award Mr. Blair with the Congressional Gold Medal. I would like to recognize Mr. Blair's—and Britain's—longstanding staunch support of our nation's democratic ideals.

Whether one supported or opposed the war in Iraq, it is true that under Blair's leadership, Britain has provided extensive military support in the war in Iraq. He has argued passionately and consistently about the threats Saddam Hussein posed in the Persian Gulf and ultimately to the Western world. Honoring Prime Minister Blair with the Congressional Gold Medal would be a fitting tribute to him, the people of Great Britain, and the thousands of British troops who fought valiantly alongside American soldiers in Iraq. We now have a historic opportunity to reaffirm our Nation's friendship with Great Britain, and our mutual commitment to freedom and democracy.

I hope that the occasion of Mr. Blair being awarded the Congressional Gold Medal will be an opportunity to invite Mr. Blair to address a joint session of Congress. I have worked with my colleague Mr. ROYCE to encourage our

Congressional leaders to invite Mr. Blair to do so, and I can think of no occasion more fitting. In light of Mr. Blair's enduring friendship with the United States, I look forward to hearing his views on the future of Iraq and the Middle East.

Mr. KING of New York. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from New York (Mr. KING) that the House suspend the rules and pass the bill, H.R. 1511.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

EXPRESSING SUPPORT FOR FREEDOM IN HONG KONG

Mr. SMITH of New Jersey. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 277) expressing support for freedom in Hong Kong.

The Clerk read as follows:

H. RES. 277

Whereas Hong Kong has long been the world's freest economy, renowned for its rule of law and its jealous protection of civil rights and civil liberties;

Whereas the 1984 Sino-British Joint Declaration explicitly guarantees that all of Hong Kong's freedoms, including press freedom, religious freedom, and freedom of association, will continue for at least 50 years;

Whereas the Government of the People's Republic of China pledged to respect Hong Kong's Basic Law of 1990, which explicitly protects freedom of speech, of the press and of publication, of association, of assembly, of procession, of demonstration, and of communication;

Whereas the Basic Law also explicitly protects freedom of conscience, religious belief, and of religious expression;

Whereas Hong Kong's traditional rule of law, which has guaranteed all of these civil rights and civil liberties, is essential to its continued freedom, and the erosion of that rule of law bodes ill for the maintenance and expansion of both economic freedom and individual civil rights;

Whereas in the United States-Hong Kong Policy Act of 1992 Congress declared: "The human rights of the people of Hong Kong are of great importance to the United States and are directly relevant to United States interests in Hong Kong. A fully successful transition in the exercise of sovereignty over Hong Kong must safeguard human rights in and of themselves. Human rights also serve as a basis for Hong Kong's continued economic prosperity.";

Whereas since Hong Kong became a Special Administrative Region (SAR) of the People's Republic of China on July 1, 1997, the Hong Kong authorities have changed the system of electing representatives to the Legislative Council, added appointed members to District Councils, invited the central government to reverse Hong Kong courts, and declined to permit the entry of some American visitors and other foreign nationals whose views are opposed by the People's Republic of China;

Whereas, despite the provisions of the Basic Law which call for a gradual and orderly process toward democratic election of the legislature and chief executive, and which call for universal suffrage, the Government of the Hong Kong SAR and the People's Republic of China have stymied this process;

Whereas the traditional liberties of Hong Kong's 7,000,000 people are now immediately threatened by Hong Kong's proposed "Article 23" laws, which were drafted under strong pressure from the Government of the People's Republic of China, dealing with sedition, treason, and subversion against the Chinese Communist Party, and the theft of state secrets;

Whereas the proposed legislation would give the Hong Kong Government discretion to imprison individuals for "attempting to commit" the undefined crime of "subversion"; would criminalize not only membership in, but even attendance at meetings of, organizations not approved by Beijing; and would threaten freedom of religion, membership in authentic trade unions, political activity of all kinds, and a wide range of public and private expression;

Whereas the proposed legislation would give Hong Kong's Secretary for Security, an appointee of the Government of the People's Republic of China, broad authority to ban organizations it deemed in opposition to the national interest, thereby threatening religious organizations such as the Falun Gong and the Roman Catholic Church;

Whereas under the proposed legislation such basic and fundamental procedural rights as notice and opportunity to be heard could be waived by the appointee of the Government of the People's Republic of China in Hong Kong if honoring these rights "would not be practicable";

Whereas the People's Republic of China's history of arbitrary application of its own criminal law against dissenters, and its pattern of imprisoning and exiling those with whom it disagrees, provide strong reasons to oppose the expansion of Beijing's ability to use its discretion against Hong Kong's freedoms;

Whereas similar subversion laws in the People's Republic of China are regularly used to convict and imprison journalists, labor activists, Internet entrepreneurs, and academics;

Whereas broad segments of the Hong Kong community have expressed strong concerns about, and opposition to, the proposed new laws;

Whereas those members of Hong Kong's Legislative Council elected by universal suffrage oppose the proposed new laws, but are powerless to stop them against the majority of votes controlled directly and indirectly by the Government of the People's Republic of China;

Whereas the scheduled consideration of these proposals to restrict Hong Kong's freedoms in the Legislative Council on July 9, 2003, makes the threat to its people clear and imminent; and

Whereas it is the duty of freedom loving people everywhere to stand with the people of Hong Kong against this dangerous erosion of its long-held and cherished rights: Now, therefore, be it

Resolved, That the House of Representatives—

(1) condemns any restriction of the freedom of thought, expression, or association in Hong Kong, consistent with the United States-Hong Kong Policy Act of 1992;

(2) recognizes that because Hong Kong exercises considerable influence in international affairs, as a developed economy, financial center, trading entrepot and shipping center, reductions in the existing freedom of the Hong Kong people would be of global significance;

(3) urges the Hong Kong Government and the People's Republic of China to withdraw the proposed implementation of Article 23 of the Basic Law insofar as it would reduce the basic human freedoms of the people of Hong Kong;

(4) calls upon the People's Republic of China, the National People's Congress, and any other groups appointed by the Government of the People's Republic of China to leave all revisions of Hong Kong law to a legislature elected by universal suffrage;

(5) urges immediate elections for the Legislative Council of Hong Kong according to rules approved by the Hong Kong people through an election-law convention, referendum, or both;

(6) calls upon the Government of the People's Republic of China to fully respect the autonomy and independence of the chief executive, the civil service, the judiciary, the police of Hong Kong, and the Independent Commission Against Corruption; and

(7) calls upon the United States Government, other governments, the people of the United States, and the people of the world to support freedom in Hong Kong by—

(A) making clear statements against any limitations on existing human freedoms in Hong Kong; and

(B) transmitting those statements to the people and the Government of the People's Republic of China.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. SMITH) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. SMITH).

GENERAL LEAVE

Mr. SMITH of New Jersey. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material on H. Res. 277, the resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. SMITH of New Jersey. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. LINCOLN DIAZ-BALART).

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I thank the gentleman from New Jersey (Mr. SMITH) for yielding me time.

Mr. Speaker, I know the hard work that the gentleman from California (Mr. COX) has put into this, along with, obviously, the leadership of the Committee on International Relations that have made it possible, the gentleman from Illinois (Mr. HYDE) and the gentleman from California (Mr. LANTOS), for this resolution to come forward in a timely basis.

Timeliness is critical here. Time is of the essence because of what the Chinese Communist regime is seeking to do precisely in these weeks in Hong Kong. It seems as though, Mr. Speaker, tyranny knows only one modus operandi, to repress the people by any means necessary to prevent dissent. We have seen this all too clearly with the dictator only 90 miles off our shores here, off the shores of the United States. And now a bastion of freedom in the face of one of the most tyrannical regimes in the world is facing a dire threat. Hong Kong may soon have its important freedoms destroyed by the so-called People's Republic of China, the PRC.

In an act of complete cowardice and desperation, the PRC has prepared new legislation called article 23 of the Basic Law which seeks to severely restrict the freedoms of the people of Hong Kong. The communist government in Beijing is pressuring the local government in Hong Kong to pass this legislation before July 9. Freedom of the press and freedom of expression are in great jeopardy because of this legislation. The actions of the Chinese regime fly in the face of promise made by Beijing of "one country, two systems," a 50-year commitment that was made to the world to preserve Hong Kong's respect for human liberties. But a mere 6 years after the British handed Hong Kong to the Communist Chinese, we see that the totalitarianism has no patience. It cannot stand to see the failures of its regime in the very face of the shining example that Hong Kong has been of freedom and civil liberties.

The elimination of freedom of speech holds countless dangers. For example, the recent SARS outbreak in China and many parts of the world was hastened in fact by the PRC's inability to deal with the truths. The regime's lies and deception hamstrung the world from dealing effectively with the crisis. The truths about the epidemic's extent were unclear; totalitarianism simply could not face or did not know how to face reality. Now, this created a grave health threat in Hong Kong and really for the rest of the world.

Freedom of speech, Mr. Speaker, is important for every aspect of life. It protects individual citizens from the deception that we saw in the example of the SARS crisis by offering multiple important sources of information. The PRC claims that this law it is seeking to impose on the people of Hong Kong is a means to ensure its national security. The rest of the world rightly sees it for what it is, an attempts to roll back liberties that Hong Kong has to thwart any pressure for greater liberties throughout the rest of China.

Now, if the world does not stand up to the PRC now, this will only be the beginning of the tightening of its totalitarian grip on the people of Hong Kong. The United States Government has an obligation to stand with the people of Hong Kong. The State Department must not fail to show the outrage of the American people at the destruction of the most basic liberties which have survived up to now on the island of freedom that is Hong Kong.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume. I rise in strong support of this resolution.

Mr. Speaker, first I would like to commend my friend, the gentleman from California (Mr. COX), the gentleman from New Jersey (Mr. SMITH), the gentleman from Florida (Mr. LINCOLN DIAZ-BALART), and the Democratic leader, the gentlewoman from California (Ms. PELOSI), for their strong support of this resolution.

Mr. Speaker, one of the most moving moments of my life in a very sad sense was the 1st of July, 1997, when I was present in Hong Kong with our then-Secretary of State Madeleine Albright as the British flag came down and the flag of Communist China went up. It was a sad moment for all of us who believe in free and open and democratic government and in human rights across the globe.

The people of Hong Kong over the decades have made an enormous contribution to the economic and cultural life of the Asia-Pacific region, and they set the standards for efficiency and honesty and integrity in government. Hong Kong has been enormously helpful to us in the war on terrorism, particularly in cracking down on the use of banks in the Asia-Pacific region to launder funds for the benefit of terrorists.

But Hong Kong's hard-earned international reputation is being severely damaged by the government's pursuit of so-called article 23 antisedition legislation.

This resolution before us expresses our strong concerns and reservations regarding these dangerous trends. And I hope that our passage of this legislation will influence consideration of article 23 by the legislature of Hong Kong.

This insidious bill proposed by the government in Hong Kong goes a long way towards giving the chief executive appointed by a Beijing-packed committee broad authority to ban organizations if they are prohibited to function in mainland China for "national security" reasons.

If this legislation in Hong Kong should pass, it is very likely that the government of Hong Kong will immediately face pressure from Beijing to ban the Falun Gong movement. Hong Kong representatives of evangelical Christian groups, labor unions, human rights organizations will find that they may also be banned in Hong Kong, as American labor activist Harry Wu was prohibited from entering Hong Kong just last year.

The ability of targeted organizations, perhaps I should say persecution organizations, to obtain a public hearing can be waived by the Hong Kong chief executive if he deems such public hearings as not practicable.

Mr. Speaker, Hong Kong's strength is its commitment to the rule of law. The legislation proposed by the Hong Kong Government calls that commitment into serious question. The democratic forces in Hong Kong, including my good friend Martin Lee, are fighting for Hong Kong's democratic future and its free and open way of life. We in this body must support their battle.

Our resolution has the strong support of both the Democratic and Republican leadership of our House, and I urge all of my colleagues to support its passage.

Mr. Speaker, I reserve the balance of my time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, today's resolution introduced by my good friend and colleague, the gentleman from California (Mr. COX), and many, many co-sponsors on freedom in Hong Kong, raises a sober question for all of us to ponder. How does a state balance a need to protect itself from acts of sedition with the equally important need to protect the civil liberties of its citizens?

This very same issue arose in the early days of our own Republic, in the year 1798 to be exact. The Adams administration and the Federalist-controlled Congress used the excuse of the extreme revolutionary fervor coming across the Atlantic from France to pass a series of legislative measures known collectively as the Alien and Sedition Act. These measures were seen as effectively nullifying the First Amendment guarantees of freedom of speech and freedom of the press. Public uproar was such that Congress repealed one of the measures and allowed the rest to die a natural death through expiration.

The point here is that all governments, as we are acutely aware of after the tragic events of September 11, have the imperative to protect their institutions and citizens from sedition, treason, and terrorism.

The question raised, however, is does article 23 of the Basic Law of the Hong Kong Special Administrative Region, to be considered by the Hong Kong Legislative Council this coming July 9, go beyond legitimate security needs? Does it, like the Alien and Sedition Act, threaten the civil liberties of the body politic as a whole? There are disturbing indications that the answer to these questions is an affirmative "yes."

The American Congress expressed its clear concern for the preservation of human rights for the people of Hong Kong through adoption of the U.S.-Hong Kong Policy Act of 1992. When Hong Kong ended British rule on July 1 of 1997 and was returned to the sovereignty of the Chinese people, an important pledge was given. That pledge was that for the next 50 years under a "one-country, two-systems" formula, Hong Kong would continue to independently exercise those economic and political freedoms which had evolved there over time.

Those who feared the worst on that July day now almost 6 years ago, the sounds of jack boots in the street of Hong Kong found that their fears were largely unfounded. There was no immediate descent of the Bamboo Curtain. Instead, however, like drops of water falling upon a rock, there has been a slow erosion of those democratic qualities which made Hong Kong unique.

American citizens of certain political or philosophical persuasions have been denied entry. An internationally respected Hong Kong newspaper whose owners turn their eyes towards Beijing have fired its most effective and outspoken journalists.

An American citizen released from a Chinese prison found the attitude of the administration at the Hong Kong university where he taught so hostile that he relocated to the United States. Ever so slowly, the rock of freedom is being washed away by these slow, but steady, drips of tyranny.

Article 23 in its present form is a major step in that erosion. This view is held not only by the overwhelming majority of the American Congress. Internationally respected Hong Kong leaders, including political leaders like Martin Li, and religious leaders like Roman Catholic Bishop Joseph Zen have reached the same conclusion, that article 23, as it is presently constructed, will open the door to a slow, steady decline of liberty in Hong Kong. The Hong Kong men and women in the street have also voiced their concerns over the implementation of article 23 and its corrosive effect on the right to peaceful assembly, such as is annually done on the streets of Hong Kong on June 4, the anniversary of the Tiananmen Square massacre.

Mr. Speaker, as a symbol of hope for the future of China, Hong Kong has great significance beyond that of a small urban enclave of international trade and commerce.

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What happens there is closely watched in Taiwan, in Beijing and in greater Asia beyond. A slow twilight, sunset of liberty in Hong Kong, therefore, will have repercussions and very negative ones far beyond its own borders.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I am proud to yield as much time as she might consume to the gentlewoman from California (Ms. PELOSI), the Democratic leader who has spent her professional life fighting for human rights and specifically fighting for human rights for the people of Hong Kong.

Ms. PELOSI. Mr. Speaker, I thank the distinguished ranking member of the Committee on International Relations for yielding the time and for his tremendous leadership.

What an honor it is to be on the floor today with my friend the gentleman from New Jersey (Mr. SMITH), the vice chair, I understand, of the Committee on International Relations, and with the gentleman from California (Mr. LANTOS), two champions of human rights every place in the world. By their leadership and their tireless energy, boundless I would say, on behalf of freedom, they have set an example, freed people, made the world a freer place, and we are all in their debt.

I am pleased to join my colleague the gentleman from Maryland (Mr. CARDIN) as well as we speak to the issue of the preservation of freedom in Hong Kong. So it is with appreciation to all of my colleagues here present on the floor and to the gentleman from California (Mr. COX), who is one of the authors of the resolution, that I join in calling for the preservation of freedom in Hong Kong, keeping promises made to the people of Hong Kong.

Mr. Speaker, when the Sino-British Joint Declaration was initiated in 1997, it guaranteed the preservation of freedoms basic to life in Hong Kong. Just 5 years later, those freedoms, freedom of press, freedom of religion, freedom of association, are under assault.

The House must act today to make clear to the Hong Kong government and to the People's Republic of China the seriousness with which the United States views any action that would subvert the promise of human rights contained in the joint resolution.

The draft provisions to implement Article 23 of Hong Kong's basic law would give Beijing the ability to determine what types of organizations could exist in Hong Kong and which views could be expressed. Many of us received a delegation led by Martin Lee, the very distinguished democracy advocate in Hong Kong, just a few weeks ago, where they expressed their concern and the impact that this action would have on Hong Kong, as we have known it, as a dynamic society where business has flourished because information has been able to flow freely.

This action is a significant threat to Hong Kong's autonomy and to the freedoms that make it a center for the exchange of information and ideas. It is an even greater concern because the movement toward popular democracy, as required under the basic law, has not begun.

I commend President Bush on the administration's forceful opposition last Thursday to the Article 23 proposal. The administration statement emphasized that: "Hong Kong's special status, endorsed by the United States under the Hong Kong Policy Act, depends on the local authorities' protection of human and civil rights and the preservation of the territory's autonomy. The United States opposes any law that threatens the territory's unique identity, including the current version of Article 23 legislation." That is from the President's statement.

Hopefully, after leaders in Hong Kong and Beijing reflect seriously on those words and the strong sentiments contained in the legislation we are considering today, they will move to amend the proposal to preserve the freedom of the people of Hong Kong that they were promised.

Mr. Speaker, I congratulate the leadership again of the Committee on International Relations, the gentleman from Illinois (Mr. HYDE), the gentleman from California (Mr. LANTOS), the gentleman from New Jersey (Mr. SMITH), and the leadership of the gentleman from California (Mr. COX) in introducing this legislation. I was pleased to join him in doing so.

The Committee on International Relations has provided an opportunity for the House to go on record in favor of the preservation of human rights in Hong Kong in opposition to actions that threaten them. I urge overwhelming adoption of this measure to underscore our commitment to the cause of freedom in Hong Kong.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 3 minutes to the gentleman from Iowa (Mr. KING), my good friend.

Mr. KING of Iowa. Mr. Speaker, I appreciate the opportunity to speak.

Today, I rise in strong support of the Hong Kong resolution. I doubt many of us in this Chamber will forget the Cold War and the United States' dedication to protect any country threatened by a Communist regime.

Today, I ask, have we forgotten the image of that one Chinese student blocking a barrage of tanks or the hurriedly erected plaster Lady liberty proudly emulating our own Statue of Liberty displayed so prominently as a symbol of the Chinese people's desire to be free? How can we ever forget the hundreds of Chinese martyrs killed on that warm June night in Tiananmen Square 14 years ago?

Because we are a Nation that does not forget the human tragedy and sufferings committed by Communist regimes in the last century, we cannot watch silently today as the freedoms enjoyed by the people of Hong Kong are being stripped away.

Prior to 1997, Hong Kong was not only an economic powerhouse, it served as a beacon of hope that one day rule of law, transparency and a republican form of government would be a reality in the People's Republic of China. However, rather than adopting Hong Kong's free society, China now flexes its oppressive muscles over Hong Kong themselves, depriving them not only of the freedom of speech, religion and association agreed to by the British and Chinese Government in 1997, but these freedoms that are guaranteed because they are inalienable and endowed to all members of the human race. As our President has said, that freedom is a right of every person and the future of every Nation.

Today, I rise to join in solidarity with the often lonely voice of Hong Kong's Bishop Joseph Zen, who is a tireless advocate of the people of Hong Kong and a vocal fundamental critic of the Chinese government's disregard of the fundamental rights of the governed. Bishop Zen risks his own life by speaking with moral authority, and his commitment to protect the dignity of each human person should be supported.

Congress must send a clear message to the Chinese Government that we expect them to abide by the premise of Hong Kong's basic law which grants gradual progress towards the democratic election of the legislature and chief executive. Furthermore, the United States must continue the fight against communism, an oppressive regime that denies each individual his or her dignity and holds countries that violate human rights accountable.

I urge my colleagues to vote in favor of this resolution because it protects what America has, what America stands for and what Hong Kong does not want to lose, the gift of freedom.

I thank the gentleman from California (Mr. COX) for his important resolution.

Mr. LANTOS. Mr. Speaker, we reserve the balance of our time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

While we are waiting for the gentleman from California (Mr. COX), the prime author of this legislation, to arrive here let me just again reiterate a few things.

I like many others have followed the ongoing human rights abuses by the People's Republic of China, and many of us had hoped, and this hope is now at grave risk, that Hong Kong might avoid the same kind of repressive regime visited upon it that other people in the People's Republic of China live with and endure each and every day.

Our hope is that the Chinese Government, especially with its work in the WTO, with its attempt to join the world leaders as a major player, that it would respect the democratic rights of Hong Kong and learn from it. Hong Kong can be a beacon for them not only economically, but also in the area of human rights and fundamental freedoms. The dictatorship in Beijing really has nothing to fear but fear itself by giving in, it seems to me, to basic and fundamental human rights.

Over time, if the PRC were to do that, they certainly would be respected, but if they do the opposite, they will be held in contempt, and what this resolution says, it is a cautionary flag, do not do it, do not bring the repressive policies that you have foisted upon your own people to the people of Hong Kong. The PRC has already promised, as we all indicated earlier, that there would be at least a 50-year hiatus where at least a semblance of freedom would be experienced.

Mr. Speaker, I yield such time as he may consume to the gentleman from California (Mr. COX), my friend and colleague.

Mr. COX. Mr. Speaker, I thank the Chairman for yielding me the time.

I rise in support of H. Res. 277, expressing the sense of this House in support of freedom in Hong Kong. Hong Kong is a jewel. We are all admirers of Hong Kong on both sides of the aisle, Democrats and Republicans.

Hong Kong has had for years what is probably the freest economy in the world, and along with that they have had civil rights and civil liberties of which Hong Kongers themselves have been jealously protective. Nothing has changed in that respect except that under the one country-two systems formula the government of the People's Republic of China is getting ahead of themselves by many decades.

They promised 50 years, and instead, they are now seeking to replace the traditional civil law of Hong Kong with a subversion law, with a national security law that will take away fundamental rights of speech, association, membership in labor unions, journalists doing their job. The scope, the breadth, the discretion given to the executive in this proposed law is absolutely breathtaking, and we feel compelled for this reason because these legal changes are imminent in Hong Kong to express ourselves in support of the people of Hong Kong.

An article in the South China Morning Post just this Saturday reported on a controversy ignited by two causes here in America: first, this resolution, the fact that it has been reported by the Committee on International Relations and has come to the floor; and second, a White House statement in support of freedom in Hong Kong. In response to these modest congressional and presidential expressions of support for freedom, noting that the Article 23 legislation being considered in Hong Kong "could harm local freedoms and autonomy over time," a spokesman for the foreign ministry in the People's Republic of China said that other nations should not interfere in the debate about free expression in Hong Kong because it is an "internal affair."

With all due respect to the PRC foreign ministry, the freedom of people to think, to express themselves, to belong to organizations, to associate with others is not an internal affair. It is a fundamental human right. The human dignity of the people of Hong Kong is of itself sufficient reason to approve this resolution, but if that were the sole justification for this resolution, then we would probably be considering thousands like it.

A second reason we act today is because it is in the interests of the United States to do so. In the Hong Kong Policy Act, approved unanimously by both Houses of Congress and signed by the President on October 5, 1992, the United States declared that, "Hong Kong plays an important role in today's regional and world economy. This role is reflected in strong economic, cultural and other ties with the United States that give the United States a strong interest in the continued vitality, prosperity and stability of Hong Kong."

Our law also declares that "support for democratization is a fundamental principle of United States foreign policy. As such, it naturally applies to United States policy toward Hong Kong. This will remain equally true after June 30, 1997," that of course being the date of the handover from the British to the Chinese of the territory of Hong Kong.

Finally, the law says, "The human rights of the people of Hong Kong are of great importance to the United States and are directly relevant to United States interests in Hong Kong. A fully successful transition in the exercise of sovereignty over Hong Kong must safeguard human rights in and of themselves.

"The United States should play an active role, before, on, and after July 1, 1997, in maintaining Hong Kong's confidence and prosperity, Hong Kong's role as an international financial center, and the mutually beneficial ties between the people of the United States and the people of Hong Kong."

That is why we are here today. If we think back to the time prior to the handover, prior to 1997, we were assured that this could not happen, that it would not happen, and yet through an excretion of changes in the law, through inroads that are being made on the traditional freedoms that Hong Kongers have enjoyed, so slowly perhaps as to be imperceptible but now this one fell swoop suddenly very noticeable, the PRC is taking away the freedom of one country-two systems, that was guaranteed in 1997.

□ 1230

Our former colleague, Connie Mack, warned us in 1994, on the 10th anniversary of the Sino-British Declaration on the question of Hong Kong, of the failure of the Communist Government of China to respect the declaration, even as of that date: "Immediately after signing the Joint Declaration, the PRC started working on the Basic Law, Hong Kong's post-1997 'mini-constitution.' The Basic Law was enacted not by Hong Kong's Legislative Council, the Legco, but by Beijing's rubber stamp National People's Congress that contravened the Joint Declaration. It subordinates the Legco to a Beijing-appointed executive; assigns a power of judicial interpretation to the Standing Committee of the National People's Congress, rather than to Hong Kong's courts; and it requires a law against 'subversion,' a concept unknown in the common law."

It is that illegitimate law against subversion that today the House revisits. This is what is about to take place in Hong Kong. If the world is silent, as this interruption, as this deprivation of freedom moves forward, then our liberties, too, will be at greater risk.

Hong Kong is a jewel for the entire planet. It is our hope that the freedom that Hong Kong has traditionally enjoyed will spread northward throughout the People's Republic of China, that that will be the ultimate result of one country, two systems, not the other way around. But what is happening now, as we meet here today, is that this island of freedom is being weighted down by the long-standing rule of the Communist Party in the People's Republic of China; that the law is simply a tool of the party itself and not independent.

Mr. Speaker, I appreciate the careful consideration that this Chamber is giving to this resolution. I want to thank the chairman and the ranking member of the Committee on International Relations for bringing this resolution to the floor in a timely fashion, and I expect that all of our colleagues will vote in support of freedom at this important time in both China's history and our own.

Mr. WU. Mr. Speaker, I rise to express my strong support for H. Res. 277, a resolution supporting freedom and democracy in Hong Kong.

Throughout its modern history, Hong Kong has stood as a beacon of freedom and stability. With the Hong Kong people's ingenuity and hard work, the territory became a stable and prosperous democracy.

Since Hong Kong's 1997 change of status, the citizens of Hong Kong have faced the challenge of maintaining their civil liberties and democratic self-governance. While the Basic Law guarantees Hong Kong fifty-years of self-governance and freedom, the Beijing-appointed government of Hong Kong has been working to limit freedom in the territory.

I strongly support the goals of H. Res. 277. As a long-time friend and supporter of Hong Kong, I believe we must continue to support the Hong Kong people's efforts to preserve and advance the cause of freedom and democracy. I applaud the gentleman from California (Mr. COX) for sponsoring this resolution and I will continue to work with my colleagues to protect and advance freedom, democracy, and the rule of law in East Asia.

The SPEAKER pro tempore (Mr. BASS). The time of the gentleman from New Jersey (Mr. SMITH) has expired.

Mr. LANTOS. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time having expired, the question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the resolution, H. Res. 277.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

EXPRESSING SENSE OF CONGRESS THAT ESCALATION OF ANTI-SEMITIC VIOLENCE WITHIN PARTICIPATING STATES OF OSCE IS OF PROFOUND CONCERN AND EFFORTS SHOULD BE UNDERTAKEN TO PREVENT FUTURE OCCURRENCES

Mr. SMITH of New Jersey. Mr. Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 49) expressing the sense of the Congress that the sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences.

The Clerk read as follows:

H. CON. RES. 49

Whereas the expressions of anti-Semitism experienced throughout the region encompassing the participating States of the Organization for Security and Cooperation in Europe (OSCE) have included physical assaults, with some instances involving weapons or stones, arson of synagogues, and desecration of Jewish cultural sites, such as cemeteries and statues;

Whereas vicious propaganda and violence in many OSCE States against Jews, foreigners, and others portrayed as alien have reached alarming levels, in part due to the dangerous promotion of aggressive nationalism by political figures and others;

Whereas violence and other manifestations of xenophobia and discrimination can never be justified by political issues or international developments;

Whereas the Copenhagen Concluding Document adopted by the OSCE in 1990 was the first international agreement to condemn anti-Semitic acts, and the OSCE participating States pledged to "clearly and unequivocally condemn totalitarianism, racial and ethnic hatred, anti-Semitism, xenophobia and discrimination against anyone as well as persecution on religious and ideological grounds";

Whereas the OSCE Parliamentary Assembly at its meeting in Berlin in July 2002 unanimously adopted a resolution that, inter alia, called upon participating States to "ensure aggressive law enforcement by local and national authorities, including thorough investigation of anti-Semitic criminal acts, apprehension of perpetrators, initiation of appropriate criminal prosecutions and judicial proceedings";

Whereas Decision No. 6 adopted by the OSCE Ministerial Council at its Tenth Meeting in Porto, Portugal in December 2002 (the "Porto Ministerial Declaration") condemned "the recent increase in anti-Semitic incidents in the OSCE area, recognizing the role that the existence of anti-Semitism has played throughout history as a major threat to freedom";

Whereas the Porto Ministerial Declaration also urged "the convening of separately designated human dimension events on issues addressed in this decision, including on the topics of anti-Semitism, discrimination and racism and xenophobia"; and

Whereas on December 10, 2002, at the Washington Parliamentary Forum on Confronting and Combating anti-Semitism in the OSCE Region, representatives of the United States Congress and the German Parliament agreed to denounce all forms of anti-Semitism and agreed that "anti-Semitic bigotry must have no place in our democratic societies": Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That it is the sense of the Congress that—

(1) officials of the executive branch and Members of Congress should raise the issue of anti-Semitism in their bilateral contacts with other countries and at multilateral fora, including meetings of the Permanent Council of the Organization for Security and Cooperation in Europe (OSCE) and the Twelfth Annual Session of the OSCE Parliamentary Assembly to be convened in July 2003;

(2) participating States of the OSCE should unequivocally condemn anti-Semitism (including violence against Jews and Jewish cultural sites), racial and ethnic hatred, xenophobia, and discrimination, as well as persecution on religious grounds whenever it occurs;

(3) participating States of the OSCE should ensure effective law enforcement by local and national authorities against criminal acts stemming from anti-Semitism, xenophobia, or racial or ethnic hatred, whether directed at individuals, communities, or property, including thorough investigation and prosecution of such acts;

(4) participating States of the OSCE should promote the creation of educational efforts throughout the region encompassing the participating States of the OSCE to counter anti-Semitic stereotypes and attitudes among younger people, increase Holocaust awareness programs, and help identify the necessary resources to accomplish this goal;

(5) legislators in all OSCE participating States should play a leading role in combating anti-Semitism and ensure that the resolution adopted at the 2002 meeting of the OSCE Parliamentary Assembly in Berlin is followed up by a series of concrete actions at the national level; and

(6) the OSCE should organize a separately designated human dimension event on anti-Semitism as early as possible in 2003, consistent with the Porto Ministerial Declaration adopted by the OSCE at the Tenth Meeting of the OSCE Ministerial Council in December 2002.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. SMITH) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. SMITH).

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, anti-Semitism is a deadly disease of the heart that leads to violence, cruelty, and unspeakable acts of horror. The anti-Semite is, as Holocaust survivor Elie Wiesel grimly wrote last week, an ideological fanatic and pathological racist: "An anti-Semite is someone who never met me, never heard of me, yet he hates me."

While we all are aware and deplore the hate crimes and cowardly acts that are committed routinely by Hamas and their like-minded murderers, what is new, Mr. Speaker, is the enormous surge in anti-Semitic acts and the resurgence of hatred for Jews in Europe, the United States, and in Canada.

Just a brief look, Mr. Speaker, of some of the startling statistics makes the point. In France, for example, there was a 600 percent increase in anti-Semitic acts from the year 2001 to the year 2002. Thankfully, the French have moved with new legislation designed to not only chronicle and get a better handle on how often these hate crimes are occurring, but they are also trying to stop them.

The Anti-Defamation League, Mr. Speaker, did a survey that also showed a spike in five other countries of Europe. They found that 21 percent of the people in those five countries had strongly anti-Semitic perspectives or views. The ADL also looked at the United States and found that 17 percent of our own people in the United States had strong anti-Semitic views. If you extrapolate that, Mr. Speaker, that is about 35 million Americans. That is up 5 percent from just 5 years ago.

H. Con. Res. 49 recognizes this dangerous and alarming trend, condemns this ancient-modern scourge, and calls on each of the 55 countries that make up the Organization for Security and Cooperation in Europe to take concrete steps to eradicate anti-Semitism. The resolution before us today is an unequivocal condemnation of violence against Jews and Jewish cultural sites, racial and ethnic hatred, xenophobia and discrimination, as well as persecution on religious grounds wherever it occurs.

The resolution calls on all the states of the OSCE to ensure effective law enforcement and prosecution of individuals perpetrating anti-Semitic violence as well as urging the parliaments of all those states to take concrete legislative action at the national level. We are encouraging, Mr. Speaker, the creation of education efforts to counter these anti-Semitic stereotypes and the attitudes that we are seeing increasingly among younger people. We are calling for an increase in Holocaust awareness programs, and seeking to identify necessary resources to accomplish these goals.

Mr. Speaker, as chairman of the Commission on Security and Cooperation in Europe, I chaired a congressional hearing and three international summits on anti-Semitism within the last year alone. Joined by my good friend and colleague from the German Bundestag, Gert Weisskirchen, at the three special summits, and my good friend and colleague, the gentleman from Maryland (Mr. CARDIN), who I thank as well for his good work on this, these summits have focused on this rising tide of anti-Semitism.

The summits, Mr. Speaker, were held in Berlin, in 2002; in Washington, in December of 2002; and in Vienna, earlier this year, in February. We heard from world renowned leaders, including Rabbi Israel Singer, President of the World Jewish Congress; Ambassador Alfred Moses, Abraham Foxman and Ken Jacobson of the Anti-Defamation League; Mark Levin from the NCSJ; Rabbi Andrew Baker of the American Jewish Committee; Dr. Shimon Samuels, director of the Weisenthal Center located in Paris; and many others. Amnesty International and other human rights' organizations, all of whom made very powerful statements about this alarming rise of hate directed towards Jews.

Let me just quote for my colleagues what Dr. Samuels said, very briefly: "The Holocaust, for 30 years, acted as a protective Teflon against blatant anti-Semitic expression. That Teflon has eroded, and what was considered distasteful and politically incorrect is becoming simply an opinion. But cocktail chatter at fine English dinners can end as Molotov cocktails against synagogues. Political correctness is also ending for others, as tolerance for multiculturalism gives way to populist voices in France, Italy, Austria, Denmark, Portugal, and the Netherlands. These countries' Jewish communities can be caught between the rock of radical Islamic violence and the hard place of a revitalized Holocaust-denying extreme right. Common cause must be sought between the victimized minorities against extremism and against fanaticism."

Dr. Jacobson pointed out, and I quote, "Sadly, some European leaders have rationalized anti-Jewish attitudes and even more violent attacks against Jews as nothing more than a sign of popular frustration with events in the Middle East. Something to be expected, even understandable, they say."

Mr. Speaker, we have been hearing more and more about this idea of pretext; that there is a disagreement with the policies of the Israeli Government, that somehow that gives license and an ability and permission for some people to hate the Jews themselves. We can disagree, as we do on this House floor. The gentleman from Florida (Mr. HASTINGS), the gentleman from Maryland (Mr. CARDIN), and I have been working on this for years, and of course the gentleman from California (Mr. LANTOS). We disagree on some issues, but anti-Semitism? We do not hate. We do not use that as a pretext, as a front to promote hatred. That is exactly what is happening in Europe, in the United States, and in Canada.

Let me point out too that, as a result of these summits, we have come up with an action plan. Mr. Weisskirchen and I have signed it, it has been agreed to by our commissions, and we are trying to promote it among all our States. Again, education, trying to get parliaments to step up to the plate, and trying to make a meaningful difference to mitigate and hopefully to end this terrible anti-Semitism.

Last week, the gentleman from Florida (Mr. HASTINGS) and I joined Rudy Giuliani in Vienna for an OSCE assembly focused on anti-Semitism. We have been doing it in the OSCE Parliamentary Assembly, but now the OSCE itself has taken up this important cause. And it will be followed up with a meeting, most likely in Berlin next year, to focus on anti-Semitism so that we rally the troops all over the world, starting with Europe, the U.S., and Canada to say "never again."

Let me also point out to my colleagues, and I thought his statement said it all, when Abraham Foxman, who gave riveting testimony at our Berlin conference, pointed out just recently in the Jerusalem Post, just a couple of days ago, and I would like to close with his statement, he said "Anti-Semitism is surging in the world to the extent unprecedented since the end of World War II. Europe must take seriously the ideology of anti-Semitism coming out of the Arab and Islamic world. It must denounce the deliberate targeting of Jews by terrorist groups, whether it be al Qaeda or Hamas. It must denounce the vicious anti-Semitic material in the Arab press and educational systems and call on Arab leaders to do something about it. It must understand that the Holocaust happened not only because Germany was taken over by the Nazis, who developed a massive military power to conquer most of Europe, but also by the complicity—active and passive—of other Europeans. Today, the great threat comes from the combination of the ideology of hatred with Islamic extremists to acquire weapons of mass destruction." And then he bottom lines it and says, "Let Europe never again be complicit in developments of this kind."

Mr. Speaker, this Congress needs to go on record in a bipartisan way, Democrats, Republicans, Conservatives, Moderates, and Liberals to say anti-Semitism, never again, and we need to do it strongly today.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume, and I rise in strong support of the resolution.

First, I want to commend my dear friend, the gentleman from New Jersey (Mr. SMITH), the chairman of our delegation to the Organization for Security and Cooperation in Europe, for his lifelong indefatigable and passionate advocacy of human rights, and his powerful opposition in all fora to anti-Semitism. We are all in his debt.

I also want to thank the gentleman from Illinois (Mr. HYDE), of the Committee on International Relations, for moving this legislation so expeditiously to the floor. And I want to thank my good friend, the gentleman from Maryland (Mr. CARDIN), the ranking Democrat on our OSCE delegation, for his outstanding work on behalf of all of the causes that the human rights community is interested in.

Mr. Speaker, as the only survivor of the Holocaust ever elected to Congress, I am acutely aware of the dangers of allowing anti-Semitism to go unchecked. The horrors of the Holocaust in World War II began with anti-Semitism. Growing up in Europe in the 1930s, I saw firsthand the horrendous results of anti-Semitic rhetoric, leading to the nightmare of anti-Semitic violence, and, ultimately, to the mass murder of 6 million innocent men, women and children.

Mr. Speaker, today, anti-Semitism in Europe, as well as in a number of other places in this world, is approaching the appalling levels that I personally experienced in the 1930s.

□ 1245

We cannot, we must not, and we will not sit idly by and ignore the sharp escalation of anti-Semitic rhetoric and anti-Semitic violence.

Our resolution notes that expressions of anti-Semitism in some European countries range from vicious propaganda to physical assaults, from the burning of synagogues to the desecration of cemeteries. Since the 1990 Copenhagen Concluding Document, a number of resolutions have been adopted by OSCE condemning anti-Semitism. In that spirit, I welcome this effort.

Our resolution urges officials of our executive branch and Members of Congress to raise the issue of anti-Semitism in their bilateral and multilateral meetings with all foreign government officials where appropriate and to condemn in the strongest possible terms not only anti-Semitism but racial and ethnic hatred, xenophobia, discrimination and religious persecution of all types. We urge all member countries of the OSCE to ensure effective law enforcement by local and national authorities against criminal actions stemming from anti-Semitism and other types of racial hatred.

Most importantly, our resolution calls upon all States to promote educational efforts to counter anti-Semitic stereotypes and attitudes and to dramatically increase Holocaust awareness. Our best ammunition in this fight against anti-Semitism is education.

Mr. Speaker, the battle against this age-old and horrendous mental sickness will not be easily won, but I believe the recognition of the problem and the call for actions to deal with it is the first critical step. I urge all of my colleagues to support this important legislation which serves to eliminate the outrage of hate-filled anti-Semitism.

Mr. Speaker, I reserve the balance of my time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Florida (Ms. ROS-LEHTINEN), the chairman of the Subcommittee on the Middle East and Central Asia.

Ms. ROS-LEHTINEN. Mr. Speaker, I am honored to be in the company of the gentleman from New Jersey (Mr. SMITH) and the gentleman from California (Mr. LANTOS) in cosponsoring this resolution. I rise in support of its passage and ask my colleagues to vote in its favor as well.

Mr. Speaker, one of the essential lessons of the Holocaust is that words lead to murder, that the teaching of contempt and acceptance of bigotry and anti-Semitism can lead to genocide. Today, over 50 years after the horrors of the Holocaust, anti-Semitism has again become a disease spreading throughout the world. In recent years I have witnessed its resurgence, particularly through my work relating to the United Nations Commission on Human Rights and legislative efforts concerning religious freedom in Europe.

At the commission, resolution after resolution, statement after statement are filled with the rhetoric of hatred, using the international fora to further promote and generate support for an anti-Semitic agenda, an agenda which condemns a freedom-loving people and a democratic nation, while many times legitimizing those regimes that torture, oppress, and subjugate their own people.

As the previous chair of the Subcommittee on Human Rights and as the current chair of the Subcommittee on the Middle East and Central Asia, and as cochair along with my colleague and friend the gentleman from California (Mr. LANTOS) of the Congressional Task Force on Anti-Semitism, I have pressed European officials to take concrete steps to monitor, investigate and prosecute to the fullest extent of the law crimes that are borne out of hatred for the Jewish people.

In January of this year, for example, Jewish leaders in France came to me with concern and anxiety about the increasing example of vandalism and personal attacks against rabbis in that country. I immediately called on the French foreign ministry officials and French parliamentarians to address this grave matter.

The situation in France, however, is only a microcosm of a growing problem that is sweeping throughout many OSCE states. While I will not delve into details because my colleagues, the gentleman from New Jersey (Mr. SMITH) and the gentleman from California (Mr. LANTOS), have already done so, I will simply note, as has been said, we must learn the lessons and the mistakes of the past, or we are condemned to repeat them.

This is why it is imperative that we take immediate action to prevent further escalation of anti-Semitism and related violence, to help ensure that the evil of the Holocaust will never again be allowed to exist.

As Eli Wiesel, a Holocaust survivor and Nobel Peace laureate has said, "A destruction, an annihilation that only man can provoke, only man can prevent." We can help prevent a repetition of history, and we can begin here today by voting in favor of this resolution. Let us adopt House Concurrent Resolution 49 and convey the commitment of the U.S. House of Representatives to work with our allies to confront and combat anti-Semitism and eradicate it from its roots.

Mr. LANTOS. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland (Mr. CARDIN), the distinguished ranking Democratic member of the Helsinki Commission, who has demonstrated a passionate commitment to human rights and on all of the issues that that commission works with.

Mr. CARDIN. Mr. Speaker, let me first thank the gentleman from California (Mr. LANTOS). There is no Member of this body who has done more in his lifetime to fight anti-Semitism than the gentleman from California (Mr. LANTOS), and I congratulate him for his effective leadership against anti-Semitism here and around the world.

I also want to thank the gentleman from New Jersey (Mr. SMITH), who is the chairman of our OSCE delegation. I have the honor of being the ranking Democratic member. The gentleman from Florida (Mr. HASTINGS), who will be speaking shortly, is one of the commissioners. We have made the fight against anti-Semitism a top priority of our delegation. We have been effective in making it a top priority within the OSCE Parliamentary Assembly.

We have done that because we have seen a rise of anti-Semitism, physical assaults on individuals solely because they are Jewish, desecration of Jewish cultural sites, propaganda in the media have all been on the rise. We must have a zero tolerance policy about anti-Semitism.

The OSCE Helsinki Commission provides a unique opportunity for us to fight anti-Semitism. It not only has in its membership all of the countries of Europe, Canada and the United States, but it has the participation of our Mediterranean partners, which include Israel, Egypt and Jordan. The OSCE Helsinki Commission has had a history of effectively dealing with human rights issues, so that is why the United States leadership has been effective in bringing about the forums to deal with anti-Semitism. I know there was just a meeting in Vienna that the gentleman from New Jersey (Chairman SMITH) and the gentleman from Florida (Mr. HASTINGS) participated in. We adopted in the OSCE Parliamentary Assembly last year a very strong resolution against anti-Semitism as a result of the U.S. leadership, and we have signed a letter of intent with Germany to spell out specific actions that we need to take in order to fight anti-Semitism.

We can never justify anti-Semitic actions by international developments or political issues. We need to have an action plan to fight anti-Semitism. We need to have strong laws that are adopted by our member states and enforced. We need to speak out against anti-Semitism as parliamentarians. Silence is not an option. As all my colleagues have expressed, we need educational programs for our children. The resolution says we need to create educational efforts throughout the region encompassing the participating states of OSCE to counter anti-Semitic stereotypes and attitudes among younger people, increase Holocaust awareness programs, and help identify the necessary resources to accomplish this goal. Our children are our future. In many of these states, we are finding there are counterproductive programs promoting anti-Semitism.

We need a proactive agenda. This resolution puts this body on record in strong support of our resolution within OSCE to continue our commitment to support action plans to stamp out anti-Semitism. I urge my colleagues to support the resolution.

Mr. SMITH of New Jersey. Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. MALONEY), who has been a champion not only of the fight against anti-Semitism but on behalf of all human rights causes.

Mrs. MALONEY. Mr. Speaker, I rise in strong support of this resolution, and I thank the gentleman from New Jersey (Mr. SMITH) and the gentleman from California (Mr. LANTOS) for their extraordinary leadership on this important issue and so many others.

We are experiencing the worst outbreak of anti-Semitism in Europe since the end of Holocaust in 1945. Just under 60 years have passed since the defeat of Hitler and now swastikas have reappeared in Europe. They can be found sprayed on Jewish schools, drawn on gravestones in a desecrated Jewish cemetery, painted on the wall of a synagogue, and stitched on the flags of anti-Israel demonstrators, and in the hearts and minds of the people who attack rabbinical students and Jewish athletes.

When we allow intolerance and hatred to fester and flourish, we are faced with tragic consequences. Put simply, hatred, violence and prejudice must not be tolerated. Countries must speak out against anti-Semitic acts, but rhetoric is not enough. Words will not restore the hundreds of Jewish cultural and religious sites which have been burned, desecrated and destroyed throughout Europe, and words alone will not prevent these tragedies from happening again.

Governments and institutions must condemn these acts as we do today, and they must ensure effective law enforcement against them. They must also promote tolerance education for their children. There is no question teaching children about the horror and tragedy of the Holocaust and other tragedies will create a generation of youth who are less likely to commit hate crimes and who are more likely to mature into adults who will envision and work towards peaceful world relations.

When this body passes H. Con. Res. 49, we will be spending a strong message to the world that anti-Semitism must be confronted and must be eradicated. I thank both leaders, particularly the gentleman from California (Mr. LANTOS), for his extraordinary life commitment to ending anti-Semitism and for world peace.

Mr. LANTOS. Mr. Speaker, I yield 4 minutes to the gentleman from Florida (Mr. HASTINGS), who has been throughout his congressional career and prior to that an indefatigable fighter for human rights.

Mr. HASTINGS of Florida. Mr. Speaker, I thank the gentleman from California (Mr. LANTOS) for yielding me this time, and before I go forward, I would be terribly remiss if I did not point out that the gentleman from California (Mr. LANTOS) has spent his lifetime in the struggle that some of us come to with equal passion, but not the clarity that he brings to the issue.

I also am happy to support the resolution offered by the chairman of the Helsinki Commission and to compliment the gentleman from New Jersey (Mr. SMITH) for his continuing work in the area of human rights and the gentleman from California (Mr. LANTOS) as being a stalwart champion for human rights.

□ 1300

As Chairman SMITH has already mentioned, last week he and I had the privilege to represent the United States at the Organization for Security and Cooperation in Europe's conference on anti-Semitism. A footnote right there. That conference came about because the gentleman from New Jersey (Mr. SMITH), the gentleman from Maryland (Mr. HOYER), the gentleman from California (Mr. LANTOS), the gentleman from Maryland (Mr. CARDIN), myself and others on the Helsinki Commission along with colleagues in Europe brought it to the attention of the parliamentary assembly by way of resolution which we will introduce yet another resolution for follow-up purposes when we are in Rotterdam 1 week from now. But it was in this body that that conference's seed was planted. The conference, which was the first of its kind, provided the OSCE's 55 member states and NGOs with an opportunity to discuss ways in which governments can work to combat anti-Semitism within their borders and abroad.

Today's resolution is an important symbolic statement of the House that the United States will not stand idly by while many European governments neglect a rise in anti-Semitism. We must work with our allies and not hesitate to apply pressure when needed to ensure that governments properly address increases in anti-Semitism and other forms of discrimination.

A few years ago, there were hopes that anti-Semitism was gradually declining and restricted to fringe elements such as neo-Nazis, white supremacists and certain conspiracy theorists. However, recent developments throughout much of Europe and the Middle East suggest that there is a resurgent anti-Semitism with a much broader base and message that resonates at an alarming level. Many European leaders have formally recognized the resurgence of anti-Semitism in their countries and have begun to take the necessary steps to stop this spreading virus. But still, more must be done to ensure that what occurred to the Jewish and minority communities in Europe during World War II will never happen again.

Sadly, Mr. Speaker, the fight against bigotry and xenophobia is an ongoing struggle as many of us know from our own personal experience. Last week when the gentleman from New Jersey and I were in Vienna, we heard from a woman whose name is Rosalia Abella of the Ontario Court of Appeals. As she noted in one of the more poignant statements made at that conference, "Indifference is injustice's incubator." Indeed it is.

Now is the time for the United States to be vocal and now is the time for the House to be active as it is today under the leadership of the gentleman from New Jersey and the gentleman from California. Today is not a day for complacency. If we remain silent, then there will be no tomorrow. We cannot legislate morality, we cannot legislate love, but we can teach tolerance and we can lead by example.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 3 minutes to the gentleman from Connecticut (Mr. SHAYS).

Mr. SHAYS. Mr. Speaker, I rise in strong support of the Smith-Cardin-Lantos resolution. I am a cosponsor of this resolution because I am deeply concerned about the surge of anti-Semitism in Europe and throughout other parts of the world, but particularly in Europe.

This is not a problem that simply can be monitored. It must be actively and aggressively dealt with, for we must never forget that just 60 years ago, Europe saw the worst scourge of systematic, government-ordained hatred, violence and murder in the history of mankind, in what was an unbelievable Holocaust.

The Organization for Security and Cooperation in Europe (OSCE) has recognized and condemned anti-Semitic violence in its member states. At its parliamentary assembly in July 2002, the OSCE resolved to aggressively enforce laws and investigate anti-Semitic criminal acts. It is important that the United States openly support the OSCE's resolution and actively encourage it to address hatred and prevent violence in Europe.

Mr. Speaker, there are several topics on which the United States and Europe disagree. There must be no disagreement, however, on the absolute right of the Jewish people to practice their religion freely and to live in peace and prosperity. The Organization for Security and Cooperation in Europe should not only investigate anti-Semitic crimes but also promote and facilitate discussions that address the root causes of xenophobic hatred.

I encourage my colleagues and the administration to take advantage of bilateral meetings with our European counterparts to reaffirm our deep commitment to the prevention of violence in Europe.

I again thank the gentleman from New Jersey for bringing this resolution to the floor and urge its adoption.

Mr. LANTOS. Mr. Speaker, I am delighted to yield 3 minutes to the gentleman from New York (Mr. CROWLEY), a distinguished member of the Committee on International Relations.

Mr. CROWLEY. I thank my good friend the gentleman from California (Mr. LANTOS) for yielding me this time.

Mr. Speaker, I rise today to strongly support this resolution, and I thank the gentleman from New Jersey for sponsoring this crucial piece of legislation. I am very aware of the danger of being inactive about the threat of anti-Semitism. It was anti-Semitism that was responsible for the horrors of the Holocaust, the most horrible crime committed against the Jewish people ever. Sadly, I have to say here today that nearly 60 years after the end of World War II, anti-Semitism in Europe, in many of the OSCE member states, is on the rise again. Once again we witness evil propaganda, physical attacks against Jews, the burning of Jewish sites and the desecration of synagogues. We must not stand aside and ignore this grave escalation of anti-Semitic violence and hatred.

This resolution addresses this threat. It particularly calls on administration officials and Members of Congress to focus on anti-Semitism in their bilateral and multilateral meetings. It calls upon OSCE member states to swiftly bring anti-Semitists to justice and to focus on educational endeavors to fight anti-Semitic stereotypes.

I would also like to point out that this piece of legislation is similar to a resolution I introduced last year. House Resolution 393 also addresses the anti-Semitic threat in the OSCE region. It urges European governments to provide security and safety of the Jewish communities, to prosecute and punish perpetrators of anti-Semitic violence, and to cultivate a climate in which all forms of anti-Semitism are rejected.

I was proud that my colleagues in Congress joined me in sending this message to the European Union, but we must go further. Anti-Semitism continues to fester throughout the OSCE region. This resolution is the right follow-up to my legislation that passed in the last Congress.

Mr. Speaker, the threat of anti-Semitism is looming large and our fight against it is far from over, but I believe that recognizing this problem and taking action is critical. I therefore urge all of my colleagues to strongly support House Resolution 49 sponsored by the gentleman from New Jersey. I would ask them all to vote for this resolution unanimously. I want to thank the gentleman from California again for his work on this resolution and all my colleagues in bringing this to the House floor.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from California (Mr. ROHRABACHER).

Mr. ROHRABACHER. Mr. Speaker, I am proud to join the gentleman from New Jersey and the gentleman from California as I have over the years on many human rights issues, and this is a human rights issue. Racism, religious hatred, these are things that decent people must condemn and we must unite in our strong opposition wherever this type of vile behavior and vile thought patterns emerge. We must recognize that there are, however, people who exploit these type of negative feelings and this type of racial hatred. Anti-Semitism is perhaps the epitome of this ignorance and irrationality and mindless hatred and it is again raising its ugly head both in Europe and in the United States.

Let us note that over 10 years ago, a major political figure in the United States referred to New York City as "Hymietown." What is important is the fact that he was winked at and that for 10 years after that statement, he still remained a recognized leader. That did tremendous harm in America's black community. It sent a horrible message to young blacks and we are paying some of the price of an increased anti-Semitism today in our black community by mistakes that we made 10 years ago by not condemning that and other types of horrible remarks that should never have been made or accepted in our political debate.

In Europe today, we see that same kind of winking going on. Oh, yes, people are ignoring statements that are being made that are totally unacceptable to people who believe in civilized behavior and are opposed to this type of vile hatred, the vile hatred in relationship to their fellow man. This is an alarm bell today. I am very proud to stand here with the gentleman from California and the gentleman from New Jersey ringing the alarm bell. We are not going to sit idly by and wink at an increase in this level of hatred towards our Jewish friends nor towards any other minority in the Western democracies. The Western democracies, our friends in Europe, just like we in the United States, have to remain vigilant and it is up to us as leaders of this society and the democratic leaders in Europe to call to task those who would wink and would not condemn this type of vicious trend in their society. We can cut it short now. Let us stand together united against anti-Semitism and all such hatred.

Mr. LANTOS. Mr. Speaker, I am delighted to yield 2 minutes to the distinguished gentleman from Massachusetts (Mr. FRANK).

Mr. FRANK of Massachusetts. Mr. Speaker, in terms that we do not usually use on this floor but in terms that may be familiar to our friends in Europe, in the American context, I am a man of the left. I voted against the war in Iraq. I will vote for the resolution later about Israel's right to respond to terrorism, but I will put into the CONGRESSIONAL RECORD Tom Friedman's article urging them to think about prudence and restraint. I think the settlements are by and large a mistake. And I speak today in defense of this resolution, specifically to others on the left in Europe, many of whom have in my judgment been morally deficient in the obligation we have to speak out against prejudice and injustice across the board. Those who hold to liberal values have no moral right to put an ideological screen between victims and those values, and those on the left who use an excuse of a disagreement with the policy of the Sharon government or the Bush government or anybody else as a reason to be soft on anti-Semitism betray liberalism and betray its values.

By the way, with regard to the government of Israel, let me speak to the people on the left. I disagree with some aspects of its policy, but I staunchly defend its right to exist. But even more important, by every value that I as a liberal hold dear, the government and society of Israel is quite morally superior to any of its neighbors, and to focus only on those aspects of disagreement and to ignore its longstanding commitment to civil rights and civil liberties, in fact I think our society, the United States, has a good deal to learn from the society of Israel about how you deal with external threats and still show a respect for civil liberties.

I thank the gentleman from California and the gentleman from New Jersey for bringing this forward and the gentleman from Illinois for his support. I want to reiterate as a man on the left who shares a great deal of both general values and specific policy prescriptions with many on the left in Europe, I am appalled at those who fail to carry out our liberal principles fully and across the board. A vigorous and ongoing condemnation of anti-Semitism is a requisite part of that commitment.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

At the most recent conference that was held in Vienna, I just want to again thank the great work that Ambassador Minikes did, our Ambassador to the OSCE. He has worked very, very hard to help put together that anti-Semitism conference. He did an outstanding job. Ambassador Cliff Sobel, our Ambassador to the Netherlands, also worked very hard on it as well, as did many others in the State Department. It was a joint effort. Again I want to thank Rudy Giuliani for the good work he did in leading that.

Let me just also say that, Mr. Speaker, next week in Rotterdam we will have an OSCE Parliamentary Assembly and I plan on offering another resolution on anti-Semitism at that and hopefully we continue not only this dialogue but this outrage that we are expressing about intolerance. The more we raise our voices, the more we have mutually reinforcing policies, including good law, good law enforcement and hopefully a chronicling of these misdeeds so that law enforcement knows that they do indeed have a problem. This has been a particular problem in Europe, where hate crimes are committed and they are not attributed to the hate crimes that they represent.

□ 1315

The more we chronicle, the more we will see that there is an explosion of anti-Semitism in Europe. This is a good resolution. I thank the gentleman from California (Mr. LANTOS), and I thank the gentleman and chairman from Illinois (Mr. HYDE) for moving this bill expeditiously through the committee and for his strong support for it.

Mr. Speaker, I yield back the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield 1 minute to the gentlewoman from Nevada (Ms. BERKLEY), a distinguished member of the Committee on International Relations and a fighter for human rights.

Ms. BERKLEY. Mr. Speaker, I would like to thank the gentleman from California (Mr. LANTOS) and the gentleman from New Jersey (Mr. SMITH) for putting this before our body.

I grew up hearing about anti-Semitism from my grandparents and my parents, things that I could not believe could have ever happened; but the anti-Semitism acts that they spoke of seemed like historic oddities to me, something from a distant time and a distant place. I never dreamed, never dreamed that anti-Semitism could ever rear its ugly head again during my lifetime or the lifetime of my children.

Especially after World War II, I thought Europe and the rest of the world had learned a very important and valuable lesson. I ran for Congress so that I could speak out against issues that I thought were horrific; and anti-Semitism, and its continued existence on this planet, is certainly something that I wish to speak out against. I am glad that we are condemning anti-Semitism in no uncertain terms and putting the United States Congress on record and speaking out forcefully against this horrible scourge and plague.

Mr. SMITH of New Jersey. Mr. Speaker, I ask unanimous consent to reclaim my time for purposes of yielding the remainder of my time to the gentleman from Maryland (Mr. HOYER).

The SPEAKER pro tempore (Mr. BASS). Is there objection to the request of the gentleman from New Jersey?

There was no objection.

The SPEAKER pro tempore. The gentleman has 1 minute.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. Mr. Speaker, I thank the chairman of the Helsinki Commission for yielding me this time. I am proud to be a co-sponsor of this very important resolution.

This is about anti-Semitism. But more broadly than that, it is about hate. It is about the human inclination from time to time to hate others who are different, to discriminate against others who are different, who have a different color of skin, who have a different religion, who have a different national origin. More human violence perhaps has been perpetrated in the name of those distinctions and prejudices and hate than any other.

It is important that we regularly and strongly and without equivocation speak out against those who would perpetrate and spread hate in our world, in our country, in our communities.

I thank the gentleman from New Jersey, and I thank my good friend, the gentleman from California, for their leadership on this issue. It is an appropriate statement for us to make as the representatives of a free and tolerant people.

Mr. LANTOS. Mr. Speaker, I yield such time as he may consume to the gentleman from Alabama (Mr. DAVIS).

Mr. DAVIS of Alabama. Mr. Speaker, I do not want this debate to end without adding my voice in support of the resolution.

Mr. LANTOS. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. NADLER), a distinguished fighter for human rights.

Mr. NADLER. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, many people thought that the Holocaust cleansed the Western world of anti-Semitism, that the catastrophe, the mass murder, and the genocide in the Holocaust caused the civilized world or at least the Western part of the civilized world to recoil in such horror that anti-Semitism would not be a major problem again. We now know that maybe it did that for a generation or two, but that the scourge of anti-Semitism is returning in great and terrible force in its ancient homeland of Europe and other places.

Today we have two major problems of anti-Semitism: in Europe and in the Muslim world. It is very appropriate that we adopt this resolution today to ask the governments of Europe through the OSCE and individually to crack down on anti-Semitism, to speak out against it, to act against it because many of the governments of Europe, many of the parts of the political left in Europe and elsewhere as well as the right have not done so. They ought to do so. And this resolution is fitting and appropriate to adopt today for that purpose.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H. Con. Res. 49, expressing the sense of Congress that the sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe is of profound concern and efforts should be undertaken to prevent future occurrences.

I begin by praising the Organization for Security and Cooperation in Europe for their conference this past weekend devoted to the issues of anti-Semitism and how to combat it. The Organization for Security and Cooperation in Europe (OSCE) is the largest regional security organization in the world with 55 participating countries from Europe, Central Asia, and North America. The OSCE has a comprehensive and cooperative approach to security, stressing preventative diplomacy and human rights.

The conference last weekend was the first high level OSCE conference devoted specifically to the issue of anti-Semitism. Over 400 government and nongovernment officials attended.

The conference took place at Vienna's Hofburg Palace. This same location is where Hitler stood, 65 years ago, proclaiming Austria's annexation to a cheering crowd of thousands. Sixty-five years later, what can we say about tolerance and diversity in Europe? What can we say about Human Rights worldwide? Specifically, 65 years after the beginning of the worst genocide in our time, what can we say we have learned about anti-Semitism and the horrors of racial hatred?

Much has changed since then. Yet today there are both overt and subtle versions of anti-Semitism, in the United States and abroad. Physical assaults, arson at synagogues and desecration of Jewish cultural sites are occurring. Unfortunately, government officials are not speaking harshly enough against them.

The conference on anti-Semitism opened a day after the Romanian Government retracted an earlier claim that "there was no Holocaust" on Romanian soil. In Greece, a recent newspaper cartoon had one Israeli soldier telling the other, "we were not in Dachau concentration camp to survive, but to learn."

France has experienced a six-fold increase in anti-Semitic incidents in the space of a year. In Poland, the word "Jewish" is used as a term of abuse for Polish soccer fans. In other parts of Europe, claims are made that Jews had forewarning of the September 11th attacks at the Pentagon and World Trade Towers.

The existence of anti-Semitism has played throughout history as a major threat to freedom. Participating states of the OSCE should unequivocally condemn anti-Semitism, racial and ethnic hatred and xenophobia, and they need to be loud and clear in their message.

We cannot allow future generations to be taught a distorted view of history. Prejudice must be rooted out of textbooks, governments must speak out against these wrongdoings, and anti-Semitic actions must be classified as hate crimes. We also need to ensure effective law enforcement. Finally, we must promote the creation of educational efforts and we must increase Holocaust awareness. I abhor and stand against all forms of hatred.

If action had been taken in the 1930s, many lives could have been saved. There are so many lessons of history that need to be learned, lest they not be repeated. For that reason I support H. Con. Res. 49.

Mr. PAUL. Mr. Speaker, I will reluctantly vote in favor of this legislation, partly because it is simply a sense of Congress resolution. But I am concerned about this bill and the others like it we face with regularity on the floor of Congress. We all condemn violence against innocents, whether it is motivated by hatred, prejudice, greed, jealousy, or whatever else. But that is not what this legislation is really about. It is about the Congress of the United States presuming to know—and to legislate on—the affairs of European countries. First, this is the United States Congress. We have no Constitutional authority to pass legislation affecting foreign countries. Second, when we get involved in matters such as this we usually get it wrong. H. Con. Res. 45 is an example of us getting it wrong on both fronts.

This legislation refers to the rise of anti-Semitism in Europe as if it is a purely home-grown phenomenon, as if native residents of European countries are suddenly committing violent crimes against Jews. But I think we are only getting part of the story here. What is absent from the legislation is mention of the well-reported fact that much of the anti-Jewish violence in Europe is perpetrated by recent immigrants from Muslim countries of the Middle East and Africa. Reporting on a firebombing of a Synagogue in Marseille, France, for example, the New York Times quotes the longtime president of that region's Jewish Council, Charles Haddad, as saying, "This is not anti-Semitic violence; it's the Middle East conflict that's playing out here."

Therefore, part of the problem in many European countries is the massive immigration from predominantly Muslim countries, where new residents bring their hatreds and prejudices with them. Those European politicians who recognize this growing problem—there are now 600,000 Jews in France and five million Muslims—are denounced as racist and worse. While I do not oppose immigration, it must be admitted that massive immigration from vastly different cultures brings a myriad of potential problems and conflicts. These are complicated issues for we in Congress to deal with here in the United States. Yes, prejudice and hatred are evil and must be opposed, but it is absurd for us to try to solve these problems in countries overseas.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 49.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on three of the motions to suspend the rules previously postponed. Votes will be taken in the following order:

S. 858, by the yeas and nays;

H.R. 2474, by the yeas and nays;

H.J. Res. 49, by the yeas and nays.

Proceedings on other postponed questions will resume later.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

ABRAHAM LINCOLN BICENTENNIAL COMMISSION

The SPEAKER pro tempore. The pending business is the question of suspending the rules and passing the Senate bill, S. 858.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Indiana (Mr. SOUDER) that the House suspend the rules and pass the Senate bill, S. 858, on which the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 409, nays 2, not voting 23, as follows:

[Roll No. 312]

YEAS—409

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baldwin
Ballance
Ballenger
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Foley
Forbes
Ford
Fossella
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline

Knollenberg
Kucinich
LaHood
Lampson
Langevin
Lantos
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)

NAYS—2

Paul
Sensenbrenner

NOT VOTING—23

Baker
Barrett (SC)
Brown-Waite, Ginny
Conyers
Cubin
Everett
Flake
Fletcher
Franks (AZ)
Hayworth
Hunter
John
Kolbe
Larsen (WA)
Renzi
Saxton
Shadegg
Skelton
Smith (WA)
Stenholm
Tauzin
Weiner
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BASS) (during the vote). Members are reminded there are 2 minutes remaining on this vote.

☐ 1342

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the remainder of this series will be conducted as 5-minute votes.

TEMPORARY AUTHORITY FOR CONGRESSIONAL HUNGER CENTER TO AWARD BILL EMERSON AND MICKEY LELAND HUNGER FELLOWSHIPS

The SPEAKER pro tempore. The pending business is the question of suspending the rules and passing the bill, H.R. 2474, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Virginia (Mr. GOODLATTE) that the House suspend the rules and pass the bill, H.R. 2474, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 411, nays 0, not voting 23, as follows:

[Roll No. 313]

YEAS—411

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Foley
Forbes
Ford
Fossella
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Langevin
Lantos
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watt
Waxman
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)

NOT VOTING—23

Barrett (SC)
Bishop (GA)
Brown-Waite, Ginny
Chocola
Conyers

Cubin
Everett
Flake
Fletcher
Franks (AZ)
Hayworth
Hunter
Kolbe
Larsen (WA)
Renzi
Saxton
Shadegg
Skelton
Smith (WA)
Stenholm
Watson
Weiner
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BASS) (during the vote). Members are advised there are 2 minutes remaining in this vote.

☐ 1351

So (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

The title of the bill was amended so as to read: "A bill to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal years 2003 and 2004.".

A motion to reconsider was laid on the table.

Stated for:

Ms. WATSON. Mr. Speaker, on rollcall 313 I would have voted "yea."

RECOGNIZING IMPORTANT SERVICE PROVIDED BY FOREIGN AGRICULTURAL SERVICE ON OCCASION OF ITS 50TH ANNIVERSARY

The SPEAKER pro tempore. The pending business is the question of suspending the rules and passing the joint resolution, H.J. Res. 49.

The Clerk read the title of the joint resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Virginia (Mr. GOODLATTE) that the House suspend the rules and pass the joint resolution, H.J. Res. 49, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 409, nays 0, not voting 25, as follows:

[Roll No. 314]

YEAS—409

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Foley
Forbes
Ford
Fossella
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Langevin
Lantos
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)

NOT VOTING—25

Barrett (SC)
Brown-Waite, Ginny
Cantor
Chocola
Conyers
Cubin
DeMint
Everett
Flake
Fletcher
Franks (AZ)
Hayworth
Hunter
Kolbe
Larsen (WA)
Linder
Miller (FL)
Pence
Renzi
Saxton
Shadegg
Skelton
Smith (WA)
Weiner
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining in this vote.

☐ 1400

So (two-thirds having voted in favor thereof) the rules were suspended and the joint resolution was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. RENZI. Mr. Speaker, I was attending Congressman Bob Stump's funeral service today and missed votes on the following measures:

1. On motion to suspend the rules and pass S. 858—Abraham Lincoln Bicentennial Commission Extension Act, roll No. 312. Had I been present, I would have voted "yea."

2. On motion to suspend the rules and pass H.R. 2474—to require that funds made available for fiscal years 2003 and 2004 for the Bill Emerson and Mickey Leland Hunger Fellowships be administered through the Congressional Hunger Center, roll No. 313. Had I been present, I would have voted "yea."

3. On motion to suspend the rules and pass H.J. Res. 49—recognizing the important service to the Nation provided by the Foreign Agriculture Service of the Department of Agriculture on the occasion of its 50th anniversary, roll No. 314. Had I been present, I would have voted "yea."

PERSONAL EXPLANATION

Mr. BARRETT of South Carolina. Mr. Speaker, due to a meeting with President Bush at the White House, I unfortunately missed three recorded votes on the House floor earlier today.

I ask that the RECORD reflect that had I not been unavoidably detained at this meeting, I would have voted "yes" on rollcall vote No. 312 (Motion to Suspend the Rules and Pass S. 858); "yes" on rollcall vote No. 313 (Motion to Suspend the Rules and Pass H.R. 2474); and "yes" on rollcall vote No. 314 (Motion to Suspend the Rules and Pass H.J. Res. 49).

□ 1400

CALLING ON CHINA TO IMMEDIATELY AND UNCONDITIONALLY RELEASE DR. YANG JIANLI

Mr. SMITH of New Jersey. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 199) calling on the Government of the People's Republic of China immediately and unconditionally to release Dr. Yang Jianli, calling on the President of the United States to continue working on behalf of Dr. Yang Jianli for his release, and for other purposes, as amended.

The Clerk read as follows:

H. RES. 199

Whereas according to the United States Department of State's 2002 Country Reports on Human Rights Practices in China, the Government of the People's Republic of China has "continued to commit numerous and serious [human rights] abuses", including "instances of . . . arbitrary arrest and detention, lengthy incommunicado detention, and denial of due process";

Whereas according to the 2002 Country Reports on Human Rights Practices in China, "the country's criminal procedures were not in compliance with international standards", "the lack of due process in the judicial system remained a serious problem", and "authorities routinely violated legal protections in the cases of political dissidents";

Whereas Dr. Yang Jianli, an internationally renowned scholar, prodemocracy activist, and President of the Foundation for China in the 21st Century, is an alien lawfully admitted for permanent residence into the United States;

Whereas Dr. Yang Jianli has been detained incommunicado by the Government of the People's Republic of China since April 26, 2002, when he was arrested for reportedly entering China with false or incomplete identity documents;

Whereas according to the United Nations Commission on Human Rights Resolution 1997/38, "prolonged incommunicado detention may . . . itself constitute a form of cruel, inhuman, or degrading treatment", which is prohibited by international law;

Whereas Dr. Yang Jianli has been deprived of his basic human rights by being denied access to legal counsel and contact with his wife and two children (who are United States citizens), and has also been denied his right to trial within a reasonable time or to release;

Whereas on May 7, 2003, the United Nations Working Group on Arbitrary Detention expressed the opinion that "[t]he non-observance of Mr. Yang Jianli's right to a fair trial is of such gravity as to give his deprivation of liberty an arbitrary character. Therefore, his arrest and detention is arbitrary being in contravention of Article 9 of the Universal Declaration on Human Rights and of Article 9 of the International Covenant on Civil and Political Rights"; and

Whereas the arbitrary imprisonment and the violation of the human rights of United States citizens and permanent resident aliens by the Government of the People's Republic of China are sources of continuing, grave concern to the House of Representatives: Now, therefore, be it

Resolved, That—

(1) the House of Representatives—

(A) condemns and deplores the incommunicado detention of Dr. Yang Jianli, and calls for his immediate and unconditional release;

(B) condemns and deplores the lack of due process afforded to Dr. Yang;

(C) strongly urges the Government of the People's Republic of China to respond to the repeated requests by Members of the House of Representatives for information about Dr. Yang's whereabouts and condition; and

(D) strongly urges the Government of the People's Republic of China to consider the implications for the broader relationship between the United States and the People's Republic of China of detaining permanent resident aliens of the United States without providing them access to legal counsel or family members; and

(2) it is the sense of the House of Representatives that the United States—

(A) should make the immediate release of Dr. Yang Jianli by the Government of the People's Republic of China a top concern of United States foreign policy;

(B) should continue to make every effort to assist Dr. Yang Jianli and his family while discussions of his release are ongoing;

(C) should make it clear to the Government of the People's Republic of China that the detention of United States citizens and permanent resident aliens and the infliction of human rights violations on these groups are not in the interest of the Government of the People's Republic of China because they create obstacles to improved bilateral relations and cooperation with the United States; and

(D) should reiterate the deep concern of the United States regarding the continued imprisonment of Dr. Yang Jianli and other United States citizens and permanent resident aliens whose human rights are being violated, and discuss their legal status and immediate humanitarian needs with the Government of the People's Republic of China.

The SPEAKER pro tempore (Mr. BASS). Pursuant to the rule, the gentleman from New Jersey (Mr. SMITH) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. SMITH).

GENERAL LEAVE

Mr. SMITH of New Jersey. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I think as every Member of this body knows, the PRC and its leadership in Beijing would love to be regarded as a respected member of the international community. In pursuit of that goal, however, the PRC has sought and obtained membership in the World Trade Organization; and it has lobbied and received the Beijing Olympics of 2008. However, trade volume alone, and there has been a great deal of trade volume particularly between the U.S. and China, is not really a measure of success, I would say to my colleagues. What really determines the quality of a country is how it treats its own citizens, and how it respects fundamental human rights.

History shows that some very unsavory regimes held the Olympic games. We all remember the Nazi Olympic Games prior to the Second World War, but holding a game, having trade, having the air of respectability does not necessarily mean that it is a respectable regime.

The government of Beijing has an enormous way to go, I would respectfully submit, to earn the international respect that it craves. The Chinese government, and I consider it to be a dictatorship, but if they really hope to earn respectability in the eyes of the world, they need to make some very needed fundamental changes, and there is a case in point that we raise today, and I thank the gentleman from Massachusetts (Mr. FRANK) for bringing this resolution before us today.

Dr. Yang Jianli is a compelling case. H. Res. 199, introduced by the gentleman from Massachusetts (Mr. FRANK) highlights the case of this U.S. lawful permanent resident who has been unjustly detained incommunicado inside China since April 26, not of this year, but of last year, 14 months. Mr. Yang was arrested for reportedly entering China with false or incompletely identifying documents, has been denied access to counsel, contact with his wife Christina Fu and their two children, Anita and Aaron, and his right to a trial within a reasonable time.

Frankly, Beijing remains more concerned about the research, at least that is our belief, that the internationally respected scholar Dr. Yang, who was conducting studies regarding labor unrest in China, rather than how he got into the country. It is all about what he was studying.

Dr. Yang's research points to the dark side of the Chinese economic miracle, the so-called workers' paradise, where the working class remains the main victim of unemployment and forced early retirement due to the restructuring of State-owned enterprises. That then is Dr. Yang's major sin in Beijing's eyes. He was documenting the anger of workers directed at party bosses mired in personnel greed and corruption despite their official pledge to serve the people.

Beijing's loss of face in this case has only been compounded by the recent determination by the United States Working Group on Arbitrary Detention, which found that Mr. Yang's detention is arbitrary and in direct contravention of the Universal Declaration on Human Rights. As the U.N. working group has so clearly pointed out, the continued arbitrary detention of this man is not the action of a great nation which seeks the full respect of the international community.

The U.S. House of Representatives today is sending a clear, not ambiguous, message to the government of Beijing: Let Dr. Yang go, let him come home to his wife, his children. His wife is here with us and his children are on the floor of this House right now.

We care about this man. We care about it in a bipartisan way, Democrats and Republicans. A lot divides us in this Chamber. The case of Dr. Yang unites us.

Mr. Speaker, I reserve the balance of our time

Mr. LANTOS. Mr. Speaker, I yield myself such time as I might consume, and I rise in strong support of this resolution.

First, Mr. Speaker, I want to commend my friend, the gentleman from New Jersey (Mr. SMITH), and the gentleman from Illinois (Mr. HYDE), the distinguished chairman of the Committee on International Relations, for moving this resolution forward so expeditiously, but I particularly want to commend my dear friend and distinguished colleague from Massachusetts (Mr. FRANK) for his outstanding leadership on this resolution and indeed on all human rights issues.

Mr. Speaker, the resolution before the House addresses one human rights case that is unfortunately part of a much larger trend in modern day China. Over the past several years, the Chinese government has deliberately targeted naturalized Americans born in China and Chinese citizens permanently residing in the United States for harassment and imprisonment in the People's Republic of China.

Instead of, as one would expect, welcoming Chinese-American talent, the People's Republic of China is sending the message to the Chinese diaspora that it returns to China at its own considerable risk.

Mr. Speaker, in the case addressed in this resolution, Dr. Yang Jianli is a scholar and a leader of a prominent human rights organization. He is a permanent legal resident of the United States. He returned to the People's Republic of China in April of last year, and he has been detained incommunicado ever since that time. He has a wife and two children in the United States, all of whom are American citizens, and he has been unable to communicate with his family since the moment of his detention. He has been denied access to legal counsel.

Mr. Speaker, it is imperative that Dr. Yang be released and allowed to return to his family in the United States as soon as possible. I would also urge the executive branch of our government to make his release a priority. Until Dr. Yang is released, an ominous shadow will lie over U.S.-Chinese relations. It is absolutely incomprehensible and insane that this great nation of 1.2 billion people should keep an American citizen, the father of two small American children, incommunicado in a Communist prison in China.

I commend the gentleman from Massachusetts (Mr. FRANK) for introducing this resolution, and I urge all of my colleagues to support it.

Mr. Speaker, I reserve the balance of my time.

The SPEAKER pro tempore (Mr. SHIMKUS). Does the gentlewoman from Florida seek unanimous consent to control the balance of the time?

Ms. ROS-LEHTINEN. Yes, I do, Mr. Speaker.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Florida?

There was no objection.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield such time as he may consume to the gentleman from California (Mr. COX), the chairman of the House Policy Conference.

Mr. COX. Mr. Speaker, I thank the chairwoman for yielding me the time.

I too rise in strong support of H. Res. 199 calling on the government of the People's Republic of China to immediately and unconditionally release Dr. Yang Jianli.

Dr. Yang is being imprisoned for his love of democracy and his love of country. As a tireless fighter for human rights and democracy in China, Dr. Yang has remained faithful to his conscience and to his cause, even at the risk of imperiling his career and his life.

Nearly 15 years ago, after studying in the United States for 4 years, Dr. Yang suspended his graduate studies and returned to the land of his birth, to China, to support the students who were working for democracy in Beijing. On June 4, 1989, he watched as the tanks rolled in Tiananmen Square and narrowly escaped himself while his fellow students and activists were imprisoned and executed.

Throughout this ordeal his wife Christina Fu did not know if he was even alive. Today, Christina is being tortured in a living hell once more because once again she does not know whether the Chinese Communist Party will return her husband alive.

Her husband's imprisonment violates all of the procedures and rules that the PRC has set out in law, and it confirms our worst fears, that when it comes to the denial of human rights, nothing in the People's Republic of China has really changed since 1989.

Today's totalitarian regime continues to view freedom and liberty as dangerous threats to the existing order and acts accordingly, punishing democracy activists like Dr. Yang with ruthless impunity.

He is a permanent resident of the United States. His family lives here. His wife Christina is with us in the Chamber as are his children Aaron and Anita. I have met with Christina and with his family many times over the last several months, and we have tried in every way to send our concerns to the rulers in Beijing. This American family deserves to have their father back, and this man, whose human rights are being abridged by the PRC's violation of its own laws and every international covenant that it had signed, deserves basic fairness.

Dr. Yang has been held incommunicado in the People's Republic of China for over 13 months, incommunicado, meaning that nobody can talk to him. We cannot get the State Department to talk to him. We cannot see this American resident. We cannot report to his family in what condition he is. He has not been properly charged in violation of Beijing's own laws.

Earlier this month on June 4, which incidentally was the 14th anniversary of the Tiananmen massacre, the United Nations Working Group on Arbitrary Detention found that China violated Dr. Yang Jianli's rights as a citizen, as a citizen of China, and violated his rights as a resident of the United States by detaining him in a Chinese prison with no access to family or to a lawyer. As a consequence of these actions, the working group concluded that China is violating the Universal Declaration on Human Rights and the International Covenant on Civil and Political Rights.

□ 1415

It is fitting that a U.N.-sponsored organization, with its diverse membership and international credentials, would single out the PRC for its dreadful behavior. The Working Group consisted of representatives from Algeria, France, Hungary, Paraguay, and Iran. That is right, even Iran has condemned this abuse of human rights by China. The PRC ought to be very ashamed.

The day after the U.N. report, the Communist regime responded that it had complied with Chinese law by advising Dr. Yang's family of his detention via telephone. The PRC's statements conveniently avoid the discussion of any of the specific laws that govern the detention process. While claiming it provided a notice of detention, the regime in Beijing forgot to add its own procedural law requires that the family or employer of a detained person be notified within 24 hours of a detention. That formal notice of detention has been sorely absent for months.

Moreover, while PRC law also permits detention of 37 days without a warrant in emergency situations, Dr. Yang has been illegally detained in China for more than a year. This blatant disregard for the due process of law is further evidence of the PRC's collective disdain towards the established rule of law. Despite the unambiguous text of its own laws and the weight of international condemnation, the communist regime continues to use deceit and manipulation to strengthen its totalitarian rule.

Just as it persecutes men and women like Dr. Yang, the PRC is attempting to extend its coercion beyond. The House is also considering today House Resolution 277, legislation that I authored to condemn the PRC's crackdown on freedom of speech in Hong Kong. As the city with the strongest tradition of freedom in China, Hong Kong is an island of liberty in a sea of oppression. Preserving free speech in Hong Kong will help ensure that liberty flourishes not just for the people of Hong Kong but throughout the PRC, so that in the future we will not be on the floor with resolutions for individual heroes and heroines such as Dr. Yang Jianli.

Mr. Speaker, securing liberty in the People's Republic of China and freedom for Dr. Yang are all part of the same struggle. The Chinese Communist Party must not be allowed to forget the sacrifices made at Tiananmen Square. They must not be allowed to extinguish the message of hope that Tiananmen survivors, like Dr. Yang, convey to the people of the People's Republic of China.

Mr. Speaker, I commend my colleague, the gentleman from Massachusetts (Mr. FRANK), for authoring this legislation; and I commend the gentleman from Illinois (Mr. HYDE), as well as the ranking member, the gentleman from California (Mr. LANTOS), for supporting freedom for Dr. Yang and freedom in China and around the world.

Mr. LANTOS. Mr. Speaker, I am delighted to yield such time as he may consume to the gentleman from Massachusetts (Mr. FRANK), the author of this resolution and one of the most indefatigable fighters for human rights in this body.

Mr. FRANK of Massachusetts. Mr. Speaker, we often congratulate and thank each other when we take these microphones, but I have to say that I do so here with the greatest sincerity of which I am capable. The gentleman from California, who has drawn on his own life experience to become an unabashed, unceasing opponent of oppression everywhere, is an inspiration to us.

I appreciate very much the chairman of the full committee, the gentleman from Illinois, for agreeing to bring this forward with great speed and allowing us to deal with it on a timetable that we hope will give it the maximum impact in freeing this brave man from a wholly unjustified imprisonment.

To the gentleman from New Jersey, who chairs the subcommittee, he has been staunch in his advocacy; and I express my great appreciation as well to the gentleman from California (Mr. COX), whose own expertise in dealing with the People's Republic of China has been built up over the years. He and my colleague, the gentleman from Massachusetts (Mr. CAPUANO), have been indispensable allies and partners in this fight.

And, Mr. Speaker, it is a very simple fight. We are saying to the government of the People's Republic of China, we understand your aspiration to be treated with all the respect due a great power. We ask you to act like one. We ask you to understand that even though there are many among us who differ with your form of government, are critical of some aspects of your society, we are prepared to recognize the fact of not just your existence but of your strength, of your power, and of your economy as it grows.

We and the Chinese Government occupy the same Earth, and that requires us to cooperate even where there are areas of disagreement. But there are limits to the extent to which this Nation, with our commitment to our basic principles, can look the other way. There are limits to the extent to which we can say economic self-interest and geopolitical self-interest preempt concern for principle. And here we have an example.

Mr. Speaker, Dr. Yang's crime is that he loved too much both liberty and China. Born in China, he worked as a Chinese citizen to bring to his fellow citizens the freedom that he understands is so important. He was expelled not because he hurt anyone, not because he stole anything, not because he mistreated anyone, but because he would not bridle his love of liberty; and so he was sent away. But he could not stay away.

He has, of course, a great love for his wife and his children, and they for him. And their commitment to his cause and the dignity with which they bear the pain of their separation inspires all of us who have worked with him. Dr. Yang risked a great deal to go back to China, not to steal, not to undermine, not to cause problems, not to engage in terrorism; but to try to help people live their lives in some freedom. And he, unfortunately, had to enter illegally. We acknowledge that. Because he would not have been allowed in that society to do what he wanted to do legally.

Having apprehended him, though I wish the Chinese had a different set of rules and did not feel threatened by a man who loved liberty and wanted to preach it, they had a right to apprehend him and send him back. And maybe they would not send him back right away; they would hold him for a week, two, three, to try to discourage him. But there is no justification for having held this wholly decent man so long without allowing him to be in touch with his family, without even any formal charges, and in a way that violated the most basic human norms. As my friend from California said, even the government of Iran, not to be confused with anybody's civil liberties union, joined in the condemnation of this mistreatment.

Mr. Speaker, we say to the government of China that many of us are prepared to go forward in a cooperative set of arrangements dictated by the interests of the peoples of the world, despite profound differences. We can talk about them. But when you impose with all the might of this great government of China, when you impose this incredibly harsh punishment on this solitary man, take him and keep him from his family, punish him so harshly for nothing that is a crime by any civilized standard, you drive a wedge between us. And I urge the government of China in its own interest to remove this wedge; to show that in fact the pessimists are wrong and that as you grow economically you can evolve socially, you can outgrow the total lack of self-confidence that makes you appear to quake before one lone individual committed to freedom.

Mr. Speaker, I urge the People's Republic of China to listen to this House of Representatives, to the President of the United States and the State Department, to the people of America and discontinue insisting on mistreating this brave man, not simply because it is the wrong thing to do on principle but because it is a very wrong thing to do practically. I urge the government of China to reconsider whether the enormous damage you are doing to relationships that you believe are important is worth the continued persecution of Dr. Yang. And I believe that rational people will come to the conclusion that the answer is "no."

Mr. Speaker, I again thank my colleagues for giving us a chance as a Nation to make this important statement of principle.

Mr. LANTOS. Mr. Speaker, I am delighted to yield 3 minutes to the gentleman from Massachusetts (Mr. CAPUANO), who has worked so hard on this resolution.

Mr. CAPUANO. Mr. Speaker, I rise to echo all the comments that have been made, but I want to make it clear. I want everyone to know what this gentleman has done.

To me, this gentleman is clearly a hero. We have used the word, but understand what he did. Here is a gentleman who came from China, established a very successful, very comfortable life here in America: a wife and two children living in one of our best and most beautiful suburbs of Boston; well-respected in the community, well thought of, well loved. Very easy for him to live out the rest of his life in that comfort without any real concerns. He could speak any way he wanted to speak, feel any way he wanted to feel, do any work he wanted to do. But what did he do? He took himself voluntarily from that comfort on his own to go back to China to fight for democracy.

If anyone here thinks they have the courage to do that, you are a better person than I am. I do not know that I would have the courage to do that. I wish I would, and maybe if faced with that someday, I hope I might be able to live up to those incredible standards. But I am not so sure. I am not so sure.

This is a true modern hero, fighting for what we all talk about all day long. We are here, with all of our differences, with all of our agreements and disagreements, fighting for a better democracy. That is what we are all here for. He is fighting for a simple democracy. We cannot abandon him. The fact that this resolution is on the floor obviously shows the U.S. Congress stands with Dr. Yang, stands with the principles that I think he epitomizes.

China, as a great country, has chosen to hold him without charges. There have been no charges. There is no lawyer assigned to him. No judge has heard this case. No jury has heard this case. No administrator has heard this case. His family has not been allowed to visit him. I went on an official delegation to China in January, and I was not allowed to visit him. No American official has been allowed to visit him. No doctor of the family, no representative of the family has been allowed to visit him. How can a great country ask us to treat them as a great country when they act in such a manner?

Any crime he might have committed has already been paid back to China in the 14 months he has been held in the manner he has been held. This man should be released immediately and returned to the bosom of his family and to a welcoming and, hopefully, grateful Nation of the American people because of what he has done for us.

Mr. WOLF. Mr. Speaker, I rise today in support of H. Res. 199, calling on the government of the People's Republic of China to immediately and unconditionally release Dr. Yang Jianli, and calling on the president of the United States to continue working on behalf of Dr. Yang Jianli's release.

Dr. Yang Jianli is an internationally renowned scholar, Harvard graduate, and the president of the Foundation for China in the 21st Century. Dr. Yang was actively involved in the Tiananmen Square protests in 1989 and was subsequently blacklisted by the Chinese government for his participation. Following Tiananmen Square, Dr. Yang fled to the United States and earned two doctorates. Dr. Yang is a permanent resident of the United States.

On April 26, 2002, Dr. Yang entered China using a friend's passport to investigate reports of labor unrest in northern China. Dr. Yang Jianli was detained eight days later and has not been heard from since. The Chinese government will not confirm where he is being held and he has been refused access to an attorney. He has been held for more than 13 months and no charges have been brought against him. The maximum fine for entering China illegally is a one-year prison sentence. Dr. Yang has already spent more than a year in detention. I call on the Chinese government for his immediate release.

The State Department's recent report on human rights states that the government of the People's Republic of China "has continued to commit numerous and serious human rights abuses, including arbitrary arrest and detention." On June 4, a United Nations working group ruled that Yang Jianli has been illegally detained by the Chinese government and called for Dr. Yang's immediate release.

China lacks due process. Citizens continue to suffer at the hands of Chinese officials. It is time for the state-sponsored, state-led persecution in China to stop. I join the members of the House of Representatives and the international community in calling for Dr. Yang's immediate release. It is my hope that he will be released quickly and free to reunite with his wife and two children back in the United States.

Mr. LANTOS. Mr. Speaker, I yield back the balance of my time.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. SHIMKUS). The question is on the motion offered by the gentlewoman from Florida (Ms. ROS-LEHTINEN) that the House suspend the rules and agree to the resolution, H. Res. 199, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

□ 1430

CONDEMNING TERRORISM INFLICTED ON ISRAEL SINCE AQABA SUMMIT AND EXPRESSING SOLIDARITY WITH THE ISRAELI PEOPLE

Ms. ROS-LEHTINEN. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 294) condemning the terrorism inflicted on Israel since the Aqaba Summit and expressing solidarity with the Israeli people in their fight against terrorism.

The Clerk read as follows:

H. RES. 294

Whereas Palestinian Authority Prime Minister Mahmoud Abbas (Abu Mazen) announced at the June 4, 2003, Aqaba Summit, "Our goal is clear, and we will implement it firmly and without compromise: a complete end to violence and terrorism";

Whereas Prime Minister Abbas also pledged at the Aqaba Summit to establish a system based on "rule of law, [a] single political authority, [and] weapons only in the hands of those who are in charge of upholding the law and order . . .";

Whereas the Middle East roadmap begins with the assertion that "A two state solution to the Israeli-Palestinian conflict will only be achieved through an end to violence and terrorism (when the Palestinian people have a leadership acting decisively against terror and willing and able to build a practicing democracy based on tolerance and liberty)";

Whereas 22 innocent Israelis nevertheless were murdered and scores wounded in three separate suicide bombings within less than a week after the Aqaba Summit, and the death toll from these terrorist actions is the equivalent of 1,100 on the basis of the United States population, nearly ten times the number of battle deaths the United States suffered in the recent Iraq War;

Whereas Palestinians are also victims of these terrorists, who undermine prospects for a just and lasting peace;

Whereas Islamic fundamentalist Hamas and Palestinian Islamic Jihad consistently make clear their opposition to Israel's existence in any form and within any borders and their determination to use violence and terrorism to achieve their anti-Israeli, anti-Semitic goals, and Hamas leader Abdel Aziz Rantisi vowed "not to leave one Jew in Palestine";

Whereas experience with terrorism demonstrates that there can be no productive negotiations or dialogue with terrorists and that a policy based on compromise with terrorists can only be doomed to failure;

Whereas the concept of "cycle of violence", which implies moral equivalence between terrorists and their victims, should be rejected as a description of Israeli-Palestinian dynamics, since Palestinian terrorism justifies Israeli counterterrorist operations as the response of a legitimate government defending its citizens;

Whereas Israeli counterterrorist operations would cease entirely were Palestinian terrorism to cease; and

Whereas Israel has no choice but to use its own measures to fight terrorism if the Palestinians are unwilling to do so: Now, therefore, be it

Resolved, That the House of Representatives—

(1) condemns in the harshest terms the recent terrorist actions that victimized innocent Israelis;

(2) expresses solidarity with the Israeli people as they respond to ongoing terrorist attacks;

(3) expresses sympathy to the families of innocent Israelis and Palestinians who have lost their lives;

(4) commends the President of the United States for his vision of two states, Israel and Palestine, living side by side in peace and security;

(5) affirms that this vision can be fully realized only once terrorism is defeated, so that a new state may be created based on rule of law and respect for human rights;

(6) recognizes and respects Israel's right to fight terrorism and acknowledges Israel's fight against terrorism as part of the global war against terrorism;

(7) calls on all states to cease recognition of and political and material support for any Palestinian and other terrorist groups;

(8) calls on all states immediately to establish effective mechanisms to ensure that funding from private citizens cannot be directed to terrorist groups for any purpose whatsoever, including ostensible humanitarian purposes;

(9) calls on all states to provide support to the Palestinian Authority in its effort to confront and fight terror; and

(10) calls on all states to assist the Palestinian people in creating the institutions of

a democratic state that will respect the rule of law and live in peace with its neighbors.

The SPEAKER pro tempore (Mr. SHIMKUS). Pursuant to the rule, the gentlewoman from Florida (Ms. ROS-LEHTINEN) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

Mr. RAHALL. Mr. Speaker, is the gentleman from California (Mr. LANTOS) opposed to the resolution?

Mr. LANTOS. Mr. Speaker, it is my resolution; and I strongly support it.

The SPEAKER pro tempore. Under clause 1(c), the Chair recognizes the gentleman from West Virginia (Mr. RAHALL) to control the time in opposition to the resolution.

Ms. ROS-LEHTINEN. Mr. Speaker, I ask unanimous consent to yield half of my time to the gentleman from California (Mr. LANTOS) and that he may control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Florida?

There was no objection.

GENERAL LEAVE

Ms. ROS-LEHTINEN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H. Res. 294.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Florida?

There was no objection.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, yesterday we marked the 1-year anniversary of the President's seminal address on the Middle East, where he underscored that "it is untenable for Israeli citizens to live in terror," and President Bush clearly outlined, "The United States will not support the establishment of a Palestinian state until its leaders engage in a sustained fight against the terrorists and dismantle their infrastructure."

At the recent summit in Aqaba, Jordan, it appeared that the vision articulated by President Bush, a vision that is embraced by Israeli Prime Minister Ariel Sharon and accepted by the Palestinian prime minister, would finally be translated into a reality. However, over the past few weeks, we have seen history repeat itself as Palestinian terrorists have conducted a series of bloody bombings and road shootings against innocent Israelis.

These acts of terrorism must be condemned in no uncertain terms. We must send a message to the terrorists that such behavior will not be tolerated, that we view such attacks through the prism of the global war against terrorism, and as such within the parameters established by the President when he underscored "you are either with us or you are with the terrorists."

The choice for the new Palestinian leadership is a simple one: end the terror. Ending the terror, however, must go beyond mere words. The resolution before us clearly acknowledges Palestinian Prime Minister Abu Mazen's reiteration at the Aqaba Summit of a "complete end to violence and terrorism."

However, such a renunciation of terror must be accompanied by concrete, verifiable steps to confront, combat, and destroy the terrorists. As long as Israeli citizens continue to be victimized by terrorists, Israel will continue to defend herself. Thus, only the full implementation of a comprehensive Palestinian anti-terrorism plan aimed at destroying the terrorist organizations will serve as a true catalyst for peace. The focus should not and must not be on a cease-fire, which history has shown us is simply a respite to rearm. The end to terror must be unconditional, and it must be complete.

The new Palestinian leadership must arrest and hold the terrorists, not release them soon afterwards. Palestinian jails must not continue to be revolving doors from which the terrorists escape. The international community must work together to support these objectives, and a critical component of this effort is to sever all ties with any and all who cavort with terror. Specifically, if Europe is committed to the road map process, as a sponsoring party, the EU must do its part to implement it. Inherent in those responsibilities is the necessity to bypass and marginalize Arafat.

Nations must end political and material support for any Palestinian terrorist group and, in turn, divert those resources to assisting the new Palestinian leadership in fighting terror and in building "a practicing democracy, based on tolerance and liberty," as President Bush has emphasized.

These concerns, the hopes that we all hold, our obligations and the cooperation we demand of our allies, and perhaps most importantly, the friendship and solidarity we feel toward Israel, are set forth in this important and comprehensive resolution.

This resolution serves as a warning to terrorists to beware. The current peace process is not business as usual. I commend the gentleman from Texas (Mr. DELAY) for his leadership on this issue, along with the gentleman from Illinois (Mr. HYDE) and especially our ranking member, the gentleman from California (Mr. LANTOS), and the gentlewoman from California (Ms. PELOSI) for their commitment. I ask my colleagues to vote "yes" on the resolution.

Mr. Speaker, I ask unanimous consent to yield the balance of my time to the gentleman from Iowa (Mr. LEACH) and that he may control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Florida?

There was no objection.

Mr. RAHALL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I deplore the bus bombings and other acts of terrorism against innocent civilians wherever heinous acts of violence occur. The violence must stop. President Bush's vision of a two-state solution, two states living side by side in the Holy Land, must be implemented. I support the road map whole heartily.

Mr. Speaker, it was just a very short time ago this year that this body passed a resolution commending Israel and condemning the Palestinian Authority and calling upon the Palestinians to elect new leadership. Now the Palestinians have done just that. They have elected their new prime minister, Mahmoud Abbas. He has been in office for less than 2 months now, and now this body all of a sudden expects him to stop the violence that has raged out of hand for close to 3 years in such a short time. Prime Minister Abbas is trying very hard to negotiate an understanding among the militant groups that will end all acts of violence against Israelis. And as we speak, as we speak, a cease-fire appears to be taking hold. There appears to be such an agreement.

This process going on in the Middle East as we speak certainly needs no help from this body with this type of one-sided, inflammatory resolution for which this body is so well noted. Prime Minister Abbas must be given the time, he must be given the space, he must be given the opportunity to assert his authority and that of his new security chief Mohammad Dakhlan, with whom our own CIA and Israeli security forces have worked very well in the past, and can do so again.

Let us attempt some objectivity here, Mr. Speaker, if we are to remain the responsible super power that we are. The single most important step that the Israelis could undertake is to stop its policy of political assassinations of Palestinians unless they are proven to be ticking time bombs. Tom Friedman said in a recent column that both sides have crossed the line where self-defense has turned into self-destruction.

Is Israel better off or worse off after carrying out these assassinations? The day after it tried unsuccessfully to kill a senior Hamas leader, a suicide bomber killed 17 innocent people aboard a bus in Jerusalem, these acts occurring since the Aqaba Summit. The bomber said this act was in retaliation for the assassination attempt the previous week. Clearly the people of Israel are questioning this policy. In a poll last week by a leading Israeli newspaper, 58 percent of the Israelis polled supported ending this type of assassination policy and cooperating with the new Palestinian government to end all violence.

The fact is, the only time the Israelis have enjoyed extended periods of peace in the last decade is when the Palestinian Security Service, under Mr. Dakhlan, have cooperated with Israel and both sides spent their energy, successfully, I might note, in preventing acts of violence.

We are right today to call upon Prime Minister Abbas and his government to make greater and more efficient efforts to control the militant groups and end violence, but we also have a responsibility in order to be objective and even-handed, to ask the government of Prime Minister Sharon in this same resolution whether these policies are making Mr. Abbas's tasks easier or harder.

The people of Israel is asking this question, so should the Congress of the United States. Let us have a little balance here. Let us have a little balance here. Let us call on the Palestinian Authority to make greater and more effective efforts against terrorists; but also, let us call on the Israeli Government to stop making Mr. Abbas's tasks more difficult. It is also time for Israel to reassess and hopefully end this process of political assassinations. We cannot allow the extremists on either side to sabotage the peace process. We cannot allow terrorists to torpedo the peace process. Let us look at some objectivity before we pass, once again, another resolution of this nature.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of this resolution which condemns the recent wave of terrorism inflicted on Israel and expresses solidarity with the people of Israel in their heroic fight against terrorism.

First, Mr. Speaker, I thank the gentleman from Illinois (Mr. HYDE) for the gentleman's cooperation in bringing this resolution to the floor. I also want to express my appreciation to the gentleman from Texas (Mr. DELAY), the Republican leader, for his principled support, and to the gentlewoman from California (Ms. PELOSI), the minority leader, for her valued cosponsorship. The fact that these three leaders of the House have cosponsored my resolution is a powerful indication that it has strong bipartisan support.

Mr. Speaker, I introduced this resolution with one basic conviction, that Israel has as much right to fight against suicide bombers and ruthless terrorists as any other free and democratic nation. At the recent Aqaba Summit, the Prime Minister of Israel, Mr. Sharon, made some extraordinary and historic statements. He called for a democratic state living at peace with Israel with mutual respect and shared prosperity.

In less than a week of the Prime Minister's landmark speech, 22 innocent Israeli men, women and children fell victim to suicide bombings and over 100 were wounded. Israel's response to this unprovoked carnage was the only response a self-respecting democratic state could offer. When Israel responds with counterterrorist operations against suicide bombers, some criticize it for provoking a cycle of violence.

This is an absurd and sinister argument. Let us be clear about one thing. As our resolution states, Israel would not conduct counterterrorist operations if Palestinian counterterrorism would cease. The bloodshed, the violence, the tragedy would end.

The term "cycle of violence" must be permanently retired from the lexicon of Middle East politics since it preposterously implies moral equivalence between suicide bombers and the justified response of a free and democratic nation.

Based on comparative populations, the 22 Israelis who were murdered in the days following the Aqaba Summit are the equivalent of 1,100 Americans. Were al Qaeda again to murder over a thousand Americans, we would demand that our government take strong measures to eliminate the threat they pose. None of us would tolerate our government waiting while someone pleads with the terrorists for a temporary cease-fire.

In my recent meeting with Palestinian Authority Prime Minister Abu Mazen in Ramallah, he told me that he is opposed to terrorism. Subsequently he repeated his statement to President Bush and many others, but Abu Mazen's effectiveness as a leader will not be judged by his words, but by his deeds. Abu Mazen's political situation is unquestionably complex; but if he continues to refuse to use force against murderous terrorists, he will soon become irrelevant and his political demise will be sure to follow.

□ 1445

But should he choose to take bold action against terrorism, he will deserve and he will receive the support of this body and the American people.

Mr. Speaker, my resolution underscores the obvious. Israel's fight against terrorism is one of the front lines of the global war against terrorism. Israel's enemies are motivated by a hate-filled, sick, totalitarian ideology, as are our terrorist foes. Israel's enemies are ruthless and bloodthirsty, just like ours. If the Palestinian Authority will not or cannot destroy and defeat Palestinian terrorist groups, Israel has no choice but to take matters into its own hands. We are fighting our enemies relentlessly. Israel, under infinitely less favorable circumstances, can do nothing less.

Mr. Speaker, it is universally accepted that it is the right of all states, including the democratic state of Israel, to make the defense of its citizens its number one priority. This is the bedrock of my resolution. I urge all of my colleagues to join me in voting for it.

Mr. Speaker, I reserve the balance of my time.

Mr. LEACH. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Michigan (Mrs. MILLER).

Mrs. MILLER of Michigan. Mr. Speaker, I rise today in support of the Israeli-Palestinian peace process. The Aqaba summit earlier this month seemed to offer hope for the road map to peace offered by President Bush. For the first time, a Palestinian leader had condemned in Arabic for the entire world to hear the use of terrorism as a solution to the problems in the Middle East. Unfortunately, terrorist groups like Hamas refuse to stop the violence. The Palestinian Authority must immediately begin to dismantle the terrorist infrastructure in the West Bank and in Gaza, because there is no chance for a Palestinian state if terrorism continues. It is in the interest of the Palestinians to put an end to the violence. The victims of these attacks are not only innocent Israelis but also the Palestinian people who continue to be held down by the most radical among them. These radical terrorists communicate to the world their ultimate goal, the destruction of Israel. Any other end is unacceptable to these terrorists. Therefore, peace will not be reached until the terrorists are destroyed.

The time has come to rekindle the hope of Aqaba, to end the terrorism, to get back on the road map to peace.

Mr. RAHALL. Mr. Speaker, I yield such time as he may consume to the distinguished dean of the House the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I rise in strong opposition to violence, killing and to the senseless murders which have been taking place in the Middle East. I also rise in support of peace. I also rise in support of the road map for Middle East peace in the hope that it will be implemented and that the United States will provide the leadership that is needed. I also rise with still some hope in my heart that we could achieve the purposes which we thought were beginning with the summit at the Gulf of Aqaba and to express the hope that we will be able to see a time coming when Israeli, Muslim, Jew, Christian and the Palestinian people can know that there is peace in the Mideast. I also look forward to the leadership of the United States in moving towards achieving the real goal of this Nation, which is peace in the Middle East so that all persons, Israelis, Palestinians and everyone else who is concerned with that area can know that there will be peace there and so that the threat to the United States and the rest of the world of terrorism will suffer a real setback of the kind all of us here hope will be achieved.

George Santayana said something that I thought was very important. He said, "He who does not learn from history is doomed to repeat it." I see that the hope that we had is being diminished both by the killings and by the fact that we are now moving away from what I had hoped would be the role of the United States in the Middle East, and that is the role of an honest broker, of a nation who could appeal to both sides to bring the killing to an end and to achieve a lasting peace negotiated by and between the parties. The Oslo process has collapsed. Eight hundred Israelis have died; 2,000 Palestinians have been killed. Twenty-two Israelis have been killed since the Aqaba summit, but about double that number of Palestinians. This is hardly the basis upon which peace can be achieved. It is also hardly the basis upon which we can say that the United States is providing the strong, the determined and the forceful leadership which is necessary to assure that both parties do the things that are needed to achieve a real and a lasting peace to the area.

I would point out that if we do not listen to George Santayana, we have the possibility of repeating the mistakes of the past. What is it that we should be directing our attention to? Forceful, forcible, vigorous, strong efforts to achieve peace, to bring the parties together, to see to it that they talk, and to achieve the reputation amongst them of an honest, impartial broker, of a nation that is interested in seeing to it that both parties not only work together but achieve the best result of their negotiation that is possible to achieve. I do not see that in this resolution and that is the vice of this resolution. This resolution takes sides.

I am not prepared to quarrel with any of my colleagues as to who is at fault over in the Mideast. That is not the function of an honest broker. I am prepared to say that our efforts today and that our efforts as a Nation should be directed at one thing, and that is achieving peace on the basis of a reputation of honesty, decency and fairness and upon the basis of the trust of the parties in the area. I do not see this document as stimulating that kind of response. This document is one-sided. It condemns violence on one side. I hear nothing about the need for the United States to, in fact, lead toward peace or that the United States wants a termination of violence by all parties. That is clearly lacking here, but it is desperately needed. Our problem if we seek to be seekers of and builders of peace is to assure that we make possible the trust of all parties, Israelis and of Palestinians, so that we can get them to the table, a difficult task, to talk about peace, about building a peace which will last, which will give justice, equality, comfort and solace to all, men, women, children and also Israelis and Palestinians. That is absent in this resolution. It is something which must not only be in the resolutions of the Congress but it must be in the policies of the United States.

I say that I took great comfort and pleasure and pride when I saw that President Bush was getting the parties together and that he was really going to lead in this undertaking. I urge him to continue that undertaking, because in that is not only the interest of the Palestinians and of the Israelis but also of the United States. And a failure for this country to take a position which achieves the trust, the respect and the support of both parties for the negotiation is assurance that we will not have the success that we want and that we need. It also is assurance that we will not have the kind of security against terrorism which finds its seeds and which finds its roots in the kind of injustice that the people of the Mideast on both sides feel exists.

I urge us, then, to be honest brokers. I urge us, then, to strive for peace and for the trust of all persons over there who seek that peace. And I urge us to take the steps that are necessary. This resolution is not one of those steps. I urge my colleagues to reject it.

Mr. LANTOS. Mr. Speaker, I am very pleased to yield 2 minutes to the gentleman from Maryland (Mr. HOYER), the distinguished Democratic whip.

Mr. HOYER. I thank the distinguished gentleman from California for yielding me this time.

Mr. Speaker, I rise in strong support of this resolution which condemns the unconscionable terrorist attacks directed at the state of Israel since the Aqaba summit earlier this month and which expresses our solidarity with the Israeli people in the fight against terrorism. I might add that we ought to have solidarity with those Palestinians who join in the fight against terrorism.

Let me add, too, I am very proud to have joined the gentleman from California as well as the chairman of the Committee on International Relations and the majority whip in circulating a letter that was signed by more than 300 Members of this House that urges President Bush to adhere to the principles he articulated a year ago concerning the Israeli-Palestinian crisis. That letter and this resolution share this nonnegotiable demand: Any road map for peace must require the Palestinian side to unconditionally cease its campaign of terror and violence against Israel. Like the Dean of the House, my good friend, I desire to be an honest broker. But in that honesty, I need to observe what each side does. We must require the Palestinian side to unconditionally cease its campaign of terror and violence against Israel.

There are some who believe the United States and other nations must demonstrate more evenhandedness on the Palestinian question. However, Mr. Speaker, we must guard against making muddled parallelisms between justified actions by Israel and terrorist tactics that are designed only to inflame and destroy and undermine. I might say, the Prime Minister of Palestine from accomplishing the objectives articulated at Aqaba. As this resolution states, we must reject the concept of a cycle of violence as the gentleman from California has so powerfully said, because it implies a moral equivalence between terrorist and victim where no such parallelism exists. The state of Israel like every other nation on Earth has the right of self-defense and this resolution expresses American solidarity with Israel as it acts to maintain and secure its independence as a free and sovereign nation.

Mr. Speaker, we must continue to work to bring peace to this savaged region of the globe and achieve justice for Israel as well as justice for the Palestinian people, so many of whom have toiled under despots who only preach death and destruction.

I urge my colleagues to adopt this resolution.

Mr. LEACH. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. DELAY), the distinguished majority leader of the House.

Mr. DELAY. I thank the gentleman for yielding me this time.

Mr. Speaker, no man knows the battle between good and evil like the gentleman from California (Mr. LANTOS). It is an honor to once again have worked with him on this resolution. I am proud to call the gentleman from California my colleague and my friend.

Mr. Speaker, today Israelis will wake up and go to work. They may drive their children to day care or have lunch with their friends. Israeli children will go to school and play with their classmates. We do not know which ones and we do not know where, but soon some of them will probably die. A bright light will flash, a terrifying concussion will bloom through the air, and in an instant fear, blood, panic, pain and death. And somewhere in Gaza, violent men will laugh. If this is not evil, nothing is.

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However unfashionable this so-called "simplistic" vocabulary is among the diplomatic elite, it is honest. It is the vocabulary of the American people and their President whose moral clarity has led our Nation in our ongoing war on terror. Individuals, nations, and organizations who equivocate, who see the savagery of terrorists and the self-defense of free states as two sides of the same coin, as a cycle of action and counteraction, undermine that clarity.

Those who say Israel's self-defense is an impediment to progress completely miss the point. The destruction of Palestinian terrorism is not an impediment to progress. It is the definition of progress. Offers of temporary cease-fires by Hamas and other terrorist groups are not the solution to the problem. The point of the war on terror is not just to defeat terror, but to destroy terrorists. Murderers who take 3-month vacations are still murderers. They are still enemies of the civilized world and must be hunted and targeted as such.

Mr. Speaker, Israel's fight is our fight. Israel's liberation from Palestinian terrorism is an essential component of the global war against terror, and in that war there is no moral equivalence between aggrieved parties engaging in a so-called cycle of violence. There is only the cold-blooded murderer and the soldier sworn to defend his nation. This resolution makes that distinction and affirms American solidarity with the people of Israel and their war against terror. It makes clear that the American people acknowledge Israel's fundamental right to defend herself and that her fight against terror is our fight, and it calls on the Palestinian leadership at long last to act in the interest of their suffering people and stop the terrorists.

No more empty promises, no more games, no more points of effort. There is a war on and the terrorists are going to lose that war. Now the only question is whether Palestinian leaders will stand with the civilized world in defiance of evil or whether they will fail like their predecessors have failed. We must not allow the Palestinian people who have been so long robbed of hope by corrupt and hateful leaders to be used as pawns to undermine this President's vision for peace.

The ascension of Palestinian Prime Minister Abbas gives us some reason to hope, but Israel and the United States must adopt a policy of trust but verify, and the only way to verify the destruction of Palestinian terrorism is the end of Palestinian terrorism, period. When the violence stops, the peace process can move forward; and until it does, Israel must defend itself. And either way, she will not stand alone because the people of the United States will never abandon their brothers and sisters in Israel or any nation that is threatened by terror.

A vote for this resolution reaffirms the House's commitment to Israel and to the moral clarity of our war on terror. So I just urge all Members to cast that vote and join Israel's heroic stand against evil.

Mr. RAHALL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I join my colleagues in expressing outrage at terrorism perpetrated by Palestinian extremists since the Aqaba Summit. The people of the United States continue to stand in solidarity with the people of Israel. But I regret this resolution is not as complete or constructive as it might be. We mourn the 22 innocent Israelis that have been killed since the summit, but over twice that number of innocent civilian Palestinians have also died as a result of military strikes from Israel. Their loss should also be explicitly recognized in such a resolution.

I sincerely wish the House had used this opportunity to offer its clear support for the President's road map to Middle East peace. This road map is not perfect, but it is currently the only legitimate way to stop terrorism and get the parties back to the path of peace. Under the road map the Palestinian Authority must crack down on terrorism, and Israel must dismantle illegal settlements and begin an end to occupation. Abandoning the road map in the wake of the recent terrorism would not help Israel. In contrast, it would reward the terrorists.

I object to the resolution's condemnation of the phrase "cycle of violence" because it is a fact for the past 2½ years we have witnessed a heartbreaking and endless cycle of terrorist attacks, assassinations, reprisals and retaliations. Since the peace process collapsed, 800 Israelis and 2,100 Palestinians have been killed. The Israeli economy has collapsed. The humanitarian crisis in the West Bank and in Gaza has intensified. Therefore, it is imperative that under the road map security cooperation would resume. This is critical because it is clear that neither prime minister, Abu Mazen nor Sharon, neither of these can stop terrorism without the other. This conflict will never end without a comprehensive political solution; and we, the United States, must lead both parties to that agreement. Otherwise Israelis and Palestinians may be doomed to a life of violence and suffering forever. It is not what these people deserve, and it is surely not what America can afford.

Mr. LANTOS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New York (Mr. ACKERMAN), the ranking Democrat on the Middle East and Central Asia Subcommittee.

Mr. ACKERMAN. Mr. Speaker, I am reminded of the old vaudeville act where the guy goes to a doctor and he says "Doctor, Doctor it hurts when I do this. What should I do? And the doctor says, 'Do not do that.' "

Every action has a reaction. And people who perpetrate violence and commit acts of violence provoke responses.

I rise in strong support of the resolution. I want to commend the gentleman from California (Mr. LANTOS), the author, for bringing it to us. The resolution brings something critical to our discussion about the future of the Israeli/Palestinian peace process, and that is moral clarity. We should be absolutely clear about this. Neither the Israeli soldier nor the American soldier who defends his nation by preemptively eliminating terrorists can with any decency be compared to the terrorist who intentionally sets out to murder innocent women and children on a bus or in a disco or in a pizzeria or in a shopping mall or in a supermarket or going to work in the Twin Towers in New York. Terrorism and the defense against terrorism are not a cycle of violence. Active defense against terrorism including strikes against terrorists and terrorist leaders and those who harbor them is a moral obligation of a free and democratic society. We do it because it is right, and Israel does it for the same reason.

Tempting as it may be, peace cannot be achieved through delusion, pretending that all parties to this conflict are of equal goodwill or everyone shares the belief that the two-state solution is a recipe for failure. Hamas and Islamic jihad engage in terrorism not to create the state of Palestine, but to destroy the State of Israel. Their victims are Jews not by coincidence of citizenship, but by active design. These are not just misguided militants or eager extremists, as our newspapers might label them. They are fanatical haters, murderous zealots committed to destroying both Israel and the Palestinian Authority, driving out both Jews and Christians and building an Islamic state on the ashes.

Mr. Speaker, peace may be possible; but it is not automatic. It is almost certainly impossible until these hate groups are crushed. The Palestinian Authority cannot succeed. It cannot fulfill its mandate as the single voice of the Palestinian people. It cannot perform its historic role as the agent of Palestinian statehood as long as these groups are allowed to exist. In the words of a former Israeli prime minister, we must pursue the peace process as if there were no terrorists, and we must pursue terrorists as if there were no peace process.

Mr. LANTOS. Mr. Speaker, since there are colleagues on various sides of this issue who wish to speak and, given the time limits, they no longer would have the opportunity, I ask unanimous consent that each side be given an additional 20 minutes.

The SPEAKER pro tempore (Mr. SHIMKUS). Is there objection to the request of the gentleman from California?

Mr. RAHALL. Mr. Speaker, reserving the right to object, do I understand the gentleman correctly that it would be split as it was originally split, 10 minutes and 10 minutes on his side?

Mr. LANTOS. Mr. Speaker, if the gentleman will yield, the gentleman is correct.

Mr. RAHALL. Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

Mr. LEACH. Mr. Speaker, reserving the right to object, it is my understanding the leadership concurred with the notion of an additional 20 minutes to be split 10 minutes for and 10 minutes against.

Mr. LANTOS. Mr. Speaker, will the gentleman yield?

Mr. LEACH. Further reserving the right to object, I yield to the gentleman from California.

Mr. LANTOS. Mr. Speaker, I think this is an important debate. A good number of colleagues wish to speak on it. We waste so much time in this body on so many unimportant issues, I think an additional 20 minutes for each side is not an unreasonable request.

Mr. LEACH. Mr. Speaker, speaking personally, I am in full concurrence. My problem, reserving the right to object, is that I have been informed that leadership is very concerned about the bill to follow and would like to stick with what I understood was an agreement of 20 minutes total, 10 minutes to be divided between each side. And based on that, I would be constrained to object to 20, but I am very pleased to assert 20 minutes to divide it 10 and 10.

Mr. RAHALL. Mr. Speaker, will the gentleman yield on his reservation?

Mr. LEACH. I yield to the gentleman from West Virginia.

Mr. RAHALL. I think for once the gentleman from California (Mr. LANTOS) and I totally agree on this particular issue. I agree with what he just said about the importance of it. I agree to the extension of time as he has requested.

Mr. LEACH. Again, I am personally in full agreement, but I am informed that this is a leadership decision and therefore would be constrained to object.

Mr. LANTOS. Mr. Speaker, will the gentleman yield?

Mr. LEACH. Further reserving the right to object, I yield to the gentleman from California.

Mr. LANTOS. Mr. Speaker, will the gentleman consult with the leadership while we take up the next 10 minutes to see if they agree to an additional 10 minutes?

Mr. LEACH. Yes. I think that is very reasonable.

The SPEAKER pro tempore. Is the gentleman from California making a new request?

Mr. LANTOS. Mr. Speaker, I am making the request that each side be given 10 minutes.

Mr. LEACH. Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

The SPEAKER pro tempore. The Chair will clarify. Is the gentleman from Iowa (Mr. LEACH) going to then yield one half of his time?

Mr. LEACH. Mr. Speaker, I am delighted to yield one-half of my time to the gentleman from California (Mr. LANTOS).

The SPEAKER pro tempore. The Chair will state that the gentleman from Iowa (Mr. LEACH) has 5 minutes, the gentleman from California (Mr. LANTOS) has 5 minutes, and the gentleman from West Virginia (Mr. RAHALL) has 10 minutes. The total times are the gentleman from West Virginia now controls 17 minutes, the gentleman from Iowa controls 5 minutes, and the gentleman from California controls 5 minutes.

Mr. LEACH. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the thrust of this resolution is four-fold:

A, it reflects America's concern for terrorism as an instrument to advance political advantage.

B, it expresses sympathy to the families of both innocent Israelis and Palestinians who have lost lives in this struggle.

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C, it commends the President for his vision of two states, Israel and Palestine, living side-by-side and, thus, implicitly affirms the peace process that the President has so wisely helped precipitate.

D, it is implicitly designed to empower the new government of the Palestinian Authority. The goal is to strengthen those who have the best chance of negotiating a long-term resolution to the Palestinian-Israeli issue.

Here let me note that at the Aqaba summit, King Abdullah of Jordan turned to the Israeli and Palestinian Prime Ministers and said, "Prime Minister Sharon, Prime Minister Abbas, I urge you today to end the designs of those who seek destruction, annihilation, and to have the will to begin to realize our dreams of peace, prosperity, and coexistence."

This sentiment is what we ask the international community to follow. This direction is where our President, as well as the king of Jordan, is leading, and this is the direction we want this Congress also to go in.

Speaking personally, I would like to stress full support for the President's road map, for peace, but I would underscore that the road has been traversed before, but proved full of cavernous holes and multiple detours. The end is in sight. Everyone knows it will relate to a resolution along the lines of Camp David and subsequent talks at Tabba. But the slower the process, the more likely terrorists will be empowered.

The issue is speed. Three weeks or 3 months are vastly preferable to 3 years or 3 decades. The violence may not end with a political resolution, but it has no chance of ending without it.

Therefore, I think it should be the goal of this Congress to stress that violence is an evil in and of itself, but a resolution of this particular circumstance in international affairs, which is the most difficult, possibly, in the history of man, is an imperative. All of us identify with all reasonable people who are attempting all reasonable techniques to bring a resolution to this issue.

Mr. Speaker, I reserve the balance of my time.

Mr. RAHALL. Mr. Speaker, I yield 2 minutes to the gentleman from North Carolina (Mr. PRICE).

Mr. PRICE of North Carolina. Mr. Speaker, many of us will vote for House Resolution 294 because we indeed deplore the terrorist attacks inflicted on Israel. We wish to express solidarity with the people of Israel. And we understand the necessity of the Palestinian Authority confronting and fighting terror and terrorist organizations.

I am baffled and dismayed, however, by the resolution's failure to straightforwardly endorse the effort of our government and our Quartet partners to implement the so-called "Roadmap" which, at this moment, represents Israel's best hope for ending terror and the Palestinians' best hope for achieving self-determination. We must condemn terrorism without qualification, and that is consistent with promoting the simultaneous accommodations by both sides which the Roadmap envisions. We must affirm Israel's right to defend itself, but that is consistent with urging on Israel tactics and timing that do not undermine the Roadmap initiative, as our President and our Secretary of State have recently articulated.

What this resolution fails fully to grasp is that concern for Israel's security and integrity is a major motivation for many of us, most of us, as we push for American leadership via the Roadmap. This effort will require all of the energy and persistence and support we can muster, in this body and in our government, in the critical weeks that lie ahead.

Mr. LANTOS. Mr. Speaker, I yield such time as she may consume to the gentlewoman from New York (Mrs. MALONEY).

Mrs. MALONEY. Mr. Speaker, I rise in strong support of this resolution, and I thank Congressman LANTOS for his leadership and determination on this issue that is a priority to so many of us in this body.

I stand here today to express my outrage and grief over the latest round of terrorist attacks in Israel since the Aqaba (Ak-a-ba) summit earlier this month.

Twenty-two innocent Israelis have been murdered since the beginning of this month and many others have been injured in three separate homicide bombings.

For most of us, September 11, 2001, forever change our way of looking at the world. We learned that even the awesome power of the United States could not protect us from terrorists bent on destruction.

It forced us into a position that Israel has been in for a very long time—trying to protect loss of innocent life against an enemy that has no reservations about killing.

I strongly believe that Israel has the right to defend itself against suicide bombings and other terrorist attacks and that the world must recognize that Israel has a right to use military means to protect its citizens and its borders.

To bring an end to terrorism in Israel and peace in the region, Prime Minister Abbas must start by living up to his agreements, including a commitment to stop this violence against civilians. That means fulfilling promises of prosecutions.

His ability to maintain the rule of law would finally demonstrate a Palestinian interest in engaging in discussions of peace.

It is my true hope that Israelis and Palestinians can one day live side-by-side in peace.

Mr. LANTOS. Mr. Speaker, I am delighted to yield 1 minute to the gentleman from California (Mr. BERMAN), my friend, the distinguished senior member of the Committee on International Relations.

Mr. BERMAN. Mr. Speaker, I appreciate the gentleman yielding me this time.

To my friends who are concerned about this resolution, I remind them of the words of Yitzak Rabin earlier quoted: "I will fight terrorism as if there were no negotiations. I will negotiate as if there was no terrorism."

While he will never admit it, Prime Minister Sharon in the last 3 weeks has moved to that position. Notwithstanding 17 Israelis killed in a bus bombing, other Israelis killed in two other terrorism attacks since the Aqaba statements, the Israeli government has continued with these negotiations.

The notion that the Roadmap would exist, that this process would be moving forward, that the hope that we heard at a conference this weekend by the Dead Sea from both Arabs and Israelis about the chances of moving forward would come because the United States played a neutral role in this conflict, are terribly misplaced.

The reason that the Israelis have the courage to move forward, notwithstanding the continued terrorist attacks, is because they know that the United States Government and particularly that the Congress stands with them in this conflict.

This is a resolution that for the first time in the history of this House of Representatives recognizes a two-State solution, an independent Palestinian State, and seeks to strengthen and embolden the Palestinian Authority in governing a State without terrorism.

I urge support for the resolution.

Mr. LEACH. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from California (Mr. ROHRABACHER).

Mr. ROHRABACHER. Mr. Speaker, I rise to discuss this resolution, although I have not yet determined how I shall vote on it.

The resolution has "resolved" clauses that speak for themselves and are reasonable. In the "resolved" clauses we do see a recognition of expression of sentiment about both the Palestinian as well as the Israeli innocent people who have been killed. Also, it recognizes the Roadmap and talks about some of the goals that we all agree on.

I do have some reservations as to the "whereas" clauses which seem to be one-sided. The clause most disconcerting to me happens to be the one that people seem to be the most frantic in trying to get across today, and that is the claim that in some way, by saying that this is a cycle of violence that is going on, as it says in the "whereas" clause, that this implies a moral equivalency. It does not. The cycle of violence could well have been started, and I do believe there is a cycle of violence going on; it could be that both sides have made mistakes. That does not mean they are both morally equivalent. Who is judging the morality of it? We are judging the reality of it.

The fact is, Israel may have made some mistakes. Certainly the Palestinians have made horrible immoral decisions in terms of suicide bombings and other types of acts of terrorism. But Israel may have made some mistakes. Was Sharon's visit to the Temple Mount, in retrospect, was that not a mistake? How about the Israeli settlement policy for these last few years? I think in retrospect these things have not furthered the cause of peace; these things have created a cycle of violence, if you will.

It is our job to try to come to grips with what is going on there and end this conflict, and quit trying to say that all of the blame is on one side. Both sides have made mistakes. Let us try to be an honest broker.

Now, I will probably be voting for the resolution, because the "resolved" clauses are things that I agree with. But I would hope that we would be honest with ourselves and try to discuss this in a way that will further the cause of peace and not just simply be one-sided.

Mr. RAHALL. Mr. Speaker, I yield 3 minutes to the gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Speaker, there is no doubt in any of our minds of this country's strong support for the State of Israel. We have shown that time and time again. But as my colleague, the gentleman from California just indicated, neither side is totally innocent of all of the violence that has occurred over the years.

But as I look at and read this resolution, I think the question all of us have to answer, the only question that we have to answer is: Will passing this resolution further the peace process? And the answer is clearly no.

A reading of the resolution will find it lacking in one major regard and that is, there is no endorsement in this resolution of the Roadmap, the Roadmap which President Bush has worked so hard to promote to both sides; the Roadmap which was a subject of the Aqaba summit. Yes, there has been a flare-up in the hostilities since the summit. But now the House comes with a resolution which is one-sided. And again, I ask: will this resolution enhance the peace process? And I say to my colleagues, the answer is no.

Only yesterday, the Palestinian Authority agreed to a 3-month truce from any further hostilities. Many of us will say, 3 months! We want it permanent. How about 6 months? Mr. Speaker, how about taking some progress when we can get it? If this 3-month truce moves along the peace process, let us take it. And then fight for another 3 months, and another 3 months. It has to be done in small steps.

Our offices just received communications from two pro-peace Jewish groups. The first group was Americans For Peace Now, a premier Jewish organization working to enhance Israel's security through the peace process, and the second group that is questioning the wisdom of this resolution is the Israel Policy Forum, which supports American efforts at resolving the conflict between Israel and its Arab neighbors.

So I say to my colleagues, let us all answer the question together when the vote comes, and that is will a vote for this resolution enhance the Roadmap, and will it further peace in the region? And again, the conclusion I draw is that the answer is no.

Mr. LANTOS. Mr. Speaker, I am delighted to yield 30 seconds to the gentleman from New York (Mr. CROWLEY), a distinguished member of the Committee on International Relations.

Mr. CROWLEY. Mr. Speaker, I rise in strong support of the Lantos resolution.

The terrorist attacks against innocent Israeli citizens have increased at a horrific rate since the Aqaba summit. Palestinian terrorists are enemies of the peace process and enemies of the Jewish people. The peace process cannot move forward until all terrorist activity ceases against the State of Israel.

The murderous ways of Hamas must be stopped, and I fully support Israel's right to defend itself by any means necessary, as Israel supported our right to defend ourselves against terrorism after the attacks of 9/11.

The press reports these killings as suicide bombings. Some in our government have taken it a step further and called them homicide bombings. I think we should go one step further and call them what they really are: genocide bombings, with the intent to annihilate the State of Israel and the Jewish people.

Mr. Speaker, I ask all of my colleagues to support this worthy resolution.

Mr. RAHALL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me correct something in which I may have misspoke earlier when we were talking about an extension of time on all sides and I said that perhaps that was the only area in which the gentleman from California (Mr. LANTOS), my good friend, and I agreed. That is not the case. It was a misstatement on my part, and I do correct it, because as he has stated and as we have discussed on numerous occasions throughout our careers in this body, we perhaps see eye-to-eye on 95 percent of the issues involved in this particular area and in the Middle East. We certainly agree on the need to stop the violence. We agree on the need to end the terrorism. We agree on the strong Israeli-U.S. relationship that must always be maintained. And we certainly agree on the need for peace for all people in the region.

I must respond to some comments that were made by the gentleman from Texas (Mr. DELAY), the majority whip of the House. He spoke quite eloquently about all of the Israeli deaths, as does this resolution refer to those numbers as well. But I never once heard the gentleman from Texas (Mr. DELAY) mention any type of sympathy for the innocent Palestinian deaths that have occurred since the Aqaba summit alone. The resolution mentions the 22 Israelis killed, but fails to mention the 55 Palestinians killed, the 258 Palestinians injured just since the Aqaba summit.

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Five ambulances have been destroyed; 33 houses have been demolished and 236 damaged; 7,116 trees uprooted; 328,000 meters of cultivated land have been destroyed; 500,000 meters of land confiscated for illegal settlement; 67 private businesses destroyed; water and irrigation pipes destroyed; homes demolished; people detained, as we saw in this morning's press.

All of these actions have occurred since the Aqaba Summit against innocent Palestinians, so it is that perspective that this resolution so much fails to mention.

I would say as well in calling upon both sides to agree with what they set upon at the Aqaba Summit, yes, there have been some illegal outposts, perhaps a flag here or a pole here that has been dismantled by the Israelis. But according to Israeli sources and journalists, 12 new outposts have been constructed since the Aqaba Summit, and there are rumored to have been five additional ones yet to be discovered. This has happened since the Aqaba Summit.

I would remind the gentleman from Texas (Mr. DELAY) that a recent poll of Christian conservatives here in the United States found that 78 percent of the Christian conservatives in this country support President Bush's vision for Middle East peace.

So, Mr. Speaker, there are a lot of areas in which all the speakers today have agreed. And certainly that makes some points of this resolution commendable.

But, again, in looking at its totality, the resolution lacks in its objectivity. It lacks, Mr. Speaker, in what I term the United States' best interest first. A lot of parallels have been drawn today between the Israeli responses to terrorism and Israel's right to defend itself and the United States' global war against terrorism and our fight against al Qaeda. I would say the main question that needs to be asked here is does the Israeli assassination policy, when there is no proven link that those assassinated are ticking time bombs, where there has been nothing judicial pending against them, there has been nothing but allegations of terrorist activity, in those type of assassinations, is that fairness? Does it promote what is justice in the region? Does it promote the United States' best interest in fairness when it is done with what is perceived to be United States approval?

Maybe there are some in the Sharon government that compare this to our fight against al Qaeda. But those educated and those that will profess some sense of fairness will view this in a different light and see that that comparison is disingenuous to say the least. Certainly, Israel has the right to defend itself against those ticking time bombs and to prevent terrorist attacks from occurring. The United States has that right to fight the global war on terrorism, to fight al Qaeda whenever and wherever we can.

But to make the comparisons between what is happening in the West Bank and Gaza by these Islamic militant groups, to compare them with al Qaeda is stretching it a bit in this gentleman's estimation. We must realize what are the true roots of the al Qaeda and the true roots of why they hate us in the Arab world. Let us look at that response before we determine if we can compare the Israeli fight against terrorism with the United States' fight against al Qaeda.

There are many countries in the world that help us in the fight against the true terrorists, which is the al Qaeda network; and it is those countries that we will continue to need their help in our coalition fight against al Qaeda.

Mr. Speaker, I do say to all those who are participating in this debate, it has been healthy. It has been what we have needed in this Congress for some time, and I hope that we will have the opportunity to debate this issue many more times. I have demonstrated during this debate the question that many Israelis have about the policies of their government in regard to fighting terrorism, and I think it is just as worthy a debate here in this country as it is in the country of Israel. We have that right in our democratic system. We also have the responsibility in this country to look at actions that we take as Members of Congress and resolutions we pass, to ask first and foremost what is in the best interest of the United States of America.

I referred earlier to the cease-fire that has just been announced today and appears to have taken hold. While this resolution does not have the force of law, we must, and we know as Members of this body that every word we utter and every resolution we pass has profound impact across this world. Whether they are actually the words of the law or not, they do send a message. I think this is the wrong message that the United States should be sending at this particular time, this precarious time in the Middle East. Some say this cease-fire is only temporary and it would give the militant a chance to rearm during a 3-month cease-fire. This is the time that the new prime minister with whom the United States has built a relationship, with whom the Israelis have built a relationship, for the newly installed Prime Minister Abu Mazen, who has been in office for less than 2 months, this is the time he needs to gain the political credibility, to gain the support among his own people, to further crack down on the militants without creating a civil war among the Palestinians.

Now, perhaps that is the goal of some on the other side, but that is not the goal of the United States; and it should not be the goal of the United States. But, rather, we should give the newly created prime minister, the newly installed prime minister in the Palestinian territories the time, the space, and the opportunity he needs to gather the support he needs to crack down and, indeed, make this cease-fire, however temporary in nature, of a permanent nature.

Mr. Speaker, I urge that my colleagues look carefully and hard at this resolution before making up their minds and cast their votes in what in their good conscience they deem to be in the United States' best interest and in the interest of peace in the Middle East.

Mr. Speaker, I yield back the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Nevada (Ms. BERKLEY) of the Committee on International Relations.

Ms. BERKLEY. Mr. Speaker, I rise in strong support of this very important resolution, and I associate myself with the remarks of the gentleman from California (Mr. LANTOS), the gentleman from New York (Mr. ACKERMAN), the gentleman from California (Mr. BERMAN), and the gentleman from Texas (Mr. DELAY).

Mr. LANTOS. Mr. Speaker, I yield 30 seconds to the gentlewoman from Georgia (Ms. MAJETTE).

Ms. MAJETTE. Mr. Speaker, I rise today to express my sorrow for the victims who continue to suffer the peril of deadly attacks of terror in Israel. I also rise in solidarity alongside the Israeli people in a stance against terrorists attempting to inhibit the progress of a successful peace process. I further rise in support of the cause of democracy and freedom in the Middle East.

In order to further a road map for peace, there must be an immediate dismantling of Hamas, Islamic jihad, and all other terrorist organizations that actively threaten the lives of those who seek to dwell peacefully in this region.

Mr. Speaker, I urge the House to support this important resolution to send a message to those who would willfully threaten the peace process.

Mr. Speaker, I rise today to express my sorrow for the victims who continue to suffer the peril of deadly acts of terror in Israel. I also rise in solidarity alongside the Israeli people in a stance against the terrorists attempting to inhibit the progress of a successful peace process. Most importantly, I rise in support of the cause of democracy and freedom in the Middle East.

A year ago, in President Bush's speech in the Rose Garden, two criteria were outlined as necessary predicates for a successful agreement: First, a change in leadership of the Palestinian people, which has already taken place, and second, changes in conditions, which have not yet been accomplished. Steps are being taken on both sides to begin to implement the "Road Map," but so much must be done. There has still been no end to the ongoing violence in the region.

At the June 4th Summit in Aqaba, the new Palestinian Prime Minister pledged to end the violence and terrorism in this region "without compromise." Since that time, there have been twenty-two innocent Israelis murdered and many others injured in three separate suicide attacks. More must be done to stop this violence now.

Mere promises are not enough. While it is promising that the radical groups Hamas, the Al Aqsa Martyrs Brigades and Islamic Jihad today offered to suspend attacks against Israelis for three months, I would note that Hamas members in Gaza have already raised doubts about the deal. In order to further a "roadmap for peace," there must be an immediate dismantling of Hamas, Islamic Jihad, and all other terrorist organizations that actively threaten the lives of those who seek to dwell peacefully in this region.

I urge the House to support this important resolution to seen a message to those who willfully threaten the peace process.

We will not tolerate violence nor yield to its demands.

We will continue to fully support the democratic state of Israel.

We support democracy and statehood for the Palestinian people.

Mr. Speaker, I would also note that what other democratic nations are doing also sends a message to the world community and to terrorists. For instance, I am deeply concerned about the plight of the Iranian opposition being detained in France today. I am concerned that the wrong message is being sent to the opponents of democracy and freedom when democratic nations punish supporters of democracy.

For these reasons, I urge my colleagues to support the measure before us, to stand up and speak loudly for democracy and freedom in the Middle East.

Mr. LANTOS. Mr. Speaker, I yield such time as he may consume to the gentleman from New York (Mr. ENGEL), a distinguished member of the Committee on International Relations.

Mr. ENGEL. Mr. Speaker, I rise in strong support of the resolution. Israel's fight against terrorism is our fight. As President Bush said, there are no good terrorists or bad terrorists, only bad terrorists.

I very strongly support this resolution standing with the people of Israel.

Mr. LANTOS. Mr. Speaker, I yield 30 seconds to the gentlewoman from California (Ms. HARMAN), the ranking Democrat on the Permanent Select Committee on Intelligence.

Ms. HARMAN. Mr. Speaker, as the daughter of a refugee from Nazi Germany, issues of anti-Semitism and the continuing terrorist violence against Israel are close to my heart.

I strongly support the resolutions debated this afternoon and commend their sponsors. There is a fleeting chance for peace in the Middle East, the first since the brutal and feckless second Intifada began almost 3 years ago. But success depends on reining in Hamas, the Palestinian Islamic jihad, and others committed to ongoing terror.

One of those others is Palestinian Authority Chairman Yassir Arafat, who should be pressed or forced to step aside in order to allow the nation's government of Mahmoud Abbas to succeed.

Mr. Speaker, 5 years ago I accompanied President Clinton to Gaza and to Israel. Much of what he sought has been undone by the second Intifada. The escalation of violence has not only killed people, it has all but killed hope. We need to rekindle that hope. I urge passage of this resolution.

Mr. LANTOS. Mr. Speaker, I yield 30 seconds to the gentleman from Texas (Mr. BELL), a distinguished member of the Committee on International Relations.

Mr. BELL. Mr. Speaker, friends of Israel recognize that the road map may bring opportunities for greater peace in our time; but for this effort to work, combatting terrorism must be the first step.

On June 4, 2003, Palestinian Prime Minister Abbas pledged a complete end to violence and terrorism. But Mr. Abbas says he is unwilling to use force to put an end to terrorists and terrorist groups, even while innocent Israelis continue to be murdered by suicide bombers and while the guaranteed and expected acts of retribution against his own people are carried out. That is why we offer this resolution to condemn the terrorism inflicted on Israel and express solidarity with the Israeli people. I urge my colleagues to support the resolution.

The SPEAKER pro tempore (Mr. SIMPSON). The gentleman from California (Mr. LANTOS) has 2 minutes remaining.

Mr. RAHALL. Mr. Speaker, I ask unanimous consent to reclaim the time I yielded back.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from West Virginia?

There was no objection.

The SPEAKER pro tempore. The gentleman from West Virginia (Mr. RAHALL) has 5½ minutes.

Mr. RAHALL. Mr. Speaker, I do that in keeping with what I said earlier was an important debate and I believe that all Members who wish to speak on this should be heard.

Mr. Speaker, I yield half of my time to the gentleman from California (Mr. LANTOS).

The SPEAKER pro tempore. The gentleman yields 2¾ minutes to the gentleman from California (Mr. LANTOS).

Mr. LANTOS. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I rise in unwaivering support of House Resolution 294, to reaffirm strong relations between the United States and Israel and condemn the acts of terror against the Israel people.

The United States has a unique relationship with Israel, the only democratic nation in the Middle East. We must continue to support nations with similar ideological goals that share the same commitment to democratic principles. Our history of friendship spans many decades, and the United States has been the strongest advocate for efforts to craft a long-term peace settlement in the region.

If the United States is truly committed to establishing a lasting peace by pursuing the road map, then we must remain true to its principles and condemn violence and terrorist attacks. We must continue our efforts in Congress to promote peace in the Middle East and maintain a strong U.S.-Israel relationship. I urge all of my colleagues to vote for the resolution before us today.

Mr. Speaker, I thank the gentleman for yielding me time.

Mr. LANTOS. Mr. Speaker, I yield 30 seconds to the gentleman from California (Mr. CARDOZA).

Mr. CARDOZA. Mr. Speaker, I rise today in support of this resolution.

Mr. Speaker, on June 24 of last year, President Bush unveiled a new vision for bringing peace in the Middle East. I support that vision. But that vision is one that we must support through a fairness situation where we do not make equivalency between what has happened by Mr. Sharon going to the Temple Mount and the death and destruction that have been wrapped upon Israel with the terrorist threat. I support the Lantos resolution.

Mr. Speaker, I rise today in support of this resolution, which condemns recent terrorist attacks against Israel and expresses solidarity with the citizens of Israel during this turbulent time.

On June 24 of last year, President Bush unveiled a new vision for bringing peace to the Middle East. He stated that the Palestinians must develop a new leadership, which must be committed to peace with Israel and to destroying the terrorist infrastructure. Only then would the United States consider recognition of a Palestinian state.

Since that time, the Palestinians have taken steps to establish a new leadership structure. Abu Mazen was appointed the first Palestinian Prime Minister following a bitter struggle with Yasser Arafat.

And I'm pleased to hear that—just this morning—Hamas, Islamic Jihad and Al Asqa have agreed to 3-month cessation of attacks against Israelis. That's a very positive step. But we've heard positive talk many times before. The proof will be borne out over time through deeds. Just this morning, the Israeli Defense Force disabled a large bomb in northern Israel. Clearly, the vigil for peace and security will have to be maintained.

I believe the key to the "Road Map" or any other effort to achieve lasting peace is to stay true to the principles outlined by the President last June; particularly, the necessity of combating terrorism as the first of a sequence of events.

And I believe the U.S. must remain supportive of Israel in its fight against terror until the Palestinian Authority is willing and able to carry out this responsibility.

Like my colleagues here today, I welcome the positive steps the Palestinians have taken, but we must also see decisive action to dismantle the terrorist infrastructure.

As Americans, we understand the fight against those who seek our destruction. We stand shoulder to shoulder with Israel in their fight against those who oppose their existence.

The citizens of Israel are our allies, and we will continue to support their fight against terrorism and their government's efforts to provide safety and stability for its people.

Mr. LANTOS. Mr. Speaker, I yield 30 seconds to the gentleman from Texas (Mr. SANDLIN).

Mr. SANDLIN. Mr. Speaker, on June 24 of last year.President Bush stated that the Palestinians must develop a new leadership not tainted by support for terror. The new leadership must be committed to peace with Israel and to destroying the terrorist infrastructure. Only then would the United States consider recognition of a Palestinian state. Israel is fulfilling its commitment by dismantling unauthorized outposts, releasing Palestinian prisoners, allowing Palestinians to work in Israel, and releasing funds out of the treasury.

They cannot be expected to give up counterterror measures so long as Palestinians fail to comply with their road map obligation to stop terror. Like every other sovereign nation, Israel has the right to self-defense. As long as Palestinian leaders do not aggressively go after the terrorist infrastructure, the Israeli government has the responsibility to protect its citizens against further terrorist attacks.

Merely negotiating a cease-fire is not enough. Terrorism must end. Peace demands it.

Mr. Speaker, I rise today to express my firm commitment to the safety and security of Israel and the Israeli people. One year ago, President Bush called upon the Palestinian people to put in place leadership not tainted by support for terrorism. Terrorism is the great scourge of our age, and there is little doubt that it represents an insurmountable threat to peace throughout the world; but most particularly in Israel and in the Middle East.

In order for peace to be realized, terrorist groups like Hamas and Islamic Jihad must be contained. The Palestinian leadership—with support from the rest of the Arab world—must take a firm stand against the blight of violence and death that terrorists spread wherever they commit their atrocities. The destruction of the terrorist infrastructure that threatens innocent Israelis everyday is a necessary precondition to the success of the peace process and the recognition of a Palestinian state.

While I am encouraged that the Bush administration appears to be re-engaged in the peace process, the fact that 22 innocent Israelis have been killed and many more injured in a serious of suicide bombings since the summit in Aqaba, Jordan, demonstrates clearly the difficult and treacherous road to peace that lies ahead.

The sad fact is that we as a nation have too often overlooked or considered route the terror that daily threatens the peace and security of Israel. So, I ask you to consider a situation that would be better understood in our country. Think about a shopping mall or a busy street in New York, Dallas, Los Angeles, Chicago or New Orleans; and think about the people who might be on the bus on their way to school or to work; people going about their daily business, shopping for groceries or picking up that last-minute necessity. Now imagine that someone came along with a bomb in one of those cities, or right here in Washington, DC, and created an explosion that killed 7 or 70 or 700 in one fiery blast.

What would the response be in America? We would call out the Army, the Navy, the Marines, the FBI, the police, every agency that could retaliate, whether to capture or kill the responsible person and the leaders of an organization that would seduce a young person to sacrifice his or her life for such a heinous purpose.

Yet, when Israel responded to the murder of 17 innocent Israelis by launching an attack on the leadership of Hamas, the Bush administration criticized the attack as heavy-handed and an unnecessary complication to the peace process.

We would not stand by five minutes and accept such attacks on American civilians. And we should not expect Israel to stand by five minutes and accept it either. We cannot look at the violence on both sides as though it is comparable. It simply is not the same.

Israel's attacks are always in retaliation for violence that radical terrorists—murderers or killers, to use the President's terms—have brought down upon them. Hamas, Islamic Jihad, and the al-Aqsa Martyrs Brigades, among others, delight in taking responsibility for a suicide bomber who walks into a cafe or disco and takes 8, 10, 20 or more innocent lives.

Like every other sovereign nation, Israel has the right to defend itself against the cowardly acts of terrorists. The United States must not be caught in the trap of thinking of Israel's response to terrorism on its soil as the equivalent of the terrorism itself. There is no doubting the difference.

Mr. Speaker, I rise in strong support of this resolution expressing our solidarity with Israel. Just as we have when the terrorist attacks were on our soil or against our national interests, we must roundly condemn the acts of terrorists in Israel, and we must continue to exert pressure on Palestinian Prime Minister Abu Mazen to use very resource at his disposal, including force, to root out terrorism and remove it as an obstacle to peace. Moreover, we must be unwavering in our support for Israel's right to defend and secure herself against such senseless violence.

If the peace process is to succeed, rather than criticizing Israel for its efforts to combat terrorism, we must offer our full support and take whatever action is necessary to ensure that Israel is free from the scourge of terrorism.

Only then will the Israeli and Palestinian people realize the promise of peace embodied in the "road map."

I have no doubt that the Israeli and Palestinian people can live side-by-side in peace and prosperity, as so many do even today throughout Israel. Yet that goal will likely never be realized unless and until terrorist organizations like Hamas, Hizbollah, Islamic Jihad, and others are removed from the equation.

Mr. Speaker, I urge all members of the House to express their full support for Israel and their continuing commitment to the eradication of terrorism wherever it rears it violent and ugly head and to vote for this important demonstration of our commitment to peace.

Mr. LANTOS. Mr. Speaker, I yield 30 seconds to the gentlewoman from Texas (Ms. JACKSON-LEE).

□ 1545

Ms. JACKSON-LEE of Texas. Mr. Speaker, this peace belongs to the American people. This peace belongs to President William Jefferson Clinton as well the present administration. This peace belongs to all of us who have worked to ensure a just and sustainable peace. The road map must be supported.

I rise, Mr. Speaker, to indicate to my colleagues that I spent 2 weekends ago in Oslo, Norway, working with women from Palestine and from Israel discussing the issue of peace.

I believe we can move forward. I am going to vote for this resolution. I believe that we can move forward, but I believe as well as we move forward we must accept the view and the understanding that as we abolish and get rid of terrorism we all believe and support an independent Palestinian State, and so I am going to associate myself with the women that I had the pleasure of being with in Oslo, Norway and will be writing a resolution to increase the number of women in the mideast peace process as we fight to secure a just and sustainable peace.

I rise today in support of House Resolution 294, condemning the terrorism inflicted on Israel since the Aqaba summit and expressing support for the Israeli people.

The Aqaba summit took place on June 4, 2003. Newly elected Palestinian Prime Minister Mahmoud Abbas proclaimed, "our goal is clear, and we will implement it firmly and without compromise: a complete end to violence and terrorism." This is a laudable statement, and we are happy to see the Palestinian government taking such strides towards democracy and stability for their nation.

Prime Minister Abbas pledged at the Aqaba summit to establish a system based on rule of law and a single political authority. His intentions are the beginning steps needed for the Middle East Roadmap to Peace.

The roadmap begins with the assertion that "a two state solution to the Israeli Palestinian conflict will only be achieved through an end to violence and terrorism." Prime Minister Abbas' leadership will be tested through these turbulent times, as terrorism is still rampant in the Middle East, and more people are suffering at the hands of violence.

Since that June 4 summit, less than three weeks have gone by, and already 22 Israelis are dead and scores more wounded. There have been three separate suicide bombings. When compared with our population, the death toll for the Israeli population would be equivalent to the loss of 1,100 American lives.

Palestinians are also victims of this violence as terrorists continue their attempts to undermine prospects for a lasting peace in the region. I was recently at a conference in Norway where Palestinian and Israeli women were joined by other leaders from around the world to seek a greater understanding of what must be done to secure peace in the region. Some progress was made but I realize that there is much that remains to be done.

Peace will continue to be undermined as long as these terror attacks persist. Sadly, anti-Israeli and anti-Semitic groups are driving a wedge into the process to peace that many Palestinians and Israelis are trying so hard to build.

This is why I condemn in the harshest terms the recent terrorist acts, and express support for a peaceful and secure Israel and Palestine. I also offer my sympathy to the families of both the Israelis an Palestinians whose lives have been lost.

The roadmap to peace is a vision, not just for our generation, but for the future of Middle East stability. This vision can only be realized once terrorism is defeated, so that a new state may be created based on rule of law and respect for human rights.

Mr. LANTOS. Mr. Speaker, I am very pleased to yield 30 seconds to the gentleman from Florida (Mr. WEXLER), a distinguished member of the Committee on International Relations, my good friend.

Mr. WEXLER. Mr. Speaker, I rise in strong support of the resolution because I support the road map plan for peace. Those of us who care so deeply about the State of Israel and its security know that there is no alternative to a peace plan led by the United States, but the Palestinian people must understand that in order to attain the state they justly deserve that their terrorist attacks of Hamas, Islamic Jihad, Hezbollah must be defeated, and one of the ways that America helps defeat terror is to stand 100 percent behind Israel's right of self-defense.

The President was mistaken last week when he condemned Israel's right of self-defense in effect, and he made a distinguishing mark between the way the United States acts and the way Israel acts.

Mr. LANTOS. Mr. Speaker, I am delighted to yield 30 seconds to the gentleman from New York (Mr. NADLER), my friend and distinguished colleague.

Mr. NADLER. Mr. Speaker, those who have opposed this resolution have opposed it for what it does not say, not for what it does.

The United States can be an honest broker and should be between Palestinians who want peace such as perhaps Abu Mazen, whose sincerity is still subject to proof, but it cannot be an honest broker with Hamas and other terrorist groups who desire genocide.

This resolution supports the road map by supporting the first preconditions for it, the disarmament of the terrorist groups, by agreement if possible, by force if necessary.

Finally, there is no equivalence between Israeli victims of premeditated murder and Palestinian victims who either were terrorists or were victims of warfare unleashed by Palestinian terrorists. This resolution strikes a proper balance, and I strongly support it.

Mr. LANTOS. May I inquire, Mr. Speaker, how much time we have left?

The SPEAKER pro tempore (Mr. UPTON). The gentleman from California (Mr. LANTOS) has 1¾ minutes remaining.

Mr. LANTOS. Mr. Speaker, I yield myself 1¾ minutes.

Mr. Speaker, all of us in this House are passionately committed to peace, and all of us in this House are passionately committed to justice. The Palestinian people are certainly entitled to an infinitely better life than what they have had for many years. The blame clearly lies with the surrounding Arab states which failed to allow them to establish civilized communities or to absorb them.

Other societies have done that. The Greeks of Cyprus absorbed the Greeks from northern Cyprus, and the people of Israel absorbed millions of their fellow nationals from all over the world.

There was a cynical attempt to perpetuate the misery of the Palestinians in refugee camps. Hopefully, with the President's vision, we will now see an end to this long, painful, tragic, misery-filled process.

To embark on that road, we must see the end of terrorism. There is no road map unless terrorism ceases, and if it does, the road map, in fact, will be implemented.

I congratulate the President for having the vision of recognizing that two states can live side by side in peace, with mutual respect and prosperity, but only if terrorism ends.

Abu Mazen, the new Prime Minister, has repeatedly indicated his opposition to terrorism. We have to help him to put an end to terrorism. He must gain control of the territory in Gaza, first in the north, then in central Gaza, then in southern Gaza and then on the West Bank, town by town, and as he does so, we will move towards peace, and the Israeli and the Palestinian people at long last will live in a civilized region.

I urge all of my colleagues to vote for the resolution.

The SPEAKER pro tempore. The gentleman's time has expired.

Mr. RAHALL. Mr. Speaker, I yield myself such time as I may consume.

This has been a good debate, a very healthy debate. There is no doubt that security cooperation needs to be restored between the Palestinians and Israelis. It has worked in the past. The road map now is the way to do it. Several of the speakers today have risen in support of the road map, and they will support this resolution. I cannot even find the word "road map" mentioned in this resolution, and that is a major, major problem with it.

The economies of both Israelis and the Palestinians are in dire shape. There is no question about it, and this road map, for which I have already commended and continue to salute the President for presenting it, is the way out.

Confidence building measures by both sides, coupled with stability and economic development, must occur, and it will help bring back the necessary hope that both sides so desperately need and the trust in one another that is so lacking at the current time.

There are obligations of both parties under the road map. This resolution, unfortunately, points only to obligations of Palestinians and insinuates they are not fulfilling those obligations. There are obligations by the Israelis as well that are very clear. Yet they are not stated in this resolution.

We must give Prime Minister Abu Mazen, a good friend with whom I have met, the help he needs to fight terrorism and we must not allow civil war among Palestinians to occur. The road map is the way to do that. It will take time.

I salute President Bush for his personal involvement, for Secretary of State Powell's involvement, for Condoleezza Rice's involvement via her trip to the region any day now, and I salute our security people, the United States security people, our CIA and others that are on the scene in an effort to help the Palestinians restore security. That takes time. That takes patience and that takes an opportunity, that we must give and Israelis must give the Palestinians to create that security that is so vital to bring peace to this area.

I am not going to urge my colleagues to vote one way or another on this resolution. They can make up their own minds, but each colleague I would say has to look in his or her conscience and has to determine in their best opinion what is in the United States' best interests in promoting the road map to peace in the Middle East.

Mr. Speaker, I yield back my time.

The SPEAKER pro tempore. The gentleman from Iowa (Mr. LEACH) has 30 seconds left.

Mr. LEACH. Mr. Speaker, I yield myself the remaining time.

In conclusion, Mr. Speaker, this resolution is about two subjects—violence and peace.

On point one, the Congress cannot be equivocal in condemning terrorism. On point two, this resolution unequivocally commends the President for a vision of two states, Israel and Palestine, living side by side in peace and security.

This is the first President to assert legitimacy of a Palestinian state, and this resolution not only implicitly endorses the President's road map for peace but breaks affirmative ground in a congressional resolution on the Palestinian legitimacy issue.

Peace is the goal. Diplomacy, not violence, must be the means. On this basis, I urge this resolution's passage.

Ms. LEE. Mr. Speaker, I rise today in strong support of security for Israel and in utter condemnation of terrorism. I cannot, however, vote for a resolution that I believe fails to advance the Middle East peace process, and it undermines hope for the Roadmap.

On May 8, 2003, I wrote President Bush commending him for his efforts to help the parties find a way out of their ongoing tragedy. This letter read in part: "I wanted to take this opportunity to applaud your efforts to reinvigorate the Israeli-Palestinian peace process. The 'Roadmap to Peace,' presented by the Quartet to the Israeli Government and Palestinian Authority, represents a welcome and desperately needed opportunity to work toward a lasting two-state solution that offers the prospect for an ordinary peace between current adversaries and with that peace, the promise of stability for the region. Such a solution is very much in our own national interest as well."

I believe the principles laid out in the Roadmap, including its emphasis on reciprocity, must continue to guide us. Ending terror is imperative, and I absolutely agree with the sentiments in this resolution decrying terror and expressing sympathy for the loss of so many lives, Israeli and Palestinian, in this conflict. However, at this critical juncture, the resolution I wish that we were voting on was one that expressed those principles while at the same time voicing solidarity toward Israel by endorsing the Roadmap as our best chance to reach the much desired destination of peace and security. This resolution fails to reflect the reciprocity that is the hallmark of the Roadmap.

Mr. SHAYS. Mr. Speaker, I rise in support of the resolution.

The Aqaba Summit presented one of the most promising moments in years of conflict between Israelis and Palestinians. At that summit, Prime Minister Abbas pledged his commitment to a complete end to the violence and terrorism that has devastated the region. Prime Minister Abbas and Israeli Prime Minister Sharon also took the first bold step on the Roadmap to Peace by recognizing the right of one another to exist in peace.

Mr. Abbas and Sharon had just returned from Aqaba, however, when violence once again flared. There is no way the peace process can continue while terrorist organization such as Hamas continue to act with impunity in the West Bank and Gaza.

Prime Minister Abbas maintains that terror can only be stopped on moral and political grounds. He remains unwilling to use force to dismantle terrorist organizations. Under current circumstances, however, Mr. Abbas doesn't have the ability to forcefully dismantle such organizations. It is critically important that the United States, Europe, Russia, the United Nations and the Arab League renew their commitment to cut terrorism at its roots, and provide Mr. Abbas the support he needs.

International support means denying the flow of dollars to Hamas. I am a cosponsor of House Resolution 285, which urges the European Union to classify all of Hamas as a terrorist organization, and not just its military wing. I find it astonishing that a distinction would be made between the political and armed divisions of a terrorist organization.

The Arab League must also commit itself to peace in Israel by denying Yasser Arafat the funding and support he needs to maintain control over security forces in the Palestinian territories.

I continue to support an active U.S. role in the Middle East peace process because the suffering of people—destined to live on the same piece of land—is too great, and the stakes for them too high.

I support this resolution's condemnation of the recent terrorist violence that victimized innocent Israelis, as well as its expression of sympathy to the families of both Israelis and Palestinians who have lost their lives. I urge its adoption and thank the gentleman from California, Mr. LANTOS, for bringing it to the floor.

Mr. FARR. Mr. Speaker, I rise today in support of H. Res. 294, condemning the terrorism inflicted on Israel, expressing solidarity with the Israeli people, and calling on the Palestinian Authority to take immediate and effective steps to dismantle the terrorist infrastructure on the West Bank and Gaza. I also rise today to express my solidarity with all those who support the efforts towards peace between Israelis and Palestinians.

Mr. Speaker, I wish to associate myself with the comments of the gentlewoman from California, Representative CAPPS. I wish to echo her reservations about this bill. The introduction of this resolution should have provided us the opportunity to restate the United States' commitment to peace, and our commitment to the President's roadmap, which lays out responsibilities for both the Israelis and the Palestinians in the pursuit of peace. The roadmap, like any negotiated plan, is imperfect. But it is supported by the President, it is supported by Israel, it is supported by the Palestinian Authority. It is the best plan that we have right now.

Having said that, I am pleased that this resolution recognizes the plight of innocent Palestinians who have been caught in a cycle of terrorist attacks and government reprisals. It also recognizes the aspiration of Palestinians to create their own state, which will live in peace and prosperity with its neighbor Israel.

I look forward to working with my colleagues here in Congress, with the Administration and with the communities in the Middle East to foster a true and lasting peace in the Middle East. I believe that peace must be the ultimate goal of the United States policy towards the region. Peace is in the national interest of Israel, the future security of a Palestinian state, and in the national security interest of the American government and its people.

Mr. MATSUI. Mr. Speaker, I rise today in support of H. Res. 294. I am deeply saddened by the loss of lives at the hands of terrorists, and it is of great disappointment to me that the terror has escalated since the Aqaba summit. As the violence continues, even in the face of efforts by all sides to bring peace to the region, the United States must show nothing short of steadfast support for Israel as it continues to bear the entire burden of ending the violence.

The U.S. and Israel both agree that Prime Minister Abbas is the legitimate alternative to Yassir Arafat as leader of the Palestinian people. We welcome his statements acknowledging the need to stop terror both on moral and political grounds. However, the terrorist infrastructure is committed to the undermining of Prime Minister Abbas and the peace process.

Earlier this month, 22 innocent Israelis were killed and many others have been injured in continuous suicide bombings. Among the obligations in the roadmap is the responsibility of the Palestinians to stop all terror and violence against Israel. Merely negotiating a cease-fire with the terrorist groups is not sufficient. Terrorist groups can simply use this time to rearm and plan future attacks against innocent civilians. Militants must be arrested and arms collected to dismantle the terrorist infrastructure.

As long as Palestinian leaders do not aggressively go after the terrorist infrastructure, the Israeli government has the sole responsibility of protecting its citizens against further terrorist attacks. Israel has an obligation to safeguard its citizens and like every other sovereign nation, Israel has the same right to self-defense. If the Palestinian Authority does not act against terrorism, Israel must.

U.S. policy needs to be supportive of Israel in its fight against terror. Just as the U.S. has the right to send soldiers around the world to fight terrorists, Israel has the same right to fight terrorism in its own neighborhood and its own capitol.

The people of Israel are confronted with the grim realities of terrorism on a daily basis. Yet the darker reality is that were it not for the successful actions Israel takes in defense of its people, terrorism against them would increase tenfold. As Israel embarks on the difficult path to peace, it is essential that her efforts to quell acts of senseless terror have the full support of the United States.

Ms. WOOLSEY. Mr. Speaker, today the House will vote on H. Res. 294, a measure expressing solidarity with the people of Israel and condemning the terrorist attacks inflicted on them since the Aqaba Summit. The timing could not be any more ironic. Today as we consider this one-sided resolution on the Mideast, there are reports of a ceasefire taking hold that underlines the need for America to find a way to condemn violence in a way that does not favor one set of innocent victims over another. Unfortunately, this resolution does not meet this standard. Instead, this resolution, in its present form, will do more to take us away from peace than to bring us closer to an agreement that serves the needs and desires of all people in the Middle East.

That is not to say that I disagree with the text of this resolution: I condemn, in the strongest terms, all terrorist attacks against Israelis and remain committed to Israel's security and the well-being of Israeli citizens. Brutal attacks against civilians are always unacceptable and as a sovereign nation, Israel has the right to defend itself from these kinds of attacks. But, this resolution, which does not address the losses on both sides, sends the wrong message to Israelis, Palestinians, and the world community.

My concern is also that this resolution does not endorse the "roadmap" for peace, nor does it recognize the commitments and obligations that Israel must implement for the peace process to move forward. Furthermore,, it does not recognize the terrible pain and suffering that Israeli occupation and crackdown has caused in the disputed territories. We need to condemn Palestinian terrorists, but acknowledge the honorable goals of peace-loving Palestinians that want nothing more than a better life. This Congress should recognize the pain of every mother that has lost an innocent child because of violence in the Mideast, not only Israeli mothers.

Mr. Speaker I share the anger and sadness of my colleagues who have brought this resolution regarding the Mideast to the floor. But, I am convinced that this resolution will not advance the prospects for the lasting peace that we all want, which, is why I will vote against it.

Mr. PAUL. Mr. Speaker, I rise in opposition to this measure. Of course we all deplore terrorism and violence that any innocents are forced to suffer. There is, sadly, plenty of this in the world today. But there is more to this resolution than just condemning the violence in the Middle East. I have a problem with most resolutions like this because they have the appearance of taking one side or the other in a conflict that has nothing to do with the United States. Our responsibility is to the American people and to the Constitution, not to adjudicate age-old conflicts half-way around the world.

When we take sides in these far off conflicts, we serve to antagonize the people affected and end up no closer to peace than when we started. This bill makes reference to the need to have solidarity with Israel. Elsewhere people say we should have solidarity with the Palestinians and the Arabs. So, as I have said before when bills such as this are on the floor, it is sort of a contest: Should we be pro-Israel or pro-Arab, or anti-Israel or anti-Arab, and how are we perceived in doing this? It is pretty important.

But I still believe, through all these bills attempting to intervene in the Middle East, that there is a third option to this that we so often forget about. Why can we not be pro-American? What is in the best interests of the United States? We do not hear much talk of that, unfortunately.

As I keep saying when votes such as this come to the floor, the best foreign policy for the United States is noninterventionism. It is a policy that puts American interests first, costs must less money, and is in keeping with a long American tradition so eloquently described by our Founders.

I hope the peoples of the Middle East are able to resolve their differences, but because whether they decide or not is not our business I urge a no vote on this resolution.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, even though I agree in principle on the intent of the resolution, I believe it could have been drafted differently. I intend to vote "yes" on H. Res. 294.

All of us who support the Middle East peace process are aware of the fragile relationship between Israelis and Palestinians. I believe that future progress toward peace will require a real commitment on the part of Israel and the Palestinians, and the active participation of the United States.

Mr. Speaker, I strongly support Israel, but I also strongly support efforts to bring about peace in the region, which will allow the Israeli and Palestinian people to live together side by side without having to endure this type of violence.

All sides of this conflict have responsibilities. Israel must take tangible steps now to ease the suffering of Palestinians and to show respect for their dignity. As progress is made toward peace, Israel must stop settlement activity in the occupied territories. Arab nations must fight terror in all forms, and recognize and state the obvious once and for all: Israel has a right to exist as a Jewish state at peace with its neighbors.

There is no excuse for terrorist acts. I want to save the lives of Israelis, and I want to save the lives of Palestinians. Both are equally precious, both deserve to live in peace and security.

It is in that spirit, and with that faith, that I will continue to work with the Administration to ensure the United States remains firm in its commitment to the principles necessary to guarantee the success of the Arab-Israeli peace process.

Mr. CARDOZA. Mr. Speaker, I rise today in support of this resolution, which condemns recent terrorist attacks against Israel and expresses solidarity with the citizens of Israel during this turbulent time.

On June 24 of last year, President Bush unveiled a new vision for bringing peace to the Middle East. He stated that the Palestinians must develop a new leadership, which must be committed to peace with Israel and to destroying the terrorist infrastructure. Only then would the United States consider recognition of a Palestinian state.

Since that time, the Palestinians have taken steps to establish a new leadership structure. Abu Mazen was appointed the first Palestinian Prime Minister following a bitter struggle with Yasser Arafat. Since assuming office, Abu Mazen has refused, however, to take concrete steps to rein in the terrorists in any way. And despite the change in leadership, Yasser Arafat maintains a high degree of control, including authority over major elements of the Palestinian security apparatus.

And I am pleased to hear that, just this morning Hamas, Islamic Jihad and Al Asqa have agreed to a 3-month cessation of attacks against Israelis. That is a very positive step. But as we have seen many times before, the proof will be borne out over time. Also just this morning, the Israeli Defense Force disabled a large bomb in northern Israel. So clearly, the vigilance for peace and security will continue.

I believe the key to the "Road Map" or any other effort to achieve lasting peace is to stay true to the principles outlined by the President last June, particularly the necessity of combating terrorism as the first of a sequence of events.

Since the Aqaba summit earlier this month, 22 Israeli civilians have been killed and many others have been injured in three separate suicide bombings. Like every other sovereign nation, Israel has the right to self-defense. Israel must act against terrorism if the Palestinian Authority does not. As long as Palestinian leaders do not aggressively go after the terrorist infrastructure, the Israeli government has a responsibility to protect its citizens against further terrorist attacks. I believe U.S. policy must be supportive of Israel in its fight against terror until the Palestinian Authority is willing and able to assume this responsibility.

We must also wholly reject the concept of a "cycle of violence." Use of that term implies a moral equivalence between those who commit terrorist acts and their victims. Israel's targeting of terrorist leaders is not the moral equivalent of targeting of innocent civilians, including women and children.

Like my colleagues here this morning, I welcome the positive steps the Palestinians have taken, but we must also see decisive action to dismantle the terrorist infrastructure. Without such action, the Road Map or any other effort, however well intentioned, will fail.

The Palestinian people deserve a leadership that looks beyond the narrow goal of nationalism and works toward bettering the lives of its people. Regrettably, the current leadership has shown no signs of embracing those goals. As Americans, we understand the fight against those who seek our destruction. We stand shoulder to shoulder with Israel in their fight against those who oppose their existence.

The citizens of Israel are our allies, and we will continue to support their fight against terrorism and their government's efforts to provide safety and stability for its people.

Mrs. McCARTHY of New York. Mr. Speaker, as we are hearing all too frequently about continued violence in Israel, I rise in support of H. Con. Res. 294, expressing solidarity with Israel.

For me, terrorism has hit close to home on too many occasions. Just last Friday, Eugene and Lorraine Goldstein, an elderly couple from Plainview, which is on Long Island, were visiting their son in Israel. It was supposed to be a time of joy for the family, but became a matter of grief.

Eugene and Lorraine Goldstein, and their son and daughter-in-law were on their way to a wedding dinner for a grandson at the Holyland Hotel, and also celebrating their son and daughter-in-law's 27th wedding anniversary. The family was traveling along Route 60, a West Bank highway.

During the drive, the Goldstein's happy day was shattered by the bullets of terrorists. The Goldsteins were shot in an attack that the Palestinian group Hamas has admitted carrying out. Within minutes Eugene and Lorraine's son was dead, their daughter-in-law was injured, and they were severely wounded, taken to a Jerusalem hospital.

Eugene Goldstein is a watch salesman at the Fortunoff store in Westbury, also in my district. Fortunoff calls Eugene a "superstar with a big wave and a big grin," and their family, friends and neighbors know the Goldsteins as good people. The family is in great shock, just one more family with lives destroyed from terrorism. I am praying that the Goldsteins recover quickly and fully, and my condolences go to their family for their loss.

Today, Israel finds herself in an unbearable situation. Despite Israeli trust, Yasser Arafat has allowed terrorism to pervade Israeli society. Prime Minister "Ma-Mood" Abbas must keep his pledge for a "complete end to violence and terrorism." Until that happens, Israel has every right to enter Palestinian cities and refugee camps to root out terror. We cannot expect Israel to sit by and watch her country crumble, and her people be murdered in groups of 20 while they ride buses.

As a Member of Congress, I will support Israel's decisions regarding security and self-defense in any way possible.

Mr. STARK. Mr. Speaker, I rise to raise concerns with House Resolution 294, Condemning The Terrorism Inflicted On Israel And Expressing Solidarity With The Israeli People.

I am greatly troubled by the violence between Palestinians and Israelis over the last two weeks. It poses a great threat to the road map toward peace before it has had a chance to progress. I am outraged by extremists on both sides who continue to frustrate and delay the peace process. For the sake of the Israeli and Palestinian people, this process must be allowed to succeed.

While I join my colleagues in denouncing all acts of terrorism, this resolution unfairly places blame on one side in the ongoing cycle of violence between the Israelis and Palestinians. The United States should always act as a fair and impartial broker in the peace process. This resolution violates that responsibility.

Let me be clear. I condemn the recent bus bombings and other acts of terrorism carried out by Hamas just as I believe Israel must halt its policy of assassinations. The day after Israel attempted to kill a senior Hamas leader, a suicide bomber killed seventeen innocent people aboard a bus in Jerusalem. The cycle of violence being perpetuated by both sides must end, but this resolution does nothing constructive to further that goal.

It is only right that Congress call upon the new government of Prime Minister Abbas to take more effective measures in controlling Hamas and ending violence. But we should also ask the government of Prime Minister Sharon to do the same. We should sponsor impartial legislation supporting continued dialogue to end the violence in the Middle East—protecting the human rights of the innocent involved in the cross fire. We must balance our demands on both of these governments.

Both sides have crossed the line—it is time to get back to the negotiating table. We are not aiding this already volatile situation by giving our weighted support to one side in this conflict. For that reason, I must abstain on this resolution.

Mr. LEACH. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Iowa (Mr. LEACH) that the House suspend the rules and agree to the resolution, H. Res. 294.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

PROVIDING FOR CONSIDERATION H.R. 2417, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 295, and ask for its immediate consideration.

The Clerk read the resolution as follows:

H. RES. 295

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Permanent Select Committee on Intelligence. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute recommended by the Permanent Select Committee on Intelligence now printed in the bill. The committee amendment in the nature of a substitute shall be considered as read. All points of order against the committee amendment in the nature of a substitute are waived. No amendment to the committee amendment in the nature of a substitute shall be in order except those printed in the report of the Committee on Rules accompanying this resolution. Each amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. All points of order against such amendments are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the committee amendment in the nature of a substitute. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentleman from Florida (Mr. GOSS) is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the distinguished gentleman from Florida (Mr. HASTINGS), my colleague and friend, who I am happy to report sits on both the Committee on Rules and the Permanent Select Committee on Intelligence with me, pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purposes of debate only.

Mr. Speaker, the Committee on Rules has granted a modified open rule for H.R. 2417, the Intelligence Authorization Act for fiscal year 2004. This is the standard rule that we have used for many years for the consideration of the intelligence authorization. The rule is fair. It will allow ample time for consideration of all matters.

The rule provides for one hour of general debate equally divided between the chairman and ranking member of the Permanent Select Committee on Intelligence. Pro forma amendments listed in the report will be debatable under the 5-minute rule.

As in past rules for this legislation, amendments were required to be preprinted. This allowed for the vetting of amendments regarding classified matters, a procedure we have found to be a very good practice, helpful to both the committee and Members.

Finally, the rule provides one motion to recommit with or without instructions, as was announced.

Mr. Speaker, as in past years, we thought it best to allow Members a good opportunity to review the bill and debate the issues that they feel are important, those particularly to our Nation's security at this time when national security is on our minds. Our classified annex and staff has been made available to any Member of Congress that was interested previously or is interested now in reviewing the underlying bill and reports.

□ 1600

H.R. 2417 is, in fact, must-do legislation because of the rules of the House. It authorizes appropriations for fiscal year 2004 intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System. In effect, what that is is the 15 agencies of the intelligence community.

In the nearly 2 years since the tragic terrorist attacks on September 11, the intelligence community continues to build its capabilities to combat new threats that are threats to our Nation's safety, the well-being of Americans at home and abroad. The bill authorizes resources to improve the analytical depth and capacity in all areas of intelligence, an area that has been in crying need. This will allow us to process and disseminate the information collected in a more efficient, hopefully wiser and more timely fashion, and make sure all interested parties have access.

In addition, this legislation continues the sustained effort and long-term strategy to enhance human intelligence, an area that is vital to our current war on terrorism and is essentially the core business of intelligence, plans, and intentions of the enemy. H.R. 2417 helps to improve information sharing among Federal, State, and local governments. This is an area and a desire where we have overlapping interests with other committees in the House. This bill also provides including increased training for State and local officials on how the intelligence community can support their counterterrorism efforts, again, a matter of some overlapping interest.

Mr. Speaker, these are only a few highlights from the bill that passed the Permanent Select Committee on Intelligence unanimously, in the true bipartisan fashion we like to operate our House Permanent Select Committee on. I am sure a whole breadth of topics will be discussed during our general debate; and I think that we have, in this modified open rule, provided ample opportunity for all matters to come to the floor.

I noted today in earlier debate that there was focus on one issue that was not necessarily the subject that was under debate, and that was the intelligence assessments of Iraq's weapons of mass destruction. Obviously, this is a topic currently under review by the House Permanent Select Committee on Intelligence, and I would like all Members and all interested listeners to understand that we have been conducting a review on the House Permanent Select Committee to discharge properly our oversight responsibilities. We have been using the tools of oversight that are available to us. I think they are adequate, and I think they are being well used. I think we are using them in a thorough and in a nonpartisan manner. And, in fact, the ranking member, the gentlewoman from California (Ms. HARMAN), and I have taken extra steps to detail how this review will be conducted and have actually issued a public statement on that.

I think it is worth rehashing what that statement says: committee hearings, closed and open, as appropriate, that will permit Members to question senior administration officials about the prewar intelligence on Iraq's weapons of mass destruction holdings and programs, and its links to terrorism, to include questions relating to the sufficiency of intelligence collection and analytical coverage on these targets.

Granting accesses to any Member of the House who wishes, under appropriate security provisions and House rules, to review the documentation provided to the Committee by the Director of Central Intelligence in response to a May 22 letter from the gentlewoman from California (Ms. HARMAN) and myself to provide information. And I am happy to report we are getting full cooperation from the Director of Central Intelligence on that.

Staff interviews of intelligence community personnel involved in drafting intelligence community analyses of Iraq's weapons of mass destruction holdings and programs and Iraqi links to terrorism.

Regular committee updates and status reports on current efforts to locate Iraq's weapons of mass destruction, which, after all, is a priority, including actions of the Iraq Survey Group and other government agencies employed in that task.

And a written report suitable to the results of the committee's review, including an unclassified summary as promptly as is possible.

In fact, I would say, Mr. Speaker, the committee has taken a very important additional step in its review. We have voted to allow access to the 19 volumes that we now have on hand of information provided by the Director of Central Intelligence outlining American intelligence analysis on Iraq and the sources that supported it. I do not believe we have ever done anything that specific before.

To those who believe that the Permanent Select Committee on Intelligence is not doing its job or that we are incapable of doing our job, they can come and literally read over our shoulder. I think that the committee is doing its job, and I am very proud of its members and its staff and the way it works; and I am very thankful that I have a ranking member who is anxious to preserve the nonpartisan approach that we take to the Nation's important security business.

Those who have questions about the competence of myself, my ranking member, or any of the other members on the Permanent Select Committee on Intelligence are welcome to express that today in a vote of no confidence; but I would urge that they not do that. We are doing our very best, and if you would like to come upstairs and help us try to do it better, we would welcome your presence.

Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I first want to thank my good friend, the gentleman from Florida (Mr. GOSS), the distinguished chairman of the Permanent Select Committee on Intelligence, for yielding me the time, and I yield myself such time as I may consume.

Mr. Speaker, I would like to first point to the extraordinary leadership of the gentleman from Florida (Mr. GOSS) and the ranking member, the gentlewoman from California (Ms. HARMAN), and the bipartisan spirit of the unanimous consent of the entire Permanent Select Committee on Intelligence in support of H.R. 2417. I rise in support of the rule providing for the consideration of that measure. It is the Intelligence Authorization Act for fiscal year 2004. This is a modified open rule, and I believe that it is adequate for a bill that is relatively noncontroversial and was reported from the Permanent Select Committee on Intelligence by unanimous vote, as I just said.

I would like to reiterate a part of what the gentleman from Florida (Mr. GOSS) has said and state to Members who wish to do so that they can go to the committee's office to examine the classified schedule of authorizations for the National Intelligence Program. This schedule includes the CIA, as well as the Foreign Intelligence and Counterintelligence programs within the Department of Defense, the National Security Agency, the FBI, and the Departments of State, Treasury, and Imaging.

Also included in the classified documents are the authorizations for the Tactical Intelligence and related activities and the Joint Military Intelligence program of the Department of Defense.

Mr. Speaker, the Intelligence Authorization Act we consider today will provide authorizations for some of the most important national security programs in this country. This bill is the result of the committee's ongoing oversight of the intelligence community and oversight responsibilities, which include hundreds of hearings, briefings, and site visits annually.

We are well aware that the global war on terrorism has focused even greater attention on the intelligence community and its mission. The men and women who serve in this community have faced many challenges in the past 21 months and, in my judgment, have responded admirably. This bill assists them in these many challenges. It fully supports the intelligence community's efforts in the war on terrorism by providing funds for analysis, analytic tools, and a unified overhead imagery architecture.

Overall, the committee found the intelligence community is making progress in many areas, but noted that there is currently no one office in the executive branch that is charged with coordinating all elements of the intelligence and law enforcement communities to ensure they cooperate and coordinate their efforts.

The committee also called on the Director of Central Intelligence to improve diversity in the workplace and special attention on recruitment initiatives for women and minorities. I would be terribly remiss right here if I did not mention two former members, one still alive and one who is deceased: former member Louis Stokes from Ohio, and our dear departed friend Julian Dixon, from California, both of whom spearheaded efforts to ensure greater diversity in the intelligence community.

I hasten to urge that the chairman of this committee, and the now leader of the Democratic Caucus, the gentlewoman from California (Ms. PELOSI), and certainly the gentlewoman from California (Ms. HARMAN), the gentlewoman from California (Ms. ESHOO), the gentleman from Texas (Mr. REYES), and the gentleman from Georgia (Mr. BISHOP), who served on the committee previously, have all been vigorous in their assertions that the intelligence community must do more in the area of diversity. So I will be introducing an amendment that I believe will assist the director in attaining the goals in this critical area.

I do urge my colleagues to support this rule and the bill; and before reserving the balance of my time, I take a point of personal privilege to thank the fine staff of the majority and the minority for the rather extraordinary work that it takes in putting this measure together, and the many measures that come across their desks on a given day, including putting up with some of us as Members and our requests. I urge my colleagues to support the rule.

Mr. Speaker, I reserve the balance of my time.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume, and I wish to thank the gentleman for his kind remarks. I also associate myself with his remarks about Lou Stokes and Julian Dixon, as well as the efforts of the gentlewoman from California (Ms. PELOSI), when she was ranking member in the committee, to deal with the diversity issue. It is critically important. And as the gentleman from Florida knows, I am prepared to accept his amendment at the appropriate time and pleased to have his leadership.

I would also point out that I believe the gentleman from Texas (Mr. REYES) has shown another element that has improved our bill that we approved and were able to bring to the floor in our mark. So that is an area that has received attention because it needed attention, and I am entirely satisfied that we are taking good steps.

I would also point out for other Members that we had a number of amendments requested. I do not think any were particularly controversial as to the bill itself. We have this year, because we are dealing with standing up the Department of Homeland Security, some questions about where we plug in the intelligence piece from our foreign intelligence community, which is a very big piece, into the homeland security apparatus. The gentlewoman from California (Ms. HARMAN) has been a leader on that and done excellent work and is working with the gentleman from California (Mr. COX) and the gentleman from Texas (Mr. TURNER), the chairman and ranking member of the Select Committee on Homeland Security.

We also, obviously, are working closely in some other areas that are a little new for us with the gentleman from Ohio (Mr. OXLEY), the chairman of the Committee on Commerce, because of some questions about how we deal with some of the Treasury aspects, and, additionally, how we deal with some of the judicial aspects as we respond to the challenge in this country of preventive enforcement for people who would take advantage of our hospitality here and do mischief. And regrettably, we do get the reports regularly that there are still some of those folks in our midst. So we are going to be working in that area.

Not all of that is going to come to a final conclusion today. We are going to go from here, from our authorization bill, to a conference process. I expect there will be progress made in some of these areas where there is some apparent overlap between now and conference time, and certainly everybody is going to be assured that this committee is interested only in the portfolio of intelligence. That is what we do, the Foreign Intelligence Program. The other committees of standing that have jurisdictional areas that are associated we will work with closely and on a friendly and nonterritorial basis. I wish to assure them all of that.

We had, I understand, some amendments that came in late and we had one amendment that was not germane; but otherwise, I understand that the Committee on Rules made six amendments in order. Five were Democratic amendments, one was a Republican amendment; and I believe that the Committee on Rules responded very fairly. I see no reason to oppose this rule and every reason to support it.

Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 3 minutes to the distinguished gentlewoman from California (Ms. HARMAN), the ranking member of the Permanent Select Committee on Intelligence.

Ms. HARMAN. Mr. Speaker, I thank the gentleman for yielding me this time, and I would state that I do not intend to use all the time. I will spend the first part of the debate on H.R. 2417 sharing my views about our bill and several other issues of enormous interest to the public.

Mr. Speaker, I rise in support of this rule and of the underlying bill, H.R. 2417. It is interesting and wonderful that both managers of this rule also ably serve on the Permanent Select Committee on Intelligence. The gentleman from Florida (Mr. GOSS) is our bipartisan and collaborative chairman, and the gentleman from Florida (Mr. HASTINGS) is a senior member on the Democratic side. Both have contributed enormously to this rule and, obviously, enormously to the product we will soon debate.

□ 1615

Under this rule, as has been explained, amendments will be considered under the 5-minute rule and thus debate on all amendments that were filed with the Rules Committee, germane and did not require waivers will be in order. I am certain we will have a spirited debate on several of those amendments, and I think that is exactly what we should be doing in the people's House. In that vein, I will conclude, and I look forward to a spirited debate in a few minutes.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 2½ minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I, too, wish to comment and respond that all of us know that individuals who accept the responsibility of the Permanent Select Committee on Intelligence go to it with nothing but good intentions and a desire to provide the greatest service to this Nation, so I appreciate very much the leadership of the gentleman from Florida (Mr. GOSS) and our ranking member, the gentlewoman from California (Ms. HARMAN). They have been unique in the shadow of the controversy of the Iraqi war to have come together on the question of weapons of mass destruction. I look forward to their work. They have come to this floor to indicate the opportunity for Members to review thousands of documents.

Mr. Speaker, I will continue to pursue my position, and that is that there should be an independent commission designed to investigate the issues dealing with the weapons of mass destruction. But in light of their bipartisan effort, I wrote an amendment that indicated subsequent to the completion of their work, 6 months subsequent to that, that we would have the opportunity to design a commission that would then be able to address the questions again, and that is an independent commission separate and apart from this body and as well, of course, the executive and legislative bodies.

I believe the intent was respectful of the Permanent Select Committee on Intelligence. I am disappointed that the amendment was not allowed to be admitted on the basis of waiving the points of order, but I will continue to insist that this is the appropriate process to proceed under.

It is not a question of whether or not we find weapons of mass destruction or not. It is not a question of whether we are in a battle over the truth. All we need is the truth, the finding of weapons of mass destruction or not. Many made the decision to vote for the war because we were told that we were about to be under imminent attack. I think the American people are owed the ultimate determination how that decision was made.

My other amendment had to do with providing local law enforcement assess to intelligence as needed and to get security clearances faster than they have been able to do so in the past. I hope we will be able to work together to ensure that happens so all of us who have local officials who need the information to perform their duties appropriately can assess this important intelligence to serve our communities. I look forward to this bill moving through the House, and working on these important issues.

Mr. Speaker, I rise in opposition to the Rule governing floor debate on H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004. I oppose this modified open Rule because it fails to make in order several amendments that improve this legislation and benefit the public.

I proposed two amendments to H.R. 2417 that were not made in order. The first amendment called for the establishment of a "National Commission on Weapons of Mass Destruction in Iraq." This Commission was to be responsible for reviewing and assessing the administration's knowledge of the status of and threats posed by Iraq's weapons of mass destruction program before America went to war. The need for and the benefits of this Commission are obvious. The administration declared war, without a declaration of war by the Congress, based upon the claim that Saddam Hussein possessed weapons of mass destruction and that the United States was in immediate danger of being attacked by the Iraqi regime. Over the several weeks of Operation Iraqi Freedom, dozens of American and British soldiers lost their lives and many more suffered grave injuries. I had the honor of personally meeting many of our valiant, injured troops on visits to Bethesda Medical Facility and Walter Reed Army Hospital. Their courage and sacrifice was overwhelming.

For many Americans, myself included, questions remain whether the deaths and injuries suffered by young Americans in Operation Iraqi Freedom were justified. To date, we have discovered no evidence of weapons of mass destruction in Iraq. Many Americans are left wondering if the justifications for waging war proffered by the administration were legitimate. That is why I proposed an amendment to H.R. 2417 calling for the establishment of a National Commission on Weapons of Mass Destruction in Iraq. We must study the intelligence available to the administration when war with Iraq was commenced. Was Saddam Hussein producing weapons of mass destruction? Was the Iraqi regime capable of producing weapons of mass destruction? Did the Iraqi regime conceal their weapons of mass destruction after Operation Iraqi Freedom began? These questions, and many more, need answers. The Commission established under my amendment would have provided those answers.

I support the amendment offered by my colleague from California, the Honorable BARBARA LEE. Her amendment calls for a General Accounting Office report on the degree to which U.S. intelligence services shared information about weapons of mass destruction sites with the United Nations inspections teams searching for those weapons in Iraq. Ms. LEE's timely and important Amendment will provide many of the answers the American public seeks.

I also proposed an amendment to H.R. 2417 to expand the security clearance for law enforcement agents, specified by State executives, so that classified and vital information related to homeland security can be shared. This amendment was also not made in order, but is vital to preparing or local communities to wage the war on terrorism. Protecting our homeland will be conducted by local law enforcement agencies and small communities across the country. It is vital for valuable, often classified information related to homeland security to be accessible to local law enforcement agents. My amendment would have expanded the security clearance for designated State and local officials and given them the ability to receive vital information.

Mr. Speaker, I reiterate my opposition to this Rule. The Rule is too narrowly drafted and fails to make in order several valuable amendments offered by myself and my colleagues. I urge my colleagues to join me in opposing the narrowly-tailored Rule and in support of the amendment to H.R. 2417 offered by my colleague Ms. BARBARA LEE.

Mr. HASTINGS of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just wish to respond to my colleague by inviting the gentlewoman from Texas (Ms. JACKSON-LEE) to come upstairs, as all Members are permitted, and see the material being worked on by the Permanent Select Committee on Intelligence and to read the mission of the committee in that regard. I think all Members would find that substantial work is being done, and I believe all Members of this body would be very proud of the efforts put forward by Permanent Select Committee on Intelligence in investigating the continuing concern that all of us in this body have, and I dare say the members of the Permanent Select Committee on Intelligence are probably more directly concerned in light of the fact that we are there on a day-to-day basis.

Mr. Speaker, I yield 3 minutes to the gentlewoman from California (Mrs. TAUSCHER).

Mrs. TAUSCHER. Mr. Speaker, I rise to oppose the rule for the Intelligence Authorization Act for fiscal year 2004. I commend the gentleman from Florida (Mr. GOSS) and the ranking member, the gentlewoman from California (Ms. HARMAN), who are doing valuable work by looking into the intelligence surrounding Operation Iraqi Freedom.

By necessity and design, their work is classified. I feel strongly that their work must continue, but that this issue is beyond the scope of a single committee and is of such importance to our democracy that responsible public hearings by a select committee of users of intelligence are necessary. Members of relevant committees such as the Committee on Armed Services and the Committee on International Relations, who use intelligence to make policy decisions every day, provide valuable perspective that should be part of a broader review.

As a member of the Committee on Armed Services, I am a user of intelligence, and the information I receive shapes the decisions I make for many men and women in uniform every day. Members of Congress and military planners need to have confidence that intelligence is objective and provides a sound basis for policy decisions.

No decision is more grave than sending American fighting men and women into harm's way. We have a duty to be certain that public policy that we base these decisions on is credible and real. With American and British soldiers continuing to be killed at an alarming rate in Iraq, we have to be sure that our intelligence is providing a realistic view of the threats they have.

Having open hearings by a select committee of policymakers who are customers of intelligence would not only allow Congress to reclaim its vital oversight role, but help convince the American people that their elected officials and President have the right tools to make the right decisions to protect them.

Mr. Speaker, this is not about the purview of the Permanent Select Committee on Intelligence. I deeply respect the work that the Permanent Select Committee on Intelligence does, but with all due respect, as a customer of that intelligence, the classified work that the committee does needs to remain classified, but after that work is declassified and moves to the National Security Agency, to the Pentagon, to the military planners, to the differing alphabet soups of agencies, who then take that classified work and begin to shape public policy with it, once that work becomes declassified and is starting to be moved into the public policy realm, I and others in relevant committees, like the Committee on Armed Services and the Committee on International Relations, need to understand what exactly is being done to that intelligence to either promote it or shape it to perhaps fit a preconceived decision by people in the administration or in other parts of the policy-making chain.

I want to know if the intelligence work that is being done so ably by our intelligence people and the analysis done by them has been shaped in any way that would change my mind when I make these decisions. That is why I think we need a select committee. I urge my colleagues to vote no on the rule, but I support the work of the Permanent Select Committee on Intelligence.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. HARMAN), the ranking member.

Ms. HARMAN. Mr. Speaker, I would just point out to the gentlewoman from California (Mrs. TAUSCHER) that our committee is one of the users of intelligence. We are part of this community that uses intelligence information; and so it seems to me her point is right, and we are, therefore, the right committee to be assessing these questions and issues..

Second, we have already agreed on a bipartisan basis to hold public hearings as appropriate, and the subject and timing of our first hearing is under active discussion right now. I am hopeful it will be held in July. I certainly agree that the public needs to know about some of these questions. We will discuss them in more detail in a moment. I do commend her for raising this issue. We are trying to address it responsibly in the Permanent Select Committee on Intelligence. If we should fail, then it would be timely to set up a different committee, or a commission, or use another mechanism.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, we are in a very curious position in Congress today. We standing here debating a critical bill to provide funding for our intelligence services while we ask whether those intelligence services might have suffered a massive failure in assessing Iraq's weapons of mass destruction program.

I use the word "might" very deliberately because we do not know whether there was an intelligence failure. That is why we need an investigation, and I commend my colleague from California for pushing for an investigation within the committee because not only the public deserves to know, but we deserve to know equally.

I am puzzled by many of my colleagues' lack of curiosity on this issue. The question of where Iraq's biological, chemical and nuclear weapons now may be is critical to the security of our Nation, and yet more than 90 days after the fall of Saddam Hussein, we have still not located one chemical weapon, biological weapon, or even their precursors production facilities or delivery systems.

We went to war because of the imminent threat those weapons posed. We need to find those weapons if they are there; and if they are not there, we need to ask the question what caused this massive intelligence failure that was presented to Congress as an imminent threat to our national security? Our soldiers in Iraq are still engaged in combat operations. Saddam Hussein may still be out there, Osama bin Laden and al Qaeda are still on the loose, and we need to ensure through our Permanent Select Committee on Intelligence that we have solid information as we move forward.

Congress has to exercise its powers of oversight openly and honestly and look into these in a thorough way. That is what our constituents deserve. That is what the American people deserve. I look forward to working with the committee to make sure this happens in a timely fashion.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. HOLT), a distinguished member of the Permanent Select Committee on Intelligence.

Mr. HOLT. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, although I think this should be a totally open rule, as has been the tradition for dealing with this bill each year, I do think that the House should understand that the bill that is being brought to the House today is not controversial in the sense that it was agreed to unanimously within the committee. I would add to the remarks of my friend from Florida that this is, once again, a truly nonpartisan and bipartisan effort. It is appropriate that the Permanent Select Committee on Intelligence should operate that way, both as the committee that provides oversight for intelligence activities and a committee that is, as the gentlewoman from California (Ms. HARMAN) points out, a consumer of intelligence product.

No doubt there will be a great deal of controversy to follow, a great deal of political discussion to follow in coming weeks and months about the intelligence that led up to the fighting and into the fighting in Iraq. In fact, I think this will be very good for the committee because it is an excellent case study of what intelligence should be, what intelligence should not be, how it can be used, and how it can be misused. I applaud the decision of the chairman and the ranking member to investigate the disturbing matter thoroughly, and I have no doubt that we will be able to investigate it thoroughly.

□ 1630

I applaud their decision to allow Members of the House to read the large volume of material that the Director of Central Intelligence has provided to the Congress. And our committee intends to issue a written report on its findings as promptly as possible.

We have only begun to examine in detail the testimony, the statements, the published intelligence relating to Iraq's weapons programs and terrorist associations. It is early in our investigation, too early in the military's search within Iraq itself to come to any definitive conclusions or explanations of our failure so far to substantiate the prewar claims and expectations of what we would find there. But I have no doubt that the House will be satisfied with the thorough and critical look that the committee will take in this issue.

There is no question that there is a lot of ambiguous information to search through. There is no doubt that there have been some exaggerated claims at least, and lives and deaths have hung on these things. We must take a thorough look at it. We will and I think the Members of the House will be satisfied with that look.

Mr. HASTINGS of Florida. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

I just wanted to add one bit of remark with regard to some of the comment we have just heard which I thought was very helpful. We understand very clearly and the Intelligence Community understands very clearly that finding the weapons of mass destruction or what happened to them or whether there was faulty intelligence is a critical issue and that is indeed ongoing. As the gentleman from New Jersey just said, we are early in the game and we have literally thousands of pages for our staff and Members to work through.

There is one thing that has not been said very clearly yet that does need to be said. I think we all share the desire to make as much of this known as possible to the public. We want the public to understand how good intelligence is and how good it is not. Frankly, I want to do everything I can to make the American people aware as well as people overseas who might be watching what we have to say here, whether they are our friends or our enemies, that our intelligence is indeed formidable and when in fact we find a place where there is a gap in it, it will be repaired and fixed and that gap will no longer be there. I think that will be a comfort to everybody. That process is partially what this bill is about. But we are doing this as regard to the debate with the weapons of mass destruction in Iraq at a time when we desire transparency but we understand that transparency might include some people who are our enemies in the Iraq area where there is still a very dangerous and difficult operational climate as we are tragically reminded every day.

I would ask that we understand that this is not just a question of going back and reviewing material at our leisure trying to come to some Solomon decision about whether it was good or bad or where we can fix it. This is matching information that we had which was the best we had at the time as far as we know with what we are beginning to find as we are able to talk to people who are captured in Iraq and other areas who are terrorists or are associated with them, document exploitation, those types of things and match that up. This process is a process that the committee has taken on. We are not just doing the prewar analysis. We are doing the what is going on now and where is it going on a daily basis.

I hope Members can be assured, we will be in a continuous position to assess, both give a score card to the community and perhaps to come back to our colleagues here and say there are some other areas where we need to invest in the Intelligence Community because a small investment will yield a greater national security return before we are through. That is an ongoing process and charge of this committee and one we take seriously.

Mr. Speaker, I urge support of the rule.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. GOSS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on H.R. 2417 and on the rule that was just passed.

The SPEAKER pro tempore (Mr. UPTON). Is there objection to the request of the gentleman from Florida?

There was no objection.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore. Pursuant to House Resolution 295 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2417.

The Chair designates the gentleman from Georgia (Mr. ISAKSON) as Chairman of the Committee of the Whole, and requests the gentleman from California (Mr. OSE) to assume the chair temporarily.

□ 1635

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, with Mr. OSE (Chairman pro tempore) in the chair.

The Clerk read the title of the bill.

The CHAIRMAN pro tempore. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Florida (Mr. GOSS) and the gentlewoman from California (Ms. HARMAN) each will control 30 minutes.

The Chair recognizes the gentleman from Florida (Mr. GOSS).

Mr. GOSS. Mr. Chairman, I yield myself such time as I may consume.

I am very pleased to bring the Intelligence Authorization Act for Fiscal Year 2004 to the floor today. As always, this authorization is the culmination of both an intensive review of the intelligence budget request and the rigorous oversight of the Intelligence Community that the committee conducts on an ongoing basis. And I mean ongoing basis. That involves Members and staff here in Washington and elsewhere around the globe.

In putting together this legislation and schedule of authorizations, the committee must first answer the question, what is the state of America's Intelligence Community? Overall there have been some significant improvements since the low point we hit in the last decade, and I am pleased about that. I applaud the President for making needed investments in intelligence capabilities and his appreciation for intelligence as a vital element of the national security of our Nation.

I am pleased to say that our intelligence authorization comes very close to the number that the President has asked for. In dollar terms, we have basically come in at exactly the level of the President's request. Within that framework and building on the progress made to date, the committee has been able to accomplish quite a bit. Among other things, the bill before us provides full support for the Intelligence Community's efforts in the war on terrorism, job one. It postures the United States for the future with a unified overhead imagery intelligence architecture.

I just can put it this way. We have been well served by technology for a number of years. Technology gets old, just like the rest of us, and gets fragile. We need to be in a position to keep a robust architecture of the best technology available and this bill goes a long way to doing that.

This bill also makes needed investments in analysis and analytic tools. Anybody who has followed the progress of the 9/11 joint review done with our colleagues in the Senate and our committees have come to the conclusion that a big part of the problem lies in the coordination and making the whole analytical piece work better. We have focused rather extensively on that this year. It is not a new subject for us.

We also address counterintelligence concerns stemming from such celebrated cases tragically as the Hanssen case and the Montes espionage cases. These cases did do us damage and there are others that can as well. Counterintelligence becomes even more important because we understand counterintelligence may stop people from doing damaging things to Americans here at home.

In addition, the bill continues the committee's push for improved and aggressive human intelligence tools and capabilities. Human intelligence, spying, espionage, getting enemies' plans and intentions is the core business of intelligence.

On the homeland front, homeland security is very much part of our mission in the sense that we must authorize the establishment of some connection between our foreign intelligence and our domestic authorities who are dealing with the problems on the homeland. So we authorize the establishment of a pilot program to enable State and local authorities to gather terrorist threat related information and push it upward to the Federal level.

The Intelligence Community must be forward leaning on this. As we have discovered consistently through our oversight and through the joint inquiry into the events of September 11, the United States does not have the luxury to be complacent about its national security requirements. Risk aversion, inattention to detail, lack of investment in capabilities, these are not options that the American people are willing to accept and certainly the committee is not willing to accept.

Mr. Chairman, I am also pleased that H.R. 2417 continues the nonpartisan tradition of the House Permanent Select Committee on Intelligence of reaching consensus. This is entirely appropriate because partisanship has no place in a debate over America's security. None at all. This measure was reported out of the committee by a unanimous vote of 16–0. And I daresay, we did not start with a piece of paper that we all agreed on. We got to 16–0 by dealing with some things that we did not necessarily all agree on but we did it in a responsible and, I would say, adult way, understanding that the flag we work for is the flag of this country, not the flag for any other agenda.

I urge the House to support H.R. 2417. I will look forward to making comments on individual amendments as they come along.

Mr. Chairman, I reserve the balance of my time.

Ms. HARMAN. Mr. Chairman, I yield myself such time as I may consume and rise in support of H.R. 2417.

First, I want to thank the chairman of our committee for the way he runs the committee. His approach is constructive, collaborative and cooperative and shows a real willingness to work with every member of the committee. I have had the privilege of serving on the Permanent Select Committee on Intelligence for 6 years. Chairman GOSS has gracefully and competently chaired the committee since 1997 and my predecessors as ranking member during my service include the late and great Julian Dixon and our able leader the gentlewoman from California (Ms. PELOSI). The membership of our committee is truly talented, diverse and hardworking, and deeply committed to fulfilling its oversight duties and responsibilities to the House. By the way, Mr. Chairman, so is our staff. Committee members and staff worked closely together to craft a bill that provides new and better capabilities to fight the war on terrorism as well as address a range of global challenges. As we have just heard from our chairman, it is a good bill and it received the unanimous vote of our committee.

An excellent summary of the public portions of our bill has been presented by the chairman, so I will not repeat it. The committee made thorough but sensible decisions to focus resources on the highest priority intelligence collections programs and placed limitations on certain new programs until they are defined in more detail. The bill also supports the strategic vision of the committee for strengthening the Intelligence Community. It provides additional support for all-source analysis and encourages virtual reorganization for better information sharing and collaboration across the agencies.

Mr. Chairman, whatever the details of this intelligence authorization bill, we all know that it was developed at a time of heightened concern about the nature and quality of the intelligence that led to the decision to go to war in Iraq. I know that there are questions on both sides of the aisle about this intelligence, questions which our committee is already asking. While an independent commission or other mechanism might be needed at some later date, the members of our committee have now initiated an investigation and I would like to spend a few minutes discussing our effort.

As our colleagues know, I voted to authorize the use of military force against Iraq because I believed the intelligence case was compelling. The Intelligence Community judged that Iraq possessed weapons of mass destruction and the danger, in the President's words, was grave and gathering. The aftermath of the war has revealed just how brutal Saddam Hussein's regime was. The discovery of mass graves in Iraq and the gut-wrenching grief of families victimized by the regime speak for themselves.

To date, however, coalition forces have only uncovered two suspected Iraqi mobile biological warfare agent production plants. Coalition forces have yet to uncover chemical or biological weapons or further evidence of Iraqi links to terrorism. Where are Iraq's chemical and biological weapons? Why can't our forces find them? For our committee, these questions have loomed over the preparation of this authorization bill. It has been anything but business as usual.

On May 22, Chairman GOSS and I sent a letter to the Director of Central Intelligence, George Tenet, expressing the committee's interest in learning in detail how the intelligence picture regarding Iraq's WMD and ties to terrorism was developed. The chairman and I have also met twice with the Director on this subject. In response to our request, the Intelligence Community has provided 19 volumes of information on Iraq's WMD programs and ties to terrorism. On June 12, the chairman and I announced the bipartisan and unanimous commitment of our committee to a serious, focused, comprehensive review of the quality and objectivity of prewar intelligence. We announced that we would hold hearings, closed and open—open means public—to question senior administration and intelligence officials about the prewar intelligence on Iraq's WMD and its links to terrorism.

□ 1645

I think it is very important that the committee hold public hearings, and I have the gentleman from Florida's (Chairman GOSS) personal commitment that we will. I hope our first hearing will occur in July. Our committee also decided to produce a written, unclassified report as promptly as possible, and in addition we agreed to give all House Members access to the materials provided by the intelligence community in response to the committee's request, under appropriate security conditions and House rules.

Last week our committee held two hearings in connection with our investigation, one examining the October, 2002, National Intelligence Estimate on Iraq's weapons of mass destruction programs and the other on the current search for Iraq's weapons. While we are still at an early stage in this investigation, I want to comment on what we have reviewed so far.

First, past possession of WMD. We know that Iraq had chemical and biological weapons in the past. In the 1980s the Iraqi military used chemical weapons against Iran and the Kurds. In the 1990s Iraq admitted to U.N. weapons inspectors that it had produced over 8,400 liters of anthrax and 3.9 tons of the chemical warfare agent VX. Drawing on both direct and circumstantial evidence collected over many years, the intelligence community also concluded that Iraq had people, planning documents, and equipment to support WMD production.

Number two, hiding WMD. The agents that comprise weapons of mass destruction are exceedingly easy to hide, a point neither the administration nor the intelligence community made adequately clear before the war in Iraq. Five hundred metric tons of bulk chemical agents would fill a backyard swimming pool. Biological agents can be hidden in small vials in private residences. But it is not so easy to hide delivery vehicles like unmanned aerial drones, missiles, or munitions. That none of these other harder-to-hide items has been found is cause for real concern.

Number three, overstating the case. When discussing Iraq's WMD, administration officials rarely included the caveats and qualifiers attached to the intelligence community's judgments. Secretary of State Powell, for example, told the U.N. Security Council that "we know that Saddam Hussein is determined to keep his weapons of mass destruction . . ." On the eve of war, President Bush said, "Intelligence gathered by this and other governments leaves no doubt that the Iraq regime continues to possess and conceal some of the most lethal weapons ever devised." And on a March 30 Sunday news show, Defense Secretary Rumsfeld said that he knew where the WMD were located. Bogus information on Iraq's alleged nuclear connection to Niger was even included in the President's State of the Union Address. For many Americans, the administration's certainty gave the impression that there was even stronger intelligence about Iraq's possession of and intention to use WMD.

Number four, circumstantial evidence. The committee is now investigating whether the intelligence case on Iraq's WMD was based on circumstantial evidence rather than hard facts and whether the intelligence community made clear to the policymakers and Congress that most of its analytic judgments were based on things like aerial photographs and Iraqi defector interviews, not hard facts. This is an issue that we have to explore.

And, finally, number five, weak ties to al Qaeda. Iraq did have ties to terrorist groups, but the investigation suggests that the intelligence linking al Qaeda to Iraq, a prominent theme in the administration's statements prior to the war, contradictary contrary to what was claimed by the administration. Much remains to be investigated in this area.

Mr. Chairman, the highest priority of our committee, and I think of our Nation, remains finding and dismantling Iraq's WMD. It is counterintuitive to think that Iraq destroyed its weapons and did not report this to the United Nations. It is conceivable that Saddam destroyed them on the eve of or even after the start of the war once he recognized the futility of using them and the political advantage of keeping the United States from finding them; but the more likely scenario is that he buried or dispersed his weapons of mass destruction and that some may now be in the hands of terrorist groups outside of Iraq or counterinsurgents in Iraq who continue to harm and kill U.S. and British troops.

But even if Iraq's chemical and biological weapons are found tomorrow, and I hope they are, these issues warrant scrutiny by the Permanent Select Committee on Intelligence. It is already clear that there were flaws in U.S. intelligence. Iraq's WMD was not located where the intelligence community thought it might be. Chemical weapons were not used in the war despite the intelligence community's judgment that their use was likely. I urge this administration not to contemplate military action, especially preemptive action, in Iran, North Korea or Syria until these issues are cleared up. Certainly this Member would not support such action until these matters are cleared up.

As the committee moves forward with its investigation, we need also be mindful of the burden the intelligence agencies are carrying, not only in Iraq but also in the war on terrorism in other areas of the world. Our Nation is best served by an effective intelligence community, not one hobbled by risk aversion and finger-pointing. The committee's review must be based on facts, which I and others intend to follow unflinchingly wherever they may lead.

Our Nation needs a robust intelligence budget, which this authorization bill supports. At the same time, the committee's immediate priority is to resolve the questions regarding Iraq's weapons of mass destruction and ties to terrorist groups. If the answers dictate changes in the future intelligence budgets or policy, I am committed to bringing those recommendations forward. Meanwhile, this authorization bill deserves our strong support.

Mr. Chairman, I reserve the balance of my time.

Mr. GOSS. Mr. Chairman, I am very pleased that we are going to have a lot of Member participation in the general debate today.

Mr. Chairman, I yield 3 minutes to the gentleman from Nevada (Mr. GIBBONS), the chairman of the Human Intelligence, Analysis and Counterintelligence Subcommittee.

Mr. GIBBONS. Mr. Chairman, I rise in support of the intelligence authorization bill, and I thank the gentleman from Florida (Mr. GOSS) for yielding me this time.

This bill addresses vital intelligence needs, and may I say there is no greater need nor more important need, in my view, than the need for more and better human intelligence, also known as HUMINT. For America's intelligence community, fighting terrorism, as the chairman has said, is job one and rightly so. In order to learn the plans and intentions of America's terrorist enemies, which we must do to defend against another terrorist attack, we must improve the quality and quantity of intelligence from human sources. Technology certainly can help, but it has limited application. For instance, the overhead collection systems of the Cold War era continue to be a wonderful resource. However, they are not much good for tracking individual terrorists, and they certainly cannot get inside the heads of those individuals who are plotting to kill Americans. For that we must have HUMINT. HUMINT is the force multiplier.

As good as the information is that the National Security Agency collects, it is that much more powerful when HUMINT officers down on the ground locate individuals who can tell them just what those electronic signals mean while talking to them in their native language. This authorization bill recognizes this fact, and I am very proud of the significant bipartisan support given to our HUMINT capabilities by the community.

As I have said previously, throughout much of the 1990s there was a debate about whether America really needed to spend so much money on defense; and as for intelligence, some people even said there was no longer any need for the CIA. Mr. Chairman, that debate is long over. The task before us now is to continue to provide the necessary resources for HUMINT programs so that our policymakers can have a better, more detailed understanding of what the intelligence analysis means.

Unfortunately, the HUMINT programs of the CIA, America's premier HUMINT agency, were nearly starved to death during the mid-1990s; and with the help from the House Permanent Select Committee on Intelligence, the Congress, and now a supportive administration, those programs are being resuscitated and brought back to new life. But despite this renewed commitment, the CIA still has to surge to cover the world's hot spots. This needs to change, and this bill helps us get there.

The men and women of the CIA wherever they are found are doing a wonderful job; but they need encouragement, they need support from Congress, and they need the support of the American people. Our committee has again this year, under the leadership of the chairman and with the support of the ranking member, made the commitment to provide the resources to properly support these fine people to add to their numbers, to improve their foreign language skills, and to get them overseas where they are needed and needed badly. The support for the effort of these people must be sustained and a vote on H.R. 2417 is a perfect expression of that support. I urge my colleagues to support this bill.

Ms. HARMAN. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. REYES), a very valuable member of our committee.

Mr. REYES. Mr. Chairman, I thank the gentlewoman, ranking member, for yielding me this time.

I want to thank the chairman for his leadership, along with our ranking member, in presenting a bill that I think addresses many of the concerns that many Members of Congress have expressed to a number of us on the committee.

H.R. 2417 expresses, among other things, the committee's deep and longstanding concern about the lack of progress made by the intelligence community in diversifying its workforce, especially in the senior ranks and the core mission areas. In fiscal year 2002, the intelligence community had a smaller proportion of women and minorities than the Federal Government workforce and the civilian workforce at large. Women and minorities continue to be especially underrepresented in senior grades GS–13 through 15 and in Senior Intelligence and Executive Services positions.

This bill requires that the Director of Central Intelligence submit a report outlining the current diversity action plan including short- and long-term goals. This report should also include the DCI's plan for implementing diversity initiatives across the intelligence community and plans for measuring the progress made by the individual agencies in the intelligence community. The bill limits the use of a portion of the money authorized to be appropriated to the Community Management Account until such time as the

Director of Central Intelligence reports to this committee on his plan for implementing an effective and a meaningful diversity plan.

Diversity in the workforce is a corporate imperative. It is critical to defeating global threats and simply makes good business sense. Therefore, the committee will look to the Director of Central Intelligence and each intelligence community agency director to ensure that more is done to diversify the intelligence workforce. The DCI and agency heads are also urged to take diversity into account when selecting officers to fill the many senior management vacancies in the agencies across the intelligence community. It makes good business sense. Therefore, I strongly urge my colleagues to support H.R. 2417.

Mr. GOSS. Mr. Chairman, I yield 4½ minutes to the distinguished gentleman from Illinois (Mr. LAHOOD), who is the chairman of the Terrorism and Homeland Security Subcommittee who has done an extraordinary job on a very difficult subject.

Mr. LAHOOD. Mr. Chairman, I rise in support of H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004.

□ 1700

I want to pay my respects and admiration to both the chairman and the ranking member who I think are extraordinary public servants and do a great job for our committee.

As chair of the HPSCI's Subcommittee on Terrorism and Homeland Security, I am continuously impressed by the men and women of the Intelligence Community. Over the past year, we have witnessed significant success in the war on terrorism, to include the capture of a number of significant terrorist operatives around the world. The men and women of the Intelligence Community have worked tirelessly to deter, disrupt, and destroy terrorist capabilities wherever they threaten our interests, and they have performed remarkably in support of our successful military action in Iraq. Their ability to carry out their mission is due, at least in part, to the support provided by the Select Committee on Intelligence.

Under the leadership of the gentleman from Florida (Chairman GOSS) and the gentlewoman from California (Ms. HARMAN), this House has consistently supported providing more resources and better tools to the Intelligence Community. This support has only now begun to reverse the underinvestment suffered by the Intelligence Community in the last decade.

As we continue to face threats to U.S. interests at home and abroad, we must remain vigilant. We must ensure that the Intelligence Community has the personnel, the skill, the languages, and the resources necessary to work against such threats. The Intelligence Community must be prepared to confront the asymmetrical threat to the future.

Mr. Chairman, to this end, H.R. 2417 provides authorization funding for the counterterrorism activities of the Intelligence Community. It provides money and other resources to deepen all-source analytical capabilities. This is most important when confronting the terrorist target. It is through our analytical efforts that all the dots that get collected ultimately get connected.

This bill also provides funding for the Terrorist Threat Integration Center proposed by the President of the United States in his State of the Union address. The TTIC is a primary example of how well the Intelligence Community is marshalling its resources, encouraging efficiencies, and disseminating timely intelligence across government in defense of the American homeland.

The President deserves a great deal of credit for his vision. The Intelligence Community deserves credit for putting that vision into action.

H.R. 2417 also authorizes additional funding to specifically improve the sharing of terrorist threat-related information across all levels of government, Federal, State and local, and it is through the aggressive collection, analysis, and dissemination of threat information that the agencies and organizations of the Federal, State, and local governments, as well as the private sector, can best protect the homeland, prosecute the war on terrorism, and work together to keep America safe.

The counterterrorism elements of the Intelligence Community are at the forefront of this effort, and this bill is an investment in that effort, and I urge support of H.R. 2417.

I want to say a word about two other issues. Some of us have been briefed on the House floor by Secretary Rumsfeld. He stood in the well of this House and briefed many Members. On one occasion, when asked the question, how do we know when we have won the war, he said three things: regime change, which we have accomplished; a new regime, which is now being put in place; and finding the weapons of mass destruction. I have great faith that with two of those goals accomplished, the third goal will be accomplished. I have great faith, after a number of briefings from folks in the Intelligence Community, that the weapons of mass destruction will be found. And I think all Members should have that kind of reassurance from the Select Committee on Intelligence, based on reports that we have received, based on information we have been given by the Secretary of Defense that that will take place.

If I could say one other thing. I want to say this, Mr. Chairman: I think our committee probably has stepped over the bounds a little bit by saying to every Member of the House they can have all of this information. I think sharing this information is going to turn out to be a mistake. This is the greatest talking body in the whole world. People love to talk. Very few listen. And I am afraid that when 435 Members have access to the information we do, a select committee, an important committee, I am afraid of what is going to happen, particularly after what the New York Times had to say about a very important meeting that we had in the Select Committee on Intelligence, which is now out in the public. Nobody knows how it got out there, but I guarantee my colleagues, if we give 435 access, we got big problems.

Ms. HARMAN. Mr. Chairman, I would say to the gentleman, I have great faith that the WMD will be found too, and in the seriousness and responsibleness of the Members of the House.

Mr. Chairman, it is my pleasure to yield 2 minutes to the gentleman from Iowa (Mr. BOSWELL), who is ranking member of the Subcommittee on Human Intelligence, Analysis and Counterintelligence.

Mr. BOSWELL. Mr. Chairman, I thank the gentlewoman for yielding me this time, and I thank the gentleman from Florida (Mr. GOSS) for his hard work. He is truly a leader, and he treats us with fairness, and he has the best interests of our Nation in his heart, as well as the gentlewoman from California (Ms. HARMAN). I appreciate that very much.

I would associate myself with some of the remarks that the previous speaker just made concerning having some faith. We are two-thirds of the way there, and I think we have reason to believe we will get there.

Mr. Chairman, I rise in support of H.R. 2417. As the ranking member of the Subcommittee on Human Intelligence, Analysis and Counterintelligence, working with the gentleman from Nevada (Mr. GIBBONS), who I appreciate very much his hard work and efforts, we have observed firsthand the dedication and the professionalism of the men and women on the frontline collecting intelligence around the globe. Through their sacrifices and their heroic efforts, they have helped make our Nation more secure and have contributed greatly to our military success in Iraq and Afghanistan. I am pleased that this bill provides the tools essential to intelligence collectors to meet operational goals; in particular, those related to military operations, combating terrorism, and countering the proliferation of weapons of mass destruction.

My colleagues will also appreciate that in H.R. 2417, it also requires the Director of Central Intelligence to report back to the committee on lessons learned from the war in Iraq. Careful analysis of the strengths and weaknesses of our technical systems and processes will allow both the executive branch and Congress to make better resource allocation decisions in the future.

H.R. 2417 also stresses the need for improved strategic and all-source intelligence analysis, both key to U.S. policymaker understanding of the capabilities and the intentions of rogue nations and individuals posing threats to U.S. interests. The bill further authorizes additional billets for analysts, as we all know we have to have people to do jobs, and additional funds for information technology upgrades to help analysts more efficiently do their job.

Mr. Chairman, this is a good bill. I trust my colleagues will support it.

Mr. GOSS. Mr. Chairman, I am pleased to yield 2 minutes to the distinguished gentleman from Georgia (Mr. COLLINS), who is a new and valued member of our committee, and we welcome him.

Mr. COLLINS. Mr. Chairman, I too rise in strong support of H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004. It is a good bill with bipartisan support and, hopefully, it will be adopted, and I feel sure it will.

Since the September 11, 2001 terrorist attacks on our Nation, the Select Committee on Intelligence has noted the urgent need for better information-sharing between and among our various Intelligence Community's agencies, and Federal, State, and even local law enforcement are enjoying better shared intelligence. Since joining the committee earlier this year, I have observed the chairman, ranking member, and committee members, how they have advocated the implementation of new policies and technologies which are designed to facilitate the timely sharing of important information among our intelligence agencies and our local law enforcement.

Technical shortfalls in communications and collaboration systems, however, have undermined efforts to fully share information across the Intelligence Community. This bill makes an effort to correct those issues. These technical limitations can be overcome with proper management and capital investments. This bill provides significant funding to assist the Intelligence Community's leadership in developing and sharing useful information, management tools, capabilities, and operating systems throughout the Intelligence Community.

As important as technological solutions to information-sharing are the needs for updated policies to direct the flow of information. The community's leadership has not been sufficiently clear about its information-sharing policies with its various component agencies. As a result, information becomes irrelevant due to outdated directives or conflicting opinions about what information can or cannot be shared, and with whom. One of the key lessons learned by the committee's 9/11 inquiry last year was that a failure to communicate sensitive data on an urgent basis among intelligence law enforcement agencies can cost our Nation dearly.

The committee has taken steps to improve this situation with this important bill. It is a good piece of legislation, a strong piece of legislation. I encourage its passage and support it fully.

Ms. HARMAN. Mr. Chairman, I yield 2 minutes to the gentleman from Minnesota (Mr. PETERSON), a valued member of our committee.

Mr. PETERSON of Minnesota. Mr. Chairman, I thank the gentlewoman for yielding me this time.

Today I rise in support of H.R. 2417, the Intelligence Authorization Bill for Fiscal Year 2004. I want to commend the gentleman from Florida (Chairman GOSS) and the gentlewoman from California (Ms. HARMAN), our ranking member, for their leadership and the professional, bipartisan manner in which they conduct the business of the Committee on Intelligence.

H.R. 2417 includes authorizations for the CIA, as well as Foreign Intelligence and Counterintelligence Programs within the Departments of Defense, Justice, State, Treasury, Energy and the FBI. The bill addresses critical threats to our national security, but it also calls attention to particular areas of concern. Among those concerns is the connection between drug trafficking and terrorist activities.

The committee is concerned about the level of personnel and funding resources dedicated to combat transnational crimes such as drug trafficking, arms smuggling, and money laundering. As seen in both Colombia and Afghanistan, the activities of terrorist organizations are closely linked to the drug trade. These illicit activities feed upon and sustain each other. To defeat terrorist organizations, the Intelligence Community must understand the transnational organized crime that supports them. Therefore, the committee calls upon the administration to reinvigorate the strategy in this area.

In addition, the bill extends the authority granted last year to allow foreign intelligence funds dedicated for Colombia to be used in a unified campaign against drug trafficking and activities by groups designated as terrorist organizations.

Finally, the bill establishes an Assistant Secretary of Intelligence and Enforcement within the Department of Treasury to enhance the identification and targeting of illicit financial transactions. This office will also seek to improve the coordination and dissemination of intelligence products concerning drug trafficking, international crime, and terrorist activities.

Mr. Chairman, I urge my colleagues to support this measure.

Mr. GOSS. Mr. Chairman, I am very happy to yield 3 minutes to the gentleman from Nebraska (Mr. BEREUTER), the distinguished vice chairman of the committee.

Mr. BEREUTER. Mr. Chairman, I thank the chairman for yielding me this time. I rise in strong support of the legislation.

This Member would like to commend the exemplary bipartisan efforts of the chairman and the distinguished ranking member, the gentlewoman from California (Ms. HARMAN). Often when people in Washington talk about the need for bipartisanship, what they really mean is that the other side should agree with them. In the case of the Committee on Intelligence, however, there has been true bipartisanship and genuine cooperation towards the goal of serving the Nation's interest. Although this bipartisanship is a tradition on the Committee on Intelligence, it is commendably reinforced by the leadership style and the efforts of the gentleman from Florida (Chairman GOSS) and the gentlewoman from California (Ms. HARMAN).

Under the chairman's leadership, and in this bill, the legislative branch will be moving rapidly to address a number of long-standing concerns in our collection and analysis of intelligence. This Member would mention just a few.

First, it should be recognized that in the aftermath of the terrorist attack of September 11, President Bush declared war on terrorist financing. There is, however, no single office in the Federal government that is responsible for ensuring that all elements of law enforcement and intelligence share terrorist information in a timely fashion. As a result, our counterterrorist financing efforts to date have not been as effective as they could be. The committee concluded that the Department of the Treasury needs to be more effective in implementing its counterterrorist financing mission from an intelligence sharing perspective. By elevating the intelligence function within the Treasury Department, this bill ensures that the coordination and information sharing between the Treasury and the rest of the Intelligence Community can be more effective.

This Member recognizes that the assistance and the cooperation of the chairman of the Committee on Financial Services, the distinguished gentleman from Ohio (Mr. OXLEY), will be required to achieve this important policy change. The Select Committee on Intelligence will continue to work with him and his committee, on which this Member also serves, to ensure that we get this correct.

Mr. Chairman, secondly, it should be noted that Americans have become painfully aware of the threats to the homeland and the risk that terrorist cells and their support networks may be operating in the United States. Several suspected cells already have been cracked. Indeed, an individual has just been convicted last week of conducting surveillance operations for possible al Qaeda attacks. The presence of this new and very real threat has compelled the FBI to transform the way it conducts investigations.

□ 1715

No longer does the FBI solely pursue investigations in order to build criminal cases. Now they are also actively at work to disrupt and destroy terrorist cells before they launch attacks. This is nothing less than revolutionary in the way that the FBI does its business. It is a very necessary transformation that the Permanent Select Committee on Intelligence is following closely through careful oversight. We in the legislative branch are attempting to ensure that the information flow between the FBI and the intelligence community is done effectively, but also within the confines of the law.

The committee intends to continue aggressive oversight. I want to assure our colleagues of this evolving relationship between this intelligence and law enforcement.

Third, and finally, this Member would remind his colleagues of the enormity of the challenge now faced by the intelligence community. The war on terrorism has required an unprecedented commitment requiring timely, actionable intelligence on a truly global scale.

In addition, our intelligence services are devoting significant resources to the effort in Iraq, not only to identify and to apprehend the remaining elements of Saddam Hussein's regime but also to locate Saddam's weapons of mass destruction. More on that subject later.

Mr. Chairman, I thank the chairman for yielding me time.

Ms. HARMAN. Mr. Chairman, I yield 2 minutes to the gentleman from Alabama (Mr. CRAMER), the distinguished ranking member of our subcommittee on Technical and Tactical Intelligence, TNT, who became a grandfather for the second time yesterday.

Mr. CRAMER. Mr. Chairman, on behalf of my new granddaughter, Patricia Lanier, I would say it is my pleasure today to speak about a very important piece of legislation that our colleagues in this House will pass judgment on.

Mr. Chairman, I rise in support of H.R. 2417, the fiscal year 2004 intelligence authorization act. I am a fairly new member of this House Permanent Select Committee on Intelligence. It is a unique opportunity for Members of the House to serve on this select committee.

I came on to the committee at the time that the joint 9-11 hearings were taking place. And as I look around the room today and I observe my colleagues that participated in those joint sessions with the Senate, I want my other colleagues that are not on this committee to know how impressed I was with the leadership of this committee and our participation with the Senate as well.

I also want to take this opportunity to thank the staff who have been most kind and generous on both sides of the aisle to participate with us as we have gone through these very tough issues.

This is a good bill. It is a complicated bill. It is hard for some Members to understand. For example, traditionally, the executive branch, the Congress, the industry, we focus on expanding the capability of sensors. Sensors are used to take pictures, to intercept communications or to measure some special signature whether they are from satellites, whether they are from aircraft, or whether they are from ships. But the government has underinvested in abilities to task the collection systems properly and to exploit and disseminate the collection data once received.

For a number of years this subcommittee that I am on on this committee has worked to improve and rectify that imbalance. This year's bill accomplishes that and expands the concept as well. In years past, the committee has stressed the need for more investment and better management at the National Imagery and Mapping Agency and the National Security Agency to improve processing, exploitation and dissemination capabilities for imagery and signals intelligence. The committee sustained these initiatives in the current bill.

We also lay a foundation for applying information technology to solve problems revealed by the congressional investigation into the September 11 tragedy as well.

This is an important bill. I urge its support. I also want to point out that the missile in space intelligence command in my district is adequately covered by funding under this important piece of legislation.

Mr. GOSS. Mr. Chairman, I yield 5 minutes to the gentleman from New York (Mr. BOEHLERT), the distinguished chairman of the House Committee on Science.

Mr. BOEHLERT. Mr. Chairman, I rise in strong support of the intelligence authorization bill, and I want to start by commending the gentleman from Florida (Mr. GOSS) and the ranking member, the gentlewoman from California (Ms. HARMAN), for their leadership, their bipartisanship and their commitment. We are all in this together. And while I am at it, I want to compliment the most professional staff that I have seen of any committees in the Congress in my years in this institution.

As a member of the committee, I know well the threats facing our country. They are many. They are varied and they are serious. The job of intelligence is challenging and never ending. All of us, not just in the Congress but across the country, have become painfully aware that while many countries of the world are working with us to promote peace and stability, there are those who are committed to undermining our efforts. The Nation has been exposed to this ugly reality. The memory of September 11 will forevermore be seared on our souls.

Our collective awareness has increased as has our understanding of the absolute need for a very capable intelligence community. This bill accelerates investment in enhanced capabilities and people to move the intelligence community from being postured from the threats of the past to being positioned to address the increasingly asymmetric threats facing us in the future.

It will not happen overnight, but the changes needed must and will come about at a rapid pace. Rebuilding the infrastructure and retooling for the future is under way even as we debate this issue. Every area of intelligence operations needs support and attention. But I want to focus on what I believe is the most critical need we face, and that is in the area of human intelligence.

Mr. Chairman, the sad fact is that we, of necessity, need to reverse course from the years of decline in investments in the people that make up our cadre of human intelligence officials. This does not mean we should not continue to invest in important technical systems, but we must not become solely dependent on them. Satellites in the heavens and all the sophisticated and complex technologies here on Earth must be complemented by our eyes and ears around the globe. There must be a proper balance between people and machines.

We are proud of our intelligence professionals because of the outstanding work they perform day in and day out, so often putting their lives at risk. What they do and how they do it is not easy. And they have earned our gratitude for their dedication and professionalism.

One of the basic tools that these professionals need in order to do their job is the ability to speak foreign languages. Quite frankly, and this is sad to say, this is a deficient area. I am not at all happy, and I will confess it up front, about the response we have received from the intelligence community leadership on this issue, despite our continuing efforts to improve language skills. We set a clear priority to ensure that we have people with native language capabilities regardless of where we might find ourselves. Yet year after year we have provided an increase in the amount of funds requested for language training, and year after year something happens that is not our intent.

The response to our concerns has been unsatisfactory. Year after year the intelligence community finds ways to avoid implementing these initiatives which are essential to its success.

Mr. Chairman, this year we insist that the community leadership resolve to fix the language inadequacy. No more finessing, no more fudging. Just do it or else.

Our country's intelligence community is still recovering from years of decline. There are fundamental shortcomings that must be addressed, and we will fail in this challenge if we do not adequately restore the resources to a sufficient level to get the job done.

While this budget represents a significant increase over the past years, we support it with the full knowledge and understanding there is a great deal more work to be done. Language being only one of the issues, but this is an issue that we have to pay attention to. It does not do us any good to have some sophisticated satellite costing a jillion dollars up in the heavens taking pictures of Afghanistan, if in the caves there are all these people bent on doing us harm and there is nobody in there who can understand them, communicate with them, or provide us with necessary intelligence. And that is what we intend to correct, and I am proud to say the committee stands strong behind this commitment and we will follow through on it.

Ms. HARMAN. Mr. Chairman, I yield myself 15 seconds. The 15 seconds is to tell the prior speaker, our wonderful colleague, that I totally agree with him. As the representative from the district in America that probably makes most of our intelligence satellites and has fabulous technology, that is great; but we need more investment in human intelligence. And he is right.

Mr. Chairman, I yield 2½ minutes to the gentlewoman from California (Ms. ESHOO), a classmate and good friend, one of the rookies on our committee, but already the ranking member on the Subcommittee on Intelligence, Policy, and National Security.

Ms. ESHOO. Mr. Chairman, I thank our distinguished ranking member, the gentlewoman from California (Ms. HARMAN), and the chairman of our committee for their joint leadership and the standards that they set for us every day.

I respect and have high regard for the men and women of the intelligence community, and I really consider it a high privilege to have been appointed to serve on the Permanent Select Committee on Intelligence in the House. As a new member, I have valued meeting and learning from the many talented and patriotic individuals in our intelligence community; and I believe it is important for the foreign policy and the national security of the United States that our intelligence community be given the tools and the support they need and that their efforts be focused on important priorities. That is why we are on the floor today in support of this authorization act for fiscal year 2004.

I do have some concerns today that I would like to voice. I serve as the ranking member of the Subcommittee of the Intelligence Policy and National Security, as the ranking member just said. The role of the subcommittee is to examine how intelligence supports national security policy, ensuring that intelligence is focused on the right priorities and is as reliable as it can be and that it is used appropriately by senior policymakers in furthering U.S. foreign policy. Issues such as potentially politicized intelligence, potential exaggeration of intelligence and imprecise characterizations of intelligence are of significant concern to me in my role on this committee. So I am very concerned about the role intelligence played in the foreign policy debates about going to war in Iraq.

The answers must await a thorough accounting, and we cannot predetermine what those outcomes are. But I am concerned that the administration and the American people and the Members of this House relied too heavily on their interpretation of the threat facing this country, a threat that was described as imminent, as grave and growing without sufficient transparency into the intelligence picture underpinning the argument for war.

I think we are learning that a foreign policy based on preemption puts far too much pressure on the intelligence community to deliver certainty when it simply cannot. So the intelligence community must be given all that they need to protect our magnificent Nation.

Every administration deserves the best intelligence that they possibly can get. But we must assure the credibility of this for the American people and for the world community.

Mr. Chairman, I urge my colleagues to vote in favor of this authorization act. It is important for our country and the protection of our people.

Mr. GOSS. Mr. Chairman, I yield 3 minutes to the gentleman from California (Mr. CUNNINGHAM), the distinguished gentleman who is a very valued member of our committees and has helped us on a number of fronts.

Mr. CUNNINGHAM. Mr. Chairman, I would like to first thank not only the chairman, the gentleman from Florida (Mr. GOSS), but the ranking member, the gentlewoman from California (Ms. HARMAN).

Our committee is a bipartisan committee. The defense committee that I sit on is also, with the gentleman from Pennsylvania (Mr. MURTHA) and the gentleman from Washington (Mr. DICKS) and people like that; and it is really a pleasure to work on.

□ 1730

When there is a pressure put on the ranking member to force political gain on weapons of mass destruction, it is a sign of true leadership and bipartisanship to not do that and to work with the chairman to come about and perform a bill like this, and we should all be proud of that, the Members, and I want to personally thank the gentlewoman from California.

The weapons of mass destruction, we cannot say too much about them, but the chairman and the gentlewoman from California (Ms. HARMAN) also made something in order that has not been done before, and that is for every single Member to be able to look at the information. I am convinced that if anyone on this floor looks at that information, they only have one conclusion. There are weapons of mass destruction still there. If we take a vial this big, the size of an eye dropper and have two seeds in it and in 2 days a person can whip up a batch to kill every man, woman and child in New York City and then try and find that with deceit, a system that was designed to hide it on deceit or destroy it if people get close, and the one thing I can say is we were told there would be absolutely no way possible for Hans Blix and the U.N. to find such things, especially with Saddam Hussein still there trying to hide it. So that was a bogus issue.

I would also tell them that the committee does not just deal with terrorism, the war on drugs, local crime and the one thing that I could say before we ever did a pre-9/11 look was that we did not fund the folks enough. We need to change some laws.

The Phoenix report, we knew there were terrorists in Arizona, but our intelligence agencies were afraid to act because they would be sued because it would be racial profiling, and these guys put out papers supporting Osama bin Laden and al Qaeda, and we could not touch them under the first amendment and that is wrong. There is the same type of people there in Arizona today. One guy was so stupid he went to navigator school. He failed that. Do my colleagues know what he is in today? Airport security, and we cannot touch him.

So I think we need to go further and change some of our laws to protect American citizens, and I know there is a fine line in protecting rights and the other, but by golly, I know where I stand and I know where the committee stands, and I am proud of them.

Ms. HARMAN. Mr. Chairman, I thank the gentleman for his comments. We are all proud to serve on this committee. It is now my pleasure to yield 3 minutes to the gentleman from Maryland (Mr. RUPPERSBERGER), the rookie on the committee and a rookie in Congress, but he is no rookie to these issues.

Mr. RUPPERSBERGER. Mr. Chairman, I too want to acknowledge the leadership of the gentleman from Florida (Mr. GOSS), the chairman, and the gentlewoman from California (Ms. HARMAN), the ranking member. I have been in local politics for 18 years, and we have tremendous leadership on this committee, and I think all members of this committee put the Nation first.

I rise in support of H.R. 2417. The bill reflects the committee's support for the Intelligence Community and the men and women who serve in the intelligence agencies. Often unrecognized, these individuals have made great sacrifices to secure our homeland and to support the war in Iraq, the global war on terrorism and other important national priorities. I am proud to represent many of the men and women who work for the National Security Agency, NSA, in Fort Meade, Maryland, my Second Congressional District.

This bill addresses concerns for the health and well-being of NSA employees by providing additional funds to ensure a cleaner, healthier and better maintained workforce. It provides tort liability protection to NSA security officers so that they have legal protections similar to those provided other law enforcement officers.

The bill gives NSA the authority to provide living quarters to the bright and talented students participating in NASA's summer and cooperative educational programs.

It also encourages NASA to continue its acquisition reform initiatives and bring its processes in line with standard commercial and government practices. It increases funds available for the recapitalization and modernization of NASA's technical systems which will allow the Nation's Signals Intelligence Systems to keep pace with changing technology.

H.R. 2417 emphasizes the need for the Federal Government to improve information sharing with State and local governments. As the Baltimore County Executive, I was the county executive during 9/11, this is very important, and where appropriate, private companies.

To make this possible, the bill allows the Director of Central Intelligence to establish pilot projects to train State and local officials to increase the flow of information between them and Federal agencies. Advisory councils on privacy and civil liberties and State and local issues will help ensure the protection of individual rights, and the needs of State and local governments need to be properly addressed.

I am also pleased that this bill provides additional funding to the Armed Forces Medical Intelligence Center to enhance the analysis of health risks to our deployed forces.

Together, the enhancements provided for in H.R. 2417 will contribute to our Nation's efforts to prevent terrorism and to curb the proliferation of weapons of mass destruction around the globe. I urge my colleagues to support this bill.

Mr. GOSS. Mr. Chairman, I am pleased to yield 2 minutes to the gentleman from North Carolina (Mr. BURR), also a valuable member of our committee.

Mr. BURR. Mr. Chairman, I rise in strong support of H.R. 2417.

After terrorists struck on September 11, 2001, our government has been engaged in an aggressive prosecution of the global war on terrorism, a war that will be fought for years to come, I fear. Our efforts I have no doubt will be successful. To ensure success, however, we must prepare for the long road ahead of us. That is exactly what this bill does.

The men and women of Intelligence and Law Enforcement Communities have been instrumental in the numerous successes thus far. I thank them for their sacrifices, for their dedication. We are indebted to them for their tireless service.

In my view, the key to success in this war on terrorism is communication. We have to improve our communication across the Federal Government. We must improve and make seamless the flow of information within our Intelligence Community. It is essential to have good communication with our liaison partners, and better communication between Federal, State and local authorities and with the private sector must be ensured.

Without doubt, intelligence and law enforcement officers are our front line defenders in our daily battle against this evil. State and local authorities also stand at the forefront of this war. Success in safeguarding the homeland lies firmly in the ability to communicate effectively and share sensitive, timely and actionable information among Federal, State and local officials.

Mr. Chairman, H.R. 2417 is an important bill because it also specifically authorizes greater training and support to local and State authorities as it relates to preventing the possible use of weapons of mass destruction in the United States.

Additionally, H.R. 2417 authorizes funding to ensure greater participation of city, county and State law enforcement officials in joint terrorism task forces that are spread across this country.

Mr. Chairman, only with better communication and sharing necessary, relevant and actionable information with State and local authorities, can we best wage the best effort on the war on terrorism in our homeland.

I urge its passage.

Ms. HARMAN. Mr. Chairman, we have no further speakers except for me and I have some brief closing remarks. So I would yield if there are speakers over there and perhaps speak just before our chairman closes this debate.

Mr. GOSS. Mr. Chairman, I am pleased to advise the Chair to advise the gentlewoman that we have no further speakers except myself to make a few household and closing remarks.

Ms. HARMAN. Mr. Chairman, I yield myself such time as I may consume.

This debate has been friendly, collaborative, supportive, not just of each other but our staffs. It is clear that committee members are putting the country first in our service on the committee. I believe that our authorization bill is putting the country first in terms of the priorities it chooses, and I believe further, Mr. Chairman, that our investigation of the quality of intelligence supporting the war in Iraq is also putting the country first.

Our investigation has a long way to go but it is serious, collaborative, and bipartisan. We will do as much as possible in public, and we will report to the public on our findings.

Should we hit the wall and fail in our endeavor, then it may be time for a commission or an alternative committee or set of committees of Congress to take over. But meanwhile, I want to commend the Members of this committee who serve with great distinction, and I urge the passage of this authorization bill, H.R. 2417.

Mr. Chairman, I yield back the balance of my time.

Mr. GOSS. Mr. Chairman, how much time do I have?

The CHAIRMAN. The gentleman from Florida has 2 minutes remaining.

Mr. GOSS. Mr. Chairman, I yield myself the remaining time.

I would like to also announce that the gentleman from Michigan (Mr. HOEKSTRA), who is the chairman of our Subcommittee on Technical and Tactical Intelligence, and the gentleman from Alabama (Mr. EVERETT) and the gentleman from California (Mr. GALLEGLY) are other members of the committee who will probably join us later on and we are equally proud of them.

We obviously have an extraordinarily high level of group of members, as my colleagues have seen, on both sides of the aisle who take this business quite seriously, and we are very pleased about that.

I would like to include for the RECORD the administration policy and exchange of correspondence with the chairmen of the appropriate committees. That would be the gentleman from Ohio (Mr. OXLEY), the gentleman from Wisconsin (Mr. SENSENBRENNER), and the gentleman from California (Mr. HUNTER).

STATEMENT OF ADMINISTRATION POLICY

H.R. 2417—INTELLIGENCE AUTHORIZATION ACT FOR FY 2004

(This statement has been coordinated by OMB with the concerned agencies.)

The Administration appreciates the support of the Permanent Select Committee on Intelligence for the work and efforts of the Intelligence Community (IC), as well as the Committee's inclusion in its bill of a significant number of requested provisions. The

Administration would support H.R. 2417 if the concerns outlined below are addressed.

The Administration has not had the opportunity to review the classified schedule of authorizations, and reserves comment on those authorizations. The Administration would strenously object if certain high priority transformational development programs affecting the IC's future collection and research and development strategies, are not authorized as requested.

The Administration appreciates the Committee's support for our initiatives to improve our nation's intelligence capabilities, and believes that section 336, regarding improved information sharing among federal, State, and local government officials, addresses significant and important issues. However, the Administration has concerns with this and other sections of the bill (such as section 321) which seek to direct specific roles and responsibilities to be carried out by particular components of the Executive Branch. They could impinge on the President's constitutional authority to determine how Executive Branch agencies should be organized to carry out national defense and anti-terrorism activities.

Section 505, concerning the measurement and signatures intelligence (MASINT) research program, would provide the Defense Department the authority to review CIA and other intelligence agencies' MASINT programs. The Administration would oppose this expanded authority for DoD, as we believe the existing authorities and responsibilities are properly vested.

The Administration looks forward to working with the Congress on these and a number of other policy and technical concerns as H.R. 2417 moves through the legislative process.

House of Representatives, Committee on the Judiciary, Rayburn House Office Building,
Washington, DC, June 17, 2003.

Hon. Porter Goss,
Chairman, Permanent Select Committee on Intelligence, House of Representatives, Washington, DC.

Dear Chairman Goss: In recognition of the desire to expedite floor consideration of H.R. 2417, the intelligence authorization bill for fiscal year 2004, the Committee on the Judiciary hereby waives consideration of the bill with the understanding that you will continue to work with me on sections within the Committee on the Judiciary's jurisdiction and that for any of those sections on which we cannot reach a mutually agreeable resolution, you will remove them before enactment. I further understand that you will support the Committee on the Judiciary's request for conferees on these sections.

The sections in the bill as reported that contain matters within the Committee on the Judiciary's Rule X jurisdiction are:

104(e) (relating to funding for the Department of Justice's National Drug Intelligence Center);

321 (relating to procedures for using classified information);

332 (relating to the use of explosives by certain qualified aliens if they are in the United States to cooperate with the CIA or the United States military);

333 (relating to the naturalization of certain persons);

334 (relating to the types of financial institutions from which law enforcement can obtain financial records for criminal investigation purposes);

335 (relating to certain aspects of the mandatory source rules for Federal Prison Industries as they relate to procurements by the Central Intelligence Agency);

336 (relating to pilot projects to encourage the sharing of intelligence information between state and local officials and representatives of critical infrastructure industries on the one hand and federal officials on the other)

401 (relating to giving certain employees of the Central Intelligence Agency the protections of the Federal Tort Claims Act when they take certain actions to prevent crime)

504 (relating to giving certain employees of the National Security Agency the protections of the Federal Tort Claims Act when they take certain actions to prevent crime)

(These section numbers refer to the bill as reported.) Based on this understanding, I will not request a sequential referral based on their inclusion in the bill as reported.

The Committee on the Judiciary takes this action with the understanding that the Committee's jurisdiction over these provisions is in no way diminished or altered. I would appreciate your including this letter in your Committee's report on H.R. 2417 and the Congressional Record during consideration of the legislation on the House floor.

Sincerely,

F. James Sensenbrenner, Jr.,
Chairman.

House of Representatives, Permanent Select Committee on Intelligence,
Washington, DC, June 16, 2003.

Hon. F. James Sensenbrenner, Jr.,
Chairman, Committee on the Judiciary, House of Representatives, Washington, DC.

Dear Chairman Sensenbrenner: Thank you for your letter regarding H.R. 2417, the intelligence authorization bill for fiscal year 2004. As you noted, several provisions of the bill as reported fall within the Rule X jurisdiction of the Committee on the Judiciary. I will continue to work with you on these sections. For any of these sections on which we cannot reach a mutually agreeable resolution, I will remove them before enactment. Further I will support the Committee on the Judiciary's request for conferees on these sections.

The sections of the bill as reported that contain matters within the Committee on the Judiciary's Rule X jurisdiction are:

104(e) (relating to funding for the Department of Justice's National Drug Intelligence Center);

321 (relating to procedures for using classified information);

332 (relating to the use of explosives by certain qualified aliens if they are in the United States to cooperate with the CIA or the United States military);

333 (relating to the naturalization of certain persons);

334 (relating to the types of financial institutions from which law enforcement can obtain financial records for criminal investigation purposes);

335 (relating to certain aspects of the mandatory source rules for Federal Prison Industries as they relate to procurements by the Central Intelligence Agency);

336 (relating to pilot projects to encourage the sharing of intelligence information between state and local officials and representatives of critical infrastructure industries on the one hand and federal officials on the other);

401 (relating to giving certain employees of the Central Intelligence Agency the protections of the Federal Tort Claims Act when they take certain actions to prevent crime);

504 (relating to giving certain employees of the National Security Agency the protections of the Federal Tort Claims Act when they take certain actions to prevent crime).

(These section numbers refer to the bill as reported.) I appreciate you willingness to forgo consideration of the bill and not request a sequential referral based on this understanding.

I acknowledge that by agreeing to waive its consideration of the bill, the Committee on the Judiciary does not waive its jurisdiction over the bill or any of the matters under your jurisdiction. I will include a copy of your letter and this response in our Committee's report on H.R. 2417 and the Congressional Record during consideration of the legislation on the House floor.

Thank you for your assistance in this matter.

Sincerely,

Porter J. Goss,
Chairman.

House of Representatives, Committee on Financial Services, Rayburn House Office Building,
Washington, DC, June 17, 2003.

Hon. Porter J. Goss,
Chairman, Select Committee on Intelligence, Washington, DC.

Dear Chairman Goss: On June 12, 2003, the Select Committee on Intelligence ordered reported H.R. 2417, The Intelligence Authorization Act for Fiscal Year 2004. As you are aware, the bill as reported contained several provisions which fall within the jurisdiction of the Committee on Financial Services pursuant to the Committee's jurisdiction under Rule X of the Rules of the House of Representatives.

As you know, we continue to have strong concerns about some of these provisions, particularly those relating to the creation of a Bureau of Enforcement and Intelligence within the Department of the Treasury. However, because of your commitment to support my position regarding all of these provisions as the bill moves through the process and the need to move this legislation expeditiously, I will waive consideration of the bill by the Financial Services Committee. By agreeing to waive its consideration of the bill, the Financial Services Committee does not waive its jurisdiction over H.R. 2417. In addition, the Committee on Financial Services reserves its authority to seek conferees on any provisions of the bill that are within the Financial Services Committee's jurisdiction during any House-Senate conference that may be convened on this legislation. I ask your commitment to support any request by the Committee on Financial Services for conferees on H.R. 2417 or related legislation.

Finally, I request that you include a copy of this letter and your response in the Select Committee's report on the bill, and that they be printed in the Congressional Record during the consideration of this legislation on the floor.

I appreciate your commitment to address my concerns as the process moves forward and willingness to work constructively toward common goals.

Sincerely,

Michael G. Oxley,
Chairman.

House of Representatives, Permanent Select Committee on Intelligence,
Washington, DC, June 17, 2003.
Hon. Michael G. Oxley,
Chairman, Committee on Financial Services, Rayburn House Office Building, Washington, DC.

Dear Chairman Oxley: On June 12, 2003, the Select Committee on Intelligence ordered reported H.R. 2417, the "Intelligence Authorization Act of Fiscal Year 2004." The bill as reported contained several provisions which fall within the jurisdiction of the Committee on Financial Services, pursuant to the Committee's jurisdiction under Rule X of the Rules of the House of Representatives.

I am quite aware of, and sensitive to the specific concerns you raise about the inclusion of section 105 in H.R. 2417 concerning the establishment of a Bureau of Intelligence and Enforcement within the Department of the Treasury. Once again, I want to convey my personal commitment to work with you to resolve this issue to our common satisfaction and support your position in a conference with the Senate on the Intelligence Authorization bill.

I very much appreciate your willingness to waive consideration of H.R. 2417 by the Financial Services Committee. I acknowledge that, by agreeing to waive its consideration of the bill, the Financial Services Committee does not waive its jurisdiction over H.R. 2417. I further recognize that the Committee on Financial Services reserves its authority to seek conferees on any provisions of the bill that are within the Financial Services Committee's jurisdiction during any House-Senate conference that may be convened on this legislation. I will support a request by the Committee on Financial Services for conferees on H.R. 2417 or related legislation.

Finally, I am pleased to accommodate your request to include a copy of your letter and my response in the Select Committee's report on the bill, and that they be printed in the Congressional Record during the consideration of this legislation on the floor.

I appreciate your commitment to work together so as to achieve an appropriate and mutually satisfactory resolution of this important national security matter.

Sincerely,
Porter J. Goss,
Chairman.

Committee on Armed Services,
House of Representatives,
Washington, DC, June 19, 2003.
Hon. Porter J. Goss,
Chairman, House Permanent Select Committee on Intelligence, Washington, DC.

Dear Chairman Goss: I am writing to you concerning the jurisdictional interest of the Committee on Armed Services in matters being considered in H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004.

I recognize the importance of H.R. 2417 and the need for this legislation to move expeditiously. Therefore, while the committee is entitled to a jurisdictional claim on this legislation, I do not intend to request a sequential referral.

The Committee on Armed Services asks that you support our request to be conferees on the provisions over which we have jurisdiction during any House-Senate conference. Additionally, I request that you include this letter as part of your committee's report on H.R. 2417.

Thank you for your cooperation in this matter.

Sincerely,
Duncan Hunter,
Chairman.

House of Representatives, Permanent Select Committee on Intelligence,
Washington, DC, June 18, 2003.
Hon. Duncan Hunter,
Chairman, Committee on Armed Services, Rayburn House Office Building, Washington, DC.

Dear Chairman Hunter: Thank you for your letter regarding H.R. 2417, the intelligence authorization bill for fiscal year 2004. As you noted, elements of the bill as reported fall within the Rule X jurisdiction of the Committee on Armed Services. I will continue to work with you on these sections. I will support the Committee on Armed Services' request for conferees on these sections.

I appreciate your willingness to forgo consideration of the bill and not request a sequential referral based on this understanding.

I acknowledge that by agreeing to waive its consideration of the bill, the Committee on Armed Services does not waive its jurisdiction over the bill or any of the matters under your jurisdiction. I will include a copy of your letter and this response in our Committee's report on H.R. 2417 and the Congressional Record during consideration of the legislation on the House floor.

Thank you for your assistance in this matter.

Sincerely,
Porter J. Goss,
Chairman.

Finally, Mr. Chairman, I want to thank our staff. We have a perfect balance, I believe, between professional management staff and expertise on the various facets of the Intelligence Community which is what we need to do our job properly in terms of providing oversight on the one hand, to make sure the Intelligence Community plays in bounds and to make sure they have the necessary wherewithal, the advocacy piece that is our other side, the other hat we wear.

I am very much convinced that intelligence is the best investment. We are involved globally. There is no question the United States of America is no secret any place around the world, and in order for us to do the best we can in terms of our security, we have to have good information. It is a good investment.

Nobody would pretend that we are fully sufficient in all that we have. We can always do better, and I think we will probably be talking about sufficiency and insufficiency as we go along in our review.

Nobody would say that we are inherent. There is no document I know that is written that is inherent with the possible exception of the Bible, and some would say the New York Times, but I think they forfeited their right to that recently, nor is there anyone infallible. We are all human beings. What I can say to the American people is that I am satisfied that the men and women of the Intelligence Community of our Nation, and there are thousands of them, are doing their best for our national security, and I think we need to be behind them, and supporting this bill would be a good way to do that.

Mr. SIMMONS. Mr. Chairman, I rise today in support of H.R. 2417, a bill to reauthorize appropriations for FY 2004 for the intelligence and intelligence-related activities of the U.S. Government.

It has been my honor to serve this Nation with the Central Intelligence Agency for 10 years, five of which were spent as an operations officer in Southeast Asia. For over 30 years I served on active and reserve duty as a Military Intelligence Officer and have also had the unique privilege of serving as Staff Director for the Senate Select Committee on Intelligence under Chairmen Barry Goldwater and Daniel Patrick Moynihan. All this service took place at a time when our Nation was seeking to win the Cold War.

The collapse of the Soviet Union changed our world for the better, but did not eliminate the need for accurate and timely intelligence. We now face a new uncertainty and risk. Rather than focusing on one or two superpowers, we have to defend against numerous lethal covert terrorist groups.

H.R. 2417 responds to these changing threats by boosting the role of human intelligence or HUMINT gathered from human sources around the world; increases our ability to analyze material from a broad spectrum of sources; increases our capability to conduct counterterrorism; and authorizes protections and benefits for our intelligence officers at home and abroad.

Mr. Chairman, it is incumbent on this body to improve the intelligence capabilities of the Nation, to better serve as the "eyes and ears" of America in a difficult and dangerous world. This bill responds to this urgent requirement, and I support it completely.

H.R. 2417—Intelligence Authorization Act for FY 2004, Updated June 24, 2003

FLOOR SITUATION

The House is scheduled to consider H.R. 2417, pursuant to a rule, on Wednesday, June 25, 2003. On Tuesday, June 24, 2003, the Rules Committee granted, by voice vote, a modified open rule providing one hour of general debate equally divided and controlled by the chairman and ranking minority member of the Permanent Select Committee on Intelligence. The rule provides that the bill shall be considered for amendment under the five-minute rule. The rule provides that it shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute now printed in the bill, which shall be considered as read. The rule waives all points of order against consideration of the bill, and against the committee amendment in the nature of a substitute. The rule provides that no amendment to the committee amendment in the nature of a substitute shall be in order except those printed in the Rules Committee report accompanying the resolution, and all points of order against said amendments are waived. The rule provides that each amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. Finally, the rule provides one motion to recommit with or without instructions.

SUMMARY

H.R. 2417 authorizes appropriations for FY 2004 for (a) the intelligence and intelligence-related activities of the U.S. Government, (b) the Community Management Account, and (c) the Central Intelligence Agency Retirement and Disability System. The authorization level is classified. The funding levels and personnel ceilings for most programs are outlined in a classified annex to the committee report, which Members only may review in the offices of the Permanent Select Committee on Intelligence in H–405 in the Capitol.

HIGHLIGHTS

H.R. 2417 will:

Provide full support for the Intelligence Community's efforts in the war on terrorism;

Focus attention on the need to enhance Human Intelligence capabilities and tools;

Authorize additional resources to improve analytical depth in all areas of intelligence, and increase our analytical capacity to process, exploit, and disseminate all of the intelligence that is collected;

Posture the Intelligence Community to develop a framework for a unified overhead imagery architecture;

Include provisions that are intended to improve the government's ability to identify any spies that might be working against the United States and to provide the government additional leverage as it moves to prosecute such traitors, such as Hanssen, Ames, and Montes;

Establish a Bureau of Intelligence and Enforcement within the Department of the Treasury, to be headed by an Assistant Secretary for Intelligence and Enforcement, that will enhance the government's ability to gather and process information about the financial support of terrorism and other illegal activity;

Require the Director of Central Intelligence (DCI) to report on lessons learned as a result of military operations in Iraq;

Improve information sharing among Federal, State, and local government officials; including increased training for state and local officials on how the intelligence community can support their counterterrorism efforts;

Require the Intelligence Community's senior leadership to comprehensively examine (and report to Congress on) policy and technical issues related to digital information sharing, electronic collaboration, and "horizontal integration" across the Intelligence Community;

Extend the authority for the use of funds designated for intelligence and intelligence-related purposes for assistance to the Government of Colombia for counter-drug activities to be used also to fund counterterrorism activities in Colombia for each of FYs 2004 through 2005;

Provide limited immunity from tort liability to those Special Police Officers of the Central Intelligence Agency and the National Security Agency;

Authorize the personnel ceilings on September 30, 2004 for the intelligence and intelligence-related activities of the U.S. Government and permit the Director of Central Intelligence to authorize personnel ceilings in Fiscal Year 2003 for any intelligence element up to two percent above the authorized levels, with the approval of the Director of the Office of Management and Budget; and

Authorize $226.4 million for the Central Intelligence Agency Retirement and Disability Fund (CIARDS) in order to fully fund the accruing cost of retirement benefits for individuals in the Civil Service Retirement System, CIARDS, and other Federal retirement systems.

BACKGROUND

Agencies' activities affected by the Intelligence Authorization Act of 2003, include fourteen agencies of the U.S. government, such as: Central Intelligence Agency; National Security Agency; Defense Intelligence Agency; National Imagery and Mapping Agency; National Reconnaissance Organization; FBI (Counterterrorism and Counterintelligence); DOE; Homeland Security; and U.S. Coast Guard.

LEGISLATIVE HISTORY

H.R. 2417 was introduced by Chairman Goss on June 11, 2003. It was reported from the Select Intelligence Committee by a vote of 16–0 on June 12, 2003 (H. Rpt. 108–163).

COST ESTIMATE

CBO estimates that the unclassified portions of this measure will cost $320 million over the 2004-2008 period, assuming appropriation of the specified and estimated amounts. CBO also estimates the bill will affect direct spending and receipts by an insignificant amount.

H.R. 2417 contains intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA), but CBO estimates that the costs of complying with these mandates will not exceed the thresholds established by that act ($59 million for intergovernmental mandates and $117 million for private-sector mandates in 2003, adjusted annually for inflation).

AMENDMENTS MADE IN ORDER UNDER THE RULE (6 AMENDMENTS)

Rep. Cox will offer an amendment (#10) on Wednesday, June 25, 2003. The amendment strikes Section 336 (Improvement of Information Sharing Among Federal, State, and Local Government Officials) of the bill. Contact: 6–8417.

Rep. Farr will offer an amendment (#9) on Wednesday, June 25, 2003. The amendment seeks to improve the foreign language training of the intelligence community by providing: (1) training in the application of standardized foreign language skill assessment mechanisms; (2) development of curriculum for advanced proficiency intelligence community foreign language speakers and interpreters; (3) non-degree training for translators and interpreters; (4) training intelligence community foreign language teachers in the use of technology geared for teaching advanced "critical languages;" (5) intensive on-site foreign language training. Contact: 5-2861.

Rep. Harman will offer an amendment (#2) on Wednesday, June 25, 2003. It amends section (g)(1) of Section 343 of the bill by requiring the Director of Central Intelligence to report on whether further consolidation or elimination of watch list databases in Federal departments and agencies would contribute to the efficacy and effectiveness of the Terrorist Identification Classification System in identifying known or suspected terrorists. If passed, it would also require the Director of Central Intelligence to report on steps required to consolidate or eliminate such watch lists. Contact: 5–8220.

Rep. Hastings (FL) will offer an amendment (#1) on Wednesday, June 25, 2003. The amendment directs the Director of Central Intelligence to establish a pilot project to improve recruitment of ethnic and cultural minorities and women to meet the diversity of skills, language, and expertise required by the current mission. Contact: 5–1313.

Rep. Kucinich will offer an amendment (#8) on Wednesday, June 25, 2003. The amendment directs the Inspector General of the Central Intelligence Agency to conduct an audit of all telephone and electronic communications between the CIA and the Office of the Vice President that relate to weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom. Not later than one year after the date of enactment, the Inspector General shall submit a report to Congress on the audit conducted. Contact: 5–5871.

Rep. Lee will offer an amendment (#7) on Wednesday, June 25, 2003. The amendment requires the Comptroller General of the United States to conduct a study to determine the extent of intelligence sharing by the Department of Defense and intelligence community with United Nations inspectors searching for weapons of mass destruction in Iraq prior to Operation Iraqi Freedom. Contact: 5–2661.

Ms. McCARTHY of Missouri. Mr. Chairman, I rise today to commend the collaborative efforts of my colleagues who serve on the Permanent Select Committee in crafting the FY2004 Intelligence Authorization, H.R. 2417.

This measure encourages information sharing among agencies, which is critical to our Nation's ability to respond to threats to our homeland security.

There are still important intelligence questions unresolved from our war in Iraq—questions that will, and should, face greater scrutiny in the coming months. This Intelligence Authorization provides added resources that will be used in securing the answers to those questions and we should support it.

Mr Chairman, in closing, I want to commend the committee for giving us a bill that strengthens the Intelligence Community and provides new and better capabilities to fight the war on terrorism, and I urge my colleagues to support this measure.

Mr. GOSS. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. All time having expired, the debate is concluded.

Mr. GOSS. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. HEFLEY) having assumed the chair, Mr. ISAKSON, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intellience-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, had come to no resolution thereon.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed.

Votes will be taken in the following order:

H. Con. Res. 49, by the yeas and nays;

H. Res. 199, by the yeas and nays;

H. Res. 294, by the yeas and nays.

The vote on H. Res. 277 will be taken tomorrow.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

EXPRESSING SENSE OF CONGRESS THAT ESCALATION OF ANTI-SEMITIC VIOLENCE WITHIN PARTICIPATING STATES OF OSCE IS OF PROFOUND CONCERN AND EFFORTS SHOULD BE UNDERTAKEN TO PREVENT FUTURE OCCURRENCES

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the concurrent resolution, H. Con. Res. 49.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 49, on which the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 412, nays 0, not voting 22, as follows:

[Roll No. 315]

YEAS—412

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Foley
Forbes
Ford
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velazquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOT VOTING—22

Brown-Waite, Ginny
Conyers
Cubin
Everett
Flake
Fletcher
Fossella
Franks (AZ)
Gephardt
Gilchrest
Hayworth
Hunter
Kolbe
Meehan
Norwood
Pombo
Renzi
Saxton
Shadegg
Skelton
Smith (WA)
Stark

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HEFLEY) (during the vote). Members are advised 2 minutes remain in this vote.

☐ 1806

So (two-thirds having voted in favor thereof) the rules were suspended and the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the remainder of this series of votes will be conducted as 5-minute votes.

CALLING ON CHINA TO IMMEDIATELY AND UNCONDITIONALLY RELEASE DR. YANG JIANLI

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the resolution, H. Res. 199, as amended.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Florida (Ms. ROS-LEHTINEN) that the House suspend the rules and agree to the resolution, H. Res. 199, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 412, nays 0, not voting 22, as follows:

[Roll No. 316]

YEAS—412

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin

Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Foley
Forbes
Ford
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velazquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOT VOTING—22

Berman
Brown-Waite, Ginny
Conyers
Cubin
Everett
Flake
Fletcher
Fossella
Franks (AZ)
Gephardt
Gilchrest
Hayworth
Hunter
Kolbe
Norwood
Pombo
Renzi
Saxton
Shadegg
Skelton
Smith (WA)
Stark

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HEFLEY) (during the vote). Members are advised that 2 minutes remain in this vote.

☐ 1814

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

CONDEMNING TERRORISM INFLICTED ON ISRAEL SINCE AQABA SUMMIT AND EXPRESSING SOLIDARITY WITH THE ISRAELI PEOPLE

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the resolution, H. Res. 294.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Florida (Ms. ROS-LEHTINEN) that the House suspend the rules and agree to the resolution, H. Res. 294, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 399, nays 5, answered "present" 7, not voting 23, as follows:

[Roll No. 317]

YEAS—399

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Foley
Forbes
Ford
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Oberstar
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Rangel
Regula
Rehberg
Reyes
Reynolds
Rodriguez
Rogers (AL)

Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Watson
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Wynn
Young (AK)
Young (FL)

NAYS—5

Dingell
Kleczka
Paul
Rahall
Woolsey

ANSWERED "PRESENT"—7

Clay
Kilpatrick
Kucinich
Lee
McDermott
Waters
Watt

NOT VOTING—23

Brown-Waite, Ginny
Conyers
Cubin
Everett
Flake
Fletcher
Fossella
Franks (AZ)
Gephardt
Gilchrest
Hayworth
Hunter
Kolbe
Moran (VA)
Norwood
Obey
Pombo
Renzi
Saxton
Shadegg
Skelton
Smith (WA)
Stark

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1823

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. RENZI. Mr. Speaker, I was attending Congressman Bob Stump's funeral service today and missed votes on the following measures:

On motion to suspend the rules and pass H. Con. Res. 49—Expressing the sense of the Congress that the sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe is of profound concern and efforts should be undertaken to prevent future occurrences (Roll No. 315). Had I been present, I would have voted "aye."

On motion to suspend the rules and pass H. Res. 199—Calling on the Government of the People's Republic of China immediately and unconditionally to release Dr. Yang Jianli, calling on the President of the United States to continue working on behalf of Dr. Yang Jianli for his release (Roll No. 316). Had I been present, I would have voted "aye."

On motion to suspend the rules and pass H. Res. 294—Condemning the terrorism inflicted on Israel since the Aqaba summit, expressing solidarity with the Israeli people, and calling on the Palestinian Authority to take immediate and effective steps to dismantle the terrorist infrastructure on the West Bank and Gaza (Roll No. 317). Had I been present, I would have voted "aye."

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore. Pursuant to House Resolution 295 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the further consideration of the bill, H.R. 2417.

□ 1824

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the further consideration of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, with Mr. SIMPSON (Chairman pro tempore) in the chair.

The Clerk read the title of the bill.

The CHAIRMAN pro tempore. When the Committee of the Whole rose earlier today, all time for general debate had expired.

Pursuant to the rule, the committee amendment in the nature of a substitute printed in the bill shall be considered as an original bill for the purpose of amendment under the 5-minute rule and shall be considered read.

The text of the committee amendment in the nature of a substitute is as follows:

H.R. 2417

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Intelligence Authorization Act for Fiscal Year 2004".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—INTELLIGENCE ACTIVITIES

Sec. 101. Authorization of appropriations.
Sec. 102. Classified schedule of authorizations.
Sec. 103. Personnel ceiling adjustments.
Sec. 104. Intelligence Community Management Account.
Sec. 105. Intelligence elements of the Department of the Treasury.

TITLE II—CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM

Sec. 201. Authorization of appropriations.

TITLE III—GENERAL PROVISIONS

Subtitle A—Recurring General Provisions

Sec. 301. Increase in employee compensation and benefits authorized by law.
Sec. 302. Restriction on conduct of intelligence activities.

Subtitle B—Intelligence

Sec. 311. Modification of notice and wait requirements on projects to construct or improve intelligence community facilities.

Subtitle C—Counterintelligence

Sec. 321. Counterintelligence initiatives for the intelligence community.

Subtitle D—Other Matters

Sec. 331. Extension of suspension of reorganization of Diplomatic Telecommunications Service Program Office.
Sec. 332. Modifications of authorities on explosive materials.
Sec. 333. Modification of prohibition on the naturalization of certain persons.
Sec. 334. Modification to definition of financial institution in the Right to Financial Privacy Act.
Sec. 335. Procedural requirements for Central Intelligence Agency relating to products of Federal prison industries.
Sec. 336. Improvement of information sharing among federal, State, and local government officials.

Subtitle E—Reports and Technical Amendments

Sec. 341. Extension of deadline for final report of the National Commission for the Review of the Research and Development Programs of the United States Intelligence Community.
Sec. 342. Modification of various reports required of intelligence community elements.
Sec. 343. Technical amendments.
Sec. 344. Report on lessons learned from military operations in Iraq.

TITLE IV—CENTRAL INTELLIGENCE AGENCY

Sec. 401. Protection from tort liability for certain Central Intelligence Agency personnel.
Sec. 402. Repeal of limitation on use of funds in Central Services Working Capital Fund.

TITLE V—DEPARTMENT OF DEFENSE INTELLIGENCE MATTERS

Sec. 501. Use of funds for counterdrug and counterterrorism activities for Colombia.
Sec. 502. Authority to provide living quarters for certain students in cooperative and summer education programs of the National Security Agency.
Sec. 503. Authority for intelligence community elements of Department of Defense to award personal service contracts.
Sec. 504. Protection of certain National Security Agency personnel from tort liability.
Sec. 505. Measurement and signatures intelligence program.

TITLE I—INTELLIGENCE ACTIVITIES

SEC. 101. AUTHORIZATION OF APPROPRIATIONS.

Funds are hereby authorized to be appropriated for fiscal year 2004 for the conduct of the intelligence and intelligence-related activities of the following elements of the United States Government:

(1) The Central Intelligence Agency.
(2) The Department of Defense.
(3) The Defense Intelligence Agency.
(4) The National Security Agency.
(5) The National Reconnaissance Office.
(6) The National Imagery and Mapping Agency.

(7) The Department of the Army, the Department of the Navy, and the Department of the Air Force.

(8) The Department of State.

(9) The Department of the Treasury.

(10) The Department of Energy.

(11) The Department of Justice.

(12) The Federal Bureau of Investigation.

(13) The Department of Homeland Security.

(14) The Coast Guard.

SEC. 102. CLASSIFIED SCHEDULE OF AUTHORIZATIONS.

(a) SPECIFICATIONS OF AMOUNTS AND PERSONNEL CEILINGS.—The amounts authorized to be appropriated under section 101, and the authorized personnel ceilings as of September 30, 2004, for the conduct of the intelligence and intelligence-related activities of the elements listed in such section, are those specified in the classified Schedule of Authorizations prepared to accompany the bill H.R. 2417 of the One Hundred Eighth Congress.

(b) AVAILABILITY OF CLASSIFIED SCHEDULE OF AUTHORIZATIONS.—The Schedule of Authorizations shall be made available to the Committees on Appropriations of the Senate and House of Representatives and to the President. The President shall provide for suitable distribution of the Schedule, or of appropriate portions of the Schedule, within the executive branch.

SEC. 103. PERSONNEL CEILING ADJUSTMENTS.

(a) AUTHORITY FOR ADJUSTMENTS.—With the approval of the Director of the Office of Management and Budget, the Director of Central Intelligence may authorize employment of civilian personnel in excess of the number authorized for fiscal year 2004 under section 102 when the Director of Central Intelligence determines that such action is necessary to, the performance of important intelligence functions, except that the number of personnel employed in excess of the number authorized under such section may not, for any element of the intelligence community, exceed 2 percent of the number of civilian personnel authorized under such section for such element.

(b) NOTICE TO INTELLIGENCE COMMITTEES.—The Director of Central Intelligence shall notify promptly the Permanent Select Committee on Intelligence of the House of Representatives and the Select Committee on Intelligence of the Senate whenever the Director exercises the authority granted by this section.

SEC. 104. INTELLIGENCE COMMUNITY MANAGEMENT ACCOUNT.

(a) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for the Intelligence Community Management Account of the Director of Central Intelligence for fiscal year 2004 the sum of $192,640,000. Within such amount, funds identified in the classified Schedule of Authorizations referred to in section 102(a) for the Advanced Research and Development Committee shall remain available until September 30, 2005.

(b) AUTHORIZED PERSONNEL LEVELS.—The elements within the Intelligence Community Management Account of the Director of Central Intelligence are authorized 320 full-time personnel as of September 30, 2004. Personnel serving in such elements may be permanent employees of the Intelligence Community Management Account or personnel detailed from other elements of the United States Government.

(c) CLASSIFIED AUTHORIZATIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—In addition to amounts authorized to be appropriated for the Intelligence Community Management Account by subsection (a), there are also authorized to be appropriated for the Intelligence Community Management Account for fiscal year 2004 such additional amounts as are specified in the classified Schedule of Authorizations referred to in section 102(a). Such additional amounts shall remain available until September 30, 2004.

(2) AUTHORIZATION OF PERSONNEL.—In addition to the personnel authorized by subsection (b) for elements of the Intelligence Community Management Account as of September 30, 2004, there are hereby authorized such additional personnel for such elements as of that date as are specified in the classified Schedule of Authorizations.

(d) REIMBURSEMENT.—Except as provided in section 113 of the National Security Act of 1947 (50 U.S.C. 404h), during fiscal year 2004 any officer or employee of the United States or a member of the Armed Forces who is detailed to the staff of the Intelligence Community Management Account from another element of the United States Government shall be detailed on a reimbursable basis, except that any such officer, employee, or member may be detailed on a nonreimbursable basis for a period of less than one year for the performance of temporary functions as required by the Director of Central Intelligence.

(e) NATIONAL DRUG INTELLIGENCE CENTER.—

(1) IN GENERAL.—Of the amount authorized to be appropriated in subsection (a), $34,248,000 shall be available for the National Drug Intelligence Center. Within such amount, funds provided for research, development, testing, and evaluation purposes shall remain available until September 30, 2005, and funds provided for procurement purposes shall remain available until September 30, 2006.

(2) TRANSFER OF FUNDS.—The Director of Central Intelligence shall transfer to the Attorney General funds available for the National Drug Intelligence Center under paragraph (1). The Attorney General shall utilize funds so transferred for the activities of the National Drug Intelligence Center.

(3) LIMITATION.—Amounts available for the National Drug Intelligence Center may not be used in contravention of the provisions of section 103(d)(1) of the National Security Act of 1947 (50 U.S.C. 403–3(d)(1)).

(4) AUTHORITY.—Notwithstanding any other provision of law, the Attorney General shall retain full authority over the operations of the National Drug Intelligence Center.

SEC. 105. INTELLIGENCE ELEMENTS OF THE DEPARTMENT OF THE TREASURY.

(a) IN GENERAL.—(1) Title I of the National Security Act of 1947 (50 U.S.C. 402 et seq.) is amended by adding at the end the following new section:

"BUREAU OF INTELLIGENCE AND ENFORCEMENT OF THE DEPARTMENT OF THE TREASURY

"SEC. 119. (a) IN GENERAL.—There is within the Department of the Treasury a Bureau of Intelligence and Enforcement headed by an Assistant Secretary for Intelligence and Enforcement, who shall be appointed by the President, by and with the advice and consent of the Senate.

"(b) RESPONSIBILITIES.—(1) The Assistant Secretary for Intelligence and Enforcement shall oversee and coordinate functions of the Bureau of Intelligence and Enforcement.

"(2) The Assistant Secretary shall report directly to the Secretary of the Treasury.

"(c) COMPOSITION OF BUREAU.—The Bureau of Intelligence and Enforcement shall consist of the following offices:

"(1) The Office of Intelligence Support.

"(2) The Office of Foreign Assets Control.

"(3) The Financial Crimes Enforcement Network.

"(4) Such other offices as the Assistant Secretary may establish.".

(2) The table of contents contained in the first section of such Act is amended by inserting after the item relating to section 118 the following new item:

"Sec. 119. Bureau of Intelligence and Enforcement of the Department of the Treasury.".

(b) CONSULTATION WITH DCI IN APPOINTMENT OF ASSISTANT SECRETARY FOR INTELLIGENCE AND ENFORCEMENT.—Section 106(b)(2) of such Act (50 U.S.C. 403–6(b)(2)) is amended by adding at the end the following new subparagraph:

"(E) The Assistant Secretary for Intelligence and Enforcement.".

(c) CONFORMING AMENDMENTS.—(1) Section 3(4) of such Act (50 U.S.C. 401a(4)) is amended—

(A) by striking "the Department of the Treasury," in subparagraph (H);

(B) by striking "and" at the end of subparagraph (J);

(C) by redesignating subparagraph (K) as subparagraph (L); and

(D) by inserting after subparagraph (J) the following new subparagraph:

"(K) the Bureau of Intelligence and Enforcement of the Department of the Treasury; and".

(2) Section 5315 of title 5, United States Code, is amended in the item relating to Assistant Secretaries of the Treasury by striking "(7)" and inserting "(8)".

TITLE II—CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM

SEC. 201. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated for the Central Intelligence Agency Retirement and Disability Fund for fiscal year 2004 the sum of $226,400,000.

TITLE III—GENERAL PROVISIONS

Subtitle A—Recurring General Provisions

SEC. 301. INCREASE IN EMPLOYEE COMPENSATION AND BENEFITS AUTHORIZED BY LAW.

Appropriations authorized by this Act for salary, pay, retirement, and other benefits for Federal employees may be increased by such additional or supplemental amounts as may be necessary for increases in such compensation or benefits authorized by law.

SEC. 302. RESTRICTION ON CONDUCT OF INTELLIGENCE ACTIVITIES.

The authorization of appropriations by this Act shall not be deemed to constitute authority for the conduct of any intelligence activity which is not otherwise permitted under the Constitution or authorized pursuant to the laws of the United States.

Subtitle B—Intelligence

SEC. 311. MODIFICATION OF NOTICE AND WAIT REQUIREMENTS ON PROJECTS TO CONSTRUCT OR IMPROVE INTELLIGENCE COMMUNITY FACILITIES.

(a) INCREASE OF THRESHOLDS FOR NOTICE.—Section 602(a) of the Intelligence Authorization Act for Fiscal Year 1995 (Public Law 103–359; 108 Stat. 3432; 50 U.S.C. 403–2b(a)) is amended—

(1) by striking "$750,000" each place it appears and inserting "$5,000,000";

(2) by striking "$500,000" each place it appears and inserting "$1,000,000"; and

(3) in paragraph (2), as amended by paragraph (2) of this subsection, by inserting after "$1,000,000" the second place it appears, the following: "but less than $5,000,000".

(b) NOTICE AND WAIT REQUIREMENTS FOR EMERGENCY PROJECTS.—Section 602(b)(2) of the Intelligence Authorization Act for Fiscal Year 1995 (Public Law 103–359; 108 Stat. 3432; 50 U.S.C. 403-2b(b)(2)) is amended—

(1) in the third sentence, by striking "21-day" and inserting "7-day"; and,

(2) by adding at the end the following new sentence: "Notwithstanding the preceding provisions of this paragraph, when the Director of Central Intelligence and Secretary of Defense jointly determine that an emergency relating to the national security or to the protection of health, safety, or environmental quality exists and that delay would irreparably harm any or all of those interests, the project may begin on

the date the notification is received by such committees.".

Subtitle C—Counterintelligence

SEC. 321. COUNTERINTELLIGENCE INITIATIVES FOR THE INTELLIGENCE COMMUNITY.

(a) In General.—(1) Title XI of the National Security Act of 1947 (50 U.S.C. 401 et seq.) is amended by adding at the end the following new section:

"COUNTERINTELLIGENCE INITIATIVES

"Sec. 1102. (a) Inspection Process.—(1) In order to protect intelligence sources and methods from unauthorized disclosure, the Director of Central Intelligence shall establish and implement an inspection process for all agencies and departments of the United States that handle classified information relating to the national security of the United States intended to assure that those agencies and departments maintain effective operational security practices and programs directed against counterintelligence activities.

"(2) The Director shall carry out the process through the Office of the National Counterintelligence Executive.

"(b) FBI Counterintelligence Office.—The Attorney General, acting through the Director of the Federal Bureau of Investigation, shall establish an Office of Counterintelligence within the Bureau to investigate potential espionage activities within the Bureau.

"(c) Annual Review of Dissemination Lists.—(1) The Director of Central Intelligence shall establish and implement a process for all elements of the intelligence community (as defined in section 101(4)) to review, on an annual basis, individuals included on distribution lists for access to classified information. Such process shall ensure that only individuals who have a particularized 'need to know' (as determined by the Director) are continued on such distribution lists.

"(2) Not later than October 15 of each year, the Director shall certify to the congressional intelligence committees that the review required under paragraph (1) has been conducted in all elements of the intelligence community during the preceding fiscal year.

"(d) Required Completion of Financial Disclosure Statements.—(1) The Director of Central Intelligence shall establish and implement a process by which heads of the elements of the intelligence community (as defined in section 101(4)) direct that all employees, in order to be granted access to classified information, submit financial disclosure forms required under section 1.3(b) of Executive Order No. 12969 (August 2, 1995; 60 F.R. 40245; 50 U.S.C. 435 note).

"(2) The Director shall carry out paragraph (1) through the Office of the National Counterintelligence Executive.

"(e) Arrangements To Handle Sensitive Information.—The Director of Central Intelligence shall establish, for all elements of the intelligence community (as defined in section 101(4)), programs and procedures by which sensitive classified information relating to human intelligence is safeguarded against unauthorized disclosure by employees of those elements.".

(2) The table of contents contained in the first section of such Act is amended in the items relating to title XI by adding at the end the following new item:

"Sec. 1102. Counterintelligence initiatives.".

(b) Intelligence and National Security Aspects of Espionage Prosecutions.—The Attorney General, acting through the Office of Intelligence Policy and Review of the Department of Justice, in consultation with the Office of the National Counterintelligence Executive, shall establish policies and procedures to assist the Attorney General in the Attorney General's consideration of intelligence and national security equities in the development of charging documents and related pleadings in espionage prosecutions.

Subtitle D—Other Matters

SEC. 331. EXTENSION OF SUSPENSION OF REORGANIZATION OF DIPLOMATIC TELECOMMUNICATIONS SERVICE PROGRAM OFFICE.

Section 311 of the Intelligence Authorization Act for Fiscal Year 2002 (Public Law 107–108; 115 Stat. 1401; 22 U.S.C. 7301 note), as amended by section 351 of the Intelligence Authorization Act for Fiscal Year 2003 (Public Law 107–306; 116 Stat. 2401; 22 U.S.C. 7301 note), is amended—

*(1) in the heading, by striking "**two-year**" before "**suspension of reorganization**"; and*

(2) in the text, by striking "ending on October 1, 2003" and inserting "ending on the date that is 60 days after the date on which appropriate congressional committees of jurisdiction (as defined in section 324(d) of that Act (22 U.S.C. 7304(d)) are notified jointly by the Secretary of State (or the Secretary's designee) and the Director of the Office of Management and Budget (or the Director's designee) that the operational framework for the office has been terminated".

SEC. 332. MODIFICATIONS OF AUTHORITIES ON EXPLOSIVE MATERIALS.

(a) Authority To Distribute Explosive Materials To Qualified Aliens.—Notwithstanding any other provision of law, it shall be lawful for any person knowingly to distribute explosive materials to any qualified alien—

(1) if, in the case of a qualified alien described in subsection (c)(1), the distribution to, shipment to, transportation to, receipt by, or possession by the alien of the explosive materials is in furtherance of such cooperation; or

(2) if, in the case of a qualified alien described in subsection (c)(2), the distribution to, shipping to, transporting to, possession by, or receipt by the alien of explosive materials is in furtherance of the authorized military purpose.

(b) Authority for Qualified Aliens To Ship Explosive Materials.—Notwithstanding any other provision of law, it shall be lawful for a qualified alien to ship or transport any explosive in or affecting interstate or foreign commerce or to receive or possess any explosive which has been shipped or transported in or affecting interstate or foreign commerce—

(1) if, in the case of a qualified alien described in subsection (c)(1), the possession, shipment, or transportation by the alien of the explosive materials is in furtherance of such cooperation; or

(2) if, in the case of a qualified alien described in subsection (c)(2), the possession, shipment, or transportation by the alien of explosive materials is in furtherance of the authorized military purpose.

(c) Qualified Alien Defined.—In this section, the term "qualified alien" means an alien—

(1) who is lawfully present in the United States in cooperation with the Director of Central Intelligence; or

(2) who is a member of a North Atlantic Treaty Organization (NATO), or other friendly foreign military force (as determined by the Attorney General with the concurrence of the Secretary of Defense) who is present in the United States under military orders for training or other military purpose authorized by the United States.

SEC. 333. MODIFICATION OF PROHIBITION ON THE NATURALIZATION OF CERTAIN PERSONS.

Section 313(e)(4) of the Immigration and Nationality Act (8 U.S.C. 1424(e)(4)) is amended—

(1) by inserting "when Department of Defense activities are relevant to the determination" after "Secretary of Defense"; and

(2) by inserting "and the Secretary of Homeland Security" after "Attorney General".

SEC. 334. MODIFICATION TO DEFINITION OF FINANCIAL INSTITUTION IN THE RIGHT TO FINANCIAL PRIVACY ACT.

(a) In General.—Section 1101(1) of the Right to Financial Privacy Act of 1978 (12 U.S.C. 3401(1)) is amended by inserting ", except as provided in section 1114," before "means any office".

(b) Definition.—Section 1114 of such Act (12 U.S.C. 3414) is amended by adding at the end the following:

"(c) For purposes of this section, the term 'financial institution' has the same meaning as in section 5312(a)(2) of title 31, United States Code, except that, for purposes of this section, such term shall include only such a financial institution any part of which is located inside any State or territory of the United States, the District of Columbia, Puerto Rico, Guam, American Samoa, or the United States Virgin Islands.".

SEC. 335. PROCEDURAL REQUIREMENTS FOR CENTRAL INTELLIGENCE AGENCY RELATING TO PRODUCTS OF FEDERAL PRISON INDUSTRIES.

The Central Intelligence Agency Act of 1949 (50 U.S.C. 403a et seq.) is amended by adding at the end the following new section:

"PROCEDURAL REQUIREMENTS FOR CENTRAL INTELLIGENCE AGENCY RELATING TO PRODUCTS OF FEDERAL PRISON INDUSTRIES

"Sec. 23. (a) Market Research.—Before purchasing a product listed in the latest edition of the Federal Prison Industries catalog under section 4124(d) of title 18, United States Code, the Director shall conduct market research to determine whether the Federal Prison Industries product is comparable to products available from the private sector that best meet the Agency's needs in terms of price, quality, and time of delivery.

"(b) Competition Requirement.—If the Director determines that a Federal Prison Industries product is not comparable in price, quality, or time of delivery to products available from the private sector that best meet the Agency's needs in terms of price, quality, and time of delivery, the Director shall use competitive procedures for the procurement of the product or shall make an individual purchase under a multiple award contract. In conducting such a competition or making such a purchase, the Director shall consider a timely offer from Federal Prison Industries.

"(c) Implementation by Director.—The Director shall ensure that—

"(1) the Agency does not purchase a Federal Prison Industries product or service unless a contracting officer of the Agency determines that the product or service is comparable to products or services available from the private sector that best meet the Agency's needs in terms of price, quality, and time of delivery; and

"(2) Federal Prison Industries performs its contractual obligations to the same extent as any other contractor for the Agency.

"(d) Market Research Determination Not Subject to Review.—A determination by a contracting officer regarding whether a product or service offered by Federal Prison Industries is comparable to products or services available from the private sector that best meet the Agency's needs in terms of price, quality, and time of delivery shall not be subject to review pursuant to section 4124(b) of title 18.

"(e) Performance as a Subcontractor.—(1) A contractor or potential contractor of the Agency may not be required to use Federal Prison Industries as a subcontractor or supplier of products or provider of services for the performance of a contract of the Agency by any means, including means such as—

"(A) a contract solicitation provision requiring a contractor to offer to make use of products or services of Federal Prison Industries in the performance of the contract;

"(B) a contract specification requiring the contractor to use specific products or services (or classes of products or services) offered by Federal Prison Industries in the performance of the contract; or

"(C) any contract modification directing the use of products or services of Federal Prison Industries in the performance of the contract.

"(2) In this subsection, the term 'contractor', with respect to a contract, includes a subcontractor at any tier under the contract.

"(f) Protection of Classified and Sensitive Information.—The Director may not enter into any contract with Federal Prison Industries under which an inmate worker would have access to—

"(1) any data that is classified;

"(2) any geographic data regarding the location of—

"(A) surface and subsurface infrastructure providing communications or water or electrical power distribution;

"(B) pipelines for the distribution of natural gas, bulk petroleum products, or other commodities; or

"(C) other utilities; or

"(3) any personal or financial information about any individual private citizen, including information relating to such person's real property however described, without the prior consent of the individual.

"(g) Application of Provision.—This section is subject to the preceding provisions of this Act, and shall not be construed as affecting any right or duty of the Director under those provisions.

"(h) Definitions.—In this section:

"(1) The terms 'competitive procedures' and 'procurement' have the meanings given such terms in section 4 of the Office of Federal Procurement Policy Act (41 U.S.C. 403).

"(2) The term 'market research' means obtaining specific information about the price, quality, and time of delivery of products available in the private sector through a variety of means, which may include—

"(A) contacting knowledgeable individuals in government and industry;

"(B) interactive communication among industry, acquisition personnel, and customers; and

"(C) interchange meetings or pre-solicitation conferences with potential offerors.".

SEC. 336. IMPROVEMENT OF INFORMATION SHARING AMONG FEDERAL, STATES, AND LOCAL GOVERNMENT OFFICIALS.

(a) Pilot Project To Encourage State and Local Officials, As Well As Representatives of Critical Infrastructure, To Collect and Share Relevant Information.—Section 892(c) of the Homeland Security Act of 2002 (Public Law 107–296; 6 U.S.C. 482) is amended by adding at the end the following new paragraph:

"(3)(A) The Under Secretary for Information Analysis and Infrastructure Protection of the Department of Homeland Security, in consultation with the Director of Central Intelligence, may conduct projects in several cities to encourage officials of State and local government, as well as representatives of industries that comprise the critical infrastructure in those cities to lawfully collect and to pass on to the appropriate Federal officials information vital for the prevention of terrorist attacks against the United States.

"(B) The Director of Central Intelligence shall carry out any duty under this paragraph through the Director of the Terrorist Threat Integration Center.

"(C) Under the projects, training shall be provided to such officials and representatives to—

"(i) identify sources of potential threats through such methods as the Secretary determines appropriate;

"(ii) report information relating to such potential threats to the appropriate Federal agencies in the appropriate form and manner; and

"(iii) assure that all reported information is systematically submitted to and passed on by the Department for use by appropriate Federal agencies.

"(D) The Under Secretary shall carry out the pilot project under this paragraph for a period of 3 years.

"(E) Not later than 1 year after the implementation of the pilot project, and annually thereafter, the Under Secretary shall submit to Congress a report on the pilot project conducted under this paragraph. Each such report shall include—

"(i) an assessment of the effectiveness of the project; and

"(ii) recommendations on the continuation of the project as well as any recommendations to improve the effectiveness of information collection and sharing by such officials and representatives and the Federal government.".

(b) Pilot Project To Test Use of Tear-line Intelligence Reports.—(1) Subtitle C of title II of the Homeland Security Act of 2002 (Public Law 107–296) is amended by adding at the end the following new section:

"SEC. 226. PILOT PROJECT TO TEST USE OF TEAR-LINE INTELLIGENCE REPORTS.

"(a) Authority.—The Under Secretary for Information Analysis and Infrastructure Protection of the Department of Homeland Security, in consultation with the Director of Central Intelligence, may carry out a pilot program under which the Under Secretary may make intelligence information in the possession of the Department available to officials of State and local governments through the use of tear-line intelligence reports.

"(b) Tear-line Intelligence Reports Described.—For purpose of this section, a tear-line report is a report containing intelligence gathered by an agency or department of the United States that is in the possession of the Department that is prepared in a manner such that information relating to intelligence sources and methods is easily severable from the report to protect such sources and methods from disclosure. Such a report may be in a paper or an electronic format.

"(c) Duration of Project.—The Under Secretary shall carry out the pilot project under this section for a period of 3 years.

"(d) Reports to Congress.—Not later than 1 year after the implementation of the pilot project, and annually thereafter, the Under Secretary shall submit to Congress a report on the pilot project conducted under this section, and shall include in the report an assessment of—

"(1) the effectiveness of the use of the tear-line reports in providing intelligence information on a timely basis to State and local authorities; and

"(2) if the use of such tear-line reports were to be made permanent, whether additional safeguards are needed with respect to the use of such reports.

"(e) Authorization of Appropriations.—There are authorized to be appropriated to the Under Secretary such sums as may be necessary to carry out this section.".

(2) The table of contents in section 1(b) of such Act is amended in subtitle C of title II by adding at the end the following new item.

"Sec. 226. Pilot project to test use of tear-line intelligence reports.".

(c) Homeland Defender Intelligence Training Program.

(1) Establishment of program.—The Director of Central Intelligence may establish a comprehensive program of orientation and training to qualified State and local officials in accessing and using available resources of the intelligence community (as defined in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401(4))).

(2) Consultation.—Insofar as the Director establishes the intelligence training program under paragraph (1), the Director shall consult and coordinate with the director of the Federal Bureau of Investigation and the Secretary of Homeland Security on the development and administration of the program.

(3) Program goals.—Any intelligence training program established under paragraph (1) shall provide qualified State and local officials instruction on the mission and roles of the intelligence community to promote more effective information sharing among Federal, State, and local officials to prevent terrorist attacks against the United States.

(4) Curriculum.—Insofar as the Director establishes the intelligence training program under paragraph (1), the Director shall develop a curriculum for the program after consultation with qualified State and local officials. The curriculum shall include classroom instruction with respect to and orientation to the various elements of the intelligence community.

(5) Reports to Congress.—Not later than 1 year after the initial implementation of the intelligence training program under paragraph (1), and annually thereafter, the Director shall submit to Congress a report on the program. Each such report shall include—

(A) an assessment of the effectiveness of the project; and

(B) recommendations on the continuation of the project as well as any recommendations to improve the effectiveness of information collection and sharing by qualified officials and representatives and the Federal government.

(6) Qualified State and Local Officials Defined.—For purposes of this subsection, the term "qualified State and local officials" means officials of State and local government agencies that Director of Central Intelligence determines—

(A) have received appropriate security clearances from the Director of the Federal Bureau of Investigation for access to classified information; and

(B) oversee or manage first responders or counterterrorism activities.

(7) Authorization of Appropriations.—There is authorized to be appropriated to the Director such sums as are necessary to carry out the intelligence training program under this subsection.

(d) Advisory Councils.—(1) The Director of the Terrorist Threat Integration Center shall establish two advisory councils (described in paragraph (2)) to provide the Director such advice and recommendations as the Director may require to effectively carry out the functions of the Center.

(2)(A) One advisory council shall have as its focus privacy and civil liberties issues.

(B) The other advisory council shall have as its focus State and local government information needs.

Subtitle E—Reports and Technical Amendments

SEC. 341. EXTENSION OF DEADLINE FOR FINAL REPORT OF THE NATIONAL COMMISSION FOR THE REVIEW OF THE RESEARCH AND DEVELOPMENT PROGRAMS OF THE UNITED STATES INTELLIGENCE COMMUNITY.

(a) In General.—Subsection (a) of section 1007 of the Intelligence Authorization Act for Fiscal Year 2003 (Public Law 107–306; 50 U.S.C. 401 note; 116 Stat. 2442) is amended by striking "September 1, 2003" and inserting "September 1, 2004".

(b) Effective Date.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 1007 of the Intelligence Authorization Act for Fiscal Year 2003.

SEC. 342. MODIFICATION OF VARIOUS REPORTS REQUIRED OF INTELLIGENCE COMMUNITY ELEMENTS.

(a) Reports on Acquisition of Technology Relating to Weapons of Mass Destruction and Advanced Conventional Munitions.—Subsection (b)(1) of section 721 of the Intelligence Authorization Act for Fiscal Year 1997 (Public Law 104–293; 110 Stat. 3474; 50 U.S.C. 2366), as amended by section 811(b)(5)(C) of the Intelligence Authorization Act for Fiscal Year 2003 (Public Law 107–306; 116 Stat. 2424; 50 U.S.C. 2366), is amended by striking "a semiannual" and inserting "an annual".

(b) Periodic and Special Reports on Disclosure of Intelligence Information to United Nations.—Section 112(b)(1) of the National Security Act of 1947 (50 U.S.C. 404g(b)(1)) is amended by striking "semiannually" and inserting "annually".

SEC. 343. TECHNICAL AMENDMENTS.

(a) National Security Act of 1947.—Section 112(d)(1) of the National Security Act of 1947 (50 U.S.C. 404g(d)(1)) is amended by striking "section 103(c)(6)" and inserting "section 103(c)(7)".

(b) Central Intelligence Agency Act of 1949.—(1) Section 6 of the Central Intelligence Agency Act of 1949 (50 U.S.C. 403g) is amended by striking "section 103(c)(6)" and inserting "section 103(c)(7)".

(2) Section 15 of such Act (50 U.S.C. 403o) is amended—

(A) in subsection (a)(1), by striking "special policemen of the General Services Administration perform under the first section of the Act entitled 'An Act to authorize the Federal Works Administrator or officials of the Federal Works Agency duly authorized by him to appoint special policeman for duty upon Federal property under the jurisdiction of the Federal Works Agency, and for other purposes'(40 U.S.C. 318)," and inserting "officers and agents of the Department of Homeland Security, as provided in section 1315(b)(2) of title 40, United States Code,"; and

(B) in subsection (b), by striking "the fourth section of the Act referred to in subsection (a) of this section (40 U.S.C. 318c)" and inserting "section 1315(c)(2) of title 40, United States Code".

(c) National Security Agency Act of 1959.—Section 11 of the National Security Agency Act of 1959 (50 U.S.C. 402 note) is amended—

(1) in subsection (a)(1), by striking "special policemen of the General Services Administration perform under the first section of the Act entitled 'An Act to authorize the Federal Works Administrator or officials of the Federal Works Agency duly authorized by him to appoint special policeman for duty upon Federal property under the jurisdiction of the Federal Works Agency, and for other purposes'(40 U.S.C. 318)" and inserting "officers and agents of the Department of Homeland Security, as provided in section 1315(b)(2) of title 40, United States Code,"; and

(2) in subsection (b), by striking "the fourth section of the Act referred to in subsection (a) (40 U.S.C. 318c)" and inserting "section 1315(c)(2) of title 40, United States Code".

(d) Intelligence Authorization Act for Fiscal Year 2003.—Section 343 of the Intelligence Authorization Act for Fiscal Year 2003 (Public Law 107–306; 116 Stat. 2399; 50 U.S.C. 404n–2) is amended—

(1) in subsection (c), by striking "section 103(c)(6) of the National Security Act of 1947 (50 U.S.C. 403–3(c)(6))" and inserting "section 103(c)(7) of the National Security Act of 1947 (50 U.S.C. 403–3(c)(7))"; and

(2) in subsection (e)(2), by striking "section 103(c)(6)" and inserting "section 103(c)(7)".

(e) Public Law 107–173.—Section 201(c)(3)(F) of the Enhanced Border Security and Visa Entry Reform Act of 2002 (Public Law 107–173; 116 Stat. 548; 8 U.S.C. 1721(c)(3)(F)) is amended by striking "section 103(c)(6) of the National Security Act of 1947 (50 U.S.C. 403–3(c)(6))" and inserting "section 103(c)(7) of the National Security Act of 1947 (50 U.S.C. 403–3(c)(7))".

(f) Federal Information Security Management Act of 2002.—Section 3535(b)(1) of title 44, United States Code, as added by section 1001(b)(1) of the Homeland Security Act of 2002 (Public Law 107–296), and section 3545(b)(1) of title 44, United States Code, as added by section 301(b)(1) of the E–Government Act of 2002 (Public Law 107–347), are each amended by inserting "or any other law" after "1978".

SEC. 344. REPORT ON LESSONS LEARNED FROM MILITARY OPERATIONS IN IRAQ.

(a) Report.—Not later than one year after the date of the enactment of this Act, the Director of Central Intelligence shall submit to the appropriate committees of Congress a report on the intelligence lessons learned as a result of Operation Iraqi Freedom, including lessons relating to the following:

(1) The tasking, collection, processing, exploitation, analysis, and dissemination of intelligence.

(2) Accuracy, timeliness, and objectivity of intelligence analysis.

(3) Intelligence support to policymakers and members of the Armed Forces in combat.

(4) Coordination of intelligence activities and operations with military operations.

(5) Strengths and limitations of intelligence systems and equipment.

(6) Such other matters as the Director considers appropriate.

(b) Recommendations.—The report under subsection (a) shall include such recommendations on improvement in the matters described in subsection (a) as the Director considers appropriate.

(c) Appropriate Committees of Congress Defined.—In this section, the term "appropriate committees of Congress" means—

(1) the Permanent Select Committee on Intelligence and the Committee on Armed Services of the House of Representatives; and

(2) the Select Committee on Intelligence and the Committee on Armed Services of the Senate.

TITLE IV—CENTRAL INTELLIGENCE AGENCY

SEC. 401. PROTECTION FROM TORT LIABILITY FOR CERTAIN CENTRAL INTELLIGENCE AGENCY PERSONNEL.

(a) In General.—Section 15 of the Central Intelligence Agency Act of 1949 (50 U.S.C. 403o) is amended by adding at the end the following new subsection:

"(d)(1) Notwithstanding any other provision of law, any Agency personnel designated by the Director under subsection (a) shall be deemed for purposes of chapter 171 of title 28, United States Code, or any other provision of law relating to tort liability, to be acting within the scope of their office or employment if the Agency personnel take reasonable action, which may include the use of force, to—

"(A) protect an individual in the presence of the Agency personnel from a crime of violence;

"(B) provide immediate assistance to an individual who has suffered or who is threatened with bodily harm; or

"(C) prevent the escape of any individual whom the Agency personnel reasonably believe to have committed a crime of violence in the presence of such personnel.

"(2) In this subsection, the term 'crime of violence' has the meaning given that term in section 16 of title 18, United States Code.".

(b) Construction.—Subsection (d) of section 15, as added by subsection (a), shall not be construed as affecting the authorities of the Attorney General under the Federal Employees Liability Reform and Tort Compensation Act of 1988 (Public Law 100–694; 28 U.S.C. 2671, 2674, 2679(b), 2679(d)).

SEC. 402. REPEAL OF LIMITATION ON USE OF FUNDS IN CENTRAL SERVICES WORKING CAPITAL FUND.

Section 21(f)(2) of the Central Intelligence Agency Act of 1949 (50 U.S.C. 403u(f)(2)) is amended—

(1) in subparagraph (A), by striking "(A) Subject to subparagraph (B), the Director" and inserting "The Director"; and

(2) by striking subparagraph (B).

TITLE V—DEPARTMENT OF DEFENSE INTELLIGENCE MATTERS

SEC. 501. USE OF FUNDS FOR COUNTERDRUG AND COUNTERTERRORISM ACTIVITIES FOR COLOMBIA.

(a) Extension of Authority.—Subsection (a) of section 501 of the Intelligence Authorization Act for Fiscal Year 2003 (Public Law 107–306; 116 Stat. 2404) is amended by striking "for fiscal years 2002 and 2003" and inserting "for each of fiscal years 2002 through 2005".

(b) Modification.—(1) Subsection (e) of such section is amended to read as follows:

"(e) Prohibition.—No United States Armed Forces personnel, United States civilian employee or contractor engaged by the United States will participate in any combat operation in connection with assistance made available under this section, except for the purpose of acting to protect the life or the physical security of others, in self defense, or during the course of search and rescue operations.".

(c) Technical Amendment.—Subsection (d) of such section is amended by striking "Sections 556, 567, and 568 of Public Law 107–115, section 8093 of the Department of Defense Appropriations Act, 2002," and inserting "Section 553 and the certification requirements of section 564(a)(2) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2003 (division E of Public Law 108–7; 117 Stat. 200, 205), and section 8093 of the Department of Defense Appropriations Act, 2003 (Public Law 107–248; 116 Stat. 1558; 10 U.S.C. 182 note),".

(d) Effective Date.—The amendments made by subsections (b) and (c) shall apply to assistance made available under such section 501 during fiscal years 2004 and 2005.

SEC. 502. AUTHORITY TO PROVIDE LIVING QUARTERS FOR CERTAIN STUDENTS IN COOPERATIVE AND SUMMER EDUCATION PROGRAMS OF THE NATIONAL SECURITY AGENCY.

Section 2195 of title 10, United States Code, is amended by adding at the end the following new subsection:

"(d)(1) The Director of the National Security Agency may provide a qualifying employee of a defense laboratory of that Agency with living quarters at no charge, or at a rate or charge prescribed by the Director by regulation, without regard to section 5911(c) of title 5.

"(2) In this subsection, the term 'qualifying employee' means a student who is employed at the National Security Agency under—

"(A) a Student Educational Employment Program of the Agency conducted under this section or any other provision of law; or

"(B) a similar cooperative or summer education program of the Agency that meets the criteria for Federal cooperative or summer education programs prescribed by the Office of Personnel Management.".

SEC. 503. AUTHORITY FOR INTELLIGENCE COMMUNITY ELEMENTS OF DEPARTMENT OF DEFENSE TO AWARD PERSONAL SERVICE CONTRACTS.

(a) In General.—Subchapter I of chapter 21 of title 10, United States Code, is amended by adding at the end the following new section:

"§426. Personal services contracts: authority and limitations

"(a) PERSONAL SERVICES.—(1) The Secretary of Defense may, notwithstanding section 3109 of title 5, enter into personal services contracts in the United States if the personal services directly support the mission of a defense intelligence component or counter-intelligence organization.

"(2) The contracting officer for a personal services contract shall be responsible for ensuring that a personal services contract is the appropriate vehicle for carrying out the purpose of the contract.

"(b) DEFINITION.—In this section, the term 'defense intelligence component' means a component of the Department of Defense that is an element of the intelligence community, as defined in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401a(4)).".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such subchapter is amended by adding at the end the following new item:

"426. Personal services contracts: authority and limitations.".

SEC. 504. PROTECTION OF CERTAIN NATIONAL SECURITY AGENCY PERSONNEL FROM TORT LIABILITY.

Section 11 of the National Security Agency Act of 1959 (50 U.S.C. 402 note) is amended by adding at the end the following new subsection:

"(d)(1) Notwithstanding any other provision of law, agency personnel designated by the Director of the National Security Agency under subsection (a) shall be considered for purposes of chapter 171 of title 28, United States Code, or any other provision of law relating to tort liability, to be acting within the scope of their office or employment when such agency personnel take reasonable action, which may include the use of force, to—

"(A) protect an individual in the presence of such agency personnel from a crime of violence;

"(B) provide immediate assistance to an individual who has suffered or who is threatened with bodily harm; or

"(C) prevent the escape of any individual whom such agency personnel reasonably believe to have committed a crime of violence in the presence of such agency personnel.

"(2) Paragraph (1) shall not affect the authorities of the Attorney General under section 2679(d)(1) of title 28, United States Code.

"(3) In this subsection, the term 'crime of violence' has the meaning given that term in section 16 of title 18, United States Code.".

SEC. 505. MEASUREMENT AND SIGNATURES INTELLIGENCE RESEARCH PROGRAM.

(a) RESEARCH PROGRAM.—The Secretary of Defense, acting through the Director of the Defense Intelligence Agency's Directorate for MASINT and Technical Collection, shall carry out a program to incorporate the results of basic research on sensors into the measurement and signatures intelligence systems of the United States, to the extent the results of such research is applicable to such systems.

(b) PROGRAM COMPONENTS.—The program under subsection (a) shall review and assess both basic research on sensors and technologies conducted by the United States Government and by non-governmental entities. In carrying out the program, the Director shall protect intellectual property rights, maintain organizational flexibility, and establish research projects, funding levels, and potential benefits in an equitable manner through Directorate.

(c) ADVISORY PANEL.—(1) The Director shall establish an advisory panel to assist the Director in carrying out the program under subsection (a).

(2) The advisory panel shall be headed by the Director who shall determine the selection, review, and assessment of the research projects under the program.

(3)(A) The Director shall appoint as members of the advisory panel representatives of each entity of the MASINT community, and may appoint as such members representatives of national laboratories, universities, and private sector entities.

(B) For purposes of this subsection the term "MASINT community" means academic, professional, industrial, and government entities that are committed towards the advancement of the sciences in measurement and signatures intelligence.

(C) The term for a member of the advisory panel shall be established by the Director, but may not exceed a period of 5 consecutive years.

(D) Members of the advisory panel may not receive additional pay, allowances, or benefits by reason of their service on the advisory panel, but may receive per diem in lieu of subsistence, in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code.

(4) The Director may accept contributions from non-governmental participants on the advisory panel to defray the expenses of the advisory panel.

The CHAIRMAN pro tempore. No amendment to the committee amendment is in order except those printed in House Report 108-176. Each amendment may be offered only in the order printed in the report, by a Member designated in the report, shall be considered read, and shall not be subject to a demand for division of the question.

It is now in order to consider amendment No. 1 printed in House Report 108-176.

AMENDMENT NO. 1 OFFERED BY MR. COX

Mr. COX. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Mr. COX:
Strike section 336.

Mr. COX. Mr. Chairman, as chairman of the Select Committee on Homeland Security, I am pleased to rise in support of H.R. 2417. The amendment that I have introduced I will address in a moment but let me state at the outset that there is no more important function in the war on terrorism than having and acting on good intelligence, intelligence about attacks that are yet to come, intelligence about who is involved, what is planned, where and when it will take place and how it might be executed.

The bill as it is written provides critical support for the Intelligence Community's efforts in the war on terrorism. I especially appreciate the provisions in the legislation focusing additional attention on enhancing our capability for gathering human intelligence as well as the provisions that provide additional resources to increase our analytical capacity to process and make use of the intelligence we do gather.

The amendment that I am offering seeks to strike section 336 of the legislation. Section 336 would amend the Homeland Security Act to create two pilot programs, one, to encourage State and local officials, critical infrastructure owners to collect and share relevant information; and, two, to test use of tear-line intelligence reports. However, Mr. Chairman, the Homeland Security Act already includes training and information sharing requirements for State, local and private sector officials. The Director of Central Intelligence, the head of the CIA, would under the language of the bill as it is written have a central role in both of these pilot programs which would inject the CIA into this domestic, homeland security function.

Under the first section 336 pilot program on sharing critical infrastructure information, the DCI would carry out his responsibilities through the Director of the Terrorist Threat Integration Center, or TTIC, which has never before been recognized in law and has no responsibilities whatever for critical infrastructure information. Using TTIC in this way would undermine the statutory function of the Office of Infrastructure Protection subdirectorate of the Department of Homeland Security. We do not need to pilotize the Department's existing statutory obligations.

The Secretary of Homeland Security, acting through the Under Secretary for Information Analysis and Infrastructure Protection, already is required to, and this is now a quote from existing law, "coordinate training and other support to the elements and personnel of the Department, other agencies of the Federal Government, and State and local governments that provide information to the Department, or are consumers of information provided by the Department, in order to facilitate the identification and sharing of information." That is the Homeland Security Act as it is written.

The Homeland Security Act already requires that the Secretary of Homeland Security "coordinate with elements of the Intelligence Community and with Federal, State, and local law enforcement agencies, and the private sector." Extensive information sharing requirements covering State, local and private officials already exist in the Homeland Security Act, for example, in sections 891 and 892.

Tear-line reporting, unclassified reports to convey the critical substance of classified intelligence reporting, is already a common practice. There is not a need for a pilot program. The Homeland Security Act already requires that the Secretary of Homeland Security "in consultation with the Director of Central Intelligence, shall work to ensure that intelligence or other information relating to terrorism to which the Department has access is appropriately shared with State and local governments."

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At this point I hope that the distinguished gentleman from Florida (Mr. GOSS), chairman of the Permanent Select Committee on Intelligence, could rise to enter into a colloquy so that I might obtain additional information on the amendments to the Homeland Security Act contained within section 336 of the legislation, and I would yield for this purpose to the chairman.

As the chairman knows, I am offering an amendment to strike section 336 of the legislation as it proposes amendments to the Homeland Security Act that fall within the jurisdiction of the Permanent Select Committee on Homeland Security. I am prepared to withdraw this amendment pending appropriate clarification by the gentleman.

Mr. GOSS. Mr. Chairman, will the gentleman yield?

Mr. COX. I yield to the gentleman from Florida.

Mr. GOSS. Mr. Chairman, I thank the gentleman for yielding.

I would like to clarify for the record that the provisions of H.R. 2417, Intelligence Authorization Act for Fiscal Year 2004, amending the Homeland Security Act, fall within the jurisdiction of the Select Committee on Homeland Security and that their inclusion in H.R. 2417 does not create a basis for the assertion of jurisdiction over the act by the Permanent Select Committee on Intelligence. Furthermore, I would like to clarify for the distinguished chairman that the chairman of the Select Committee on Homeland Security and I have indeed agreed upon a revision of the provisions that are acceptable to both our ranking members, that is, the gentlewoman from California (Ms. HARMAN) and the gentleman from Texas (Mr. TURNER), the gentleman's committee's ranking member. I will commit to work with the gentleman's committee and the Committee on the Judiciary for substitution of the revised language in the conference negotiations between the House and the Senate, and to that end I have also agreed to support the request of the Select Committee on Homeland Security for the appointment of two conferees on H.R. 2417.

Mr. COX. Mr. Chairman, reclaiming my time, I thank the gentleman for his comments.

I include in the CONGRESSIONAL RECORD copies of the exchange of correspondence between our two committees on this topic.

U.S. HOUSE OF REPRESENTATIVES,
PERMANENT SELECT COMMITTEE ON INTELLIGENCE,
Washington, DC, June 25, 2003.

Hon. CHRISTOPHER COX,
Chairman,
Select Committee on Homeland Security, Washington, DC.

DEAR MR. CHAIRMAN: This letter is to memorialize our understanding that the provisions of H.R. 2417 (the “provisions”) amending the Homeland Security Act (the “Act”) fall within the jurisdiction of the Select Committee on Homeland Security, and that their inclusion in H.R. 2417 does not create a basis for the assertion of jurisdiction over the Act by the Permanent Select Committee on Intelligence.

We have agreed upon a revision of the provisions that is acceptable to both of our Ranking Members, a copy of which is attached, and we agree to work for a mutually agreeable resolution of this provision with your Committee and the Committee on the Judiciary, for substitution in the conference negotiations between the House and the Senate.

To that end, I have agreed to support the request of the Select Committee on Homeland Security for the appointment of two conferees on H.R. 2417.

Sincerely,

PORTER J. GOSS,
Chairman.

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON HOMELAND SECURITY,
Washington, DC, June 25, 2003.

Hon. PORTER GOSS,
Chairman,
House Permanent Select Committee on Intelligence, Washington, DC.

DEAR CHAIRMAN GOSS: This letter is to memorialize our understanding that the provisions of H.R. 2417 (the “provisions”) amending the Homeland Security Act (the “Act”) fall within the jurisdiction of the Select Committee on Homeland Security, and that their inclusion in H.R. 2417 does not create a basis for the assertion of jurisdiction over the Act by the Permanent Select Committee on Intelligence.

We have agreed upon a revision of the provisions that is acceptable to both of our Ranking Members, a copy of which is attached, and we agree to work for substitution of the revised language in the conference negotiations between the House and the Senate.

To that end, I have agreed to support the request of the Select Committee on Homeland Security for the appointment of two conferees on H.R. 2417.

Sincerely,

CHRISTOPHER COX,
Chairman.

AMENDMENT TO H.R. 2417, AS REPORTED OFFERED BY MR. COX OF CALIFORNIA (FOR HIMSELF AND MR. TURNER OF TEXAS)

Amend section 336 to read as follows:

SEC. 336. IMPROVEMENT OF INFORMATION SHARING AMONG FEDERAL, STATE, AND LOCAL GOVERNMENT OFFICIALS.

(a) IN GENERAL.—Section 892(c) of the Homeland Security Act of 2002 (Public Law 107–296; 6 U.S.C. 482) is amended by adding at the end the following new paragraph:

“(3)(A) The Secretary shall establish a program to provide appropriate training to officials described in subparagraph (B) in order to assist such officials in—

“(i) identifying sources of potential terrorist threats through such methods as the Secretary determines appropriate;

“(ii) reporting information relating to such potential terrorist threats to the appropriate Federal agencies in the appropriate form and manner;

“(iii) assuring that all reported information is systematically submitted to and passed on by the Department for use by appropriate Federal agencies; and

“(iv) understanding the mission and roles of the intelligence community to promote more effective information sharing among Federal, State, and local officials to prevent terrorist attacks against the United States.

“(B) The officials referred to in subparagraph (A) are officials of State and local government agencies that oversee or manage first responders or counterterrorism activities.

“(C) The Secretary shall consult with the Attorney General to ensure that the training program established in subparagraph (A) does not duplicate the training program established in section 908 of the USA PATRIOT Act (Public Law 107–56; 28 U.S.C. 509 note).

“(D) The Secretary shall carry out this paragraph through the Under Secretary for Information Analysis and Infrastructure Protection (acting pursuant to the duties described in section 201(d)(16)), in consultation with the Director of Central Intelligence and the Attorney General.”.

(b) REPORT.—(1) Not later than 30 days after the date of the enactment of this Act, the Secretary of Homeland Security shall submit to Congress a report that describes the Secretary's plan for implementing such section 892 (as in effect on the day before the date of the enactment of this Act) and an estimated date of completion of the implementation.

Because of the agreement between our two committees, I will also ask unanimous consent to withdraw the amendment.

I look forward to working with the chairman and members of the Permanent Select Committee on Intelligence for an agreeable resolution of this matter in conference.

Mr. Chairman, if I have remaining time, I yield to the gentlewoman from California (Ms. HARMAN), the ranking member.

Ms. HARMAN. Mr. Chairman, I thank the gentleman for yielding. I rise to state that I fully support the agreement that has been worked out between the chairmen of the two committees on which I serve. Since the language at issue was language that was inserted in our bill at my request, I want to make clear that we should work out these jurisdictional issues, but we also should proceed to find the right sections of the right bills to insert additional language on information sharing which is still a critical need in the homeland security and the terrorist threat areas.

We also need to insert language at the right places about the protection of civil liberties. I listened to the comments by the gentleman from California (Mr. COX) concerning the fact that we have no statutory language for TTIC, the Terrorist Threat Integration Center, and perhaps we should decide about that in some other forum. Nonetheless, TTIC exists, and it is critically important that we make sure that it respects the civil liberties of Americans. So we will continue to search for new venues, but I thank both chairmen for finding the proper way to solve this issue.

Mr. GOSS. Mr. Chairman, I move to strike the last word.

Mr. Chairman, I am not going to use the 5 minutes. I just want to clarify this point while the distinguished chairman of the Select Committee on Homeland Security is here that his efforts and the gentlewoman from California's (Ms. HARMAN) efforts to work out acceptable language had in fact transpired and we were prepared to accept an amendment to the bill to do that. There is another party involved, and we wanted to make sure that the appropriate full dialogue took place because what we are about here is really trying to plug in a Foreign Intelligence Program, which is what our portfolio is with the new efforts domestically to deal with terrorism on the homeland.

We are not interested in any territorial acquisition, as I have said many times. We are interested in plugging in the national foreign intelligence activity and capability in the right places in the right way. That will involve working with a number of committees. Fortunately, we have good Members who serve on a number of committees and we are using that expertise to make these bridging arrangements. I would like to publicly thank the gentlewoman from California (Ms. HARMAN) and the gentleman from California (Mr. COX) for their efforts to get the homeland security piece done. We have more work to do on this particular element. They have my pledge in the colloquy that we will work together to get this done properly, and I have nothing further to add to that.

Mr. COX. Mr. Chairman, will the gentleman yield?

Mr. GOSS. I yield to the gentleman from California.

Mr. COX. Mr. Chairman, I want to return the favor and thank both the gentleman from Florida (Chairman GOSS) and the gentlewoman from California (Ms. HARMAN), ranking member, for all of the work that went into making this language acceptable, the language that we had agreed upon. I am sorry it cannot be included procedurally, but our understanding to do it at the next step is certainly satisfactory to me; and I just want to say that I could not agree more with the sentiments of both the chairman and the ranking member about the importance of sharing information. That is what the mission of Homeland Security is all about, and we do have between us and among us ample opportunity to amend whatever laws it takes to get this job done; and I would point out that the Speaker has made it possible for all three of us to work together on the Select Committee on Homeland Security. So we are doing our version of fusion here in the House, and I am confident we will succeed.

Mr. Chairman, I ask unanimous consent to withdraw the amendment.

The CHAIRMAN pro tempore (Mr. SIMPSON). Is there objection to the request of the gentleman from California?

There was no objection.

The CHAIRMAN pro tempore. It is now in order to consider amendment No. 2 printed in House Report 108–176.

If the amendment proposed by the gentleman from California (Mr. FARR) is not to be offered, then it is now in order to consider amendment No. 3 printed in House Report 108–176.

AMENDMENT NO. 3 OFFERED BY MS. HARMAN

Ms. HARMAN. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 3 offered by Ms. HARMAN:

At the end of title III, add the following new section:

SEC. 345. MODIFICATION OF TERRORIST IDENTIFICATION CLASSIFICATION SYSTEM.

(a) CERTIFICATION REQUIREMENT FOR CONSOLIDATION OF WATCH LISTS.—Subsection (g)(1) of section 343 of the Intelligence Authorization Act for Fiscal Year 2003 (Public Law 107–306; 116 Stat. 2399; 50 U.S.C. 404n2) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E);

(2) by inserting after subparagraph (C) the following new subparagraph:

"(D) Whether further consolidation or elimination of watch list databases in the departments and agencies with access to the System would contribute to the efficiency and effectiveness of the System in identifying individuals who are known or suspected international terrorists."; and

(3) in subparagraph (E), as so redesignated, by adding at the end the following: "If the certification under subparagraph (D) is in the positive, the steps required to consolidate or eliminate such watch lists.".

(b) ESTABLISHMENT OF ADVISORY COUNCIL.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

"(4) The Director shall establish an advisory council comprised of experts in the field of civil liberties and privacy issues to advise the Director on issues of civil liberties and privacy as they relate to the maintenance of the System.".

Ms. HARMAN. Mr. Chairman, let me say first that the amendment which the gentleman from California (Mr. FARR) would have offered is an excellent amendment having to do with language skills, and my understanding is that we have accommodated him in some other way. I am sure the chairman will speak to that. And I would be happy to yield to him first on that subject.

Mr. GOSS. Mr. Chairman, will the gentlewoman yield?

Ms. HARMAN. I yield to the gentleman from Florida.

Mr. GOSS. Mr. Chairman, I appreciate the gentlewoman for yielding.

All I would say is that I was going to compliment the gentleman from California (Mr. FARR) for a very helpful, thoughtful contribution to our work product. In fact, we have been working on this subject for a number of years, which is the training question and the language question; and the gentleman has some very unique perspectives on this which have been very helpful to us. We are improved in our committee for his participation in this process. I do not believe it is necessary to offer the amendment. Apparently he has not, but I nevertheless wanted to appreciate publicly the contribution he has made.

Ms. HARMAN. Mr. Chairman, turning to my amendment, in August, 2001, the FBI was frantically looking for two men who became part of the terrorist suicide team on 9–11. Had we been able to find Nawaf al-Hazmi and Khaled al-Mihdhar, we may have been able to unravel the plot for 9–11. At least we would have stopped these two individuals from participating in it.

The problem, it turns out, was that the State Department and INS watchlists, which included their names, were not available to the FAA and the airlines. So the hijackers were freely allowed to board the ill-fated American Airlines Flight 77.

Two years later, the Federal Government still has as many as 50 databases used for tracking international terrorists and international terrorist organizations. Just recently, the GAO highlighted 12 watchlists run by nine agencies.

This is shocking. Information contained in one database need not be connected to information in another. Vital data that could help prevent the next terrorist attack could be missed. We must consolidate or at least ensure the interoperability of government watchlists, and my amendment pending before this House to this intelligence authorization bill addresses this.

In last year's intelligence authorization act, the Congress required the creation of a Terrorist Identification Classification System, TICS. This system is intended to be an authoritative real-time compilation of individuals and organizations known or suspected of international terrorism derived from all-source intelligence and available for use by other government agencies. The establishment of TICS is still a work in progress. The Director of Central Intelligence is required to report on progress by the end of November.

My amendment requires the Director of Central Intelligence to certify whether further consolidation, or increased interoperability, is the best way to increase the efficiency and effectiveness of TICS. Either way we go, the point is to connect the dots in real time.

The concept of a single government database to track suspected terrorists does raise some civil liberties concerns. To address the privacy and civil liberties concerns, my amendment requires the Director of Central Intelligence to establish an advisory council of experts on matters of civil liberties and privacy.

Mr. Chairman, the relationship of civil liberties and security has been an abiding concern for this committee. The gentleman from New Jersey (Mr. HOLT), one of our members, has been active in this area, and so has our chairman, who convened the first hearing, public hearing, on civil liberties earlier this year where a panel of witnesses from the ACLU to the Heritage Foundation agreed that we need to balance civil liberty and security.

As Ben Franklin once said: "They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety." The Harman amendment addresses both liberty and safety, and I urge its adoption.

Mr. GOSS. Mr. Chairman, I move to strike the last word.

First of all, I want to congratulate the gentlewoman on an amendment that she has worked hard on and I know cares a great deal about, and I will say right up front that the amendment is acceptable to the committee. I do want to make a comment on it, though.

The amendment requires the DCI to consider whether further consolidation of the various U.S. Government terrorist watchlist databases might add to the efficiency of the watchlist system in identifying known or suspected terrorists. Absolutely a goal that we have to achieve. The question is what is the right way to do it? And the gentlewoman has raised the question properly. I commend her for it. Her dedication and expertise on counterterrorism issues I think is well known. She has served not only the Permanent Select Committee on Intelligence of this Congress but previous iterations of this effort on national commissions and so forth; and I think we all very much respect her judgment.

And as I said, this amendment is a good one and it brings the issue to the floor. It asks the DCI to review and determine how much more consolidation of the various terrorist watchlists is needed, but I would add the words "if any." And the reason I say that is I am concerned about the potential loss of data that might result from the consolidation of all the watchlists available to the government. I do not know that that would happen. It is a question that has to be asked.

Additionally, I would think that there is one other area that I worry about a little bit, and that is sort of the idea of Big Brother. The one big unified, centralized U.S. Government computer database with all of the information available to the U.S. Government on individuals and their associates might be viewed to some as concerning, particularly those who worry about Big Brother invading their privacy.

I am not saying I have the answer; but at this stage of my thinking, I am sort of in the position to be inclined to support a network solution that virtually combines the data in various databases without actually dumping all of the information from all the databases into one big government Big Brother database. So I would think that something on the order perhaps of Web browser or Web sniffer, some way of searching out all the databases simultaneously, using some of those extraordinary technological tools that are developed in the gentlewoman's district, the software that is out there that not only searches all of them at the same time but also crossreferences the search results in such a way that maximizes the researchers' efficiencies and at the same time gives us some of the safeguards, or the appearance of safeguards anyway, the perception that we are safeguarding better than one big database.

I do not wish to prejudge the outcome of the review. As we always do, we candidly state our positions on these things. As I said, I think the gentlewoman has raised exactly the right question. I thank her for her contribution in doing that, and I believe the amendment is worded properly so we go forward, and I will accept the amendment on behalf of the committee.

Mr. HOLT. Mr. Chairman, I move to strike the requisite number of words.

I support the gentlewoman's amendment also, and I am very pleased to acknowledge the atmosphere in this committee that allows us to function so well. It is what a committee should be. The gentleman from Florida (Chairman GOSS) and the gentlewoman from California (Ms. HARMAN), ranking member, avoid, I think, destructive partisanship and allow us to air our differences in a very constructive way.

I would like to draw attention to section 336 of this bill that includes a provision that I have strongly advocated for to require the director of the Terrorist Threat Integration Center to establish two advisory councils to help the center carry out its critical and time-sensitive work, Mr. Chairman.

□ 1845

One Advisory Council will focus on privacy and civil liberty concerns. We all know and understand that we are engaged in an ongoing fight against global terrorism and that our entire Intelligence Community is central to prosecuting and winning this struggle. But, at the same time, as we enhance our intelligence-gathering and analysis, it is equally important that the Director of the Terrorist Threat Integration Center and all employees there must respect the basic civil liberties that define our lives as Americans. Surely this Advisory Council will help us more nearly achieve the right delicate balance between security and liberty.

Now, equally important, this section of the bill also requires an Advisory Council to the Director of the Terrorist Threat Integration Center be established to concentrate on getting more and better information to State and local governments. The efforts to improve substantially our homeland security as a matter of urgency fall primarily upon our first responders and the local and State governments who employ them. In my meetings with State and local officials in New Jersey, and with first responders in my district, I have heard repeatedly that they receive only the most general and vague and almost useless information from Washington. They seldom, if ever, receive any more specific information about what they should guard against. Clearly, they deserve more timely and useful information if they are to function to protect the lives, the safety, and the security of Americans. This Advisory Council should help overcome this incomplete communication of practically useful intelligence information from the Federal to the community level.

Third, I would like to comment about the importance of incorporating information based on open sources. These sources of information are not classified secret. And traditionally, within the Intelligence Community and to this day, some individuals seem to think that if information is not classified secret, it is not valuable. In the 21st century this institutionalized mindset is unfortunate, since our sources of information and the amount of information readily available to the public domain and in the public domain have grown enormously. The Internet has enabled one to access information that was once extremely hard or impractical to obtain, and the dynamics of globalization, the accelerated integration of global industry, commerce, communication, and travel have created many new sources of information. The civil and commercial sectors, for instance, are looking into subjects and technologies that once were the exclusive preserve of governments and intelligence services. A prominent example is imagery from satellites that is publicly or commercially available. In HUMINT intelligence, open access to officials and experts is unparalleled today.

I believe that the Intelligence Community should be exploiting such open source information far more than it is today, and achieving this goal will require a culture change and the application of technology. I thank the chairman for agreeing to include in the report a call for the Director of Central Intelligence to study and report back to Congress within 6 months how to incorporate and use open source material in virtually every aspect of intelligence, from collection to analysis, and across all disciplines. There are many instances where open source information can be useful, perhaps even more useful than classified sources, and surely, in many cases, cheaper.

Now, Mr. Chairman, I spoke earlier about the decision by the gentleman from Florida (Chairman GOSS) and the gentlewoman from California (Ranking Member HARMAN) to investigate thoroughly concerns about weapons of mass destruction and the intelligence that led into our fighting in Iraq. Our committee intends to issue a written report on its findings as promptly as possible, and I spoke about that earlier.

I would like to say a bit more, though. One concern that I have had is that the administration officials too often appear to have dropped the caveats and the uncertainties expressed in the intelligence reporting. Another concern is that at times the intelligence reporting or the officials presenting the intelligence appear to have been very certain about their conclusions that were based on uncertain evidence.

The CHAIRMAN pro tempore (Mr. SIMPSON). The time of the gentleman from New Jersey (Mr. HOLT) has expired.

(By unanimous consent, Mr. HOLT was allowed to proceed for 1 additional minute.)

Mr. HOLT. Mr. Chairman, it is critically important to determine whether the Intelligence Community's estimates on Iraq were badly off base, or whether the Iraqi regime managed to destroy or spirit away the suspect weapons or materials. Either way, it seems clear that performance of the Intelligence Community was less than we would expect. It is clear to all of the world that the coalition did not have the intelligence information specific enough to find, identify, and secure any massively destructive weapons. That realization certainly raises questions about whether we were ready to go to war if the Commander in Chief and the Pentagon were convinced that the weapons were real, but they did not know quite where they were or how we would secure them once we went to war. But that is a question for another day. We will be talking about that in weeks to come.

Now, I would say, with the amendments that we have in front of us today, I offer my full support to this legislation.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentlewoman from California (Ms. HARMAN).

The amendment was agreed to.

The CHAIRMAN pro tempore. It is now in order to consider Amendment No. 4 printed in House Report 108–176.

AMENDMENT NO. 4 OFFERED BY MR. HASTINGS OF FLORIDA

Mr. HASTINGS of Florida. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 4 offered by Mr. HASTINGS of Florida:

At the end of subtitle D of title III, insert the following new section:

SEC. 337. IMPROVEMENT OF RECRUITMENT, HIRING AND RETENTION OF ETHNIC AND CULTURAL MINORITIES IN THE INTELLIGENCE COMMUNITY.

(a) PILOT PROJECT TO IMPROVE DIVERSITY THROUGHOUT THE INTELLIGENCE COMMUNITY USING INNOVATIVE METHODOLOGIES FOR THE RECRUITMENT, HIRING AND RETENTION OF ETHNIC AND CULTURAL MINORITIES AND WOMEN WITH THE DIVERSITY OF SKILLS, LANGUAGES AND EXPERTISE REFLECTIVE OF THE CURRENT MISSION.—The Director of Central Intelligence shall carry out a pilot project under this section to test and evaluate alternative, innovative methods to recruit and hire for the intelligence community women and minorities with diverse ethnic and cultural backgrounds, skills, language proficiency, and expertise.

(b) METHODS.—In carrying out the pilot project, the Director shall employ methods such as advertising in foreign language newspapers in the United States, site visits to institutions with a high percentage of students who study English as a second language, and other methods that are not used by the Director under the DCI Diversity Strategic Plan to increase diversity of officers and employees in the intelligence community.

(c) DURATION OF PROJECT.—The Director shall carry out the project under this section for a 3-year period.

(d) REPORT.—Not later than 2 years after the date the Director implements the pilot project under this section, the Director shall submit to Congress a report on the project. The report shall include—

(1) an assessment of the effectiveness of the project; and

(2) recommendations on the continuation of the project as well as for improving the effectiveness of the project in meeting the goals of increasing the recruiting and hiring of women and minorities within the intelligence community.

(e) DIVERSITY PLAN.—(1) Not later than February 15, 2004, the Director of Central Intelligence shall submit to Congress a report which describes the plan of the Director, entitled the "DCI Diversity Strategic Plan", and any subsequent revision to that plan, to increase diversity of officers and employees in the intelligence community, including the short- and long-term goals of the plan. The report shall also provide a detailed description of the progress that has been made by each element of the intelligence community in implementing the plan.

(2) In implementing the plan, the Director shall incorporate innovative methods for the recruitment and hiring of women and minorities that the Director has determined to be effective from the pilot project carried out under this section.

(f) DEFINITION.—In this section, the term "intelligence community" has the meaning given that term in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401(4)).

Mr. HASTINGS of Florida. Mr. Chairman, I rise today to offer an amendment to the Intelligence Authorization bill on behalf of myself and the following members who are immediate cosponsors of the Select Committee on Intelligence: The gentlewoman from California (Ms. HARMAN), the gentleman from Texas (Mr. REYES), the gentlewoman from California (Ms. ESHOO), the gentleman from Maryland (Mr. RUPPERSBERGER), and the gentleman from Iowa (Mr. BOSWELL). I would also like to thank the chairman of the committee, my good friend, the gentleman from Florida (Mr. GOSS), for his previously stated support for this amendment.

Further, I would be remiss if I did not recognize the efforts of former member Louis Stokes and now departed and former member Julian Dixon; our present minority leader of the Democratic Caucus, the gentlewoman from California (Ms. PELOSI), and the gentleman from Georgia (Mr. BISHOP), and I had forgotten about Tim Roemer, who also was very instrumental in this particular arena as a former member, and others on both sides of the aisle that have been interested in this issue.

Mr. Chairman, this amendment directs the Director of Central Intelligence to establish a pilot program to improve the recruitment, hiring, and retention of ethnic and cultural minorities throughout the Intelligence Community.

Leaders in the Intelligence Community have, for a number of years, expressed the view that diversity within their population can pay dividends with respect to cultural understanding and especially language capabilities. And, for an equal number of years, the Select Committee on Intelligence has urged them to improve their efforts of hiring, promoting, and retaining individuals from diverse backgrounds.

While we noted in our report to accompany H.R. 2417 that progress has been made and, indeed, it has been, especially in the more recent years just passed, we also noted a lack of progress with respect to hiring, promotion, and retention of women and minorities under the current plan. The Secretary of Defense has stated that, "The current personnel system is not flexible enough to confront the dangers of the 21st century."

The amendment we offer today addresses one of the many concerns raised by the Secretary and proposes a potential solution. It directs the DCI to develop a pilot program to achieve the goals for increased diversity amongst the Intelligence Community staff.

This amendment requires that the Director use methods such as advertising in foreign language newspapers or conducting site visits to high schools, and I would even encourage middle schools as we look toward the future, because it is interesting that in those areas I feel we find many of our grandchildren and little children know a lot about computers that a lot of us older hands do not know about; and colleges as well, with a high percentage of students from diverse backgrounds as two or more recruitment methods. It also requires an annual report from the Director to assess the effectiveness of this project in meeting his goals.

If the horrors of 9/11 taught us anything, it is that the biggest threat to our democratic ideals and cultural beliefs comes from those who do not share our ideals and beliefs.

The war on terrorism has focused even greater attention on the Intelligence Community as they have collectively faced these and many other challenges with commendable determination. It will take time, innovation, and a long-term strategy to ensure that the Intelligence Community remains capable of both understanding and responding to the threats of the 21st century.

I believe that this amendment will help the Intelligence Community meet the goals they have set for themselves and challenges in the decades to come. I urge my colleagues to support this noncontroversial amendment.

Mr. GOSS. Mr. Chairman, I rise in support of the amendment.

Mr. Chairman, I am pleased that this amendment is before us. It is entirely consistent with the committee position, and I am very happy to accept it. I want to congratulate the gentleman from Florida (Mr. HASTINGS) for his continued, persistent, effective leadership on this, along with our colleague, the gentleman from Texas (Mr. REYES), who have both done the committee a big favor by keeping us focused on this.

The amendment directs the DCI to establish a pilot project to test and evaluate alternative and innovative methods to recruit and hire women and minorities with diverse skills, expertise, cultural, and ethnic backgrounds, and language proficiencies. That is obviously a very rich contribution to the Intelligence Community.

The pilot project would be carried out for a 3-year period, with a report on the effectiveness of the project at the end of the second year, as I understand the amendment.

The amendment also includes direction to the DCI to report to the committee by mid-February of the next calendar year on the DCI's diversity strategic plan, which is something we have been after for a while. This aspect of this amendment incorporates, in part, the amendment made to the schedule of authorizations by the gentleman from Texas (Mr. REYES) in the committee's markup. I think they are complementary to each other. I see no conflict, and I think that combined, they are a benefit.

Both members deserve and are commended for promoting the needs of the Intelligence Community in the area of diversity of skills, expertise, languages, cultural understanding, and ethnic background, which is not a fully met need, very clearly, in the Community, as we know.

In the committee report we stated that, and I am going to quote the language, "Diversity throughout the Intelligence Community population can pay dividends with respect to the richness it brings to the work of the IC, particularly as it relates to cultural understandings of particular target sets, increased language capabilities, and increased skills to address particular intelligence problems." Amen.

I believe that this project will help. I very eagerly accept the amendment without reservation, and I am pleased that the gentleman has offered it.

Ms. HARMAN. Mr. Chairman, will the gentleman yield?

Mr. GOSS. I yield to the gentlewoman from California.

Ms. HARMAN. Mr. Chairman, I thank the chairman for the civilized and collaborative way in which this whole debate is going.

I rise in strong support of this amendment, and I just want to make a few brief points, Mr. Chairman.

When the DDCICM, the Deputy Director of Central Intelligence for Community Management—that is a mouthful—Joan Dempsey, came to say goodbye recently, it occurred to me that she was one of the few senior women in the entire Intelligence Community. The only other one I can think of is Joanne Isham, who is the Deputy Director of the National Security Agency. The same story can be said about people from other ethnic groups. That is unfortunate.

This amendment, which is carefully drafted and consistent with our policy in our committee for the last 15 years, will hopefully move the Community forward.

□ 1900

Earlier in this debate, I spoke, and others did, about the importance of beefing up HUMINT, our human intelligence resources. What is the point of human intelligence? The point is obviously to learn about terrorists. Their plans and intentions.

How do you do that? Well, you try to penetrate terrorist cells. How do you do that? Well, it would help if you looked like the terrorists and spoke their languages. And we cannot succeed in our effort if we just recruit the same old, same old. So it should be obvious that this is not the politically correct thing to do; it is the intelligent thing to do if we are trying to expand the talent pool and the capability of our intelligence agencies.

I strongly support this amendment. I thank the gentleman from Florida (Mr. HASTINGS), and the gentleman from Texas (Mr. REYES). They and others have done us a huge service.

Mr. REYES. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in strong support of the Hastings amendment. As has been stated, and I hope those that are watching this debate tonight can see the kind of cooperation and willingness to work together to solve some of the issues that greatly effect the national security of our country watching our chairman and ranking member and other members of the committee talk about what is good for our country.

Mr. Chairman, I think that people of diverse backgrounds can bring their unique cultural experiences, skills and language proficiencies to bear on intelligence problems, intelligence issues and intelligence expertise. The percentage of women and minorities in the intelligence community has for way too many years been smaller than the percentage of women and minorities in the total Federal workforce and the civilian workforce. Fiscal year 2002 data demonstrates that women and minorities continue to be under-represented in the intelligence community, especially in core mission areas and the senior ranks, as has been noted here by other members of our committee.

The committee has repeatedly expressed grave concern about the lack of progress made by the intelligence community in recruiting, in hiring and retaining a diverse workforce, essential if we are going to protect our country's national security. New tools must be brought to bear on the challenge of sufficiently diversifying the intelligence community workforce. Intelligence agencies must think, as we like to say, outside the box. I believe that the Hastings amendment encourages this kind of thinking, out-of-the-box thinking, by requiring the Director of Central Intelligence to carry out a pilot project to test and evaluate innovative alternative methods for recruiting and hiring people with diverse backgrounds.

The amendment, like the general provisions that have been reported out of our committee, also requires that the DCI report to Congress on his current diversity plan, including short- and long-term goals and the progress that is being made in implementing it by each of the intelligence community agencies.

Mr. Chairman, not only does this make good sense. It is good practice, it is good business, and it is good public policy. And, therefore, I urge all of my colleagues to support the Hastings amendment.

Mr. BOSWELL. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I thank the gentleman from Florida (Mr. HASTINGS) for putting this before us. I think its time is overdue, and I think it is reasonable that he would have a pilot project.

I just have to think back on my own life experience, and I will not tell you about that today, in starting in a country home, way out in the country. But I go to schools a lot, and I particularly want to talk to the young folk in regard to their futures and education and what it means to them. And I often tell them my story and, again, I will not tell you tonight, but what it can do for equal opportunity. It is the road to success.

So I think that it would be very good if I can go to my African American schools, which I will, to my Hispanic community, to my Asian-Americans and all the others and say to them, this opportunity is happening and you too can be an effective person if you will get your education and come forth, and we will have a pilot project to show that; but you can come forth, and you can be in the high-level place to make sure our country is secure as the others have done before you.

So I encourage you to do this, and I am really glad that you have done this. It is a reasonable request that is needed. It ought to be done, and I am glad to hear the responses that we are hearing here tonight. I congratulate the gentleman, and I thank the gentleman.

Mr. Chairman, I yield to the gentleman from New Jersey (Mr. HOLT).

Mr. HOLT. Mr. Chairman, I thank my colleague for yielding. I join him in expressing support for this amendment and accolades to the gentleman from Florida (Mr. HASTINGS), the gentleman from Texas (Mr. REYES), and the others who are working on this.

I wanted to reiterate my concern about the lack of racial, linguistic, cultural and gender diversity within the intelligence community. Our intelligence network should reflect much more of the diversity and multicultural composition of the American people and of the world that we seek to understand. But no one should be comforted by the words in this amendment. This is the umpteenth time that the problem has been identified and that intelligence agencies have been exhorted, even required, to do better. I hope this amendment produces real results.

Mr. BOSWELL. Mr. Chairman, I thank the gentleman for his comments.

Mr. BISHOP of Georgia. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I would like to take this opportunity to congratulate the gentleman from Florida (Mr. HASTINGS), the chairman, and the members of committee for the sensitivity and the concern that we are now paying to the issue of diversity.

For some time now this committee has been wrestling with the idea of diversity going back to former chairman Lou Stokes, former ranking member Julian Dixon. In my service on the committee for 6 years up until this term of Congress we have repeatedly been concerned. And I believe that the director has made it clear that diversity, cultural diversity, lingual diversity is a matter of good business sense for the intelligence community.

We all wish that we had been a little more sensitive and a little more knowledgeable prior to 9-11. But this I think is an opportunity now for us to get it right. And the gentleman from Florida (Mr. HASTINGS) has done an excellent job in helping us to think out of the box by requiring the director to carry out this pilot test project to evaluate innovative alternative methods for recruiting and hiring and retaining members of the intelligence community with a diverse background.

Let me take this opportunity to mention just one member of the African American community who is completing 30 years of service to both the military and the intelligence community, and that is Mr. Garnett Stowe who has retired as chief of staff of the National Reconnaissance Office. Mr. Stowe made tremendous contributions in his own right as a member of the intelligence community, but he too was very sensitive. And he took the time to come with the Congressional Black Caucus last year to appear on a panel that we had dealing with this issue of diversity in diplomatic and intelligence matters.

He has made a tremendous contribution to our country, to the free world through his 30 years of service; and I certainly would like to take this opportunity as we debate this bill to congratulate him on a career of great service and wish him well in the future.

With that, I would just like to associate myself with all of the remarks that have been said in a positive way in support of the Hastings amendment. I worked very hard when I was on the committee. I am delighted that the gentleman from Florida (Mr. HASTINGS) and the gentleman from Texas (Mr. REYES) and the other members of the committee are continuing this work because it is one on which we must be vigilant. We cannot afford to give it up. We have got to get it done, and we have got to do it until we get it right. And I want to commend the committee and commend my colleagues for a job well done. Hopefully, we can complete this and get on the road to having the best real-time intelligence for our policymakers and our war fighters based on the most broad net of collection devices and individuals.

Mr. GOSS. Mr. Chairman, will the gentleman yield?

Mr. BISHOP of Georgia. I yield to the gentleman from Florida.

Mr. GOSS. I appreciate the gentleman yielding. I just wanted to say I was remiss in my remarks not to note the gentleman's service on the committee on this particular issue and many other issues as well. It is a pleasure to welcome you back to the debate here.

Mr. BISHOP of Georgia. Mr. Chairman, I thank the gentleman very much.

Ms. JACKSON-LEE of Texas. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise to support the Hastings amendment and to again restate my appreciation for the service of the gentleman from Florida (Chairman Goss) and the service of the ranking member, the gentlewoman from California (Ms. HARMAN). I also want to thank the members who served on this committee, and I do not want to say served, I want to have it correct, the gentleman from Florida (Mr. HASTINGS) is still serving on the Permanent Select Committee on Intelligence. His leadership we have appreciated.

In the debate previously, he extended to me an opportunity to pursue reviewing a number of documents dealing with the question of the weapons of mass destruction. I wanted to publicly say to him that I noted in my remarks earlier how pleased I was in a bipartisan way this committee would not only open up this massive documentation but also work together in a bipartisan way to find out the truth. And I still hold to that, and I will comment very briefly in my remarks on that point. But I wanted to rise initially to support the Hastings amendment because we learned a lot after 9-11.

We learned that information would come or has come or needs to come from people from all walks of life, ethnic backgrounds and languages. We found that in our intelligence community we did not have the reach that we possibly needed to ensure the safety of this Nation, to secure the kind of intelligence we needed to have representation in parts of the world where languages are spoken that we may not be familiar with. And so the issue of diversity is crucial. Not only that, I think it is important to have the "mosaicness" of America represented in the intelligence community, the intellect that they bring, the sensitivity that they bring, the cultural understanding that they bring, the knowledge that they bring about the Muslim faith, and also the understanding that all immigration, all people who are different does not equate to terrorism. That comes from a cultural understanding.

We know that in the United States military, we found that the military expanded its chaplain corps and that is, of course, to include people from many different faiths, and that those serving in the military come from many different faiths and many different racial and ethnic backgrounds. Many Hispanics are serving. Many Muslims are serving, many Native Americans, African Americans, obviously Caucasians, and certainly the wide breadth of diversity, Asian-Americans, in our Nation.

So this is a very good amendment, and I applaud the gentleman and I believe this will go a long way in securing America because that is what we are talking about in actually securing America.

I would like to take this opportunity also to lend my support to the Kucinich amendment. That clearly speaks to, I think, us getting at the truth, and that is to secure an audit that would include information about telephone and electronic communications between the CIA and the office of the Vice President.

I also lend my support to the distinguished representative, the gentlewoman from California (Ms. LEE), her amendment to require the Government Accounting Office to conduct a study to determine the extent of intelligence sharing by the Defense Department and the intelligence community with the United Nations.

Collectively, these amendments do not in any way indict the good work of the intelligence committee. What it does is helps to build, it provides anchors, it moves us forward in staffing diversity, but it also moves us forward in finding out particular aspects of this question dealing with the weapons of mass destruction.

I have already said on this floor that I believe that ultimately a commission, after the work of this House committee and after the work of the Senate committee, whatever their processes will be, that we look at creating an independent commission. I also believe that if we are to find wrong-doing that a special prosecutor would be appropriate as well.

I am prepared to work in this bipartisan effort, but I think truth is important. And, again, it is important not only for the American people, but my colleagues who in good faith, many who, sincerely, all of us, might I say came to the floor of the House and voted our conscience, many voting because they believed that we were under imminent attack by the alleged weapons of mass destruction. Many would say that those of us who argue this point will find it out. We will get ours. They will find the weapons of mass destruction.

□ 1915

Mr. Chairman, I will not be in any way offended because the question of America is about democracy and truth. It is about sharing with the American people the reasons why we make such decisions. It is not about a "get you" foreign policy. I do not need a "get you" foreign policy. I do not need to be victorious in this independent commission or the work of the intelligence committee. I do not need to find out that there were no weapons of mass destruction. I simply need to find the truth because the administration is obligated to tell the truth to the American people and to this Congress, for us to make the life and death decision of war and peace.

I also believe that war should have been the last option, but I believe my colleagues voted in good faith, and therefore, they should have the truth, the American people should have the truth, and I think a commission will bring us to a point of securing the truth.

So I rise in support of the Hastings amendment enthusiastically, the Kucinich amendment and the Lee amendment so we can move forward in a bipartisan manner.

The CHAIRMAN pro tempore (Mr. SIMPSON). The question is on the amendment offered by the gentleman from Florida (Mr. HASTINGS).

The question was taken; and the Chairman pro tempore announced that the ayes appeared to have it.

Mr. HASTINGS of Florida. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from Florida (Mr. HASTINGS) will be postponed.

It is now in order to consider amendment No. 5 printed in House report 108-176.

AMENDMENT NO. 5 OFFERED BY MR. KUCINICH

Mr. KUCINICH. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 5 offered by Mr. KUCINICH:

At the end of title III, add the following new section:

SEC. 345. REPORT ON COMMUNICATIONS BETWEEN THE CENTRAL INTELLIGENCE AGENCY AND THE OFFICE OF THE VICE PRESIDENT ON WEAPONS OF MASS DESTRUCTION IN IRAQ.

(a) AUDIT.—The Inspector General of the Central Intelligence Agency shall conduct an audit of all telephone and electronic communications between the Central Intelligence Agency and the Office of the Vice President that relate to weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom on or after September 11, 2001.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the audit conducted under subsection (a). The report shall be submitted in unclassified form, but may contain a classified annex.

Mr. KUCINICH. Mr. Chairman, we now know that there were not vast stockpiles of weapons of mass destruction in Iraq when the U.S. invaded and that, therefore, Iraq did not pose an imminent threat to the United States, as the administration claimed before the war.

The question remaining is whether the administration compelled the Central Intelligence Agency to release raw, undisseminated information they knew to be unreliable because it helped support the worst case scenario concerning Iraq's weapons program and, therefore, helped make the case, an erroneous case it turns out, that Iraq posed an imminent threat to the United States.

The administration has made numerous assertions. The President in his State of the Union said, The British government has learned that Saddam Hussein recently sought significant quantities of uranium from Africa. Our intelligence sources tell us that he has attempted to purchase high strength aluminum tubes suitable for nuclear weapons production.

Number one, the claim about uranium from Africa was forged. Number two, the aluminum tubes were not suitable for a nuclear enrichment program. These assertions made by the President in his State of the Union to justify an immediate war with Iraq were false.

Did the Vice President play a role in making false information become the public reason the President went to war in Iraq? The Vice President, as reported in the Washington Post of June 5, 2003, Vice President CHENEY and his most senior aide made multiple trips to the CIA over the past year to question analysts studying Iraq's weapons programs and alleged links to al Qaeda, creating an environment in which some analysts felt they were being pressured to make their assessments fit with the Bush administration's policy objectives. That is from the Washington Post on June 5, 2003.

Number two, the Vice President knew or should have known that documents purporting to show that Iraq had bought uranium from Niger were forged. On March 7, the IAEA Director General Mohamed ElBaradei reported the following to the U.N. Security Council: These documents which form the basis for reports of recent uranium transactions between Iraq and Niger are, in fact, not authentic. We have, therefore, concluded that these specific allegations are unfounded. We have found no evidence or plausible indication of the revival of a nuclear weapons program in Iraq.

It turns out that the forgeries were crude. Anyone with an Internet search engine could determine that these documents were forgeries. Yet on March 16, nine days afterwards, the Vice President repeated the falsehood on national television. He said, We believe, and he was talking about Hussein, has in fact reconstituted nuclear weapons.

The Vice President knew 1 year earlier, it appears, that the documents were forgeries and, therefore, the allegations false. According to the New York Times of May 6, 2003, More than a year ago the Vice President's office asked for an investigation of the uranium deal. So a former U.S. ambassador to Africa was dispatched to Niger. In February 2002, according to someone present at the meetings, that envoy reported to the CIA and the State Department that the information was unequivocally wrong and that the documents had been forged.

So public reports indicate the Vice President made assertions which were unreliable, and the Vice President visited the CIA, making analysts there feel, according to the Washington Post, that a certain output was desired from here.

In summary, what this amendment seeks to do is to probe what role the Vice President played in causing the CIA to disseminate unreliable, raw, previously undisseminated, untrue information about Iraq's alleged threat to the United States.

Specifically, this amendment would direct the Inspector General of the Central Intelligence Agency to audit all electronic and telephone communications between the Office of the Vice President and the CIA which would answer the question about how extensive the visits by the Vice President to the CIA were.

Mr. BEREUTER. Mr. Chairman, I rise in opposition to the Kucinich amendment.

The gentleman from Ohio has woven an interesting story and made a number of bald and bold assertions, but I think it is important to look at what the amendment says.

The amendment calls for the Inspector General of the CIA to conduct an audit of all telephone electronic communications between the CIA and the Office of the Vice President relating to Iraq and WMD. The amendment is unusual and frankly a bit confusing. It purports to address what is allegedly a very serious issue, the altering or shading of intelligence for political, perhaps for strategic, purposes, but then it focuses only on the Vice President and only on his phone and e-mail communications.

If there was a real problem, one would expect a comprehensive review, but the amendment targets only one individual, the Vice President, and this is an individual who has the right, indeed he has the obligation, to receive information related to, for example, Iraq WMD and a run-up to a war.

However, the Vice President's telephone conversations are not recorded. Thus, the information that is sought in this amendment does not exist when it comes to telephone calls. Perhaps a record of the number of telephone conversations between the Vice President and the CIA could be compiled, but this would tell us only how many calls were made and when they occurred. Frankly, this is not useful information.

Mr. Chairman, the fact that the Vice President was in contact with the Intelligence Community should not be surprising. Frankly, it would be very upsetting if there was insufficient contact. These are sensitive communications, of course, on important matters. We should all expect the Vice President's office to talk regularly with the CIA, to visit the CIA for that matter, and the rest of the Intelligence Community. So should not the Vice President and the President be avid consumers of intelligence in order to be well-informed in the decisions that they make?

Remember what the amendment says. It is targeting the telephone calls between the Vice President, only the Vice President, and the CIA, only that component of the Intelligence Community, and the electronic communications that took place between that individual and that agency.

So it seems very clear to me that it is not a comprehensive review. It is targeted at the Vice President, and one simply has to realize that it is going to be unsuccessful in really revealing any information that it purports to have as an interest of the amendment.

Mr. Chairman, I think the amendment should be defeated.

Mr. KUCINICH. Mr. Chairman, will the gentleman yield?

Mr. BEREUTER. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, I want to point out for clarification purposes, and I thank the gentleman for yielding, that the result of this amendment would be both a count of the number of communications and an inventory of the substance of the communications. The count would establish the number of times the Vice President took the unusual step of traveling to the CIA to meet directly with CIA analysts and the inventory would establish the nature of those visits.

I thank the gentleman for yielding.

Ms. HARMAN. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, the gentleman from Ohio raises the serious issue of politicization of intelligence. The question of the integrity of the intelligence process is a legitimate one and has been a continuing concern in the oversight of the intelligence agencies. The question of politicization of intelligence is an area that our committee, the Permanent Select Committee on Intelligence, will explore in its investigation of Iraq intelligence.

I must, however, oppose the gentleman's amendment. The amendment, in my view, does not take the best approach to ensuring a comprehensive look at the matter. It is narrowly focused on one possible area for investigation, and it addresses that one area in a way I believe would be counterproductive.

It is not clear to me that the audit as described in the amendment would develop useful information. The offices of the Inspectors General can be effectively utilized in congressional investigations and oversight, but the resources of these offices should be deployed according to a comprehensive plan of investigation.

In sum, I believe the gentleman has raised an important issue, and that issue should and will be examined in the context of our committee's investigation. The amendment in this form should be defeated.

Mr. KUCINICH. Mr. Chairman, will the gentlewoman yield?

Ms. HARMAN. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, just to point out to the gentlewoman that I think it would be helpful if the committee supported the amendment because, at worst, if the amendment would be repeating the work of the committee, if it would be essentially redundant, then it could not hurt, and I would also want to point out that the gentlewoman is correct.

I mean, this amendment is narrowly focused, and it is aiming specifically at obtaining information relative to the relationship between the Vice President and the CIA. I thank the gentlewoman for yielding.

Ms. HARMAN. Just to conclude, Mr. Chairman, I believe that we can get to the issue of politicization of intelligence in a different manner, one that is bipartisan and one that falls within the thorough and comprehensive investigation of this committee. That would be a better way for this House to go.

Once again, I commend the gentleman for raising this issue but hope that we will decide to take a different course on this subject.

Mr. LaHOOD. Mr. Chairman, I move to strike the last word.

Mr. Chairman, the way I would characterize this amendment is as the cheap shot amendment. This is a totally political amendment. It is a totally cheap shot at the Vice President. It is an extension of a campaign being waged by the gentleman from Ohio who has made a number of speeches on this floor and around the country. I believe it is an extension of his presidential campaign to try and besmirch the record of this administration, to besmirch the good name of the Vice President, and I think when people have an opportunity to really look at the amendment, they can see that it is so shallow in its wording and in its nature, that it is what it is.

It is a political amendment. It is only brought here to the floor to continue an opportunity for the gentleman from Ohio to try and find something that simply cannot be found.

It also, I think, degrades the work of the Permanent Select Committee on Intelligence. This gentleman who is offering this amendment has been a Member of this House. He knows of the work of the Permanent Select Committee on Intelligence. He knows that if he had some kind of a complaint about the kind of activity that he is trying to allege the Vice President has engaged in that he could come to the Permanent Select Committee on Intelligence. He could petition the chairman, he could petition the ranking member. He could ask the Permanent Select Committee on Intelligence. I guess we are not good enough to do our work that you have to seek some kind of an outside counsel or outside organization to try and look into it.

□ 1930

This is unprecedented what this amendment asks for. It is unprecedented in its nature to think that this body, under this amendment, is going to go after the phone records of the Vice President. Now, anybody who does not see the politicizing of what is going on here cannot see the nature of it. You can see it in the words, because they are very shallow.

Mr. KUCINICH. Mr. Chairman, will the gentleman yield?

Mr. LaHOOD. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, I thank the gentleman. Under the gentleman's logic, there would be no reason at all for any amendments to be offered from this floor. We might as well dispense with the amendment process and move to a system in which the committees of Congress report bills for a simple up or down vote from the whole House. So we might as well extend the suspension calendar for all bills.

Mr. LaHOOD. Reclaiming my time, Mr. Chairman, let me respond to the gentleman by saying this. If this is the authorization for the intelligence bill, and the gentleman is offering this amendment under our authorization, why does the gentleman not give some direction to the Permanent Select Committee on Intelligence to look into the matter? Why does the gentleman have to find somebody else to do it? And the gentleman may respond, if he would like.

Mr. KUCINICH. Well, Mr. Chairman, I thank the gentleman for continuing to yield, and I would say that, first of all, the idea that it is the committee's jurisdiction and, therefore, should be left to the committee, I do not believe the gentleman is seriously proposing what I think is an absurdity, but the argument rests on the same absurd logic. All Members of the Congress have the privilege to offer amendments, and if a majority of the House agrees with the amendment, it passes. However, I do not believe it is legitimate or logical against my amendment to say that the Permanent Select Committee on Intelligence should enjoy an exemption from the amendment process.

Mr. LaHOOD. Mr. Chairman, what I am saying to the gentleman is apparently the gentleman does not think the Permanent Select Committee on Intelligence is doing their job. Apparently, the gentleman does not think we have the capability to carry this out, and so he has crafted an amendment to go to some outside group, some outside organization because the gentleman does not have trust and faith in what we have been doing and the work that we have been doing.

Mr. KUCINICH. Mr. Chairman, if the gentleman will continue to yield, I would ask that the gentleman not take offense. This is certainly, I would hope the gentleman would agree, a salient issue of interest to the American people and that the public does have a right to know, and there have been published statements that provide contradictory information relative to what is really a question of a singular cause of war. So I respect the gentleman's right to make these statements, and I would ask the gentleman to respect my right as a Member of Congress to offer this amendment.

Mr. LaHOOD. Well, I would say, Mr. Chairman, that if the gentleman wanted to offer an amendment on our authorization bill, at least he ought to give us the benefit of the doubt that we have professional staff and we have people who spend an inordinate amount of time, including the gentleman's ranking member because this is her only committee assignment. She spends all of her time in this Congress working on intelligence activities. Apparently the gentleman does not think enough of her expertise and the expertise of the committee staff on that side to give them some kind of an assignment.

And why the Vice President? Why not the President? Why not the Director of the CIA? Why not the Director of the FBI? This is a political amendment. This is an extension of a campaign.

The CHAIRMAN pro tempore (Mr. Upton). The time of the gentleman from Illinois (Mr. LaHood) has expired.

Mr. LaHOOD. Mr. Chairman, I ask unanimous consent to proceed for 2 additional minutes.

The CHAIRMAN pro tempore. Is there objection to the request of the gentleman from Illinois?

Mr. KUCINICH. Reserving the right to object, I would be happy to grant the gentleman an additional 2 minutes if he would be happy to return the favor to me.

Mr. LaHOOD. I will be more than happy to yield to the gentleman.

Mr. KUCINICH. Mr. Chairman, I withdraw my reservation of objection.

The CHAIRMAN pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

The CHAIRMAN pro tempore. The gentleman from Illinois (Mr. LaHood) is recognized for 2 additional minutes.

Mr. LaHOOD. Why the Vice President? Why not other officials of the government? Why not officials of the government who have direct responsibility for intelligence-gathering information? If there is some kinds of a cabal going on around here, why did the gentleman just happen to pick this individual?

I believe this is what it is. This is a political amendment. This is an amendment to try and embarrass one member of this administration. This is an amendment to try and embarrass the second-highest-ranking elected official in our government by some way, shape, or form, thinking that if the gentleman gets some kind of phone records he is going to find something out.

As members of the Permanent Select Committee on Intelligence, we get information every day, 24-7, our staff. Pretty much 24-7, our staff are working on gathering intelligence; and this is a slap in the face at the Permanent Select Committee on Intelligence, to the gentleman's own members, to our members.

It really is what it is. It is a political amendment, and I stand by what I said. It is the cheap shot amendment. It is the cheap shot amendment of the year. It gets the award, in my opinion; and I hope people see it for what it is.

Mr. KUCINICH. Mr. Chairman, I ask unanimous consent for an additional 2 minutes.

The CHAIRMAN pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

The CHAIRMAN pro tempore. The gentleman from Ohio (Mr. Kucinich) is recognized for 2 minutes.

Mr. KUCINICH. Mr. Chairman, I want to say to my friend, the gentleman from Illinois (Mr. LaHood), that I would hope the gentleman would appreciate receiving clear direction for an inquiry. I can only assume that the gentleman does not want the direction of the whole Congress to get to the bottom of the Vice President's role.

Mr. LaHOOD. Mr. Chairman, will the gentleman yield?

Mr. KUCINICH. I yield to the gentleman from Illinois.

Mr. LaHOOD. Mr. Chairman, I simply would say to the gentleman that he knows that we have established in this bill two advisory committees. We had people on the floor earlier suggesting a commission; but apparently, the gentleman does not think the oversight obligation that we serve, as the Permanent Select Committee on Intelligence, is enough. And I say it is a slight. It is a slap at us.

Mr. KUCINICH. Reclaiming my time, Mr. Chairman, I would just tell the gentleman that as a member of the Committee on Government Reform I certainly appreciate the role of government oversight, and I certainly appreciate the role of the Permanent Select Committee on Intelligence as well. I would say that if the gentleman did not want to get to the bottom of the role of the Vice President, which has been a matter of public contest and controversy long before I have spoken here, that would indeed be a reason to oppose the amendment; but it would not be a reason for anyone else in Congress to vote "no" on the amendment.

And to the Members of Congress, I say if they want to demand a thorough investigation into the role that the

Vice President may have played in offering the American public discredited intelligence reports of a nonexisting Iraqi weapons program, then they should vote "yes" for my amendment.

Mr. LAHOOD. Mr. Chairman, will the gentleman yield once again?

Mr. KUCINICH. I yield to the gentleman from Illinois.

Mr. LAHOOD. Mr. Chairman, let me simply say this. I would say that the gentleman's ranking member has bent over backwards. It was the gentleman from New Jersey (Mr. HOLT) and others who asked for the two advisory committees. And it is other people on the gentleman's side who are asking for some kind of a commission. Now, we have not acted on that, and that is not in this bill; but I think every request that was made by the gentleman's side to the chairman has been granted.

The CHAIRMAN pro tempore. Time of the gentleman from Ohio (Mr. KUCINICH) has expired.

Mr. LAHOOD. Mr. Chairman, I ask unanimous consent to proceed for 2 additional minutes.

The CHAIRMAN pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

The CHAIRMAN pro tempore. The gentleman from Illinois (Mr. LAHOOD) is recognized for 2 additional minutes.

Mr. LAHOOD. Really, Mr. Chairman, I think we have done everything we can. Now, to go outside of the jurisdiction of the committee and to take a cheap shot at the Vice President, it makes no sense, I say to the gentleman. It really does not. I think, really, the truth is, after listening to this and listening to the fact that the gentleman's ranking member is not going to support the gentleman's amendment, I think it is in his best interest to withdraw the amendment.

Ms. HARMAN. Mr. Chairman, will the gentleman yield?

Mr. LAHOOD. I yield to the gentlewoman from California.

Ms. HARMAN. Mr. Chairman, I appreciate the kind words, and it's nice that the gentleman from Illinois is worried about me and whether I am respected. I believe I am respected, and I believe that the person who offers this amendment respects me, and I certainly hope that he respects our committee.

I just want repeat something I said earlier, which is that our investigation will be thorough and it will be bipartisan and we will follow the facts unflinchingly. So I do not want the gentleman from Ohio to assert, because it is not correct, that we are taking things off limits. The reason I oppose the gentleman's amendment is that I think we will do a comprehensive job in a fair way, and all of us, on a unanimous basis, will proceed and go forward. We will do the right job for this House, and we should have a chance to proceed and do it that way.

Mr. KUCINICH. Mr. Chairman, will the gentleman yield?

Mr. LAHOOD. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, I take great pride in serving in the Congress with the gentlewoman and the gentleman. I would say, though, that I do not see this so much as being a battle over turf as I see it being an assertion of the need for pursuing the truth. And I would expect that the Permanent Select Committee on Intelligence has the capability to do the job, but I also think that this particular matter is so unique that it receive the attention of the House, which is why I have offered this amendment and why I will continue to insist on it.

Mr. HOEKSTRA. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I rise in opposition to my colleague's amendment, and I put it in the context of the work that this committee has done and that we have accomplished and the vision that we outlined in the Intelligence Authorization Act for 2004.

I serve as chairman of the Subcommittee on Technical and Tactical Intelligence. As such, one of our jobs is to oversee some of the Nation's most sophisticated intelligence technologies. I have the opportunity and responsibility for critically reviewing new concepts of operation. I must ensure that currently fielded systems continue to be capable of meeting the needs that we have outlined.

In this area, we are pursuing aggressive oversight. We have worked with the ranking member. We have been to the ranking member's district to meet with some of the contractors there; and I think it is a good example of how, in a bipartisan way, we have asked some tough questions of the intelligence community and of those groups that provide us with the materials and the equipment that we need. We have asked the Director of the Central Intelligence Agency to provide us with a long-range plan and how all of these pieces will fit together and what a strategic plan may look like for the next 6 to 10 years.

In the comments attached to the bill, we have outlined our disappointment that that plan has not come forward to the committee, so that we are moving forward with a little bit less information, perhaps, at this time, than what we would like to have had. But I do not think that the amendment that the gentleman is bringing up is one that is going to work in the best interest of what we are trying to get accomplished.

On a weekly basis, this committee meets with the communities analytic cadre. We have met with them on a regular basis to review the intelligence that they prepared for us and they prepared for the President, the Vice President and Members of Congress; and that information is now available to all 435 Members of Congress so that they can take a look at what we were looking at and how we were shaping our judgments and where we were getting our information from.

I think it is important for the American people to know that. That information is not secret. We are being very open with our colleagues because we recognize the importance of maintaining the credibility of the process, the individuals, and the analysis that goes into the intelligence that we have gathered. We take this job very, very seriously.

One of the things that I am concerned about with this gentleman's amendment is that if we pursue this path, and in this case it identifies the Vice President but also implicates the folks at the different intelligence agencies as perhaps not keeping the best interest of the country in the forefront, then what we will end up with, and I agree with my colleague from Illinois that it is a cheap shot amendment because there is not a basis in fact to make these accusations against the Vice President or against the folks at the intelligence agency, but the result and danger is that what we are going to end up with is we are going to end up with a cadre of analysts that are going to be intimidated to such a point that they are going to go through the process, they are going to gather the intelligence, and they are going to be sitting there and saying, you know, I really cannot take the next step of providing some expert judgment, which I have been trained for, 5, 10, 15, 20, 25 years. I am not going to be able to share that expert judgment with the folks who recognize the source and the art of this work.

Remember, the job we give these folks, in plain English, is we ask them to go out and steal other people's secrets. We ask them to do that in an imprecise way and to put the pieces together. And when they have a few pieces of the puzzle, we ask them to try to paint for us what the picture and what the final puzzle may look like. If we put a cloud over their heads and say every time you have a few of the pieces out there and you have painted a picture for us, for us to better understand the environment after the fact, if what you laid out beforehand does not perfectly match what we find out afterwards, you have failed.

In reality, these are talented people. They are doing a very, very good job.

The CHAIRMAN pro tempore. The time of the gentleman from Michigan (Mr. HOEKSTRA) has expired.

(By unanimous consent, Mr. HOEKSTRA was allowed to proceed for 2 additional minutes.)

□ 1945

Mr. HOEKSTRA. They come back and they give us their best judgment. I am impressed with the work of the chairman and the ranking member, how they have set a course that says we are going to go through this in a bipartisan way. We are going to take a look at the information and how the people processed the information. We are going to take a look at how we analyzed it and how decisions were made off that information, but we are going to do that in a bipartisan way and we are going to make sure that we do not take this down a road of pure partisan politics because in the 2½ years I have been on this committee, in a bipartisan way we have kept as our primary focus what is good for this country, recognizing the sensitive nature of the information that we deal with, recognizing the importance of us to work through very, very difficult issues, but to reach a consensus that enables us to move forward.

That is exactly what the leadership of this committee has done, it is exactly the way that the members of the committee have guided their behavior, and it is what sets the behavior of our committee and the members of that committee apart from the amendment that is brought forward at this time.

It is a partisan amendment, it has a potential to be used in many, many different ways, but primarily in my analysis it hurts the prospect of truly improving the process so that when we move forward in the future, we will have the intelligence, the capability and the right people in place to ensure that we make the best possible decisions.

Mr. HOLT. Mr. Chairman, I move to strike the requisite number of words.

I rise to underscore the right of the gentleman from Ohio (Mr. KUCINICH) to offer this amendment and say that he is getting at a very important point, but to say further it is a bad amendment and should be opposed. It is both too narrow and too broad. He is certainly intending to get at an important point, but it is too narrow in that it deals with the phone records of one public official, and it is too broad in the sense that it is a fishing expedition. It is the kind of fishing expedition which I think so sullied some previous Congresses.

The question of whether intelligence has been cooked or coerced is a critical question, and I thank the gentleman for raising it. But in fact in the Permanent Select Committee on Intelligence we have already raised that, and we will continue to raise that issue. I ask the assistance of every Member of this body on both sides of the aisle to help us formulate the questions that need to be asked and to hold us to task that those questions are asked to the satisfaction of all Members of this body and of the citizens of America. But I do not believe that this amendment will help us do that. I must oppose this amendment, and I encourage my colleagues to oppose it.

Mr. KUCINICH. Mr. Chairman, will the gentleman yield?

Mr. HOLT. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, I think it would be useful as we begin these debates for us to reflect on the essential constitutional role of the Congress and on the importance of separation of powers and on the cause which took a Nation into war because we are not talking about just any other matter here, we are talking about a matter that resulted in the people of this country having their sons and daughters sent to Iraq.

Nothing less than the entire involvement of this Congress will do to be able to hold safe the constitutional prerogatives of separation of powers. No congressional committee can override the requirements of the Constitution and the role of this Congress.

When Members of this Congress gave the President authority to pursue an attack against Iraq, they took upon themselves a serious and grave responsibility, and since information has been presented that raises grave questions about the cause of our action against Iraq, we have a moral obligation to get into this, and I take nothing away from the Permanent Select Committee on Intelligence, but I would tell Members, the Permanent Select Committee on Intelligence should take nothing away from Members of the House.

Mr. HOLT. Mr. Chairman, reclaiming my time, perhaps the gentleman did not hear me earlier this evening when I said that what we are looking at are critical questions that have to do with lives and deaths that have occurred or might occur. It has a lot to do with the future direction of our country; but I do not believe that this amendment will help us carry out the investigation that we need to carry out and ask the questions that we need to ask and have for the future the kind of truth-telling intelligence agents and analysts who will help this country get where we want to go.

Mr. LAHOOD. Mr. Chairman, will the gentleman yield?

Mr. HOLT. I yield to the gentleman from Illinois.

Mr. LAHOOD. Mr. Chairman, I want to respond to the latest speech of the gentleman from Ohio (Mr. KUCINICH), and that is to say if the gentleman really wants the prerogatives of the House to be worked out, let the Permanent Select Committee on Intelligence do it. The gentleman's amendment says the IG or the GAO is supposed to go in and get the Vice President's phone records. If the gentleman thinks it is such a great idea, let us do it. We have been doing it. Why have some outside group do it? That is the flaw in the gentleman's amendment. That is what our committee is supposed to do. That is the flaw, and that is what politicizes it.

Mr. KUCINICH. Mr. Chairman, will the gentleman yield?

Mr. HOLT. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, I would direct the gentleman from Illinois to an article in the Washington Post on June 5 which says that the esteemed chairman of the Permanent Select Committee on Intelligence said there is "no indication that analysts at DIA or CIA changed their analysis to fit what they perceived as the desire of the administration officials."

The CHAIRMAN pro tempore (Mr. SIMPSON). The time of the gentleman from New Jersey (Mr. HOLT) has expired.

(On request of Mr. KUCINICH, and by unanimous consent, Mr. HOLT was allowed to proceed for 1 additional minute.)

Mr. KUCINICH. Mr. Chairman, will the gentleman yield?

Mr. HOLT. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, it goes on to say the intelligence oversight panels have received no whistleblower complaints from the CIA or other intelligence agencies on the issue. I would maintain that this would not be a subject of whistleblowing, and only the Office of Inspector General or in this case the investigative agency would have an opportunity to be able to get this in an evenhanded way, and it takes it out of politics at a time when Members suggest this is only political.

I might further add that I did not make my reputation in this House by raising partisan issues, and I do not see this as a partisan issue, I see this as justifying the administration's claim that this country had to go to war against Iraq because there was imminent threat.

Mr. GOSS. Mr. Chairman, I move to strike the requisite number of words.

I want to point out two things, and they are meant to be constructive. First of all, it is certainly true everybody in the United States counts on it being true and it is true that the Vice President and the President are responsible for the protection of the national security. The national security team involves the Vice President. The President and the Vice President are regular consumers of intelligence information, and were they not, we probably should be calling for some kind of an investigation.

I do recall it was not so long ago that one of the complaints from one of the Directors of the CIA was in fact just that, that he did not get enough quality time and enough access with the top leaders of the country and the Intelligence Community was not being well-served. That was at another time and we need not go into that.

My suggestion to the gentleman from Ohio (Mr. KUCINICH), who I have great respect for, is that this amendment is truly not worthy of his best efforts. I do not believe the gentleman is fully informed on it. It appears that the gentleman is basing his amendment and information and his case on media. Again, at the risk of getting impaled by the media, I have this trouble with the errancy problem in the media.

Media simply does not know everything, and if they did, they would stop asking me and the gentlewoman from California (Ms. HARMAN) and other members of the committee questions. Believe me, the media does not know everything. They are not fully informed, and if the gentleman is using the media, the gentleman is not fully informed.

I invite the gentleman to come upstairs, sign the secrecy agreement if the gentleman has not already, and review the material. That is why we have it there. If the gentleman took advantage of that, the gentleman would be better able to understand what we are doing, and I would hope would be supportive of our efforts. Having said all that, I hope we are getting ready for a vote on this amendment.

Ms. LEE. Mr. Chairman, I move to strike the requisite number of words.

I rise in support of the Kucinich amendment.

Mr. KUCINICH. Mr. Chairman, will the gentlewoman yield?

Ms. LEE. I yield to the gentleman from Ohio.

Mr. KUCINICH. The gentleman from Florida (Chairman GOSS) is familiar with the amendment and the letter of the amendment, and I would ask if the chairman would be willing to commit the Permanent Select Committee on Intelligence to seeking specifically the information that I am asking here of the Inspector General. Would the Permanent Select Committee on Intelligence be willing to conduct publicly an audit of all telephone and electronic communications between the Central Intelligence Agency and the Office of the Vice President as they relate to this matter?

Mr. GOSS. Mr. Chairman, will the gentlewoman yield?

Ms. LEE. I yield to the gentleman from Florida.

Mr. GOSS. Mr. Chairman, certainly we will publicly not commit to that. We will publicly commit to where the review of the information takes us. We have a bipartisan agreement on that. We have 20 able members who are members of good judgment and good sense who will follow the review and the material that comes in to the appropriate places.

The gentlewoman from California (Ms. HARMAN) has used the word "unflinching." It is a fair word. I assure the gentleman I am going where the information takes us.

Mr. KUCINICH. Mr. Chairman, will the gentlewoman yield?

Ms. LEE. I yield to the gentleman from Ohio.

Mr. KUCINICH. I would suggest to the gentleman and I would not impugn his answer by stating that his unwillingness to clearly commit to gathering this information publicly would in any way reflect a partisan position on his part, just as my desire to have the Inspector General bring that information forward is not reflective of a partisan position on my part.

Mr. GOSS. Mr. Chairman, will the gentlewoman yield?

Ms. LEE. I yield to the gentleman from Florida.

Mr. GOSS. There are two reasons why this would be a difficult task to do publicly, and I would not make that broad a commitment. The first is that much of the material that the gentleman is talking about is probably classified if the gentleman is talking about the content of what may or may not be involved in calls, and I cannot go there.

The second part is the matter of Constitution which does understand that working documents and so forth of the executive are respected and privileged. That has always been the case no matter who is in the White House.

Mr. KUCINICH. Mr. Chairman, will the gentlewoman yield?

Ms. LEE. I yield to the gentleman from Ohio.

Mr. KUCINICH. Mr. Chairman, it would be more than instructive. It would be classified information if the Vice President manipulated CIA analysts to disseminate false, raw unreliable information to justify a war in Iraq. I am hopeful no one is saying that and I am not aware that the administration has asserted executive privilege in an attempt to shield such information from the Congress. I am not aware of that at all. Maybe that has happened privately, but I am not aware that such an assertion can be private and that in fact such an assertion has been made.

Mr. GOSS. Mr. Chairman, will the gentlewoman yield?

Ms. LEE. I yield to the gentleman from Florida.

Mr. GOSS. That is an option that they have and that is why I cannot make a commitment. I cannot overcome that.

Mr. KUCINICH. Mr. Chairman, will the gentlewoman yield?

Ms. LEE. I yield to the gentleman from Ohio.

Mr. KUCINICH. I would say in order for the test to be made to make the request first then imposes our responsibility as Members of Congress, and as a coequal branch of government, we are entitled to do that and the executive branch is entitled to assert executive privilege, if they so choose, and that would be illuminating, I think.

Ms. WATERS. Mr. Chairman, I rise today to ask that the Bush administration provide the American people with a full account of the events leading up to the war with Iraq.

The amendment sponsored by Representative KUCINICH is a good starting point but there is still much that we do not know about the basis of our war with Iraq. Since August of last year, when the administration began beating the war drum, they have offered little concrete evidence backing up their claims that Iraq posed an "imminent threat" to the United States.

The rhetoric employed by the administration was strong and unwavering:

On September 12, 2002, the President told the UN: "Right now, Iraq is expanding and improving facilities that were used for the production of biological weapons . . . . Iraq has made several attempts to buy high-strength aluminum tubes used to enrich uranium for a nuclear weapon."

On October 7, 2002, the President said: "It [Iraq] possesses and produces chemical and biological weapons. It is seeking nuclear weapons."

The Vice President said earlier this year on "Meet The Press" that: "we believe he [Saddam Hussein] has, in fact, reconstituted nuclear weapons."

And the Secretary of Defense joined in saying: "We know where they [weapons of mass destruction] are, they are in the area around Tikrit and Baghdad."

Yet, despite this certainty, 3 months after the fall of Baghdad, no chemical, biological or nuclear weapons have been found. Nor have the facilities to make these weapons been found. The administration has tried to capitalize on our fears born out of the September 11th terrorist attacks, suggesting there was a link between Saddam Hussein and leaders of al Qaeda.

Even though this connection has been disproved consistently, the President still cites it as fact.

And today, we learned that at least one member of the intelligence community felt pressured to shape his reports to fit the administration's position on weapons of mass destruction even though he had no evidence to support those claims.

Congress must work to ensure that the information that comes out of the intelligence community is reliable and is not unduly influenced by anyone. This is not a partisan issue. This is about restoring the credibility of the United States both with our constituents and throughout the world.

The President has said that he is confident that weapons of mass destruction will be found; the evidence is strong he says.

I encourage him to shine the light of day on the evidence so that the world can understand why the United States went to war—unprovoked—and put the lives of thousands in danger.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from Ohio (Mr. KUCINICH).

The question was taken; and the Chairman pro tempore announced that the noes appeared to have it.

Mr. KUCINICH. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN pro tempore. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from Ohio (Mr. KUCINICH) will be postponed.

□ 2000

It is now in order to consider amendment No. 6 printed in House Report 108-176.

AMENDMENT NO. 6 OFFERED BY MS. LEE

Ms. LEE. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore (Mr. SIMPSON). The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 6 offered by Ms. LEE:

At the end of title III, add the following new section:

SEC. 345. REPORT ON INTELLIGENCE SHARING WITH UNITED NATIONS WEAPONS INSPECTORS SEARCHING FOR WEAPONS OF MASS DESTRUCTION IN IRAQ.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study to determine the extent to which intelligence developed by the Department of Defense and by the intelligence community with respect to weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom was made available to the United Nations weapons inspectors and the quantity and quality of the information that was provided (if any).

(b) SPECIFIC MATTER STUDIED.—The study shall provide for an analysis of the sufficiency of the intelligence provided by the Director of Central Intelligence to those weapons inspectors, and whether the information was provided in a timely manner and in a sufficient quantity and quality to enable the inspectors to locate, visit, and conduct investigations on all high and medium value suspected sites of weapons of mass destruction.

(c) ACCESS TO INFORMATION.—(1) Subject to paragraph (2), the Comptroller General may secure directly from any agency or department of the United States information necessary to carry out the study under subsection (a).

(2) The appropriate Federal agencies or departments shall cooperate with the Comptroller General in expeditiously providing appropriate security clearances to individuals carrying out the study to the extent possible pursuant to existing procedures and requirements, except that no person shall be provided with access to classified information under this section without the appropriate security clearances.

(d) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall be submitted in unclassified form, but may contain a classified annex.

Ms. LEE. Mr. Chairman, first I would like to thank the gentleman from Florida (Mr. GOSS) and the gentlewoman from California (Ms. HARMAN) for her support and her leadership in crafting this bipartisan bill. Also to my staff, Julie Little and Shannon Smith, I want to thank them for their very diligent work.

This is a commonsense amendment seeking an answer to a question that the American people have a right to know: How was our intelligence regarding Iraqi weapons of mass destruction handled in the months before the war? Specifically, this amendment seeks a GAO study to determine the extent and timeliness with which the Intelligence Community shared information about suspected weapons in Iraq with the United Nations inspectors on the ground searching for those weapons.

There are growing questions being raised about the use or possible misuse of intelligence in the months leading up to the war against Iraq. If intelligence was distorted, that raises serious doubts around the world about United States credibility. Our President told the American people, the Congress and the world that inspections had failed, that Iraq unquestionably possessed weapons of mass destruction, and that these weapons posed such a dire, imminent threat to the United States that we had no choice but to go to war. All other options, he said, had been exhausted. But the question we must continue to ask is, were those options truly exhausted? Were they, in fact, fully pursued? Did the United States Intelligence Community share information with the United Nations inspectors about suspected weapons sites? Did it happen in a timely and sufficient manner?

President Bush went before the United Nations General Assembly and stated, "My nation will work with the U.N. Security Council to meet our common challenge." He and Secretary Powell pledged to work with the United Nations to pursue inspections to seek out and destroy weapons of mass destruction. What we have before us is a question of both policy and credibility. If we failed to fully share intelligence with United Nations inspectors, we may have undermined their effectiveness. If we relied on intelligence that was distorted or less complete than implied, if we failed to share crucial information with our allies, then we have undermined our own national credibility.

This Nation launched a preemptive war based on what it claimed was indisputable evidence. If that evidence was not so solid and especially if it was distorted, then we severely undercut our ability to convince the world about future dangers from weapons of mass destruction in other countries. The doctrine of preemption, which I happen incidentally to strongly oppose, totally collapses without credibility.

For these reasons, we need to find the answer to these questions. The American people have a right to know. A respected and esteemed member of the Senate Select Committee on Intelligence said that he has been working for the last 6 months to try to force disclosure of important facts relevant to the sharing of intelligence information on suspect weapons of mass destruction sites by the CIA with the United Nations arms inspectors.

He continued, and I quote, "If it had been public knowledge in February or March of this year that the CIA had not shared information on all of the top Iraqi WMD suspect sites with the United Nations inspectors, it could have worked against the administration's timetable for initiating military action against Iraq. There could have been questions as to why; it could have made the administration's decision to cut short the U.N. inspection process and to institute military action less compelling; and there could have been greater demand that we share all such information with the United Nations before abandoning the inspection process."

I share his concerns and I echo his call for a bipartisan investigation. These are not partisan issues, they are fundamental questions about credibility and they need to be answered. This amendment calls for a GAO study into the sharing of United States intelligence with the U.N. inspections teams. It calls for a report to Congress with a classified annex if necessary for security reasons. We are all aware that to date the United States military has not found weapons of mass destruction in its searches since the end of the war. We also know that that does not prove the weapons are not there. They may well be. And I believe we should bring in more IAEA and United Nations inspectors to help seek out, secure and destroy them if they are hidden in Iraq.

Given the Administration's confident and unequivocal statements that Iraq possessed weapons of mass destruction and given the President's assurances that he wanted to work with the United Nations to seek non-military solutions through a renewed inspections process, it is important that we learn to answer to the question of whether or not intelligence was shared in a timely and sufficient manner with the UN inspections teams.

I urge you to support this amendment.

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore. Members are reminded to refrain from improper references to the Senate.

Mr. BEREUTER. Mr. Chairman, I move to strike the last word. I rise in opposition to the Lee amendment. It calls, of course, for the Comptroller General of the United States to conduct a study and determine the extent of intelligence sharing within the Intelligence Community, DOD and the U.N. inspectors in Iraq.

I would like to make two general points first. As a part of the Permanent Select Committee on Intelligence's review of the Intelligence Community regarding prewar intelligence on Iraq, the committee has already begun to examine this issue and will assess the effectiveness and procedures governing the sharing of intelligence to international and foreign bodies.

Secondly, the committee acknowledges that the Comptroller has some capabilities for investigation. But I would note that the Permanent Select Committee on Intelligence has a long and distinguished record of conducting bipartisan and thorough reviews of intelligence matters. Therefore, before outside help is requested, it seems only appropriate that the committee should have an opportunity to fulfill its mandate for the House and for the Congress to conduct rigorous oversight of the Intelligence Community. This subject area of the amendment is not going to be neglected.

Now a few details. In the run-up to renewed weapons inspections in Iraq late last year, U.N. weapons inspector Hans Blix told the press that although his team could use U.S. intelligence, the team was not supposed to trust anyone, and that it was the team's decision, not a particular government's, as to what facilities and where the inspections were to be carried out.

The earlier U.N. mission to Iraq was accused of spying for the United States. Therefore, Hans Blix indicated that he had to make the distinction between his possible use of intelligence and his team's ability to conduct an independent and neutral investigation of Iraq's WMD facilities. Blix admitted using CIA reports in a November 28 interview with CNN but cautioned that he would not allow his team to be dictated to by a foreign government.

Some have suggested that the U.S. failed to provide the arms inspectors with useful information. At this point, this Member believes that this is simply not true, not true at all. We are going to find out about that, however, when we complete our investigation. Hans Blix actually received, I think, unprecedented access to intelligence.

The U.S. provided the U.N. weapons inspectors with the ability to task and assign U.S. U-2 surveillance aircraft operating over Iraq. He told the U-2s where to go and what to target. This is virtually unheard of. U.N. civilians ordering U.S. pilots on hazardous missions. Why did we do this? Why did we give a U.N. official this extraordinary opportunity and authority? In the words of Hans Blix, "The U-2 data will improve our ability to carry out our inspections."

If there was a problem in timely response to intelligence, the problem was in the U.N.'s ability to act on information after they had received it from the United States or from other sources. This is not really too surprising since there were literally hundreds of Iraqi agents or personnel whose job it was to slow down the inspectors, to send them in the wrong direction, or to make sure they would end up in the wrong place, or to report on their progress so that deception and deceit and cover-up could take place before they arrived. This is not a failing of the United States but, rather, the inability of UNMOVIC to overcome Iraqi denial and deception techniques.

The gentlewoman, I hope, would understand that if there were problems in communication of intelligence, much of the problem was the U.N. reluctance to rely on U.S. sources. This is addressed in an article in USA Today and I do not cite it except that they are quoting Blix. They were reluctant, they said, to rely on U.S. intelligence for fear that Iraq would accuse them of spying for the United States, an accusation that Iraq made, of course, the first time we had inspectors in. Here is a quote:

"Still smarting from their admission that U.S. intelligence gave inspectors secret missions during the last round of inspections in 1998, U.N. officials have deliberately curbed access to the CIA and allied intelligence agencies."

The ground rules established by the U.N. stipulated that the CIA would not equip the inspectors, unofficial discussions between the CIA and the inspectors were prohibited, and only the U.N. would be allowed to analyze the data that was collected.

We have got a lot to look at. Members will have access to some of this very information across the board in an unprecedented fashion. This is a responsibility of the Permanent Select Committee on Intelligence. We have the capabilities. We have the intent. I would say we ought to be given the opportunity. Therefore, I rise in opposition to the gentlewoman's amendment. I hope it will be rejected.

Ms. HARMAN. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I have enormous respect for the sponsor of this amendment. She is prepared to vote her conscience in this House, even if she is a minority of one. I think that is admirable, courageous and her constituents should be enormously proud to be represented by her. I am certainly proud to serve with her.

I listened carefully to the comments made by the gentleman from Nebraska. Frankly, I agree with them. I think that is the context of the search for weapons by the U.N. inspector. However, agreeing with them does not get me to his conclusion. My conclusion is that we should support this amendment because it contains a specific request for a discrete investigation that would be of value in understanding precisely what information was shared with the U.N. weapons inspectors.

It may turn out that more was shared than we know. It may turn out that less was shared than we know. And it may turn out, and I think it will, that what the gentleman from Nebraska had to say includes the context in which it was shared. Nonetheless, I think this investigation could provide a constructive baseline in understanding the difficulties of conducting U.N. inspections.

Finally, Mr. Chairman, let me just say that the specific matters to be studied under this amendment are not to my knowledge currently part of the scope of our Committee's review. We are not specifically investigating what information was shared with the U.N., though we certainly could, I suppose. Thus, I believe the amendment is helpful and I would urge us to support it.

Ms. WOOLSEY. Mr. Chairman, I move to strike the requisite number of words.

I rise to support the Lee amendment. I thank the ranking member for her support. As this House, our Nation and the world debate the quality of the intelligence that the war in Iraq was fought over, it is too easy to forget that our troops were not the first to search the Iraqi desert for weapons of mass destruction. United Nations inspectors spent a decade searching for and destroying illegal Iraqi weapons facilities, but in the days and months leading up to the war, they were scorned for their failure to find weapons of mass destruction.

This resolution calls on the GAO to investigate how much cooperation the United States intelligence agencies gave United Nations inspectors. Understanding about that cooperation with the United Nations, or lack thereof, will give us a better picture of the efforts this Nation took to avoid war with Iraq. If America did not fully share its intelligence with U.N. inspectors, Congress needs to find out why.

The fact is that the rhetoric leading up to the war in Iraq led many Americans to believe that finding weapons of mass destruction would be absolutely easy, that the U.N. inspectors must have been grossly incompetent. But I do not believe that to be true and I think that our inability to find weapons of mass destruction now requires the United States to reexamine the rhetoric and the events that led up to the war. We need to find out beyond reports from USA Today if our U.S. intelligence agencies were cooperating fully with the U.N. inspectors. And we need to find out if the prewar rhetoric reflected the intelligence we shared with the United Nations.

This amendment is about getting answers to questions that we are all asking in this country. I urge my colleagues to support the Lee amendment.

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Mr. GOSS. Mr. Chairman, I move to strike the requisite number of words.

I have given this amendment very careful consideration, and I appreciate the effort. I do believe we have got the matter handled already in the committee, and I will tell the gentlewoman that; and I would invite the gentlewoman upstairs to talk to us about it in a classified setting if she would like to.

The reason I say that I think this is unnecessary is I think it is duplicative of work we are doing that, frankly, we are best prepared to do. But I would like to point out there are a couple of problems with the United Nations that we have been working with for quite a number of years, and I think we, frankly, have the expertise to judge better than anybody else. Perhaps our sister body in the Senate, Senate Intelligence Committee, would dispute that; but I would say that either the Senate or us are going to do a pretty good job on this, and in fact we are both working on it.

The question of how much information we shared with the U.N. is a fair question to ask, and the answer is we shared a remarkable amount, more than they could handle. It turns out as we heard from the gentleman from Nebraska's (Mr. BEREUTER) comments that the U.N. inspectors were very worried about being called spies of the United States and there was quite a debate about taking any information from the United States at all lest this be a U.S.-driven thing and Hans Blix did not want that and he said so publicly a number of times and said that frankly they could do the job fine without us.

But notwithstanding, we had been working with them for some time and giving them some good information and frankly at some peril because the U.N. leaks like a sieve, and there are some things about the U.N. that are worth noting. Not all the members of the U.N. are particularly friendly to the United States of America, and that brings us to the question of do Americans want us to be sharing our crown jewels and our sovereignty with nations who may not want to be particularly helpful to us and some who may actually want to be harmful to us.

So there is a question there of whether our American constituency would like us to keep this in control in the House or get it out where some other people might want to make some mischief for the United States of America and our security. And I am very much aware of that because we have actually had problems in the past that are documented, which I am not going to go into but which are documented, where materials and information was not properly safeguarded or was willfully given to the wrong people in the U.N. That is not a good track record and I think would not be prudent of us to ignore.

I would say that for some time U.N. weapons inspectors had unprecedented access to U.S. intelligence information. Whether they used it or not or wanted to use it was their problem, including analytical reports. We obviously protected our sources. We had imagery from the U–2 reconnaissance aircraft, which I think everybody knows now. Probably what some people do not know which I believe I can say is that the U.N. inspectors had the ability, the task to request how that U–2 was used. That is rather remarkable, turning over an asset like that to another country, a set of countries.

I believe everybody knows that Colin Powell played intercepts for the Security Council that are frankly things that do not happen in our committee very often. They do not play intercepts for us very often. So I would say an unusual amount of information, perhaps more than I would have approved of, was given to the U.N.

And there is a problem with the U.N. that I want to go into a little further, and it is an appearance problem; and it is one I think we are better prepared to handle in the House than an outside group trying to come in here. There is a lot of feeling, I think, that the U.N. does not always get it right in terms of our national purpose or national mission, and I would point out that the presidency of the Security Council for the month of June is the Russian Federation. I would like to also point out, and I think I can say this in a responsible way, that there are an extraordinary number of Russian espionage activities going on in our Nation's capital as I speak, even though we are on a friendly basis. Nations do spy on each other. Russians are still in a little bit of their paranoia and their conspiratorial mode that there are things to find out about us that if they just ask us, they will not believe the answer; so they have to spy on us. We have a good friendship with them, but it has got a ways to go. There is a little bit of a problem there.

There is a problem with Syria which is on our terrorist list being on the Security Council. These kinds of things lead one to pause about how we do business, and these are matters which we are well aware of on our committee. And on the Commission on Human Rights, which has recently been in the news at the U.N., it is clearly true that the U.N. took a slap at the United States by throwing us off that commission in order to put Cuba on it. That is not really great. The chairmanship of that committee, I understand, right now is Libya. Libya's human rights record is not worth commenting on, it is so terrible. Zimbabwe? Give me a break.

The CHAIRMAN pro tempore (Mr. SIMPSON). The time of the gentleman from Florida (Mr. GOSS) has expired.

(By unanimous consent, Mr. GOSS was allowed to proceed for 1 additional minute.)

Mr. GOSS. Mr. Chairman, when we take a look at this, the U.N. business is a complicated, complex business. We work closely with the Department of State, I&R, and others in this. We for years had a good working relationship. I do not think it is necessary for us to abandon that relationship or supplement it. So I am going to urge that we do not mess with what we have got now. If it turns out that there is a need to do that down the road, I will come back and admit it. But I do not think we are there at this point; so I will thank the gentlewoman for her amendment and the spirit in which it is offered.

Ms. LEE. Mr. Chairman, will the gentleman yield?

Mr. GOSS. I yield to the gentlewoman from California.

Ms. LEE. Mr. Chairman, let me just thank the gentleman very much for his response and for this debate, but I want to reiterate the purpose of this amendment, really, and it has nothing to do with whether one supports or opposes the United Nations. Basically, this amendment requires the GAO to conduct a study, a report, that would be submitted in an unclassified form but may contain a classified annex with regard to the sharing of information between our intelligence agencies and the United Nations leading up to the war against Iraq. I believe the American people have a right to know this and this is what this sentiment of this amendment is, and I would urge the gentleman to reconsider.

The CHAIRMAN pro tempore. The time of the gentleman from Florida (Mr. GOSS) has again expired.

(By unanimous consent, Mr. GOSS was allowed to proceed for 1 additional minute.)

Mr. GOSS. Mr. Chairman, I well understand the purpose of the gentlewoman's amendment, and what I am trying to say and outline for her is that dealing with the United Nations with intelligence is an extraordinarily complex issue, and I do not think there is a particular body in Congress that has more experience than the oversight committees on intelligence, House and Senate. And I therefore say give us a chance to do our job and I think she will understand. If the gentlewoman wants to know how much intelligence has been shared with the U.N., I guarantee we can find out upstairs.

Ms. LEE. Mr. Chairman, will the gentleman yield?

Mr. GOSS. I yield to the gentlewoman from California.

Ms. LEE. Mr. Chairman, I thank the gentleman again for that response; but, again, this amendment allows the American people to know what that information was in a declassified form. This amendment allows for a classified index, and I believe in terms of the fact that U.S. tax dollars were of course used in this war that people, the American people, just have a right to ask these questions and have the right to know. This has nothing to do with whether one supports or opposes the United Nations.

Mr. GOSS. Reclaiming my time, this is not supporting or opposing the U.N. I will tell the gentlewoman flat out that I do not have the capacity to declassify information. Our committee does not. We can get involved in a process, but the declassification question is another issue which I would love to enlist her support on on how we can make it better, but that is not part of this amendment.

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore. The Chair will once again remind Members to refrain from improper references to the Senate.

The question is on the amendment offered by the gentlewoman from California (Ms. LEE).

The question was taken; and the Chairman pro tempore announced that the noes appeared to have it.

Ms. LEE. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN pro tempore. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentlewoman from California (Ms. LEE) will be postponed.

Mr. GOSS. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. DREIER) having assumed the chair, Mr. SIMPSON, Chairman pro tempore of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, had come to no resolution thereon.

SPECIAL ORDERS

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under the Speaker's announced policy of January 7, 2003, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

EXCHANGE OF SPECIAL ORDER TIME

Mr. BROWN of Ohio. Mr. Speaker, I ask unanimous consent to take the Special Order time of the gentleman from New York (Mr. HINCHEY).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

MEDICARE: H.R. 1 TURNS BACK THE CLOCK

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. BROWN) is recognized for 5 minutes.

Mr. BROWN of Ohio. Mr. Speaker, as a member of the Committee on Energy and Commerce, I worked on the markup of the prescription drug bill, the Republican Medicare privatization bill, the other day; and I really could not figure out why Republicans were in every case doing the bidding of the drug companies and in every case doing the bidding of the insurance companies.

□ 2030

I asked the chairman if it could be perhaps that because the drug companies contributed about $80 million to campaigns last year, about 85 percent of that to Republicans, and the chairman said that could not be it. I asked if because our committee markup on two different occasions was delayed, stopped until the next day, stopped early because President Bush was headlining a major Republican event honoring the CEO of Glaxo Wellcome, one of the largest drug companies in the world, in this case a British drug company. He said that had nothing to do with it. I asked if it could be perhaps because President Bush was in the midst of raising millions of dollars this year from the drug companies and the insurance companies, if that is why the Republican drug bill was written by the drug industry and the insurance industry, and he said no to that.

Now, I will take the chairman of the Committee on Energy and Commerce at his word, that Republicans were not at the beck and call of the drug and insurance industry because the drug and insurance industry so richly funds the Republican Party. I will take them at their word.

But I finally figured out the reason that Republicans always do the bidding of the drug and insurance companies and why the Republicans want to privatize Medicare is because they just do not much like Medicare. And while that may sound strange to some Members of this House or anyone else that might be watching, I think we need to look at the history of Medicare.

In 1965, there were only 11 Republican Members of Congress out of 150 or 160 or so, only 11 Members of Congress on that side of the aisle that actually supported the creation of Medicare. Gerald Ford, later to become President, opposed it. Bob Dole, later to be a Senator and then a presidential nominee. Opposed the creation of Medicare. Strom Thurmond, a longtime, longest-serving Senator in U.S. history, opposed the creation of Medicare. Donald Rumsfeld, now the Secretary of Defense, was a Member of the House in those days and he opposed the creation of Medicare. Basically, almost every single Republican opposed the creation of Medicare. They made all kinds of comments about big government and socialized medicine, all of those kinds of things they said because they just did not want a government health care program like Medicare.

Then, during the Reagan administration, Republicans tried several attempts to privatize Medicare. They cut reimbursement for hospitals, they cut reimbursement for doctors, they tried to scale back the Medicare benefit for seniors, but they really could not get much through a Democratic Congress. But then, the day came in 1995 when Newt Gingrich came on the scene as the new Speaker and Newt Gingrich literally waited fewer than 100 days, literally fewer than 100 days until he tried the beginning of the dismantling of Medicare.

What Speaker Gingrich did was he tried to cut Medicare $270 million and then to turn around and give a major tax cut, taking the money from Medicare, and giving a major tax cut to the wealthiest people in sight. Does that sound familiar? That is what they are basically doing today, giving tax cuts to the wealthiest 1 percent. In this case, the tax cut for millionaires is $90,000.

Speaker Gingrich also made a statement. He said, "We can't get rid of Medicare"; this was back in 1995. He said, "We can't get rid of Medicare in round one because we don't think that is politically smart, but we believe it is going to wither on the vine."

Bob Dole that same year bragged to a conservative group, a group of conservative politicians who do not like Medicare; sort of the Republican line. He said, Bob Dole said, I was there 30 years ago fighting the fight, voting against Medicare, trying to stop it from ever being created.

So it is pretty clear, Mr. Speaker, that it may not be just the fact that Republicans raise a ton of money from the drug companies and a ton of money from the insurance companies, and that is why they are for Medicare privatization and that is why they want to turn Medicare over to the drug and insurance industries. It may not be that; it may be that they have an honest, philosophical difference with us and with 90 percent of the American public. They just do not like Medicare. They voted against creating it. They bragged about voting against creating it. Speaker Gingrich voted to cut it on several occasions.

And now in 2003, with a Republican President, a Republican Senate and a Republican House, this is their golden opportunity to privatize Medicare. That is what this vote is all about this week. The Republicans, at the behest of the insurance companies and the drug companies, want to privatize the health care system that has worked for America's seniors.

The gentleman from California (Mr. THOMAS), the new Republican star in their efforts to privatize Medicare, in their efforts to dismantle Medicare, has said, and I will end with this, Mr. Speaker, he said, to those who would say the bill would end Medicare as we know it, our answer is, from the gentleman from California (Mr. THOMAS), Republican chairman of the Committee on Ways and Means, we certainly hope so. Old fashioned Medicare is not very good. We want to end it.

Mr. Speaker, we need to vote "no" on the Republican plan, vote "yes" on the Democratic plan that will preserve Medicare and provide a solid prescription drug benefit for our seniors.

THE SONS OF COLVILL

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under a previous order of the House, the gentleman from Minnesota (Mr. GUTKNECHT) is recognized for 5 minutes.

Mr. GUTKNECHT. Mr. Speaker, I rise tonight in honor of Minnesota's 135th Infantry.

It is hard for us to imagine what it must have been like in the spring of 1861 when cannons announced the first battle of the Civil War by firing on Fort Sumter in Charleston Harbor. Minnesota's first Governor, Alexander Ramsey, happened to be in Washington on other business. Upon learning the news, he raced to the White House to become the first Governor to volunteer troops for the Union Army.

A few nights later, in Red Wing, Minnesota, William Colvill used his considerable size and agility, as he stood almost 5 feet, 5 inches tall, to elbow his way to the front of the line to become the first volunteer in the first regiment of the first State that volunteered troops to preserve the Union.

Minnesota's First Regiment fought with distinction in many of the bloodiest battles in the Civil War, including Fredericksburg, Bull Run, and Antietam. American history has a special footnote, however, to commemorate their actions on July 2, 1863 in that most famous of Civil War contests, the Battle of Gettysburg.

General Winfield Scott Hancock, commander of the Union forces, saw the vulnerability of General Sickles' New Yorkers, who had moved forward, leaving a huge gap in the Union line. Hancock noticed that the First was positioned somewhat south of the middle of the long Union line on Cemetery Ridge. He nervously rode up and asked, Colonel Colvill, how long can you hold your position? Colvill, who spoke in short, crisp sentences firmly answered, "General, to the last man."

Now, this was no idle boast. By the end of that day, the regiment would suffer 82 percent casualties.

That single phrase, "to the last man," survives today as the motto of the Minnesota National Guard detachment that traces its heritage to the Minnesota First Regiment.

When the regiment headed off to war from Fort Snelling in 1861, they were 1,023 strong. After Pickett's charge at Gettysburg had been repelled only 2 years later, just 67 men could answer the call.

The Minnesota First went on to see action in the Spanish American War and served with distinction in the Philippine Insurrection. During World War I it was mustered into service, but did not see action as a unit.

That changed in 1941 when war clouds gathered far across the sea. The 135th Infantry became the first division to be activated and shipped out. Advance units of the 135th sailed to Africa to take on the famed Africa Corps of Field Marshal Rommel. Despite being outmanned and underequipped, the 135th turned back the Desert Fox and his Army.

After World War II, the 135th once again saw action in Korea.

Today, the 135th is a battalion; no longer a regiment. It has five companies compared with 20 years past. It is concentrated in southeastern Minnesota as a member of the historic 34th Red Bull National Guard Division.

That is why, this July 11 through 13, the thin ranks of the 135th Infantry's combat veterans of World War II and the Korean War, the "Sons of Colvill" as they are known, will gather to remember. They will close ranks in Mankato, Minnesota, to honor those who have fallen and to remember one more time the sacrifices of a generation.

Once again, they will listen to the special music that identifies the 135th: "March of the Red Bull Lesions," "The Old Gray Mayor," "The Sons of Colvill." It will be a final hoo-ah for the surviving men of World War II, and it will be one more commemoration for the thinning ranks of the Korean War vets. And, it will be one last chance for us to say, "thank you, well done, oh good and noble servants. You have brought hope and freedom to millions who will never know your names."

Mr. Speaker, I salute the brave Minnesotans who have given so much to keep the lamp of liberty burning brightly throughout the world. To the families of those who have made the supreme sacrifice, we cannot adequately salve the wounds that will never heal. The best that we can say is that we will never forget.

May God bless you. May God continue to bless our country and all who defend her.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from the District of Columbia (Ms. NORTON) is recognized for 5 minutes.

EXCHANGE OF SPECIAL ORDER TIME

Ms. WOOLSEY. Mr. Speaker, I ask unanimous consent to take the time of the gentlewoman from the District of Columbia.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

WOMEN AND PRESCRIPTION DRUGS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WOOLSEY) is recognized for 5 minutes.

Ms. WOOLSEY. Mr. Speaker, like the gentleman from Ohio (Mr. BROWN) said, this is deja vu all over again. Here we are, once again, discussing ways to help seniors afford the prescription drugs that they need and must have and, once again, the majority insists on a sham proposal that gives seniors nothing more than a false sense of security.

I am here tonight with the gentlewoman from California (Ms. LEE) to remind everyone that as we debate proposals to add a prescription drug benefit to Medicare, the decisions we make will overwhelmingly impact the mothers, grandmothers, sisters, and aunts across this country. Women are living longer than ever, and they are living longer than men. That is good news. However, the poverty that many women experience during their final years is certainly not good news.

There are several reasons women's golden years are not so golden. While most women have worked their entire lives, a good portion of this work was not in the paid workforce. You do not earn a pension for the time spent caring for children or elderly parents. When many of our mothers and grandmothers were in the workforce, they were denied equal pay for equal work, therefore earning less. Some worked only part-time, trying to balance the responsibilities of their jobs and their families. As a result, they have made less over their lifetimes, and now their monthly Social Security benefit is considerably smaller than their male counterparts.

These women deserve financial stability and still, the Republican prescription drug proposal denies them the security that comes with knowing that they can afford to pay for their medical care. Not only will the majority's plan not help senior women, it will push Medicare beneficiaries into HMOs, creating more instability. I am not speculating: I have watched it happen in my district.

Just a few years ago, the Health Plan of the Redwoods, a good, small HMO that served my constituents in Sonoma and Marin Counties, went bankrupt. After first limiting services and physician payments, they had to close their doors. This bankruptcy interrupted care for a number of my constituents, a great number of them senior women.

We should not force Medicare beneficiaries to accept the same kind of instability in exchange for a prescription drug benefit. The Republican plan ignores the proverbial 800-pound elephant in the room: the astronomically high prices of prescription drugs.

Take a minute and think about the reason our senior women cannot afford prescription drugs. It is because prescription drugs are too expensive. To me, it is good, old-fashioned, common sense that we should take steps that address the root of the problem and find ways to reduce these prices. But the majority apparently does not enjoy the same common sense that my democratic colleagues and I do.

Their plan specifically forbids the Secretary of Health and Human Services from negotiating lower prescription drug prices. Can my colleagues imagine that? The Republican plan prohibits the Secretary of Health and Human Services from trying to make the cost of prescription drugs lower.

□ 2045

Private insurance companies then must on their own negotiate with far less bargaining power. The Veterans Administration has proven that negotiating can result in lower prices, but the Republicans have once again proven that they care more about the profits of the pharmaceutical companies than the bottom lines or about senior women.

Many older women have little or no financial security. But there is one thing even more dangerous than that, and that is a false sense of security. Millions of women will read the newspapers; they will be delighted to learn that there is now a Medicare prescription drug benefit. But imagine their surprise, imagine the surprise of the typical elderly woman when she learns that her so-called benefit will require her to pay $4,000 of the first $5,000 in annual drug expenses. And that is on top of a monthly premium that is yet to be determined.

Frankly, I find it shameful that the majority claims that they are delivering a drug benefit to seniors when in reality the plan will cover only a small portion of their expenses. And it will actually outlaw practical steps to reduce these expenses in the first place. I dare my Republican colleagues to tell their mothers what they are doing to Medicare.

After a lifetime of hard work, both in and out of the home, our mothers and grandmothers deserve better than this fraudulent plan the Republicans are pushing. We can do better and we must.

PRESCRIPTION DRUG PLAN NOT FAIR TO OUR CHILDREN

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under a previous order of the House, the gentleman from Michigan (Mr. SMITH) is recognized for 5 minutes.

Mr. SMITH of Michigan. Mr. Speaker, I agree with the previous speaker on several issues, and that is that we should delay this bill and try to improve it. And I am going to make comments suggesting that it is not fair to seniors, but it is not fair to our kids and our grandkids. I have four children, and they are trying to save money to send my grandchildren to college. And one question I would pose is, why should they pay more taxes to pay for seniors' prescription drugs?

The retiring seniors that we are going to see over the next 10 years are probably the wealthiest seniors this country has ever had in the past, probably will ever have in the future. Mr. Speaker, we now expect a vote on the addition of a prescription drug benefit to Medicare on June 26. And this vote would authorize the largest expansion of our entitlement programs since we amended the Social Security bill back in 1965 and added Medicare. So Social Security, because of the allure of more senior votes, Members of Congress and the President decided to expand the benefits to seniors to add Medicare.

When Medicare was under consideration in 1965, a few Members realized the sort of burdens that would come to place on future taxpayers, and Chairman Wilbur Mills of the House Committee on Ways and Means predicted in September of 1964 that the costs of even part A of Medicare, which was then under consideration, would soon exceed projections and that ever-increasing taxes would be needed to finance it. He predicted it would come to pass that Medicare costs would leave Congress hamstrung, facing uncontrolled increases in costs and to the indefinite future. Mills dropped his opposition to Medicare under pressure from the President of his own party, but he was right about the program's consequences.

This summer, as Congress considers the largest single expansion of any entitlement program since 1965, we should consider how a prescription drug benefit will burden future workers and taxpayers and not give seniors what they expect. The Federal Government is in serious financial problems. When the baby boomers start retiring in the next 10 to 12 years, we see more people going out of the workforce, if you will, paying in to Social Security and taxes and taking out benefits from Medicare and Social Security.

When the Federal Government comes to a pinch in another 12 to 15 years, guess what is going to happen to the prescription drug program that has been promised? Number one, I suggest that government, Congress and the President will say, well, to reduce costs, we need to spread the costs over a wider segment of the population, and so we are going to require all seniors, regardless of whether you have prescription drugs in your retirement program or not, regardless of whether you have a good insurance program that covers prescription drugs, we are going to require everybody to take the government's system.

Guess what comes next as government faces this fiscal pinch? Rationing, and then the government will follow what many other countries have done such as Canada and many other countries that have government-run programs. They are going to say, well, we are going to limit the prescription drugs that are available to seniors. This proposal suggest that $400 billion, and it is pretty much used up, is going to be required for spending in the next 10 years for prescription drugs. We should think carefully about the consequences of making a whatever-it-costs commitment into the indefinite future.

I chair the Subcommittee on Research in Science and the medical technology is now expanding more rapidly than our ability to pay for it. That means the medical technology of the future is going to be very impressive and very successful on maintaining our health and helping us to live longer. In fact, the future has suggested that in the next 20 years, anybody who wants to live to be 100 can do so, but it will cost money. And we are sort of programming that we will pay for those benefits, whether it is $40,000 a treatment or $60,000 a treatment after they finish their first deductible and the 3,000 or whatever we end up with. And that is another question, none of us have read this bill yet.

It now looks like a bill we will consider this week will add prescription drug benefits with minimum offsets for Medicare. It is not fair to our kids to add this responsibility to everybody else's kids and grandkids and my 10 grandkids, and I would hope we look more carefully at this and review it over the Fourth of July recess and come back and try to have a better bill.

This will add enormous liabilities to a Medicare system which is already predicted to be insolvent. Economists calculate that the newly created unfunded liability of such a reform is $7.5 trillion. This means that a prescription drug bill that adds 12 percent to Medicare's costs comes with a present cost of $7.5 trillion, or a bit more than the entire public debt. You add this to an unfunded liability of $9 trillion for Social Security and you end up saddling our kids with a huge debt.

These projections assume that prescription drug costs will grow at the same rate as the rest of Medicare, and that the prescription drug benefit will not be expanded over time. Recent history would suggest that prescription drug costs are growing more rapidly than the rest of Medicare. In 1965, OMB projected that Medicare would spend $9 billion in 1990. The actual figure was $67 billion. Having projected $26 billion in spending for 2003, we will spend $245 billion. Because medical technology—the cost of prescription drugs will be much higher.

This drives home the point that any expansion of Medicare imposes a cost on taxpayers. Such a reform basically transfers the burden from retirees to taxpayers. More accurately, it means that we are transferring costs from us to our children and grandchildren. We're spending now and sending the bill to people who are yet to be born or too young to defend themselves.

This is selfish and it is wrong. I'm not against a prescription drug benefit if it is responsible. But it must not place heavy and increasing burdens on workers, taxpayers, and the economy in the future. I oppose the bill that is now under consideration because it does not meet this test.

Once again, we have not had an opportunity to see and review a bill on an important topic before we are required to vote on it. It is rumored, in fact, that changes are still being made. Few members will actually know exactly what's in this bill until after it has passed.

I believe that the better approach would be to release the bill tomorrow and then delay the vote until after the upcoming Fourth of July work period. That would allow all of us in Congress to read the bill, consult with our constituents, and make a fully informed decision on a program that could profoundly affect our future and that of our children and grandchildren.

I urge Congress to reject the bill tomorrow so we can take a more responsible and deliberate approach to reforming an important program like Medicare.

PRESCRIPTION DRUG PLAN SHOULD BENEFIT SENIORS, NOT DRUG COMPANIES

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. LEE) is recognized for 5 minutes.

Ms. LEE. Mr. Speaker, I rise today to ask Congress to pass a prescription drug bill for our senior citizens, not for the insurance and the pharmaceutical industries. The Bush administration continues to sell our Federal domestic programs to corporations and to industry donors.

Today, hundreds of seniors stood against the Republican prescription privatization plan. They blew the whistle on this. They blew the whistle on this deceptive legislation; and tonight, we too are blowing the whistle. Their bill will dismantle Medicare as we know it.

This prescription drug bill does not provide affordable drugs under Medicare. Instead, it leaves seniors, particularly women, to pay the price for pharmaceutical advertising and insurance industry lobbyists. Democrats have been fighting against these industry economics for years, and we know what a good Medicare prescription drug benefit looks like. It is affordable and available to all. It is inclusive and provides drug coverage for all communities, rural and urban. It includes all seniors and all walks of life without establishing a means tests or a voucher system.

Last week, the House Republicans under the leadership of really the Bush administration released their prescription drug benefit. The Republicans contend that seniors should be forced to use private insurance companies for drug coverage rather than Medicare in order to force competition. But the bottom line is the Republicans are really providing a benefit to the insurance industry and to the pharmaceutical industry.

The industry would have the ability to design their own prescription drug plan. The industry would decide what to charge and which drugs seniors can get. The Republican plan exploits seniors and the disabled by requiring private insurance plans to stay in the program for only 1 year. This could leave seniors vulnerable to unavailable plans, rotating doctors and shifting prescriptions. Just thinking about all of these threats to our seniors really does make me sick.

Tonight I want to focus on women and remind the Republicans of the voters really that they are ignoring. Women in this country will suffer first hand if the Republican prescription privatization bill passes, not only because we live longer, but because we pay into the Medicare system longer. Almost eight out of 10 women on Medicare use prescription drugs regularly, though most pay for these medications out of pocket. Women on Medicare spend 20 percent more on prescription drugs than men. And in 1999 alone, women on Medicare spent $430 more a year on medications than men. The Republican bill puts women, it puts our seniors, our disabled really on the industry's chopping block. It should make you really cringe to witness the corporate welfare that the Republicans are creating for the insurance and pharmaceutical industry in their bill.

Since 1980, drug prices have increased by over 256 percent, while the consumer price index on which Social Security's cost-of-living adjustments are based rose just 98 percent. And in their bill they will not even allow our Secretary of Health and Human Services to discuss and negotiate lower prices for their medications. How shameful that is.

In the Bay Area, specifically in my home town of Oakland, California, my elderly and disabled constituents are paying up to $2000 more a year for basic drugs than in Canada, Europe and Japan. These disparities may seem bad now; but under the Republican plan before us, they will only get worse. I could go on and on, but the point is that seniors and the disabled are paying on average 89 percent more than our international counterparts. This is just dangerous and downright unfair. It is bad public policy.

Our senior women are having to make hard decisions about which drugs they can afford and if they should really buy drugs or pay for food. There is a better way.

Democrats have a low-cost prescription drug plan that does not pit seniors against one another, but makes access to prescription drugs a reality for all. The plan has incorporated many of the components of another plan called the Meds Plan, which many of us are supporting.

Under this plan, we ensure that seniors and people with disabilities have affordable, comprehensive and guaranteed access to prescription drug coverage. The proof is in the details. A $25 a month premium, a $100 a year deductible, an 80/20 cost-sharing between Medicare beneficiaries, a $2,000 minimum for Medicare beneficiaries, and a sliding scale for low-income individuals for up to 150 percent of the median.

Under the Republican plan, let me state that the bill that the Republicans have put forward will really punish people for getting sick. The Democrats will not punish our seniors for getting sick. The Republican plan gives authority to insurance companies and HMOs to really prey on Medicare and Medicaid beneficiaries. The Democratic plan reduces the costs of drugs. The Republican plan does not. The Democratic plan does not end Medicare. The Republican plan does.

The Democratic plan does not end Medicare. The Republican plan does.

The Democratic plan reduces the costs of drugs. The Republican plan does not.

In short, the Democratic plan brings our country one step closer to insuring access to all people for much needed care, while the Republican Prescription Privatization plan is a divisive tool that will enrich the insurance and pharmaceutical industry.

The Republican plan gives authority to insurance companies and HMOs to prey on Medicare and Medicaid beneficiaries.

Unlike the Republican bill, the Democrats won't punish you for getting sick.

I urge my colleagues to vote against the Republican Prescription Privatization bill.

HELL IN A CUBAN PRISON

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida (Mr. LINCOLN DIAZ-BALART) is recognized for 5 minutes.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, the gentleman from New Jersey (Mr. SMITH) had a wonderful idea the other week. We should speak every single week about the men and women who are languishing in prisons in the totalitarian state of Cuba, that island that has been for 44 years oppressed by a totalitarian dictator. So each week we bring forth, a number of us here, different political prisoners and speak specifically about their cases to remind our colleagues and those who will listen about the horrors just 90 miles from the shores of the United States.

□ 2100

The following are excerpts, Mr. Speaker, from a letter from dissident Juan Carlos Gonzalez Leyva who is blind. These excerpts of a letter were sent out of his prison in Holguin, Cuba, as recorded by his wife Maritza Calderin. The letter was sent to the United Nations Human Rights Commission in Geneva.

To Sylvia Iriondo of Mothers and Women Against Repression. This is a letter, Mr. Speaker, sent out of prison by Juan Carlos Gonzalez Leyva.

After 13 months in prison, I have not been tried or sentenced by any court even as efforts have been made to persuade me to betray God and human rights and collaborate with the dictatorship. Since mid-December, State security used inmate Joe Prado, as he calls himself, to throw in my cell a substance that produced a burning sensation on the skin and nasal congestion, a great deal of phlegm and bronchial inflammation. The situation still continues.

Since January, they have added another substance to the sawdust they throw at me. This one gives me the sensation of millions of bugs constantly running all over me. It causes a great deal of itching and prevents me from sleeping. I do not know if this is a biological substance or chemical agent, but I know it is not insects because when I touch my skin there are no actual bugs that I can feel, although this sensation is palpable.

Normally the sawdust shower is a daily occurrence. Yesterday it started around 6:00 p.m. when I was on my knees praying. The sensation is that of a multitude of bugs suddenly coming down on my face and my body. This torment continues until 2:00 or 3:00 in the morning.

The inmate follows me everywhere. I have to eat out of a can that I try to keep covered all the time because he will throw the nausea-provoking substance into the food.

Sometimes I feel as if I have a chain attached to my body and the weight of the world on my shoulders. I feel that I am going to collapse, that I cannot take this anymore, but I pray to God, and Jesus Christ gives me strength. It is a constant struggle, a constant torture.

On February 1, I placed my mattress in front of the cell's iron bar doors to get some fresh air. Officer Fabu, the unit chief, snatched the mattress away from me, threw me on the floor, took me by the neck and dragged me. He told me that if I wanted to sleep, I could sleep on the bare floor with the dirt, other prisoner's shoes, roaches, ants, mice, et cetera.

One night they threw so much of the substance into the cell that it was as if the walls were boiling. So I had to retreat to my bed and resign myself to do without the little bit of fresh air I was getting through the iron bars.

The substance also causes acute pain in both of my eye sockets. The pain is so severe that at times it seems my eyes are popping out. Every day the unit chief threatens me with death if I continue the hunger strike to protest the prosecution's request of 8 years in prison.

They do not allow me to speak to my lawyer and I do not have religious assistance or access to any information. I am only allowed to listen to the round tables and the State-run newscasts. For the skeptics, I can say that hell does exist and Satan shows all of his faces here.

In here, I listen to the weeping of young and old women, their terrible and frightful laments forever embedded in my mind. They plead because they are locked in cells that are like drawers where are held men, women and the elderly, the sick and the incapacitated. They plead because the four walls become a grave site.

These are catacombs where people scream but the sound is drowned out by a hermetically sealed metal door. When the women plead, the prison guards laugh and say, "What they want is a man."

I trust God and our Lord, Jesus Christ, to give me the strength to face any situation, whether to live in squalor, as I live now, or to die and meet my Lord and my God.

The political prisoner of Cuba, Mr. Speaker, 90 miles from the shores of the United States, an island that has suffered 44 years of totalitarian and oppression while the world does nothing, but we do not forget and we will not continue denouncing the horrors of the totalitarianism that the people in Cuba suffer and we will not stop struggling until Cuba is free.

CHECK WITH THE SENIOR CITIZENS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Illinois (Ms. SCHAKOWSKY) is recognized for 5 minutes.

Ms. SCHAKOWSKY. Mr. Speaker, once upon a time, in 1989, there was a bill that had passed the United States Congress and was signed into law called the catastrophic health care bill, and it had bipartisan support, and all of the national organizations of senior citizens supported that legislation, and it was supposed to provide catastrophic coverage to senior citizens for health care.

One problem, no one had really checked with rank and file senior citizens to find out if they wanted this legislation that caused them to have the highest effective tax rate of any Americans, to pay for benefits that they thought simply were not worth it. In other words, the senior citizens sat down with their calculators and figured out they were not interested in this legislation that had passed.

This is a photo that appeared on the front page of the Chicago Tribune in August of 1989. Here we see some senior citizens who are clearly very angry, with signs surrounding an automobile in which was the chairman of the powerful House Committee on Ways and Means. These senior citizens were not exactly in a friendly mood and were telling this chairman in no uncertain terms that they wanted the repeal of the catastrophic health care bill.

It was not very long afterwards that this sparked a rebellion of senior citizens across the country, and in a rare occurrence in this body the catastrophic health care bill was repealed.

I think this should serve as a warning to all of my colleagues. Check with the senior citizens. You can sit here all day and all night and say the problem is that Medicare is outdated, that it is antiquated or you can say what the Chairman of the powerful House Committee on Ways and Means of today said, To those who say that the bill proposed by the Republicans would end Medicare as we know it, our answer is we certainly hope so. Seniors listen: We certainly hope so.

Mr. Speaker, I hope the seniors are listening. Old fashioned Medicare is not very good, says the chairman, the Republican chairman of the House Committee on Ways and Means.

You better check with those seniors, because what they tell us is they like Medicare. They want Medicare. The only thing wrong with Medicare is that it does not cover enough, like prescription drugs, but what they like about it is that it is a known benefit, it is a known premium, and it is there for them when they need it.

Another word that is used all the time is choice. We are going to give senior citizens choices now. Well, I have to tell my colleagues, in all the years that I was the executive director of the Illinois State Council of Senior Citizens and in all the years that I was in the State legislature and now in Congress, never has a senior citizen come up to me and said, Congresswoman, what I want is a choice of HMOs, a choice of insurance companies, send me those brochures so I can pick, tell those insurance agents to get me on the phone so they can pitch their insurance company to me.

Seniors want the kind of choice they get under Medicare, a choice of doctors, a choice of hospitals, a choice of specialists. That is the kind of choices that they want.

In fact, the only choice under this Republican bill is the choice that HMOs and insurers get, not senior citizens, because private drug plans, HMOs, get to choose what premiums to charge. There is no uniform benefit of premium under Medicare.

Private drug plans get to choose the copayments that they will charge. Private drug plans get to choose what pharmacies are in their network. They get to choose what drugs are covered. So if you want to give the HMOs and the insurance companies that kind of choice, then this bill is for you, but if you want to give senior citizens what they really want, then you are going to expand Medicare the way the Democrats have proposed, by giving them a prescription drug benefit under Medicare that they can count on, that they know what the premium is.

This legislation that is passed in the House is going to do exactly what the chairman said. It is going to destroy Medicare. It will be the end of Medicare. That is what happens in 2010 with this bill. So if you do not want to be chased down the street, then all of us better say no to the Republican bill.

HOMELAND SECURITY TECHNICAL CORRECTIONS ACT OF 2003

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. COX) is recognized for 5 minutes.

Mr. COX. Mr. Speaker, I include for the RECORD the following exchange of letters relating to yesterday's debate on H.R. 1416, the Homeland Security Technical Corrections Act of 2003.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC, May 14, 2003.

Hon. CHRIS COX,
Chairman, Select Committee on Homeland Security, House of Representatives, Washington, DC.

DEAR CHAIRMAN COX: In recognition of the desire to expedite floor consideration of H.R. 1416, the "Homeland Security Technical Corrections Act of 2003," the Committee on the Judiciary hereby waives consideration of the bill. Section 11 of H.R. 1416 creates new §5 in the Homeland Security Act of 2002 (Public Law 107-296). New §5 mandates that any report or notification required by the Homeland Security Act be submitted to the Select Committee on Homeland Security as well as to any other Committees named in the Act. Section 225 of the Homeland Security Act incorporated the Cyber Security Enhancement Act which, among many other things, requires the Attorney General to report to the Judiciary Committee regarding the use of electronic surveillance in emergency situations and requires the U.S. Sentencing Commission to submit a report in response to the Cyber Security Enhancement Act. To the extent that §11 of H.R. 1416 affects these reports required by §225 of the Homeland Security Act, these provisions fall within the Committee on the Judiciary's Rule X jurisdiction. However, given the need to expedite this legislation, I will not seek a sequential referral based on their inclusion.

The Committee on the Judiciary takes this action with the understanding that the Committee's jurisdiction over these provisions is in no way diminished or altered. I would appreciate your including this letter in the Congressional Record during consideration of H.R. 1416 on the House floor.

Sincerely,

F. JAMES SENSENBRENNER, Jr.,
Chairman.

SELECT COMMITTEE ON HOMELAND SECURITY, HOUSE OF REPRESENTATIVES,
Washington, DC, May 15, 2003.

Hon. F. JAMES SENSENBRENNER, Jr.,
Chairman, Committee on the Judiciary, House of Representatives, Washington, DC.

DEAR CHAIRMAN SENSENBRENNER: Thank you for your letter regarding H.R. 1416, the "Homeland Security Technical Corrections Act of 2003." As you noted, §11 of the bill falls within the Rule X jurisdiction of the Committee on the Judiciary to the extent it concerns the two reports described in your letter. I appreciate your willingness to forgo consideration of the bill, and I acknowledge that by agreeing to waive its consideration of the bill, the Committee on the Judiciary does not waive its jurisdiction over this provision.

I will include a copy of your letter and this response in our committee report and in the Congressional Record during consideration of H.R. 1416 on the House floor.

Thank you for your assistance in this matter.

Sincerely,

CHRISTOPHER COX,
Chairman.

MEDICARE PRESCRIPTION DRUGS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. LORETTA SANCHEZ) is recognized for 5 minutes.

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I come before you tonight to talk about the Medicare Prescription Drug and Modernization Act of 2003 and to place it in context with the overall goals and beliefs of the President and the Republican party.

The Republican bill, H.R. 1, is quite simply a first step toward the Republicans' goal to privatize Medicare. My colleagues on the other side of the aisle want to do this for a couple of reasons.

The first is that they firmly believe that the private sector and the free market are always right and that government is always wrong. I am afraid that they have a very narrow-minded and simplistic view of how our economy, our government and our country are supposed to function.

There has been a shift in the rhetoric used during political debate in this country since the election of this President. There has been a conscious effort by his office and the Republican leadership of the House to use language that paints critical issues in simplistic black and white, us versus them, good versus evil, terms, ultimately simplifying the debate into a three word sound byte.

I view this as a very unfortunate occurrence because it allows a certain mental laziness to take over this body. When it is really our duty, it is our duty to debate, to discuss and to think very carefully and critically about very complex and important work that we do in this Chamber.

No one here has more respect for the power, the creativity and problem solving ability of the free market as I do. I am a hard-nosed, show-me-the-bottom-line businesswoman through and through, but my admiration of the market is based on years of deep study of its function and a real understanding of how it works.

My Republican colleagues, on the other hand, seem to feel that the invisible hand of Adam Smith and the hand of God are the same thing but our free market is not an all powerful system without limitations.

The free market is an incredible tool that has advanced many areas of human endeavor, but in order for it to work, it must include one very important ingredient, profit, and without this critical component, the free market system is useless.

Medicare was created in 1965 precisely to address the failure in this market. It was not profitable to treat our seniors with a free market health insurance industry so they found a solution to insuring the elderly. They just decided that they would not cover them. After all, old people get sick too much and insurance companies would have to pay. They figured that if you want to make money in the medical insurance game, insure young, healthy people; not old sick people.

Luckily for America, during the 1960s and 1970s and 1980s Democrats controlled this Congress and they were not satisfied with the solution that would push our mothers and our fathers, our grandmothers, our grandfathers out into the cold. So Democrats set up the government entitlement called Medicare.

□ 2115

We said, we value our elders. Even though the market says leave them behind, we will not. We will protect you and treat you with compassion and the dignity that you deserve in your old age.

So why do the Republicans want to privatize Medicare so badly? Maybe they have amnesia. Maybe they do not remember what happened when we left the health care of aging parents and grandparents to the free markets. Or maybe they are so swept up in their blind faith in the market that they believe that somehow the market will just take care of things. But we have already tried them and it did not work. Remember?

Taking care of the elderly is not profitable, nor should it be. Profit is not always the most important thing. These are the people that reared us. They are the people that took care of us when we were sick. They are the people that taught us right from wrong. I will not be a party to this slap in the face to my parents and to the seniors in my community being offered by the Republican majority of this body. Their bill purports to offer a prescription drug benefit for Medicare beneficiaries, but it fails to offer any guarantee that seniors will actually receive it.

The prescription drug plan is only available through private insurance companies or HMOs.

And besides all this, it does not ensure that all seniors will get this coverage. The eligibility of all seniors has been a hallmark of the Medicare program.

If that was not bad enough, in a provision of the bill completely unrelated to creating a prescription drug benefit, the House GOP bill would increase seniors' costs for doctor visits by raising the Part B premium and indexing it to inflation.

This provision is included for no other reason than to raise the cost of traditional Medicare and force seniors into Managed Care Plans.

And who does this benefit? Seniors? I think not. It benefits Insurance Companies and Pharmaceutical Manufacturers—the real constituents of the Republican Party.

Republicans are doing in this bill what they have consistently done this whole Congress: Advantaged the wealthy and the powerful and put the screws to the little guy.

Just last night, DAVID OBEY stood on this floor and asked the Republicans to cut back, from $88,000 to $83,000, the tax cut for those whose annual income is over 1 million dollars in order to pay for desperately needed homeland security projects.

The Republicans said "no." Cutting taxes for the wealthy and powerful is more important.

Just a few weeks ago, I tried to offer an amendment to the tax bill that would have pushed back the start date of the dividend portion of the tax cut for 1 year—just seven-tenths of one percent of the tax cut—to fund homeland security projects to make our country safer.

The Republicans said "no." Cutting taxes when we are in astronomical debt is more important.

How about the Child Tax credit? "No," say the Republicans, we are not going to help out poor children or the children of veterans of a war in Iraq where Marines and Soldiers are still dying.

Today, I offered an amendment to the Medicare Bill, in order to offer a real prescription drug benefit to all seniors, and to do it through Medicare.

I hope that the committee will allow this amendment to be considered on the floor of this House. It is an important amendment because it is not designed to protect the profits of the insurance companies or the pharmaceutical industry. It is designed to help our seniors.

It is clear to me and to my Democratic colleagues where the Majority's loyalties lie. From homeland security to education, from veterans benefits to the Child Tax credit, and now finally to the health and well being of our parents and grandparents, the Republican message is clear: We do not care about you.

OLDER WOMEN AND MEDICARE

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WATSON) is recognized for 5 minutes.

Ms. WATSON. Mr. Speaker, I want to stress the importance of a health safety net that has worked for the American people. It is our duty to protect the seniors that have contributed to society over their lifetimes. Our older constituents have built or supported most of what America is today and we owe them respect. We owe them the safety net that is called Medicare.

I want Congress to know that not only is Medicare important for the American people, it is a huge issue for America's women. Women, indeed, are the face of Medicare. Women constitute 58 percent of the Medicare population at 65, and women constitute 71 percent of the Medicare population over the age of 85. Women can expect to live on the average 19 years into retirement, while men can only expect to live 15 years. We must take care of our mothers, our sisters, and our daughters. We can do no less.

Across the breadth of the United States, the older and the poorer the woman, the higher the out-of-pocket health costs. The more she needs assistance, the less she will actually receive. Because of barriers to enrollment, close to half of older women with incomes below the poverty line are not enrolled in Medicaid. Research suggests that women on Medicare spend 20 percent more on prescription drugs than their male counterparts. Middle class women who have made wise financial planning decisions, can quickly find that high drug costs will eat away any retirement security they have worked to establish.

Mr. Speaker, I want to give you some thoughts on cultural diversity in regards to women and Medicare. More minority women than Caucasian women are uninsured or rely on public rather than private health insurance. Minority women are more likely to have lower incomes and to live in poverty than other women. The percentage of women on Medicare with incomes of less than $10,000 a year is a very telling statistic. Twenty-four percent of white women, or 14.7 million; 56 percent of African women, and there are 1.8 million; and 58 percent of Latina women, and there are 1.2 million, live way below the poverty line. Clearly, not only should we strengthen the safety net but we should find out why so many women need that net.

So, Mr. Speaker, a health safety net for the American person is imperative. Our older constituents have built or supported most of what America is today, and we owe them a great amount of gratitude. They should go to bed each evening feeling secure that they have health benefits when they are needed. They should know that their benefits are universal and affordable.

What a shame, a shame, that our seniors have to leave the United States and go to Canada or Mexico, where the same prescription drugs, same ingredients, are much, much cheaper. We have seniors who are eating dog food rather than regular food because they have to pay the cost of these expensive drugs.

In closing, Mr. Speaker, these older Americans should be given a benefit that they can rely on, that they will know they can live a quality of life with respect rather than the one they would have to live if we whittle away at Medicare. Let us honor our seniors.

REPUBLICAN PRESCRIPTION DRUG BILL

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Nevada (Ms. BERKLEY) is recognized for 5 minutes.

Ms. BERKLEY. Mr. Speaker, I oppose the Republican prescription drug plan. I represent the fastest growing Congressional District in the United States. I represent the fastest growing senior citizen population in the United States. When I came to Congress, I thought I would modernize Medicare, improve Medicare, strengthen Medicare. I never dreamed that I would participate in the destruction of Medicare. This legislation before us this week destroys the Medicare system.

I oppose this plan. It does not offer a guaranteed prescription drug benefit for seniors. It ends traditional Medicare that seniors in my district and throughout the United States rely on. Under this Republican proposal, there is no guarantee that private insurance companies will offer prescription drug coverage. While Republicans estimate that the cost of the premium would be $35, the fact is we do not know how much the premium is going to be. Private insurance companies can devise their own plan and raise premiums whenever they want to meet their bottom line rather than meet the needs of our senior citizens.

The Republican plan does not guarantee that seniors will receive any help with rising drug costs. The plan creates a donut hole in the coverage. Seniors who have more than $2,000 in prescription drug expenses are responsible for all of their drug costs until they reach $5,000 in medical costs. And they still have to pay the premium. Forty-seven percent of seniors in the United States fall into this gap.

The plan does not guarantee that private insurance companies will remain in the market for more than 12 months. Seniors could be forced to change insurance plans with different doctor panels every year. Seniors know and trust their doctors. Many seniors have received care from the same doctors for years. Placing this burden on our seniors is unconscionable.

The Republican plan does not modernize Medicare. It does not improve Medicare. It does not strengthen Medicare. It dismantles benefits and puts seniors into HMOs and PPOs. In 2010, Medicare will compete with private health care plans. This will result in higher premiums for hospitals and physician benefits. Seniors, particularly women, will bear the burden of these increased costs. Instead of dismantling traditional Medicare, we should strengthen the program to provide the best care for our seniors.

We should be adding a prescription Medicaid benefit to Medicare, and I also support adding a provision to increase Medicare provider reimbursements. Thousands of doctors are leaving Medicare because Medicare reimbursements do not cover nearly enough of the patient's health care costs, leaving the doctors to make up the remainder of the costs. Increasing reimbursements allows physicians to continue treating Medicare patients while confronting rising health care costs.

It makes absolutely no sense to me that we have a Medicare system that allows people to see the doctor of their choice, and when the doctor provides a prescription medication, a senior cannot afford that press medication. How outrageous is that in our Nation?

I also support provisions to simplify the Medicare paperwork process. Today, doctors are spending far too much time filling out forms; not enough time treating their patients. Many doctors say if we could cut through this red tape, they could devote more time to caring for their patients. And what is best for the patient is why we are here tonight.

Las Vegas has one of the fastest growing populations of seniors in the Nation. I owe it to the seniors in my district to support a meaningful prescription drug benefit; a benefit that is available to all seniors who need it, a benefit that does not have significant coverage gaps, and a benefit that allows seniors, and not insurance companies, to choose their doctors and not force seniors to leave the Medicare system that they know and they trust in order to receive desperately-needed prescription medication.

I ask all of my colleagues to join me in opposing the Republican plan, supporting the Democratic plan that is easier, fairer, and that our seniors approve and agree with.

HEALTH CARE REFORM

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. DAVIS) is recognized for 5 minutes.

Mr. DAVIS of Illinois. Mr. Speaker, the current Medicare debate highlights the need for fundamental changes in the way that health care is provided in the United States. The Medicare prescription drug bill currently before the House fails to address any of the fundamental problems in our health care system.

The need for affordable prescription drugs for our Nation's seniors is one component of the health care reform needed in the United States. And just like last year, this House will pass a Medicare prescription drug bill that fails millions of Americans. The current plan will perpetuate the inequalities in health care suffered by poor and rural Americans, as this plan hurts both groups.

Seniors with incomes between 135 and 150 percent of the Federal poverty level will pay the same deductible and copays as someone with an income 300, 500, or 1,000 percent of the poverty level. The only relief is a sliding scale premium. Those with incomes 150 to 200 percent of poverty will receive no relief at all.

Rural Americans have already faced severe restrictions in their choice of providers. And in 2003, only 19 percent of rural Medicare beneficiaries have the option of enrolling in a Medicare managed care plan.

□ 2130

These seniors are likely to face similar restrictions in the choice of prescription drug plans, without a fallback prescription plan through Medicare. This discrimination against certain seniors is intolerable. Not only does the current plan restrict access to drugs, but it also could limit what drugs seniors can take. In 2002, 55 percent of all Medicare private plans covered only generic drugs, provided no coverage for brand names. This means that those who must take a specific brand-name medication for which no generic form exists or need a new, more effective drug cannot obtain them. The answer is not to provide more private prescription drug plans.

The current Medicare prescription drug bill only perpetuates the failures of our health system. The solution to the current crisis lies in a prescription drug benefit that helps to contain prescription drug costs, provides better access to generic drugs, and is built into Medicare. Absent a comprehensive solution that provides medical and prescription drug coverage for all Americans, there is no excuse for restricting the access of our Nation's seniors to prescription drug coverage. Our seniors need a comprehensive standard benefit for all. We cannot afford to further privatize Medicare, offer different plans to different people, and threaten the program that has provided health care for over 39 million people.

Our Nation's seniors need a uniform, comprehensive plan. Absent a comprehensive solution that provides medical and prescription drug coverage for all Americans, there is no excuse to do anything less. The solution to the current crisis lies in a plan that helps to contain prescription drug costs, provide better access to generic drugs, and is built into Medicare.

Just as hospital and physician coverage is assured by Medicare and includes a standard benefit for all seniors, so must prescription drug coverage. In the complex world of medical insurance, it is crucial for us to provide reliable coverage under one plan to reduce confusion on the part of Medicare beneficiaries. We cannot afford to further privatize Medicare, turning it only into a health voucher program by the end of the decade, and threatens the program which has provided health care for over 39 million Americans. Let us be real and have a real prescription drug program for our seniors.

AMERICANS SHOULD COME FIRST IN PRIORITIES

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under a previous order of the House, the gentleman from Illinois (Mr. EMANUEL) is recognized for 5 minutes.

Mr. EMANUEL. Mr. Speaker, I agree with a number of our preceding speakers who have talked about the importance of Medicare and why their principles and values are different than some of our other colleagues.

Tonight I would like to address another subject in the closing days before our July 4th district work period, and that is a child tax credit.

Mr. Speaker, yesterday the president of Pakistan was here and the President of the United States guaranteed $3.5 billion to Pakistan. He came in, got a nice reception at Camp David, and flew out with a check for $3.5 billion. That is equal to the amount that it would cost to provide the 12 million children, 6.5 million working families a full $1,000 tax credit in this country; yet they are not receiving it.

In Pakistan they came in, smiled, shook hands, and walked out with $3.5 billion. In America, 12 million American children will be left without a tax cut as they go into the summer months. As their parents buy clothes and shoes and backpacks for the coming school year, they will not have the full $1,000 child credit.

Two weeks ago, The New York Times reported that we are providing 200,000 Iraqis $20 a day for no-show jobs. I come from Chicago. We know something about no-show jobs. We think we understand no-show jobs. Yet while we provide these Iraqis $20 a day, 200,000 of them for the last 2 months, that comes to about $1,000, we have 200,000 active duty GIs who in the Republican tax bill are not provided the full $1,000 tax credit. Somehow we have put in this administration and in this Congress more priority on the 200,000 no-show Iraqis who are getting $20 a day than our active men and women who are getting shot at and could lose their lives. They deserve a tax cut.

I noted the other day in our commitment to Iraq for reconstruction, we committed to 20,000 units of housing reconstruction; and yet here in America under the President's budget, there are only 5,000 units of public housing. We committed to 13 million Iraqis getting universal health care, half the population, yet not a dime for America for the uninsured who work full time. We committed to rebuilding 12,500 schools in Iraq, yet in many of our schools across this country, there are no dollars for investment in remodernization.

What makes Iraqis and the investments in Iraq more important than investments here? I support rebuilding Iraq, given the war; but we should not deconstruct here in America. We have set a set of priorities and principles in place that has put America behind where we put our priorities overseas. This administration needs to remember that here at home working families deserve a tax cut, the 12 million children of working parents, 6.5 million working families who will not get the $1,000 tax cut because this Congress, under the stewardship and leadership of this administration, is too busy.

Yet the Premier of Pakistan came in and walked out with an equal amount of dollars, $3.5 billion. In Iraq, folks will be getting $20 a day who do not show up for work, yet our GIs on active duty will not get the full $1,000 tax cut they are promised. Where are the values? Where are the principles that say you should do that? I think I know a number of my colleagues on the other side of the aisle who have good values. We have talked about our families, our hopes and faith. If their mothers knew what they were doing here, giving 200,000 Iraqis $20 a day, denying a tax cut to our GIs, I think they would have another view because those are not the values their mothers raised them with.

In closing, we make choices. President Kennedy once said to govern is to choose. I am saddened that, as we get ready to start sending out checks to the top 1 percent in the sense of wealth, that the 12 million children of working families will have been forgotten and will go without that tax cut.

Mr. Speaker, we will go home with unfinished business as it relates to our values and our principles. We should remember the folks who get up every morning, go to work, try to make that paycheck stretch all the way to the 31st of the month. We should remember what they are trying to do with their children, to know the difference between right from wrong; and what do we say to them, we are going to keep that speed bump in your way so your day is harder. But somehow, we are putting a better sense of values on the Premier of Pakistan who walked out in one day with $3.5 billion, equal to the amount it would cost to rectify the error in the conference when the Republican leadership of the Senate and the Republican leadership of the House and the Vice President of the United States sat in the room and cut those kids out of the tax cut.

BETTER PRESCRIPTION DRUG PLAN NEEDED

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I wish to join my colleagues tonight. Many of the women of the United States Congress have made a commitment to their constituents to represent them in a very fair manner, but they also recognize the importance of not leaving the sensitivity and the understanding of the needs of the women of America at the door as they take their oath to be Members of Congress.

So today I rise to join my colleagues to emphasize the importance of the Medicare prescription drug debate on the women of America. This is one of the most important debates; and unfortunately, as we rallied today with many of the senior citizens from all over the country, many of them were women. We were not able to say to them that this House had come to a reasonable conclusion and a reasonable proposal that responds to their needs.

The Republican prescription drug plan ignores the needs of our sisters, mothers and grandmothers; and we oppose the passage of such legislation. It ignores the reality that women often outlive their male counterparts, making Medicare beneficiaries disproportionately female. It ignores the points that if these females outlive their spouses, in many instances their income is lower. Many might say does that not give them a double benefit? No it does not. In many instances they may be living on Social Security. That is not enough. They may also be living on a small pension; sometimes one is diminished because of the other. Social Security is lowered because you may have a small pension. Many of them are elderly, and many of them are sick. Some of them face catastrophic illnesses.

In the course of trying to live their life, provide housing, food, they have to make choices. I have seen constituents, particularly in the elderly population, who have had to choose prescription drugs over food and nutrition, who have had to choose prescription drugs over a place to live or the right kind of place to live.

It is very important tomorrow when we debate this issue, if we do, that we concentrate on this enormous deficit as relates to the Republican plan, the doughnut, the hole, if you will, that our dear friend, the gentleman from New Jersey (Mr. PALLONE), has so eloquently articulated, the very large gap between the monies you receive and the amount of monies you will ultimately get at a point when you max out, if you will, $2,000 maybe, and then for a long period of time our senior citizens, those who will be under Medicare, will get no money whatsoever until they reach a certain amount.

Mr. Speaker, this is intolerable. It makes it very difficult for someone on a fixed budget. This makes any decision regarding the future of Medicare critically important to millions of women, and that is because they live in many instances a longer period of time. And many women spend time out of the workforce caring for their children and sometimes for their own parents. Let me add another component. Many women sometimes go into a second generation of raising their grandchildren, and so they have the expenses of their grandchildren; but yet they have the needs of their own health needs. While in the workforce, they often earn less than their male counterparts, and for these reasons women earn less then men over their lifetime and their Social Security monthly benefits are smaller.

As a result, an older woman is more likely to face serious financial pressures, and she needs Medicare to be meaningful. She needs us to close the doughnut. We need a guaranteed prescription drug benefit that provides an even, unending source of guaranteed prescription drug benefit to provide the support that these women need. This is not done by the Republican plan. In fact, what the Republican plan does is it unravels the safety net that has been provided for older women.

The proposal replaces a real safety net with a false sense of security by promising a prescription drug benefit, but allowing women to slip through the doughnut hole, the coverage gap. Imagine a beneficiary's surprise when she discovers that Medicare will not help her cover her prescription drug costs after $2,000. She must wait until she qualifies for catastrophic coverage with a drug cost of over $4,900.

Mr. Speaker, we must work closely with colleagues to craft a bill that answers the question of a guaranteed prescription drug benefit. As I close, this issue is crucial to the American psyche, to the American needs of our elderly citizens.

Finally, I want to add just a moment about affirmative action, the decision that was rendered just a couple of days ago by the Supreme Court. Let me congratulate the interpretation which we felt would have always been the right interpretation, that is, that race can be a factor in equalizing the playing field and that the positions held by the University of Michigan were not quotas.

Mr. Speaker, let me say we need to do a better job in serving the American people with a better prescription drug plan that will deal and address the needs of women of America; and thank goodness for the Supreme Court decision on affirmative action.

□ 2145

MEDICARE MODERNIZATION LEGISLATION

The SPEAKER pro tempore (Mr. GARRETT). Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

Ms. KAPTUR. Mr. Speaker, here it is in Washington, nearly 10 o'clock at night and the Republican leadership of this institution does not even have a prescription drug bill ready for us to read as homework tonight. They tell us that we are going to debate this tomorrow, maybe 2 hours at the most, one of the most important changes in our country's history in terms of health care for our seniors. They tell us maybe after midnight tonight we might be able to go up to the Rules Committee to offer our amendments and to have them considered. They will deny most of those amendments, but the interesting thing about going to the Rules Committee after midnight, no press is there. Nobody will know, in one of the most significant pieces of legislation that will be considered in this 21st century. So the American people will not know. The press will not know.

I am here tonight to say I intend to offer an amendment before the Rules Committee that is likely to be rejected, but it is a very important amendment. This amendment says that whatever prescription drug plan is considered here tomorrow, under their very restrictive rules, should do exactly what we do in the Department of Veterans Affairs and exactly what we do at the Department of Defense and that is have negotiated pricing for the drugs that our seniors will buy. Why? You get the best price. Everybody knows when you buy in quantity, you get a cheaper price. It is a very simple concept. But what has the Republican majority in this House, the radical right, done? They have actually put a provision in the bill and here it is. This is the bill that was before the committee and we know this provision will be retained in whatever the Rules Committee considers tonight, but it basically says that it prohibits our government, our Secretary of Health and Human Services from negotiating with the biggest drug companies in the world to get the best price for prescription drugs for our seniors. So what they are going to do, imagine they have got a provision that prohibits what we do at the Department of Veterans Affairs already and it prohibits what we do at the Department of Defense already in our financial purchasing system which gets our people the best prices. That is in the base bill. My amendment would get rid of that and it would say, hey, if you are going to do it and we have success across our government, just like Canada has success in their country by negotiating with the most powerful pharmaceutical companies in the world, why should we treat seniors any differently? Why should we make them pay higher prices? Indeed, in the Republican bill they make seniors pay any cost of drugs over $2,000 a year up to a level of perhaps $3,500 and it might be more because they are drafting the bill somewhere here in the Capitol. I do not know where they are. I went up to the Rules Committee to find the bill and the doors were all locked to the chairman's office.

But in any case here is what is currently being paid, for example, in the United States. Let us just take one of these drugs here, Norvasc, which is for high blood pressure. Normally it sells in one of our pharmacies for about $182.99, the Canadian price is $152.82, and the price at the Department of Veterans Affairs is $102. It is a definite savings. That is true with a whole series of pharmaceutical products that could be available to our seniors. So what the Republicans are basically saying in their bill to our seniors is, you have to pay the higher price because we won't permit you to negotiate price, we won't negotiate it for you, because our bill fundamentally denies it. This provision was written by the pharmaceutical companies themselves. Gee, does that surprise anybody?

I am only one Member of Congress representing 660,000 beautiful people in the northern part of Ohio. I am only one. Do you know there are six lobbyists for the pharmaceutical companies in this town for every one of me that there is? So basically many times I go home at night and I say to myself, folks back home, I am all you got and I am sticking with you. And I say to the pharmaceutical companies, I don't take your money, I don't want your money, but I'll show the public where your money goes. Is it any wonder why they put the provision in the base bill that went through the Committee on Energy and Commerce like lightning the other day?

Let us take a look at PhRMA. This group is so powerful that just in the last election cycle, just in one year, 2002, they contributed over $3 million. Ninety-five percent of it went to, guess, which party? The Republican Party. I happen to be a Democrat. Too bad for the Democrats. They only get 5 percent of the $3,100,000 that was donated just in the fiscal year 2002. Why do you think they gave all that money to the leadership of this institution? Take a look at Pfizer. They gave 80 percent of the $1.8 million they just contributed in 2002 to one party, the Republican Party. You can go down the list. Almost all the money goes to one party. So is it any surprise to us why the bill that we cannot find here in the Capitol and we will not even be allowed to talk about until after midnight and we are all staying up late to do that for our constituents, do you really wonder whether this government is on the level?

I urge my colleagues tomorrow to vote "no" on this bill and to vote "no" on these pharmaceutical companies until we can get negotiated pricing in this bill.

TITLE VIII—SECTION 1809(C)(1)(D)

Noninterference—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title. The Administrator may not:

(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

(ii) interfere in any way with negotiations between PDP sponsors and Medicare Advantage organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatients drugs; and

(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

U.S., CANADIAN, NEGOTIATED VA/DOD PRESCRIPTION DRUG PRICES

Drug name/prescribed for	U.S. retail price	Canadian retail price	FSS negotiated price (VA & DoD)
Glucophage/Diabetes Millitus	$69.99	$30.16	$60.95
K-Dur 20/Low potassium levels	55.99	29.01	25.58
Norvasc/High blood pressure	182.99	152.82	102.11
Prilosec/Heartburn	134.99	67.71	63.32
Prozac/Depression	302.97	140.69	186.98
Synthroid/Hypothyroidism	39.09	17.82	29.73

Comparison is drawn between drugs of equal dosage and quantity.

Sources: Data compiled from Veterans' Affairs Commission and Alliance for Retired Americans.

2002 PHARMACEUTICAL CONTRIBUTIONS, BY PARTY

Rank	Organization	Amount	Democrats (percent)	Republicans (percent)
1	Pharmaceutical Research & Manufacturers of America	$3,180,552	5	95
2	Pfizer Inc	1,804,522	20	80
3	Bristol-Myers Squibb	1,590,813	16	83
4	Eli Lilly & Co	1,581,531	25	75
5	Pharmacia Corp	1,480,241	22	78
6	GlaxoSmithKline	1,301,438	22	78
7	Wyeth	1,188,919	17	83
8	Johnson & Johnson	1,075,371	39	61
9	Schering-Plough Corp	1,057,978	21	79
10	Aventis	954,349	22	78

Source: Center for Responsive Politics.

REGARDING REDISTRICTING HEARING IN HOUSTON THIS SATURDAY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. FROST) is recognized for 5 minutes.

Mr. FROST. Mr. Speaker, I rise this evening to call attention to the House to a racist piece of literature currently being circulated by the Harris County Republican Party to its e-mail subscribers. There is going to be a redistricting hearing in Harris County, Houston, on Saturday and so the Harris County Republican Party is right now e-mailing this information to all its regular subscribers. It says:

"She will be there to express her views. Will you be there to express yours?"

Who is "she"? She is the gentlewoman who is here with us right now, SHEILA JACKSON-LEE. There is a very nice colored picture of SHEILA, whom everyone can see is African American. SHEILA is one of four Democratic Congress Members from Harris County. The other three are white. One African American, three whites. Of course, the gentlewoman appears in this e-mail and there is no picture of GENE GREEN, who is white, there is no picture of CHRIS BELL, who is white, and there is no picture of NICK LAMPSON, who is white, there is only a picture of the one African-American Member.

And so what does it say? "She will be there to express her views. Will you be there to express yours? Reminder: Redistricting Hearing in Houston this Saturday." Then it gives the time and the place and the details. I would ask the gentlewoman from Houston, what does she think about this e-mail posted by the Harris County Republican Party on their Web site?

Ms. JACKSON-LEE of Texas. Mr. Speaker, will the gentleman yield?

Mr. FROST. I yield to the gentlewoman from Texas.

Ms. JACKSON-LEE of Texas. Obviously I think it is important that we all establish the fact that redistricting is a political process. That, in fact, our lines have been drawn by a duly organized and sanctioned Federal court, that we are in lines that have been reapproved by the voters of our respective districts and that this has not been done in the last 50 years, the redrawing of district lines. I am delighted to be one of four colleagues in the Harris County area, but I am offended by the fact that my picture is used to provoke members of the Republican Party to attend a hearing that happens to be in my congressional district. It is true that my district by the Republican plan offered by the Republicans of Washington will be a plan that literally destroys the 18th Congressional District, cuts it in half, takes out the heart of that district, the very birthplace of the Honorable Barbara Jordan and Mickey Leland, will be taken out of the 18th District. In fact, one of my good constituents says that the 18th does not need a bypass nor does it need heart surgery.

And so I do not mind in an open hearing anyone coming. It is an open hearing. But I am certainly concerned. What is the message of my face being utilized over my colleagues' faces? What is the intent of even putting up a picture? They might say, "SHEILA JACKSON-LEE, GENE GREEN, CHRIS BELL and NICK LAMPSON will be present. Will you be there?" That is a fair enough statement. That is a political statement. "The Democrats will be there. Will you be there?" But, no, in subtlety, not even the dignity of the name. I should sound a little bit modest. I would imagine there would be a lot of people who would not know who this is, but they know it is a black face. So maybe they are suggesting that a black person will be there to offer their views. Would you not want to run to the hearing so that you can offer yours?

I think this is a sad commentary. I believe and I hope that as I look at the Web page of Democrats and others who are working to get their constituents to this hearing that we will not stoop to this level. I want to simply say to my constituents in the 18th Congressional District in Texas, come out and have your voices heard. Come out and speak your views. You may agree or disagree with me. But I realize that those who want to be empowered will agree that this plan that they are putting forward does not help the people of the 18th Congressional District or the minorities who are represented in that district or the people that are represented in that district.

By the way, as the gentleman well knows, I represent a very diverse district and proudly so. People from all walks of life. But shame on the Harris County Republican Party. Shame on them for stooping to this level. Frankly, I am going to be reaching out and I am going to ask my constituents to call the Harris County Republican Party and ask them, do they not have a better way of communicating to the people a reasonable expression of soliciting their coming to this particular meeting.

Mr. FROST. I thank the gentlewoman for her eloquent statement. I would only observe that this type of racist appeal is something that we saw in our State 20 or 30 years ago. I thought we had moved beyond that. I am ashamed for the State of Texas and I am particularly ashamed for the Harris County Republican Party that they would stoop to racism in the year 2003.

FEDERAL SPENDING

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Tennessee (Mr. DUNCAN) is recognized for 5 minutes.

Mr. DUNCAN. Mr. Speaker, it seems that the Federal Government is so big and bureaucratic that it cannot do anything in an economical or efficient way. In fact, we read and hear about so many examples of waste of Federal money that we too often take it for granted or shrug our shoulders about it.

The San Francisco Chronicle reported recently that the Defense Department "couldn't account for more than a trillion dollars in financial transactions, not to mention dozens of tanks, missiles and planes." Listen to what this story said:

"Though defense has long been notorious for waste, recent government reports suggest the Pentagon's money management woes have reached astronomical proportions. A study by the Defense Department's Inspector General found that the Pentagon couldn't properly account for more than a trillion dollars in monies spent. A GAO report found defense inventory systems so lax that the U.S. Army lost track of 56 airplanes, 32 tanks and 36 Javelin missile command launch units."

This story, Mr. Speaker, was not based on reports from some antidefense group. It came from studies done by the Defense Department's own Inspector General and the General Accounting Office of the Congress. This comes on the heels of the Congress overwhelmingly voting for the biggest increase in defense spending ever. And now the Defense Department wants another mega-billion increase and a mega-billion supplemental appropriation, all taking place after we downsized the military by about 1 million troops and closed several bases. All of us want to support the military, but surely we cannot just sit around and allow such horrendous waste to continue.

Then there is the case, Mr. Speaker, of Eric Rudolph. The FBI spent untold millions and had hundreds of agents involved over several years in this manhunt. The FBI should be embarrassed that Rudolph was finally found by a rookie local small-town police officer who had only been on the force for about 9 months. And he found him in Rudolph's home area. We give far too much of our law enforcement dollar to Federal agencies which make only a very tiny fraction of the arrests, probably less than 1 percent. What we need to do is give far more of our law enforcement money to local police and sheriff's departments. They are the officers who are fighting the real crime, the street crime that people want fought.

Finally, Mr. Speaker, talk about waste, we have spent hundreds of billions, with a B, on our intelligence agencies over the last 10 or 15 years. We spend more on intelligence than all the rest of the world combined. We will vote to authorize even more spending on intelligence tomorrow. Yet during this time our intelligence agencies missed the coming down of the Berlin Wall; they missed, failed to predict, the breakup of the Soviet Union; they missed on 9/11. Worst of all, they missed or exaggerated on Iraq. Even the Weekly Standard, probably the most pro-war publication in America today said, "The failure to discover stocks of WMD material in post-Saddam Iraq raises legitimate questions about the quality of U.S. and allied intelligence."

Columnist Josh Marshall, writing in The Hill newspaper asked: "Did we have bad intelligence? Did political appointees dismiss good, but less threatening intelligence? Or was damning intelligence actually cooked up for political purposes? Those are all legitimate questions. But when Congress starts trying to get at the answers, we should be open to the more complex but in its own way no less disturbing possibility that at least some of the main proponents of this war were so consumed by their goal to crush Saddam and so driven by ideology that they fooled themselves as much as anyone else."

These are good, legitimate and very important questions. Another good question: Why did the National Security Agency find out "about the attacks of 9/11 by watching CNN," as reported by intelligence expert and author James Bamford?

□ 2200

This is an agency that we built a plush supertechnical $320 million building for a few years ago at a cost of $320 a square foot. Probably the most important question of all, why are we getting so little and so much of that for all these hundreds of billions of taxpayer money?

The standard response of all Federal departments and agencies when they are criticized is that they were underfunded. If they had just been given more money, this or that problem would not have occurred. These agencies, if anything, are overfunded, far more money than any company in the private sector. Our intelligence committees are filled with good people; but no one seeks to serve, much less is appointed, to the intelligence committees unless they are strong supporters of the intelligence community. Once they are on the committee, they are heavily courted by the intelligence agencies. So it will be very difficult for a member of these committees in either body to ask the really tough questions that need to be asked. But, Mr. Speaker, I hope for the sake of our own taxpayers and for the future of national security of this Nation that someone on one of the intelligence committees will start asking the hard questions and demanding the truthful answers that our citizens deserve.

MEDICARE

The SPEAKER pro tempore (Mr. GARRETT of New Jersey). Under a previous order of the House, the gentlewoman from California (Mrs. CAPPS) is recognized for 5 minutes.

Mrs. CAPPS. Mr. Speaker, I stand here this evening on the east coast. It is 10 o'clock, and our schedule is such that in the House of Representatives tomorrow we should be debating on this floor a bill to provide a more modernized Medicare delivery system which will focus on the needs of those receiving Medicare, mostly seniors, senior citizens, and also those with disabilities, their needs for medication. And as I am speaking, one of the last to speak this evening, remarking on the particular needs that women have, women my age because I am in that category who live longer and perhaps have worked out of the home less because of the needs of caring for both children and sometimes elders, and, therefore, pensions and other means of having security and retirement are not quite as readily available. So this burden weighs heavily on me. As I speak this moment, deliberations are under way for the rules for which we will debate this legislation tomorrow, and we will see what comes out of our time together on the floor of the House tomorrow.

It is a momentous occasion because in my time of being a Member of Congress, having come to this place out of the health care field, having been a public health nurse for quite a few years in my community on the central coast of California, I have listened to my constituents in this new role of being their representative in the House of Representatives, the people's House, which by its very definition connects us to the citizens for whom we have this great opportunity and responsibility of being their voice here in the Federal Government to make sure that their needs and their inspiration and their motivations are heard.

So I take seriously when many folks in my congressional district tell me that they are the ones who are buying these medications because their heart ailment or their arthritis or their different chronic conditions are requiring them to take medications, that they really cannot afford these if they are retired or living on a fixed income because of Social Security requirements and also maybe their pension.

These are not exorbitant amounts usually. They do not consider themselves poor. They have worked all their life, done well really, the Greatest Generation is what many have called them; and yet they find themselves struggling at a time when they had looked to their government with the promise of Medicare, which they had seen there for their parents, this program that was instituted in the 1960's, and they say why is it that I cannot pay for my medications? They are so expensive. I go one month and it is a particular cost, sometimes $100 or several hundred; go another month and it has been practically doubled in price. It is terrifying for seniors who face perhaps hospital stays if they do not take their medication. The blood pressure shooting up, consequences and side effects to conditions that they want to control so that they can live independent lives, not to be dependent on their children or on others or on society, God forbid, having lived independent lives.

So I carry this burden to Congress, and I am proud of being part of a country that had the wherewithal and the mindset, first of all, to start the Social Security system so that we recognize that we really do want to respect the security needs of our seniors; and then when we recognized that health care was beyond the reach of many of them in the 1960's, we devised a plan. I was not here then, of course; but I saw that it made such an impact on citizens that I was working with and dealing with living amongst my own family members to see that Medicare could be there because the private sector, the insurance companies found that this population was hard to insure. These are the years when people need their medical doctors and their sometimes hospital stays and often medications to stay alive and to stay healthy, and Medicare has been a blessing because people are living longer. I think there is a direct connection.

Now we face this crisis. I commend this administration and this Congress foreseeing that this is a time that we must do something about this. But we now must do it in the right way. We have seen that a public provision is what is needed for Medicare. We must also make sure that we do not go off that track and try to privatize this one aspect of it. We have had that option, and that itself was rather an experiment to offer Medicare+Choice. A few years ago that became very popular. That has not worked in my area on the central coast of California, and it is rural.

I will wrap this up by saying that the decisions that we will make tomorrow will have tremendous ramifications, and we need to learn from the people we represent and listen to them and do what they have asked us to do, which is to keep this plan a public plan as it has been, provide the prescription medication in the way that we know that will serve their needs best.

THE REPUBLICANS' MEDICARE PRESCRIPTION DRUG PROPOSAL

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, the gentleman from New Jersey (Mr. PALLONE) is recognized for half the time until midnight as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, many of my Democratic colleagues took to the well this evening to talk about their concerns over the Republican Medicare bill, the Republican Medicare prescription drug bill that we expect to come to the floor here in the House of Representatives tomorrow. But I have to start out this evening by pointing out unfortunately that we do not really know what bill is going to come up tomorrow. We are waiting. Many of us are actually waiting right now to see what the Committee on Rules will do. The Republican bill has not actually been filed yet, and the latest information is it may not be filed until 11 or 12 o'clock and Committee on Rules will then consider the bill an hour after that, which might be one or two o'clock in the morning, and at that time Members, particularly Democratic Members, would be asked to come, review the bill very quickly obviously, and suggest any amendments or changes they might have to the Republican bill.

And I would suggest that that is certainly not the way to operate, particularly on a bill that is so important. I think all of us agree that Medicare is one of the most important programs that the Federal Government has ever offered, and to think that most of us will come here tomorrow and will not have even had the opportunity to see the bill and that the Republicans in having this Committee on Rules meet late at night where they would consider amendments would do such so late when most Members will not even be able to offer an amendment, it is just really a travesty of the process; and I have to believe that it is intentional. I do not think there is any question about it. The last vote today in the House of Representatives was about 5 o'clock. Why could all this not begin during the day or just after the session ended? Why does it have to take place at 12 o'clock midnight or even later?

It puts a great deal of fear in me, and it is pretty obvious from looking at some of the proposals that have already been considered in the committee, both in the Committee on Energy and Commerce, where I serve, as well as in the Committee on Ways and Means, that what the Republicans have in mind essentially kills Medicare. And I know that is a very severe thing to say. Many of my colleagues have said that this evening, that the Republican Medicare prescription drug proposal actually kills or destroys Medicare, and one might say to oneself how could we make such a statement? What is the basis for our making that statement? And I would say that the real reason we say it is because if we look at the Republican bill here in the House, it essentially privatizes Medicare. What does that mean?

The Federal Government operates a Medicare program. It is a Federal program operated by the government. And what the Republicans are proposing in this bill is that rather than have the government run a health care program for seniors and pay out the money for the program to the doctors and the hospitals, that rather they would give seniors a certain amount of money. We call it a voucher. And those seniors would instead under the Republican plan be expected to go out and purchase their health insurance privately just like somebody might who is younger.

The problem with that, though, is that historically when Medicare was started back in the 1960s under President Lyndon Johnson, the majority of seniors could not find health insurance. They were unable to buy health insurance because the way insurance works, it is like a pool, and people who are older tend to be frailer, tend to be sick or tend to have to go to the hospital more. Those are not the people that insurance companies want to sell a policy to because they cannot make any money. And most of the insurance companies have told us that effectively they are not going to sell those insurance policies because they still cannot make any money today.

Nothing has changed from the 1960s until this year. Seniors are still the most vulnerable and the sickest population, the population that has to go to the hospital and to the doctor most often. Why in the world would anybody want to sell an insurance policy to seniors or at least to a lot of seniors?

What we are seeing here is that the Republicans, maybe because of their ideology, maybe because of their being beholden to the insurance companies, whatever reason there is, they essentially want to set up a system whereby the traditional Medicare that we have, which is a government program that guarantees certain benefits, would now essentially be privatized and they would get a certain amount of money and hope that they could go out and buy health insurance in the private market. It is a very vicious, in my opinion, thing to do. It is a wrong thing to do because Medicare has been a very successful program.

If we look at Medicare at the time when Lyndon Johnson signed the first bill, the situation for America's seniors has just changed dramatically. Most seniors had no health insurance. Many of them could not afford any kind of significant health care. They had to go to a clinic or they had to go to charity care in order to pay for their health care, but all that has changed. Right now America's seniors have high-quality medical care, and they have protection from the devastating causes of illness because of this Federal program. And each of the 40 million Americans served by America today can attest to the program's stability, its affordability, and universal nature that has touched all seniors as well as disabled people alike. So why do the Republicans want to change that? What possible reason could they have to change it?

I would hope that the Republican majority would realize that if they do pass legislation that changes and drastically changes Medicare and privatizes it that they are not really modernizing the program and what they are effectively doing is killing the program.

□ 2215

Now, I cannot say that I am optimistic about what the Republicans might do tonight in the Committee on Rules. It just seems like many Republicans, because of their idealogy, want to dismantle Medicare or they want to privatize drug coverage, or they want the prices of prescription drugs to continue to soar. It really gets to my second point which I think was very well made by my colleague, the gentlewoman from Ohio (Ms. KAPTUR), just a little earlier this evening.

She pointed out, essentially, that not only do the Republicans, in their effort to change Medicare and, I say, essentially destroy Medicare, not only do they not want to continue the traditional government program that we have had so successfully under Medicare, but in putting together what they claim will be a prescription drug program, which is the reason, theoretically now, why they are changing Medicare, is because they want to provide some kind of prescription drug program. However, they are doing it in a way that does not really add a meaningful prescription drug benefit, and that makes seniors pay a lot of money for their prescription drugs and, in some cases, more out-of-pocket than they would have to pay now, even without a benefit program. But, most of all, they do not want to address the issue of price.

Mr. Speaker, when I go around to my senior citizens, they tell me they like Medicare but, they say, the only thing they do not like about Medicare is that it does not cover prescription drugs, and the reason they feel that it should cover prescription drugs is because the cost of prescription drugs has gone up so much that they simply cannot afford to pay for those prescription drugs out-of-pocket.

Now, one might say to oneself, if the real problem with prescription drugs is the increasing costs, then why do the Republicans not want to do something about it? Why do they not just say in their bill that one of the ways that we are going to help senior citizens is by saying that the Secretary of Health and Human Services, or the Administrator in Washington of the Medicare program, could take the buying power of all of these senior citizens and essentially negotiate lower prices? I mean this is what the HMOs do now, they negotiate lower prices when they buy prescription drugs. This is what the Veterans' Administration does. This is what the military does. They try to negotiate lower prices for prescription drugs, as the gentlewoman from Ohio said, by buying in bulk.

But what we find in this Republican bill is that they not only do not want to do that, in the same way that they were concerned about insurance companies, wanting to help them, now they want to help the drug companies by not allowing any mechanism in the bill that would lower drug costs or that would allow the Federal Government to lower drug costs.

So what we have, and the gentlewoman from Ohio pointed it out very effectively, we actually have in the Republican prescription drug bill a clause which is entitled the "Noninterference Clause" that says, "In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator," and that refers to the Medicare Administrator, "may not require a particular formula or institute a price structure for the reimbursement of covered outpatient drugs; interfere in any way with negotiations that are taking place between some of the other elements of the plan; or otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations."

This is a little roundabout way of saying that the Administrator of the Medicare program cannot do anything to interfere with price. He cannot negotiate price reductions. He cannot say to the drug companies, well, one of you give me a better price than the other. And the reason for that is because essentially, they do not want the drug companies to have to worry about possibly losing some money or not making as much money because the price goes down.

I only mention this by way of introduction, because there are a lot more things that I want to say tonight about the Republican bill that is going to be before us tomorrow, Mr. Speaker. But I only say this because I think that the sort of hallmark of this Republican legislation, and the greatest criticism that I have and that most of my Democratic colleagues have about it, is one, it tries to destroy Medicare by privatizing it, which may be, in some ways, a boon to the insurance companies or a way of helping the insurance companies; and secondly, it does nothing about lowering the price of prescription drugs, which again I think is some significant effort on the part of the Republicans to help the prescription drug companies.

So instead of looking at this legislation as a way of trying to help seniors improve Medicare by simply adding a prescription drug benefit, what we see is the Republican Party and the Republican leadership in the House essentially being in bed with the insurance companies and the drug companies to make sure that whatever is offered for Medicare and for prescription drugs does not in any way harm them or their interests.

Mr. Speaker, I do not have any problem if an insurance company or a drug company wants to make some money. There are a lot of drug companies in my State of New Jersey, and God bless them, they should make money and they should hire more people. But it is ridiculous that in crafting this legislation that is so important to the future of America's seniors, that the two things that are most important, the two things that are most important to the Republicans is that they do not do anything to hurt the insurance companies or anything to hurt the drug companies. I think that says a lot about where they are coming from with this bill that we expect to be considered tomorrow.

Mr. Speaker, I yield to the gentleman from Ohio (Mr. BROWN), who is the ranking member on our Subcommittee on Health and who has been here every night talking about the need for a prescription drug benefit, but realizes, as I do, that this Republican bill falls short and, in fact, hurts the Medicare program.

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from New Jersey (Mr. PALLONE), my friend, and the fabulous work he has done and the courage he has shown in standing up to very powerful interest groups in this country in supporting and fighting for a drug benefit.

I noticed something that the gentleman just said as I was sitting here watching this evening, that this bill does nothing to hurt the drug industry or the insurance industry. In fact, this bill, by and large, was written by the drug and insurance industries.

Let us talk for a moment about price. When any of us, Republicans or Democrats, people on that side of the room and people on this side of the room, go to a town meeting or go to a senior center or walk down the street or walk downtown or walk through a shopping mall and talk to people of all ages, especially seniors, but people of all ages about the whole issue of prescription drugs, the first thing they say is, why are our drug prices higher than the drug prices anywhere else in the world? And these are prescription drugs generally made in the United States, developed in the United States, manufactured in the United States. And, in fact, these drugs often, much of the research and development for these drugs was done in America and funded by U.S. taxpayers through the National Institutes of Health.

So we have the most profitable industry in America, 20 years running, whether it is return on investment, return on sales, return on equity, the drug industry, we have an industry that enjoys the lowest tax rate in America, in large part because of what this Congress and this President have done in giving them tax advantages. And, on top of that, we have an industry where much of the research, almost half of the research and development which leads to this industry's profits, to the drugs this industry manufactures, almost half of the research and development has been done by taxpayers, a full half has been done by taxpayers and by foundations. We put all of that together, and then we say, why is it fair that this industry charges American consumers more than consumers in any other country in the world?

I have sponsored a dozen or so bus trips to Canada for seniors in my district and people who are not seniors, on some occasions. It is about a 2½ hour ride from Lorain in my district. We have taken trips from Medina and we will take them from Akron. It is about a 2, 2½, 2¾ hour drive to Canada. They buy their prescriptions, they have saved literally hundreds of dollars per person, sometimes even more than that.

But why should drugs made in the United States and, in many cases, underwritten by taxpayer research, why should those drugs cost two and three times more here than they do in Canada? The reason is, frankly, because of the drug industry's influence on my colleagues on the other side of the aisle. The reason is President Bush's close alliances with the drug companies and the fact that the drug industry funds large parts of his campaign.

The gentleman from New Jersey may remember a couple of years ago, last year when we considered this drug bill about this time of year, we were in the middle of our committee work and the gentleman from Louisiana (Chairman TAUZIN) recessed the committee for the day at about 5 or 6 o'clock because all of the Republican Members had to go off to a fundraiser headlined by President Bush, sponsored by the CEO of Glaxo Wellcome, a British drug company who makes millions of dollars a year, sponsored by them and headlined by President Bush. President Bush personally thanked the CEO of Glaxo Wellcome for all of the work they did in raising literally millions of dollars. Then, it is no surprise that come election time, the drug industry put in literally $80 million, hard money, soft money, independent expenditures, all the way, directly or indirectly, they put money into campaigns, they put that kind of money into these political campaigns. We can see the chart, if the gentleman from New Jersey would point out the chart next to him and in front of me, about drug company contributions, and if the gentleman would explain that.

Mr. PALLONE. Well, the gentleman mentioned Glaxo. Down here I guess is line 6. GlaxoSmithKline in the last congressional campaign gave $1.3 million to congressional candidates. Twenty-two percent went to Democrats, 78 percent went to Republicans. And then if you look at all of the PhRMA, which is the prescription drug trade company, they spent $3.1 million, 5 percent for Democrats, 95 percent for Republicans. So those statistics alone give us an idea of where the money is going.

Mr. BROWN of Ohio. Mr. Speaker, if the gentleman will yield, the issue is partly campaign money, but the real issue is the fact that Republicans and President Bush have invited the drug companies into their offices, into the Oval Office to meet with the President's people, into the Lincoln bedroom, if you will, in terms of putting big amounts of money into the White House, big amounts of money into President Bush's campaign and getting out pieces of legislation that benefit them.

In this country we continue to pay two and three and four times what the Canadians pay, the French pay, the Germans pay, the Japanese, the Israelis, the Finns, the Brits, all of the wealthy countries in the world, we pay two and three and four times what they do. And this drug bill, written by the drug companies and introduced by the Republicans, there is nothing in this bill, nothing in this bill to get prices under control. And that is what is outrageous, when the drug industry continues to fleece the American public. And it does not just hurt every senior who reaches into his pocket to pay the high cost of drugs, it is also what it does to American business, what it does to GM, or what it does to GoJo Industries in Akron or what it does to Inyacare in Elyria.

On the one hand, taxpayers are paying for all of this research and, on the other hand, Medicaid and other tax-supported institutions in this country are paying high prices for prescription drugs. I yield back to the gentleman.

Mr. PALLONE. Mr. Speaker, I just wanted to explain, if I could just briefly, and then I would ask the gentleman from Ohio (Mr. BROWN) to comment on it as well, why I say that what the Republicans are proposing here is basically a boondoggle for the insurance companies as well as for the drug companies, and why, the very fact of the Republicans trying to do their bidding is going to destroy the program.

I talked earlier about two things. I said on the one hand, we know that insurance companies, generally speaking, do not want to cover senior citizens because they are older, they are frailer, they are more expensive. So in suggesting in the bill, in mandating, I should say, in the Republican version of the bill, in the House version, that by a certain year seniors will get a voucher and they will have to go out and shop for their insurance privately, we know that no insurance company is going to want to offer that insurance.

So what the Republicans do is they subsidize the private insurance companies. Basically, at our Committee on Energy and Commerce Committee markup the other day when we were both there, some questions were asked by the Democrats about how this process is going to work. How is it that you are going to give a voucher to seniors and they are going to go out into the private sector to buy insurance instead of Medicare when we know that insurance companies do not want to offer that coverage because they cannot afford it? The response that came back from the Republicans and the counsel for the Republicans: we will just keep giving them more and more money, higher and higher subsidies, until someone finally provides this type of insurance privately.

Now, what does that do? That means that these insurance companies are going to have a windfall, but they are not going to provide the same kind of coverage that seniors have now under the government-run Medicare program, so the seniors are going to get less services and the Federal Government is going to be paying more money. It undermines the very nature of the program and simply lines the pockets of the insurance companies. Talk about that, and then we will go to the drugs.

Mr. BROWN of Ohio. Mr. Speaker, if the gentleman will yield, Congress continues, as they have done with Medicare HMOs, as President Bush has pushed for, and as the Republicans in their drug plan, cowritten by the drug and insurance industries suggest and propose, we have continued to "subsidize" is one word, "pay off" is another one; we continue to dump more and more millions and tens of millions, hundreds of millions of dollars, ultimately billions of dollars we dump into these insurance companies, and what are we getting?

There was a study put out literally today by a group called Families USA, a group that represents seniors and especially families around the country, a large organization.

□ 2230

They did a study of the average salary of CEOs for big insurance companies, the big HMOs that will benefit from this Medicare privatization plan. So understand, President Bush wants seniors out of traditional Medicare, put them in these private insurance HMOs. Now the average pay for the CEOs of these largest insurance companies, HMOs that will be handling Medicare if the Republicans get their way, is more than $15 million.

Now, contrast the $15 million salary, plus I am not even counting stock options and all that, but just their base salary, contrast $15 million the CEO of the insurance companies make with the $130,000, which is what the CEO, if you will, Tom Scully of the Center for Medicare and Medicaid Services makes, the agency that runs Medicare for our government.

So you have got $15 million on the average for the CEO of the insurance companies which will run Medicare if the Republicans get their way, versus $130,000 running Medicare the way it is done now, traditional Medicare.

You make one other comparison. You have the insurance companies are spending three and four times on administrative expenses more than Medicare spends. Medicare's administrative expenses are between 1 and 2 percent. Insurance company Medicare expenses are between three and four times that amount. And then the last comparison if you are in traditional Medicare, you stay in Medicare. They do not cut you out. They do not throw you off. They do not decide to abandon you. They do not take your plan out of the county. If you are in a private Medicare HMO, even with these big salaries they are paying the executives, maybe because of that, they pull out of a county. They drop tens of thousands, hundreds of thousands of seniors out of their plan.

One CEO in particular, United Health Care, a big insurance company HMO, paid Norm Payson, last year he was paid $76 million. And that $76 million could cover about 30,000 seniors for prescription drugs. So look at what you have got. You have got big salaries, high administrative expenses, and organizations that will dump seniors out, that is, unreliable care; or you have lower salaries, smaller bureaucracy, a government program which will never ever dump seniors, which will provide reliable care, which will always be there for those seniors.

It is a pretty easy choice. You have the Republican plan, the privatized plan; or you have the Democratic plan, traditional Medicare, which seniors in this country have used and plans that have obviously served seniors well for 38 years.

Mr. PALLONE. I agree with the gentleman completely. And my only point I am trying to stress here tonight and the gentleman certainly made the same point is because of the fact that the Republicans want to cater to the insurance interests and to the prescription drug pharmaceutical companies' interests, they are essentially going to destroy the Medicare program, in other words, if you look at the insurance aspect. If they keep giving more and more larger subsidies to private insurance companies so they will eventually cover senior citizens, there will be so little money left in the traditional Medicare program that is government run that it will be broke. The government will not be able to pay for it anymore.

So essentially by giving all this money to the private insurance companies to get them to try to insure seniors, we will make it much more difficult for the traditional Medicare program to operate.

Let us go to the prescription drugs part. We know there are several problems with the Republican plan on prescription drugs. First of all, it is not very generous. In other words, you will have to pay a lot more than out-of-pocket and not get much of a benefit. In the case of the House plan, there is a huge doughnut hole so that if your expenses are over $2,000 until maybe

$4,000 or $4,500, you get no benefit. In the case of the Republican plan in the Senate, it only pays for 50 percent of your coverage. So seniors are going to have to pay a lot of money out of pocket, and they are going to have to get very, very little in return. In addition to that, in order to get the plan, they have to join an HMO. So, again, here we go back to the same thing again which is the Republicans are saying if you wanted to get any kind of drug benefit, and it is not even a good benefit, you have to join an HMO; and if no HMO wants to join the drug plan, we will give them more money so eventually they will.

But the real problem is we know that unless something is done by the Federal Government to control the price of the drugs, the cost of the drugs is going to rise and the Federal Government will not be able to pay for the program. In other words, I am saying because you do not have any way of controlling prices either through negotiation or some other means, the cost of prescription drugs is going to continue to go up and the drug companies are going to get all of this money.

But at the same time, the Federal Government is going to have an increasing problem paying for it. In other words, if you were able to control prices in some way by having the Secretary or the Medicare administrator negotiate prices, you would save money for the program and you would not have to keep shelling out all these dollars or limiting the generosity of the program so that seniors do not get much of a benefit. They are going to kill the whole idea of the drug program by not having some limitation on price.

Mr. BROWN of Ohio. It can be so simple. In Canada, what the Canadian people do, what the Canadian Government does is they have created a small office with a board called the Pricing Board and the Pricing Board negotiates on behalf of 29 million Canadians with individual drug companies. German companies, French companies, American companies, Canadian companies. They negotiate price and then the drug is sold, for every drug manufactured, then the drugs are sold to retailers, sold wholesale into Canada at those much, much lower prices because they have negotiated them on behalf of 29 million Canadians. Then the drug stores negotiate, and they end up with much lower prices.

So it would not be difficult for this Congress to figure out a way, there are a dozen ways, the Canadian way is a very simple and effective way obviously because you can tell from the prices there, but it is not difficult to come up with a way to bring prices down.

The reason that the Republicans have not chosen any of those methods is anybody's guess; but it is hard to believe that they are doing it for any other reason than their political closeness, if you will, political allegiances to the big drug manufacturers.

I know it offended our chairman in the markup and it offends some Republicans, including the President, to suggest that their behavior on this bill is connected to their drug company contributions. But when you saw the drug companies spend 80 or $90 million last year, 85 percent of it going to Republicans, when they spend that kind of money, it is hard to believe that the Republicans would do anything without the drug companies' approval.

I would argue the Republicans have not just not done anything without drug company approval. I suggest they have turned over the writing of the legislation to the drug companies. They could not have done a less effective job. They could not have done a worse job of controlling prices, of ratcheting drug prices down than this bill does.

As the gentlewoman from Ohio (Ms. KAPTUR) pointed out, as the gentleman from New Jersey (Mr. PALLONE) pointed out earlier this evening, this bill not only does not do anything to try to restrain prices, to ratchet prices down; it expressly prohibits the government from doing anything to get the price down. It is so logical to say to the Secretary of Health and Human Services, all you have to do is negotiate on behalf of U.S. consumers, Medicare beneficiaries or the entire consuming public of all ages. You simply need to negotiate price.

Another way we could do it is say that Medicare should pay no more than the Canadian price or the average price of the G–7 nations, the largest economies in the world, whatever price they are paying. There is a lot of ways to do it; but the way not to do it is the Republican way of doing nothing and actually prohibiting the government from doing anything from getting prices down. The higher prices are hurting seniors individually, hurting American business, and American competitiveness in this economy that continues to drift, continues to stagnate; and it obviously is hurting U.S. taxpayers because we are paying too much for drugs.

I yield back because I think the gentleman wants to share with other Members of the House the language that is actually in the Republican drug bill.

Mr. PALLONE. Absolutely. And I mentioned this noninterference clause, and I will mention it again. Before I do that, just quickly, I know we have spent a lot of time tonight, not only us but our Democratic colleagues earlier this evening, talking about what is wrong with the Republican plan. Maybe we should quickly explain what our alternative is, and the gentleman talked about it in terms of the price.

We are saying forget about all this nonsense of changing Medicare and privatizing Medicare. Forget about all this nonsense about having to go to an HMO to get your prescription drugs. Just take the same Medicare program that has been so successful and add a prescription drug benefit in the same way that we added a few years ago a program under part B that pays for your doctor bills.

In other words, without getting too complicated, Medicare part A pays for your hospitalization. Medicare part B is a program where you pay a certain amount of money per month for a premium, and when you go to your doctor there is a $100 deductible for the whole year, and 80 percent of the costs of your doctor bill is paid for by the Federal Government and 20 percent is paid for by you. Very simple program. You pay a small premium, 80 percent of the costs by the Federal Government, 20 percent co-pay by you, a $100 deductible which is not much. You might go through that on your first doctor visit.

What we are saying is do the same thing with the prescription drug benefit. Add another part to Medicare, charge $25 a month for a premium, have a $100 deductible for the first $100 drug expense you pay in the course of the year; and then after that, 80 percent of the cost of your prescription drugs are paid for by the Federal Government and 20 percent are paid for by you up to a certain level, 3, $4,000 catastrophic when it is all paid for by the Federal Government.

But most important, what we put in the Democratic alternative which is what my colleague from Ohio mentioned, is we have mandated that the Secretary of Health and Human Services or the Medicare administrator has to negotiate lower prices because now that person has 40 million seniors that they can negotiate in bulk as the gentlewoman from Ohio (Ms. KAPTUR) said and try to get a lower price.

Now, if you do that, you save so much money that you can afford to essentially have a program that covers all seniors and gives them a guaranteed benefit and does not have any doughnut hole or time, if you will, when they are not covered. I used this chart during the Committee on Commerce of a dunking doughnut, and I said the GOP is dunking seniors because one out of every two seniors is in the hole. I guess it is a cute way to say that under the House Republican plan one out of two seniors is going to be in a situation where at some point they are going to have to pay 100 percent of their drug costs because the Republicans say that up to $2,000 we will pay a certain percent, but after that we will not, and so for one out of two seniors they will be in a situation where they do not have any coverage during the course of the year.

Mr. BROWN of Ohio. That is exactly my argument. Under the Republican plan, you just simply do the math, and we know that seniors around the country will do the math. I hope they do the math before tomorrow when we vote on this bill because once they have, they will see they are not getting very much in this benefit. For a senior in the United States under the Republican plan who has $5,000 in drug costs, the government will only pick up $1,000. Four thousand of that will come from out-of-pocket costs. So $5,000 drug costs, saving only 20 percent of that. The government will only pay 20 percent. The senior will pay $4,000 out-of-pocket costs. What is so disingenuous about the Republican plan is that it is hard to figure out because they charge a premium. They say it might be $35, but the only time it has ever been tried it was $85 a month. Then there is a $250 deductible. Then they pay 20 percent of the first $2,000, but after $2,000 they pay zero percent. The government does of the next $2,100. It is very complicated.

That is what you are talking about. The Democratic plan operates the same way traditional Medicare does. It is a simple $35 premium, $250 deductible, 20 percent co-pay, and then 100 percent coverage by the government of catastrophic coverage if you have huge drug bills.

It is very simple by the way the Democrats do it because it operates the same way that traditional Medicare does. Seniors know how Medicare operates. The Republican plan is so confusing, so Rube Goldberg-like, so complex, so difficult to understand, I challenge my Republican friends on the other side of the aisle to try to explain it. I do not think anybody can explain it very well. But they will have to explain it when seniors see, if this bill passes, seniors see how difficult it is to understand that.

The point the gentleman made too is that not only is the Democratic plan simple and the Republican plan a Rube Goldberg, complex, almost unfathomable kind of plan, but the Republican plan does nothing to keep prices down. And the Democratic plan gives the Secretary of Health and Human Services the right to negotiate and bring prices down the way the Canadians do and to reimport drugs, to bring drugs in from Canada if they are not cheap enough in the United States.

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And that simply makes all the difference in the world: that our plan is simple, and our plan will bring drug prices down, and our plan is a generous, adequate benefit for America's seniors.

Mr. PALLONE. And again, because the gentleman and I feel very strongly about the fact that we feel the Republicans are just catering to the insurance companies and to the prescription drug companies, the very reason why the Republican plan, in my opinion, is so complicated and ultimately, I think, breaks Medicare and destroys Medicare is because they are going out of their way to try to cater to these two special interests. Because to the extent that they feel the necessity of privatizing and having seniors eventually buy private health insurance, they are essentially breaking the system.

And in the same way because they refuse to have any kind of negotiated price and bring prices down, they are making the prescription drug program essentially not a generous plan because what they want to do essentially is have more seniors buy drugs at higher prices but not allow them to have a plan that is really something that is going to be meaningful for them and help them.

I feel strongly what is going to happen if this Republican plan were to ever become law, and hopefully it does not, but probably what would happen is most seniors would not opt for it because they would find it is not worth having. And just to illustrate that, I think pretty dramatically, the Consumers Union put out a report on June 17, just a week ago, that was entitled “Skimpy Benefits and Unchecked Expenditures. Medicare prescription drug bills fail to offer adequate protections for seniors and peoples with disabilities.” And in talking about how skimpy these benefits were and why most seniors probably would not opt for them, they gave some examples which I thought were pretty significant.

Specifically, we found, the report says, that the average Medicare beneficiary, without prescription drug coverage, spending $2,318 in this year, 2003, would find that his or her out-of-pocket costs for prescription drugs, including premium deductible copayments and the donut, are higher in 2007 despite the new prescription drug benefit, and would total $2,954 in real 2003 dollars.

So what they are saying is for the average Medicare beneficiary, who spends about $2,300 a year in out-of-pocket costs, if they had to pay the premium and they were under the deductible and the copayments in the donut hole that the Republicans here in the House have proposed, they would actually end up spending more money out-of-pocket with the Republican plan than they are spending now. So why in the world would anybody buy it?

What is going to happen here is that the senior citizens are going to realize that this is not even worth having, and they are going to vote with their feet. They are not even going to take advantage of the plan because they are going to realize that it is worthless.

Here is another example. A Medicare beneficiary with the relatively low expenditures in 2003 of $500, in other words these are the seniors that do not spend much for drugs, maybe a third of the senior population, would find his or her out-of-pocket payments for prescription drugs are $790 in 2007. So, again, if they do not spend much money on prescription drugs, they would have absolutely no reason to opt for this Republican plan.

Then they go to a person in the top third of prescription drug spending with costs of $3,000 in 2003 would find his or her out-of-pocket costs reaching $4,000 in 2007.

I do not want to go on and on here with this, but the only point I want to make is that it is such a hoax. Because we can talk here all night about why they are privatizing and why that is bad or why they have the donut hole or why they are not doing anything about price, but the bottom line is nobody is even going to want this plan. Why in the world would they even buy it when it is going to cost them more if they have it, for most seniors, than if they do not?

That is what all the senior groups are pointing out. This is a huge hoax because most seniors will calculate and figure out it is not even worth having this plan. That, I think, is the worst aspect of all. Because there is all this hype, with the President getting on TV and saying we are going to do this plan and we are going to provide prescription drugs, and it is not anything anybody is even going to want because it is not worth having.

Mr. BROWN of Ohio. Mr. Speaker, if the gentleman will yield, the President has been bringing Members to the White House today and lobbying them, and I also know the President this week has raised a lot of drug company money and insurance company money. The President is using the power of the Presidency trying to get people to pass this. And from the reports coming out of the meetings from Members whom I have talked to, in both parties, the President is not talking about the details of the bill. He is just saying you have to do this for me. We need a prescription drug benefit. Seniors deserve it. But he is not doing the math for them.

If every Member of Congress tonight, tomorrow morning, before we vote on this tomorrow during the day would sit down and calculate, listen to the discussions like this and calculate individual numbers about what seniors are going to get, and then would look at what drug prices are, as the gentlewoman from Ohio (Ms. KAPTUR) pointed out, what drug prices are in Canada, France, and Germany, what they are in the United States, and how this bill does nothing about that, and then look at how this bill privatizes Medicare in 2010, I think Members, particularly if they began to listen to what people at home are saying, would have a very different take on this bill, no matter what the President said, no matter how many campaign contributors that Republican leadership and the President of the United States want to honor by passing this legislation.

Mr. PALLONE. Mr. Speaker, I yield to the gentlewoman from Ohio.

Ms. KAPTUR. Mr. Speaker, I would just like to thank my very able colleagues, the gentleman from New Jersey (Mr. PALLONE), who led this fight in the committee, and also the gentleman from Ohio (Mr. BROWN), who has helped turn this into a major national issue, finally, as it should be. The sad fact is that here in the House the bill that is going to be produced is, I suppose you could say is a mouse. It will not be a lion that roars for all Americans seniors.

If you earn $8,000 a year on Social Security, the Republican plan will cause you to pay whatever is left over after $2,000 of expenses up to the level of, I think it is over $3,500. You are not covered. Where are you going to get that kind of money if you only earn $8,000 a year on Social Security?

The amendment I am waiting here to offer, it is now 11 p.m. at night here in Washington, would require the executive branch to negotiate price across the government for Medicare part D, in the same way as we negotiate for the Department of Veterans Affairs and the Department of Defense. They call it the FSS negotiated price. And I will just go through a couple of these drugs here, but the main point is that the Republican radical right bill forbids negotiated pricing in Medicare. It actually, in title VIII of the bill, forbids negotiated pricing, which we already do in the VA, in the Department of Veterans Affairs.

Let us go through a couple of the costs. If you look at a drug like K-Dur 20, which helps if you have low potassium levels, U.S. retail price for that is $55.99, the Canadian price is $29, and the price that is negotiated through the Department of Veterans Affairs is $25.58. A negotiated price, because you have group buying, reduces the cost to all.

To send an individual senior out there in their own little canoe in a very big ocean, they have very little consumer power. Only with group buying, as we do through the Department of Veterans Affairs, do you really get the same kind of prices that the Canadians have. Group buying. Yet the Republican bill denies that negotiated price.

Another drug. If you look at Prozac, for depression, U.S. retail price over $300. The VA negotiated price $186.98. It is obvious. It is obvious, is it not, that a negotiated pricing is what should be embedded in the bill? But it is not in there. In fact, it is forbidden.

If we really want to understand why, and the gentleman from Ohio (Mr. BROWN) and the gentleman from New Jersey (Mr. PALLONE) have really become experts at identifying what is going on around this Capitol, we should take a look at the contributions of the major pharmaceutical companies. Take a look at a company like Bristol-Myers Squibb, who gave over a $1.5 million in the year 2002 for lobbying Members of Congress. Eighty-three percent of those funds went to the Republican side of the aisle. Millions and millions of dollars from companies that make billions by overpricing the American consumer. It is very clear that they have at least six lobbyists here for every one of us.

So here we stand at a few minutes to midnight waiting for the Republicans to produce a bill. Nobody knows where they are. The doors are closed. Such an important bill that will serve our people, hopefully serve our people, for generations to come. We cannot even find the bill. What are they doing? Where are they?

I would say to the majority leader, the gentleman from Texas (Mr. DELAY), this is no way to run the country. You should have had this bill on the floor 2 weeks ago. We should have gone through every line so every Member here would understand what is in it. But rather than that, you are having your fund-raisers. And, in fact, Pfizer Company just contributed $200,000. That was the price of one of the big seats at the roundtable dinner President Bush just had, and they were able to contribute. You think there is no connection? We were not born yesterday, were we?

So we have a bill that forbids negotiated pricing, even though we know that is one of the few protections we can offer seniors. The Democratic bill provides a real defined benefit. Every senior qualifies. It has a $25 premium per month. It does not force you to pay those high costs, over $2,000. It has negotiated pricing. It is for everyone. And it lets you keep your doctor. It lets you have negotiated pricing, and it does not make you go into an HMO, a Medicare HMO, which have all failed in most places in the country. And that is what the Republican bill does, it tries to privatize that and put you out of the overall Medicare system.

So I just want to thank my colleagues for being here tonight and allowing me to share in this special order, and thank you both for your royal, royal fight to in order to get fair and affordable prescription drug coverage for all of our seniors.

Mr. BROWN of Ohio. If the gentleman will yield for just a moment, and I know the gentleman from Connecticut (Mr. LARSON) is here, but the gentlewoman from Ohio (Ms. KAPTUR) just talked about privatization, as we have. We know that idealogically, in addition to the drug company and the insurance industry contributions to the Republicans and how that seems to affect their thinking, we also know that some Republicans just do not like Medicare. There is a history of it.

Donald Rumsfeld, Gerald Ford, and Bob Dole voted against it when it was created 38 years ago. Newt Gingrich tried to cut it so he would have money for his tax cuts. Same old story. But the gentleman from California (Mr. THOMAS), who is the number one point man in this entire Congress to privatize Medicare, he said this morning, and the gentleman from California (Mr. THOMAS) is the Republican chairman of the Committee on Ways and Means, he said, "To those who say that the bill would end Medicare as we know it, our answer is, we certainly hope so. Old-fashioned Medicare isn't very good."

That is like Newt Gingrich saying Medicare would wither on the vine and Bob Dole, just a few years ago, before he ran for President, saying I fought the fight to try to stop Medicare from being created. These guys do not like Medicare.

Mr. PALLONE. I just want to say, they operate on the premise, and they keep saying it over and over again, I have heard it on the other side in the well, on the Republican side, that Medicare is broke, Medicare needs to be fixed, and Medicare does not work. It is not true. They say those things in order to set up Medicare to be changed significantly.

The bottom line is my seniors tell me Medicare works. Medicare is good. That is what the gentleman from California (Mr. THOMAS) is essentially saying, keep this line up that Medicare is bad and broken, then you can make all these changes because you say you are going to improve. But it is not being improved. It is actually being destroyed by what they are trying to do.

Mr. Speaker, I now yield to the gentleman from Connecticut (Mr. LARSON).

Mr. LARSON of Connecticut. I thank the gentleman from New Jersey, Mr. Speaker, and I am proud to join my colleagues from Ohio, the gentlewoman and the gentleman from the Buckeye State, as we talk this evening. And as my colleagues have eloquently expressed, I want to associate myself with their remarks.

I think Roosevelt said it best of our colleagues on the other side of the aisle: The Republicans seem frozen, frozen in the ice of their own indifference. Their indifference to what this proposal will mean to the elderly. The hypocrisy of having this much-needed benefit not take effect until 2006 shows the indifference of Members having to return to their districts and go to senior centers and telling them that the much-waited benefit that they so desperately need will not be there for another 3 years. We can afford trillions in tax cuts, but we cannot afford to put into effect a program that will benefit them.

□ 2300

Mr. Speaker, as the gentleman has pointed out this evening, the most galling thing for seniors and for Members of Congress, several on the other side of the aisle who have recognized the importance of using the full faith and credit of the United States Government to leverage the cost of prescription drugs, at the end of the day, this is a cost issue. When we think about it, what we have done is asked our senior citizens to subsidize not only all the private plans in the United States of America and all the programs that are available to Federal employees, but basically all the programs available around the globe because pharmaceutical companies have stated that while those prices can be fixed, the only prices in the industrialized world that are not are those that are imposed on the backs of those who can least afford them, the seniors of the United States.

All this lip service to the Greatest Generation ever is dashed when we talk about the hypocrisy of making a program available 3 years from now. For someone in my district who has to make the choice between the food they put on their table, heating and cooling their homes, and the prescription drugs that they need to take, we have turned them into refugees from their own health care system. They have to board buses and go to Canada in order to get the drugs at a price that they can afford. We are a better Nation than that. The indifference of the other party to the needs of these elderly, the indifference in their proposal.

I come from the insurance capital of the world. The HMOs are not going to cover a program that is actuarially infeasible to make a profit on. To have a program that is full of the so-called doughnut where we know that the elderly will fall into this hole, and the programs could be pulled at any moment with no specific guarantee, none of the entitlements that are under the Medicare system. And the further indifference, to try to delude the elderly into thinking their plan comes under Medicare by creating a new subsection which basically defers responsibility to the future and to companies that are unwilling to write the prescription drug benefits.

I applaud the gentleman for being down here night after night. When I go to my district, my constituents ask why are the Democrats not saying anything? And as the gentlewoman from Ohio said, it is because all of the deliberations are taking place behind closed doors, and what can and cannot be said will be determined after midnight upstairs on the third floor with no member of the press present, with no C-SPAN cameras covering what goes on in the Committee on Rules, and that will ultimately determine the fate of seniors and whether or not Democrats will be able to put their proposals side by side and have them voted up or down.

I thank the gentleman for waging this fight. I fear we will have to take this fight to the streets in order to get our point across.

Mr. PALLONE. Mr. Speaker, I yield to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. Mr. Speaker, I associate myself with the remarks of the gentleman from Connecticut (Mr. LARSON) and to say it is important to remind ourselves why Medicare was first set up. The gentleman talked about actuarial soundness.

We have Medicare because the private market will not serve this segment of American society. That is why Lyndon Johnson worked so hard after 50 years of Democratic effort to enact Medicare in this Congress. To say to seniors you can go out in a private HMO Medicare, we will call it Medicare but it is really not Medicare because it is not guaranteed, all of the HMOs dealing with Medicare in my region have collapsed.

They are not going to be there. It is just like physicians trying to take assignment. How many physicians do not take assignment even today? Do we think that without Medicare we are going to be able to serve this population? We have to have the strength of group buying and of the Medicare program nationally for this drug benefit or, indeed, for all seniors across this country to be helped.

I want to thank these fine Members of Congress, but Americans first, who are here tonight, to be voices for those who expect us to do the job for 40 million people who cannot be in this Chamber tonight; and I am proud to be here a few minutes before midnight with the gentleman from New Jersey (Mr. PALLONE), the gentleman from Connecticut (Mr. LARSON), and the gentleman from Ohio (Mr. BROWN), who understand the Johnson-Roosevelt legacy and refused to cower before this radical right wing which has taken control of this Chamber.

Mr. PALLONE. Mr. Speaker, I want to say I think all of us feel very strongly that we want to look at this practically. We are not ideologically driven. We are not driven by campaign contributions. We just feel it is time to add a prescription drug benefit to Medicare; and we feel strongly that Medicare works, it is a good program. It is not something that needs to be scrapped because the seniors are not telling us they do not like Medicare.

The simple thing the Democrats say is we need a prescription drug benefit. It is time for that. Let us simply add it to the existing Medicare program. Let us set it up like we do with part B and have a low premium and a low deductible and 80 percent of the cost paid for by the Federal Government. And as the gentlewoman from Ohio (Ms. KAPTUR) said, we have to have negotiated prices because otherwise the cost of the program is going to become so prohibitive the Federal Government would not be able to pay for it eventually.

Ms. KAPTUR. It will just become an entitlement program for all of these pharmaceutical companies to load up and raid the pockets of seniors across this country, bankrupt them, really.

Mr. PALLONE. Exactly. We are going to have the debate tomorrow, I hope. I just do not understand why something which is so simple is not understood by our Republican colleagues, and I come to the conclusion that they are in the pocket of the special interests, whether it is the insurance companies or the pharmaceutical companies. Otherwise it does not make sense.

Mr. BROWN of Ohio. Mr. Speaker, I would add it is pretty clear there are two things going on. One is the huge contributions from drug and insurance interests and connections between that and the Republican plan, essentially since it is pretty clear those interest groups wrote the plan.

Second, they just do not like Medicare. There is clear evidence of a 38-year history of that. But the proof is in the pudding. One, it is what the legislation looks like. The second way the proof is in the pudding is that this debate is held in the middle of the night. The Committee on Rules will meet later this evening. It is already 5 after 11 in Washington. The Committee on Rules will meet behind closed doors with no C-SPAN and no reporters basically there to make these decisions.

And while the Senate is debating their plan, which is moving toward some bipartisanship, for several days, we will have a debate tomorrow of only a few hours. That will be the end of it. The Republicans do not want the public to learn about this. That is why it is so important that our colleagues speak out and make sure that people understand the difference between the simple Democratic plan that adequately covers seniors and ratchets down the price of prescription drugs, and the Republican confusing plan which gives very little benefit, is written by the drug companies, pushes seniors out of traditional Medicare into private plans, and does nothing about getting prices down.

Mr. PALLONE. Mr. Speaker, in closing, I thank the Members, and we will go onward to the Committee on Rules. Let us hope that they actually meet sometime before midnight. We will certainly carry this forward tomorrow because we are not going to stop until we have the opportunity to have a really good Medicare prescription drug plan.

□ 2310

MEDICARE MODERNIZATION

The SPEAKER pro tempore (Mr. GARRETT). Under a previous order of the House, the gentleman from Connecticut (Mr. LARSON) is recognized for 5 minutes.

Mr. LARSON of Connecticut. Mr. Speaker, again I would like to commend the gentleman from New Jersey, the gentlewoman from Ohio and the gentleman from Ohio for their remarks. I plan to attend the Rules Committee meeting, whenever it is called to order, to put forward an amendment, an amendment that I believe is much needed. As I said earlier this evening, I believe ultimately, Mr. Speaker, that this comes down to cost. For us to have the elderly of this country unfairly bear the cost not only of private sector plans, Federal Government plans in this country but around the globe is just flat out unfair. There is no reason why we cannot do for Medicare what the VA does for its veterans. There is no reason why we cannot have formularies, why we cannot have pricing. Those who would argue that this would amount to price fixing have to come to grips with reality, that the price is fixed. In this case it is a price that is fixed on the backs of senior citizens across our country, senior citizens who, as I said earlier, feel as though they are refugees from their own health care plan, who board buses to go to Canada to get prices that they are denied here in their own country. Every western democracy, every industrialized nation in the world has seen fit to leverage the full faith and credit of their governments on behalf of their seniors except the United States of America. The preeminent military, social, culture and economic leader in the world cannot find it within itself to provide senior citizens in this country with a benefit they richly deserve and need.

My proposal is a very simple one. It takes into account what the VA is capable to do for veterans. It takes into account what the private sector offers, what our own Federal employees are able to receive, what you would be able to get as a prescription price if you traveled to Canada, and says, take HHS, take the Department of Defense and the VA and impacted Federal agencies and have them collectively come up with a price that ultimately takes into consideration the need for research and development but also the need to come up with a fair and equitable price for the elderly. No matter what plan ultimately is conceived, if at the center of that plan we do not address the issue of cost, then we have gained nothing. And to have a plan and to be able to go back to your district and say that we propose a plan that does not take effect until 2006 when in the presidential campaign both candidates and every Member of this body, I daresay, campaigned on the fact that they were going to provide seniors with the prescription drug relief that they needed, to renege on that promise is a travesty. To be frozen in indifference, indifference to the need and wants of our senior citizens, is a sham. We have to speak out about that. Ronald Reagan said that facts are a stubborn thing and the fact of the matter is that seniors all across this Nation pay a disproportionate amount of their moneys to get prescription drugs.

My father, God rest his soul, used to say to my mother, Jesus, Mary and Joseph, Pauline, who won the war? The very nations that we defeated in the Second World War provide prescription drug relief for their citizens and yet we, the greatest country on the face of the earth, cannot find the money. Oh, we have plenty of money to give to the wealthiest 1 percent of this country by way of a tax cut, but we cannot find the wherewithal to come up with a prescription drug program for the greatest generation in America.

RECESS

Mr. BROWN of Ohio. Mr. Speaker, I move the House adjourn until tomorrow at 10 a.m.

Mr. PALLONE. I second the motion, Mr. Speaker.

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

PARLIAMENTARY INQUIRY

Mr. BROWN of Ohio. Mr. Speaker, parliamentary inquiry. Does a motion to adjourn not take precedence over any other motion?

The SPEAKER pro tempore. The chair did not recognize the gentleman for that purpose. There is therefore no question now pending before the Chair at this time, and the Chair may declare a recess.

Ms. KAPTUR. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. For what purpose does the gentlewoman from Ohio rise?

Ms. KAPTUR. I would like to make an inquiry of the Chair as to why the gentleman from Ohio's parliamentary request to adjourn the House was not received by the Chair.

The SPEAKER pro tempore. When there is no question pending, the Chair has the authority to declare the House in recess. As such, pursuant to clause 12(a) of rule I, the chair declares a recess subject to the Call of the Chair.

Accordingly (at 11 o'clock and 15 minutes p.m.), the House stood in recess subject to the call of the Chair.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2839. A letter from the President and Chairman, Export-Import Bank of the United States, transmitting a report involving U.S. exports to Vietnam, pursuant to 12 U.S.C. 635(b)(3)(i); to the Committee on Financial Services.

2840. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed Manufacturing License Agreement with South Korea [Transmittal No. DDTC 034-03], pursuant to 22 U.S.C. 2776(c) and 22 U.S.C. 2776(d); to the Committee on International Relations.

2841. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed Manufacturing License Agreement with Canada [Transmittal No. DDTC 012-03], pursuant to 22 U.S.C. 2776(d); to the Committee on International Relations.

2842. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to South Korea (Transmittal No. DDTC 043-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2843. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 035-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2844. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 036-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2845. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 037-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2846. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Israel (Transmittal No. DDTC 038-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2847. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Belgium, Canada, Denmark, France, Germany, Ireland, Italy, Norway and the United Kingdom (Transmittal No. DDTC 010-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2848. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 039-03), pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on International Relations.

2849. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Ridgely, MD [Docket No. FAA-2002-13936; Airspace Docket No. 02-AEA-22] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2850. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class D Airspace; and Modification of Class E Airspace; Topeka, Phillip Billard Municipal Airport, KS [Docket No.

FAA-2003-14347; Airspace Docket No. 03-ACE-4] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2851. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Clinton, IA [Docket No. FAA-2003-14460; Airspace Docket No. 03-ACE-13] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2852. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Davenport, IA [Docket No. FAA-2003-14461; Airspace Docket No. 03-ACE-14] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2853. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Independence, IA [Docket No. FAA-2003-14598; Airspace Docket No. 03-ACE-21] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2854. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Muskegon, MI [Docket No. FAA-2002-13818; Airspace Docket No. 02-AGL-19] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2855. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Eureka, KS [Docket No. FAA-2003-14847; Airspace Docket No. 03-ACE-32] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2856. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Moundridge, KS; Correction [Airspace Docket No. 02-ACE-12] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2857. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Cavelier, ND [Docket No. FAA-2002-14044; Airspace Docket No. 02-AGL-22] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2858. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Amendment to Class E Airspace; Windsor Locks, Bradley International Airport, CT [Docket No. FAA-2003-14868; Airspace Docket No. 2003-ANE-103] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2859. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and MD-11F Airplanes [Docket No. 2001-NM-166-AD; Amendment 39-13066; AD 2003-04-17] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2860. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and MD-11F Airplanes [Docket No. 2001-NM-160-AD; Amendment 39-13065; AD 2003-04-16] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2861. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and -11F Airplanes [Docket No. 2001-NM-56-AD; Amendment 39-13120; AD 2003-08-09] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2862. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and -11F Airplanes [Docket No. 2001-NM-62-AD; Amendment 39-13119; AD 2003-08-08] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2863. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Aerospatiale Model ATR42-500 Series Airplanes, and Model ATR72-102, -202, -212, and -212A Series Airplanes [Docket No. 2002-NM-73-AD; Amendment 39-13122; AD 2003-08-10] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2864. A letter from the Program Analyst, FAA, Department of Transportation, transmitting The Department's final rule — Airworthiness Directives; McDonnell Douglas Model DC-10-10, DC-10-10F, DC-10-15, DC-10-30, DC-10-30F, DC-10-30F (KC10A and KDC-10), DC-10-40, DC-10-40F, MD-10-10F, and MD-10-30F Airplanes [Docket No. 2001-NM-99-AD; Amendment 39-13114; AD 2003-08-03] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2865. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Pilatus Aircraft Ltd. Models PC-12 and PC-12/45 Airplanes [Docket No. 2003-CE-06-AD; Amendment 39-13140; AD 2003-09-11] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2866. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 767-200, -300, and -300F Series Airplanes [Docket No. 2002-NM-158-AD; Amendment 39-13137; AD 2003-09-08] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2867. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Air Tractor, Inc. Models AT-300, AT-400, AT-400A, AT-401, AT-401B, AT-402, AT-402A, AT-402B, AT-501, AT-502, and AT-502B Airplanes [Docket No. 2000-CE-59-AD; Amendment 39-13100; AD 2003-07-04] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2868. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Stemme GmbH & Co. KG Models S10 and S10-V Sailplanes [Docket No. 2002-CE-52-AD; Amendment 39-13101; AD 2003-07-05] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2869. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; British Aerospace Model HP.137 Jetstream Mk.1, Jetstream Series 200, Jetstream Series 3101, and Jetstream Model 3201 Airplanes [Docket No. 2002-CE-56-AD; Amendment 39-13102; AD 2003-07-06] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2870. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd. & Co KG. Model Tay 650-15 Turbofan Engines [Docket No. 2003-NE-06-AD; Amendment 39-13112; AD 2003-08-01] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2871. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 767-300 Series Airplanes Modified by Supplemental Type Certificate ST01783AT-D [[Docket No. 2002-NM-54-AD; Amendment 39-1311; AD 2003-07-15] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2872. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 390 Airplanes [Docket No. 2003-CE-18-AD; Amendment 39-13139; AD 2003-09-10] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2873. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Twin Commander Aircraft Corporation Models 690D, 695A, and 695B Airplanes [Docket No. 2000-CE-56-AD; Amendment 39-13099; AD 2003-07-03] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2874. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Quality Aerospace, Inc. S2R Series and Model 600 S2D Airplanes [Docket No. 2001-CE-37-AD; Amendment 39-13097; AD 2003-07-01] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2875. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Kaman Aerospace Corporation Model K-1200 Helicopters [Docket No. 2000-SW-50-AD; Amendment 39-13123; AD 2001-13-03 R1] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2876. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 747-100,

-200B, -200F, -200C, -100B, -300, -100B SUD, -400, -400D, and -400F Series Airplanes; and Model 747SR Series Airplanes [Docket No. 2003-NM-15-AD; Amendment 39-13124; AD 2003-08-11] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2877. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-1A11 (CL-600), CL-600-2A12 (CL-601), and CL-600-2B16 (CL-601-3A, CL-601-3R, and CL-604) Series Airplanes [Docket No. 2002-NM-317-AD; Amendment 39-13125; AD 2003-08-12] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2878. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 737-200, -200C, -300, -400, and -500 Series Airplanes [Docket No. 2002-NM-329-AD; Amendment 39-13128; AD 2003-08-15] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2879. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Pilatus Aircraft Ltd. Models PC-12 adn PC-12/45 Airplanes [Docket No. 2003-CE-02-AD; Amendment 39-13106; AD 2003-07-10] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2880. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada Model 222, 222B, 222U, and 230 Helicopters [Docket No. 2003-SW-01-AD; Amendment 39-13118; AD 2003-08-07] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2881. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model DC-10-10, DC-10-10F, DC-10-15, DC-10-30, DC-10-30F, DC-10-30F (KC10A and KDC-10), DC-10-40, DC-10-40F, MD-10-10F, MD-10-30F, MD-11, and MD-11F Airplanes [Docket No. 2003-NM-42-AD; Amendment 39-13127; AD 2003-08-14] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2882. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model AS350B3 Helicopters [Docket No. 2002-SW-05-AD; Amendment 39-13116; AD 2003-08-05] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2883. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model AS350B, B1, B2, BA, and D Helicopters [Docket No. 2002-SW-37-AD; Amendment 39-13117; AD 2003-08-06] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2884. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas DC-10-30 Airplane [Docket No. 2002-NM-134-AD; Amendment 39-13110; AD 2003-07-14] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2885. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model EC120B Helicopters [Docket No. 2001-SW-52-AD; Amendment 39-13115; AD 2003-08-04] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

□ 0618

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. DREIER) at 6 o'clock and 18 minutes a.m., Thursday, June 26, 2003, Legislative Day, Wednesday, June 25, 2003.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

Ms. PRYCE of Ohio, from the Committee on Rules, submitted a privileged report (Rept. No. 108–179) on the resolution (H. Res. 297) providing for consideration of motions to suspend the rules, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2559, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2004

Ms. PRYCE of Ohio, from the Committee on Rules, submitted a privileged report (Rept. No. 108–180) on the resolution (H. Res. 298) providing for consideration of the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

Ms. PRYCE of Ohio, from the Committee on Rules, submitted a privileged report (Rept. No. 108–181) on the resolution (H. Res. 299) providing for consideration of the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes, and for consideration of the bill (H.R. 2596) to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes, which was referred to the House Calendar and ordered to be printed.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. SMITH of Washington (at the request of Ms. PELOSI) for June 23 and the balance of the week on account of personal reasons.

Mr. STARK (at the request of Ms. PELOSI) for today after 5:30 p.m. on account of family matters.

Mr. EVERETT (at the request of Mr. DELAY) for today on account of attending the funeral of former Representative Bob Stump.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. BROWN of Ohio) to revise and extend their remarks and include extraneous material:)

Mr. HINCHEY, for 5 minutes, today.

Mr. BROWN of Ohio, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. FILNER, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. EMANUEL, for 5 minutes, today.

Ms. SCHAKOWSKY, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Ms. LEE, for 5 minutes, today.

Mr. BORDALLO, for 5 minutes, today.

Mrs. CAPPS, for 5 minutes, today.

Ms. LORETTA SANCHEZ of California, for 5 minutes, today.

Ms. EDDIE BERNICE JOHNSON of Texas, for 5 minutes, today.

Ms. WATSON, for 5 minutes, today.

Ms. MILLENDER-MCDONALD, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Ms. CORRINE BROWN of Florida, for 5 minutes, today.

Ms. SOLIS, for 5 minutes, today.

Mrs. DAVIS of California, for 5 minutes, today.

Ms. BALDWIN, for 5 minutes, today.

Ms. ESHOO, for 5 minutes, today.

Ms. BERKLEY, for 5 minutes, today.

Ms. KILPATRICK, for 5 minutes, today.

Mrs. MALONEY, for 5 minutes, today.

Mr. WYNN, for 5 minutes, today.

Mr. STUPAK, for 5 minutes, today.

Mr. RUSH, for 5 minutes, today.

Mr. PASCRELL, for 5 minutes, today.

Mr. DAVIS of Illinois, for 5 minutes, today.

Mr. MARSHALL, for 5 minutes, today.

Mr. CUMMINGS, for 5 minutes, today.

(The following Members (at the request of Mr. GOSS) to revise and extend their remarks and include extraneous material:)

Mr. DUNCAN, for 5 minutes, today.

Mr. COX, for 5 minutes, today.

Mr. LINCOLN DIAZ-BALART of Florida, for 5 minutes, today.

(The following Members (at their own request) to revise and extend their remarks and include extraneous material:)

Mr. FROST, for 5 minutes, today.

Mr. LARSON of Connecticut, for 5 minutes, today.

BILLS PRESENTED TO THE PRESIDENT

Jeff Trandahl, Clerk of the House reports that on June 24, 2003 he presented to the President of the United States, for his approval, the following bills.

H.R. 658. To provide for the protection of investors, increase confidence in the capital markets system, and fully implement the Sarbanes-Oxley Act of 2002 by streamlining the hiring process for certain employment positions in the Securities and Exchange Commission.

H.R. 2312. To amend the Communications Satellite of 1962 to provide for the orderly dilution of the ownership interest in Inmarsat by former signatories to the Inmarsat Operating Agreement.

ADJOURNMENT

Ms. PRYCE of Ohio. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 6 o'clock and 20 minutes a.m.), the House adjourned until today, Thursday, June 26, 2003, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2839. A letter from the President and Chairman, Export-Import Bank of the United States, transmitting a report involving U.S. exports to Vietnam, pursuant to 12 U.S.C. 635(b)(3)(i); to the Committee on Financial Services.

2840. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed Manufacturing License Agreement with South Korea [Transmittal No. DDTC 034-03], pursuant to 22 U.S.C. 2776(c) and 22 U.S.C. 2776(d); to the Committee on International Relations.

2841. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed Manufacturing License Agreement with Canada [Transmittal No. DDTC 012-03], pursuant to 22 U.S.C. 2776(d); to the Committee on International Relations.

2842. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to South Korea (Transmittal No. DDTC 043-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2843. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 035-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2844. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 036-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2845. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 037-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2846. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Israel (Transmittal No. DDTC 038-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2847. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Belgium, Canada, Denmark, France, Germany, Ireland, Italy, Norway, and the United Kingdom (Transmittal No. DDTC 010-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

2848. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold under a contract to Japan (Transmittal No. DDTC 039-03), pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on International Relations.

2849. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Ridgely, MD [Docket No. FAA-2002-13936; Airspace Docket No. 02-AEA-22] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2850. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class D Airspace; and Modification of Class E Airspace; Topeka, Phillip Billard Municipal Airport, KS [Docket No. FAA-2003-14347; Airspace Docket No. 03-ACE-4] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2851. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Clinton, IA [Docket No. FAA-2003-14460; Airspace Docket No. 03-ACE-13] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2852. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Davenport, IA [Docket No. FAA-2003-14461; Airspace Docket No. 03-ACE-14] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2853. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Independence, IA [Docket No. FAA-2003-14598; Airspace Docket No. 03-ACE-21] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2854. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Muskegon, MI [Docket No. FAA-2002-13818; Airspace Docket No. 02-AGL-19] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2855. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Eureka, KS [Docket No. FAA-2003-14847; Airspace Docket No. 03-ACE-32] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2856. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Moundridge, KS; Correction [Airspace Docket No. 02-ACE-12] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2857. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Cavelier, ND [Docket No. FAA-2002-14044; Airspace Docket No. 02-AGL-22] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2858. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Amendment to Class E Airspace; Windsor Locks, Bradley International Airport, CT [Docket No. FAA-2003-14868; Airspace Docket No. 2003-ANE-103] received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2859. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and MD-11F Airplanes [Docket No. 2001-NM-166-AD; Amendment 39-13066; AD 2003-04-17] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2860. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and MD-11F Airplanes [Docket No. 2001-NM-160-AD; Amendment 39-13065; AD 2003-04-16] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2861. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas

Model MD-11 and -11F Airplanes [Docket No. 2001-NM-56-AD; Amendment 39-13120; AD 2003-08-09] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2862. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and -11F Airplanes [Docket No. 2001-NM-62-AD; Amendment 39-13119; AD 2003-08-08] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2863. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Aerospatiale Model ATR42-500 Series Airplanes, and Model ATR72-102, -202, -212, and -212A Series Airplanes [Docket No. 2002-NM-73-AD; Amendment 39-13122; AD 2003-08-10] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2864. A letter from the Program Analyst, FAA, Department of Transportation, transmitting The Department's final rule — Airworthiness Directives; McDonnell Douglas Model DC-10-10, DC-10-10F, DC-10-15, DC-10-30, DC-10-30F, DC-10-30F (KC10A and KDC-10), DC-10-40, DC-10-40F, MD-10-10F, and MD-10-30F Airplanes [Docket No. 2001-NM-99-AD; Amendment 39-13114; AD 2003-08-03] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2865. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Pilatus Aircraft Ltd. Models PC-12 and PC-12/45 Airplanes [Docket No. 2003-CE-06-AD; Amendment 39-13140; AD 2003-09-11] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2866. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 767-200, -300, and -300F Series Airplanes [Docket No. 2002-NM-158-AD; Amendment 39-13137; AD 2003-09-08] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2867. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Air Tractor, Inc. Models AT-300, AT-400, AT-400A, AT-401, AT-401B, AT-402, AT-402A, AT-402B, AT-501, AT-502, and AT-502B Airplanes [Docket No. 2000-CE-59-AD; Amendment 39-13100; AD 2003-07-04] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2868. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Stemme GmbH & Co. KG Models S10 and S10-V Sailplanes [Docket No. 2002-CE-52-AD; Amendment 39-13101; AD 2003-07-05] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2869. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; British Aerospace Model HP.137 Jetstream Mk.1, Jetstream Series 200, Jetstream Series 3101, and Jetstream Model 3201 Airplanes [Docket No. 2002-CE-56-AD; Amendment 39-13102; AD 2003-07-06] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2870. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd. & Co KG, Model Tay 650-15 Turbofan Engines [Docket No. 2003-NE-06-AD; Amendment 39-13112; AD 2003-08-01] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2871. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 767-300 Series Airplanes Modified by Supplemental Type Certificate ST01783AT-D [[Docket No. 2002-NM-54-AD; Amendment 39-1311; AD 2003-07-15] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2872. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 390 Airplanes [Docket No. 2003-CE-18-AD; Amendment 39-13139; AD 2003-09-10] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2873. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Twin Commander Aircraft Corporation Models 690D, 695A, and 695B Airplanes [Docket No. 2000-CE-56-AD; Amendment 39-13099; AD 2003-07-03] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2874. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Quality Aerospace, Inc. S2R Series and Model 600 S2D Airplanes [Docket No. 2001-CE-37-AD; Amendment 39-13097; AD 2003-07-01] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2875. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Kaman Aerospace Corporation Model K-1200 Helicopters [Docket No. 2000-SW-50-AD; Amendment 39-13123; AD 2001-13-03 R1] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2876. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 747-100, -200B, -200F, -200C, -100B, -300, -100B SUD, -400, -400D, and -400F Series Airplanes; and Model 747SR Series Airplanes [Docket No. 2003-NM-15-AD; Amendment 39-13124; AD 2003-08-11] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2877. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-1A11 (CL-600), CL-600-2A12 (CL-601), and CL-600-2B16 (CL-601-3A, CL-601-3R, and CL-604) Series Airplanes [Docket No. 2002-NM-317-AD; Amendment 39-13125; AD 2003-08-12] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2878. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 737-200, -200C, -300, -400, and -500 Series Airplanes [Docket No. 2002-NM-329-AD; Amendment 39-13128; AD 2003-08-15] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2879. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Pilatus Aircraft Ltd. Models PC-12 adn PC-12/45 Airplanes [Docket No. 2003-CE-02-AD; Amendment 39-13106; AD 2003-07-10] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2880. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada Model 222, 222B, 222U, and 230 Helicopters [Docket No. 2003-SW-01-AD; Amendment 39-13118; AD 2003-08-07] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2881. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model DC-10-10, DC-10-10F, DC-10-15, DC-10-30, DC-10-30F, DC-10-30F (KC10A and KDC-10), DC-10-40, DC-10-40F, MD-10-10F, MD-10-30F, MD-11, and MD-11F Airplanes [Docket No. 2003-NM-42-AD; Amendment 39-13127; AD 2003-08-14] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2882. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model AS350B3 Helicopters [Docket No. 2002-SW-05-AD; Amendment 39-13116; AD 2003-08-05] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2883. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model AS350B, B1, B2, BA, and D Helicopters [Docket No. 2002-SW-37-AD; Amendment 39-13117; AD 2003-08-06] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2884. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas DC-10-30 Airplane [Docket No. 2002-NM-134-AD; Amendment 39-13110; AD 2003-07-14] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2885. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France

Model EC120B Helicopters [Docket No. 2001-SW-52-AD; Amendment 39-13115; AD 2003-08-04] (RIN: 2120-AA64) received June 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. THOMAS: Committee on Ways and Means. H.R. 2351. A bill to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings accounts and to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements; with an amendment (Rept. 108–177). Referred to the Committee of the Whole House on the State of the Union.

Mr. TAUZIN: Committee on Energy and Commerce. H.R. 2473. A bill to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes; with an amendment (Rept. 108–178 Pt. 1). Ordered to be printed.

[June 26 (legislative day of June 25), 2003]

Mr. LINDER. Committee on Rules. House Resolution 297. Resolution providing for motions to suspend the rules (Rept. 108–179). Referred to the House Calendar.

Mrs. MYRICK: Committee on Rules. House Resolution 298. Resolution providing for consideration of the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes (Rept. 108–180). Referred to the House Calendar.

Ms. PRYCE of Ohio: Committee on Rules. House Resolution 299. Resolution providing for consideration of the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes and providing for consideration of the bill (H.R. 2596) to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes (Rept. 108–181). Referred to the House Calendar.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. HASTERT (for himself, Mr. DeLay, Mr. Blunt, Ms. Pryce of Ohio, Mr. Thomas, Mr. Tauzin, Mrs. Johnson of Connecticut, Mr. Bilirakis, Mr. Peterson of Minnesota, Mrs. Capito, Ms. Ginny Brown-Waite of Florida, Mr. Bradley of New Hampshire, Mr. Burns, Ms. Dunn, Mr. Fletcher, Mr. Goss, Mr. Graves, Mr. McCrery, Mr. Nunes, Mr. Simmons, and Mr. Sullivan):

H.R. 1. A bill to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes; referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SMITH of New Jersey (for himself, Mr. Evans, Mr. Renzi, and Mr. Udall of New Mexico):

H.R. 2595. A bill to restore the operation of the Native American Veteran Housing Loan Program during fiscal year 2003 to the scope of that program as in effect on September 30, 2002; to the Committee on Veterans' Affairs.

By Mr. THOMAS:

H.R. 2596. A bill to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes; to the Committee on Ways and Means.

By Mr. ABERCROMBIE (for himself and Mr. Case):

H.R. 2597. A bill to amend the Native Hawaiian Health Care Improvement Act to revise and extend that Act; to the Committee on Energy and Commerce.

By Mr. BRADLEY of New Hampshire (for himself and Mr. Cantor):

H.R. 2598. A bill to amend title II of the Social Security Act to authorize waivers by the Commissioner of Social Security of the 5-month waiting period for entitlement to benefits based on disability in cases in which the Commissioner determines that such waiting period would cause undue hardship to terminally ill beneficiaries; to the Committee on Ways and Means.

By Mr. DOOLITTLE (for himself and Mr. Herger):

H.R. 2599. A bill to direct the Secretary of the Interior to quitclaim to Yuba River Properties certain land in Yuba County, California, so as to extinguish a claim of title asserted by the Department of the Interior; to the Committee on Resources.

By Mr. FALEOMAVAEGA:

H.R. 2600. A bill to amend the Immigration and Nationality Act to simplify the requirements for United States nationals to become citizens; to the Committee on the Judiciary.

By Ms. LOFGREN (for herself and Mr. Doolittle):

H.R. 2601. A bill to amend title 17, United States Code, to allow abandoned copyrighted works to enter the public domain after 50 years; to the Committee on the Judiciary.

By Mr. OTTER:

H.R. 2602. A bill to amend the Endangered Species Act of 1973 to make the authority of the Secretary to designate critical habitat discretionary instead of mandatory, and for other purposes; to the Committee on Resources.

By Mr. PEARCE:

H.R. 2603. A bill to impose limitations on the authority of the Secretary of the Interior to claim title or other rights to water absent specific direction of law or to abrogate, injure, or otherwise impair any right to the use of any quantity of water; to the Committee on Resources.

By Mr. RANGEL:

H.R. 2604. A bill to amend the Internal Revenue Code of 1986 to provide tax incentives to encourage diversity of ownership of telecommunications businesses, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Small Business, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SCOTT of Virginia (for himself, Mr. Edwards, Mr. Nadler, Mr. Frank of Massachusetts, Mr. Van Hollen, Ms. Jackson-Lee of Texas, Mr. Grijalva, Mr. Wynn, Mr. McGovern, Mr. Farr, Mr. Hinchey, Mr. Payne, Ms. Lee, Mr. Serrano, Mr. Reyes, Mr. Case, Mr. Watt, Mr. Davis of Alabama, Mr. Hoeffel, Mr. George Miller of California, Mr. Conyers, Mr. Davis of Illinois, Mrs. Jones of Ohio, Mr. Green of Texas, Mr. Clyburn, and Mr. Owens):

H.R. 2605. A bill to nullify the effect of section 4 of Executive Order 13279; to the Committee on Education and the Workforce, and in addition to the Committee on Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. THOMPSON of California (for himself, Mr. Stenholm, Mr. Tanner, Mr. Turner of Texas, Mr. Berry, Mr. Bishop of Georgia, Mr. Boyd, Mr. Davis of Tennessee, Mr. Ford, Mr. Holden, Mr. Israel, Mr. John, Mr. Lucas of Kentucky, Mr. Matheson, Mr. McIntyre, Mr. Michaud, Mr. Moore, Mr. Pomeroy, Mr. Scott of Georgia, Mr. Lipinski, Mr. Alexander, and Mr. Cardoza):

H.R. 2606. A bill to amend title XVIII of the Social Security Act to provide prescription drug coverage under the Medicare Program, to make improvements in Medicare payment for rural providers, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HAYES (for himself, Mr. Hayworth, Ms. DeLauro, Ms. Ros-Lehtinen, Mr. Boswell, Mr. Stupak, Mr. Ballance, Mr. Bereuter, Mr. Ortiz, Mr. Deutsch, and Mr. Ryan of Wisconsin):

H. Con. Res. 230. Concurrent resolution honoring the 10 communities selected to receive the 2003 All-America City Award; to the Committee on Government Reform.

MEMORIALS

Under clause 3 of rule XII, memorials were presented and referred as follows:

128. The SPEAKER presented a memorial of the Legislature of the State of Louisiana, relative to House Concurrent Resolution No. 187 memorializing the United States Congress to enact legislation preventing the Federal Communications Commission from reimposing wireless number portability rules until such time as it finds that implementation of the capabilities necessary for emergency communications and homeland security and compliance with the FCC's E-911 mandates are complete; to the Committee on Energy and Commerce.

129. Also, a memorial of the Legislature of the Commonwealth of The Mariana Islands,

relative to House Resolution No. 13-150 memorializing the United States Congress to act favorably and expeditiously on H.R. 1189, affecting the United States insular territories of American Samoa, Guam, the Virgin Islands and the Commonwealth of the Northern Mariana Islands; to the Committee on Resources.

130. Also, a memorial of the Legislature of the State of Montana, relative to Senate Joint Resolution No. 22 memorializing the United States Congress to be urged to take action to stabilize domestic crude oil supplies through facilitating additional production, to decrease our nation's need for foreign oil from undependable sources, to increase federal and state revenue from oil and gas leasing; jointly to the Committees on Resources and Energy and Commerce.

131. Also, a memorial of the Senate of the State of Louisiana, relative to Senate Concurrent Resolution No. 22 memorializing the United States Congress to appropriate for and expedite funding of state and local homeland defense activities; jointly to the Committees on the Judiciary and Transportation and Infrastructure.

132. Also, a memorial of the Senate of the State of Wisconsin, relative to Senate Resolution No. 7, memorializing the United States Congress to urge the Wisconsin congressional delegation to work to enact legislation that would reform the current Medicare system and create a funding method that will dispense equal benefits regardless of geography; jointly to the Committees on Ways and Means and Education and the Workforce.

133. Also, a memorial of the General Assembly of the State of Rhode Island, relative to House Resolution 2003-H 5247 memorializing the Congress of the United States to enact legislation that would permanently eliminate the fifteen percent (15%) reduction in home health Medicare payments implemented October 1, 2002; jointly to the Committees on Ways and Means and Energy and Commerce.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 58: Mr. Andrews, Mr. Fletcher, and Mr. Cummings.

H.R. 97: Mrs. Capito, Mr. Vitter, Mr. Costello, and Mr. Weiner.

H.R. 111: Mr. Fattah.

H.R. 220: Mr. Pearce.

H.R. 227: Mr. McDermott and Mr. Owens.

H.R. 235: Mr. Hastings of Washington, Mr. Crenshaw, Mr. Ryan of Wisconsin, and Mr. Isakson.

H.R. 236: Ms. Harman, Mr. Boucher, and Mr. Ortiz.

H.R. 303: Mr. Price of North Carolina.

H.R. 369: Mr. Ehlers.

H.R. 438: Mr. Jenkins.

H.R. 439: Mr. Owens.

H.R. 528: Mr. McHugh.

H.R. 531: Mr. Weiner.

H.R. 627: Mr. Larson of Connecticut.

H.R. 668: Mr. Owens.

H.R. 687: Mr. Janklow and Mr. Boozman.

H.R. 709: Mrs. Kelly.

H.R. 737: Mr. Davis of Illinois.

H.R. 785: Mr. Michaud.

H.R. 792: Mr. Hill, Mr. Jefferson, Mrs. Napolitano, and Ms. Ros-Lehtinen.

H.R. 817: Mr. Gingrey.

H.R. 832: Mr. Gephardt and Ms. Berkley.

H.R. 852: Mr. Van Hollen, Mr. Sanders, and Mr. Blumenauer.

H.R. 869: Mr. Evans.

H.R. 873: Mrs. Jo Ann Davis of Virginia.

H.R. 898: Mr. Strickland, Mr. Gordon, and Mr. Lantos.

H.R. 996: Mr. Reyes, Mr. Davis of Tennessee, Mr. Ryun of Kansas, Ms. Hart, Mr. Jefferson, Mr. Wilson of South Carolina, Mrs. Blackburn, Mr. Jenkins, and Mr. Larson of Connecticut.

H.R. 1099: Mr. Gutknecht.

H.R. 1125: Mr. Rehberg, Mr. Barrett of South Carolina, and Mr. Weldon of Pennsylvania.

H.R. 1157: Mr. Gilchrest.

H.R. 1167: Mr. Udall of New Mexico, Mr. Moore, and Mr. Carter.

H.R. 1177: Mr. Bishop of Utah, Mr. Platts, and Mr. Owens.

H.R. 1214: Mr. Terry, Mr. Pallone, Mr. Pickering, Mr. Knollenberg, Mr. Grijalva, Mr. Rush, Mr. Markey, and Mr. Clay.

H.R. 1215: Mr. Frost, Mr. Jefferson, Mr. Van Hollen, Mr. Rangel, and Mr. Owens.

H.R. 1216: Mr. Frost, Mr. Skelton, Mr. Case, Mr. Rangel, Mr. Sanders, Mr. Ryan of Ohio, and Mr. Owens.

H.R. 1217: Mr. Case, Mr. Sanders, Mr. Ryan of Ohio, and Mr. Owens.

H.R. 1218: Mr. Duncan, Mr. Evans, Ms. Woolsey, and Mr. Owens.

H.R. 1238: Mr. McDermott.

H.R. 1285: Ms. DeGette.

H.R. 1296: Ms. Watson and Mr. Owens.

H.R. 1310: Mr. Wu, Mr. Sam Johnson of Texas, Mr. Beauprez, and Mr. Boehlert.

H.R. 1323: Mr. Janklow.

H.R. 1377: Mr. Udall of Colorado.

H.R. 1388: Mr. Foley.

H.R. 1411: Mr. Frost, Mr. Rahall, Ms. Corrine Brown of Florida, Mr. Taylor of Mississippi, Mr. Grijalva, Mr. Doyle, Mr. Rangel, and Mr. Owens.

H.R. 1473: Mr. Clyburn.

H.R. 1479: Mr. Simmons and Mr. Houghton.

H.R. 1489: Mr. Lucas of Kentucky and Mr. Shaw.

H.R. 1499: Ms. Berkley and Mrs. Christensen.

H.R. 1516: Mr. Wilson of South Carolina.

H.R. 1551: Mr. Payne, Mr. Pallone, and Mrs. Capps.

H.R. 1568: Mr. Van Hollen.

H.R. 1585: Ms. Hooley of Oregon.

H.R. 1660: Mr. Sensenbrenner.

H.R. 1671: Mr. Nunes.

H.R. 1677: Mr. Lipinski.

H.R. 1693: Mr. Lipinski.

H.R. 1695: Ms. Corrine Brown of Florida, Mr. Cardin, Mr. Frank of Massachusetts, Mr. Hinchey, Ms. Jackson-Lee of Texas, Mr. McGovern, Ms. Millender-McDonald, Mr. Owens, and Ms. Woolsey.

H.R. 1730: Mr. Blumenauer.

H.R. 1751: Mr. Clyburn.

H.R. 1755: Mr. Turner of Ohio.

H.R. 1767: Mr. Carter.

H.R. 1769: Mr. Hunter and Mr. Lipinski.

H.R. 1784: Mr. Issa, Mr. Fletcher, and Ms. Jackson-Lee of Texas.

H.R. 1793: Mr. Barrett of South Carolina and Mrs. Blackburn.

H.R. 1812: Mr. Crowley, Mr. Greenwood, Mr. Bell, Mr. Honda, Ms. DeGette, Mr. Wu, Ms. Solis, Mr. Michaud, and Mr. Price of North Carolina.

H.R. 1813: Mrs. Napolitano, Mr. McNulty, Mr. Lewis of Georgia, Mr. Udall of Colorado, and Ms. Lofgren.

H.R. 1838: Mr. Udall of New Mexico.

H.R. 1871: Ms. Woolsey and Mr. Owens.

H.R. 1873: Mrs. Kelly.

H.R. 1933: Mr. Grijalva and Ms. DeLauro.

H.R. 1964: Mr. Frank of Massachusetts.

H.R. 1991: Mr. Owens.

H.R. 1998: Ms. Baldwin, Ms. DeGette, Mr. Green of Texas, Ms. Eshoo, Mr. Fletcher, Mr. Walsh, and Mr. Costello.

H.R. 2032: Mr. Stupak, Ms. Kaptur, Mr. Sullivan, and Mr. Carson of Oklahoma.

H.R. 2065: Mr. Paul.

H.R. 2081: Mr. Owens.

H.R. 2124: Mr. Owens and Mr. Frost.

H.R. 2127: Mr. Kolbe.

H.R. 2137: Mr. Frost, Mr. Green of Texas, Ms. Ros-Lehtinen, and Mr. Owens.

H.R. 2163: Mr. Evans.

H.R. 2164: Mr. Gutierrez, Ms. Corrine Brown of Florida, Mr. Rodriguez, Mr. Strickland, Mr. Evans, Mr. Filner, and Mr. Udall of New Mexico.

H.R. 2173: Mr. Owens.

H.R. 2174: Mr. Frost.

H.R. 2176: Mrs. Jo Ann Davis of Virginia, Mr. Owens, Mr. Janklow, and Mr. Brown of Ohio.

H.R. 2182: Mr. Bell, Mr. Doyle, Ms. Jackson-Lee of Texas, Mr. Sanders, and Mrs. Christensen.

H.R. 2183: Mr. Wilson of South Carolina, Mr. Owens, Mr. Pickering, and Mr. Clay.

H.R. 2198: Mr. Case.

H.R. 2208: Ms. Pryce of Ohio.

H.R. 2214: Mr. Smith of Texas, Mr. Blumenauer, Mr. Green of Wisconsin, Mr. Foley, Mr. Case, and Mr. McHugh.

H.R. 2216: Mrs. Christensen, Mr. Frost, and Mr. Janklow.

H.R. 2249: Mr. Carson of Oklahoma and Mr. Bereuter.

H.R. 2260: Mr. Walsh, Mr. Latham, Mr. Boyd, Mr. Lampson, Mr. Baker, Mr. Towns, Mr. Platts, Mr. Leach, Mr. Frost, Mr. Burns, Mr. Mollohan, Mr. George Miller of California, Ms. Carson of Indiana, Mr. Green of Texas, Mr. DeLauro, Mr. Hoeffel, Ms. Jackson-Lee of Texas, Mr. Delahunt, Mr. Menendez, Mr. Stupak, Mr. Moran of Virginia, and Mr. Wu.

H.R. 2301: Mr. Owens.

H.R. 2316: Mr. Frost, Mr. LaTourette, Ms. Slaughter, Mr. Frank of Massachusetts, Mr. Owens, and Mr. Lantos.

H.R. 2318: Mr. Platts.

H.R. 2321: Mr. Kildee.

H.R. 2323: Ms. Kilpatrick.

H.R. 2329: Ms. Slaughter and Ms. Jackson-Lee of Texas.

H.R. 2340: Mr. English, Mr. McHugh, Mr. Barrett of South Carolina, and Mr. Paul.

H.R. 2357: Mr. Jones of North Carolina, Ms. Bordallo, Mrs. Blackburn, Mr. Frost, and Mr. Deal of Georgia.

H.R. 2361: Mr. Lewis of Kentucky.

H.R. 2379: Mr. Udall of New Mexico and Mr. Bereuter.

H.R. 2394: Mr. Spratt, Mr. Abercrombie, Mr. Owens, and Mrs. Davis of California.

H.R. 2433: Mr. Miller of Florida and Mr. Ryun of Kansas.

H.R. 2444: Mr. Brown of South Carolina, Mr. Miller of Florida, Mr. Burton of Indiana, and Mr. Hensarling.

H.R. 2455: Mr. Case, Ms. Kaptur, Mr. Stark, Mrs. Maloney, and Mr. Owens.

H.R. 2462: Mr. Wexler, Mr. Price of North Carolina, Mr. McNulty, and Mr. Spratt.

H.R. 2474: Ms. McCarthy of Missouri.

H.R. 2475: Mr. Lewis of Kentucky.

H.R. 2490: Mr. Engel.

H.R. 2497: Mr. Blumenauer.

H.R. 2514: Mr. Stupak.

H.R. 2524: Ms. Carson of Indiana.

H.R. 2532: Mrs. Christensen.

H.R. 2546: Mr. Stark and Mr. Owens.

H.R. 2556: Mr. Beauprez, Mr. Franks of Arizona, Mr. McKeon, Mr. Tiberi, and Mrs. Musgrave.

H.R. 2569: Ms. Pelosi, Mr. Michaud, Mr. Rahall, Mrs. McCarthy of New York, Mr.

TIERNEY, Mr. RYAN of Ohio, Mr. STRICKLAND, Mr. MCNULTY, Mrs. MALONEY, Mr. GRIJALVA, Mr. TURNER of Texas, Mr. SANDLIN, Mr. PALLONE, Mr. HOLDEN, Mr. KIND, Mr. JOHN, Mr. CUMMINGS, Mr. FARR, Mr. WYNN, Ms. WATERS, and Ms. SLAUGHTER.

H.J. Res. 56: Mr. MILLER of Florida and Mr. LEWIS of Kentucky.

H. Con. Res. 30: Mr. WU.

H. Con. Res. 60: Mr. MCINTYRE, Mr. LATOURETTE, Mr. SOUDER, Mr. CHABOT, Mr. WILSON of South Carolina, and Mr. SAXTON.

H. Con. Res. 175: Ms. LINDA T. SÁNCHEZ of California.

H. Con. Res. 212: Mr. CAPUANO.

H. Con. Res. 215: Mr. CONYERS, Mr. KILDEE, Mr. LEVIN, Mr. MCCOTTER, Mrs. MILLER of Michigan, and Mr. UPTON.

H. Res. 137: Mr. DOYLE and Mr. ALLEN.

H. Res. 144: Ms. WATSON, Mr. BELL, Mr. HOLDEN, Mr. WAXMAN, Ms. WOOLSEY, Mr. MCDERMOTT, and Mr. OWENS.

H. Res. 228: Ms. SOLIS.

H. Res. 234: Mr. CROWLEY and Ms. CARSON of Indiana.

H. Res. 254: Mr. KING of New York and Mr. OWENS.

H. Res. 290: Mr. LANTOS, Mr. SMITH of New Jersey, Mr. HOEFFEL, Mr. DOYLE, Mr. GREEN of Wisconsin, Mr. BELL, Ms. LINDA T. SÁNCHEZ of California, Ms. WATSON, Mr. BROWN of Ohio, Mr. SHERMAN, Mr. BERMAN, Mr. ENGEL, Mrs. MCCARTHY of New York, Mr. PAYNE, Ms. LEE, Mr. CROWLEY, Mr. SMITH of Michigan, Mr. MEEKS of New York, Mr. WEXLER, Mr. HASTINGS of Florida, and Mr. BURTON of Indiana.

H. Res. 294: Mr. CROWLEY, Ms. BERKLEY, Mr. CARDOZA, Mr. ROTHMAN, Mr. BERMAN, Mr. ACKERMAN, Mr. RAMSTAD, Mr. DEUTSCH, Ms. SCHAKOWSKY, Mr. BURNS, Mr. SCHIFF, Mr. WEINER, Mr. KENNEDY of Minnesota, Mrs. MCCARTHY of New York, Mr. CARDIN, Mr. WEXLER, and Mr. ENGEL.

AMENDMENTS

Under clause 8 of rule XVIII, proposed amendments were submitted as follows:

H.R. 1

OFFERED BY: MR. KING OF IOWA

AMENDMENT NO. 1: At the end of title VII add the following new section:

SEC. 735. ENCOURAGEMENT OF PROVISION OF HIGH-QUALITY, COST-EFFECTIVE INPATIENT HOSPITAL SERVICES.

(a) PURPOSE.—The purpose under this section is to encourage the provision of high-quality, cost-effective health care to beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) by providing incentive payments to hospitals located in States in which high-quality and cost-effective services are being provided in order to finance further quality improvements.

(b) INTENT.—It is the intent of Congress to provide incentives for States to deliver high quality health care and to create incentives that assures medicare recognizes value in the products and services that the program purchases on behalf of medicare beneficiaries.

(c) MECHANISM.—

(1) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall establish a mechanism under which—

(A) the Secretary provides economic incentives to providers of inpatient hospital services that deliver high-quality health care at low costs in accordance with the methodology established by the Agency for Healthcare Research and Quality under paragraph (2) with a 5 percent add-on bonus payment to providers of inpatient hospital services within the top ten performing States; and

(B) the Secretary necessarily recognizes and includes measurements that factor both the quality of care delivered in a medicare purchasing region or in the event that purchasing regions are not developed, then in a State, to medicare beneficiaries and consumption of resources, including but not limited to labor, technology, capital infrastructure and pharmaceuticals in the delivery of services to medicare beneficiaries under the medicare program under title XVIII of the Social Security Act.

(2) VALUE AND QUALITY RANKING METHODOLOGY.—

(A) IN GENERAL.—The Agency for Healthcare Research and Quality shall establish a value and quality ranking methodology under which the Secretary awards bonus payments to providers of inpatient hospital services located in those States that demonstrate that such providers in the State are providing high value because of the high-quality, cost-effective health care services being provided to medicare beneficiaries.

(B) BASIS.—The methodology established under subparagraph (A) shall be based on the rank and performance on medicare quality indicators published annually in the Journal of the American Medical Association (JAMA) that uses Medicare's current quality of care measures. Cost rankings will be based on the Centers for Medicare and Medicaid Services (CMS) annual report ranking States based on average Medicare spending per recipient for each State.

(d) DEFINITIONS.—In this section:

(1) PROVIDER OF INPATIENT HOSPITAL SERVICES.—The term "provider of inpatient hospital services" means any individual or entity that receives payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for providing an inpatient hospital services (as defined in section 1861(b) of such Act (42 U.S.C. 1395x(b)).

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

H.R. 1

OFFERED BY: MR. SANDERS

AMENDMENT NO. 2: Amend title I to read as follows:

TITLE I—MEDICARE EXTENSION OF DRUGS TO SENIORS (MEDS)

SEC. 101. FINDINGS.

Congress makes the following findings:

(1) Prescription medicine coverage was not a standard part of health insurance when the medicare program under title XVIII of the Social Security Act was enacted in 1965. Since 1965, however, medicine coverage has become a key component of most private and public health insurance coverage, except for the medicare program.

(2) At least ⅔ of medicare beneficiaries have unreliable, inadequate, or no medicine coverage at all.

(3) Seniors who do not have medicine coverage typically pay, at a minimum, 15 percent more than people with coverage.

(4) Medicare beneficiaries at all income levels lack prescription medicine coverage, with more than ½ of such beneficiaries having incomes greater than 150 percent of the poverty line.

(5) The number of private firms offering retiree health coverage is declining.

(6) Medigap premiums for medicines are too expensive for most beneficiaries and are highest for older senior citizens, who need prescription medicine coverage the most and typically have the lowest incomes.

(7) All medicare beneficiaries should have access to a voluntary, reliable, affordable, and defined outpatient medicine benefit as part of the medicare program that assists with the high cost of prescription medicines and protects them against excessive out-of-pocket costs.

SEC. 102. PRESCRIPTION MEDICINE BENEFIT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

"PART D—PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND DISABLED

"ESTABLISHMENT OF PRESCRIPTION MEDICINE BENEFIT PROGRAM FOR THE AGED AND DISABLED

"SEC. 1860. (a) IN GENERAL.—There is established a voluntary insurance program to provide prescription medicine benefits, including pharmacy services, in accordance with the provisions of this part for individuals who are aged or disabled or have end-stage renal disease and who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

"(b) SUNSET FOR EXCESSIVE COSTS.—Notwithstanding any other provision of law, the Secretary shall determine the net amount of expenditures resulting from the enactment of the Medicare Prescription Drug and Modernization Act of 2003 during the period beginning with fiscal year 2004 and ending with fiscal year 2013, including the provisions of this part. If the Secretary determines that such net expenditures during such period (without regard to this subsection) will exceed $400,000,000,000, then the Secretary shall provide for the termination of the program under this part as of such date as will assure that such net expenditures do not exceed $400,000,000,000 during such period.

"SCOPE OF BENEFITS

"SEC. 1860A. (a) IN GENERAL.—The benefits provided to an individual enrolled in the insurance program under this part shall consist of—

"(1) payments made, in accordance with the provisions of this part, for covered prescription medicines (as specified in subsection (b)) dispensed by any pharmacy participating in the program under this part (and, in circumstances designated by the Secretary, by a nonparticipating pharmacy), including any specifically named medicine prescribed for the individual by a qualified health care professional regardless of whether the medicine is included in any formulary established under this part if such medicine is certified as medically necessary by such health care professional (except that the Secretary shall encourage to the maximum extent possible the substitution and use of lower-cost generics), up to the benefit limits specified in section 1860B; and

"(2) charging by pharmacies of the negotiated price—

"(A) for all covered prescription medicines, without regard to such benefit limit; and

"(B) established with respect to any drugs or classes of drugs described in subparagraphs (A), (B), (D), (E), or (F) of section 1927(d)(2) that are available to individuals receiving benefits under this title.

"(b) COVERED PRESCRIPTION MEDICINES.—

"(1) IN GENERAL.—Covered prescription medicines, for purposes of this part, include all prescription medicines (as defined in section 1860K(1)), including smoking cessation agents, except as otherwise provided in this subsection.

"(2) EXCLUSIONS FROM COVERAGE.—Covered prescription medicines shall not include drugs or classes of drugs described in subparagraphs (A) through (D) and (F) through (H) of section 1927(d)(2) unless—

"(A) specifically provided otherwise by the Secretary with respect to a drug in any of such classes; or

"(B) a drug in any of such classes is certified to be medically necessary by a health care professional.

"(3) EXCLUSION OF PRESCRIPTION MEDICINES TO THE EXTENT COVERED UNDER PART A OR B.—A medicine prescribed for an individual that would otherwise be a covered prescription medicine under this part shall not be so considered to the extent that payment for such medicine is available under part A or B, including all injectable drugs and biologicals for which payment was made or should have been made by a carrier under section 1861(s)(2) (A) or (B) as of the date of enactment of the Medicare Extension of Drugs to Seniors (MEDS) Act of 2003. Medicines otherwise covered under part A or B shall be covered under this part to the extent that benefits under part A or B are exhausted.

"(4) STUDY ON INCLUSION OF HOME INFUSION THERAPY SERVICES.—Not later than one year after the date of the enactment of the Medicare Extension of Drugs to Seniors (MEDS) Act of 2003, the Secretary shall submit to Congress a legislative proposal for the delivery of home infusion therapy services under this title and for a system of payment for such a benefit that coordinates items and services furnished under part B and under this part.

"PAYMENT OF BENEFITS; BENEFIT LIMITS

"SEC. 1860B. (a) PAYMENT OF BENEFITS.—

"(1) IN GENERAL.—There shall be paid from the Prescription Medicine Insurance Account within the Supplementary Medical Insurance Trust Fund, in the case of each individual who is enrolled in the insurance program under this part and who purchases covered prescription medicines in a calendar year—

"(A) with respect to costs incurred for covered prescription medicine furnished during a year, before the individual has incurred out-of-pocket expenses under this subsection equal to the catastrophic out-of-pocket limit specified in subsection (b), an amount equal to the applicable percentage (specified in paragraph (2)) of the negotiated price for each such covered prescription medicine or such higher percentage as is proposed under section 1860G(b)(7); and

"(B) with respect to costs incurred for covered prescription medicine furnished during a year, after the individual has incurred out-of-pocket expenses under this subsection equal to the catastrophic out-of-pocket limit specified in subsection (b), an amount equal to 100 percent of the negotiated price for each such covered prescription medicine.

"(2) APPLICABLE PERCENTAGE.—The applicable percentage specified in this paragraph is 80 percent or such higher percentage as is proposed under section 1860G(b)(7), if the Secretary finds that such higher percentage will not increase aggregate costs to the Prescription Medicine Insurance Account.

"(b) CATASTROPHIC LIMIT ON OUT-OF-POCKET EXPENSES.—

"(1) IN GENERAL.—The catastrophic limit on out-of-pocket expenses specified in this subsection for—

"(A) for each of calendar years 2005 and 2006, $2,000; and

"(B) subject to paragraph (2), for calendar year 2007 and each subsequent calendar year is equal the limit for the preceding year under this paragraph adjusted by the sustainable growth rate percentage (determined under section 1861I(b)) for the year involved.

"(2) ROUNDING.—Any amount determined under paragraph (1)(E) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"ELIGIBILITY AND ENROLLMENT

"SEC. 1860C. (a) ELIGIBILITY.—Every individual who, in or after 2005, is entitled to hospital insurance benefits under part A or enrolled in the medical insurance program under part B is eligible to enroll, in accordance with the provisions of this section, in the insurance program under this part, during an enrollment period prescribed in or under this section, in such manner and form as may be prescribed by regulations.

"(b) ENROLLMENT.—

"(1) IN GENERAL.—Each individual who satisfies subsection (a) shall be enrolled (or eligible to enroll) in the program under this part in accordance with the provisions of section 1837, as if that section applied to this part, except as otherwise explicitly provided in this part.

"(2) SINGLE ENROLLMENT PERIOD.—Except as provided in section 1837(i) (as such section applies to this part), 1860E, or 1860H(e), or as otherwise explicitly provided, no individual shall be entitled to enroll in the program under this part at any time after the initial enrollment period without penalty, and in the case of all other late enrollments, the Secretary shall develop a late enrollment penalty for the individual that fully recovers the additional actuarial risk involved providing coverage for the individual.

"(3) SPECIAL ENROLLMENT PERIOD FOR 2005.—

"(A) IN GENERAL.—An individual who first satisfies subsection (a) in 2005 may, at any time on or before December 31, 2005—

"(i) enroll in the program under this part; and

"(ii) enroll or reenroll in such program after having previously declined or terminated enrollment in such program.

"(B) EFFECTIVE DATE OF COVERAGE.—An individual who enrolls under the program under this part pursuant to subparagraph (A) shall be entitled to benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

"(c) PERIOD OF COVERAGE.—

"(1) IN GENERAL.—Except as otherwise provided in this part, an individual's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

"(2) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—In addition to the causes of termination specified in section 1838, an individual's coverage under this part shall be terminated when the individual retains coverage under neither the program under part A nor the program under part B, effective on the effective date of termination of coverage under part A or (if later) under part B.

"PREMIUMS

"SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF MONTHLY PREMIUM RATES.—

"(1) IN GENERAL.—The Secretary shall, during September of 2004 and of each succeeding year, determine and promulgate a monthly premium rate for the succeeding year in accordance with the provisions of this subsection.

"(2) INITIAL PREMIUMS.—For months in 2005, the monthly premium rate under this subsection shall be—

"(A) $24, in the case of premiums paid by an individual enrolled in the program under this part; and

"(B) $32, in the case of premiums paid for such an individual by a former employer (as defined in section 1860H(f)(2)).

"(3) SUBSEQUENT YEARS.—

"(A) IN GENERAL.—For months in a year after 2005, the monthly premium under this subsection shall be (subject to subparagraph (B)) the monthly premium (computed under this subsection without regard to subparagraph (B)) for the previous year increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient medicines in the United States for medicare beneficiaries, as estimated and published by the Secretary in September before the year and for the year involved.

"(B) ROUNDING.—The monthly premium determined under subparagraph (A) shall be rounded to the nearest multiple of 10 cents if it is not a multiple of 10 cents.

"(C) PUBLICATION OF ASSUMPTIONS.—The Secretary shall publish, together with the promulgation of the monthly premium rates under this paragraph, a statement setting forth the actuarial assumptions and bases employed in arriving at the monthly premium under subparagraph (A).

"(b) PAYMENT OF PREMIUMS.—

"(1) PAYMENTS BY DEDUCTION FROM SOCIAL SECURITY, RAILROAD RETIREMENT BENEFITS, OR BENEFITS ADMINISTERED BY OPM.—

"(A) DEDUCTION FROM BENEFITS.—In the case of an individual who is entitled to or receiving benefits as described in subsection (a), (b), or (d) of section 1840, premiums payable under this part shall be collected by deduction from such benefits at the same time and in the same manner as premiums payable under part B are collected pursuant to section 1840.

"(B) TRANSFERS TO PRESCRIPTION MEDICINE INSURANCE ACCOUNT.—The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer premiums collected pursuant to subparagraph (A) to the Prescription Medicine Insurance Account from the appropriate funds and accounts described in subsections (a)(2), (b)(2), and (d)(2) of section 1840, on the basis of the certifications described in such subsections. The amounts of such transfers shall be appropriately adjusted to the extent that prior transfers were too great or too small.

"(2) DIRECT PAYMENTS TO SECRETARY.—

"(A) ADDITIONAL PAYMENT BY ENROLLEE.—An individual to whom paragraph (1) applies (other than an individual receiving benefits as described in section 1840(d)) and who estimates that the amount that will be available for deduction under such paragraph for any premium payment period will be less than the amount of the monthly premiums for such period may (under regulations) pay to the Secretary the estimated balance, or such greater portion of the monthly premium as the individual chooses.

"(B) PAYMENTS BY OTHER ENROLLEES.—An individual enrolled in the insurance program under this part with respect to whom none of the preceding provisions of this subsection applies (or to whom section 1840(c) applies) shall pay premiums to the Secretary at such times and in such manner as the Secretary shall by regulations prescribe.

‘‘(C) Deposit of premiums.—Amounts paid to the Secretary under this paragraph shall be deposited in the Treasury to the credit of the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund.

‘‘(c) Certain Low-Income Individuals.—For rules concerning premiums for certain low-income individuals, see section 1860E.

‘‘SPECIAL ELIGIBILITY, ENROLLMENT, AND CO-PAYMENT RULES FOR LOW-INCOME INDIVIDUALS

‘‘Sec. 1860E. (a) State Agreements for Coverage.—

‘‘(1) In general.—The Secretary shall, at the request of a State, enter into an agreement with the State under which all individuals described in paragraph (2) are enrolled in the program under this part, without regard to whether any such individual has previously declined the opportunity to enroll in such program.

‘‘(2) Eligibility groups.—The individuals described in this paragraph, for purposes of paragraph (1), are individuals who satisfy section 1860C(a) and who are—

‘‘(A)(i) eligible individuals within the meaning of section 1843; and

‘‘(ii) in a coverage group or groups permitted under section 1843 (as selected by the State and specified in the agreement); or

‘‘(B) qualified medicare medicine beneficiaries (as defined in subsection (e)(1)).

‘‘(3) Coverage period.—The period of coverage under this part of an individual enrolled under an agreement under this subsection shall be as follows:

‘‘(A) Individuals eligible (at state option) for part B buy-in.—In the case of an individual described in subsection (a)(2)(A), the coverage period shall be the same period that applies (or would apply) pursuant to section 1843(d).

‘‘(B) Qualified medicare medicine beneficiaries.—In the case of an individual described in subsection (a)(2)(B)—

‘‘(i) the coverage period shall begin on the latest of—

‘‘(I) January 1, 2005;

‘‘(II) the first day of the third month following the month in which the State agreement is entered into; or

‘‘(III) the first day of the first month following the month in which the individual satisfies section 1860C(a); and

‘‘(ii) the coverage period shall end on the last day of the month in which the individual is determined by the State to have become ineligible for medicare medicine cost-sharing.

‘‘(4) Alternative enrollment methods.—In the process of enrolling low-income individuals under this part, the Secretary shall use the system provided under section 154 of the Social Security Act Amendments of 1994 for newly eligible medicare beneficiaries and shall apply a similar system for other medicare beneficiaries. Such system shall use existing Federal government databases to identify eligibility. Such system shall not require that beneficiaries apply for, or enroll through, State medicaid systems in order to obtain low-income assistance described in this section.

‘‘(b) Special Part D Enrollment Opportunity for Individuals Losing Medicaid Eligibility.—In the case of an individual who—

‘‘(1) satisfies section 1860C(a); and

‘‘(2) loses eligibility for benefits under the State plan under title XIX after having been enrolled under such plan or having been determined eligible for such benefits;

the Secretary shall provide an opportunity for enrollment under the program under this part during the period that begins on the date that such individual loses such eligibility and ends on the date specified by the Secretary.

‘‘(c) State Option to Buy-In Dually Eligible Individuals.—

‘‘(1) Coverage of premiums as medical assistance.—For purposes of applying the second sentence of section 1905(a), any reference to premiums under part B shall be considered to include a reference to premiums under this part.

‘‘(2) State commitment to continue participation in part D after benefit limit reached.—As a condition of additional funding to a State under subsection (d), the State, in its State plan under title XIX, shall provide that in the case of any individual whose eligibility for medical assistance under title XIX is not limited to medicare cost-sharing and for whom the State elects to pay premiums under this part pursuant to this section, the State will purchase all prescription medicines for such individual in accordance with the provisions of this part without regard to whether the benefit limit for such individual under section 1860B(b) has been reached.

‘‘(3) Medicare cost-sharing required for qualified medicare beneficiaries.—In applying title XIX, the term ‘medicare cost-sharing’ (as defined in section 1905(p)(3)) is deemed to include—

‘‘(A) premiums under section 1860D; and

‘‘(B) the difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to ‘80 percent’ in subsection (a)(2) of such section were deemed a reference to ‘100 percent’ (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).

‘‘(d) Payment to States for Coverage of Certain Medicare Cost-sharing.—

‘‘(1) In general.—The Secretary shall provide for payment under this subsection to each State that provides for—

‘‘(A) medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan; and

‘‘(B) medicare medicine cost-sharing (as defined in subsection (e)(2)) for qualified medicare medicine beneficiaries described in subsection (e)(1).

‘‘(2) Amount of payment.—The amount of payment under paragraph (1) shall equal 100 percent of the cost-sharing described in such paragraph, except that, in the case of an individual whose eligibility for medical assistance under title XIX is not limited to medicare cost-sharing or medicare medicine cost-sharing, the amount of payment under paragraph (1)(B) shall be equal to the Federal medical assistance percentage described in section 1905(b)) of amounts as expended for such cost-sharing.

‘‘(3) Method of payment; relation to other payments.—Amounts shall be paid to States under this subsection in a manner similar to that provided under section 1903(d). Payments under this subsection shall be made in lieu of any payments that otherwise may be made for medical assistance provided under section 1902(a)(10)(E)(iv).

‘‘(4) Treatment of territories.—

‘‘(A) In general.—Subject to subparagraph (B), this subsection shall not apply to States other than the 50 States and the District of Columbia.

‘‘(B) Payments.—In the case of a State (other than the 50 States and the District of Columbia) that develops and implements a plan of assistance for pharmaceuticals provided to low-income medicare beneficiaries, the Secretary shall provide for payment to the State in an amount that is reasonable in relation to the payment levels provided to other States under paragraph (2).

‘‘(e) Definitions; Special Rules.—For purposes of this section:

‘‘(1) Qualified medicare medicine beneficiary.—The term ‘qualified medicare medicine beneficiary’ means an individual—

‘‘(A) who is entitled to hospital insurance benefits under part A (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A);

‘‘(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in section 1905(p)(2)(D)) is above 100 percent but below 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

‘‘(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

‘‘(2) Medicare medicine cost-sharing.—The term ‘medicare medicine cost-sharing’ means the following costs incurred with respect to a qualified medicare medicine beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under a State plan under title XIX:

‘‘(A) In the case of a qualified medicare medicine beneficiary whose income (as determined under paragraph (1)) is less than 135 percent of the official poverty line—

‘‘(i) premiums under section 1860D; and

‘‘(ii) the difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to ‘50 percent’ therein were deemed a reference to ‘100 percent’ (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).

‘‘(B) In the case of a qualified medicare medicine beneficiary whose income (as determined under paragraph (1)) is at least 135 percent but less than 150 percent of the official poverty line, a percentage of premiums under section 1860D, determined on a linear sliding scale ranging from 100 percent for individuals with incomes at 135 percent of such line to 0 percent for individuals with incomes at 150 percent of such line.

‘‘(3) State.—The term ‘State’ has the meaning given such term under section 1101(a) for purposes of title XIX.

‘‘(4) Treatment of drugs purchased.—The provisions of section 1927 shall not apply to prescription drugs purchased under this part pursuant to an agreement with the Secretary under this section (including any drugs so purchased after the limit under section 1860B(b) has been exceeded).

"PRESCRIPTION MEDICINE INSURANCE ACCOUNT

"SEC. 1860F. (a) ESTABLISHMENT.—There is created within the Federal Supplemental Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Medicine Insurance Account' (in this section referred to as the 'Account').

"(b) AMOUNTS IN ACCOUNT.—

"(1) IN GENERAL.—The Account shall consist of—

"(A) such amounts as may be deposited in, or appropriated to, such fund as provided in this part; and

"(B) such gifts and bequests as may be made as provided in section 201(i)(1).

"(2) SEPARATION OF FUNDS.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplemental Medical Insurance Trust Fund.

"(c) PAYMENTS FROM ACCOUNT.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g).

"ADMINISTRATION OF BENEFITS

"SEC. 1860G. (a) THROUGH CMS.—The Secretary shall provide for administration of the benefits under this part through the Centers for Medicare & Medicaid Services in accordance with the provisions of this section. The Administrator of such Centers may enter into contracts with carriers to administer this part in the same manner as the Administrator enters into such contracts to administer part B. Any such contract shall be separate from any contract under section 1842.

"(b) ADMINISTRATION FUNCTIONS.—In carrying out this part, the Administrator (or a carrier under a contract with the Administrator) shall (or in the case of the function described in paragraph (9), may) perform the following functions:

"(1) PARTICIPATION AGREEMENTS, PRICES, AND FEES.—

"(A) NEGOTIATED PRICES.—Establish, through negotiations with medicine manufacturers and wholesalers and pharmacies, a schedule of prices for covered prescription medicines.

"(B) AGREEMENTS WITH PHARMACIES.—Enter into participation agreements under subsection (c) with pharmacies, that include terms that—

"(i) secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access);

"(ii) permit the participation of any pharmacy in the service area that meets the participation requirements described in subsection (c); and

"(iii) allow for reasonable dispensing and consultation fees for pharmacies.

"(C) LISTS OF PRICES AND PARTICIPATING PHARMACIES.—Ensure that the negotiated prices established under subparagraph (A) and the list of pharmacies with agreements under subsection (c) are regularly updated and readily available to health care professionals authorized to prescribe medicines, participating pharmacies, and enrolled individuals.

"(2) TRACKING OF COVERED ENROLLED INDIVIDUALS.—Maintain accurate, updated records of all enrolled individuals (other than individuals enrolled in a plan under part C).

"(3) PAYMENT AND COORDINATION OF BENEFITS.—

"(A) PAYMENT.—

"(i) Administer claims for payment of benefits under this part and encourage, to the maximum extent possible, use of electronic means for the submissions of claims.

"(ii) Determine amounts of benefit payments to be made.

"(iii) Receive, disburse, and account for funds used in making such payments, including through the activities specified in the provisions of this paragraph.

"(B) COORDINATION.—Coordinate with other private benefit providers, pharmacies, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals, including coordination of access to and payment for covered prescription medicines according to an individual's in-service area plan provisions, when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

"(C) EXPLANATION OF BENEFITS.—Furnish to enrolled individuals an explanation of benefits in accordance with section 1806(a), and a notice of the balance of benefits remaining for the current year, whenever prescription medicine benefits are provided under this part (except that such notice need not be provided more often than monthly).

"(4) RULES RELATING TO PROVISION OF BENEFITS.—

"(A) IN GENERAL.—In providing benefits under this part, the Secretary (directly or through contracts) shall employ mechanisms to provide benefits economically, including the use of—

"(i) formularies (consistent with subparagraph (B));

"(ii) automatic generic medicine substitution (unless the physician specifies otherwise, in which case a 30-day prescription may be dispensed pending a consultation with the physician on whether a generic substitute can be dispensed in the future);

"(iii) tiered copayments (which may include copayments at a rate lower than 20 percent) to encourage the use of the lowest cost, on-formulary product in cases where there is no restrictive prescription (described in subparagraph (D)(i)); and

"(iv) therapeutic interchange.

"(B) REQUIREMENTS WITH RESPECT TO FORMULARIES.—If a formulary is used to contain costs under this part—

"(i) use an advisory committee (or a therapeutics committee) comprised of licensed practicing physicians, pharmacists, and other health care practitioners to develop and manage the formulary;

"(ii) include in the formulary at least 1 medicine from each therapeutic class and, if available, a generic equivalent thereof; and

"(iii) disclose to current and prospective enrollees and to participating providers and pharmacies, the nature of the formulary restrictions, including information regarding the medicines included in the formulary and any difference in cost-sharing amounts.

"(C) CONSTRUCTION.—Nothing in this subsection shall be construed to prevent the Secretary (directly or through contracts) from using incentives (including a lower beneficiary coinsurance) to encourage enrollees to select generic or other cost-effective medicines, so long as—

"(i) such incentives are designed not to result in any increase in the aggregate expenditures under the Federal Medicare Prescription Medicine Trust Fund;

"(ii) the average coinsurance charged to all beneficiaries by the Secretary (directly or through contractors) shall seek to approximate (but in no case exceed) 20 percent for on-formulary medicines;

"(iii) a beneficiary's coinsurance shall be no greater than 20 percent if the prescription is a restrictive prescription; and

"(iv) the reimbursement for a prescribed nonformulary medicine without a restrictive prescription in no case shall be more than the lowest reimbursement for a formulary medicine in the therapeutic class of the prescribed medicine.

"(D) RESTRICTIVE PRESCRIPTION.—For purposes of this section:

"(i) WRITTEN PRESCRIPTIONS.—In the case of a written prescription for a medicine, it is a restrictive prescription only if the prescription indicates, in the writing of the physician or other qualified person prescribing the medicine and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that a particular medicine product must be dispensed based upon a belief by the physician or person prescribing the medicine that the particular medicine will provide even marginally superior therapeutic benefits to the individual for whom the medicine is prescribed or would have marginally fewer adverse reactions with respect to such individual.

"(ii) TELEPHONE PRESCRIPTIONS.—In the case of a prescription issued by telephone for a medicine, it is a restrictive prescription only if the prescription cannot be longer than 30 days and the physician or other qualified person prescribing the medicine (through use of such an appropriate phrase) states that a particular medicine product must be dispensed, and the physician or other qualified person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation from the physician or other qualified person prescribing the medicine and which indicates with such appropriate phrase that the particular medicine product was required to have been dispensed based upon a belief by the physician or person prescribing the medicine that the particular medicine will provide even marginally superior therapeutic benefits to the individual for whom the medicine is prescribed or would have marginally fewer adverse reactions with respect to such individual. Such written confirmation is required to refill the prescription.

"(iii) REVIEW OF RESTRICTIVE PRESCRIPTIONS.—The advisory committee (established under subparagraph (B)(i)) may decide to review a restrictive prescription and, if so, it may approve or disapprove such restrictive prescription. It may not disapprove such restrictive prescription unless it finds that there is no literature approved by the Food and Drug Administration that supports a determination that the particular medicine provides even marginally superior therapeutic benefits to the individual for whom the medicine is prescribed or would have marginally fewer adverse reactions with respect to such individual. If it disapproves, upon request of the prescribing physician or the enrollee, the committee must provide for a review by an independent contractor of such decision within 48 hours of the time of submission of the prescription, to determine whether the prescription is an eligible benefit under this part. The Secretary shall ensure that independent contractors so used are completely independent of the contractor or its advisory committee.

"(5) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—Have in place effective cost and utilization management, drug utilization review, quality assurance measures, and systems to reduce medical errors, including at least the following, together with such additional measures as the Administrator may specify:

“(A) Drug utilization review.—A drug utilization review program conforming to the standards provided in section 1927(g)(2) (with such modifications as the Administrator finds appropriate).

“(B) Fraud and abuse control.—Activities to control fraud, abuse, and waste, including prevention of diversion of pharmaceuticals to the illegal market.

“(C) Medication therapy management.—

“(i) In general.—A program of medicine therapy management and medication administration that is designed to assure that covered outpatient medicines are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

“(ii) Elements.—Such program may include—

“(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means; and

“(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means.

“(iii) Development of program in cooperation with licensed pharmacists.—The program shall be developed in cooperation with licensed pharmacists and physicians.

“(iv) Considerations in pharmacy fees.—There shall be taken into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

“(6) Education and information activities.—Have in place mechanisms for disseminating educational and informational materials to enrolled individuals and health care providers designed to encourage effective and cost-effective use of prescription medicine benefits and to ensure that enrolled individuals understand their rights and obligations under the program.

“(7) Beneficiary protections.—

“(A) Confidentiality of health information.—Have in effect systems to safeguard the confidentiality of health care information on enrolled individuals, which comply with section 1106 and with section 552a of title 5, United States Code, and meet such additional standards as the Administrator may prescribe.

“(B) Grievance and appeal procedures.—Have in place such procedures as the Administrator may specify for hearing and resolving grievances and appeals, including expedited appeals, brought by enrolled individuals against the Administrator or a pharmacy concerning benefits under this part, which shall include procedures equivalent to those specified in subsections (f) and (g) of section 1852.

“(8) Records, reports, and audits.—

“(A) Records and audits.—Maintain adequate records, and afford the Administrator access to such records (including for audit purposes).

“(B) Reports.—Make such reports and submissions of financial and utilization data as the Administrator may require taking into account standard commercial practices.

“(9) Proposal for alternative coinsurance amount.—

“(A) Submission.—The Administrator may provide for increased Government cost-sharing for generic prescription medicines, prescription medicines on a formulary, or prescription medicines obtained through mail order pharmacies.

“(B) Contents.—The proposal submitted under subparagraph (A) shall contain evidence that such increased cost-sharing would not result in an increase in aggregate costs to the Account, including an analysis of differences in projected drug utilization patterns by beneficiaries whose cost-sharing would be reduced under the proposal and those making the cost-sharing payments that would otherwise apply.

“(10) Other requirements.—Meet such other requirements as the Secretary may specify.

The Administrator shall negotiate a schedule of prices under paragraph (1)(A), except that nothing in this sentence shall prevent a carrier under a contract with the Administrator from negotiating a lower schedule of prices for covered prescription medicines.

“(c) Pharmacy Participation Agreements.—

“(1) In general.—A pharmacy that meets the requirements of this subsection shall be eligible to enter an agreement with the Administrator to furnish covered prescription medicines and pharmacists' services to enrolled individuals.

“(2) Terms of agreement.—An agreement under this subsection shall include the following terms and requirements:

“(A) Licensing.—The pharmacy and pharmacists shall meet (and throughout the contract period will continue to meet) all applicable State and local licensing requirements.

“(B) Limitation on charges.—Pharmacies participating under this part shall not charge an enrolled individual more than the negotiated price for an individual medicine as established under subsection (b)(1), regardless of whether such individual has attained the benefit limit under section 1860B(b), and shall not charge an enrolled individual more than the individual's share of the negotiated price as determined under the provisions of this part.

“(C) Performance standards.—The pharmacy and the pharmacist shall comply with performance standards relating to—

“(i) measures for quality assurance, reduction of medical errors, and participation in the drug utilization review program described in subsection (b)(3)(A);

“(ii) systems to ensure compliance with the confidentiality standards applicable under subsection (b)(5)(A); and

“(iii) other requirements as the Secretary may impose to ensure integrity, efficiency, and the quality of the program.

“(D) Disclosure of price of generic medicine.—A pharmacy participating under this part shall inform an enrollee of the difference in price between generic and non-generic equivalents.

“(d) Special Attention to Rural and Hard-To-Serve Areas.—

“(1) In general.—The Secretary shall ensure that all beneficiaries have access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas (as the Secretary may define by regulation).

“(2) Special attention defined.—For purposes of paragraph (1), the term ‘special attention’ may include bonus payments to retail pharmacists in rural areas and any other actions the Secretary determines are necessary to ensure full access to rural and hard-to-serve beneficiaries.

“(3) GAO report.—Not later than 2 years after the implementation of this part the Comptroller General of the United States shall submit to Congress a report on the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in rural and hard-to-serve areas under this part together with any recommendations of the Comptroller General regarding any additional steps the Secretary may need to take to ensure the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in such areas under this part.

“(e) Incentives for Cost and Utilization Management and Quality Improvement.—The Secretary is authorized to include in a contract awarded under subsection (b) with a carrier such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate, including—

“(1) bonus and penalty incentives to encourage administrative efficiency;

“(2) incentives under which carriers share in any benefit savings achieved;

“(3) risk-sharing arrangements related to initiatives to encourage savings in benefit payments;

“(4) financial incentives under which savings derived from the substitution of generic medicines in lieu of non-generic medicines are made available to carriers, pharmacies, and the Prescription Medicine Insurance Account; and

“(5) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization.

“EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE MEDICINE COVERAGE

“Sec. 1860H. (a) Program Authority.—The Secretary shall develop and implement a program under this section called the ‘Employer Incentive Program’ that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription medicine benefits to retired individuals and to maintain such existing benefit programs, by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

“(b) Sponsor Requirements.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription medicine plan (as defined in subsection (f)(3)), a sponsor shall meet the following requirements:

“(1) Assurances.—The sponsor shall—

“(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription medicine plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

“(B) guarantee that it will give notice to the Secretary and covered retirees—

“(i) at least 120 days before terminating its plan; and

“(ii) immediately upon determining that the actuarial value of the prescription medicine benefit under the plan falls below the actuarial value of the insurance benefit under this part.

“(2) Other requirements.—The sponsor shall provide such information, and comply with such requirements, including information requirements to ensure the integrity of the program, as the Secretary may find necessary to administer the program under this section.

“(c) Incentive Payment.—

“(1) In general.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall have payment made by the Secretary on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined as described in paragraph (2), for each retired individual (or spouse) who—

“(A) was covered under the sponsor's qualified retiree prescription medicine plan during such quarter; and

“(B) was eligible for but was not enrolled in the insurance program under this part.

“(2) Amount of incentive.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to ⅔ of the monthly premium amount payable from the Prescription Medicine Insurance Account for an enrolled individual, as set for the calendar year pursuant to section 1860D(a)(2).

“(3) Payment date.—The incentive under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

“(d) Civil Money Penalties.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount equal to $2,000 for each false representation plus an amount not to exceed 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

“(e) Part D Enrollment for Certain Individuals Covered by Employment-Based Retiree Health Coverage Plans.—

“(1) Eligible individuals.—An individual shall be given the opportunity to enroll in the program under this part during the period specified in paragraph (2) if—

“(A) the individual declined enrollment in the program under this part at the time the individual first satisfied section 1860C(a);

“(B) at that time, the individual was covered under a qualified retiree prescription medicine plan for which an incentive payment was paid under this section; and

“(C)(i) the sponsor subsequently ceased to offer such plan; or

“(ii) the value of prescription medicine coverage under such plan is reduced below the value of the coverage provided at the time the individual first became eligible to participate in the program under this part.

“(2) Special enrollment period.—An individual described in paragraph (1) shall be eligible to enroll in the program under this part during the 6-month period beginning on the first day of the month in which—

“(A) the individual receives a notice that coverage under such plan has terminated (in the circumstance described in paragraph (1)(C)(i)) or notice that a claim has been denied because of such a termination; or

“(B) the individual received notice of the change in benefits (in the circumstance described in paragraph (1)(C)(ii)).

“(f) Definitions.—In this section:

“(1) Employment-based retiree health coverage.—The term ‘employment-based retiree health coverage’ means health insurance or other coverage of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

“(2) Employer.—The term ‘employer’ has the meaning given to such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

“(3) Qualified retiree prescription medicine plan.—The term ‘qualified retiree prescription medicine plan’ means health insurance coverage included in employment-based retiree health coverage that—

“(A) provides coverage of the cost of prescription medicines whose actuarial value to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the program under this part; and

“(B) does not deny, limit, or condition the coverage or provision of prescription medicine benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

“(4) Sponsor.—The term ‘sponsor’ has the meaning given the term ‘plan sponsor’ by section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

“PROMOTION OF PHARMACEUTICAL RESEARCH ON BREAK-THROUGH MEDICINES WHILE PROVIDING PROGRAM COST CONTAINMENT

“Sec. 1860I. (a) Monitoring Expenditures.—The Secretary shall monitor expenditures under this part. On October 1, 2005, Secretary shall estimate total expenditures under this part for 2005.

“(b) Establishment of Sustainable Growth Rate.—

“(1) In general.—The Secretary shall establish a sustainable growth rate prescription medicine target system for expenditures under this part for each year after 2005.

“(2) Initial computation.—Such target shall equal the amount of total expenditures estimated for 2005 adjusted by the Secretary's estimate of a sustainable growth rate (in this section referred to as an ‘SGR’) percentage between 2005 and 2006. Such SGR shall be estimated based on the following:

“(A) Reasonable changes in the cost of production or price of covered pharmaceuticals, but in no event more than the rate of increase in the consumer price index for all urban consumers for the period involved.

“(B) Population enrolled in this part, both in numbers and in average age and severity of chronic and acute illnesses.

“(C) Appropriate changes in utilization of pharmaceuticals, as determined by the Drug Review Board (established under subsection (c)(3)) and based on best estimates of utilization change if there were no direct-to-consumer advertising or promotions to providers.

“(D) Productivity index of manufacturers and distributors.

“(E) Percentage of products with patent and market exclusivity protection versus products without patent protection and changes in the availability of generic substitutes.

“(F) Such other factors as the Secretary may determine are appropriate.

In no event may the sustainable growth rate exceed 120 percent of the estimated per capita growth in total spending under this title.

“(3) Computation for subsequent years.—In October of 2006 and each year thereafter, for purposes of setting the SGRs for the succeeding year, the Secretary shall adjust each current year's estimated expenditures by the estimated SGR for the succeeding year, further adjusted for corrections in earlier estimates and the receipt of additional data on previous years spending as follows:

“(A) Error estimates.—An adjustment (up or down) for errors in the estimate of total expenditures under this part for the previous year.

“(B) Costs.—An adjustment (up or down) for corrections in the cost of production of prescriptions covered under this part between the current calendar year and the previous year.

“(C) Target.—An adjustment for any amount (over or under) that expenditures in the current year under this part are estimated to differ from the target amount set for the year. If expenditures in the current year are estimated to be—

“(i) less than the target amount, future target amounts will be adjusted downward; or

“(ii) more than the target amount, the Secretary shall notify all pharmaceutical manufacturers with sales of pharmaceutical prescription medicine products to medicare beneficiaries under this part, of a rebate requirement (except as provided in this subparagraph) to be deposited in the Federal Medicare Prescription Medicine Trust Fund.

“(D) Rebate determination.—The amount of the rebate described in subparagraph (C)(ii) may vary among manufacturers and shall be based on the manufacturer's estimated contribution to the expenditure above the target amount, taking into consideration such factors as—

“(i) above average increases in the cost of the manufacturer's product;

“(ii) increases in utilization due to promotion activities of the manufacturer, wholesaler, or retailer;

“(iii) launch prices of new drugs at the same or higher prices as similar drugs already in the marketplace (so-called ‘me too’ or ‘copy-cat’ drugs);

“(iv) the role of the manufacturer in delaying the entry of generic products into the market; and

“(v) such other actions by the manufacturer that the Secretary may determine has contributed to the failure to meet the SGR target.

The rebates shall be established under such subparagraph so that the total amount of the rebates is estimated to ensure that the amount the target for the current year is estimated to be exceeded is recovered in lower spending in the subsequent year; except that, no rebate shall be made in any manufacturer's product which the Food and Drug Administration has determined is a breakthrough medicine (as determined under subsection (c)) or an orphan medicine.

“(c) Breakthrough Medicines.—

“(1) Determination.—For purposes of this section, a medicine is a ‘breakthrough medicine’ if the Drug Review Board (established under paragraph (3)) determines—

“(A) it is a new product that will make a significant and major improvement by reducing physical or mental illness, reducing mortality, or reducing disability; and

“(B) that no other product is available to beneficiaries that achieves similar results for the same condition at a lower cost.

“(2) Condition.—An exemption from rebates under subsection (b)(3) for a breakthrough medicine shall continue as long as the medicine is certified as a breakthrough medicine but shall be limited to 7 calendar years from 2003 or 7 calendar years from the date of the initial determination under paragraph (1), whichever is later.

“(3) Drug review board.—The Drug Review Board under this paragraph shall consist of the Commissioner of Food and Drugs, the Directors of the National Institutes of Health, the Director of the National Science

Foundation, and 10 experts in pharmaceuticals, medical research, and clinical care, selected by the Commissioner of Food and Drugs from the faculty of academic medical centers, except that no person who has (or who has an immediate family member that has) any conflict of interest with any pharmaceutical manufacturer shall serve on the Board.

"(d) No Review.—The Secretary's determination of the rebate amounts under this section, and the Drug Review Board's determination of what is a breakthrough drug, are not subject to administrative or judicial review.

"APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS

"Sec. 1860J. (a) In General.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Prescription Medicine Insurance Account, a Government contribution equal to—

"(1) the aggregate premiums payable for a month pursuant to section 1860D(a)(2) by individuals enrolled in the program under this part; plus

"(2) one-half the aggregate premiums payable for a month pursuant to such section for such individuals by former employers; plus

"(3) the benefits payable by reason of the application of paragraph (2) of section 1860B(a) (relating to catastrophic benefits).

"(b) Appropriations to Cover Incentives for Employment-Based Retiree Medicine Coverage.—There are authorized to be appropriated to the Prescription Medicine Insurance Account from time to time, out of any moneys in the Treasury not otherwise appropriated such sums as may be necessary for payment of incentive payments under section 1860H(c).

"PRESCRIPTION MEDICINE DEFINED

"Sec. 1860K. As used in this part, the term 'prescription medicine' means—

"(1) a drug that may be dispensed only upon a prescription, and that is described in subparagraph (A)(i), (A)(ii), or (B) of section 1927(k)(2); and

"(2) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act, and needles, syringes, and disposable pumps for the administration of such insulin.

"STUDY

"Sec. 1860L. (a) In General.—The Secretary shall conduct a study of the efficiency, cost-effectiveness, and impact on health outcomes of the program under this part. The Secretary shall include in such study an analysis of the savings from the cost containment provisions of this part as well as a projection of future costs.

"(b) Report.—The Secretary shall submit to Congress a report on the study under subsection (a) by not later than 3 years after the date the program under this part is first implemented.".

(b) Conforming Amendments.—

(1) Amendments to federal supplementary health insurance trust fund.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(A) in the last sentence of subsection (a)—

(i) by striking "and" after "section 201(i)(1)"; and

(ii) by inserting before the period the following: ", and such amounts as may be deposited in, or appropriated to, the Prescription Medicine Insurance Account established by section 1860F";

(B) in subsection (g), by inserting after "by this part," the following: "the payments provided for under part D (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund),";

(C) in the first sentence of subsection (h), by inserting before the period the following: "and section 1860D(b)(4) (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund)"; and

(D) in the first sentence of subsection (i)—

(i) by striking "and" after "section 1840(b)(1)"; and

(ii) by inserting before the period the following: ", section 1860D(b)(2) (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund)".

(2) Prescription medicine option under medicare+choice plans.—

(A) Eligibility, election, and enrollment.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(i) in subsection (a)(1)(A), by striking "parts A and B" inserting "parts A, B, and D"; and

(ii) in subsection (i)(1), by striking "parts A and B" and inserting "parts A, B, and D".

(B) Voluntary beneficiary enrollment for medicine coverage.—Section 1852(a)(1)(A) of such Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting "(and under part D to individuals also enrolled uhder that part)" after "parts A and B".

(C) Access to services.—Section 1852(d)(1) of such Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(i) in subparagraph (D), by striking "and" at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting "; and"; and

(iii) by adding at the end the following new subparagraph:

"(F) the plan for prescription medicine benefits under part D guarantees coverage of any specifically named covered prescription medicine for an enrollee, when prescribed by a physician in accordance with the provisions of such part, regardless of whether such medicine would otherwise be covered under an applicable formulary or discount arrangement.".

(D) Payments to organizations.—Section 1853(a)(1)(A) of such Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(i) by inserting "determined separately for benefits under parts A and B and under part D (for individuals enrolled under that part)" after "as calculated under subsection (c)";

(ii) by striking "that area, adjusted for such risk factors" and inserting "that area. In the case of payment for benefits under parts A and B, such payment shall be adjusted for such risk factors as"; and

(iii) by inserting before the last sentence the following: "In the case of the payments for benefits under part D, such payment shall initially be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate. By 2008, the adjustments would be for the same risk factors applicable for benefits under parts A and B.".

(E) Calculation of annual medicare+choice capitation rates.—Section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1), in the matter preceding subparagraph (A), by inserting "for benefits under parts A and B" after "capitation rate";

(ii) in paragraph (6)(A), by striking "rate of growth in expenditures under this title" and inserting "rate of growth in expenditures for benefits available under parts A and B"; and

(iii) by adding at the end the following new paragraph:

"(8) Payment for prescription medicines.—The Secretary shall determine a capitation rate for prescription medicines—

"(A) dispensed in 2005, which is based on the projected national per capita costs for prescription medicine benefits under part D and associated claims processing costs for beneficiaries under the original medicare fee-for-service program; and

"(B) dispensed in each subsequent year, which shall be equal to the rate for the previous year updated by the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual enrolled under part D.".

(F) Limitation on enrollee liability.—Section 1854(e) of such Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

"(5) Special rule for provision of part D benefits.—In no event may a Medicare+Choice organization include as part of a plan for prescription medicine benefits under part D a requirement that an enrollee pay a deductible, or a coinsurance percentage that exceeds 20 percent.".

(G) Requirement for additional benefits.—Section 1854(f)(1) of such Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: "Such determination shall be made separately for benefits under parts A and B and for prescription medicine benefits under part D.".

(3) Exclusions from coverage.—

(A) Application to part D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking "part A or part B" and inserting "part A, B, or D".

(B) Prescription medicines not excluded from coverage if appropriately prescribed.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (H), by striking "and" at the end;

(ii) in subparagraph (I), by striking the semicolon at the end and inserting ", and"; and

(iii) by adding at the end the following new subparagraph:

"(J) in the case of prescription medicines covered under part D, which are not prescribed in accordance with such part;".

SEC. 103. SUBSTANTIAL REDUCTIONS IN THE PRICE OF PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES.

(a) Participating Manufacturers.—

(1) In general.—Each participating manufacturer of a covered outpatient drug shall make available for purchase by each pharmacy such covered outpatient drug in the amount described in paragraph (2) at the price described in paragraph (3).

(2) Description of amount of drugs.—The amount of a covered outpatient drug that a participating manufacturer shall make available for purchase by a pharmacy is an amount equal to the aggregate amount of the covered outpatient drug sold or distributed by the pharmacy to medicare beneficiaries.

(3) Description of price.—The price at which a participating manufacturer shall make a covered outpatient drug available for purchase by a pharmacy is the price equal to the lowest of the following:

(A) The lowest price paid for the covered outpatient drug by any agency or department of the United States.

(B) The manufacturer's best price for the covered outpatient drug, as defined in section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)).

(C) The lowest price at which the drug is available (as determined by the Secretary) through importation consistent with the provisions of section 804 of the Federal Food, Drug, and Cosmetic Act.

(b) SPECIAL PROVISION WITH RESPECT TO HOSPICE PROGRAMS.—For purposes of determining the amount of a covered outpatient drug that a participating manufacturer shall make available for purchase by a pharmacy under subsection (a), there shall be included in the calculation of such amount the amount of the covered outpatient drug sold or distributed by a pharmacy to a hospice program. In calculating such amount, only amounts of the covered outpatient drug furnished to a medicare beneficiary enrolled in the hospice program shall be included.

(c) ADMINISTRATION.—The Secretary shall issue such regulations as may be necessary to implement this section.

(d) REPORTS TO CONGRESS REGARDING EFFECTIVENESS OF SECTION.—

(1) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary shall report to the Congress regarding the effectiveness of this section in—

(A) protecting medicare beneficiaries from discriminatory pricing by drug manufacturers; and

(B) making prescription drugs available to medicare beneficiaries at substantially reduced prices.

(2) CONSULTATION.—In preparing such reports, the Secretary shall consult with public health experts, affected industries, organizations representing consumers and older Americans, and other interested persons.

(3) RECOMMENDATIONS.—The Secretary shall include in such reports any recommendations they consider appropriate for changes in this section to further reduce the cost of covered outpatient drugs to medicare beneficiaries.

(f) DEFINITIONS.—For purposes of this section:

(1) PARTICIPATING MANUFACTURER.—The term "participating manufacturer" means any manufacturer of drugs or biologicals that, on or after the date of the enactment of this Act, enters into a contract or agreement with the United States for the sale or distribution of covered outpatient drugs to the United States.

(2) COVERED OUTPATIENT DRUG.—The term "covered outpatient drug" has the meaning given that term in section 1927(k)(2) of the Social Security Act (42 U.S.C. 1396r–8(k)(2)).

(3) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, or both.

(4) HOSPICE PROGRAM.—The term "hospice program" has the meaning given that term under section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)).

(5) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(f) EFFECTIVE DATE.—The Secretary shall implement this section as expeditiously as practicable and in a manner consistent with the obligations of the United States.

SEC. 104. IMPORTATION OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

"SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

"(a) DEFINITIONS.—In this section:

"(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

"(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

"(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

"(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

"(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

"(C) an infused drug (including a peritoneal dialysis solution);

"(D) an intravenously injected drug; or

"(E) a drug that is inhaled during surgery.

"(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

"(5) WHOLESALER.—

"(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A)

"(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

"(b) REGULATIONS.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

"(c) LIMITATION.—The regulations under subsection (b) shall—

"(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

"(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

"(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

"(d) INFORMATION AND RECORDS.—

"(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

"(A) The name and quantity of the active ingredient of the prescription drug.

"(B) A description of the dosage form of the prescription drug.

"(C) The date on which the prescription drug is shipped.

"(D) The quantity of the prescription drug that is shipped.

"(E) The point of origin and destination of the prescription drug.

"(F) The price paid by the importer for the prescription drug.

"(G) Documentation from the foreign seller specifying—

"(i) the original source of the prescription drug; and

"(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

"(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

"(I) The name, address, telephone number, and professional license number (if any) of the importer.

"(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

"(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

"(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

"(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

"(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

"(i) is approved for marketing in the United States; and

"(ii) meets all labeling requirements under this Act.

"(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

"(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

"(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

"(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

"(e) TESTING.—The regulations under subsection (b) shall require—

"(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

"(2) if the tests are conducted by the importer—

"(A) that information needed to—

"(i) authenticate the prescription drug being tested; and

"(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

"(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

"(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

"(f) Registration of Foreign Sellers.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

"(g) Suspension of Importation.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of the prescription drugs or by the importer that is counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

"(h) Approved Labeling.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

"(i) Prohibition of Discrimination.—

"(1) In general.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

"(2) Discrimination.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

"(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

"(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

"(j) Charitable Contributions.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

"(k) Waiver Authority for Importation by Individuals.—

"(1) Declarations.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

"(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

"(B) exercise discretion to permit individuals to make such importations in circumstances in which—

"(i) the importation is clearly for personal use; and

"(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

"(2) Waiver authority.—

"(A) In general.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

"(B) Guidance on case-by-case waivers.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

"(3) Drugs imported from Canada.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

"(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

"(B) is accompanied by a copy of a valid prescription;

"(C) is imported from Canada, from a seller registered with the Secretary;

"(D) is a prescription drug approved by the Secretary under chapter V;

"(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

"(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

"(l) Studies; Reports.—

"(1) By the Institute of Medicine of the National Academy of Sciences.—

"(A) Study.—

"(i) In general.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

"(I) importations of prescription drugs made under the regulations under subsection (b); and

"(II) information and documentation submitted under subsection (d).

"(ii) Requirements.—In conducting the study, the Institute of Medicine shall—

"(I) evaluate the compliance of importers with the regulations under subsection (b);

"(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

"(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

"(B) Report.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(2) By the Comptroller General.—

"(A) Study.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

"(B) Report.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(m) Construction.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

"(n) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.".

(b) Conforming Amendments.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking "covered product in violation of section 804" and inserting "prescription drug in violation of section 804";

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(a)" and inserting "prescription drug under section 804(b)".

SEC. 105. REASONABLE PRICE AGREEMENT FOR FEDERALLY FUNDED RESEARCH.

(a) In General.—If any Federal agency or any non-profit entity undertakes federally funded health care research and development and is to convey or provide a patent or other exclusive right to use such research and development for a drug or other health care technology, such agency or entity shall not make such conveyance or provide such patent or other right until the person who will receive such conveyance or patent or other right first agrees to a reasonable pricing agreement with the Secretary of Health and Human Services or the Secretary makes a determination that the public interest is served by a waiver of the reasonable pricing agreement provided in accordance with subsection (c).

(b) Consideration of Competitive Bidding.—In cases where the Federal Government conveys or licenses exclusive rights to federally funded research under subsection (a), consideration shall be given to mechanisms for determining reasonable prices which are based upon a competitive bidding process. When appropriate, the mechanisms should be considered where—

(1) qualified bidders compete on the basis of the lowest prices that will be charged to consumers;

(2) qualified bidders compete on the basis of the least sales revenues before prices are adjusted in accordance with a cost based reasonable pricing formula;

(3) qualified bidders compete on the basis of the least period of time before prices are adjusted in accordance with a cost based reasonable pricing formula;

(4) qualified bidders compete on the basis of the shortest period of exclusivity; or

(5) qualified bidders compete under other competitive bidding systems.

Such competitive bidding process may incorporate requirements for minimum levels of expenditures on research, marketing, maximum price, or other factors.

(c) Waiver.—No waiver shall take effect under subsection (a) before the public is given notice of the proposed waiver and provided a reasonable opportunity to comment on the proposed waiver. A decision to grant a waiver shall set out the Secretary's finding that such a waiver is in the public interest.

SEC. 106. GAO ONGOING STUDIES AND REPORTS ON PROGRAM; MISCELLANEOUS REPORTS.

(a) Ongoing Study.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the prescription medicine benefit program under part D of the medicare program under title XVIII of the Social Security Act (as added by section 102 of this Act), including an analysis of each of the following:

(1) The extent to which the administering entities have achieved volume-based discounts similar to the favored price paid by other large purchasers.

(2) Whether access to the benefits under such program are in fact available to all beneficiaries, with special attention given to access for beneficiaries living in rural and hard-to-serve areas.

(3) The success of such program in reducing medication error and adverse medicine reactions and improving quality of care, and whether it is probable that the program has resulted in savings through reduced hospitalizations and morbidity due to medication errors and adverse medicine reactions.

(4) Whether patient medical record confidentiality is being maintained and safeguarded.

(5) Such other issues as the Comptroller General may consider.

(b) Reports.—The Comptroller General shall issue such reports on the results of the ongoing study described in (a) as the Comptroller General shall deem appropriate and shall notify Congress on a timely basis of significant problems in the operation of the part D prescription medicine program and the need for legislative adjustments and improvements.

(c) Miscellaneous Studies and Reports.—

(1) Study on methods to encourage additional research on breakthrough pharmaceuticals.—

(A) In general.—The Secretary of Health and Human Services shall seek the advice of the Secretary of the Treasury on possible tax and trade law changes to encourage increased original research on new pharmaceutical breakthrough products designed to address disease and illness.

(B) Report.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on such study. The report shall include recommended methods to encourage the pharmaceutical industry to devote more resources to research and development of new covered products than it devotes to overhead expenses.

(2) Study on pharmaceutical sales practices and impact on costs and quality of care.—

(A) In general.—The Secretary of Health and Human Services shall conduct a study on the methods used by the pharmaceutical industry to advertise and sell to consumers and educate and sell to providers.

(B) Report.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on such study. The report shall include the estimated direct and indirect costs of the sales methods used, the quality of the information conveyed, and whether such sales efforts leads (or could lead) to inappropriate prescribing. Such report may include legislative and regulatory recommendations to encourage more appropriate education and prescribing practices.

(3) Study on cost of pharmaceutical research.—

(A) In general.—The Secretary of Health and Human Services shall conduct a study on the costs of, and needs for, the pharmaceutical research and the role that the taxpayer provides in encouraging such research.

(B) Report.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on such study. The report shall include a description of the full-range of taxpayer-assisted programs impacting pharmaceutical research, including tax, trade, government research, and regulatory assistance. The report may also include legislative and regulatory recommendations that are designed to ensure that the taxpayer's investment in pharmaceutical research results in the availability of pharmaceuticals at reasonable prices.

(4) Report on pharmaceutical prices in major foreign nations.—Not later than January 1, 2005, the Secretary of Health and Human Services shall submit to Congress a report on the retail price of major pharmaceutical products in various developed nations, compared to prices for the same or similar products in the United States. The report shall include a description of the principal reasons for any price differences that may exist.

SEC. 107. MEDIGAP TRANSITION PROVISIONS.

(a) In General.—Notwithstanding any other provision of law, no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under section 1882 of the Social Security Act on or after January 1, 2005, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

(b) Issuance of Substitute Policies if Obtaining Prescription Drug Coverage Through Medicare.—

(1) In general.—The issuer of a medicare supplemental policy—

(A) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as "A", "B", "C", "D", "E", "F", or "G" (under the standards established under subsection (p)(2) of section 1882 of the Social Security Act, 42 U.S.C. 1395ss) and that is offered and is available for issuance to new enrollees by such issuer;

(B) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(C) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in paragraph (2) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(2) Individual covered.—An individual described in this paragraph is an individual who—

(A) enrolls in a prescription drug plan under part D of title XVIII of the Social Security Act; and

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as "H", "I", or "J" under the standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

(3) Enforcement.—The provisions of paragraph (1) shall be enforced as though they were included in section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)).

(4) Definitions.—For purposes of this subsection, the term "medicare supplemental policy" has the meaning given such term in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)).

H.R. 1

Offered By: Mr. Sanders

Amendment No. 3: Add at the end of title I the following new section:

SEC. 108. IMPORTATION OF PRESCRIPTION DRUGS.

(a) In General.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

"SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

"(a) Definitions.—In this section:

"(1) Importer.—The term 'importer' means a pharmacist or wholesaler.

"(2) Pharmacist.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

"(3) Prescription drug.—The term 'prescription drug' means a drug subject to section 503(b), other than—

"(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

"(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

"(C) an infused drug (including a peritoneal dialysis solution);

"(D) an intravenously injected drug; or

"(E) a drug that is inhaled during surgery.

"(4) Qualifying laboratory.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

"(5) Wholesaler.—

"(A) In general.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

"(B) Exclusion.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

"(b) Regulations.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

"(c) Limitation.—The regulations under subsection (b) shall—

"(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

"(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

"(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

"(d) Information and Records.—

"(1) In general.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

"(A) The name and quantity of the active ingredient of the prescription drug.

"(B) A description of the dosage form of the prescription drug.

"(C) The date on which the prescription drug is shipped.

"(D) The quantity of the prescription drug that is shipped.

“(E) The point of origin and destination of the prescription drug.

“(F) The price paid by the importer for the prescription drug.

“(G) Documentation from the foreign seller specifying—

“(i) the original source of the prescription drug; and

“(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

“(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

“(I) The name, address, telephone number, and professional license number (if any) of the importer.

“(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

“(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

“(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

“(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

“(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

“(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

“(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

“(i) is approved for marketing in the United States; and

“(ii) meets all labeling requirements under this Act.

“(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

“(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

“(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

“(2) Maintenance by the secretary.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

“(e) Testing.—The regulations under subsection (b) shall require—

“(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

“(2) if the tests are conducted by the importer—

“(A) that information needed to—

“(i) authenticate the prescription drug being tested; and

“(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

“(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

“(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

“(f) Registration of Foreign Sellers.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

“(g) Suspension of Importation.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of the prescription drugs or by the importer that is counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

“(h) Approved Labeling.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

“(i) Prohibition of Discrimination.—

“(1) In general.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

“(2) Discrimination.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

“(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

“(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

“(j) Charitable Contributions.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

“(k) Waiver Authority for Importation by Individuals.—

“(1) Declarations.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

“(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

“(B) exercise discretion to permit individuals to make such importations in circumstances in which—

“(i) the importation is clearly for personal use; and

“(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

“(2) Waiver authority.—

“(A) In general.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

“(B) Guidance on case-by-case waivers.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

“(3) Drugs imported from Canada.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

“(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

“(B) is accompanied by a copy of a valid prescription;

“(C) is imported from Canada, from a seller registered with the Secretary;

“(D) is a prescription drug approved by the Secretary under chapter V;

“(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

“(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

“(l) Studies; Reports.—

“(1) By the institute of medicine of the national academy of sciences.—

“(A) Study.—

“(i) In general.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

“(I) importations of prescription drugs made under the regulations under subsection (b); and

“(II) information and documentation submitted under subsection (d).

“(ii) Requirements.—In conducting the study, the Institute of Medicine shall—

“(I) evaluate the compliance of importers with the regulations under subsection (b);

“(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

“(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

"(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(2) BY THE COMPTROLLER GENERAL.—

"(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

"(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

"(n) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.".

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking "covered product in violation of section 804" and inserting "prescription drug in violation of section 804";

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(a)" and inserting "prescription drug under section 804(b)".

EXTENSIONS OF REMARKS

THE GIFT OF OPPORTUNITY

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to read the essay of Laura Mendoza, a member of the Valley Center Teenage Republican Club.

Like every Friday morning, my mother had snuggled into bed with me; soon I was to get up and go to school. Only, on this morning, I was quite lazy and pleaded with my mom so that she would allow me to stay home. Like any other day she simply gave me a "no." It had been worth a shot! As we laid in bed she said to me, "Laura, you must strive for your goals and never allow anyone to prohibit you from following them. Take advantage of every moment and savor it, for you do not know what may lie ahead." What could possibly make her think I would understand her words at the age of eleven?

Now, I'm seventeen and I understand what she was implying. Throughout the years I have learned about my mother. My mother was unable to go to school due to many reasons, none that she could control. To begin with there wasn't a school in sight for about 20 miles and she had no transportation to get there. By the time there was a school that was somewhat near she was eight and her father was very unsupportive. He once told her not to worry about getting an education, instead she was to stay home and help in the fields and with the animals. "Besides" he said, "you don't need to worry about being educated because you're going to end up married to some guy who will provide for you and your family. All you need to worry about is taking care of the house and children."

I can see that my mother was denied a natural part of life. My mother was brought up in Mexico, where education is nothing big. It's like a luxury; if you have the time, then you can go to school; if not, you must stay home and attend to the responsibilities there. Education in Mexico has not changed much over the years, only four of my cousins go to school, and they're all boys. The females in my family are either married or living at home, helping out their parents.

I appreciate the many sacrifices my parents have done for my siblings and me. They have done everything possible and impossible so that we can receive a good education and so that one day we don't have to go through the same things and our own families will succeed. My parents are my inspiration. I know for a fact that if my parents had decided to stay in Mexico, all that I have achieved would have been unrealized. This is why education is so sacred to me. In my opinion, education is the key to my goals and I know that my parents weren't wrong when they saw something special in this land of opportunity. That is why they decided to bring our family here. I will not let my parents' sacrifice or the opportunity given to me go to waste. I now understand my mother's words and will live by them for the rest of my life.

A PROCLAMATION RECOGNIZING RAMSEY NABIL ALLOUSH

HON. ROBERT W. NEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. NEY. Mr. Speaker, whereas, Ramsey Alloush graduated from John F. Kennedy High School on June 7, 2003; and

Whereas, Ramsey Alloush has demonstrated a commitment to education; and

Whereas, Ramsey Alloush should be commended for reaching this academic milestone;

Therefore, I join with the residents of the entire 18th Congressional District of Ohio in honoring and congratulating Ramsey Nabil Alloush for his outstanding accomplishment.

HONORING THE 100TH ANNIVERSARY OF BRYN MAWR FIRE COMPANY

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. GERLACH. Mr. Speaker, I rise today to honor the Bryn Mawr Fire Company of Bryn Mawr, PA on its 100th anniversary.

Almost a century ago, citizens of Bryn Mawr, Haverford and Rosemont came together to form a fire company. The Montgomery County Court of Common Pleas approved the Certificate of Incorporation for the Bryn Mawr Fire Company on December 21, 1903, even before the Township in which it was located was chartered. The Company acquired its first horse-drawn engine the following year and the fire house was dedicated 2 years later in May of 1906.

The Bryn Mawr Fire Company has served its community in exemplary fashion over the past 100 years and today there are almost 40 volunteer firefighters in the Company. The Company responds to over 500 calls per year throughout Lower Merion, Radnor and Haverford Townships.

The volunteers of the Bryn Mawr Fire Company take every aspect of their job very seriously. Members drill every Monday night and participate in a live burn drill each month. Firefighters from the Company attend schools and conferences all across the country. The Company sends members into the local schools to talk about fire prevention and hosts an open house every year to educate the public about fire safety.

For the past 100 years, the citizens of Bryn Mawr and the surrounding communities have been able to depend on the courageous men and women of the Bryn Mawr Fire Company. I encourage my colleagues to join me in saluting the Bryn Mawr Fire Company on reaching this important milestone.

ESSAY OF MICHELLE WILKINSON

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to read the essay of Michelle Wilkinson, a member of the Valley Center Teenage Republican Club. "The Republican Party embraces many noteworthy values, including personal responsibility, service, and integrity. Throughout my life, I have been taught to follow these principles. As a student in an AP Government class and as a member of the Teenage Republican Club, I have come to realize how these values have influenced my life.

A major Republican value is personal responsibility. From a political view, this means that the government should only do what individuals cannot do by themselves. To me, personal responsibility is a way of living so that I am a contributing member of society rather than a burden. In my life, I have taken the accountability for my studies and other extracurricular activities. Because I know that I am responsible for my own actions, I have been able to excel in school, and have been accepted to the school of my choice. I have tried to make the most of my opportunity to attend school and believe that my efforts have been rewarding and worthwhile. As a Republican, I hope to be able to elect officers who believe in personal responsibility and strive to create laws that promote self-reliance in American citizens. I plan to major in History Education, and, as a teacher, I want my students to know how important this ideal was to our founding fathers. I will personally teach my children and my students to be conscientious and charitable members of the community in which they live. People who have cultivated an independent lifestyle are better able to give service to others.

Service to others is an integral part of the Republican ideal. When individuals voluntarily give their time and means, resources are used efficiently where they are truly needed. Government entitlements are not conducive to a strong work ethic and should only be depended upon for true emergencies, not as a planned lifestyle. Some of my service experiences include: registering voters, organizing a concert for an elderly care center, quilting blankets for a women's shelter, and organizing a dance for mentally and physically handicapped adults. Although no one expected or demanded my service, they were all very grateful for my time and talents, which I give freely because of the joy I receive in return. I know that I will continue to give my time and resources how and when I choose. I believe that I should be able to choose how my resources are used so that I know they are being used wisely and effectively. When we

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

are compelled to give our resources through high taxes, we are deprived of the feelings of generosity and benevolence. I will continue to use my influence and my vote to elect Republicans who share this ideal.

Finally, integrity is a vital Republican value. We must elect officials who will do what they believe is right even if it is not popular or easy. Karl G. Maeser, an educator, once said,

> I have been asked what I mean by my word of honor . . . Place me behind prison walls . . . there is a possibility that in some way or another I may be able to escape, but stand me on that floor and draw a chalk line around me and have me give my word of honor never to cross it. Can I get out? No, never! I'd die first!

We need public officials who will abide by their word of honor, not the shifting of polls and public opinion. I have sought to be honest with all people, even if it is not to my advantage. The reward of integrity is trust, which is broken much easier than it is built. Our country has suffered from the lack of integrity in our leaders, I hope that we can find leaders who can restore honor and integrity to public offices. As a mother and a teacher, I will instill the value of honesty into my children and students. I will teach them that their word of honor defines their character.

I know that there are many problems with our current system of government. I also believe, however, that they can be reformed if the ideals of responsibility, service, and integrity, are utilized. Despite imperfections, I know that our country is the best in the world. I am grateful and proud to be an American."

A PROCLAMATION RECOGNIZING BASEL ALLOUSH

HON. ROBERT W. NEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. NEY. Mr. Speaker,

Whereas, Basel Alloush graduated from Kent State University on December 14, 2002; and

Whereas, Basel Alloush earned a Bachelor's Degree in Business Administration and Marketing; and

Whereas, Basel Alloush has demonstrated a strong devotion to academics; and

Whereas, Basel Alloush should be commended for reaching this milestone;

Therefore, I join with the residents of the entire 18th Congressional District of Ohio in honoring and congratulating Basel Alloush for his distinguished achievement.

COMMENDING ALEXANDRA SCOTT FOR HER EFFORTS IN THE FIGHT AGAINST CANCER

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. GERLACH. Mr. Speaker; I rise today to commend my constituent, 7-year-old Alexandra Scott, for the work she is doing to raise money for those living with cancer.

Alex was diagnosed with neuroblastoma, a cancer of the nervous system, when she was just a year old. Six years later, she has had six surgeries and still undergoes chemotherapy treatments at Children's Hospital of Philadelphia.

When Alex was four, she told her mother that she wanted to have a lemonade stand and give the money that she made to her hospital in Connecticut, where they lived at the time. In July of 2000, Alex started her first lemonade stand and raised over $2000. Shortly thereafter, the Scott family moved to Wynnewood, Pennsylvania. Each summer, Alex has opened her lemonade stand with proceeds going to help others battling cancer.

So far, Alex has raised over $80,000 for cancer research. Money has been donated to Children's Hospital of Philadelphia, Connecticut Children's Medical Center, and Toireasa's Dream, a neuroblastoma research fund set up in memory of Alex's friend, Toireasa Barry. The Philadelphia Foundation recently presented Alex with its "Philanthropist of the Year" award.

I encourage my colleagues to join me in applauding Alexandra Scott on her accomplishments and in sending her our prayers for her recovery. May she continue to serve as a role model for all of us.

ESSAY BY HEATHER MACPHEE

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to read the essay of Heather MacPhee, a member of the Valley Center Teenage Republican Club.

"As a sophomore at Valley Center High School, I had a basic idea of where I stood in the world. Despite my lack of experience and knowledge, I knew that I valued being a conservative woman in a time of uncertainty and compromise. I was confident in my beliefs, but could not effectively defend or even explain my reasoning. That was the year I became involved with the Teenage Republican Club, and now I have no doubts that I have the knowledge to proudly register as a Republican voter.

Two seniors I admired and looked up to introduced me to the Teenage Republican Club. Melissa Hill and Nicolete Lawrence were smart young women that I respected very much. I hoped to be like them when I was a senior and was extremely flattered when they recommended me for the 2–1 Federation for Republican Women Advocacy Workshop. While at the Advocacy, I was exposed to the true enthusiasm of the Republican Party. During the short two days in Sacramento, I learned from party members, including state legislators, where Republicans stood on big issues and the little known issues. I learned from first hand experience how our state government operates and the importance of individuals in our society. Since the Advocacy, I have done my best to be involved in my political surroundings.

T.A.R.S. has given me the opportunity to fulfill my desires to play an active role in local government. Until last week, I was unable to vote, but through T.A.R.S. I assisted other people in taking advantage of their right to vote. I have registered voters at North County Fair and encouraged seniors around me to cast their votes. I have also assisted with the Federated Republican Women's Club fundraiser so that they could adequately publicize, encourage, educate, and spread Republican ideals. I personally feel the most satisfaction from being a leader. I know that the biggest impact I will make will be through my actions and not my words. With this in mind, I attempt to live each day in accordance to my faith and values which are inherently Republican. The best expression of my thoughts happens to be from the Republican Oath:

"I believe that Americans value and should preserve their feeling of national strength and pride, and at the same time, share with people everywhere a desire for peace and freedom and the extension of human rights throughout the world. Finally, I believe that the Republican Party is the best vehicle for translating these ideals into positive and successful principles of government."

As I grow older, my appreciation for the freedoms of this country and the enthusiasm behind my beliefs will only become greater. I hope to take advantage of all opportunities to vote and never lose sight of the direction of our government. I will continue to serve our nation through my career and participation in the political process. I will also continue to proudly support the Grand Old Party.

A PROCLAMATION HONORING MONSIGNOR PAUL E. METZGER ON THE 60TH ANNIVERSARY OF ORDINATION

HON. ROBERT W. NEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. NEY. Mr. Speaker,

Whereas, Monsignor Paul E. Metzger celebrated the 60th anniversary of his ordination on April 17, 2003; and

Whereas, Monsignor Paul E. Metzger should be commended for his faithfulness to the church; and

Whereas, Monsignor Paul E. Metzger served as a pastor for the St. John Church in Bellaire, Ohio for 26 years; and

Whereas, Monsignor Paul E. Metzger continues to serve the community of Middletown as the Director of Residential Individual Options and through his dedication to the Holy Family Parish;

Therefore, I join with the residents of the entire 18th Congressional District in recognizing Monsignor Paul E. Metzger as he celebrates the 60th Anniversary of Ordination.

DEEPLY ROOTED PRINCIPLES

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to read the essay of Patrick Anabaldi, a member of the Valley Center Teenage Republican Club. He is currently a senior at Valley Center High School.

"As an active Teenage Republican Club (TARS) member for the past two years, I have come to realize what the Republican tenets are all about. The Republican Party has been around for quite a while now proving that it can stand the test of time. Over these years the GOP has also shown that its economic and social policy are fully capable of leading this country into times of economic expansion and much needed ethical revival. Some of the events that have aided in my political education include TARS meeting, the advocacy workshop, Advanced Placement (AP) Government class, and AP macroeconomics class. Because of the truth that the republican principles hold I have firmly established them into my own life.

One of the most politically education functions I have ever participated in was the Advocacy workshop, which took place in our state capital Sacramento. This was a TARS function supported by the charitable Federated Republican Women of Valley Center. During this trip I not only got to meet some powerful political leaders in today's world, but was also taught some key issues that separate us as republicans. For instance, I discovered why we hold to our economic ideals though the whole scandal that involved Gray Davis, electricity and our horrendous deficit here in California. At this point I began to see that Republicans have great solutions for our state and nation's numerous problems. At the conclusion of this trip I took advantage of the opportunity to tell the whole Valley Center Federated Republican Women's group what I had learned and how it had impacted my life. This was a clear milestone in the maturing of my political life. I was acting like a Republican not only by standing up and publicly proclaiming what I had leaned about the GOP, but also what I now believe.

I have earned the reputation of an accomplished scholar at VCHS by taking the hardest courses and excelling in them. AP government and AP Macroeconomics are the two current classes of mine that deal with politics. In these classes there is much debate about heated political issues, and this is another part of my life that reveals my sincerity to the republican values. I am known by my peers to thrive in this kind of environment not only because I know what I believe in as a republican, but also because I have a vehement passion to prove it right. I have revealed my opinion in class on countless issues. Some of these issues have dealt with fiscal policy, the role of our government bureaucracy, the office of the President, war and abortion. Not once has my view been contrary to that of the GOP, I am a proud member of the Republican Party!

Next year I will be attending a California University. These days Californian schools tend to be incredibly liberal. We've seen this in the news through 'war protests' and 'prochoice rallies'. As a right-wing Republican it will be quite a task attending college. But I will persevere despite the obstacles in my path because of how deeply rooted the values are in my life."

THE SAVE SOCIAL SECURITY FIRST ACT

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. KENNEDY of Rhode Island. Mr. Speaker, I rise today in support of a bill that will correct the mistake that the House made last week when it voted to repeal the estate tax. Not only that, but the Save Social Security First Act will also restore some credibility to the commitment that both parties in this House have made to safeguarding the Social Security trust fund.

In March of 2001, Speaker Hastert said, "We are going to wall off Social Security trust funds." Two years later, our fiscal stability has eroded and we are racing towards half-trillion dollar annual deficits. Rather than protecting it, we are now dipping into the Social Security trust fund to finance another round of tax cuts for millionaires and billionaires. The wealthy few in our country are benefitting at the expense of the millions of seniors who currently rely on Social Security and the millions of American workers who will rely on it in the future.

The question is a simple one, Mr. Speaker. Would you rather add an additional $588 billion to the Social Security trust fund over the next 20 years, or give that money to families whose wealth already dwarfs the lifetime earnings of many Americans? The answer seems obvious. I believe that this House should keep its promise to protect Social Security and stop sacrificing the needs of the vast majority of Americans for the benefit of the privileged few. It is for these reasons that I have introduced the Save Social Security First Act.

The act will accelerate estate tax relief while not entirely repealing the tax. It raises the exemption amount to $3 million per person, or $6 million per couple, beginning in 2004, and dedicates all estate tax revenue to the Social Security trust fund. Many of those who voted to repeal the estate tax last week argued that the tax unjustly forces small business owners to sell their business in order to pay the tax rather than be able to pass the business on to the next generation. According to a Treasury Department study, however, this is very rarely the case. In only 1.6 percent of taxable estates did a family-owned business comprise at least half of the value of the estate, and that was with an exemption just one-fifth of what is proposed by the bill I have introduced. We do not need to fully repeal the tax in order to keep it from unfairly impacting small businesses.

Under the Save Social Security First Act, only the truly wealthy will remain subject to the estate tax, while 99.5 percent of families will be exempt from it. The whole country will benefit from the $588 billion that this bill will put into Social Security over the next 20 years. Over the next 75 years, it will make up for almost one quarter of the projected shortfall in Social Security funding.

Mr. Speaker, it's about time that we got our priorities straight. This bill says that even if you feel that fully repealing the estate tax is a priority, it is not a higher priority than ensuring the solvency of Social Security. It says that we should be committed to the growing number of seniors in our country. It says that we should be committed to today's workers who are depending on Social Security for their retirement. And it says that we should be committed to our children, who should not be forced to foot the bill of our fiscal irresponsibility.

I strongly urge this House to join me in supporting the Save Social Security First Act. We have two futures to choose from: on the one hand, we can make a tiny sliver of the wealthiest people in the country even wealthier. On the other, we can help save a program that will benefit untold millions of Americans for generations to come. This should be one of the easiest choices that we have made in a long time, and I hope to see my colleagues on both sides of the aisle join me to support this important bill.

JAMES ETTER HONORED BY THE SMALL BUSINESS ADMINISTRATION

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. WOLF. Mr. Speaker, I want to share with our colleagues that Mr. James Etter has been selected by the Small Business Administration, SBA, as a Virginia Small Business and Business Advocate Award winner, and named the Veteran Small Business Advocate of the Year for 2003. Mr. Etter is founder/chancellor of American Public University in Manassas, VA, and was also a winner at the regional level, receiving the Region III SBA award. SBA's Region III includes the States of Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia. As the Region III winner, Mr. Etter is one of only 10 Veteran's Advocate winners in the Nation.

Mr. Etter, a retired U.S. Marine Corps officer, founded the university in 1991 to find innovative ways to empower veterans and active duty military, by providing educational opportunities. The university courses are delivered exclusively through distance learning. Before distance learning was an everyday concept, James Etter developed a way for veterans and active duty military stationed abroad or locked into rigid schedules to work toward their undergraduate or master of arts degrees. From an initial enrollment of 18 students, American Public University has grown to over 10,000 registered students, of which approximately 70 percent are active and reserve duty military. The nearly 600 faculty, 76 percent of whom are veterans, provide instruction and mentoring to students from all 50 States and 30 countries. I have been told that the university maintains the most expansive military studies, strategy and history curriculum in the world. Continuing education, through the flexibility of distance learning, affords veterans and active duty military the foundation they need to become entrepreneurs.

Virginia's SBA Award winners were honored at an Awards Gala in May that also celebrated the Small Business Administration's Richmond District Office's 50th Anniversary. Mr. Etter was nominated for the award by Linda Decker, who serves as president and CEO of the Flory Small Business Center in Manassas. She also serves as the chairman of the Virginia Small Business Awards Foundation.

Other winners included: Virginia Small Business Persons of the Year—Sharon Bennett, Founder & CEO and Evan Wooton, President, Premier Pet Products, LLC, Richmond; Runners Up for Small Business Person of the Year—Maxanne Taverniti, Williamsburg Group Tour Service, Williamsburg and James Cheng, President, Computer & Hi-Tech Management, Inc., Virginia Beach; Small Business Accountant Advocate of the Year—Elizabeth Moore, Partner, Goodman & Company, LLP, Newport News; Small Business Exporter of the Year—Marti Morenings, Universal Companies, Inc., Bristol; Financial Services Advocate of the Year—Teresa Walker, Vice President and Senior Community Development Officer, Wachovia Corporation, Roanoke; Small Business Journalist of the Year—Mary Flachsenhaar, Inside Business, Norfolk; Minority Small Business Advocate of the Year—Dr. Donald Jones, Director, Office of Minority Procurement, University of Virginia, Charlottesville; Women in Business Advocate of the Year—Claire Gastañaga, Principal, CG2 Consulting, Richmond; Young Entrepreneur of the Year—Bryce Lee Robertson, LowTechWeb.com, Mechanicsville and Entrepreneurial Success of the Year—Dennis Gilbert, President, Tesoro Corporation, Virginia Beach.

ESSAY BY DANIEL ZAJDA

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to read the essay of Daniel Zajda, a member of the Valley Center Teenage Republican Club.

"As a T.A.R.S. member, I have worked hard for the Republican Party and have accepted the Republican values. These values have affected me in many ways and believe that they will stay positive in the future. For the past three years I have been an active supporter and beneficiary of the Teen Age Republicans at Valley Center High School. I have held many positions of office, including being a main contributor in the efforts of gaining an official club charter. As a Vice president in my sophomore year, I helped moderate the agenda and served as a stand in for the President, however, I didn't know much about the difference between conservatives and liberals, but all that eventually changed when I got the privilege to attend the Republican Advocacy Workshop in our state capitol. This particular journey opened my eyes to many of the problems that our state has burdened itself with, due to the incompetence of our governing office. After experience first hand what goes on at the capitol building, I realized the power of politics and eventually realized that I would lead a moral and conservative life as a Republican Party member.

The following year I was elected as President of the T.A.R.S. club and donated much of my time to the development and expansion of our organization. I can recall spending countless hours in hope of registering voters and urging people to get out and vote.

But now our country is dealing with different issues and right now is a great time for our nation to show their support and back our President. And that's exactly what the Republican Party is doing and I am proud to be a part of it."

COMMENDING THE FIRST GRADUATING CLASS OF THE CONNECTICUT INTERNATIONAL BACCALAUREATE ACADEMY

HON. JOHN B. LARSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. LARSON of Connecticut. Mr. Speaker, I rise today to pay tribute to a group of young constituents of mine in the First Congressional District. They are the first graduating class of the Connecticut International Baccalaureate Academy in my hometown of East Hartford. I would also like to specifically recognize one of the graduates, Alix Prinstil, for the extraordinary speech he gave at the graduation exercises, which I also had the honor of attending. Alix's words and the sentiments he expressed are of lasting value to the school and indeed to our entire education system in Connecticut. I am proud to insert his remarks into the RECORD today and again offer my sincerest congratulations to the Class of 2003.

GRADUATION EXERCISES

(Oration by Alix Prinstil)

So we've finally arrived at this day: Our High School Graduation Ceremony. Since I was in about 3rd grade, I dreamed about what it would be like at my high school graduation. This speech, as a matter of fact, was for the most part written in my mind for the past . . . let's see, 12th grade – 4th grade = 8 years! I always pictured what the audience's reaction would be when I'd start off with:

"Many graduation speeches begin with, Graduation, Webster's Dictionary defines it as—the award or acceptance of an academic degree or diploma. But you won't hear such a definition in this speech."

In light of what this program has brought to our attention, however, this definition that was probably established centuries ago barely skims the threshold of what "graduation" really means, especially for this C.I.B.A. class.

Ever since we were freshmen, I don't have to remind us how we've constantly been asked by not only friends, but parents and even strangers, the question: "What is I.B.?" But how many of us, except maybe Mr. Abelon, can even now give a detailed (or even correct) answer? If, at this point though, we were asked: What does IB do for a student?", I think we could all give an appropriate response. To make a long explanation short, I'll partially quote the words of Mr. Abelon almost 4 years ago: "It's a rigorous program established to produce a well-rounded-out individual." Well when he said "rigorous" that day, not only did I not know what I was in for, but I apparently didn't know what "rigorous" really meant.

We all walked in the first day with our middle school work ethic, bags that we'd soon discover weren't big enough, and among the presence of a group of approximately 50 people, most we never seen in our lives, and probably never would have. Never did I think that someone my age from towns like Marlborough and Ellington would be in the same classroom. It was through this school that every single one of us was able to see and experience diverse personalities and people from various towns of Connecticut. This diverse group of young people is one of the things within the Academy that I'll probably remember the most. And we've all grown along the way, now looking forward to this summer so we can catch up on the sleep we've lost.

But we can't just think about what we the students went through. Let me remind you, the audience: this is the first school in New England governed by the International Baccalaureate Organization. Our teachers were just as new and in for a treat just as much as we were. Those countless hours of homework that we received every night was put right back into the hands of our teachers who would sometimes experience countless hours of grading, whether it be watching our Chinese characters develop as we got older, reading how students explained why a dog isn't a cat, or grading a couple of derivative and integral problems. At this point, I'd really like to give a round of applause to the teachers who have gone through this alongside their students for the first 4 years of this school's establishment, to those who we've recently had, and to those we have had and lost.

Now after all of this reminiscing, we must examine what this graduation really means for us now and what it will mean for us in the future. When we go home this evening (whatever time that may be), what will we all think about? Parents: is the first thing that occurs to you going to be what color your child's room will be painted for that office or gym you always wanted after they go to college? Graduates: will you be wondering what you're going to do for fun tomorrow . . . if we can wake up for tomorrow? With 4 years of such great education behind us, I think we should all go home and take some time to reflect on the advantages we have gained over the majority of students in this state; country; and even the world.

Now for the backbone of this delivery; what I've been trying to lead into for the past 687 words . . .

I need to refer back to the beginning of this speech when I said that graduation means more than just receiving a diploma; more than just moving a tassel from one side of our hat to the other and officially ending the part of our lives as high school students. Graduation is what you make of it. And after experiencing life under the wings of the IBO, I should be correct when I say that the lives of each and every one of us will be successful ones, no matter where we go. When we have our 5 or 10-year reunion, or whenever Allison wants to organize it, I strongly doubt that my statement will be false. After 4 years of seeing the same exact faces everyday all day, we're finally each going our separate ways. College life is going to be much different from what we have had. Let's not forget exactly where we came from. We've put up with each other for what seemed forever. But I have to say something I realized just two days ago and that I got a little emotional when typing this: friends aren't always people you talk to everyday. There are a lot of people in the world that you may call a friend and could be one of the worst individuals to be involved with. But being with you guys for 4 years has showed me that there's greatness in every single one of you, things unmentionable to the mind's recollection, and that I really have to say I love you all. There was apparently a part in my heart that was being saved to be filled by a group of people, and I realized that the 21 of you, in each of your own ways, filled that void with a better feeling than I've had in a long time. The feeling I'll have for you next year is beyond the word "miss". I just hope the person I've been will be imprinted into your hearts as well. Please remember that this isn't goodbye, it's just "see you later."

Once again, I would like to thank Mr. Abelon for being patient with this class, the Governing Committee, the East Hartford Board of Education, Mr. Jordan, especially Dr. Fallon, our Guidance Counselor Mr. Spiller for being there almost everyday for not only being a Guidance Counselor who organized our schedules, but a friend to talk to, teachers who made our high school transition the easiest and wonderful four years to look back on (I'd love to mention every single one but it would make this speech longer than it is), East Hartford High School staff but most importantly, the parents, who brought us onto this Earth, gave us life, and raised us to the best of their ability. And when I say best, I mean BEST. Whether they show it or not, every second we're alive on this Earth, they love us in a way we may not understand. We wouldn't be here today if it weren't for them. To this first CIBA graduating Class of 2003: The programs and tickets call this a Commencement of the Class of 2003. This means we're just starting where our lives will begin to pick up. Make this graduation one of dignity and remembrance; and treat today as your first big step into the real world.

Thank you.

HONORING CHAIRMAN BOB STUMP

HON. DARRELL E. ISSA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. ISSA. Mr. Speaker, I rise tonight to remember the life and work of former Congressman Bob Stump. Mr. Stump was a true gentleman with whom I had the privilege of serving in this body for two years.

Before being elected to Congress, Mr. Stump served in the United States Navy and also served in the Arizona House of Representatives and in the Arizona State Senate.

He was first elected to Congress November 3, 1976, where he faithfully served the people of Arizona for 26 years in the U.S. House of Representatives. Mr. Stump was a man whose congressional career was spent working for our Nation's men and women in uniform. His commitment to the military and to our Nation's defense should be an example to us all.

I send my condolences to his wife Nancy, three children, and five grandchildren.

THE AMERICAN DREAM

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to read the essay of Elizabeth Hernandez, a member of the Valley Center Teenage Republican Club:

For many years people from Mexico have been coming to this country for a better opportunity, better life and a future for their children and family, the most common reason why they choose to come here, is because America gives them a chance to start a new life. They have special programs from which they can benefit, so they can progress in life and have something they can call their own. The economy has a great influence in this too. Mexico has many states that are very poor.

Economic issues are a strong reason why America is a good target for them. Mexico has many states that are poor and do not have the sufficient resources that a person should have during this century. Most towns are still without electricity, water pumps, and telephones. This makes daily life more difficult. They always hear that in America all of this is not an issue; that you can practically go everywhere and all of these resources are given to you. In Mexico, jobs are everywhere but they don't get enough money to have an average life. The cost of food constantly increases but the wages stay the same. That makes it harder to buy or afford anything. Here in America, we don't see that problem because if food or the daily necessity goes up, so does the minimum wage for every job. In Mexico, there is not a law that tells companies how much they have to pay their employees. Most of the time they pay a small amount of money for the amount of time they work. Some occasions they work up to sixteen hours straight a day for five or six days a week. Here in America you can't do that, the hours you can work is a maximum of forty hours a week; after that they have to pay you overtime. When this happens in Mexico, parents can't afford to feed their children because they are not paid overtime. That is why they choose to come to America so they can have food on their table every night and a few other luxuries.

For that same reason, their education is affected. Most parents make their children work so they can get more money to be able to buy food and clothing. Usually the children drop out of school at an early age, some of them just complete the fifth grade. Children that keep on going to school usually have money or they live in the city. People that don't live in a major city don't have the same opportunity. In America there is always a public school minutes away from where you live even if you don't live in a major city. You are guaranteed a free education all the way until high school and after that you can also get a college education in a community college that is less expensive than a University. That is why the people of Mexico come to America so they can put food on their table and their children are guaranteed an education regardless from what country they originate. That is why the "American Dream" is the way they refer to America.

CONGRATULATIONS TO THE ALABAMA STATE DOCKS FOR 75 YEARS OF SERVICE TO SOCIETY

HON. JO BONNER

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. BONNER. Mr. Speaker, it gives me great pleasure to recognize the Alabama State Docks on the occasion of the 75th anniversary of its official dedication. The dedication took place on June 25, 1928, with several dignitaries attending, including Governor Bibb Graves, U.S. Congressman John McDuffie, U.S. Senator Hugo Black and the Assistant Chief of the United States Department of Transportation. Since that time, the port city of Mobile has enjoyed a lengthy history as an integral part of the State and National economy.

In 1519, just a short 27 years following Christopher Columbus's discovery of the New World, Spanish explorer Admiral Alvarez de Pineda sailed into what is now called Mobile Bay. The present-day city of Mobile was founded in 1702 by French explorers Jean Baptiste Le Moyne and Sieur de Bienville. The port of Mobile, which lies at the mouth of the Mobile River and the head of Mobile Bay, began contributing to the economy of the region by becoming one of the leading exporters of cotton. Since the early part of the 17th century, the port city has flourished to become Alabama's third largest city and among the national leaders in international trade.

The current 45 foot deep navigational channel, which is maintained by the U.S. Army Corps of Engineers, serves the port well in connecting Mobile to the Gulf of Mexico. The Mobile River, which is formed by the confluence of the Black Warrior and Tombigbee Rivers, functions as the gateway for the Tennessee/Tombigbee Waterway. The obvious economic possibilities and the lack of central organizational operation spurred the Alabama Legislature to submit a constitutional amendment to develop Alabama's Seaport with state financial assistance. The amendment was passed in 1922 and the State Docks Commission was formed to build, operate and maintain the facilities of the State Docks. With just $10 million to spend, the Commission chose retired Major General William L. Sibert to engineer and construct one of the finest seaports on the Gulf Coast. Construction was not yet completed when the new Docks received their first cargo ship in May of 1927.

The port, which ranked 14th in total tonnage in 1999, is ahead of other ports such as Tampa, Seattle, Charleston, and Savannah. Mobile also ranks first nationally in wood pulp and Gulf coast forest products exports. The State Docks has made an overwhelming impact on the State economy by generating approximately $3 billion in revenues statewide each year. With the ability to service many different products, the port continues to position itself among the leaders in international trade. And as a self-supporting enterprise agency of the executive branch of State government, the facilities prove that they can compete and operate to the benefit of not only the people of Alabama but also the Nation.

I ask my colleagues to join me today in recognizing the Alabama State Docks for 75 years of excellence and leadership in the shipping industry. The residents of Alabama and the American people have all benefited greatly from the Docks' existence and its important role in today's economy.

CONGRATULATIONS TO MS. KATHLEEN McGRATH ON ELECTION INTO NATIONAL TEACHERS HALL OF FAME

HON. CLIFF STEARNS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. STEARNS. The National Teachers Hall of Fame is an organization which recognizes and honors exceptional teachers and the teaching profession. The Hall of Fame annually honors five teachers who have demonstrated commitment and dedication to teaching our Nation's children. This year, I am fortunate to have one of my constituents, Kathleen McGrath, elected as a member of the Class of 2003.

Kathleen is a fifth grade teacher at Saddlewood Elementary School in Ocala, FL and has been teaching for 22 years at various schools throughout Marion County. Kathleen creates a learning environment in her class where students feel safe to take risks and strive to do their personal best each day. Her classroom is a safe haven, where learning is natural and anything is attainable.

I would like to congratulate Ms. Kathleen McGrath on her election into the National Teachers Hall of Fame, and for continuing to provide the children of Marion County with a fun and inspiring learning environment.

INTERNATIONAL DAY IN SUPPORT OF THE VICTIMS OF TORTURE

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. SMITH of New Jersey. Mr. Speaker, as Chairman of the Commission on Security and Cooperation in Europe, I find myself dealing with the issue of torture many times over during the course of any given year—torture committed by Russian forces in Chechnya, systematic police abuse of Roma in Greece, prisoners tortured to death in Uzbekistan, to give just a few recent examples. Unfortunately, torture remains the weapon of choice by many oppressive regimes, systematically used to silence political opposition, punish religious minorities, or target those who are ethnically or racially different from those in power.

But on the occasion of the United Nations' Day in Support of the Victims of Torture, I'd like to reflect on the steps that can be taken to help prevent torture from occurring in the first place.

Torture is prohibited by a multitude of international instruments, including documents of the Organization on Security and Cooperation in Europe (OSCE). Moreover, it is absolute and nonderogable under any circumstances, even wartime. The challenge, then, is to translate this commitment into practice.

Amnesty International has issued a number of recommendations to help end torture. They are remarkably straightforward and easy to grasp: officials at the highest level should condemn torture; governments should ensure access to prisoners; secret detentions should be prohibited; and confessions obtained through torture should be excluded from evidence in the courtroom. I believe the implementation of these fundamental principles would have a significant impact in reducing torture. At the OSCE Parliamentary Assembly's Annual Session two years ago, I introduced a resolution, passed by the Assembly, that built on these basic concepts.

While we work to eradicate torture, we must not forget those who have already become its victims. Along with Representative TOM LANTOS, I have introduced H.R. 1813, legislation to reauthorize the Torture Victims Relief Act and the list of cosponsors is growing. The Senate companion bill, S. 854, was introduced by Senator COLEMAN. This reauthorization will continue funding for centers here in the United States that help provide treatment for the estimated half million survivors, most of whom came to this country as refugees. It will also provide funds, distributed through the Agency for International Development or the U.N. Voluntary Fund for the Victims of Torture, for treatment centers abroad. While life for torture survivors can never be the same, treatment can provide victims the hope of becoming stable and productive members of their communities. I urge my colleagues in the House to join in supporting this measure as a tangible support of the victims of torture.

HONORING DR. JAN VAN WAGTENDONK

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. RADANOVICH. Mr. Speaker, I rise today to recognize Dr. Jan van Wagtendonk, who recently received the 2002 Excellence in Wilderness Stewardship Research Award. Van Wagtendonk was presented the award on June 12, 2003 at the Forest Service's 2002 National Wilderness Awards ceremony in Arlington, VA.

Dr. Wagtendonk has been involved in wilderness science for over 30 years. Van Wagtendonk grew up in Indiana where he studied forestry at Purdue University. During the summer, he worked as a smokejumper for the U.S. Forest Service and the Bureau of Land Management. This led him to Oregon State University where he received his B.S. in Forest Management. He then served four and a half years in the U.S. Army as an officer in the 101st Airborne Division where he was also an advisor to the Vietnamese army. He entered graduate school at University of California, Berkeley where he received his M.S. in Range Management and his Ph.D. in Wildland Resource Science with a specialty in fire ecology. From 1972 through 1993, van Wagtendonk was a research scientist with the National Park Service at Yosemite National Park. Since then he has been a research scientist with the U.S. Geological Survey. In 2001, van Wagtendonk was chosen to be an invited speaker at the 7th World Wilderness Congress held in South Africa.

Through his extensive research, interagency wilderness programs in the Sierra Nevadas have improved greatly. His contributions have not only helped in Yosemite, but across the country, with his work on fuels dynamics, fire prescriptions, remote sensing and the application of geographic information systems to fire management. The techniques developed through van Wagtendonk's work have been used in the wildernesses of national forests in Oregon, North Carolina and California. Dr. David Parsons nominated van Wagtendonk for this because "his dedication to providing sound science to the challenging dilemmas facing wilderness managers in Yosemite and across the country is unparalleled."

Mr. Speaker, I urge my colleagues to join me in recognizing Dr. Jan van Wagtendonk for his significant and steadfast efforts to preserve and manage the wilderness of the United States.

SUPPORTING THE EFFORTS OF PUBLIC TRANSPORTATION ADVOCATES

HON. EARL BLUMENAUER

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. BLUMENAUER. Mr. Speaker, I rise today to show my support for the efforts of public transportation advocates around the country.

Today, the National Alliance of Public Transportation Advocates (NAPTA) is distributing a letter to the Hill, which asks Congress to double the investment in public transportation to $14 billion by FY2009 when it reauthorizes the federal surface transportation program.

Providing increased, guaranteed transit funding is critical to improving the livability of our communities. In Portland, we have been proud to be leaders in understanding the connection between land use and transportation. Our light rail system has not only provided additional choices to our residents, it has also helped with environmental problems.

Portland's transit system, Tri-Met, has the 13th largest ridership in the nation, despite being only the 29th largest transit district. Rider totals increased 65 percent the last decade. This growth is a reflection of the increased transit investment provided by the federal, state and local levels. In my community, transit truly is making a difference in the quality of life for our citizens.

NAPTA also points to the strong success of such existing programs as the Congestion Mitigation and Air Quality (CMAQ), Enhancements, and Transportation and Community and System Pilot Preservation Program (TCSP).

Communities nationwide are experiencing the flexibility and freedom of having more public transportation choices. For every federal dollar invested in public transportation, as many as $6 are returned in congestion reduction, safety benefits and access to economic opportunity. At the same time, 47,500 jobs are created for each $1 billion invested. Increasing guaranteed federal funding in public transportation can bring these benefits to people across the country.

TRIBUTE TO THE EMPLOYEES OF WYETH-PHARMACEUTICALS IN RICHMOND, VIRGINIA

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CANTOR. Mr. Speaker, the breakthroughs in medicine now occurring on a daily basis were unimaginable 40 years ago when Medicare was established. Seniors lead better lives due to these research breakthroughs and new prescription drugs; however, these medical breakthroughs are meaningless if seniors cannot access these lifesaving medications prescribed by their doctor.

Last year a constituent of mine from Bumpass, Virginia wrote me because she could not afford her mother's private assisted living care. She was paying over $550 a month for her mother's prescription drugs, and those huge costs severely limited the care available for her mother. I can only imagine how heartbreaking a decision this must have been for a daughter and her mother—choosing medicine over assisted living care.

That is why I want to recognize the 1,465 Richmond-based employees of Wyeth-Pharmaceuticals, a world-class pharmaceutical research company. These employees participate in charitable company program that offers patients lifesaving medications, free of charge. The Wyeth Patient Assistant Program has been a very successful way for seniors in Richmond and the Nation to get lifesaving medicines free of charge. Wyeth employees are good community partners for Richmond and a group of people that we need to recognize for their kindness and compassion.

But we as Americans can and must do more to help our seniors afford prescription drugs.

Providing voluntary prescription drug coverage to Medicare beneficiaries will ensure that America's seniors will be able to enjoy their golden years while we as their children and grandchildren will be able to enjoy their wisdom and good health. Both a noble and worthy cause.

TRIBUTE TO THE HONORABLE BOB STUMP

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. SKELTON. Mr. Speaker, today I join my colleagues as we pay tribute to our friend, Bob Stump of Arizona. I was deeply saddened to learn of his passing last weekend. I join my colleagues in extending our deepest sympathy to Bob's wife, Nancy, his children, and his entire family.

Bob Stump was my first friend in Congress. Almost 26 years ago, two newly-elected Members of Congress sat down next to each other at an organizational caucus for the 95th Congress, and formed a friendship that has endured and grown through the years. You have to understand that when we met, Bob Stump and I thought we were pretty important. After all, we had both served in the State Legislatures of Arizona and Missouri—as Senators. But we both adjusted and came to love the House of Representatives.

It should be no surprise that I liked Bob from the first time I met him. I could tell immediately that he was a person of character and integrity. He was a true son of the old Southwest:

Strong, yet gentle.
Tough, yet compassionate.
Fiercely independent, yet unfailingly loyal.

He was born in Phoenix in 1927, just 15 years after Arizona joined the Union as the 48th State. He was only 16 when he demonstrated the love of country and the patriotism that would characterize his life in public service. He left high school to join the Navy in 1943, and before his 20th birthday, he had served in combat in World War II. It was no doubt during this time that Bob acquired his life-long respect for the men and women who serve our Nation in uniform. This respect became a commitment, and the commitment became the hallmark of Bob's service here in Congress. As Chairman of both the Armed Services Committee and the Veterans Committee, he worked tirelessly on behalf of our men and women in uniform and our veterans.

No one has done more to ensure that our military and their families have decent pay and benefits, the best equipment and training, and quality housing and facilities. No one has done more to ensure that our Nation honors its commitments to its veterans.

Only last October, Bob's portrait was unveiled at the Armed Services Committee and placed up on the wall where it belongs—among the other great leaders who have chaired the Committee through the years. I feel blessed that I had the opportunity to work closely with Bob during the past two years in my role as Ranking Member of the House Armed Services Committee. As Chairman, he was respectful of others, fair, and honorable. Knowing him as I do, I would have expected no less. On most issues which Congress has faced over these many years, we agreed. On those rare occasions where we did not agree, our disagreement never got in the way of our friendship, and for that I am grateful.

KELLY SHINN'S ESSAY

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to read the essay of Kelly Shinn, a member of the Valley Center Teenage Republican Club.

Being a part of the Teenage Republican club and working for the Republican Party means I have accepted the republican values. By accepting these values I have so far been affected by the party's efforts to keep public schools excellent and accountable. These values will also affect me in the future.

The value of ensuring affordable and accessible health care for children, families, and seniors has already affected my life. Without affordable health care I would not have been able to receive the medical assistance I needed to treat my Irritable Bowel Syndrome and get rid of a stomach parasite. These values will also affect my future and the future of my family. When I start a family of my own I will need affordable health care to keep my husband and children healthy and safe.

Also the value to ensure excellent and accountable public schools for children has already affected and will continue to affect me later in life. I have always attended public schools and because of the Republican Party's fight to keep the public school districts accountable, I have received a wonderful education. My education has given me the confidence I need to continue learning after high school. Keeping schools accountable and excellent will also affect my children. I want to give my children the same opportunity to receive a solid education and the only way to do this is to support the Republican Party.

All of the values that are held by the Republican Party will help secure a government that exists to protect the freedom of each individual. And this means that America will continue to be the home of the brave.

IN RECOGNITION OF CHRISTOPHER BALOGH FOR BEING HONORED WITH THE CONGRESSIONAL AWARD GOLD MEDAL

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. SHAW. Mr. Speaker, I rise today to recognize Christopher Balogh of Jupiter, FL, for receiving the Congressional Award Gold Medal. It is my pleasure to congratulate this fine young resident of the 22nd Congressional District of Florida who has been incredibly dedicated to the betterment of not only his community but himself.

Mr. Speaker, the Congressional Award Gold Medal requires more than 3 years to complete a minimum of 800 hours of community service, 200 hours in both personal development and physical fitness, in addition to a total of four nights of expedition/exploration. These are cumulative hours as Christopher has previously earned the Bronze and Silver Medals. I applaud his hard work and dedication.

Mr. Speaker, I would like to again congratulate Christopher Balogh of my district who is being presented with the Congressional Award Gold Medal today. The outstanding work done by this dedicated young man has been truly influential in his community, and I congratulate him as he is recognized among the Nation's most outstanding young people.

RECOGNIZING THE COMMITTEE FOR CITIZEN AWARENESS

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CRANE. Mr. Speaker, at a time when strained Federal, State, and local budgets are affecting our country's funding for the education of our people, some individuals and organizations in our private sector are doing something about it. They have combined efforts with the Committee for Citizen Awareness (CCA) to provide all the secondary schools and many others in their area with free educational videotapes. These videotapes explain civic issues about our country and how our government works.

The CCA is a nearly two-decade-old not-for-profit organization that produces and distributes award-winning educational videotapes that focus on civic issues. These videotapes feature appearances by people such as Secretary of State Colin Powell, Supreme Court Justice Ruth Bader Ginsburg, many Members of the U.S. House of Representatives, U.S. Senators, and other pertinent individuals.

The subjects covered in these videotapes are particularly important for a number of reasons. For example, although America is the world's greatest democracy, our people vote at a rate lower than any other country. Surveys have shown that one of the major reasons for not using the right to vote is a general lack of understanding of our government and the citizen's role in it. One of the many civic goals of the CCA and these civic-minded individuals and organizations is to correct this problem with the gift of these educational videotapes.

The videotapes are given free to all the public and private high schools, community and junior colleges, community access television stations, and to many libraries and chambers of commerce. Our country and our democracy are better because of the efforts of the CCA and because of its countless dedicated sponsors.

IN RECOGNITION OF ELIZABETH COUNTS FOR BEING HONORED WITH THE CONGRESSIONAL AWARD GOLD MEDAL

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. SHAW. Mr. Speaker, I rise today to recognize Elizabeth Counts of Jupiter, FL, for receiving the Congressional Award Gold Medal. It is my pleasure to congratulate this fine young resident of the 22nd Congressional District of Florida who has been incredibly dedicated to the betterment of not only her community but herself.

Mr. Speaker, the Congressional Award Gold Medal requires more than 3 years to complete a minimum of 800 hours of community service, 200 hours in both personal development and physical fitness, in addition to a total of four nights of expedition/exploration. These are cumulative hours as Elizabeth has previously earned the Bronze and Silver Medals. I applaud her for her hard work and dedication.

I would also like to take this opportunity to recognize Elizabeth's advisor, Ms. Lynn Lyons, who has shown tireless dedication to the Youth Congressional Award and has mentored countless youth over the years. The relationship between Ms. Lyons and her students has been an extraordinary one. Ms. Lyons is now retired after her years of teaching at St. Mark's Episcopal School.

Mr. Speaker, I would like to again congratulate Elizabeth Counts of my district who is being presented with the Congressional Award Gold Medal today. The outstanding work done by this dedicated young women has been truly influential in her community, and I congratulate her as she is recognized among the Nation's most outstanding young people.

HONORING RALPH NURNBERGER

HON. JAMES P. MORAN

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. MORAN of Virginia. Mr. Speaker, today I rise to honor Mr. Ralph Nurnberger who was honored by Georgetown University with their Excellence in Teaching Faculty Award. His dedication to the students and the Liberal Studies Program at Georgetown makes him most deserving of this honor.

Ralph has extensive experience on Capitol Hill. In former Senator James Person's office as the foreign policy legislative assistant and as professional staff on the Senate Foreign Relations committee, he became an international affairs expert.

After his time on the Hill, Ralph became a Senior Fellow and director of congressional relations at the Center for Strategic and International Studies, and later worked for eight years as a lobbyist with the American Israel Public Affairs Committee. Following the historic signing of the Oslo Accords, he was appointed as the Executive Director of "Builders of Peace," an organization set up under the guidance of Vice President Al Gore to aid in the Arab-Israeli peace process. Through his work, Ralph can lead us down a roadmap to a sustainable peace.

Currently, Ralph is with Preston Gates Ellis and Rouvelas Meeds law firm and also heads the government relations firm, Nurnberger and Associates. He has also published extensively and written several books, sharing his insight and knowledge on the Middle-East and the foreign policy of the United States.

While his work with all of these organizations is impressive and worthy of praise, it is through his teaching that he has touched the most lives. Ralph's students have always showered him with the highest praise and always leave his classes with insights that only Professor Nurnberger can give. He engages his students and helps them to understand the most complicated situations through his real life experiences.

Most importantly, Ralph has taught his students how to have a debate over a contentious issue with civility. He encourages his students to hold conversations based on facts, rather than with the emotional intensity that some subjects conjure. Through his classes, Ralph has taught students to be thoughtful and considerate when engaged in civil discourse, something that is too rare in this world.

Ralph Nurnberger is very deserving of this award from Georgetown University. He has helped shape the minds of his students and colleagues with insights on the major issues facing the United States. I congratulate Ralph on all his accomplishments, and I look forward to seeing him one day in a deserved position of national leadership on international relations. Our Nation would be very well served.

IN RECOGNITION OF MATTHEW MILLS FOR BEING HONORED WITH THE CONGRESSIONAL AWARD GOLD MEDAL

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. SHAW. Mr. Speaker, I rise today to recognize Matthew Mills of Jupiter, FL, for receiving the Congressional Award Gold Medal. It is my pleasure to congratulate this fine young resident of the 22nd Congressional District of Florida who have been incredibly dedicated to the betterment of not only his community but himself.

Mr. Speaker, the Congressional Award Gold Medal requires more than 3 years to complete a minimum of 800 hours of community service, 200 hours in both personal development and physical fitness, in addition to a total of four nights of expedition/exploration. These are cumulative hours as Matthew has previously earned the Bronze and Silver Medals. I applaud his hard work and dedication.

I would also like to take this opportunity to recognize Matthew's advisor, Ms. Lynn Lyons, who has shown tireless dedication to the Youth Congressional Award and has mentored countless youth over the years. The relationship between Ms. Lyons and her students has been an extraordinary one. Ms. Lyons is now retired after her years of teaching at St. Mark's Episcopal School.

Mr. Speaker, I would like to again congratulate Matthew Mills of my district who is being presented with the Congressional Award Gold Medal today. The outstanding work done by this dedicated young man has been truly influential in his community, and I congratulate him as he is recognized among the Nation's most outstanding young people.

IN HONOR OF THE MINORITY BUSINESS AND PROFESSIONALS NETWORK'S "FIFTY INFLUENTIAL MINORITIES IN BUSINESS" ANNUAL AWARDS GALA

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. MENENDEZ. Mr. Speaker, I rise today to honor fifty men and women for their outstanding achievements as influential leaders in business. They will be recognized at the Minority Business and Professionals Network's 5th Annual Award Gala at the Crystal Gateway Marriott in Crystal City, Virginia, on June 25, 2003.

The fifty men and women being honored represent a leadership that is diverse, innovative, and incredibly driven. While there have been impressive advancements for minority-owned businesses and minority business leaders, there is much work to be done, and it is critical that such leadership continues to gain strength. These awardees help ensure that minority leadership is growing, and that the voices of minorities are not ignored. Their influence is critical to securing the future success of minority-owned businesses, and their efforts and achievements are a symbol of the strength of minority leadership. As dynamic leaders in their fields and in their communities, their accomplishments are an inspiration to all those looking to succeed.

I would like to recognize the importance of the Minority Business and Professionals Network for providing critical resources that continue to support minority-owned businesses. I thank the Network and its president, Debra Williams, for providing an opportunity to recognize and acknowledge these important leaders.

Today, I ask my colleagues to join me in honoring the Fifty Influential Minorities in Business and congratulating them on their achievements. I wish them continued success as they continue to lead the way for minorities in business.

HUMAN RIGHTS IN CUBA

HON. WALTER B. JONES

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. JONES of North Carolina. Mr. Speaker, I rise today to submit this letter to the Editor for the CONGRESSIONAL RECORD.

The letter was written by a man for whom I have endless respect—my friend Ray Flynn, the President of the American Catholic Alliance, former Mayor of Boston and U.S. Ambassador to the Vatican.

Like myself, Ambassador Flynn believes strongly in fighting for increased human rights and religious freedom throughout the world.

I support Ambassador Flynn and the entire American Catholic Alliance in their efforts to right the wrongs in Cuba.

I would like to enter this document from Ambassador Flynn, entitled, "Human Rights in Cuba" for the RECORD.

HUMAN RIGHTS IN CUBA

Dear Editor: Pope John Paul II publicly released a letter that the Vatican sent to Fidel Castro a couple of weeks ago expressing dismay at Cuba's crackdown on political dissent.

The pope personally appealed to Castro to show leniency with dissidents recently given harsh prison sentences and denounced the execution of the men who seized a ferry to reach the United States.

The letter, which was signed by the Vatican Secretary of State Angelo Cardinal Sodano, stated in part, "The Holy Father felt deeply pained when he learned of the harsh sentences recently imposed on numerous Cuban citizens. And even, for some of them, the death penalty." Thus far, Castro has not acknowledged the letter.

Speaking at a political luncheon in Boston and also later on MSNBC national television on Saturday, I said, "Castro has a human rights record of shame. He has oppressed and persecuted many Cubans including those in the Catholic Church and priests whose only objective was to teach the world about God." The U.S. Government and the international community have closed their eyes to this injustice and terror in Cuba for forty years.

Cuba sits only ninety miles off the United States coast, but it continues to be one of the world's worst violators of human rights. When you see what has been happening in Cuba these many years, you have to be concerned about whether we have lost our moral compass. Our government policy of looking the other way when it comes to human rights abuses must be changed. When members of the U.S. Congress visit Castro in the future, they should demand that the Cuban leader recognize and respect the God given rights of all individuals. Our policy in Cuba has been a failure. Economic boycotts and expanding business opportunities have not worked.

Pope John Paul II has been a clear and consistent moral voice on human rights issues throughout the world, but the international community must be equally committed.

IN RECOGNITION OF PETER BRANNEN, FOR BEING HONORED WITH THE CONGRESSIONAL AWARD GOLD MEDAL

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. SHAW. Mr. Speaker, I rise today to recognize Peter Brannen of Palm Beach Gardens, Florida for receiving the Congressional Award Gold Medal. It is my pleasure to congratulate this fine young resident of the 22nd Congressional District of Florida who has been incredibly dedicated to the betterment of not only his community but himself.

Mr. Speaker, the Congressional Award Gold Medal requires more than three years to complete a minimum of 800 hours of community service, 200 hours in both personal development and physical fitness, in addition to a total of four nights of expedition/exploration. These are cumulative hours as Peter has previously earned the Bronze and Silver Medals. I applaud him and his hard work and dedication.

I would also like to take this opportunity to recognize Peter's advisor, Ms. Lynn Lyons, who has shown tireless dedication to the Youth Congressional Award and has mentored countless youth over the years. The relationship between Ms. Lyons and her students has been an extraordinary one. Ms. Lyons is now retired after her years of teaching at St. Mark's Episcopal School.

Mr. Speaker, I would like to again congratulate Peter Brannen of my district who is being presented with the Congressional Award Gold Medal today. The outstanding work done by this dedicated young man has been truly influential in his community of Florida, and I congratulate him as he is recognized among the nation's most outstanding young people.

IN MEMORY AND PRAISE OF MAYNARD HOLBROOK JACKSON

HON. MAJOR R. OWENS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. OWENS. Mr. Speaker, I join with all of my colleagues, with the family and with all Americans in mourning the passage of a great political leader and a personal friend, Mayor Maynard Jackson. I rise to salute the outstanding achievements of the former Mayor of Atlanta who was also a national political leader and a major asset of the Democratic Party. But before I sound the loud trumpets which are appropriate for the highlighting of Mayor Jackson's public life, I would like to pause and note my fond personal memories of Maynard.

In the Morehouse College class of 1956 he was my classmate. But even more intimate than that space were the roles we shared as part of an experimental program sponsored by the Ford Foundation. Maynard and I were two of 30 college freshmen who had been admitted without completing the last 2 years of high school. Most of the so called "Ford Boys" were 16 years old. Maynard was the youngest at age 14.

Maynard was a native of Atlanta, the location of Morehouse College. He was a member of one of the oldest African American leadership families. Maynard even at that early age had a strong sense of mission and personal responsibility. Despite his youth he became the host for our group of 30 special students. We were from very different worlds. My father was a factory worker who had never earned more than the minimum wage. But during that freshman year Maynard's father who was the minister of one of Atlanta's most prestigious churches, died suddenly. My mother also died in the Spring of that year. Few understand better than I did the sudden escalated maturation of the 14 year old Maynard. It was probably the first great crisis of his life but he rallied his personal resources and he overcame that great emotional obstacle. It was a challenge which set a pattern for the rest of his life and career.

My classmate, Mayor Maynard Jackson leaves a clear and shining legacy for all to see and for African American leaders to utilize as a guiding beacon. Mayor Maynard sought power and through a very creative strategy and set of tactics he won power. But the truly distinguishing achievement of Mayor Maynard Jackson was his bold and uncompromising use of his power to further empower the African American community of Atlanta. In very concrete dollar and cents terms he confronted the business elite of Atlanta and forced the opening of new doors of significant business opportunities for minorities.

Under Mayor Jackson's early leadership as Mayor, Atlanta City contracts soared from less than 1 per cent in 1973 to 39 per cent within 5 years. Many of these contracts were related to the construction of the expanded world class Atlanta airport. It is believed that several dozen new black millionaires were created via Maynard's mandated joint venture models. It is important to note that the airport expansion was still completed ahead of time and under budget. For African Americans unprecedented new opportunities were opened up as a result of the Mayor's confrontation with the white business establishment. Maynard Jackson could never be called an "empty suit" concerned only with the ceremony and symbolism of being the first Black Mayor of Atlanta. The legacy he leaves is a lesson for all African American leaders: power is acquired for the purpose of empowering those who lacked power before. Martin Luther King's movement and the Voting Rights Act were constructed, not to install peacocks with their limited agendas for personal wealth and fame; instead the assumption of public office is a method of extending the struggle.

Let it be noted and fully understood that Maynard Jackson had to pay a price for his courage and his boldness on behalf of the continuing struggle. When he left office as Mayor, the white establishment attempted to lynch him economically by denying him an appropriate berth in the private sector. Fortunately, it was one more hurdle which Maynard overcame. More of the story of the battle of Atlanta must be told in order for the legacy to be understood clearly. Mayor Maynard Jackson was more than just a successful politician. He was a trailblazer, a hero who set high standards that all African American public officials must measure up to in performance.

ANNE E. SMITH—2003 PRESIDENTIAL SCHOLAR

HON. JULIA CARSON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Ms. CARSON of Indiana. Mr. Speaker, it is with a great sense of pride that I rise today to extend heartfelt congratulations to Anne Elizabeth Smith, 2003 Presidential Scholar, Indianapolis, IN.

Anne is a recent graduate of North Central High School, Indianapolis, IN. Her myriad achievements include the prestigious Indiana Honor Diploma and the North Central Honor Diploma. Anne will continue her education at Williams College, Williamstown, MA.

The United States Presidential Scholars Program was established in 1964, by Executive Order of the President. This program was established to recognize and honor some of our Nation's distinguished graduating high school seniors. In almost 40 years since this program was implemented, 4,000 students have been recognized for their outstanding achievement in leadership, scholarship, and community.

I would like to welcome Anne to Washington, DC, for National Recognition Week, where scholars are recognized for their academic achievements.

I would also like to thank Anne's parents, David and Alyson Smith, for providing Anne with the exceptional parental guidance that has contributed to her success.

I ask the House of Representatives to join me in saluting this extraordinary young woman for her academic excellence.

IN RECOGNITION OF CHAD VEZIN FOR BEING HONORED WITH THE CONGRESSIONAL AWARD GOLD MEDAL

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. SHAW. Mr. Speaker, I rise today to recognize Chad Vezin of Jupiter, Florida for receiving the Congressional Award Gold Medal. It is my pleasure to congratulate this fine young resident of the 22nd Congressional District of Florida who has been incredibly dedicated to the betterment of not only his community but himself.

Mr. Speaker, the Congressional Award Gold Medal requires more than three years to complete a minimum of 800 hours of community service, 200 hours in both personal development and physical fitness, in addition to a total of four nights of expedition/exploration. These are cumulative hours as Chad has previously earned the Bronze and Silver Medals. I applaud him for his hard work and dedication.

I would also like to take this opportunity to recognize Chad's advisor, Ms. Lynn Lyons, who has shown tireless dedication to the Youth Congressional Award and has mentored countless youth over the years. The relationship between Ms. Lyons and her students has been an extraordinary one. Ms. Lyons is now retired after her years of teaching at St. Mark's Episcopal School.

Mr. Speaker, I would like to again congratulate Chad Vezin a resident of my district who is being presented with the Congressional Award Gold Medal today. The outstanding work done by this dedicated young man has been truly influential in his community, and I congratulate him as he is recognized among the nation's most outstanding young people.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, June 26, 2003 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

JULY 9

10 a.m.
Indian Affairs
To hold oversight hearings to examine the Indian Gaming Regulatory Act.
SD-106

JULY 16

10 a.m.
Indian Affairs
To hold hearings to examine S. 556, to amend the Indian Health Care Improvement Act to revise and extend that Act.
SR-485

JULY 23

10 a.m.
Indian Affairs
To hold hearings to examine S. 556, to amend the Indian Health Care Improvement Act to revise and extend that Act.
SR-485
Judiciary
To hold oversight hearings to examine certain pending matters.
SD-226

JULY 30

10 a.m.
Indian Affairs
To hold hearings to examine S. 578, to amend the Homeland Security Act of 2002 to include Indian tribes among the entities consulted with respect to activities carried out by the Secretary of Homeland Security.
SR-485

HOUSE OF REPRESENTATIVES—*Thursday, June 26, 2003*

The House met at 10 a.m.

Rabbi Milton Balkany, Dean, Bais Yaakov of Brooklyn, New York, offered the following prayer:

Our Father in Heaven, the majestic sequoias tower over the Alpine expanses, and yet they continue to stretch upward toward the Sun. The mighty Colorado River carved the awesome grandeur of the Grand Canyon eons ago, yet it continues to surge ever onward. The thrashing tide of the Atlantic has brought innumerable ships to port, and yet the waves ebb and flow without cease. I stand here today among the jewels of our Nation, among men and women who are precious, who radiate dedication, and they have been selected as the leaders of our land. And I pray to You, O Lord, that they too remain unsatisfied with yesterday. Let them grow with insight and turn the tide for our land, for we need them, their wisdom, devotion and energy, now more than ever. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

Mr. MCNULTY. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER. The question is on the Speaker's approval of the Journal.

The question was taken; and the Speaker announced that the ayes appeared to have it.

Mr. MCNULTY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER. Pursuant to clause 8, rule XX, further proceedings on this question are postponed until later today.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Tennessee (Mr. COOPER) come forward and lead the House in the Pledge of Allegiance.

Mr. COOPER led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed without amendment bills of the House of the following titles:

H.R. 825. An act to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the "Michael J. Healy Post Office Building".

H.R. 917. An act to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the "Floyd Spence Post Office Building".

H.R. 925. An act to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the "Cesar Chavez Post Office".

H.R. 981. An act to designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the "James R. Merry Post Office".

H.R. 985. An act to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the "Delbert L. Latta Post Office Building".

H.R. 1055. An act to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the "Dr. Roswell N. Beck Post Office Building".

H.R. 1368. An act to designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the "Norman D. Shumway Post Office Building".

H.R. 1465. An act to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the "General Charles Gabriel Post Office".

H.R. 1596. An act to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the "Timothy Michael Gaffney Post Office Building".

H.R. 1609. An act to redesignate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the "Admiral Donald Davis Post Office Building".

H.R. 1740. An act to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the "Dr. Caesar A.W. Clark, Sr. Post Office Building".

H.R. 2030. An act to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building".

The message also announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 163. An act to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes.

S. 498. An act to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine, in recognition of his contributions to the Nation.

S. 867. An act to designate the facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, as the "Ronald Reagan Post Office Building".

S. 1207. An act to redesignate the facility of the United States Postal Service located at 120 East Ritchie Avenue in Marceline, Missouri, as the "Walt Disney Post Office Building".

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The gentlewoman from New York (Mrs. KELLY) will be recognized for 1 minute, followed by 5 one-minutes on each side.

WELCOMING RABBI MILTON BALKANY

(Mrs. KELLY asked and was given permission to address the House for 1 minute.)

Mrs. KELLY. Mr. Speaker, Rabbi Milton Balkany, Dean of Bais Yaakov in Brooklyn, New York, is an acquaintance of mine. He has been an active participant and leader in the Jewish community in New York City for many, many years. Rabbi Balkany has worked hard to bring the community together in order to continue traditional religious and cultural values. Not only does he help younger generations understand the intrinsic and extraordinary Jewish culture to which they belong, but he also welcomes others of all religions to engage in prayer, meditation and community.

I applaud you, Rabbi, on this special occasion and welcome you as the guest chaplain of the House of Representatives.

REGARDING AMENDMENT TO INTELLIGENCE BILL

(Mr. KUCINICH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KUCINICH. Madam Speaker, yesterday in debate over H.R. 2417, the intelligence bill, the chairman of the committee refused to commit to an Intelligence Committee audit of all telephone and electronic communications between the Central Intelligence Agency and the Vice President to determine whether or not the Vice President influenced intelligence produced by the CIA on Iraq's alleged weapons of mass destruction, the cause of war. First, the chairman said the material may be classified and, second, working documents of the executive are respected and privileged. Some Members want the Permanent Select Committee on Intelligence to have jurisdiction over

☐This symbol represents the time of day during the House proceedings, e.g., ☐1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

the issue which top committee members clearly do not want to investigate. If an executive official pressured or manipulated CIA analysts to disseminate false, raw, unreliable information to justify a war, that matter should be neither classified nor shielded nor privileged. My amendment to the intelligence bill would direct the Inspector General of the CIA to audit all electronic communications between the Office of the Vice President and CIA to get to the bottom of numerous public reports which raise questions as to whether or not the Vice President played a role in making false information to become the public reason the President went to war in Iraq.

MEDICARE MODERNIZATION

(Mr. FORBES asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. FORBES. Madam Speaker, I rise today in support of a comprehensive prescription drug benefit for all seniors. The Prescription Drug and Medicare Modernization Act of 2003 will guarantee prescription drug coverage to all our seniors and future generations. I firmly belief that no senior should be forced to choose between putting food on the table or buying the medicines they need. The Prescription Drug and Medicare Modernization Act would build on the strengths and successes of the current Medicare system while guaranteeing that all seniors will have access to a prescription drug benefit.

Just the other day the Secretary of Health and Human Services released a study which says that seniors will get an up-front drug discount of 25 percent. That is a significant savings for many of the seniors in my district. The reforms in this legislation will put patients before paperwork and ensure that doctors will continue to serve seniors through Medicare. The House has acted in the past and will work with the Senate to provide affordable, voluntary coverage for every senior immediately. Let us pass this important legislation. Our seniors have waited too long for this much-needed relief.

MEDICARE MODERNIZATION

(Mr. DeFAZIO asked and was given permission to address the House for 1 minute.)

Mr. DEFAZIO. Madam Speaker, the Republican Medicare prescription drug bill will provide unprecedented benefits and protection. Unfortunately, the benefits and protection under this perverse legislation will all flow to the pharmaceutical and insurance industries, not the seniors who need help paying their prescription drug bills. That is right. The biggest beneficiaries are the wildly profitable pharmaceutical industry and the anticompetitive insurance industry. You cannot provide a meaningful benefit unless you deal with the obscene price of prescription drugs. And this bill does nothing, not reasonable pricing, not reimportation, not negotiated lowering of prices, nothing, because that would hurt the profits of the pharmaceutical industry. The insurance industry, they will get a subsidy under this bill to offer some sort of benefit without any requirement what those benefits might be, without any limit on the premiums they might charge, without any requirement who they might provide coverage to or exclude, all beginning in 2006.

We just heard about the great affordable plan we are going to offer today. This begins in the year 2006 and seniors who pay $4,500 a year for drugs will get $3,500 out of their pocket and a thousand from this bill. This is the pharmaceutical industry and insurance industry protection legislation.

HONORING THE 40TH ANNIVERSARY OF THE NATIONAL DRAFT GOLDWATER RALLY

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Madam Speaker, yesterday was the funeral for a great statesman from Arizona, former House Armed Services Chairman Bob Stump. I was reminded of another late Arizona statesman, Senator Barry Goldwater. In fact, next week marks the 40th anniversary of his significant step in the historic presidential campaign he waged in 1964. On July 4, 1963, the National Draft Goldwater Rally was held at the Washington National Guard Armory. I was honored as a young teenager to come on a bus from South Carolina with some of the founders of the modern Republican Party, Drake Edens, Floyd Spence and Rusty DePass. This failed presidential campaign actually was spectacularly successful in launching a political revolution for limited government and expanded freedom. Especially in the South, Republican conservatism has risen from virtual nonexistence to majority status on the local, State and Federal level.

I am grateful for the lasting influence of Barry Goldwater, who inspired victory over communism, achieved by Ronald Reagan, and an emphasis on expanding freedom by reducing taxation, promoted by George W. Bush.

In conclusion, God bless our troops.

MEDICARE PRESCRIPTION DRUG BENEFIT

(Mr. COOPER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. COOPER. Madam Speaker, today is the day that our seniors have been waiting for for many, many years, the day that we will pass a Medicare prescription drug benefit. Unfortunately, the real debate took place last night upstairs in an attic room in this building in the dark of night, literally starting after midnight, from 1 to 4 a.m., burglar hours, not lawmaker hours. In that debate, they foreclosed real debate on this floor today. They allowed only two bills to be considered, the Republican plan which is deeply flawed, which will end Medicare as we know it, and another plan which is too large to fit within the budget window. I supported the Dooley alternative, a much more sensible piece of legislation. Our seniors deserve better, much better than will be done for them on this House floor today.

□ 1015

PRESCRIPTION DRUG LEGISLATION

(Mr. PENCE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PENCE. Madam Speaker, as Congress considers the prescription drug legislation today, I think it is important for the American people to remember a few simple facts. This would be the biggest new Federal entitlement since 1965 when Medicare was created. Medicare currently costs seven and a half times what this Congress said it would cost when they invented it.

Seventy-six percent of seniors in America today already have prescription drug coverage and according to the CBO under some versions of this legislation more than a third of those Americans who enjoy coverage from a private employer from whom they have retired could lose that coverage.

If the foundations be destroyed, what can the righteous do? Let us not in this Congress today sow the seeds to destroy the foundation of a free market system by creating a universal drug benefit in Medicare. The answer is the reforms the President called for giving Americans the same choices that the Members of Congress have. It is not to create a massive new Federal entitlement.

REPUBLICAN MEDICARE BILL

(Ms. LORETTA SANCHEZ of California asked and was given permission to address the House for 1 minute.)

Ms. LORETTA SANCHEZ of California. Madam Speaker, I heard a strange rumor last night that the Republican Party was going to change its mascot from the elephant to the night owl. This would be fitting since most legislation these days is being discussed by Republicans in the dark of night behind closed doors without giving Democrats a fair chance to debate it here on the House floor.

Today we are going to vote on legislation that will provide the most significant reform in Medicare since its creation in 1965. This legislation will impact millions of seniors across the Nation, yet many of the Representatives in Congress will not have seen this legislation until today. Would someone sign their name on a long-term mortgage for their home if they had never stepped inside that house?

Moreover, many well thought out amendments today will not be debated. For example, my simple, cost effective proposal for a Medicare prescription drug benefit, they did not allow us to bring it to the floor to discuss it. The night owls have yet again ruined a perfect opportunity on what should really be bipartisan legislation. Ain't that a hoot.

HONORING SERGEANT JACOB BUTLER

(Mr. RYUN of Kansas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. RYUN of Kansas. Mr. Speaker, I rise today on behalf of a true patriot. It will soon be July 4, a date etched in America's heart. A day that serves as a time of reflection and celebration in the memory of sacrifices made; sacrifices made throughout history that granted us the freedoms that we enjoy today.

As our Nation celebrates our independence, it seems appropriate to pay tribute to an Army sergeant that meant a great deal to Kansas and our country. Sergeant Jacob Butler, from Wellsville, Kansas, joined the Army as a private at the young age of 19. He later rose to the rank of sergeant and accepted the demanding task of a scout. Unfortunately, Jacob Butler was killed April 1 when a rocket propelled grenade hit his vehicle in Iraq. It was an honor to attend Jacob's memorial service and funeral with his parents, Jim and Cindy, his friends, his family, and his fellow soldiers. The ceremony reminded me once again that great sacrifices for the causes of freedom did not end on July 4, 1776. Sacrifices continue today.

Jacob is no longer only a blessing to his friends and family, he is now a blessing to an entire Nation. On behalf of the people of Kansas and this grateful Nation, I ask that we remember Sergeant Jacob Butler as a son, a friend, a soldier, and a patriot.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore (Mr. PENCE). Pursuant to House Resolution 295 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the further consideration of the bill, H.R. 2417.

□ 1020

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the further consideration of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, with Mrs. BIGGERT (Chairman pro tempore) in the chair.

The Clerk read the title of the bill.

The CHAIRMAN pro tempore. When the Committee of the Whole rose on Wednesday, June 25, 2003, a request for a recorded vote on amendment No. 6 printed in House report 108–176 by the gentlewoman from California (Ms. LEE) had been postponed.

SEQUENTIAL VOTES POSTPONED IN COMMITTEE OF THE WHOLE

The CHAIRMAN pro tempore. Pursuant to clause 6 of rule XVIII, proceedings will now resume on those amendments on which further proceedings were postponed in the following order:

Amendment No. 4 offered by the gentleman from Florida (Mr. HASTINGS); amendment No. 5 offered by the gentleman from Ohio (Mr. KUCINICH); amendment No. 6 by the gentlewoman from California (Ms. LEE).

The first electronic vote, if ordered, will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

AMENDMENT NO. 4 OFFERED BY HASTINGS OF FLORIDA

The CHAIRMAN pro tempore. The unfinished business is the demand for a recorded vote on the amendment offered by the gentleman from Florida (Mr. HASTINGS) on which further proceedings were postponed and on which the ayes prevailed by voice vote.

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 4 offered by Mr. HASTINGS of Florida:

At the end of subtitle D of title III, insert the following new section:

SEC. 337. IMPROVEMENT OF RECRUITMENT, HIRING AND RETENTION OF ETHNIC AND CULTURAL MINORITIES IN THE INTELLIGENCE COMMUNITY.

(a) PILOT PROJECT TO IMPROVE DIVERSITY THROUGHOUT THE INTELLIGENCE COMMUNITY USING INNOVATIVE METHODOLOGIES FOR THE RECRUITMENT, HIRING AND RETENTION OF ETHNIC AND CULTURAL MINORITIES AND WOMEN WITH THE DIVERSITY OF SKILLS, LANGUAGES AND EXPERTISE REFLECTIVE OF THE CURRENT MISSION.—The Director of Central Intelligence shall carry out a pilot project under this section to test and evaluate alternative, innovative methods to recruit and hire for the intelligence community women and minorities with diverse ethnic and cultural backgrounds, skills, language proficiency, and expertise.

(b) METHODS.—In carrying out the pilot project, the Director shall employ methods such as advertising in foreign language newspapers in the United States, site visits to institutions with a high percentage of students who study English as a second language, and other methods that are not used by the Director under the DCI Diversity Strategic Plan to increase diversity of officers and employees in the intelligence community.

(c) DURATION OF PROJECT.—The Director shall carry out the project under this section for a 3-year period.

(d) REPORT.—Not later than 2 years after the date the Director implements the pilot project under this section, the Director shall submit to Congress a report on the project. The report shall include—

(1) an assessment of the effectiveness of the project; and

(2) recommendations on the continuation of the project as well as for improving the effectiveness of the project in meeting the goals of increasing the recruiting and hiring of women and minorities within the intelligence community.

(e) DIVERSITY PLAN.—(1) Not later than February 15, 2004, the Director of Central Intelligence shall submit to Congress a report which describes the plan of the Director, entitled the "DCI Diversity Strategic Plan", and any subsequent revision to that plan, to increase diversity of officers and employees in the intelligence community, including the short- and long-term goals of the plan. The report shall also provide a detailed description of the progress that has been made by each element of the intelligence community in implementing the plan.

(2) In implementing the plan, the Director shall incorporate innovative methods for the recruitment and hiring of women and minorities that the Director has determined to be effective from the pilot project carried out under this section.

(f) DEFINITION.—In this section, the term "intelligence community" has the meaning given that term in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401(4)).

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 418, noes 0, not voting 16, as follows:

[Roll No. 318]

AYES—418

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor

Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
English
Eshoo
Etheridge
Evans
Everett
Farr
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Young (FL)

NOT VOTING—16

Brown-Waite, Ginny
Conyers
Cubin
Engel
Fattah
Gephardt
Hulshof
Jefferson
Kaptur
Kleczka
Rangel
Sessions
Smith (WA)
Weldon (PA)
Wynn
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (Mrs. BIGGERT) (during the vote). Members are reminded there are 2 minutes remaining on this vote.

☐ 1042

Messrs. TANCREDO, SIMPSON, CANTOR, GARY G. MILLER of California, and FLAKE changed their vote from "no" to "aye."

So the amendment was agreed to.

The result of the vote was announced as above recorded.

AMENDMENT NO. 5 OFFERED BY MR. KUCINICH

The CHAIRMAN pro tempore. The unfinished business is the demand for a recorded vote on Amendment No. 5 offered by the gentleman from Ohio (Mr. KUCINICH) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 5 offered by Mr. KUCINICH:

At the end of title III, add the following new section:

SEC. 345. REPORT ON COMMUNICATIONS BETWEEN THE CENTRAL INTELLIGENCE AGENCY AND THE OFFICE OF THE VICE PRESIDENT ON WEAPONS OF MASS DESTRUCTION IN IRAQ.

(a) AUDIT.—The Inspector General of the Central Intelligence Agency shall conduct an audit of all telephone and electronic communications between the Central Intelligence Agency and the Office of the Vice President that relate to weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom on or after September 11, 2001.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the audit conducted under subsection (a). The report shall be submitted in unclassified form, but may contain a classified annex.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The CHAIRMAN pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 76, noes 347, not voting 11, as follows:

[Roll No. 319]

AYES—76

Allen
Baldwin
Becerra
Berkley
Blumenauer
Brown (OH)
Brown, Corrine
Capps
Capuano
Carson (IN)
Clay
Clyburn
Davis (IL)
DeFazio
Delahunt
Dingell
Doggett
Farr
Filner
Frank (MA)
Grijalva
Gutierrez
Hinchey
Honda
Inslee
Jackson (IL)
Jackson-Lee (TX)
Johnson, E. B.
Jones (OH)
Kleczka
Kucinich
Lee
Lewis (GA)
Lofgren
Maloney
Markey
McDermott
McGovern
Meehan
Meeks (NY)
Miller, George
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Olver
Owens
Pastor
Paul
Payne
Rahall
Rush
Ryan (OH)
Sanders
Schakowsky
Scott (VA)
Serrano
Slaughter
Solis
Stark
Strickland
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey

NOES—347

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Andrews
Baca
Bachus
Baird
Baker
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bell
Bereuter
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardin
Cardoza
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Fattah
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Isakson

Israel
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Kanjorski
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Manzullo
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McHugh
McInnis
McIntyre
McKeon
McNulty
Meek (FL)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mollohan
Moore
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Obey
Ortiz
Osborne
Ose
Otter
Oxley
Pallone
Pascrell
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schiff
Schrock
Scott (GA)
Sensenbrenner
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Souder
Spratt
Stearns
Stenholm
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Turner (TX)
Upton
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (FL)

NOT VOTING—11

Brown-Waite, Ginny
Conyers
Cubin
Gephardt
Jefferson
Kaptur
Rangel
Sessions
Smith (WA)
Wynn
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (Mrs. BIGGERT) (during the vote). Members are reminded that there are 2 minutes remaining in this vote.

□ 1051

Ms. DeLAURO and Mr. REYNOLDS changed their vote from "aye" to "no."

So the amendment was rejected.

The result of the vote was announced as above recorded.

AMENDMENT NO. 6 OFFERED BY MS. LEE

The CHAIRMAN pro tempore. The unfinished business is the demand for a recorded vote on amendment No. 6 offered by the gentlewoman from California (Ms. LEE) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 6 offered by Ms. LEE:

At the end of title III, add the following new section:

SEC. 345. REPORT ON INTELLIGENCE SHARING WITH UNITED NATIONS WEAPONS INSPECTORS SEARCHING FOR WEAPONS OF MASS DESTRUCTION IN IRAQ.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study to determine the extent to which intelligence developed by the Department of Defense and by the intelligence community with respect to weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom was made available to the United Nations weapons inspectors and the quantity and quality of the information that was provided (if any).

(b) SPECIFIC MATTER STUDIED.—The study shall provide for an analysis of the sufficiency of the intelligence provided by the Director of Central Intelligence to those weapons inspectors, and whether the information was provided in a timely manner and in a sufficient quantity and quality to enable the inspectors to locate, visit, and conduct investigations on all high and medium value suspected sites of weapons of mass destruction.

(c) ACCESS TO INFORMATION.—(1) Subject to paragraph (2), the Comptroller General may secure directly from any agency or department of the United States information necessary to carry out the study under subsection (a).

(2) The appropriate Federal agencies or departments shall cooperate with the Comptroller General in expeditiously providing appropriate security clearance to individuals carrying out the study to the extent possible pursuant to existing procedures and requirements, except that no person shall be provided with access to classified information under this section without the appropriate security clearances.

(d) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall be submitted in unclassified form, but may contain a classified annex.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The CHAIRMAN pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 185, noes 239, not voting 10, as follows:

[Roll No. 320]

AYES—185

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Majette
Maloney
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Moore
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu

NOES—239

Aderholt
Akin
Alexander
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardoza
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cooper
Cox
Cramer
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Holden
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline

Knollenberg
Kolbe
LaHood
Lantos
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Marshall
McCotter
McCrery
McHugh
McInnis
McKeon
McNulty
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mollohan
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ruppersberger
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (FL)

NOT VOTING—10

Brown-Waite, Ginny
Conyers
Cubin
Gephardt
Lynch
Rangel
Sessions
Smith (WA)
Wynn
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (during the vote). Members are reminded that there are 2 minutes remaining in this vote.

☐ 1059

So the amendment was rejected.

The result of the vote was announced as above recorded.

☐ 1100

The CHAIRMAN pro tempore (Mrs. BIGGERT). The question is on the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The CHAIRMAN pro tempore. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. SHIMKUS) having assumed the chair, Mrs. BIGGERT, Chairman pro tempore of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, pursuant to House Resolution 295, she reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment to the committee amendment in the nature of a substitute adopted by the Committee of the Whole? If not, the question is on the amendment.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

(By unanimous consent, Mrs. HARMAN was allowed to speak out of order.)

THANKING MEMBERS AND STAFF

Ms. HARMAN. Mr. Speaker, now that we have completed debate on our intelligence authorization bill for 2004, I just wanted to thank our chairman who is graceful, collaborative and bipartisan and the members and staff on the majority side and to thank the strong team we have on the Democratic side and especially our staff. By name: Christine Healey, John Keefe, Marcel Lettre, Wyndee Parker, Beth Larson, Kirk McConnell, Bob Emmett and Ilene Romack; and also David Flanders of my personal staff for all the effort they put into yesterday's very thorough and, I thought, outstanding debate.

(By unanimous consent, Mr. GOSS was allowed to speak out of order.)

THANKING MEMBERS AND STAFF

Mr. GOSS. Mr. Speaker, I too would like to congratulate my ranking member and the members of the staff on both sides of the aisle. Normally I would name all those staff. This year I am just going to point to one individual who really was the architect of the bill for the majority, put it together, did the hard work as he always does. He does the budget number and he understands the programs. His name is Mike Meermans. In addition to the spectacular work he did for us in a bipartisan and a thoroughly professional way, Mr. Meermans and his family had a sudden and significant illness in the family. We wish his family well and we wish his son Godspeed, full and complete recovery.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GOSS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

GENERAL LEAVE

Mr. GOSS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on H.R. 2417.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

Mr. LINDER. Madam Speaker, by direction of the Committee on Rules, I call up House Resolution 297 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 297

Resolved, That during the remainder of the One Hundred Eighth Congress, the Speaker may entertain motions that the House suspend the rules on Wednesdays as though under clause 1 of rule XV.

The SPEAKER pro tempore (Mrs. BIGGERT). The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

Mr. LINDER. Madam Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Madam Speaker, H. Res. 297 is a simple, straightforward measure that authorizes the Speaker to entertain motions to suspend the rules on Wednesdays for the remainder of the 108th Congress. I strongly supported this proposal and urge all of my colleagues in the House to join with me in approving this measure.

This past Monday, the Rules Subcommittee on Technology and the House, which I chair, held a hearing to consider this very proposal. The chairman of the Committee on Rules testified on this proposal, and the subcommittee gathered testimony from the minority whip, the gentleman from Maryland (Mr. HOYER), and the gentleman from Massachusetts (Mr. FRANK) as well.

During the debate on H. Res. 297, I urge my colleagues to keep their remarks to the underlying measure, rather than use this modest proposal as an excuse to debate other matters. Extending the Speaker's ability to entertain motions to suspend the rules on Wednesdays provides the House leadership with another tool that can be used to easily move noncontroversial legislation through the Chamber.

By way of background, when the House convened on January 7, 2003, we adopted H. Res. 5, the House rules for the 108th Congress. Specifically, clause 1 of rule XV provides that it is in order for the House to entertain a motion to suspend the rules on Mondays, Tuesdays, and in the last 6 days of session of Congress. That very same day, the House also approved a standing order that authorized the Speaker to entertain motions to suspend the rules on Wednesdays, through the second Wednesday in April. On April 30, 2003, the House adopted a unanimous consent agreement that extended the authority of the Speaker to entertain motions to suspend the rules through yesterday, June 25. There have been a total of 16 Wednesdays this year on which the House could have considered legislation under suspension of the rules. Through yesterday, this authority was exercised 13 times.

Entertaining motions to suspend the rules on Wednesdays has been a valuable and helpful tool for the House leadership. In fact, just a few weeks ago, the minority showed how much clout they can have actually in defeating these suspensions when they opposed two Senate-passed public lands bills and both measures failed under suspension of the rules. Eventually, we brought both measures back to the floor where they were overwhelmingly approved. There is simply no evidence to support any claim that permitting the Speaker to entertain motions to suspend the rules on Wednesdays limits or infringes on the rights of the minority.

Madam Speaker, approving this resolution is the right thing to do.

Madam Speaker, I reserve the balance of my time.

Mr. McGOVERN. Madam Speaker, I thank the gentleman from Georgia for yielding me this time, and I yield myself 5½ minutes.

This resolution is simple. It allows the Republican leadership to consider suspension bills on Wednesdays. Current rules allow this body to consider suspension bills on Mondays and Tuesdays. A special provision in the rules allows the majority to place items under the suspension of the rules on Wednesday as well. That special provision expires soon, and it is my understanding that the majority would like to extend it through the 108th Congress.

Madam Speaker, I am rising today to strongly oppose this resolution, and I urge my colleagues to vote "no" and defeat the resolution. I have serious concerns about not only the suspension process but about the way this House is being managed. Suspensions should be reserved for noncontroversial items that do not require lengthy debate by the full House. Controversial issues or substantive issues should not be brought to the House floor under the suspension process, a process that allows little debate and no amendments.

But, Madam Speaker, this House is becoming a place where trivial issues get debated passionately and important ones not at all. The majority of this House already allows far too little debate on critical issues facing the American people. Later today, we will debate the most sweeping changes to Medicare since the program was created 38 years ago. Two days ago, I asked the chairman of the Committee on Rules when as a Member of the House I could examine this hugely important bill, and I was told emphatically that it would be available online yesterday morning. So I got up early yesterday morning, and I logged on at home; but there was no bill. I checked again during the day, but again no bill. Finally at 11:50 p.m. last night, we were given a copy of the bill and told the Committee on Rules would hold an emergency meeting an hour later to consider this bill, and we reported the rule at 5 a.m. this morning.

Why the rush to do this bill in the middle of the night? Is this bill so important, so time sensitive that the Republicans need to force it through the Committee on Rules in the dead of night? When I asked the distinguished chairman of the Committee on Rules why it was considered an emergency hearing, all he could tell me was that he called the emergency hearing because it is his prerogative as chairman of the committee and he wanted to do it this way. We had only an hour to look at this final bill, a bill that is close to 700 pages long.

This process, Madam Speaker, is disgraceful. It demeans this body, and it insults the American people who rely on us to read, to debate, and to vote knowledgeably on legislation. It is clear that the Republican leadership wants to rush this bill through this body as quickly as possible. The other body has already spent 2 weeks debating this bill. They will consider over 70 amendments before they are done. Republicans and Democrats alike have been able to bring their amendments to the floor in the other body and to be heard and to debate these issues. Fifty-eight amendments on the Medicare bill were brought to the Committee on Rules this morning. Only one substitute was made in order. Everything else, including some very thoughtful amendments offered by Republicans, was denied. We will have a grand total of 4 hours to discuss a bill that will fundamentally change the way 40 million Americans pay for the medicines that they need.

This process is awful, Madam Speaker; and this resolution will make it worse. The question is quite simple. Rather than naming more post offices on Wednesdays, why do we not have more debate? What is wrong, for example, with this House spending a few days or even a week on the Medicare prescription drug bill? Why not let more Members, Democrats and Republicans alike, have an opportunity to be heard? We obviously have the time; otherwise you would not be here asking for more suspensions to be scheduled. I understand that the majority has a responsibility to run the House, to move legislation through this process. The Committee on Rules can be a tool in that effort; but under this Republican leadership, the Committee on Rules has become not a tool but a weapon, a weapon that stifles debate, that shuts Members and their constituents out of the legislative process, destroys the committee process and harms the public interest, all behind closed doors and often in the middle of the night.

As Members know, and the American people are noticing, the Committee on Rules is where the sausage gets made and it is not pretty.

□ 1115

The facts speak for themselves. Two thirds of the rules reported by this committee in the 106th Congress were closed or restricted. That increased almost three-fourths in the 107th Congress. In fact, less than 30 percent of the rules reported by this committee in the 107th Congress were open. And so far this year of the 52 rules reported by the Committee on Rules six have been open rules, six of 52.

All of this may sound like Inside Baseball to most Americans, but as we can see with the prescription drug bill this stuff matters. In the House of Representatives process determines a great deal, and lately, Madam Speaker, the process around here has been lousy.

When they were in the minority, Republicans consistently complained about their treatment by the then Democratic majority. So if this is payback for the way Democrats ran the House, then call it payback, but please do not claim that this is fair and balanced when it is clearly not. Americans are better served with an open democratic process. It is in the public interest to allow the full and free debate and to have many people and many different points of view heard and considered by Members of the people's House.

In 1994, while still in the minority, Chairman DREIER gave a speech about the undemocratic nature of the Committee on Rules. In that speech he said that "the arrogance of power with which they prevent Members, rank-and-file Democrats and Republicans, from being able to offer amendments, that is what really creates the outrage here." The wisdom of his words still apply today. The arrogance of power is indeed a dangerous thing.

Madam Speaker, I reserve the balance of my time.

Mr. LINDER. Madam Speaker, I reserve the balance of my time.

Mr. McGOVERN. Madam Speaker, I yield 5 minutes to the distinguished gentleman from Texas (Mr. FROST), the ranking member on the House Committee on Rules.

Mr. FROST. Madam Speaker, I thank the gentleman for yielding me this time.

Let us be very clear about what is happening on the floor today. The

United States Senate has a procedure called a filibuster where Members can get up and talk and fill time. Up until today the House does not have a filibuster. What we are doing is to pass a bill, a change in our rules, that would create a filibuster on the floor of the House and prevent Members from having the opportunity to debate substantive matters.

Why do I say that? We are going to add an extra day of suspensions. Why do the Republicans want to add an extra day of suspensions? They want to use our valuable floor time for minor noncontroversial matters. Why do they want to use our valuable floor time for minor noncontroversial matters? Because they do not want to provide full debate on matters like changing Medicare and the new prescription drug plan. Why do they not want to provide full debate on Medicare and prescription drugs? They do not have enough time. There is not enough time for us to do this. Why do not we have enough time? Because they are bringing more noncontroversial bills to the floor.

It is very interesting. This is of course the oft remarked case of the young person who killed his parents and throws himself on the mercy of the court because he is an orphan.

Let us be very clear what the Republicans are doing. They do not want to debate the key substantive issues that face this country. What did they do in the rule last night, this morning? We were here until 5:15 a.m. this morning. Why were we here until 5:15 a.m. this morning in the Committee on Rules? Because our meeting did not start until 12:50 a.m. this morning. Why did it not start until 12:50 this morning? Because the Republicans did not want a meeting that would be widely covered by the press and it would be easily accessible to our Members to come and testify. A lot of very good Members, a lot of conscientious Members on both sides of the aisle stayed up. They were there at 12:50 a.m. and they testified until 5 a.m. this morning, and what did the Republicans on the Committee on Rules do? They told them thanks for coming but no thanks, they are not going to give them any time on the floor, they will not give them an amendment. They did this to some of their own Members as well as to Democrats. Why are they doing that? Because they do not want their own Members to have to vote on things that might be embarrassing for them when they go back to the next election.

So that brings us to where we are today. We are going to create a filibuster rule in the House. We are going to permit the Republican leadership to filibuster, to use our time, our valuable floor time, by bringing noncontroversial bills commending people for things they have done, naming facilities, all kinds of things. We used to just do those in a day or two. Now we are going to have 3 days of those bills and now, "Oh, by the way, we will not have any time for you to offer your amendment on Medicare, we will not have any time for you to offer your amendment on prescription drugs. We have used up all our time. We have created another suspension day."

Mr. LINDER. Madam Speaker, I reserve the balance of my time.

Mr. McGOVERN. Madam Speaker, I yield 3½ minutes to the distinguished gentleman from Florida (Mr. HASTINGS), another member of the Committee on Rules.

Mr. HASTINGS of Florida. Madam Speaker, I thank the gentleman from Massachusetts (Mr. McGOVERN) for yielding me this time. And the gentleman from Texas (Mr. FROST), the ranking member who is a most distinguished member of the Committee on Rules, is very generous to my colleagues on other side when he says they will bring up nonsubstantive matters on the suspension calendar under the rule that is proposed now, to add a day where suspension matters of the rules can be brought to our attention.

I am not that generous because among the things that I believe that are likely to happen is that we are going to see substantive legislation here on the floor of the House under the suspension calendar. And when that happens that means it did not come to the Committee on Rules. Members did not have an opportunity to amend it. When it is here on the House floor they each have 20 minutes per side and one can bring the most major matter; for example, we were up last night, as has been pointed out, from 12:50 until 5:15 this morning in the Committee on Rules. That is all right, but would the Members believe that under this particular rule that is coming in the middle of a session that what we could also do is bring this same Medicare measure up if we wanted to under the majority provision?

I cannot say it too well, but I said to the chairman of the committee, why are we doing this in the middle of the night? It would seem to me that what we can do is work 9 to 5 Monday through Friday rather than having to have this lack of time. The American people send us up here to work. They do not send us up here to avoid time.

Mr. DREIER. Madam Speaker, will the gentleman yield?

Mr. HASTINGS of Florida. I yield to the gentleman from California.

Mr. DREIER. Madam Speaker, I thank my friend for yielding. And let me begin by expressing my appreciation to him for the hard work that he put into the Committee on Rules meeting last night.

My friend just mentioned the fact that measures that are considered under suspension of the rules are nonsubstantive and his concern is the fact that we may bring up substantive measures under suspension of the rules. The fact of the matter is major substantive pieces of legislation should come up under suspension of the rules. They can only pass if there is a two-thirds vote. The only requirement is that in fact 61 Democrats joined with every Republican to pass the measure.

I thank my friend for yielding. I just wanted to make that clear.

Mr. HASTINGS of Florida. Madam Speaker, reclaiming my time, the gentleman from Massachusetts (Mr. FRANK) will speak to that a little later and tell us how tricky that is when they put matters on and Members cannot, for example, make a distinction between whether they want to vote yes or no and when many times they will want to vote no and find themselves in a box. I believe the gentleman from Massachusetts (Mr. FRANK) will be able to explain it better than I.

The gentleman's chairman and mine, the gentleman's good friend and mine, Gerald Solomon, said the following: Every time we deny an open amendment process on an important piece of legislation, we are disenfranchising the people and their representatives from the legislative process. The people and their representatives are not being even treated as second class citizens. And what I said to the chairman is that roughly 48.9 percent of the people in this country are represented by Democrats.

Let me end by saying what Gerald Solomon said: The people are sick and tired of this political gamesmanship. They want back into their House, and they do want it open and democratic, not closed and dictatorial.

Anybody that believes that this measure is going to help this House of Representatives is participating in what Gerald Solomon described as a closed and dictatorial body, and time will tell.

Mr. LINDER. Madam Speaker, I reserve the balance of my time.

Mr. McGOVERN. Madam Speaker, I yield 2 minutes to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. Madam Speaker, I thank the gentleman for yielding me this time and rise in strong opposition to this rule today. Imagine, a bill that will affect over 40 million people. But not until 2006 they tell us, which is very interesting, and we do not even get a chance to read the bill before we vote on it. Last night, I was one of those people that managed to stay in the Committee on Rules until 5 a.m. this morning trying to amend this bill. I thought: "What a punitive process." Yet this is how they are treating the American people, too. It will be harder on them than it was obviously on us staying up all night on this measure that is so vastly important to grandmothers, grandfathers, to older citizens across this country.

They want to privatize Medicare. They want to take this prescription drug benefit and put our seniors into Medicare HMOs. Try to find one that still exists in your area. And they denied me the opportunity to offer my amendment to permit the Secretary of Health and Human Services to have negotiated prices for prescription drugs. Everybody knows bulk buying gets one a better price. They denied me that ability, and not only that but in the base bill in section 8-1800 they forbid the Secretary of Health and Human Services to have negotiated prices to get people the best price for prescription drugs, moreover, in their bill, if a person's drugs cost over $2,000 a year, well, it's just too bad. Seniors will have to pay between $2,000 and $4,000 for what they cannot afford. How many seniors earning $8,000 a year on Social Security can afford that?

What is the matter with you people? What is the matter with you?

And then they try to limit the amount of time for debate on the floor here. Let's look at negotiated prices on this accompanying chart, which I am trying to get in this bill, take this medicine for high blood pressure, for example, in Canada that costs about $152. In our country it costs about $182 if one goes to the regular drugstore. And if one has a negotiated price like the Department of Veterans Affairs has, you can get it for $102. The consumer saves all that money.

All my amendment tries to do is to use what the Department of Veterans Affairs does to have bulk buying, to have negotiated prices, and apply it to this program so we use the power of the people, the consumer power of the people, to get them the best price for prescription drugs. They will not allow my amendment on this floor today.

I should at least have the right to offer my amendment. You can vote no on it, but you have no right to do this to the senior citizens of our country. I urge my colleagues to vote no on this rule.

Mr. LINDER. Madam Speaker, on my time, I would like to ask the Clerk to reread the rule.

The SPEAKER pro tempore (Mrs. BIGGERT). Without objection, the Clerk will reread the resolution.

There was no objection.

The Clerk reread the resolution.

Mr. LINDER. Madam Speaker, I thought I was correct. This is a rule on suspensions, not on Medicare.

Madam Speaker, I continue to reserve the balance of my time.

Mr. MCGOVERN. Madam Speaker, I yield 2½ minutes to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Madam Speaker, I thank the gentleman from Massachusetts (Mr. MCGOVERN) for yielding me this time.

What are the consequences of what we are talking about? I will give an example. When we were debating the tax bill a couple weeks ago, we found out after the fact because we only had an hour to debate this major tax bill that 12 million children of working parents, 6½ million families, were left on the editing room floor not getting a tax cut that they were promised, a $1,000 tax cut. It costs us $3.5 billion to make those children whole while millionaires were getting their tax cut.

General Musharraf of Pakistan came to the White House the other day, walked out in 24 hours with a $3.5 billion check, equal to the amount it would be to keep the children, 12 million children, 6½ million families, the same amount of money to give them a full $1,000 child tax credit.

They do not have time to debate these things. They learn the consequences later that 12 million children, American children, have been left on the editing room floor because they did not have a lobbyist in the conference room. And we did not know this fact because we had to debate this bill and move it immediately within 1 hour. Six and one half million working families who make $12,000 a year, equal to what a Member of Congress earns in 1 month, yet General Musharraf of Pakistan walked out in 24 hours with that check, equal amount.

That is a consequence. It is a real consequence about whether we have time on the floor to debate these issues, give voice to our values and principles. Whether they are Democrats or Republicans, there are common values, common principles we can find.

□ 1130

Now, if we want to have noncontroversial time on the floor, that is fine. But find in your heart, in your mind, that same sense of justice for controversial issues to debate. Respect the public that we are here to give voice to their values, that we should debate those issues. That is just one consequence.

I had a bipartisan amendment on the prescription drug bill that would allow generics to come to market to compete with name brands to reduce prices. It would also allow us to import drugs from American-made drugs that are sold in Canada, Germany, and England at cheaper prices, that would bring market forces to bear, bring real competition, make drugs affordable, would save close to a half of $1 trillion. There was no room for this debate on prescription drugs for that amendment.

So whether we want noncontroversial, it is not controversial to me, but whether we have real issues debated here on this floor, so people can vote and be held accountable, that, to me, is significant. Let us have time to bring our common values and common principles, to debate them, and stand up in front of our public to let them know where we stand.

Mr. LINDER. Madam Speaker, I reserve the balance of my time.

Mr. MCGOVERN. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Madam Speaker, I thank my colleague from Massachusetts for allowing me to talk on this rule, but mainly talk about a rule that will come up in a few minutes.

Madam Speaker, a critical part of the legislative process is to be able to amend legislation so that we can improve it. The rule on Medicare prescription drugs does not allow us to do that. The continued efforts by the leadership of the House to stifle debate on this issue can no longer be tolerated.

Although the rule does allow a substitute, which is better than last year, which I appreciate, there are so many other important amendments that should be debated on the floor on this, one of the most important issues this Congress will consider this year, this prescription drug package for our senior citizens.

The Committee on Energy and Commerce marked up this legislation for 3 days last week, the Democratic side offered dozens of amendments that would significantly improve the legislation. Several of these amendments were very close or tie votes, including one amendment that I offered to close that gap in coverage that is part of the so-called prescription drug benefit plan. That would close that doughnut hole that our seniors are going to fall into under the majority Republican plan. But the Committee on Rules would not let us offer these same amendments, amendments which should have been offered and may have passed on this floor.

One amendment was discussed by my colleague, the gentlewoman from Ohio, regarding a provision in this bill that prohibits the Health and Human Services Secretary from negotiating for cheaper prices for our seniors. That is just wrong. We do not prohibit the VA from doing it. We do not prohibit our States from doing it. In fact, the Committee on Energy and Commerce bill that passed allowed States to do that; yet we are saying that the Federal Government cannot get cheaper prices for our seniors. That amendment should be on this floor.

Madam Speaker, it is far too important for us to rush a debate on a prescription drug benefit for seniors and only have 1 day. The Senate has been debating this bill for the past 2 weeks, but in the House we are going to do this and rush it through in one afternoon. That is not the way our forefathers designed this House to legislate.

I urge my colleagues to oppose the rule when it comes up and obviously to oppose the underlying bill.

Mr. LINDER. Madam Speaker, I reserve the balance of my time.

Mr. MCGOVERN. Madam Speaker, I yield 5½ minutes to the gentleman from Massachusetts (Mr. FRANK).

Mr. FRANK of Massachusetts. Madam Speaker, the disrespect that the majority has for the democratic process is evident today.

The majority brings this to the floor, does not deign to discuss it. Perhaps they are going to wait until they have the very last word, which they are entitled to under the rule; but I do not understand why they should think it is not worth their time and energy to discuss the issues we are trying to solve.

Mr. LINDER. Madam Speaker, will the gentleman yield?

Mr. FRANK of Massachusetts. I will yield to the gentleman from Georgia on his time.

Mr. LINDER. Madam Speaker, I am happy to give the gentleman 2 minutes.

Mr. FRANK of Massachusetts. Madam Speaker, I am happy to yield.

Mr. LINDER. Madam Speaker, I have explained this rule, and the Clerk has read it twice. I do not know what the gentleman does not understand about it or what needs to be discussed about it. This was a rule that was passed in April under unanimous consent. If the gentleman wants to discuss the rule, I will be delighted to engage him. But if the gentleman wants to discuss something else, he is all on his own.

Mr. FRANK of Massachusetts. Madam Speaker, reclaiming my time, I thank the gentleman for confirming my point. He said the Clerk has read it twice. Okay, America. You have heard specifically the language read twice. You should be grateful for that.

There are philosophical implications here. We have been meeting only on an average of 2½ days a week. You are now going to make 3 out of 2½ days eligible for suspensions.

The chairman of the Committee on Rules said previously, 25 years ago the Democrats went from 1 day to 2. That was 2 days out of 4 days. You have shrunk the time we are in session and increased the amount for suspensions.

The refusal to discuss this announcement, arrogantly, Hey, I read the rule, what more do you want, is what we are getting at.

What we have here is what political philosophers have called authoritarian democracy. It is a view that as long as ultimately a majority ratifies a result, that is all that counts. Well, that is a very unfortunate view of democracy. It is not the view of democracy of the U.S. Constitution, of the Rules of the House of Representatives, or any self-respecting parliamentary democracy.

What we want to have is debate. What we want to have is to air for the public. We are here as the representative body for a great democracy. What is important is not simply the result, not simply your ability, which I envy, to get your Members to vote in a majority for things that they do not like. You are going to produce a majority today for a prescription drug bill for which most of your Members are going to go home and take a prescription drug to cure the headache and the stomach ache and the backache and the twisted arms that they are going to get either from voting for it or after voting for it. But you can get them to do it.

Well, here is what happens. In fact, the chairman of the Committee on Rules said as we debated this in the Committee on Rules, it is partly because there is such a narrow majority that you have to go to these tactics. That is backwards. The narrower the majority in the House, the more respect there ought to be for the procedural forums that allow things not to be forced.

Here is what we have: an ideologically driven majority on the Republican side, very much controlled on key issues by their most extreme ideological cohort, and they are determined to put legislation through that many of their Members do not like. And the key, by the way, is not yes or no on the final bill. This is where you go on suspension. It is a terrible abuse of the democratic process to take a complex issue like we had on Israel yesterday, and I voted for it, but I would have liked to have voted for some amendments. I would like to be able to affirm that Israel has a right of self-defense, but ought to consider as a matter of prudence and as a matter of their own self-interests whether or not they should use it as often as they are entitled to. But it comes up on suspension.

And the important questions are often not "yes" or "no," but "yes, but," and "no, except." You do not allow that. You bring them up under suspension because this is your view, only the end result counts. If you can get a majority for the end result, the debate process gets collapsed; and whether or not there are amendments, whether or not there is any modification, that is not allowed.

Here is why: there are people on the Republican side who campaign in their own districts on one set of principles and then come here and enable exactly the opposite to become the law of the land. And here is how they do it. They say to people, oh, I would not vote on that. We are going to vote next week on whether or not, or 2 weeks, whether or not you should be allowed to receive Federal money for secular purposes, and then deny employment to people because you do not like their religion. That is what is going to be up. And we are not going to get to vote on this if past practice is any guide, because we have twice asked to vote on that specific issue; and the Republicans said, no, no, we do not want you to vote on that.

The reason is that if their Members had to vote individually on that, many of them would have to vote not to allow that discrimination because that is what they told people they stand for. So what the Republicans will do will be to bring forward what we call a rule. It is a procedure which will prevent people from voting on the very issue that they claim to support. And then having voted to prevent themselves from voting, they will go to their own constituents and say, you know, I agree; but I was not given a chance to vote. That is what we are dealing with.

That is what happens when you have more suspensions, and this is very relevant to this rule. You take things like the Israel resolution and resolutions on the war and on the troops and on genetically modified foods, all of those were resolutions which I supported, but with which I had some subordinate cause differences. I would have liked to have been able to participate in a democratic process to try to amend them, I think, to strengthen them.

You were afraid, you in the majority, Madam Speaker, to allow that to happen. You wanted to make some political points, so you bring these forward in an unamendable form and you say to people, you are going to have to vote for it. Even if you only agree with 90 percent, we are not going to let you try and change or modify the 10 percent, because then we will say, oh, you are not patriotic, you are not a supporter of the State of Israel, you are not a supporter of the American economy.

That is an abuse of the process, because democracy does not simply means the end result. It means an open process of debate. It means letting people try to change each other's minds. It means letting the American people through the media understand what is going on. What we have is a systemic process here not to allow that.

Madam Speaker, it is not a matter of time. We are told we do not have enough time.

By the way, when I came here and was told by the majority, well, that is the way it used to be. No, it was not. By the way, to the extent that there were abuses in the past, I objected. When I was in the majority, I helped lead a change in the rules because too often, both sides in a conference report took the same position. And I fought for the rights of minorities to take 20 minutes on the conference report.

Madam Speaker, when I came here, we had something called the 5-minute rule. We debated. We yielded to each other. We debated defense bills for 3, 4, and 5 days.

The majority, in the interests of making sure that it gets its Members to do whatever they are told to do without being embarrassed on subordinate issues, has beaten down democracy. They have collapsed democracy into meaning simply the end product. And debates on amendments and public discussion, as evidenced by this today, hey, I read the rule; what do you need? Well, democracy needs debate, discussion. It needs a joinder of the issues.

and we do not get that. And we do not get it, as I said, primarily to protect; and we have Members who are not as conservative as the center of gravity on the Republican Party, and I apologize to some in the Republican Party for saying "center of gravity," because I know to many of them "center" is a dirty word.

So there are moderate Republicans, so-called, who do not agree with their party's positions. What they are now doing is voting with their party on a series of procedures that disallow democracy, disallow debate, disallow amendments, and that allows them then to appear to be for certain positions when they have voted to collapse them. That is why this rule is a great disservice to democracy.

Mr. LINDER. Madam Speaker, I reserve the balance of my time.

Mr. McGOVERN. Madam Speaker, I yield myself the balance of my time.

First of all, let me echo a point that was made by my colleague from Massachusetts about the importance of the amendment process and how it promotes congressional accountability. Let me read my colleagues a quote: "What does the ability to offer an amendment have to do with accountability? If a Member has the power to offer an amendment, he can no longer claim to support one thing, but then say that he was blocked in his effort to make a change in the law. In addition, with more floor votes and more clear issues, Members will be forced to take clear positions with their votes. That is exactly what the American people want: fewer excuses and more elected officials who actually stand for something."

That quote, Madam Speaker, was made by the distinguished chairman of the Committee on Rules, the gentleman from California (Mr. DREIER). I agree with that quote.

The gentleman from Georgia (Mr. LINDER), my friend, seems confused as to why we are having this debate. He has asked for the amendment resolution to be read over and over, so let me try to clear something up. The reason why we are having this debate today is because we believe that this House is becoming a place where trivial issues get debated passionately, and important ones, not at all. The fact that what they are asking for is an additional day to debate essentially nonconsequential, trivial issues bothers us because we are constantly being told by the majority that we do not have enough time to make everybody's amendments in order. We do not have enough time to allow this House to deliberate. We do not have enough time to make sure that the democratic process works, and that all Members, Democrats and Republicans, have an opportunity to have their constituents' voices be heard on this House floor. So that is why we are having this debate.

We are having it in a particularly passionate way today because of what went on earlier this morning in the Committee on Rules. The prescription drug bill, perhaps one of the most important pieces of legislation that we will deal with, an issue that impacts 40 million of our senior citizens in this country, this bill was brought to the Committee on Rules in the middle of the night, and virtually every amendment and all of the substitutes except one were ruled out of order, were denied. So these people will not have an opportunity to be heard on the floor today.

□ 1145

I mean, we are stunned. We are shocked. We are appalled that on a bill this important that they are rushing it to the floor under an extremely restrictive process, limiting debate so that we are not going to have much of a debate here on this House floor.

In the other body they have been debating it for 2 weeks, over 70 amendments, and they are still debating it; but here in the people's House, we are supposed to represent the people. We are supposed to be the body of government closest to the people. We are being told that we have to do it in a matter of a few hours, let us do it quickly, no amendments and get out of here. That is not the way to do it.

This is too important; and for some of us who worry that they are trying to privatize and weaken Medicare, it is appalling that we do not have an opportunity to have amendments on this floor to protect Medicare, to make sure that it does not wither on the vine, to make sure that it is there for future generations.

That is what is at stake here. That is what we are talking about is so important.

I want to close by making an appeal to some of my Republican colleagues who routinely come before the Committee on Rules and, like many Democrats, get routinely shut out of the process. Many of them were there last night, early this morning, at 2:00, 3:00, 4:00 in the morning trying to get their amendments made in order, very thoughtful amendments. They were shut out of the process. I want to speak to them just for one second and urge them to join with us in voting against this resolution. Send a message to your leadership that everybody in this Congress deserves respect and everybody should be heard, that the constituents that I represent are as important as the constituents that you represent, are as important as the constituents that are represented by the Speaker of the House and the majority leader of this Chamber.

So this is an important vote, and the debate we are having today is very relevant and very relevant to the topic at hand. So I urge my colleagues on both sides of the aisle to vote "no" on this. We are spending too much time naming post offices and not enough time debating the issues that real people care about. So I urge a "no" vote.

Madam Speaker, I yield back the remainder of my time.

Mr. LINDER. Madam Speaker, I yield myself such time as I may consume.

I do not agree with my Massachusetts colleague who said it is dumbing down democracy to do suspensions and not have amendments. To get to a conclusion at many times is good for the process, good for the country.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in opposition to H. Res. 297 which provides for the Speaker the option to entertain motions to suspend the rules on Wednesdays during the remainder of the One Hundred Eighth Congress. Functionally, this proposal hinders the legislative business of the House. Furthermore, by implication, this bill appears to be nothing more than an another attempt by the Majority to diminish the opportunity of the Minority to debate more substantive issues on this floor.

The purpose for allocating time for these items is to expedite their adoption and entry into the records because they are not controversial. To slow down the legislative calender with three days, instead of two, of noncontroversial items is patently wasteful. Passing legislation to commemorate great citizens and to instill widely-held moral values is quite important but should yield to the simple principle of prioritization. An appropriations bill for projects queued by the Department of Homeland Security to protect our Nation's critical infrastructure and bioterrorism readiness clearly deserve's priority over non-substantive matters. We have a moral duty not to take lightly the lives of our children and grandchildren. Quite frankly, this bill appears to be somewhat of a mockery to our democratic process.

In the years leading up to the election of 1994, the Republican Party in the House of Representatives complained loudly and vociferously that the then-Democratic majority ruled the House with an autocratic iron fist. The Members of the Rules Committee heard this complaint on a daily basis. Democrats were accused of stifling debate and gagging the House.

After eight and a half years of a Republican-controlled House, the Democratic Members of the Rules Committee can report that the House of Representatives is less democratic and more autocratic than ever before. Instead of reforming the House, the Republican majority has taken filibuster and gagging the House to new heights. The Democratic Members of the Rules Committee, as do the other Members of the Democratic Caucus, believe that the Republican majority has, in the years since it took control of this institution, made a concerted effort to shut down debate and stifle the deserving advocates of this legislative institution. We believe this effort by the Republic leadership goes against the public interest and the pledges made by a host of Republican Members in the years leading up to the 1994 election. Furthermore, the "substance" of this bill, if you will, completely obliterates legitimate legislative order.

Mr. Speaker, I point that our children and grandchildren deserve better. The first responders on the front line awaiting the necessary funds to staff the ports and the posts against the threat of terrorist attack deserve better. Our brothers in Liberia who have been displaced because of civil and political strife deserve better. The seniors citizens whose ability to obtain prescription drugs in a reasonable fashion deserve better. We, as Member of the House of Representatives are charged to do better.

For the foregoing reasons, I oppose H. Res. 297.

Mr. LINDER. Madam Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. McGOVERN. Madam Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 8, rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

The point of no quorum is considered withdrawn.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 11 o'clock and 48 minutes a.m.), the House stood in recess subject to the call of the Chair.

☐ 1253

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. LATOURETTE) at 12 o'clock and 53 minutes p.m.

PROVIDING FOR CONSIDERATION OF H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

Ms. PRYCE of Ohio. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 299 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 299

Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order to consider in the House the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes. The bill shall be considered as a read for amendment. The previous question shall be considered as ordered on the bill and on any amendment thereto to final passage without intervening motion except: (1) three hours of debate on the bill equally divided among and controlled by the chairmen and ranking minority members of the Committee on Energy and Commerce and the Committee on Ways and Means; (2) the amendment printed in the report of the Committee on Rules accompanying this resolution, if offered by Representative Rangel of New York or his designee, which shall be in order without intervention of any point of order, shall be considered as read, and shall be considered as read, and shall be separately debatable for one hour equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit with or without instructions.

SEC. 2. Upon the adoption of this resolution it shall be in order on the legislative day of June 26 or June 27, 2003, without intervention of any point of order to consider in the House the bill (H.R. 2596) to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes. The bill shall be considered as read for amendment. The previous question shall be considered as ordered on the bill to final passage without intervening motion except: (1) one hour of debate on the bill equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means; and (2) one motion to recommit.

SEC. 3. (a) In the engrossment of H.R. 1, the Clerk shall await the disposition of H.R. 2596 under section 2.

(b) If H.R. 2596 is passed by the House, the Clerk shall—

(1) add the text of H.R. 2596 as new matter at the end of H.R. 1;

(2) conform the title of H.R. 1 to reflect the addition of the text of H.R. 2596 to the engrossment;

(3) assign appropriate designations to provisions within the engrossment; and

(4) conform provisions for short titles within the engrossment.

(c) Upon the addition of the text of H.R. 2596 to the engrossment of H.R. 1, H.R. 2596 shall be laid on the table.

SEC. 4. During consideration of H.R. 1 and H.R. 2596 pursuant to this resolution, notwithstanding the operation of the previous question, the Chair may postpone further consideration of either bill to a time designated by the Speaker.

SEC. 5. Upon the adoption of this resolution it shall be in order, any rule of the House to the contrary notwithstanding, to consider concurrent resolutions providing for adjournment of the House and Senate during the month of July.

SEC. 6. The Committee on Appropriations may have until midnight on Thursday, July 3, 2003, to file a report to accompany a bill making appropriations for the Department of defense for the fiscal year ending September 30, 2004, and for other purposes.

The SPEAKER pro tempore. The gentlewoman from Ohio is recognized for 1 hour.

Ms. PRYCE of Ohio. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentlewoman from New York (Ms. SLAUGHTER), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purposes of debate only.

Mr. Speaker, House Resolution 299 is a multi-part rule providing for the consideration of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, and H.R. 2596, the Health Savings and Affordability Act of 2003.

This rule provides for consideration of H.R. 1 under a modified closed rule, an appropriate rule for such a delicate, complex, and historic piece of legislation. The rule provides for 3 hours of general debate equally divided between the chairmen and ranking minority members of the Committee on Energy and Commerce and the Committee on Ways and Means. The rule waives all points of order against consideration of H.R. 1.

After general debate it will be in order to consider an amendment printed in the report accompanying this resolution, if offered, by the gentleman from New York (Mr. RANGEL) or his designee and debatable for 1 hour. All points of order are waived against the amendment. Finally, the rule permits the minority to offer a motion to recommit to H.R. 1 with or without instructions.

Section 2 of this rule provides for the consideration of H.R. 2596, the Health Savings and Affordability Act of 2003, either today, the legislative day of June 26, or tomorrow, June 27, under a closed rule. The rule provides 1 hour of general debate in the House equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means. All points of order against the consideration of H.R. 2596 are waived. Finally, the rule provides for one motion to recommit with or without instructions.

☐ 1300

I would like to take a moment to clarify for my colleagues that upon passage of both pieces of legislation, the text of H.R. 2596 shall be added as a new matter at the end of H.R. 1. In simple terms, these two bills will become one. However, this bill does not preclude either bill from moving forward independently.

Finally, the remaining sections of this rule provide for some housekeeping provisions and provisions which will allow this body to move forward in the appropriations process.

Mr. Speaker, today is a historic day. For years now, seniors across this country have consistently voiced to Congress the same major concerns: the skyrocketing costs of prescription drugs. Their concerns are not perceived; they are very, very real. Each year, a typical senior pays approximately $1.300 on prescription drugs, filling about 22 prescriptions on average. Today, the House will consider a plan to give all seniors a prescription drug benefit through Medicare.

In passing this bill, as I believe we will do before this day is over, we will renew America's promise to our seniors, reduce the cost of prescription drugs, and revolutionize medicine in the 21st century.

I would like to thank the gentleman from California (Chairman THOMAS) and the gentleman from Louisiana (Chairman TAUZIN) for their exemplary cooperation, their remarkable leadership, and inspiring vision they have provided on this complex, yet very much-needed legislation. I would like to take a moment just to give special thanks to them for working so closely with me on a couple of provisions that will greatly benefit cancer patients and hospitals across the country. Included in this legislation is immediate Medicare coverage for oral anticancer drugs through a demonstration project that will offer extraordinary support to seniors who are fighting cancer. It will enable them to afford the newest lifesaving medicines in the comfort of their own homes, rather than be hooked up to chemotherapies by infusions in a hospital or clinical setting.

I also commend the chairmen's interest and support in assisting hospitals who serve a disproportionate number of uninsured and indigent populations. Hospitals across this country, including many of our Nation's children's hospitals, will be better able to serve their patients with over $3 billion in additional funding. Finally, rural hospitals are finally getting their fair share: $27.2 billion.

Since 1965, Medicare has provided a guarantee of health care coverage for more than 40 million seniors. Today, our seniors are counting on the stability, longevity, and integrity of this program for their secure retirement. But if we do not act and pass this bill before us today, the future of Medicare will be certain: certain bankruptcy. Our inaction will have sealed the fate for one of our Nation's most trusted programs.

So today, we will do two long-overdue things. First, we will modernize Medicare to save it for future seniors; and, second, we will provide the much-needed prescription drug coverage.

The prescription drug package the House is considering here today will provide the same universal guaranteed Medicare health services as those that currently exist. If you are 65 or older, you qualify for Medicare, and you qualify for this benefit. It is that simple. And we provide significant and immediate savings for seniors on their medicines. Specifically, this plan provides Medicare beneficiaries with a prescription drug discount card offering over 25 percent in savings, catastrophic protections, giving seniors 100 percent coverage for out-of-control drug costs beyond $3,500 year, and full assistance for our neediest citizens.

Equally important, this rule makes in order a provision establishing health savings accounts, a revolutionary tool, so that every American, not just seniors, can set aside savings now for their medical expenses, tax-free. With over 40 million uninsured, this is so important, and the plan provides for a catch-up provision so that seniors can take advantage and set aside more money more quickly.

Mr. Speaker, this is a remedy for what ails America's uninsured. Our plan is designed for those people who might be shut out of work-based coverage and offers all Americans, regardless of their income or age, access to health coverage with no bureaucracy or costly mandates.

Finally, this package includes chronic care management for all Medicare beneficiaries.

Mr. Speaker, one-third of Medicare beneficiaries have one or more chronic illnesses. This provision will help better manage diseases, reduce health care costs, and enhance health and quality of life.

So here we are at a major crossroad. Seniors continue to tell us that adding a prescription drug benefit to Medicare is not some pie-in-the-sky policy that they would merely prefer become law. No. The majority of seniors are telling us that they cannot go another year without help, without any assistance, without any help with their drug costs, and without access to higher-quality health care.

Therefore, some questions need to be asked for those who will come forward in the next few hours and oppose this package. Ask them: How is this package not an improvement for our seniors who have no coverage and are struggling to pay for their medications? And ask them: How is the huge prescription drug savings that will result from this plan not useful to seniors? Ask them: How is bringing Medicare into the 21st century and saving it for future generations not wise for our children, our grandchildren, and our great grandchildren?

Now, some of my colleagues will no doubt put forth $1 trillion, pie-in-the-sky plans. These packages would bust any budget, Republican, Democrat, or otherwise. As a matter of fact, the Democrat substitute actually is larger than the sum of two budgets. The Democrat Spratt budget had $528 billion for Medicare, and the Democrat Blue Dog budget had $400 billion dedicated to Medicare. That is a total of $920 billion. But the Democrat substitute that they are offering today is over $1 trillion, more than the combination of those two Democrat budgets. Mr. Speaker, that is unacceptable.

Mr. Speaker, the lack of prescription drug coverage under Medicare is exactly what age discrimination looks like in 2003. Seniors are the last group of people who are forced to pay retail costs for their medications and, Mr. Speaker, that should be enough of a violation of civil rights to get even the ACLU involved.

I said just a moment ago that today is a historic day, and it is. Today we apply a little common sense by recognizing that health care is simply not what it was 30 years ago, and that Medicare is not what it was 30 years ago. It must change to keep up. Today, we will take the first steps in creating the next generation of quality health care, a new era where prescription drugs make regular doctor visits less frequent, where cutting-edge treatments make hospital stays nearly obsolete in the future, and where lifesaving medications reduce formerly deadly diseases to mere manageable symptoms within longer and healthier lives.

Today I urge my colleagues to be bold, to be courageous, to show leadership, and to take America's health care system into a new frontier, a place where it has needed to go for far too long now. Time is precious and so are our seniors. I urge this Congress to pass the underlying rule and approve H.R. 1, the Medicare Improvement and Prescription Drug Act of 2003.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I thank the gentlewoman from Ohio for yielding me the customary 30 minutes, and I yield myself such time as I may consume.

Mr. Speaker, this is a very sad day for most of us. A program that has served America well and has given peace of mind and good health care to seniors for over 40 years is under threat today; and actually, what we know is going to be before us is the death of Medicare.

One of the saddest parts about this bill today is that the Democrats have no role in it. To all of my colleagues who showed up last night at the Committee on Rules, or this morning, actually, at the Committee on Rules with amendments that they thought that they could use to strengthen the bill, I apologize to you that there is no possibility in the world that you could do it. I hope that you did not hate yourself this morning for all the sleep that you lost for nothing.

Mr. Speaker, this rule is an affront to the democratic process. The underlying bill will harm every single one of the 40 million Americans served by Medicare. At 1 a.m. this morning, with absolutely no meaningful opportunity to review the almost 700-page prescription drug legislation, the Committee on Rules met to consider the resolution now before us. By now I should be used to it, but we cannot tolerate these continual attacks on democracy. When you refuse to allow half this House to speak and to give their amendments, you are cutting out half of the population of the United States from any participation in the legislation that goes on here. It defies reason and it defies common sense that political expediency and newspaper headlines could force this monumental legislation, probably the most monumental that any of us will do in our tenure in the Congress of the United States, to force it through the Chamber with little more than cursory consideration.

The other body, on the other hand, has spent over 2 weeks debating similar legislation. In stark contrast, we meet when nobody is around, up in the attic, as someone said today, and are permitted only 3 hours to discuss the largest overhaul of Medicare in its history. The people we represent would be disgusted if they understood how this issue is being handled.

We are not naming a post office here. We are considering, as I said, the most important change to Medicare since its creation. This decision will affect so many people. It is no simple undertaking, and it certainly deserves more debate than allowed by this rule.

To add even more confusion to the messy process, the Committee on Rules incorporated the so-called Health Savings Account bill into the rule for the Medicare overhaul legislation, so what we are doing here are two rules. So-called health savings accounts would create a new tax advantage, personal savings accounts, used to pay the out-of-pocket medical expenses. At first glance, perhaps it sounds innocuous. But when you look at the fine print, you see that it basically amounts to a $72 billion tax cut over the next 10 years while the Federal deficit continues to grow out of control. Even worse, it is a tax break with a destructive purpose: to threaten the traditional employer-based health care by actually encouraging companies to reduce their employees' health coverage.

Mr. Speaker, perhaps the most egregious problem with the legislation before us is it does nothing to address the skyrocketing prices of prescription drugs. Oh, sure, they will tell us that we can import drugs from Canada, but the fact of the matter is that an amendment inserted into the Senate bill by one of our Senators says that it cannot be done unless it is certified by the Secretary of HHS, who has stated already that he will not do it. Therefore, any debate today about being able to import drugs is absolutely a farce.

The consumer price index on which Social Security cost-of-living adjustments are based rose 98 percent, and the prescription drug costs that are crippling older Americans rose even higher. Seniors on Medicare are expected to spend $1.8 trillion on prescription drugs over the next decade.

Today's Washington Post tells a story of Marie Urban of Cleveland. After her housing and Medicare payment, she has $459 a month for utilities, food, car insurance, taxes, and medication. She told The Post that some months she has 87 cents left over. This is wrong. She deserves better. A few years ago, as a temporary Band-Aid, I organized a bus load of seniors to travel to Canada to purchase medications at fractions of the prices charged in the American market. We had dozens more people interested than we could accommodate, but those who went saved anywhere from $100 to $650 on a 3-month supply of medication.

We are fortunate to live in an age when science provides the medications that cure illness and improve the quality of life and extend life. But the promise of the wonder drug is meaningless if you cannot afford to buy it. The skyrocketing price of prescription drugs is the number one concern of American seniors and, indeed, most Americans. H.R. 1 does nothing to freeze or reduce the exorbitant cost of prescription drugs. In fact, again, the idea of going to Canada and handing it out with one hand and taking it away with the other is something that the drug companies will be very happy about, because they have fought in every possible venue to keep the reimportation of drugs.

At the same time, we hoped that we might do what the Veterans Administration has done with great success. By negotiating for the people that they represent with the drug companies, they have been able to save many of their veterans a great deal of money. Seniors fear this bill is a rush to privatize Medicare. We saw the flop of Medicare+Choice when many, many private insurance companies pulled out completely on senior citizens, leaving many of them in parts of the United States completely uncovered. Indeed, they have told us again, they do not want to cover a prescription drug program. One hundred percent of the people they cover will buy medicine. This is not what they consider a good business proposition.

Forty years ago, Congress created the Medicare program because private industry would not offer health insurance to older people. Companies saw the older people as a threat to their profits. We should have learned this lesson in the 1960s, because nothing has changed; and now we are today taking away what is probably the most important issue to senior citizens, will they be able to get health care.

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Don Young, who is the President of the Health Insurance Association of Americans, quoted here often, has said, "We caution Congress against relying on drug only insurance as a mechanism to deliver a benefit."

Ira Loss, an analyst with Washington Analysis, said, "The private sector that is supposed to be excited about this isn't. It creates a new benefit program built around insurance products that do not exist and are likely to never exist."

Mr. Speaker, this proposal would replace Medicare's guaranteed coverage with what is essentially a voucher program to purchase private insurance, assuming that there is an insurer willing to sell it to you. But those who want the traditional fee-for-service Medicare will be forced to pay higher premiums. We have no idea, for example, what Part B would cost because it is not in the bill, which is intended to force the beneficiaries out of traditional Medicare and into private insurance.

Mr. Speaker, senior citizens do not want this legislation. We have all received call after call and letter after letter beseeching us to oppose this plan. They did not contact me because they need prescription drug coverage. They called and wrote me because they know this bill will not provide them with the help they desperately need.

According to the Consumers Union, the average Medicare user spends $2,318 for prescription medicine. Under this plan, the out-of-pocket drugs would rise to $2,954 for the average senior on Medicare. So this program is a placebo, not a cure, legislation crafted to provide political cover for the majority, not provide prescription drug coverage for seniors. Some may argue that this is something better than nothing, but it is only a start and, frankly, what we have in Medicare has not been that bad. But as many of our constituents say, a bad bill is worse than no bill.

Mr. Speaker, this bill that will raise premiums and reduce their choices and dismantle Medicare is a very bad bill. I urge my colleagues to oppose the rule.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. WOOLSEY).

Ms. WOOLSEY. Mr. Speaker, this sham Republican bill fails to provide women with the real prescription drug coverage they need and they deserve.

Here we are, again, discussing ways to help seniors afford the prescription drugs that they need. And once again, the majority insists on a sham proposal that gives seniors nothing more than a false sense of security.

My female colleagues and I would like to remind everyone that as we debate proposals to add a prescription drug benefit to Medicare, the decisions we make will overwhelmingly impact our mothers, grandmothers, sisters, and aunts. Women are living longer than ever, and longer than men—this is good news. However, the poverty that many women experience during their final years is certainly not good news.

There are several reasons women's "golden years" are not so golden. While most women have worked their entire lives, a good portion of this work was not in the paid workforce. You don't earn a pension for time spent caring for children or elderly parents.

When many of our mothers and grandmothers were in the workforce, they were denied equal pay for equal work. Some worked only part time, trying to balance the responsibilities of their jobs and their families. As a result, they've made less over their lifetimes—and now their monthly Social Security benefit is smaller. These women deserve financial stability, and still, the Republican prescription drug proposal denies them the security that comes with knowing that can afford to pay for their medical care.

No one needs a drug benefit more than elderly women. But instead of a real prescription drug benefit, all they are getting from the majority are empty promises, a "donut hole" coverage gap, and increased premiums for the services they already enjoy. Our mothers and grandmothers deserve better. We can and we must do better. Oppose this sham Republican plan, and support the Democratic alternative.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. LINDA T. SÁNCHEZ.)

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, this sham Republican prescription bill provides elderly women with nothing more than a false sense of security.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. SOLIS).

Ms. SOLIS. Mr. Speaker, this bill is a sham. It does not provide adequate prescription drug benefit.

Este projecto de ley no ayudara a los ancionos. No ayudara ni a nuestras madres ni a nuestras abuelitas.

(English translation of the above statement is as follows:)

It will not help our mothers, nor our grandmothers.

Mr. Speaker, I rise to call attention to the American women who will be disproportionately impacted by Medicare reform. The reality we must confront is that women simply live longer than men—about 19 years into retirement, while men can expect to live 15 years. So although this means we have longer to cherish our mothers and grandmothers, it also means that women are more susceptible to multiple and chronic illness, and require more long-term care needs.

It is no surprise then that women comprise the majority of Medicare. In fact, we constitute 58 percent of the Medicare population at 65, and 71 percent at the age of 85. Yet even more crucial is the fact that four out of five of America's elderly women are widowed and almost half live out their days alone. Compound this misfortune with the reality that these widowed women are four times more likely, and a single or divorced woman are five times more likely, to live in poverty after retirement than a married man.

America's elderly women, many of whom live alone and in poverty, have higher out-of-pocket health care costs and are now being denied access to a secure and responsible Medicare prescription drug plan under the Republican Plan. Almost 8 out of 10 women on Medicare use prescription drugs regularly, though most pay for these medications out-of-pocket. Now we are telling these women, who already spend 20 percent more on prescription drugs than their male counterparts, that they must navigate the privatized ropes, and we can only hope, not guarantee, that they will have affordable coverage and monthly premiums. Even middle-class women who have made wise financial planning decisions will quickly find that high drug costs may undermine any retirement security they have worked hard to establish.

My district, which is predominately Latino, will be one of the hardest hit by this new legislation. Latina women make up the largest minority percentage (58 percent) on Medicare with incomes less than $10,000. These minority women historically rely on public, rather than private, health insurance. Now, we are stripping their only health coverage security and implementing a new, privatized and completely unmapable plan!

Have we not learned our lessons from Medicare+Choice that private plans do not participate in many regions, that their premiums and benefits vary greatly by geographic area, that participation by Medicare HMO's has been unstable, and that private plans are not less costly than traditional Medicare?

By 2025, Latinos are expected to comprise 18 percent of the elderly population and they are continually encountering strategically placed barriers that hinder their equal right to quality health care.

Let's not forget all the mothers, grandmothers, and sisters now and in the future for whom Medicare represents a lifeline to a healthy retirement. Who wants to tell the millions of hard working women who take care of their families that once again, because of irresponsible and unbalanced tax cuts, their health care and prescription drug needs will be sacrificed?

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. HARMAN).

Ms. HARMAN. Mr. Speaker, I rise in opposition to the bill to end Medicare as we know it, which will hurt our sisters, mothers, and grandmothers.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Mr. Speaker, I rise in opposition to this bill which fails to provide women with the affordable and reliable Medicare prescription drug coverage that they desperately need and deserve.

Mr. Speaker, I urge my colleagues to vote against this sham of a bill. It seeks to privatize Medicare and does not provide a real, guaranteed, affordable drug benefit that our seniors desperately need.

When I am home in Wisconsin, one of the issues I hear most about, in the grocery store, on the street, at the airport baggage claim, or in meetings from Monroe to Baraboo, is that seniors cannot afford to pay their prescription drug coverage. Seniors send me receipts for their drug bills and ask me how they are supposed to afford their rising drug costs on a fixed budget.

The Republican drug bill on the floor today is not going to provide seniors with the relief they deserve. Instead of providing a real, affordable prescription drug benefit, this bill seeks to privatize the Medicare program. It is my belief that privatization of Medicare is unwarranted. Medicare has been a vital component of our Nation's health care system since its creation in 1965. In fact, Medicare was originally created because private insurance plans were simply not providing health insurance to seniors and people with disabilities. For nearly 40 years, Medicare has done the job that private insurers would not—or could not—do.

Why then, would we rely on private insurers to provide a Medicare prescription drug benefit to our Nation's seniors? This bill relies on private insurers to provide a prescription drug benefit. Seniors would have to join HMOs and private insurance plans to get the benefit. The prices and benefits under this private coverage would vary from region to region, so that a senior in Wisconsin would have to pay a different premium than a senior in Florida. These geographic disparities are simply unacceptable.

There are no assurances in this bill that prescription drugs would be affordable. In fact, this bill takes no steps to stop or slow the skyrocketing cost of prescription drugs. Instead, this bill provides partial coverage of drug spending until $2,000 and then leaves seniors high and dry. There is a huge gap in coverage where seniors may pay 100 percent out of pocket and continue paying premiums, until they reach a high out-of-pocket cap. Half of all seniors will fall into this gaping hole. I believe seniors deserve affordable drug coverage, and we should not help some seniors cover their drug costs while leaving others out in the cold.

Lastly, the Republican drug plan does not offer the same benefit to everyone on Medicare. This plan calls for "means-testing" for Medicare benefits, meaning seniors with higher incomes would have to pay more money out-of-pocket before they reach the catastrophic limit. This provision would fundamentally change the Medicare program. Since its inception in 1965, the central promise of Medicare was that it would provide a consistent benefit for everyone, and means-testing would violate this promise.

I support the Democratic proposal that will be offered as an amendment today. This proposal would add a new Part D in Medicare to provide voluntary prescription drug coverage for all Medicare beneficiaries. This proposal would provide the same benefits, premiums, and cost sharing for all beneficiaries no matter where they live. It would guarantee fair drug prices by giving the Secretary of the Department of Health and Human Services the authority to use the collective bargaining clout of all 40 million Medicare beneficiaries to negotiate drug prices. The savings would then be passed on to seniors. In addition, the Democratic proposal makes drugs more affordable by allowing the safe reimportation of drugs from Canada and makes lower cost generic drugs available more quickly. Unlike the Republican bill, there are no gaps in coverage in the Democratic proposal. Coverage is provided for any drug a senior's doctor provides. Seniors would be able to choose where to fill their prescriptions and would not have to join an HMO or private insurance plan to get drug coverage. This is the proposal seniors have been asking for, not one full of complexities and gaps in coverage like the Republican plan we will vote on shortly.

Today we are voting on a bill that is a sham. It is a sad mockery of what seniors in our country deserve. Instead of providing a comprehensive Medicare prescription drug benefit for America's seniors, the Republicans have decided to make sure this bill suits the big drug companies and leads down the road of privatizing Medicare. This is just plain wrong for the retirees of the greatest generation, who worked hard, lived through the depression, won a war, and raised their families.

Seniors need a comprehensive prescription drug benefit that is affordable and dependable for all—with no gaps or gimmicks in coverage. The Republican proposal fails on all these counts, and I urge my colleagues to vote against it.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I oppose this Republican prescription bill because it provides elderly women with nothing more than a false sense of security.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. WATSON).

Ms. WATSON. Mr. Speaker, I rise in opposition to this sham Republican Medicare bill. That is why I wear my black arm band because it is the death of Medicare and it does not provide the adequate prescription drug coverage our mothers, grandmothers, sisters, and nieces deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. DAVIS).

Mrs. DAVIS of California. Mr. Speaker, I oppose this unacceptable bill that is particularly harmful to senior women.

Mr. Speaker, I rise to talk about older women and their need for a real prescription drug benefit. The legislation we have before us represents a hollow substitute for a bona fide Medicare prescription drug benefit. Some will claim that the Republican Medicare reform legislation provides a prescription drug benefit and declare success. Well, Mr. Speaker, we aren't fooling anyone.

We aren't fooling Donna Koski, from San Diego, who cannot afford her medication. She wrote to tell me, "HMOs are no longer helping us with the cost [of drugs]. I worked and paid taxes all my life, raised five kids in California and now have five grandkids. I can't afford rent or so many things that I once took for granted would be there when I retired. What is to become of senior citizens [like me]?" We aren't fooling Sidney and Edith Horwitz, from La Jolla, who told me, "Figure out a way to give us drug benefits without joining a HMO. Deregulation and outsourcing to private companies has been a travesty to consumers."

Mr. Speaker, my constituents want an affordable prescription drug benefit that will be there when they need it. They do not want to privatize Medicare. However, the bill we will discuss dismantles Medicare and does nothing to lower prescription drug prices. This proposal eliminates the security of traditional Medicare by requiring it to compete with private plans in 2010. It would transform Medicare from a defined benefit to a defined contribution program and ultimately eliminate Medicare as we know it. Because, private Medicare plans tend to aggressively recruit younger and healthier seniors, open competition will mean rising out-of-pocket costs for the vast majority who would choose the stable benefits and premiums of traditional Medicare. The result of open competition will be the transformation of today's universal, national risk pool into a multitude of regional pools segmented by age, income, residence and health status. To many, this transformation sounds more like a scheme than meaningful reform.

Our seniors need more stability and certainty than this—especially older women who are counting on Congress to provide a real solution to the rising cost of prescription drugs. Women, literally, are the face of Medicare. They constitute 58 percent of the Medicare population at 65. They constitute 71 percent of the Medicare population at 85. Women have a greater rate of health problems since they live longer. They have lower incomes, which make access to affordable prescription drugs more difficult. More than 1 in 3 women on Medicare (nearly 7 million) lack prescription drug coverage.

The Republication Medicare reform plan will only perpetuate these health care disparities. Where is the benefit for our seniors who are living on a fixed income and cannot afford to pay out-of-pocket during the coverage gap? Where is the benefit for the women who, because they were stay-at-home mothers and did not earn a pension, cannot afford the prescription drugs they desperately need?

For my constituents, the Republican proposal is not good enough. I cannot support this legislation when I know we can do better. We are doing more than providing prescription drugs, we are legislating the future of Medicare.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Georgia (Ms. MAJETTE).

Ms. MAJETTE. Mr. Speaker, I oppose this sham Republican Medicare bill because it does not provide the adequate prescription drug coverage that our mothers and grandmothers absolutely deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from New York (Mrs. MALONEY).

Mrs. MALONEY. Mr. Speaker, I oppose this Republican Medicare bill, and I urge every woman, man, every American to read the fine print. There are gaping holes. There are problems. I will put this into the RECORD and I am totally opposed to this bill.

Mr. Speaker, the health of America's older women is at serious risk. Whatever Medicare Prescription Drug bill we pass will have an enormous impact on older women, both now and in the future, and women are concerned.

More than half of Medicare recipients age 65 are women; by age 85, 71 percent are women. And most older women live on fixed incomes. Older women tend to have more chronic health conditions than men, and eight of ten women on Medicare use prescription drugs regularly.

In the face of these facts, the "bait and switch" tactics of the Republican Medicare Prescription Drug bill are simply outrageous. Seniors think we're giving them help with high cost drugs. They think we're offering them supplemental insurance—guaranteed, cheaper and permanent—to ease their burden of skyrocketing drug costs on fixed incomes. But the Republican bill is a cruel trick. Seniors who are sickest and taking expensive medications—mostly women on fixed incomes—get a little bit of help with the first 2000 bucks of drug expenses. But then they get the "donut hole"—a big fat zero until they pay a $3000 ransom to get more help with their drug bills.

The fiscal irresponsibility of the Republican bill is stunning and illogical. Instead of putting the purchasing power of America's seniors to work as a huge bargaining chip to lower prescription drug costs, the Republicans prohibit the Secretary of HHS from negotiating for lower drug prices on behalf of seniors. The Democrats believe prescription drugs should be affordable for seniors—but our amendments to have the Secretary negotiate on seniors' behalf were defeated.

The height of hypocrisy in the Republican bill is the fact that it actually discourages employers from continuing to offer drug coverage for retired seniors who have already paid health insurance premiums throughout their working lives. The Congressional Budget Office estimates that a third of employers will drop retiree drug benefit coverage if the Republic bill becomes law.

Frankly, the Republican Medicare Prescription Drug bill is cruel. This is not compassionate conservatism. It is blatant bias against elderly, against women, and against the poor. It is the first step in doing away with Medicare as an entitlement and it is the first step toward dividing our elderly into the needy and those who can afford to "buy out". The purpose of Medicare was to help the elderly with needed care as they age, and to do it with dignity and not on the basis of ability to pay.

Prescription drug coverage would save money in the long term because drug therapies can be substituted for more costly treatments like hospitalization and surgery. But what seniors—men and women—need and want is help that they can understand and can rely on, not the "bait and switch" of the Republican plan.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, the Republican Medicare bill fails to provide Americans with real prescription drug coverage, that which they need and that which they deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I rise against the Republican bill that kills Medicare and fails to provide affordable prescription coverage to the elderly and people with disabilities.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. LEE).

Ms. LEE. Mr. Speaker, this bogus Republican prescription drug bill will effectively dismantle and kill Medicare and leave millions of seniors, especially our women, our mothers, our grandmothers behind.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Minnesota (Ms. MCCOLLUM).

Ms. MCCOLLUM. Mr. Speaker, this Medicare bill fails to provide women with real prescription drug coverage they need and deserve.

Ms. SLAUGHTER. Mr. Speaker, I reserve the balance of my time.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from Kentucky (Mr. FLETCHER) for some substantive remarks. Dr. FLETCHER is a member of the Committee on Energy and Commerce and also a member of the medical profession, and we look forward to what he has to add to this debate.

Mr. FLETCHER. Mr. Speaker, let me thank the gentlewoman from Ohio (Ms. PRYCE) for her leadership in chairing our majority conference as well as her leadership on this issue and this rule.

Mr. Speaker, I find it interesting to see and observe the number of people that have stood in line here to talk about this bill, even though CBO estimates that 93 percent of our seniors will take advantage of this bill. That means many of the sisters, mothers and family members that these Members have just spoken about will take advantage of this legislation. As a matter of fact, I would imagine if we asked these Members how many of them take advantage of the Federal Health Benefit Plan, that probably the majority of them, if not all of them, choose to participate in that.

Now, we offer something here in this prescription drug bill that gives them a similar choice, and yet for some reason they seem to deride what we are doing.

This is the single most pressing health care issue facing our country: providing prescription drugs for our seniors. This bill does several things. One, it is a voluntary program. Two, it provides something that is affordable, not only affordable for seniors but affordable for taxpayers, and it is something that far exceeds anything that has been looked at or has had a reasonable opportunity of being passed that this Congress has ever put forth. It is flexible. It provides choice and security. It provides a modernization of Medicare that will address the concerns of prevention and chronic disease management which are so needed in this country.

It also prevents a catastrophic illness from bankrupting a family. Often a catastrophic illness can bankrupt a family, and we know of families that have saved money their entire life and then one illness in the family has bankrupted them. This bill absolutely prevents that from happening due to the cost of prescription drugs.

We also find that it helps a number of low income seniors, particularly women, and I am shocked that these Members would not stand up and support this bill, because women are particularly affected. Many women live on fixed incomes of Social Security and are having to choose between food and medicine. I saw them as a physician. I saw them as patients of mine. In Kentucky nearly 35 percent of Medicare beneficiaries will qualify for low income assistance under this bill.

Mr. Speaker, not only that but in Kentucky, Medicare recipients are spending 67 percent of their total prescription drug costs out-of-pocket, which is the highest in the Nation.

Additionally, with this bill, they were talking about Democrats not having input, but we had 30 hours of debate in the Committee on Energy and Commerce. As a matter of fact, a Democratic colleague of mine, the gentleman from Texas (Mr. GREEN) and I put forward an amendment for diabetes screening. We passed that. It is part of this bill.

So I think this is a tremendously important piece of legislation. Every senior will have reduced costs in the prescription drug expenses that they pay because the Federal Government will negotiate a lower price for these drugs. What we see here is an opportunity. We will negotiate a lower price for the prescription drugs.

Mr. Speaker, I would hope Members would support this rule and that Members would support this prescription drug bill.

Ms. SLAUGHTER. Mr. Speaker, we have so little time to try to make any points here.

Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), a member of Committee on Rules.

Mr. MCGOVERN. Mr. Speaker, this is a sad day for this House and, more importantly, it is a sad day for America's senior citizens.

This bill is a complex and controversial $400 billion Medicare privatization plan that will affect the lives of 40 million senior citizens. For 38 years Medicare has been there for our parents and our grandparents, helping them live longer, more healthy lives. It is a sacred promise with the elderly of this country and this House is about to radically and fundamentally break that promise.

If that were not bad enough, the Republican leadership blocks out all amendments and all but one substitute to this bill. For example, this bill mandates for the first time a co-payment for senior citizens who receive Medicare home health care. I have been fighting for years to protect home health care from cuts, so I had an amendment before the Committee on Rules around 4:30 this morning to eliminate that co-pay because I think it is unfair and I think we should help seniors who use home health care, not charge them more money. But like every single other amendment, Democrat or Republican, my amendment was not made in order.

The other body has spent the last 2 weeks, Mr. Speaker, debating, discussing and amending their prescription drug bill. They seem to recognize that this is a big deal. So how much time do we give our seniors in this House? Not 2 weeks, not even 2 days. Three hours. What a terrible disservice to the people I represent, the people we all represent.

This bill ends Medicare as we know it and turns it into a convoluted, complicated voucher program of HMOs and PPOs and shifting coverage. It is a bill that leaves a huge gap in coverage, penalizing people for getting sick. It is a bill that moves us towards privatizing Medicare and leaves our seniors at the mercy of the insurance industry and the big drug companies. It is a bill that only a CEO could love. Senior citizens deserve a drug benefit within Medicare. They should not be left at the mercy of the HMO accountants who are more concerned with the bottom line and profit margins than with adequate health care.

Our substitute works like the rest of Medicare. It tackles the high cost of drugs and it guarantees our seniors meaningful, consistent prescription drug coverage. That is what our seniors deserve. I urge my colleagues to vote no on the rule and yes on the Democratic substitute.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from New Hampshire (Mr. BRADLEY).

Mr. BRADLEY of New Hampshire. Mr. Speaker, I rise today in support of H.R. 1 and the rule that accompanies this important legislation, for today we will begin to finally provide for a prescription drug benefit under Medicare for America's senior citizens.

H.R. 1 will ease the financial burden placed on America's seniors, improve access to the medications they need, and introduce market measures that will curb future cost increases.

According to a recent study, the House plan, our plan, would reduce the average overall cost of prescription drugs by 25 percent through aggregating the purchasing power of seniors. In addition to these overall savings, the plan provides significant and immediate savings for seniors through provisions, including a prescription drug discount card which would provide a 10 to 15 percent savings; significant front-end coverage with a cost sharing agreement that has seniors paying 20 percent on the first $2,000 of drug costs after they pay a deductible and a monthly membership fee. Beyond that it involves catastrophic protection providing 100 percent coverage for out of control drug costs beyond $3,500. And, lastly, and perhaps most importantly, assistance for low income seniors, enabling those Medicare beneficiaries that have income of 135 percent of the poverty line to receive full coverage on their prescription drugs.

Mr. Speaker, the advancement of medical research and technology has led to the development of new drugs that can dramatically reduce the need for surgery, for hospitalization and for nursing home care.

□ 1330

It is high time that we provide America's senior citizens with improved access to these drugs at prices they can afford. I urge my colleagues to support the rule and to support the legislation.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank my friend from New York for yielding me the time.

Mr. Speaker, we should reject this rule because H.R. 1 offers the wrong vision for Medicare. H.R. 1 asks every Member a fundamental question, what do you want Medicare to be? If you want Medicare coverage that is guaranteed, dependable, universal and fair, you will vote against H.R. 1. If you want Medicare to cover every senior everywhere, you will vote against H.R. 1. If you want Medicare to offer the same coverage to seniors on Park Avenue as seniors in Appalachian, Ohio, you will vote against H.R. 1.

But Mr. Speaker, if you want Medicare to offer unreliable, selective, discriminatory coverage, you will support H.R. 1. If you want Medicare to offer seniors in Appalachian, Ohio, less coverage than seniors on Park Avenue or no coverage at all, you will vote for H.R. 1. If you want Medicare to offer rural seniors coverage, but at three or four times the price, then you will vote for H.R. 1. If you want a plan written by the drug companies and by the insurance companies because of their huge contributions to the Republican Party, if you want that, then you will vote for H.R. 1; and if you want a bill that will force people who now have prescription drug coverage, a bill that will force seniors who now have prescription drug coverage to drop that coverage, then you will vote for H.R. 1.

The gentleman from New York (Mr. RANGEL) and the gentleman from Michigan (Mr. DINGELL) will offer a substitute amendment with a different version of Medicare. The Rangel-Dingell substitute strengthens Medicare by adding a prescription drug benefit, no unaffordable cost sharing, no gaps in coverage. The Rangel-Dingell substitute would maintain Medicare's guaranteed coverage, remaining faithful to the trust Medicare has earned from America's seniors.

The Rangel-Dingell substitute harnesses seniors' purchasing power to demand better prices from the drug industry. My friend from Kentucky had it all wrong when he said the Republican plan does that. The Republican plan, because it was written by the drug companies, does nothing to bring prices down.

Vote "no" on the rule. Vote "no" on H.R. 1. Vote "yes" on the Rangel-Dingell substitute.

Ms. PRYCE of Ohio. Mr. Speaker, I am pleased to yield such time as he may consume to the gentleman from California (Mr. ISSA), my distinguished colleague.

Mr. ISSA. Mr. Speaker, I support this bipartisan, Republican-led, legendary, historic event that we are participating in here today.

Mr. Speaker, I rise today to comment Chairman THOMAS, Chairman TAUZIN, and the House Republican leadership for their work on H.R. 1.

This landmark legislation will provide America's seniors with a lifetime prescription drug benefit through Medicare. This new benefit will mean permanent prescription drug access, lower drug costs and a limit on catastrophic drug expenses for all beneficiaries.

I am especially pleased to see that this bill enacts meaningful Medicare reforms that specifically affect California and my constituents in the 49th Congressional District.

H.R. 1 includes language that allows the Secretary of Health and Human Services to designate plans that serve special needs beneficiaries as Specialized Medicare Advantage plans. This provision enhances the development of more effective approaches to chronic illness care by providing an opportunity for additional frail elderly demonstrations to move into mainstream Medicare. One example of this type of demonstration is the SCAN program, which currently serves over 50,000 Southern Californians—including 10,000 who live inside the 49th Congressional District.

I also want to thank leadership for their work to ensure stable funding in the Medicaid disproportionate share hospital (DSH) program. H.R. 1 provides all states with a one time 20% increase in their DSH allotments. This 20% increase means an additional $184 million in Fiscal Year 2004 for California's safety net hospitals. This additional funding will help ensure that services to the most vulnerable populations remain available.

I believe that we must bring Medicare into the 21st century and that no American should be denied needed prescription drugs because he or she cannot afford them. I recognize that the lack of a prescription drug benefit for our seniors signifies the fact that Medicare has fallen behind the times. H.R. 1 is the best prescription drug benefit plan for America and I urge my colleagues to support its passage.

Ms. PRYCE of Ohio. Mr. Speaker, I am pleased to yield such time as he may consume to the gentleman from California (Mr. DREIER), my distinguished colleague, the chairman of the Committee on Rules, who led us through our hearing on this last night to the historic conclusion today on the floor.

Mr. DREIER. Mr. Speaker, the first revision I would like to make to my very good friend and the role that I play was leading us through this morning as we did, in fact, as has been pointed out, beginning late at night. We began late at night because we were all working together to fashion a bill which I am convinced that at the end of the day will enjoy bipartisan support in this House of Representatives.

It has been the gentleman from Illinois (Mr. HASTERT), the Speaker, who, as the author of this legislation, has been in the lead on not only the issue of bringing about measures to strengthen and protect and improve Medicare but also to put into place a very important expansion of medical savings accounts, which I joined him in championing for many, many years.

This is a historic day, as many as have said; and my colleague, the gentlewoman from Ohio (Ms. PRYCE), has been working diligently over the last several days and weeks and months to get us here.

I mentioned the gentleman from Illinois (Speaker HASTERT). There are lots of other people, the gentleman from California (Mr. THOMAS), the chairman of the Committee on Ways and Means; the gentleman from Louisiana (Mr. TAUZIN), the chairman of the Committee on Energy and Commerce; but I would like to talk about the Representatives who did at 12:50 this morning appear before the Committee on Rules.

The gentleman from Oregon (Mr. WALDEN) represented the Committee on Energy and Commerce and did a wonderful job; but no one has been more intimately involved in dealing with health care issues than the gentlewoman from Connecticut (Mrs. JOHNSON), and I was very impressed with the fact that she was able, in her presentation before the Committee on Rules, over a 90-minute period, to deal with virtually every question that came forward; and, Mr. Speaker, it was so apparent that her grasp of this issue, coupled with her commitment to ensure that our senior citizens finally have the opportunity for the first time under the structure put in place for Medicare have access to affordable prescription drugs; and, Mr. Speaker, it was very interesting to note that while there was bipartisan praise for the gentlewoman from Connecticut (Mrs. JOHNSON) as this hearing began at 12:50 this morning, the final panel that came before us at probably about 4:30 or so, I cannot remember exactly what time it was, maybe 4:15 this morning, had a

Democrat on the final panel praising the gentlewoman from Connecticut (Mrs. JOHNSON), not necessarily agreeing with everything that she said, but praising her for the fine work that she has involved herself in on this issue.

I believe that as we look at what it is that we are trying to do here there are so many very important and positive developments that have taken place. I know my friend from Ohio has just mentioned the very important issue of the disproportionate share of hospitals that provide assistance under Medicaid. Increasing the level of funding for those hospitals that are shouldering that responsibility has been one of the challenges that the Los Angeles area, which I am honored to represent, has faced; and we, I believe, are going to be able to help deal with that.

At the same time, I have to say that in looking at some of the things that have been said that were critical of this rule and of the measure, first on the rule, Mr. Speaker, we have put into place what I believe is a very fair rule. In the 107th Congress we all know that we dealt with this issue, and there was no substitute made in order. So in this Congress we have done that, but in bringing the health savings accounts, which are a very important item, designed to provide incentives for people to make choices and plan for their long-term health care needs by bringing this measure in with our very important Medicare package, what we have done is we have provided the minority with three opportunities, the substitute and two opportunities to offer motions to recommit, and there was no substitute offered on the other and I suspect we would have made that. We conceivably could have had four opportunities for the minority, if they had submitted those to us, that would have been made in order; and we, as the majority, have basically one opportunity and that is our bill.

I acknowledge that as members of the majority we have been able under Speaker HASTERT's leadership to put this package together; but anyone who claims that we are not giving an opportunity to the minority for their proposals to be considered is really wrong, and we have provided the proposal which was submitted to us by the ranking minority member of the Committee on Ways and Means and ranking minority member on the Committee on Energy and Commerce. So I believe we are going to, as this debate proceeds, find that there are Democrats who will want to join with us; and I congratulate them for understanding the fact that this is going to be the first opportunity to truly provide access to affordable prescription drugs to our senior citizens.

I will tell my colleagues, Mr. Speaker, in voting "no" on this package, at the end of the day we will see Members saying no to our attempt to put into place a program that will meet that very important need. So I just want to say that I know there a lot of staff people who have been involved in this, and I particularly want to express my appreciation to the members of the Committee on Rules, very ably led staff on our side by my friend Billy Pitts, and we on this committee had members on both the Democratic and the Republican side who did meet from 12:50 this morning until our filing of the rule by the gentlewoman from Ohio (Ms. PRYCE) and I at 6:20 this morning.

And the reason we did it is that this is such an important issue. The reason we did it is that we want to make sure that we get this done for the American people, and I am convinced that our chance to come together has been made possible by all those who were involved in this, and I thank my friend for yielding me the time.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield such time as she may consume to the gentlewoman from California (Ms. PELOSI), the minority leader.

Ms. PELOSI. Mr. Speaker, I thank the gentlewoman for yielding me the time. I think this is a sham Republican Medicare bill which fails to provide women with a real prescription drug benefit which they need and they deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from New York (Ms. VELÁZQUEZ).

Ms. VELÁZQUEZ. Mr. Speaker, I think the sham Republican Medicare bill fails to provide women with the real prescription drug coverage that they need and deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. WATERS).

Ms. WATERS. Mr. Speaker, I think this is a sham Republican prescription bill because elderly women are dying from preventable diseases. This is nothing more than a false sense of security.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. NAPOLITANO).

Mrs. NAPOLITANO. Mr. Speaker, I think this is an unfinished Republican Medicare bill because it does not provide the simple, adequate prescription drug coverage for all our mothers, our sisters, and our grandmothers.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I thank my colleague for yielding me the time.

Mr. Speaker, I rise in opposition to this rule and to the Medicare bill. The rule is unfair. The bill is unacceptable. It provides spotty coverage that will not help seniors with their expensive medications, and it reneges on a promise we have made to America's seniors and those with disabilities by ending Medicare as we have known it.

I want to speak about a provision in the bill that still cuts, even with yesterday's revisions, hundreds of millions of dollars for cancer care. A cut like this will be devastating to seniors with cancer.

If this bill is passed, cancer centers will close, especially satellite centers that are located close to where seniors live. Those that remain open will admit fewer patients and lay off oncology nurses.

Medicare beneficiaries do pay too much for their oncology medications. We all agree that we must fix this, but Medicare also pays way too little for essential oncology services. The overpayments for oncology drugs has been used to pay for treatments oncologists provide to cancer patients. So we must fix both parts of this problem.

The bill fixes overpayment of drugs, but still cuts some $300 million from cancer care to do it. The quality of cancer care will suffer.

The gentleman from Georgia (Mr. NORWOOD) and I submitted amendments last night to fix both parts of this problem and protect the quality of cancer care for all Americans, but these amendments were not made in order; and now seniors will not only not get sufficient prescription drug coverage but those with cancer, seniors with cancer, will see their treatments jeopardized, thwarted, cut off. What will seniors with cancer do?

I urge my colleagues to vote against the rule and against this bill.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

In response to the gentlewoman from California (Mrs. CAPPS), who we both share an abiding concern about cancer patients and their treatment, I would just like to set the record straight in that the bill on the floor today increases oncology practice expenses by $190 million. That is 83 percent over their current payment, and it is 50 percent higher than any other specialty. It also includes an average sales price plus 12 percent for 2 years. Now, that is $240 to $250 million on top of a $190 million increase in practice expenses.

In addition to that, we have provided for oral cancer therapies, the new, upcoming way to treat cancer, so that chemotherapies are not the only treatment that seniors can get. They can stay home and take a pill in their own surroundings rather than go be hooked up to some infusion device.

These are wonderful steps forward for the cancer community.

Mrs. CAPPS. Mr. Speaker, will the gentlewoman yield?

Ms. PRYCE of Ohio. I yield to the gentlewoman from California.

Mrs. CAPPS. Mr. Speaker, I thank my colleague for yielding, and we do share a very strong interest in this issue, and we both also know that oncology services involve more than the oncologist, and, yes, this bill does raise from the terrible low cut that was originally in it some 12 percent; but it still leaves a huge vacuum for the services that are provided by oncology nurses, the whole panoply of outpatient and clinic setting services that patients who are receiving chemotherapy, which is such a devastating treatment to go through, need in order to maintain.

It is really a life-and-death situation for people who receive a diagnosis of cancer and then find out that they have to go to the doctor and get their medication, and then they have to find some way to have the services delivered because Medicare will not cover this wide comprehensive care in a cancer center, and that is what we need to have a full debate upon.

Ms. PRYCE of Ohio. Reclaiming my time, I disagree with the gentlewoman's analysis of how it works. There is a provision that will allow physicians to stockpile, if they prefer.

□ 1345

But on to another issue, Mr. Speaker. There were statements made earlier that there were no cost savings in this bill, by a former speaker. There are cost savings. There is group purchasing and insurance benefits, a 25 to 30 percent savings. There is a discount card, 15 to 20 percent savings. There is a Medicare best price, $18 billion in savings. Average wholesale price reform, $15 billion in savings. There is Hatch-Waxman reforms and reimportation reforms, all generating savings. And that is how we are able to expand and generate better treatment for seniors through the upcoming years.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I rise in opposition to the proposed rule providing for consideration of the Medicare Prescription Drug and Modernization Act.

This rule restricts the House to 3 hours of debate on the largest ever overhaul of a program that has been critical to the health of our Nation's seniors for 38 years. Furthermore, the rule blocked dozens of amendments, including one of my own, which could have resulted in tremendous savings for seniors by opening the door for the Health and Human Services Department to use the bulk purchasing power of America's 40 million Medicare beneficiaries to negotiate lower medication prices for them.

As a result, Members are denied the opportunity to address many disturbing provisions in this bill. To mention just a few, the failure to address the rapidly rising cost of prescription drugs that will soon render this benefit meaningless; the tremendous gaps in coverage that will result in less help for those who need it most; and the provisions that fundamentally alter the structure and entitlement of Medicare by requiring the program to compete with private plans beginning in 2010.

Mr. Speaker, the list of Members' concerns with this bill goes on and on and on. The other Chamber has been debating this bill for 2 weeks, meanwhile the United States House of Representatives will have a mere 3 hours of debate on this bill that we are presented with. This is an affront to democracy.

Ms. PRYCE of Ohio. Mr. Speaker, I continue to reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, I thank the gentlewoman for yielding me this time.

We have heard a lot about the new benefits and protections that will be afforded by this bill. Unfortunately, most of the benefits and protections will not go to seniors in need, they will go to the pharmaceutical and the insurance industry. This bill will do a good job of protecting the monopoly profits and price gouging by the pharmaceutical industry.

Perhaps the gentleman from Kentucky has not read or at least he doesn't understand the bill. Section 1801 prohibits the Federal Government, Medicare, from negotiating lower prices from the pharmaceutical industry, a provision inserted at the behest of the pharmaceutical industry to protect their profits. The VA negotiates very successfully, and that would lower the cost of drugs much more than the puny benefits in this bill at a cost of $400 billion. But, no, that is prohibited in this legislation.

The bill does not allow the reimportation of U.S. manufactured drugs from Canada because that would provide a greater benefit than the puny benefits in this bill. Here are three drugs: Tamoxifen. If we could just reimport, if Americans could just buy the drug by mail from Canada, they would save 90 percent. But a couple with a $4,500 a year drug bill will get a 22 percent benefit under this legislation. For Vioxx, for arthritis, 52 percent if you could just buy it in Canada and bring it back into this country. Under this bill, a 22 percent reduction for seniors who pay $4,500 a year for drugs. And then Xalatan, for glaucoma, a little closer, 33 percent from Canada, 22 percent under this bill.

So without any cost, without spending $400 billion and without spending a penny, but impinging on the profits of the pharmaceutical industry, we could provide much better benefits by negotiating or allowing reimportation.

But it does not stop there. It also benefits the insurance industry. It is going to drive seniors from Medicare into private insurance, provide subsidies to private insurance to provide unspecified benefits at a cost to be determined in the future when those benefits might become available in the year 2006, and they can be withdrawn at any time by those industries.

This is not the security our seniors deserve and it is outrageous that this should be offered without any amendments being allowed to this party.

Ms. PRYCE of Ohio. Mr. Speaker, I continue to reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, this House has sometimes risen to the occasion on matters of great national importance; the first Gulf War, September 11, when we came together to bind the Nation's wounds and provide for the national security of the Nation. Unfortunately, this legislation does not rise to the occasion. It does not deliver an adequate prescription drug benefit or hold down the cost of drugs. What it does do is open the door to the privatization of Medicare. It turns it over to the HMOs, to the private insurance market which has dropped over half of the Medicare enrollees in my State of Connecticut over the last 4 years. And seniors have not forgotten.

This bill does nothing to contain costs. It prohibits the Secretary of Health and Human Services from even engaging in negotiations with the drug companies to lower prices. As a result, many seniors will pay more than they do now and their premiums will rise as the cost of drugs rises.

Throughout my time in Congress, the single most common concern I have heard from seniors at the local stop-and-shops where I meet with them every weekend is how expensive their prescription drug bills are. Seniors know that they are being taken advantage of. They know they can get drugs cheaper in Canada and overseas. And when seniors find out that we are doing nothing to hold down the excessive profiteering of the pharmaceutical companies, when they find out that their coverage essentially stops during midsummer while they still have to pay the premiums, they are going to feel betrayed. And they are being betrayed.

If we allow this bill to become law, we would be saying that guaranteed health care for our seniors is no longer the obligation or the responsibility of this government. I did not come to the Congress to preside over the dismantling of Medicare. Our social contract with our seniors must be honored, and I urge my colleagues to support a plan that does that and not this Republican sham. Oppose the rule and oppose the bill.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Tennessee (Mr. COOPER).

Mr. COOPER. Mr. Speaker, I thank the gentlewoman for yielding me this time.

Mr. Speaker, this should be a great day for this country. We should be on the verge of passing a real Medicare prescription drug benefit for our seniors. But, unfortunately, we are not. The Republican majority is rushing through a sham bill in this House in barely 24 hours. They would not let anybody see a copy of this bill until 11:50 p.m. last night. The Committee on Rules' deliberations began at 12:50 a.m. last night and lasted, as has been mentioned, until 4 a.m.

What are they afraid of? What are they hiding? And why would they not allow amendments like the Dooley amendment to be offered on this floor? It is my understanding in the other body that Senators HAGEL, ENSIGN, and CLINTON will be offering the Dooley approach as a substitute to that legislation. The other body has deliberated on this matter for some 2 weeks in the full light of day so that all senior citizens around this country, all families around this country, could pay attention to the details of this legislation and judge for themselves whether it is good medicine for the American people or not.

But not only is the Republican majority hiding the real substance of this bill, they have failed to learn the lessons of past efforts of this House to reform the health care system. Number one, health care legislation that works must not be partisan. This bill is almost an entirely Republican-only bill. That dooms it to failure from the start. Second, real health care reform must not be overly complex. This is one of the most complex bills that seniors could ever imagine facing. The red tape is incredible. And, third, this bill should not be overly burdensome to seniors, but it is. Watch out when your seniors back home realize they have to pay $35 a month for a very questionable benefit.

There is a donut hole in coverage, and that is almost too complex to explain in the 2 minutes I am allowed here, but this bill is so inferior to the Dooley bill, which solves these problems in a simple, clear and fair fashion. Under the Dooley bill, there is a zero monthly premium.

Mr. Speaker, I urge a "no" vote on the previous question.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Mr. Speaker, like the preceding speaker before me from Tennessee, my good friend, the Dooley-Tauscher bill, I think, addresses the right priorities, the right common values we have. It does not try to end Medicare as we know it. It keeps Medicare, that has done so well over 40 years, intact. And unlike the other bills, it lives within the $400 billion frame. It is true to the principles that have held Medicare true. It relies on part B of Medicare to deliver the benefit. It does not try to privatize that benefit. It is a low-income benefit for our seniors. But, most importantly, it is universal in its benefit. Everybody would get it. There would be a minimum of a 25 to 30 percent discount on drugs.

One of the biggest debates here is not only a benefit under Medicare of prescription drugs, but it is making the drugs that our elderly need every day when they go to the drugstore or their local pharmacy, making those medications affordable. The benefit accounts for all drug spending. That is the core principle here. It is a universal benefit.

So this is the right type of approach. The other day the Washington Post endorsed it. And, today, in the other body, a bipartisan group of Senators will be introducing it. I think it expresses our common values and our common principles of what is true to our vision of what Medicare should be, not what it should not be.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. DAVIS).

Mr. DAVIS of Florida. Mr. Speaker, one of the things that we can all agree upon here today is that there ought to be an open and honest debate in our country and with our seniors as to exactly how to accomplish writing a prescription drug benefit. There are Democrats here who recognize that we have to live within the budget constraints that have been forced upon us, and we are ready to take the first step, even though it would not be the final step we would take. We are ready to work with Republicans.

This bill that is being forced on the House of Representatives today with a minimum amount of debate is a sham. There are many ways to illustrate the point. Probably the best is the private insurance companies who are being asked to provide this drug benefit are saying, once again, we do not want to do it. We do not want your money. There are not many people here in Washington who tell the government we do not want your money. These private insurance companies do not want to write this drug benefit. This bill is a sham.

The bill sets no details on premium, no details on the scope of the coverage. What are seniors getting under this bill? They do not know because we honestly do not know. The Dooley bill deserves a debate here today. It represents a compromise between what the Senate and the House is trying to do here and what the Democrats are proposing in the substitute. We deserve to have a debate on the Dooley bill.

Mr. Speaker, the rule should be defeated, the motion should be defeated, and we should debate the Dooley bill.

Ms. PRYCE of Ohio. Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as he may consume to the gentleman from Massachusetts (Mr. TIERNEY).

Mr. TIERNEY. Mr. Speaker, I rise in opposition to this bill, which is not modernization of Medicare. It ends it, it does not mend it. And there is no choice here for doctors, only for insurance companies. It is going to put a lot of seniors who have good retirement plans back into the Medicare system without the care and the prescription drugs they need.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE). The Chair has an announcement. As indicated by previous occupants of the Chair on June 27, 2002, and on March 24, 1995, although a unanimous consent request to insert remarks in debate may comprise a simple declarative statement of the Member's attitude toward the pending measure, it is improper for a Member to embellish such a request with other oratory, and it can become an imposition on the time of the Member who has yielded for that purpose.

Ms. SLAUGHTER. Mr. Speaker, we will pay attention to that.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from Indiana (Ms. CARSON).

Ms. CARSON of Indiana. Mr. Speaker, I will be brief, and I appreciate the opportunity to speak about how the Medicare bill fails to provide women with the real prescription drug coverage that they need, especially to senior women of this Nation.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Wisconsin (Mr. KIND).

□ 1400

Mr. KIND. Mr. Speaker, I rise in opposition to the rule, and encourage my colleagues to vote "no" on the previous question so we can have a real and honest debate today, and make in order the Dooley substitute.

I, along with others in the New Democratic Coalition, have worked long and hard to offer a viable alternative to the base bill. The bill before us, unfortunately, will jeopardize the very sanctity of the Medicare program. The Dooley bill, on the other hand, is simple, progressive and affordable. It helps those seniors who needs the most assistance, the low-income and those with high drug costs. It offers zero premium payments; it is Medicare as seniors know it. The benefits are integrated into Medicare part B, and every beneficiary gets a guaranteed benefit for no additional premium.

Unlike the House and Senate Republican bills, this bill has no gap in coverage, and it is fiscally responsible. It fits within the budget resolution that was passed earlier this year.

Later today, it is my understanding that Senators HAGEL and CLINTON and ENSIGN will be offering the same exact Dooley substitute on the Senate floor. We should be allowed to debate the same measure today. I urge a "no" vote on the previous question.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. THOMPSON).

Mr. THOMPSON of California. Mr. Speaker, I rise today against this rule. Members should have an opportunity to vote on an enhanced version of the bipartisan Senate bill. That is the Blue Dog prescription drug benefit bill. Unfortunately for seniors across this country, our friends across the aisle have disallowed a debate on this better bill. It is better because it has a guaranteed fall-back, which means if seniors cannot get a PPO, they will have Medicare. It is better because there are no premium supports, which means seniors are not going to be penalize for staying in Medicare; and it is better because it does not privatize Medicare. Medicare is an important program that has saved the lives of many seniors, and an inclusion of a prescription drug benefit deserves an open debate.

Mr. Speaker, I urge opposition to this rule so the Blue Dog proposal can be debated and seniors can have the best coverage that we can afford at this time.

Mr. Speaker, today I rise in opposition to the rule of the Republican Medicare Prescription Drug Bill, H.R. 1. It serves only one purpose—ensuring that the voices of several in the Democratic Party are never heard on this critical issue.

I stand here on behalf of the Blue Dog Coalition—a group which engaged in this debate by crafting a moderate, affordable prescription drug alternative that would have appealed to Members on both sides of the aisle. But this body will never consider the Blue Dog substitute, because the Rules Committee denied us the opportunity to debate our proposal and have a vote on the House floor.

As you know, the Blue Dogs are a group of fiscally conservative Democrats, who are committed—as a coalition—to the passage of a prescription drug benefit that fits within our $400 billion budget window. On Tuesday evening, the Coalition formally endorsed legislation based upon the bipartisan Senate Medicare bill (S. 1).

The Senate has come together to develop a strong bipartisan benefit. It is not perfect. But, in recent years, the perfect has become the enemy of the good and, unfortunately, the perfect is out of our price range. The Senate offers America's seniors a good benefit. It carries a monthly premium of $35. A deductible of $275. A 50 percent cost-share through the first $4500 of drug spending. And, it offers a catastrophic benefit that kicks in after beneficiaries have spent $3700 out of pocket. Further, it corrects a variety of inadequacies in our Medicare reimbursement system for rural providers. And, it does all of this without putting Medicare on the path to privatization. But, with a score of $389 billion, there was some room for improvements. And, that is just what the Blue Dog Coalition has done.

We have strengthened the rural provider package by accelerating the start dates to 2004. And, we have improved the adjustments made to the wage index labor share—dropping the labor share to 62 percent.

We have built upon the Senate's critically important fall-back provisions. The fall-back means that seniors—such as those living in rural areas without two or more plans providing service—will always have access to a drug benefit. We have provided an additional layer of stability for those seniors, by requiring the fall-back plans to contract for two years as opposed to one.

We have included the Senate Generic drug amendment, which has been scored by CBO as a cost-saver because it streamlines and clarifies the process by which generic medications can be brought to market. This will increase the amount of affordable medications available to all of our seniors.

We have incorporated disclosure requirements, to ensure that our plans are fully demonstrating how savings are passed on to our beneficiaries.

We allow the Secretary to negotiate on behalf of all Medicare beneficiaries for the best prices possible.

We permit the re-importation of medications from Canada, provided that the Secretary certifies that such action would not jeopardize the health and safety of the American public.

We allow Medicare to operate as the primary payor for all dually eligible beneficiaries, lifting some of the financial burden off of the shoulders of our states.

We allow a portion of employer contributions to be counted towards the beneficiary out of pocket limits, encouraging our employers to continue sponsoring retiree health plans.

And we are able to make these improvements within the confines of the $400 billion budget allocation.

Unfortunately, the Congressional Budget Office was not able to complete a score on our legislation prior to the convening of the Rules Committee. However, the majority of the changes we have made to the already-scored Senate bill were based upon Senate amendments that have either been introduced and passed or are pending introduction. As such, they have all been scored by CBO for their sponsoring offices. The availability of that information has allowed the Blue Dogs to say with certainty that this legislation fits within the $400 billion budget window.

But, Members with questions about the Blue Dog substitute will never have the opportunity to pose them because the rule has prevented all debate on this alternative. Medicare is a complex program and the debate on the addition of a new prescription drug benefit cannot be a simple one. Voices should be heard, debate should be had, and all options should be fully explored before one course of action is decided upon. Unfortunately—to the detriment of this body and America's seniors—that is not happening.

I urge my colleagues to oppose this rule, and in doing so allow the House of Representatives to give this critical issue the open and deliberate debate that it fully deserves.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. GINGREY), another physician in our conference.

Mr. GINGREY. Mr. Speaker, I thank the gentlewoman from Ohio (Ms. PRYCE) for giving me an opportunity to speak on this issue. I rise in favor of the rule and in favor of this bill.

I have delivered probably 5,000 or more babies over a 30-year medical career; but I will be prouder today of this delivery that we are giving to our seniors, that we have promised them for the last 2 years. Finally today that delivery will occur. This will be the best delivery that I have ever given because what we are talking about is not just a prescription drug benefit; we are also talking about modernizing Medicare so that it will not be going bankrupt by the year 2030.

With a prescription drug benefit, we will have an opportunity for our seniors to avoid prolonged hospital stays and prolonged nursing home stays, difficult expensive surgery. Let them take those medications early in the disease process so that high blood pressure does not result in a stroke or heart attack or so the diabetes they are suffering with does not end up in them being a dialysis patient.

This is a good bill. This is a bill that our leadership is finally going to give to our seniors; and I tell Members this is the day to do it, and this is the finest delivery we can offer to our seniors.

Ms. SLAUGHTER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am sure the gentleman from Georgia (Mr. GINGREY) is pleased that the Democrats tried to make the gentleman's amendment in order last night.

Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. TAUSCHER).

Mrs. TAUSCHER. Mr. Speaker, I rise today to strongly urge my colleagues to vote against the rule and to defeat the previous question. This will allow us to debate a much more realistic and fiscally responsible Medicare bill.

It is clear that the status quo is not working to make prescription drugs affordable for seniors. It is also clear that our country's economic situation does not give Congress a lot of options for solving this growing problem. Under the Dooley-Tauscher plan, seniors do not have to pay a premium, and the generous low-income benefit far exceeds the one offered by the majority. For seniors whose income is 150 percent of the Federal poverty level, roughly equal to $13,400, they will only have a 10 percent cost share.

Furthermore, any prescription drug plan needs to be part of Medicare, which seniors like and trust. Our plan is managed by Medicare. The benefit is integrated into Medicare part B, and every beneficiary gets a guaranteed benefit at no additional cost. By leveraging the buying power of all seniors, our plan allows every single person on Medicare to benefit from immediate drug savings regardless of how many prescriptions they are filling a month.

Finally, Mr. Speaker, our seniors need to be protected from catastrophic drug costs. Seniors who have high drug costs will be able to access the full benefit sooner because our plan focuses on the total cost of the drug, not discounted price paid out of pocket. Our plan has an extra safety net for those who really need it, people with total drug costs of $4,000 a year.

Under our bill, companies that currently provide prescription drug coverage to their retirees will have the incentive to continue doing so because the Federal Government will assume the risk of drug coverage once beneficiaries reach their deductible.

We need to be smart and realistic about how we can provide every American senior with prescription drug coverage. Given the current economic situation, our plan is the one that provides this coverage and is fiscally achievable. I urge my colleagues to defeat the previous question and support the Dooley-Tauscher substitute.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I rise in opposition to the sham Republican Medicare bill which fails to provide women with the real prescription drug coverage that they need and deserve, and undermines the entire program.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. DOOLEY).

Mr. DOOLEY of California. Mr. Speaker, I rise to ask that the previous question be defeated so we can offer a real prescription drug benefit to seniors. It is unfortunate that the bill being offered by our Republican colleagues is one that seniors are going to find is so complex that it is going to result in taxpayers displacing a lot of private sector contributions which are already providing prescription drug benefits.

Why in the world would we design a drug benefit program where we are actually going to be trading taxpayer dollars for dollars that are already being spent by corporations for their retirees?

There is a better alternative, and that is the bill we would like to offer, that is, we take the $400 billion that President Bush has talked about, roll it into Medicare part B, and use a drug card much like President Bush has talked about which ensures that every senior will have access to negotiated prices which ensures that they have 10 to 20 percent savings. We do this without an increase in premiums. We also target seniors facing catastrophic health care costs by ensuring that after they have purchased drugs that cost $4,000, that the Federal Government will be there to pick up the vast majority of their drug costs from that point on.

We also recognize that there are a lot of seniors in this country that cannot afford the $4,000, so we provide a low-income benefit that provides significant assistance to all those seniors who have incomes less than 200 percent of poverty. This would ensure that 50 percent of the seniors on Medicare today would have a subsidized low-income benefit that would help provide them access to much-needed prescription drugs.

It is time for this Congress to come together and say, if seniors have a limited amount of resources, let us target those resources of those seniors that are in greatest need. Those are the seniors with very high drug costs and those seniors with the least ability to pay, and the system should be simple.

The Republican plan that we are going to be considering on the floor today provides seniors the benefit if they are low-income, but not if they have $6,000 in assets or a car that is too valuable. We need a plan that seniors can understand, that they do not need to be an accountant to figure out; and that is what our alternative would provide.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. WHITFIELD), a member of the Committee on Energy and Commerce.

Mr. WHITFIELD. Mr. Speaker, today represents the culmination of 4 to 5 years of Congress' efforts to provide a prescription drug benefit for senior citizens on Medicare. Two years ago, the House of Representatives passed a prescription drug benefit for senior citizens. Last year we did the same. The Senate did not do it the year before, nor did they do it last year; but this year both the House and the Senate will pass a prescription drug benefit.

This is a meaningful plan. It is going to provide basically free medicines for any senior citizen on Medicare who is at 135 percent of the poverty level and below. The only thing they will be expected to pay is a small $2 copay for generic drugs and a small $5 copay for name-brand drugs.

I have heard a lot of comments today about private insurance companies are going to be involved in administering this plan. I think it is important to recognize that today's Medicare plan uses private insurance companies to handle all of the reimbursement charges for Medicare. So we are not doing anything dramatically different in this bill than what is being done today.

I would also say the fact that this bill would provide catastrophic coverage for seniors is going to be a tremendous benefit. It will give them the peace of mind to know that no matter how high their drug costs may be, at some point the Federal Government will pay for all of it, the taxpayers will pay for all of it. I would also say that this bill provides an important rural health benefit package that is going to benefit all of rural America. It also provides additional monies, important monies that are needed for disproportionate share hospitals. It will benefit every children's hospital in America today. All those hospitals that provide care for people on Medicaid will receive additional funds. I think this is an important bill, and I urge Members to vote for the previous question and to adopt this new prescription drug benefit for Medicare beneficiaries.

Ms. SLAUGHTER. Mr. Speaker, I yield myself the balance of my time.

Today, the House votes on the biggest change in Medicare in its 40-year history, a change that will affect 40 million Americans; but the Republican leaders have rigged the rules to prevent the House from voting on serious alternatives offered by Republicans and Democrats alike.

Mr. Speaker, I will call for a "no" vote on the previous question in the hope that the House gets the chance to consider an additional alternative that the Republican leaders fear. If the previous question is defeated, I will offer an amendment to the rule that will make in order the Dooley prescription drug alternative substitute. It makes all senior citizens enrolled in Medicare part B eligible for prescription drug assistance without increasing their premiums. Unlike the Republican bill, it has no sickness penalty or doughnut hole that seniors can fall through. Unlike the Republican bill, it does not encourage companies to drop seniors' existing drug plans.

Let me make it clear that a "no" vote on the previous question will not stop the consideration of H.R. 1. It will simply allow the House to vote on the Dooley substitute. However, a "yes" vote on the previous question will prevent the House from voting. I urge a "no" vote.

Mr. Speaker, I ask unanimous consent that the text of the amendment be printed in the RECORD immediately prior to the vote on the previous question.

The SPEAKER pro tempore (Mr. LATOURETTE). Is there objection to the request of the gentlewoman from New York?

There was no objection.

Ms. SLAUGHTER. Mr. Speaker, I yield back the balance of my time.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, passing this plan is the right thing to do. It makes the kind of commonsense changes to the health care system in this country that the American public needs. Adding this Medicare benefit will renew our promise to our seniors. It will reduce the cost of prescription drugs, and it will revolutionize medicine for the 21st century. Seniors deserve this assistance now. They deserved it yesterday. They deserved it last week; and actually, they deserved it last year. It is time for this body to act. I urge my colleagues to support this fair rule and pass the needed reform today.

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The material previously referred to by Ms. SLAUGHTER is as follows:

PREVIOUS QUESTION FOR H. RES. 299—RULE ON H.R. 1 AND H.R. 2596 MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT AND HEALTH SAVINGS AND AFFORDABILITY ACT

In the first section of the resolution strike "and (3)" and insert the following:

"(3) the further amendment in the nature of a substitute specified in section 7 of this resolution if offered by Representative Doley of California or a designee, which shall be in order without intervention of any point of order, shall be considered as read, and shall be separately debatable for 60 minutes equally divided and controlled by the proponent and an opponent; and (4)"

At the end of the resolution add the following new section:

"Sec. 7. The further amendment in the nature of a substitute referred to in the first section of this resolution is as follows:"

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Rx Now Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE RX NOW

Sec. 100. Purpose.

Subtitle A—Part B Drug Benefit with High Deductible and No Premium

Sec. 101. Inclusion of high-deductible outpatient prescription drug benefit under part B.
Sec. 102. Provision of benefits through medicare approved prescription drug plans.

Subtitle B—Benefits for Low-income Beneficiaries

Sec. 111. Benefits for low-income beneficiaries.
Sec. 112. Improving enrollment process under medicaid.

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

Sec. 201. Fairness in the medicare disproportionate share hospital (DSH) adjustment for rural hospitals.
Sec. 202. Immediate establishment of uniform standardized amount in rural and small urban areas.
Sec. 203. Establishment of essential rural hospital classification.
Sec. 204. More frequent update in weights used in hospital market basket.
Sec. 205. Improvements to critical access hospital program.
Sec. 206. Redistribution of unused resident positions.
Sec. 207. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under prospective payment system for hospital outpatient department services.
Sec. 208. Exclusion of certain rural health clinic and Federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 209. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 210. Improvement in payments to retain emergency capacity for ambulance services in rural areas.
Sec. 211. Three-year increase for home health services furnished in a rural area.
Sec. 212. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 213. GAO study of geographic differences in payments for physicians' services.
Sec. 214. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 215. Extension of telemedicine demonstration project.
Sec. 216. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.
Sec. 217. Establishment of floor on geographic adjustments of payments for physicians' services.

TITLE I—MEDICARE RX NOW

SEC. 100. PURPOSE.

The purpose of this title is to provide for outpatient prescription drug benefits to medicare beneficiaries in the following manner:

(1) Medicare beneficiaries enrolled under medicare part B qualify for outpatient prescription drug benefits after an annual deductible (initially set at $4,000) has been met. This benefit is available without any additional premium.

(2) There are fixed dollar copayments for this coverage, with the average of such copayments equal to 20 percent of the benefits and the amount of the copayments varying depending upon whether the drugs are generic, preferred brand-name, or non-preferred brand-name drugs.

(3) The benefits are provided through medicare-approved prescription drug plans. These plans may be current plans, such as Medicare+Choice plans, employer-based retiree coverage, medigap plans, State assistance programs, medicaid, drug discount card plans, and other qualified plans (as determined by the Secretary). All of these plans must offer, in addition to the high-deductible coverage, discounts for prescription drugs both while the annual deductible is being satisfied and after it is satisfied.

(4) To assure access to medicare-approved prescription drug plans for all medicare beneficiaries, the Secretary will solicit bids for prescription drug discount plans that will be available in all geographic regions to all medicare beneficiaries.

(5) All pharmacies that comply with electronic claims processing standards may provide drugs under the program.

(6) This title also provides for the availability of additional benefits in the form of a waiver of the annual deductible and reduced copayments, thereby providing immediate entitlement to prescription drug benefits, for medicare beneficiaries who have incomes under 200 percent of the poverty line and who are not eligible for medicaid prescription drug benefits.

Subtitle A—Part B Drug Benefit with High Deductible and No Premium

SEC. 101. INCLUSION OF HIGH-DEDUCTIBLE OUTPATIENT PRESCRIPTION DRUG BENEFIT UNDER PART B.

(a) COVERAGE.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) by striking "and" at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(3) entitlement to have access to a prescription drug plan that provides discounts on purchases for outpatient prescription drugs and, effective beginning with 2006, for payment made on his behalf (subject to the provisions of this part) for high-deductible outpatient prescription drug coverage under section 1845.".

(b) DESCRIPTION OF HIGH-DEDUCTIBLE PRESCRIPTION DRUG BENEFIT.—Title XVIII is amended by inserting after section 1844 the following new section:

"OUTPATIENT PRESCRIPTION DRUG COVERAGE

"SEC. 1845. (a) HIGH-DEDUCTIBLE OUTPATIENT PRESCRIPTION DRUG COVERAGE DEFINED.—

"(1) IN GENERAL.—For purposes of this part, the term 'high-deductible outpatient prescription drug coverage' means payment of—

"(A) expenses for covered outpatient prescription drugs incurred in a year after the individual has incurred expenses for such drugs in the year of an amount equal to the annual deductible specified in paragraph (2); reduced by

"(B) cost-sharing described in paragraph (3).

For periods before 2006, such coverage shall consist of access to discounts for prescription drugs under a medicare-approved prescription drug plan.

"(2) ANNUAL DEDUCTIBLE.—

"(A) IN GENERAL.—The annual deductible under this paragraph—

"(i) for 2006 is equal to $4,000; and

"(ii) for a subsequent year is equal to the amount specified in subparagraph (B) for that year, except that, if the amount specified in such subparagraph is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

"(B) INFLATIONARY ADJUSTMENT.—The amount specified in this subparagraph—

"(i) for 2006, is $4,000; or

"(ii) the amount specified in this subparagraph for a subsequent year is the amount specified in this subparagraph for the previous year increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient prescription drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year.

"(3) COST-SHARING.—

"(A) THREE-TIERED COPAYMENT STRUCTURE.—Subject to the succeeding provisions of this paragraph , in the case of a covered outpatient drug that is dispensed in a year to an eligible individual, the individual shall be responsible for a copayment for the drug in an amount equal to the following (or, if less, the price for the drug negotiated pursuant to subsection (c)(5)):

"(i) GENERIC DRUGS.—In the case of a generic covered outpatient drug, the base copayment amount specified in accordance with subparagraph (B) for each prescription (as defined by the Secretary) of such drug.

"(ii) PREFERRED BRAND NAME DRUGS.—In the case of a preferred brand name covered outpatient drug, 4 times the copayment amount applied under clause (i) for each prescription (as so defined) of such drug.

"(iii) NONPREFERRED BRAND NAME DRUG.—In the case of a nonpreferred brand name covered outpatient drug, 150 percent of the copayment amount applied under clause (ii) for each prescription (as so defined) of such drug.

"(B) ESTABLISHMENT OF BASE COPAYMENT AMOUNT CONSISTENT WITH 80:20 BENEFIT RATIO.—For each year beginning with 2006 the Secretary shall establish a base copayment amount in a manner consistent with the principle (subject to reasonable rounding rules) that the ratio of the aggregate amount of benefits provided under this section to the aggregate copayments under this paragraph for each year should be approximately equal to 80 to 20.

"(C) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—A medicare-approved prescription drug plan may reduce copayments for its designees below the level otherwise provided under this paragraph, but in no case shall such a reduction result in an increase in payments made by the Secretary under this section to a plan.

"(D) TREATMENT OF MEDICALLY NECESSARY NONPREFERRED DRUGS.—A nonpreferred brand name drug shall be treated as a preferred brand name drug under this paragraph if such nonpreferred drug is determined (pursuant to procedures established under subsection (c)(6)) to be medically necessary.

"(E) REQUIREMENT FOR DESIGNATION OF PREFERRED BRAND NAME DRUGS.—Within each category of therapeutic-equivalent covered outpatient prescription drugs (as defined by the Secretary, in consultation with the Medicare Payment Advisory Commission, each medicare-approved prescription drug plan shall provide for the designation of at least one preferred brand name covered outpatient drug.

"(4) PAYMENT OF BENEFITS BEYOND DEDUCTIBLE.—

"(A) IN GENERAL.—There shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for covered outpatient prescription drugs with respect to which benefits are payable under this section, amounts equal to the amounts provided under paragraph (1).

"(B) COUNTING OF INCURRED EXPENSES.—Expenses with respect to covered outpatient prescription drugs under this section shall—

"(i) be treated as incurred regardless of whether they are reimbursed by a third-party payor;

"(ii) not be treated as incurred unless the expenses were incurred during a period in which the individual was covered under this part; and

"(iii) not be treated as incurred unless information concerning the transaction giving rise to such expenses has been electronically transmitted by the pharmacy or other entity dispensing the covered outpatient prescription drugs to the medicare-approved prescription drug plan consistent with electronic claims standards established under subsection (c)(3).".

SEC. 102. PROVISION OF BENEFITS THROUGH MEDICARE APPROVED PRESCRIPTION DRUG PLANS.

(a) IN GENERAL.—Section 1845 of the Social Security Act, as inserted by section 101(a), is further amended by adding at the end the following:

"(b) PROVISION OF BENEFITS THROUGH A MEDICARE APPROVED PRESCRIPTION DRUG PLAN.—

"(1) IN GENERAL.—In the case of an individual entitled to benefits for high-deductible outpatient prescription drug coverage under this section, the individual shall obtain such benefits through a medicare-approved prescription drug plan that is designated under this subsection.

"(2) DESIGNATION PROCESS.—The Secretary shall provide for a process for designation of medicare-approved prescription drug plans consistent with the following:

"(A) FREQUENCY OF DESIGNATIONS.—The Secretary shall permit individuals, on an annual basis and at such other times during a year as the Secretary may specify, to change the plan designated.

"(B) DISSEMINATION OF INFORMATION.—The Secretary shall provide for the dissemination of information on designation of plans under this subsection. Such dissemination may be coordinated with the dissemination of information on Medicare+Choice plan selection under part C.

"(C) DEFAULT ASSIGNMENT.—In the case of an individual who is enrolled under this part who has not otherwise designated a medicare-approved prescription drug plan, the Secretary shall assign the individual to an appropriate prescription drug discount card plan serving the area in which the individual resides.

"(D) DEEMED DESIGNATION.—The Secretary may deem an individual who is enrolled in a medicare-approved prescription drug plan described in subparagraph (A) through (E) of subsection (c)(2) as having designated such plan, but shall permit the individual to designate a prescription drug discount card plan instead. The Secretary shall establish rules in cases where an individual is enrolled in more than one such plan.

"(3) DESIGNEE DEFINED.—In this section, the term 'designee' means such an individual who makes such a designation and, with respect to a plan, an individual who has designated that plan under this subsection.

"(c) MEDICARE-APPROVED PRESCRIPTION DRUG PLANS.—

"(1) IN GENERAL.—For purposes of this part, the term 'medicare-approved prescription drug plan' means a health plan or program described in paragraph (2) that—

"(A) beginning with 2006, provides at least high-deductible outpatient prescription drug coverage to designees of that plan or program;

"(B) meets the applicable requirements of paragraph (3) and succeeding paragraphs of this subsection with respect to such designees;

"(C) has entered into an agreement with the Secretary to provide and exchange electronically such information as the Secretary may require for the administration of the program of benefits under this section; and

"(D) meets such additional requirements as the Secretary may specify, including requiring the provision of appropriate periodic audits.

"(2) TYPES OF PLANS AND PROGRAMS THAT MAY QUALIFY.—The types of plans and programs that may qualify as a medicare-approved prescription drug plan are the following:

"(A) A Medicare+Choice plan.

"(B) A group health plan, including a retirement health benefits plan, that provides prescription drug coverage.

"(C) A State plan under title XIX.

"(D) A health benefits plan under the Federal employees' health benefits program under chapter 89 of title 5, United States Code.

"(E) A medicare supplemental policy.

"(F) State pharmaceutical assistance program.

"(G) A prescription drug discount card plan (described in subsection (d)).

"(H) Any other prescription drug plan that is determined to meet such requirements as the Secretary establishes.

"(3) ADMINISTRATION THROUGH CARD-BASED ELECTRONIC MECHANISM.—

"(A) USE OF MEDICARE PRESCRIPTION DRUG CARD.—Claims for benefits under this section under a medicare-approved prescription drug plan may only be made electronically through the use of an electronic prescription card system (in this paragraph referred to as the 'system').

"(B) STANDARDS FOR ELECTRONIC PRESCRIPTION CARD SYSTEM.—The Secretary shall establish standards for the system, including the following:

"(i) CARDS.—Standards for claims cards to be used by designees under the system.

"(ii) COORDINATION OF ELECTRONIC INFORMATION.—Standards for the real-time transmittal among pharmacies, medicare-approved prescription drug plans, and the Secretary (including an appropriate data clearinghouse operated by or under contract with the Secretary) of information on expenses incurred for covered outpatient prescription drugs by designees.

"(iii) CONFIDENTIALITY.—Standards that assure the confidentiality of individually identifiable information of designees and that are consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(iv) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions must be written and transmitted electronically (other than by facsimile), except in emergency cases and other exceptional circumstances recognized by the Secretary.

"(v) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides for the electronic transmittal to the prescribing health care professional of information that includes—

"(I) information (to the extent available and feasible) on the drug or drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

"(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

"(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

"(C) STANDARDS.—

"(i) DEVELOPMENT.—The Secretary shall provide for the development of uniform standards relating to the electronic prescription drug program described in subparagraph (B). Such standards shall be compatible with standards established under part C of title XI.

“(ii) ADVISORY TASK FORCE.—In developing such standards the Secretary shall establish a task force that includes representatives of physicians, hospitals, pharmacies, beneficiaries, pharmacy benefit managers, individuals with expertise in information technology, and pharmacy benefit experts of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

“(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

“(II) The extent to which such standards and systems reduce medication errors and can be readily implemented by physicians, pharmacies, and hospitals.

“(III) Efforts to develop uniform standards and a common software platform for the secure electronic communication of medication history, eligibility, benefit, and prescription information.

“(IV) Efforts to develop and promote universal connectivity and interoperability for the secure electronic exchange of such information.

“(V) The cost of implementing such systems in the range of hospital and physician office settings and pharmacies, including hardware, software, and training costs.

“(VI) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

“(iii) DEADLINES.—

“(I) The Secretary shall constitute the task force under clause (ii) by not later than April 1, 2004.

“(II) Such task force shall submit recommendations to the Secretary by not later than January 1, 2005.

“(III) The Secretary shall provide for the development and promulgation, by not later than January 1, 2006, of national standards relating to the electronic prescription drug program described in clause (ii). Such standards shall be issued by a standards organization accredited by the American National Standards Institute (ANSI) and shall be compatible with standards established under part C of title XI.

“(4) ACCEPTANCE OF CLAIMS THROUGH ALL QUALIFYING PHARMACIES.—A medicare-approved prescription drug plan shall—

“(A) permit the participation of any pharmacy that meets terms and conditions that the plan has established;

“(B) provide for acceptance and process of claims for designees from any pharmacy that meets standards the Secretary has established under paragraph (3) to carry out real-time transmittal of claims to such plans and that provides for disclosure, in the case of dispensing of a brand name drug to a designee, of information on the availability of generic equivalents at reduced cost to the designee; and

“(C) permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, with any differential in cost paid by such enrollees.

“(5) REQUIREMENT TO NEGOTIATE DISCOUNTS AND GENERIC EQUIVALENTS.—A medicare-approved prescription drug plan shall provide designees of the plan with the following:

“(A) NEGOTIATED PRICES.—Access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits or only partial benefits may be payable with respect to such drugs because of the application of the deductible under subsection (a)(2) or copayment under subsection (a)(3) or because the drugs are procured before January 1, 2006.

“(B) GENERIC EQUIVALENTS.—Information on the availability of generic equivalents at reduced cost to such designees.

“(6) TREATMENT OF NONPREFERRED BRAND NAME DRUGS.—

“(A) PROCEDURES REGARDING THE DETERMINATION OF DRUGS THAT ARE MEDICALLY NECESSARY.—

“(i) IN GENERAL.—A medicare-approved prescription drug plan shall have in place procedures on a case-by-case basis to treat a nonpreferred brand name drug as a preferred brand name drug for purposes of subsection (a) if the nonpreferred brand name drug is determined—

“(I) to be not as effective for the designee in preventing or slowing the deterioration of, or improving or maintaining, the health of the individual; or

“(II) to have a significant adverse effect on the individual.

“(ii) REQUIREMENT.—The procedures under clause (i) shall require that determinations under such clause are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

“(B) PROCEDURES REGARDING APPEAL RIGHTS WITH RESPECT TO DENIALS OF CARE.—Such a plan shall have in place procedures to ensure a timely internal review (and timely independent external review) for resolution of denials of coverage in accordance with the medical exigencies of the case in accordance with requirements established by the Secretary that are comparable to such requirements for Medicare+Choice organizations under part C and to ensure notice to designees regarding such procedures. A designee shall have the further right to an appeal of such a denial of coverage in the same manner as is provided under section 1852(g)(5) in the case of a failure to receive health services under a Medicare+Choice plan.

“(7) PROMPT PAYMENT OF PHARMACIES FOR COVERED BENEFITS.—Medicare-approved prescription drug plans shall provide for payment to qualifying pharmacies of benefits under subsection (a)(4) promptly in accordance with rules no less generous than the rules applicable under section 1842(c)(2)(B).

“(8) EDUCATION.—Medicare-approved prescription drug plans shall apply methods to identify and educate providers, pharmacists, and designees regarding—

“(A) instances or patterns concerning the unnecessary or inappropriate prescribing or dispensing of covered outpatient prescription drugs;

“(B) instances or patterns of substandard care;

“(C) potential adverse reactions to covered outpatient prescription drugs;

“(D) inappropriate use of antibiotics;

“(E) appropriate use of generic products; and

“(F) the importance of using covered outpatient prescription drugs in accordance with the instruction of prescribing providers.

“(9) NOT AT FINANCIAL RISK.—The entity offering a medicare-approved prescription drug plan shall not be at financial risk for the provision of high-deductible prescription drug coverage under the plan to designees, but there shall be performance incentives (based on risk corridors negotiated between the entity and the Secretary and subject to audit) in relation to the administration of the contract and the entity's ability to reduce costs through appropriate incentive mechanisms.

“(10) PROVISION OF DATA.—The entity offering such a plan shall provide the Secretary with such information as is required to make payments to the entity under this section.

“(d) PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

“(1) SOLICITATION OF BIDS.—The Secretary shall solicit bids from entities to offer prescription drug discount card plans to individuals enrolled under this part either nationwide or in large geographic areas. The Secretary shall award bids in a manner so that such plans are offered in all areas of the United States. The Secretary may not award a contract based on such a bid to an entity with respect to a plan unless the entity and plan meet the applicable requirements to be a medicare-approved prescription drug plan under this section.

“(2) LIMITATION ON BENEFITS.—The entity offering a prescription drug discount card plan shall not offer (or charge for) benefits to designees of the plan in addition to high-deductible prescription drug coverage, access to negotiated prices, and other benefits required under this section and, in the case of subsidy eligible individuals, benefits under subsection (h).

“(e) PAYMENT OF PLANS.—

“(1) IN GENERAL.—The Secretary shall provide, in the contract entered into between the Secretary and entities that offer medicare-approved prescription drug plans, for payment to the plans for high-deductible prescription drug coverage offered through the plan, including expanded coverage for low-income individuals under subsection (g) and taking into account performance incentives described in paragraph (2). In addition, in the case of prescription drug discount card plans, the Secretary shall provide for payment of administrative costs in carrying out the contract (taking into account the performance incentives described in paragraph (2)), based on rates negotiated between the Secretary and the entity in the solicitation process under subsection (d).

“(2) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary shall include in the contract such financial or other performance incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate.

“(f) COVERED OUTPATIENT PRESCRIPTION DRUGS DEFINED.—

“(1) IN GENERAL.—Except as provided in this subsection, for purposes of this section, the term ‘covered outpatient prescription drug’ means—

“(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

“(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

“(2) EXCLUSIONS.—

“(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section

1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3), as the Secretary may specify and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this section.

"(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient prescription drug under this section shall not be so considered if payment for such drug is available under part A or under this part (other than under this section).".

(b) NO EFFECT ON PART B PREMIUM.—

(1) IN GENERAL.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended by adding at the end the following new paragraph:

"(5) Notwithstanding the previous provisions of this subsection, in computing actuarial rates there shall not be taken into account benefits and administrative costs that are attributable to the prescription drug coverage provided under section 1845.".

(2) SPECIAL ENROLLMENT PERIOD; WAIVER OF LATE ENROLLMENT PENALTY.—

(A) Section 1837 (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

"(k) There shall also be a general enrollment period during the period beginning on July 1, 2005, and ending on November 30, 2005.".

(B) Section 1838(a) (42 U.S.C. 1395q(a)) is amended—

(i) by striking "or" at the end of paragraph (2);

(ii) by striking the period at the end of paragraph (3) and inserting ", or"; and

(iii) by adding at the end the following new paragraph:

"(4) in the case of an individual who enrolls pursuant to subsection (k) of section 1837, January 1, 2006.".

(C) Section 1839(b) (42 U.S.C. 1395r(b)) is amended by inserting "or a general enrollment period under section 1837(k)" after "not pursuant to a special enrollment period under section 1837(i)(4)".

(3) GOVERNMENT CONTRIBUTION.—Section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) is amended—

(A) by striking "plus" at the end of subparagraph (A);

(B) by striking "; plus" at the end of subparagraph (B) and inserting ", plus"; and

(C) by adding at the end the following new subparagraph:

"(C) a Government contribution equal to the aggregate amounts expended from the Trust Fund for benefits and administrative expenses attributable to the prescription drug coverage provided under section 1845; plus".

(c) MEDICARE AS PRIMARY PAYOR.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

"(7) EXCEPTION FOR OUTPATIENT PRESCRIPTION DRUG BENEFIT.—The previous provisions of this subsection shall not apply to benefits provided under section 1845.".

Subtitle B—Benefits for Low-income Beneficiaries

SEC. 111. BENEFITS FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—

(1) FIRST DOLLAR COVERAGE.—Section 1845, as inserted by section 101(b), is amended by adding at the end the following new subsection:

"(g) FIRST DOLLAR COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.—

"(1) IN GENERAL.—In the case of a subsidy eligible individual (as defined in paragraph (2)), this section shall be applied as if the annual deductible were equal to zero but, with respect to costs incurred before the amount of the annual deductible otherwise applicable, the following copayment amounts shall apply:

"(A) 10 PERCENT COPAYMENT FOR INDIVIDUALS WITH INCOMES UP TO 150 PERCENT OF POVERTY.—For subsidy eligible individuals with income that does not exceed 150 percent of the poverty line, the copayment amounts shall be the copayments amounts specified in subsection (a)(3), which reflects an average benefit percentage of 90 percent.

"(B) 50 PERCENT COPAYMENT FOR INDIVIDUALS WITH INCOMES ABOVE 150 PERCENT OF POVERTY.—For subsidy eligible individuals with income that exceeds 150 percent of the poverty line, the copayment amounts shall be the copayments amounts specified in subsection (a)(3) increased by 150 percent, which reflects an average benefit percentage of 50 percent, but in no case shall such copayment amount exceed the price negotiated for the drug involved.

"(2) DETERMINATION OF ELIGIBILITY.—

"(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

"(i) is enrolled under this part;

"(ii) has income below 150 percent (or such higher percent, not to exceed 200 percent, as a State may specify under subparagraph (B)) of the Federal poverty line; and

"(iii) is not eligible for medical assistance with respect to prescription drugs under title XIX.

For purposes of this section, an individual shall not be treated as eligible for medical assistance with respect to prescription drugs under title XIX (including under a waiver under section 1115) only if, with respect to such assistance, the individual is charged a copayment greater than a nominal amount (as described in section 1916(a)(3)) and there is no monthly or similar dollar limit established for the amount of such assistance over any period of time.

"(B) COVERAGE OF INDIVIDUALS WITH INCOME UP TO 200 PERCENT OF POVERTY AT STATE OPTION.—One of the 50 States or the District of Columbia may, at its option and subject to section 1935(c), specify a percent of income, that exceeds 150 percent but does not exceed 200 percent, that will apply for purposes of this subsection to individuals residing in the State.

"(C) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

"(D) INCOME DETERMINATIONS.—For purposes of applying this subsection—

"(i) income shall be determined in the manner no less restrictive than the manner described in section 1905(p)(1)(B); and

"(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(E) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(f).

"(3) ADMINISTRATION OF SUBSIDY PROGRAM.—The Secretary shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in a medicare-approved prescription drug plan—

"(A) the Secretary provides for a notification of the entity offering the plan that the individual is eligible for a subsidy under paragraph (1);

"(B) such entity adjusts the benefits for prescription drug coverage accordingly and submits to the Secretary information on the amount of such benefits provided; and

"(C) the Secretary periodically and on a timely basis reimburses the entity for the amount of such benefits (including reasonable related administrative costs) that are provided only because of the application of this subsection.

"(4) RELATION TO MEDICAID PROGRAM.—

"(A) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

"(B) COORDINATION.—The Secretary shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Secretary shall involve the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts and representatives of low-income medicare beneficiaries.".

(2) REDUCTION IN CATASTROPHIC COPAYMENTS FOR LOW INCOME INDIVIDUALS.—Section 1845(a), as inserted by section 101(b), is amended—

(A) in paragraph (3)(A), by inserting "and paragraph (5)" after "Subject to the succeeding provisions of this paragraph"; and

(B) by adding at the end the following new paragraph:

"(5) REDUCTION IN COPAYMENTS FOR LOW-INCOME INDIVIDUALS TO 10 PERCENT.—In the case of a subsidy eligible individual with income that does not exceed 150 percent of the poverty line (as defined for purposes of subsection (g)), the copayment otherwise applicable under paragraph (3) shall be ½ of the copayment amount otherwise applicable.".

(b) MEDICAID AMENDMENTS.—

(1) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(A) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(i) by striking "and" at the end of paragraph (64);

(ii) by striking the period at the end of paragraph (65) and inserting "; and"; and

(iii) by inserting after paragraph (65) the following new paragraph:

"(66) provide for making eligibility determinations under sections 1845(a)(5), 1845(g), and 1935(a).".

(2) NEW SECTION.—Title XIX of such Act is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

"SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

"SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDY.—

"(1) IN GENERAL.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

"(A) make determinations of eligibility for subsidies under (and in accordance with) sections 1845(g) and 1845(a)(5);

"(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

"(C) otherwise provide the Secretary with such information as may be required to carry out section 1845.

"(2) STATE OPTION FOR COVERAGE OF ADDITIONAL LOW-INCOME INDIVIDUALS.—A State may elect under paragraph (2)(B) of section 1845(g) to cover additional low-income medicare beneficiaries under the prescription drug subsidy program provided under such subsection, subject to contribution under subsection (c).

"(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

"(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows (but in no case shall the rate as so increased exceed 100 percent):

"(A) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

"(B)(i) For expenditures attributable to costs incurred during 2007 and each subsequent year through 2013, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

"(ii) For purposes of clause (i), the 'applicable percent' for—

"(I) 2007 is 20 percent; or

"(II) a subsequent year is the applicable percent under this clause for the previous year increased by 10 percentage points.

"(C) For expenditures attributable to costs incurred after 2013, the otherwise applicable Federal matching rate shall be increased to 100 percent.

"(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.

"(c) STATE CONTRIBUTION AT SCHIP MATCHING RATE TOWARDS ADDITIONAL LOW-INCOME SUBSIDIES FOR OPTIONAL SUBSIDY ELIGIBLE INDIVIDUALS COVERED UNDER STATE OPTION.—In the case of a State that specifies a percent of income under section 1845(g)(2)(B) for a quarter, the amount of payment made to the State under section 1903(a)(1) for the quarter shall be reduced by the product of—

"(1) 100 percent less the enhanced FMAP described in section 2105(b) for that State and quarter; and

"(2) the additional amount of payment made under section 1845 because of the application of such specification.".

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(d)(1) for the State and the quarter".

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

"(d) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the sum of the product described in paragraph (3) plus the product of the following:

"(A) MEDICARE BENEFITS FOR MEDICAID ELIGIBLES.—The total amount of payments made in the quarter because of the operation of section 1845 that are attributable to individuals who are residents of the State and are eligible for medical assistance with respect to prescription drugs under this title. For purposes of this subparagraph, an individual shall not be treated as eligible for medical assistance with respect to prescription drugs under title XIX (including under a waiver under section 1115) only if, with respect to such assistance, the individual is charged a copayment greater than a nominal amount (as described in section 1916(a)(3)) and there is no monthly or similar dollar limit established for the amount of such assistance over any period of time.

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

"(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

"(A) 2006 is 90 percent;

"(B) a subsequent year before 2014, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

"(C) a year after 2013 is 0 percent.

"(3) PRODUCT.—The product described in this paragraph for a State for a calendar quarter is the State matching rate described in paragraph (1)(B) for that State and quarter multiplied by the additional expenditures made under section 1845 as a result of the following:

"(A) REDUCTIONS IN CATASTROPHIC COPAYMENTS.—The application of subsection (a)(5) thereof.

"(B) FIRST DOLLAR COVERAGE.—The application under subsection (g) of reduced copayments amounts insofar as such amounts are less than 25 percent of the amount of the price otherwise negotiated for the drug involved.

(3) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

"(e) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to benefits under part B of title XVIII and is eligible for medical assistance with respect to prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under such part B, without regard to section 1902(n)(2).".

(4) CLARIFYING AMENDMENTS.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(A) in subparagraph (B), by inserting ", but not including any copayments under section 1845" after "section 1813"; and

(B) in subparagraph (C), by inserting ", but not including any deductible under section 1845" after "section 1833(b)"..

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935 of such Act, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting "subject to subsection (f)" after "section 1903(a)";

(B) in subsection (c)(1), by inserting "subject to subsection (f)" after "1903(a)(1)"; and

(C) by adding at the end the following new subsection:

"(f) TREATMENT OF TERRITORIES.—

"(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

"(A) the previous provisions of this section shall not apply to residents of such State; and

"(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries under section 1845(g)), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

"(2) PLAN.—The plan described in this paragraph is a plan that—

"(A) provides medical assistance under section 1845(g) with respect to the provision of covered outpatient drugs to low-income medicare beneficiaries whose income does not exceed an income level specified under the plan; and

"(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

"(3) INCREASED AMOUNT.—

"(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

"(i) the aggregate amount specified in subparagraph (B); and

"(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

"(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

"(i) 2006, is equal to $25,000,000; or

"(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1845(a)(2)(B) for the year involved.

"(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.".

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(f)(1)(B)" after "Subject to subsection (g)".

(e) MEDICAID REDUCTION OF COPAYMENTS FOR QMBS.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended by adding at the end the following new subparagraph:

"(E) The difference between the copayment amounts established under sections 1845(g)(1)(A) and 1845(a)(5) for covered outpatient drugs and the nominal copayment amounts that would apply to such drugs if covered under this title, pursuant to section 1916(a).".

(f) Renegotiation of Pharmacy Plus Waivers.—In the case of States which as of the date of the enactment of this Act have entered into demonstration projects (popularly known as pharmacy plus waivers) under section 1115 of the Social Security Act under which the State is provided flexibility to offer medical assistance for prescription drug coverage in return for limitations on payments for certain optional populations, the Secretary of Health and Human Services shall renegotiate such projects in order to account for the additional prescription drug benefits made available under the amendments made by this title.

SEC. 112. IMPROVING ENROLLMENT PROCESS UNDER MEDICAID.

(a) Automatic Reenrollment Without Need To Reapply.—

(1) In general.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(A) by redesignating paragraph (6) as paragraph (9); and

(B) by inserting after paragraph (5), the following new paragraph:

"(6) In the case of an individual who has been determined to qualify as a qualified medicare beneficiary or to be eligible for benefits under section 1902(a)(10)(E)(iii), the individual shall be deemed to continue to be so qualified or eligible without the need for any annual or periodic application unless and until the individual notifies the State that the individual's eligibility conditions have changed so that the individual is no longer so qualified or eligible.".

(2) Conforming amendment.—Section 1902(e)(8) (42 U.S.C. 1396a(e)(8)) is amended by striking the second sentence.

(b) Use of Simplified Application Process.—Such section 1905(p) is further amended by adding at the end the following new paragraph:

"(7) A State shall permit individuals to apply to qualify as a qualified medicare beneficiary or for benefits under section 1902(a)(10)(E)(iii) through the use of the simplified application form developed under section 1905(p)(5)(A) and shall permit such an application to be made over the telephone, the Internet, or by mail, without the need for an interview in person by the applicant or a representative of the applicant.".

(c) Role of Social Security Offices.—

(1) Enrollment and provision of information at social security offices.—Such section is further amended by adding at the end the following new paragraph:

"(8) The Commissioner of Social Security shall provide, through local offices of the Social Security Administration—

"(A) for the enrollment under State plans under this title for appropriate medicare cost-sharing benefits for individuals who qualify as a qualified medicare beneficiary or for benefits under section 1902(a)(10)(E)(iii); and

"(B) for providing oral and written notice of the availability of such benefits.".

(2) Clarifying amendment.—Section 1902(a)(5) (42 U.S.C. 1396a(a)(5)) is amended by inserting "as provided in section 1905(p)(10)" before "except".

(d) Outstationing of State Eligibility Workers at SSA Field Offices.—Section 1902(a)(55) (42 U.S.C. 1396a(a)(55)) is amended—

(1) by striking "subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)" and inserting "paragraph (10)(A)(i)(IV), (10)(A)(i)(VI), (10)(A)(i)(VII), (10)(A)(ii)(IX), or (10)(E)"; and

(2) in subparagraph (A), by inserting "and in the case of applications of individuals for medical assistance under paragraph (10)(E), at locations that include field offices of the Social Security Administration".

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

SEC. 201. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) Equalizing DSH Payment Amounts.—

(1) In general.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting ", and, after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(I)" in the matter preceding subclause (I).

(2) Conforming amendments.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xiii)";

(ii) in subclause (III)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xii)";

(iii) in subclause (IV)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (x) or (xi)";

(iv) in subclause (V)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xi)"; and

(v) in subclause (VI)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (x)";

(B) in clause (viii), by striking "The formula" and inserting "For discharges occurring before October 1, 2003, the formula"; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "With respect to discharges occurring before October 1, 2003, for purposes".

(b) Effective Date.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 202. IMMEDIATE ESTABLISHMENT OF UNIFORM STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS.

(a) In General.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

(1) in clause (iv), by inserting "and ending on or before September 30, 2003," after "October 1, 1995,"; and

(2) by redesignating clauses (v) and (vi) as clauses (vii) and (viii), respectively, and inserting after clause (iv) the following new clauses:

"(v) For discharges occurring in the fiscal year beginning on October 1, 2003, the average standardized amount for hospitals located in areas other than a large urban area shall be equal to the average standardized amount for hospitals located in a large urban area.".

(b) Conforming Amendments.—

(1) Computing DRG-specific rates.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "in different areas";

(B) in the matter preceding clause (i), by striking ", each of";

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking "and" after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking the period at the end and inserting "; and"; and

(E) by adding at the end the following new clause:

"(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

"(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.".

(2) Technical conforming sunset.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting ", for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting ", for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region.".

SEC. 203. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

(a) Classification.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended—

(1) in the heading by adding "Essential Rural Hospitals" at the end; and

(2) by adding at the end the following new paragraphs:

"(4)(A) The term 'essential rural hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is located in a rural area (as defined for purposes of section 1886(d)), has more than 25 licensed acute care inpatient beds, has applied to the Secretary for classification as such a hospital, and with respect to which the Secretary has determined that the closure of the hospital would significantly diminish the ability of medicare beneficiaries to obtain essential health care services.

"(B) The determination under subparagraph (A) shall be based on the following criteria:

"(i) High proportion of medicare beneficiaries receiving care from hospital.—(I) A high percentage of such beneficiaries residing in the area of the hospital who are hospitalized (during the most recent year for which complete data are available) receive basic inpatient medical care at the hospital.

"(II) For a hospital with more than 200 licensed beds, a high percentage of such beneficiaries residing in such area who are hospitalized (during such recent year) receive specialized surgical inpatient care at the hospital.

"(III) Almost all physicians described in section 1861(r)(1) in such area have privileges at the hospital and provide their inpatient services primarily at the hospital.

"(ii) SIGNIFICANT ADVERSE IMPACT IN ABSENCE OF HOSPITAL.—If the hospital were to close—

"(I) there would be a significant amount of time needed for residents to reach emergency treatment, resulting in a potential significant harm to beneficiaries with critical illnesses or injuries:

"(II) there would be an inability in the community to stablize emergency cases for transfers to another acute care setting, resulting in a potential for significant harm to medicare beneficiaries; and

"(III) any other nearby hospital lacks the physical and clinical capacity to take over the hospital's typical admissions.

"(C) In making such determination, the Secretary may also consider the following:

"(i) Free-standing ambulatory surgery centers, office-based oncology care, and imaging center services are insufficient in the hospital's area to handle the outpatient care of the hospital.

"(ii) Beneficiaries in nearby areas would be adversely affected if the hospital were to close as the hospital provides specialized knowledge and services to a network of smaller hospitals and critical access hospitals.

"(iii) Medicare beneficiaries would have difficulty in accessing care if the hospital were to close as the hospital provides significant subsidies to support ambulatory care in local clinics, including mental health clinics and to support post acute care.

"(iv) The hospital has a committment to provide graduate medical education in a rural area.

"(C) QUALITY CARE.—The hospital inpatient score for quality of care is not less than the median hospital score for qualify of care for hospitals in the State, as established under standards of the utilization and quality control peer review organization under part B of title XI or other quality standards recognized by the Secretary.

A hospital classified as an essential rural hospital may not change such classification and a hospital so classified shall not be treated as a sole community hospital, medicare dependent hospital, or rural referral center for purposes of section 1886.".

(b) PAYMENT BASED ON 102 PERCENT OF ALLOWED COSTS.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

"(11) In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for inpatient hospital services for discharges occurring during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this paragraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under part A or as waiving any requirement for billing for such services.".

(2) HOSPITAL OUTPATIENT SERVICES.—Section 1833(t)(13) (42 U.S.C. 1395l(t)(13)) is amended by adding at the end the following new subparagraph:

"(B) SPECIAL RULE FOR ESSENTIAL RURAL HOSPITALS.—In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for covered OPD services during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this subparagraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under this part or as waiving any requirement for billing for such services.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2004.

SEC. 204. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) REPORT.—Not later than October 1, 2004, the Secretary shall submit a report to Congress on the frequency established under subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 205. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l); 1395m(g)(1); 42 U.S.C. 1395tt(a)(3)) are each amended by inserting "equal to 102 percent of" before "the reasonable costs".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after October 1, 2003.

(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services" and inserting "services covered under this title".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to costs incurred for services provided on or after January 1, 2004.

(c) MODIFICATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by adding at the end the following: "The limitation described in the matter following subparagraph (B) in the previous sentence shall not apply if the ambulance services are furnished by such a provider or supplier of ambulance services who is a first responder to emergencies (as determined by the Secretary).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to ambulances services furnished on or after the first cost reporting period that begins after the date of the enactment of this Act.

(d) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting ", in the cases described in subparagraphs (A) through (D)" after "1986";and

(B) by striking "and" at the end of subparagraph (C);

(C) by adding "and" at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

(2) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

(3) REINSTATEMENT OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after January 1, 2004.

(e) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

"The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective as if included in the enactment of section 403(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–371).

(f) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as follows:

"(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;".

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2004.

(g) ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR GRANT PROGRAM.—

(1) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraph:

"(4) FUNDING.—

"(A) IN GENERAL.—Subject to subparagraph (B), payment for grants made under this subsection during fiscal years 2004 through 2008 shall be made from the Federal Hospital Insurance Trust Fund.

"(B) ANNUAL AGGREGATE LIMITATION.—In no case may the amount of payment provided for under subparagraph (A) for a fiscal year exceed $25,000,000.".

(2) CONFORMING AMENDMENT.—Section 1820 (42 U.S.C. 1395i-4) is amended by striking subsection (j).

SEC. 206. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting "subject to subparagraph (I)," after "October 1, 1997,";

(2) in subparagraph (H)(i), by inserting "subject to subparagraph (I)," after "subparagraphs (F) and (G),"; and

(3) by adding at the end the following new subparagraph:

"(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

"(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

"(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2004, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

"(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2002.

"(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

"(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2003.

"(V) AFFILIATION.—With respect to hospitals which are members of the same affiliated group (as defined by the Secretary under subparagraph (H)(ii)), the provisions of this section shall be applied with respect to such an affiliated group by deeming the affiliated group to be a single hospital.

"(ii) REDISTRIBUTION.—

"(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

"(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2004, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2005.

"(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

"(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

"(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

"(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

"(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

"(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

"(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.".

(b) CONFORMING AMENDMENT TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: "The provisions of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentece of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection.".

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

SEC. 207. TWO-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking "SMALL" and inserting "CERTAIN";

(B) by inserting "or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area" after "100 beds"; and

(C) by striking "2004" and inserting "2006".

(2) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply with respect to payment for OPD services furnished on and after January 1, 2004.

(b) STUDY; ADJUSTMENT.—

(1) STUDY.—The Secretary shall conduct a study to determine if, under the prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), costs incurred by rural providers of services by ambulatory payment classification groups (APCs) exceed those costs incurred by urban providers of services.

(2) ADJUSTMENT.—Insofar as the Secretary determines under paragraph (1) that costs incurred by rural providers exceed those costs incurred by urban providers of services, the Secretary shall provide for an appropriate adjustment under such section 1833(t) to reflect those higher costs by January 1, 2005.

SEC. 208. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C. 1395yy(e)(2)(A)) is amended—

(1) in clause (i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

(2) by adding at the end the following new clause:

"(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

"(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

"(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were not furnished by an individual affiliated with a rural health clinic or a Federally qualified health center.".

(b) CERTAIN SERVICES FURNISHED BY AN ENTITY JOINTLY OWNED BY HOSPITALS AND CRITICAL ACCESS HOSPITALS.—For purposes of applying section 411.15(p)-(3)(iii) of title 42 of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned as a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) TECHNICAL AMENDMENTS.—Sections 1842(b)(6)(E) and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E); 1395cc(a)(1)(H)(ii)) are each amended by striking "section 1888(e)(2)(A)(ii)" and inserting "clauses (ii), (iii), and (iv) of section 1888(e)(2)(A)".

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2004.

SEC. 209. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting "or nurse practitioner (as defined in subsection (aa)(5))" after "the physician (as defined in subsection (r)(1))".

(b) PROHIBITION ON NURSE PRACTITIONER CERTIFYING NEED FOR HOSPICE.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting "(which for purposes of this subparagraph does not include a nurse practitioner)" after "attending physician (as defined in section 1861(dd)(3)(B))".

SEC. 210. IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9); and

(2) by adding at the end the following new paragraph:

"(10) Assistance for rural providers furnishing services in low medicare population density areas.—

"(A) In general.—In the case of ground ambulance services furnished on or after January 1, 2004, for which the transportation originates in a qualified rural area (as defined in subparagraph (B)), the Secretary shall provide for an increase in the base rate of the fee schedule for mileage for a trip established under this subsection. In establishing such increase, the Secretary shall, based on the relationship of cost and volume, estimate the average increase in cost per trip for such services as compared with the cost per trip for the average ambulance service.

"(B) Qualified rural area defined.—For purposes of subparagraph (A), the term 'qualified rural area' is a rural area (as defined in section 1886(d)(2)(D)) with a population density of medicare beneficiaries residing in the area that is in the lowest three quartiles of all rural county populations.".

SEC. 211. THREE-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) In General.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) during 2004, 2005, and 2006, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) Waiving Budget Neutrality.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 212. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) In General.—Section 1128B(b)(3) (42 U.S.C. 1320a–7(b)(3)), as amended by section 101(b)(2), is amended—

(1) in subparagraph (F), by striking "and" after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(H) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.".

(b) Rulemaking for Exception for Health Center Entity Arrangements.—

(1) Establishment.—

(A) In general.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) Factors to consider.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) Interim final effect.—No later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 213. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) Study.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions; and

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component.

(b) Report.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 214. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) In General.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

"(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.".

(b) Effective Date.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 215. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking "4-year" and inserting "8-year"; and

(2) in subsection (d)(3), by striking "$30,000,000" and inserting "$60,000,000".

SEC. 216. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) In General.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking "wage levels.—The Secretary" and inserting "wage levels.—

"(i) In general.—Except as provided in clause (ii), the Secretary"; and

(2) by adding at the end the following new clause:

"(ii) Alternative proportion to be adjusted beginning in fiscal year 2004.—

"(I) In general.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2003, the Secretary shall substitute the '62 percent' for the proportion described in the first sentence of clause (i).

"(II) Hold harmless for certain hospitals.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.".

(b) Waiving Budget Neutrality.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: "The Secretary shall apply the previous sentence for any period as if the amendments made by section 202(a) of the Medicare Rx Now Act of 2003 had not been enacted.".

SEC. 217. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking "subparagraphs (B) and (C)" and inserting "subparagraphs (B), (C), (E), and (F)"; and

(2) by adding at the end the following new subparagraphs:

"(E) Floor for work geographic indices.—

"(i) In general.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

"(ii) Work floor index.—For purposes of clause (i), the term 'applicable floor index' means—

"(I) 0.980 with respect to services furnished during 2004; and

"(II) 1.000 for services furnished during 2005, 2006, and 2007.

"(F) Floor for practice expense and malpractice geographic indices.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.".

Ms. PRYCE of Ohio. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. LATOURETTE). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. SLAUGHTER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clauses 8 and 9 of rule XX, this 15-minute vote on ordering the previous question will be followed by 5-minute votes on adopting the resolution, if ordered, and on adopting House Resolution 297 which was debated earlier today.

The vote was taken by electronic device, and there were—yeas 226, nays 203, not voting 6, as follows:

[Roll No. 321]

YEAS—226

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—6

Brown-Waite, Ginny
Cummings
Gephardt
Johnson (CT)
McInnis
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1436

Mr. SANDLIN and Mr. TURNER of Texas changed their vote from "yea" to "nay."

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. LATOURETTE). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Ms. SLAUGHTER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote, followed by a second 5-minute vote on the question of adoption of House Resolution 297 debated earlier today.

The vote was taken by electronic device, and there were—ayes 221, noes 203, not voting 11, as follows:

[Roll No. 322]

AYES—221

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter

McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Young (AK)
Young (FL)

NOES—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Bartlett (MD)
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hefley
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Toomey
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—11

Carter
Gephardt
Gutknecht
Istook
Jones (NC)
Matsui
McInnis
Rush
Smith (WA)
Watson
Wolf

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1444

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated against:

Mr. MATSUI. Mr. Speaker, on rollcall No. 322, had I been present, I would have voted "no."

The SPEAKER pro tempore. Pursuant to section 6 of House Resolution 299 and clause 1 of rule XXI, all points of order are reserved against provisions contained in the bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

The SPEAKER pro tempore. The pending business is the question of agreeing to the resolution, House Resolution 297.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. McGOVERN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 226, noes 203, not voting 5, as follows:

[Roll No. 323]

AYES—226

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cubin
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich

Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—5

Cox
Gephardt
McInnis
Slaughter
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are reminded there are 2 minutes remaining on this vote.

□ 1453

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PROVIDING FOR CONSIDERATION OF H.R. 2559, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2004

Mrs. MYRICK. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 298 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 298

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes. The first reading of the bills shall be dispensed with. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations. After general debate the bill shall be considered for amendment under the five-minute rule. Points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived. During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the CONGRESSIONAL RECORD designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto the final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentlewoman from North Carolina (Mrs. MYRICK) is recognized for 1 hour.

Mrs. MYRICK. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. McGOVERN), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Last night, the Committee on Rules met and granted an open rule for H.R. 2559, the Fiscal Year 2004 Military Construction Appropriations Act.

The United States military is clearly the best in the world. The young men and women in our Army, Navy, Air Force, Marines, and Coast Guard are thoroughly dedicated and patriotic professionals, the best our Nation has to offer. We are asking a lot from our military today. Our personnel on active duty know that they may well be deployed overseas and, perhaps, on dangerous missions. So we want to provide them a quality of life for themselves and their families that will allow them to serve, knowing that their families will be taken care of with good housing and good health care.

Mr. Speaker, H.R. 2559 recognizes the dedication and commitment of our troops by providing for their most basic needs: improved military facilities, including the previously mentioned housing and medical facilities.

□ 1500

Mr. Speaker, we must honor the most basic commitments we have made to the men and women of our Armed Services. We must ensure a reasonable quality of life to recruit and retain the best and brightest for America's fighting forces. Most importantly, we must do it all, everything in our power to ensure a strong, able, dedicated American military so this Nation will be ever vigilant, ever prepared, so much more important now than it has been in the past.

This bill provides nearly $1.2 billion for barracks, and $176 million for hospitals and medical facilities for our troops and their families. It also provides $2.7 billion to operate and maintain existing housing units, and $1.2 billion for new housing units, much, much needed.

Military families also have a tremendous need for quality child care, especially single parents and families in which one or both parents may face lengthy deployment. To help meet this need, the bill provides $16 million for child development centers. H.R. 2559 is more than just a signal to our soldiers, sailors, airmen and Marines that this Nation recognizes their services and their sacrifice. It is a means by which we meet our commitment to providing them a decent quality of life so as to sustain the commitment and professionalism of America's all voluntary armed services and the families that support them.

While our men and women in uniform have swiftly dispatched our enemies abroad, they face increasingly complex personal and professional challenges here at home. We must do more to take care of those who are putting their lives on the line to defend our freedoms, and for the families who support them in their efforts. And I am really glad we are getting this done before we head home for the July 4th work break.

Mr. Speaker, I urge my colleagues to support the rule and to support the conference report.

Mr. Speaker, I reserve the balance of my time.

Mr. McGOVERN. Mr. Speaker, I yield myself 6½ minutes.

Mr. Speaker, I thank the gentlewoman from North Carolina (Mrs. MYRICK) for yielding me the customary 30 minutes.

Mr. Speaker, the rule under consideration for H.R. 2559, the Fiscal Year 2004 Military Construction Appropriations Act, is an open rule. It provides for one hour of general debate, waives all points of order against consideration of the bill, allows for germane amendments and provides for one motion to recommit with or without instructions.

Mr. Speaker, I would like to express my appreciation for the work of the gentleman from Michigan (Chairman KNOLLENBERG) and the ranking member, the gentleman from Texas (Mr. EDWARDS) of the Subcommittee on Military Construction along with the chairman of the Committee on Appropriations, the gentleman from Florida (Chairman YOUNG) and the ranking member, the gentleman from Wisconsin (Mr. OBEY) for continuing the tradition of bipartisan action on this bill and for doing the best with a terrible allocation.

Mr. Speaker, I have a terrible feeling of deja vu. Almost exactly 1 year ago, on June 27 of 2002, I stood on this House floor as the minority manager of the rule on the fiscal year 2003 military construction bill. Along with the then-chairman, the gentleman from Ohio (Mr. HOBSON) and the ranking member, the gentleman from Massachusetts (Mr. OLVER), we all bemoaned the inadequacy of that bill. We all pledged to do better next year and called upon

President Bush to increase the budget for desperately needed military construction, housing, base realignment and base closure.

Well, 1 year later none of that has happened. In fact, this year is even worse. If last year's appropriations bill was inadequate, this one is woefully inadequate, to quote the gentleman from Michigan (Chairman KNOLLENBERG). In fact, the fiscal year 2004 bill is $1.5 billion less than last year's bill. Let me repeat that. This bill is $1.5 billion less than the fiscal year 2003 funding levels. It is even $41 million less than the chairman's request.

Mr. Speaker, I would ask my colleagues what in the world are we doing? How can we stand on this House floor day after day, week after week and declare how much we support our uniformed men and women when the funding provided for family housing in this bill is $270 million less than last year? How can we stand on the floor of this House day after day, week after week and say that we are engaged in a long-term struggle against a global enemy when funding for military construction in this bill is $1 billion less than last year?

Mr. Speaker, poor facility conditions are not only unsafe, they hamper readiness and decrease troop retention. According to the Pentagon, 180,000 of the 300,000 units of military housing are substandard. According to the Pentagon, 68 percent of the Department's facilities have deficiencies so serious that they might impede mission readiness or they are so deteriorated that they cannot support mission requirements. The current reductions in funding for construction in these facility categories means that the rate at which buildings are renovated or replaced has just increased from 83 years to 150 years.

This is a national scandal. And let us be clear, this bill is not only about new housing, it is about the operation and maintenance of existing family housing. One of the few increases in family housing in this bill is for the Army. It receives an $81 million increase. Unfortunately, funding for the operation and maintenance of existing Army family housing is cut by $63 million, allowing more and more current housing units to deteriorate and fall into substandard condition. Talk about robbing Peter to pay Paul.

Mr. Speaker, I keep hearing that since the events of September 11 we live in a changed world. I keep on hearing how much we appreciate our Armed Forces, how much we appreciate their sacrifice and service. Then why do we keep cutting and cutting and cutting the military construction appropriations bill? We obviously do not appreciate them enough to give them decent housing. We obviously do not admire them enough to give them quality facilities. Are we going to be on the floor of this House next year expressing our disappointment over how inadequate the military construction appropriations bill is again?

Now, I have been told that we should just wait until the 2005 round of base closings, then we will see some modest increases for housing at the bases that survive the next round of closures. That is as cynical a rationalization as I have ever heard. Do we honestly believe that inadequate housing and facilities exist only on bases likely to be closed down?

Mr. Speaker, this crisis in funding for family housing and military construction is nationwide. It exists at nearly every single base and installation across the land and overseas, and it affects every branch of our Armed Forces. And if base closure is somehow magically supposed to balance the ledgers, then why are we in such a housing and construction crisis right now?

It does not have to be this way, Mr. Speaker, and there is a remedy. The ranking member of the Committee on Appropriations, the gentleman from Wisconsin (Mr. OBEY), tried to provide an extra $958 million above the allocation level for military construction and housing. His solution is not hard to accept. This House would simply scale back 5 percent of the scheduled tax cut for people with adjusted gross incomes of over $1 million for 1 year. This would mean that the tax refund for these individuals would be reduced from about $88,000 to $83,000.

Now, Mr. Speaker, according to the most recent census, there are more than 280 million people in the United States. This modest change in the tax cut would affect about 200,000 individuals, or less than one-tenth of 1 percent of all taxpayers. Such a small adjustment, however, would provide nearly a billion dollars to help ensure that more than 1.4 million men and women who serve our country on active duty have decent housing and workplaces for themselves and their families. But the Republicans on the Committee on Appropriations rejected the gentleman from Wisconsin's (Mr. OBEY) proposal, and last night the Republicans on the Committee on Rules refused to allow the gentleman from Wisconsin's (Mr. OBEY) amendment to even be debated and voted on in this House.

So we are faced with the results of what happens when we rob our Nation of the most basic revenue needed to adequately fund our Nation's priorities. We rob our valiant military personnel of decent homes and facilities. We rob our veterans of their basic benefits. We cut back funding for schools and child care for military families. And we are faced with passing this woefully inadequate bill, a bill I believe that for all the hard work of the gentleman from Michigan (Chairman KNOLLENBERG) and the ranking member, the gentleman from Texas (Mr. EDWARDS), can only be viewed as a shameful scandal on the part of this House.

Mr. Speaker, I reserve the balance of my time.

Mrs. MYRICK. Mr. Speaker, I reserve the balance of my time.

Mr. McGOVERN. Mr. Speaker, I yield 9 minutes to the distinguished gentleman from Wisconsin (Mr. OBEY), the ranking Democrat on the Committee on Appropriations.

Mr. OBEY. Mr. Speaker, it would be so nice if the force of our rhetoric is matched by the force of our deeds. That certainly is not the case with this bill.

Just a few months ago this House passed this resolution and it said, among other things, "Resolved by the House of Representatives, the Senate concurring, that the Congress express the unequivocal support and appreciation of the Nation to the members of the United States Armed Forces serving in Operation Iraqi Freedom who are carrying out their missions with excellence, patriotism and bravery and also to their families."

Well, the sad news, unfortunately, is that the check is not in the mail. We have given them a resolution but we are short-sheeting them in terms of things that military families need in order to make their life better. I do not understand why we are doing that. This bill shows the House's "support and appreciation" by providing $1.5 billion less than we appropriated last year to provide the military with decent housing and work places.

The bill also thanks the military supposedly by cutting the President's own request for the Pentagon by $180 million. This is for hangers, offices, fitness centers and teaching facilities that even OMB and the administration said the military needed. But this bill cuts them out.

Many Members of this House have seen the problems for themselves. The Pentagon itself rates the readiness of most military facilities as marginal or worse. Over 225,000 service members and their families cannot get decent barracks or decent housing. This bill is not up to the job and we all know why. It is not the fault of the subcommittee chairman. It is the fault of every single Member of this House who voted for the budget resolution which said that the only priorities for this year was going to be tax cuts. And as you know, the lion's share of the tax cuts went into the pockets of the most wealthy 1 percent of people in this country.

So as a result of that decision by the Republican leadership to put tax cuts as the primary goal of this Congress, the budget resolution, for instance, that was passed is on track to cut $28 billion from veterans benefits. There would be, under the White House budget, $200 million in cuts to impact aid to the school districts that educate the children of military families. As many as 230,000 military families have been cut out of the low income child tax provision.

We are taking millionaires off the tax roll, but we are not giving the people who need the help the most anything but table scraps on the tax side.

The defense bill, which was marked up this morning in full committee, will cut raises for the most junior enlisted and officer personnel from the 4.1 percent they have been expecting to just 2 percent. I want to see how many of you who have cried about the fact that you have Army personnel on food stamps, I want to see how many of you vote to cut that. I want to watch that.

A realistic budget resolution has been beyond the reach of the Congress, and this is the result as we are seeing today. Now, I want to be able to offer an amendment to correct the problem. My amendment would reinstate the $160 million in cuts from the President's budget. I would like to restore all of them. I think the White House is right. We need them. I would also add $480 million for family housing. That would help at least 2,500 military families. That would be a useful first step in replacing the 134,000 inadequate units that service members and their families are forced to live in today.

Finally, the amendment would provide $318 million for new barracks that would help 5,300 single service members into decent housing. The Pentagon says we need over 83,000 units, so even this amendment goes just an inch. My amendment is an opportunity to restore the projects the President said were needed, to help about 8,000 service members and their families, and it would help Congress to keep its promise to the troops.

Now, as the gentleman from Massachusetts has indicated, I would pay for it by changing the tax package that was just passed by this Congress. What I would say is that for persons with adjusted gross incomes of more than $1 million, instead of their getting the $88,000 tax cut they will get next year, we would cut that to $83,000. That is hardly starvation wages. Now, these are not just millionaires. These are people with adjusted gross incomes of more than $1 million each year, about 200,000 people in this society. And I bet if you asked them, they would say they would happily take that reduction in order to provide a real improvement in the quality of life for our troops.

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We are saying let them keep 95 percent of their tax cut but use that $5,000 difference to give people who are putting their lives on the line for this country better living conditions.

I do not know if you saw the article in the "Army Times" June 30, 2003. Mr. Speaker, I will insert this article in the RECORD immediately after my remarks.

I would also like to read you two paragraphs from a news story today out of The New York Times. It reads as follows: "The 400 wealthiest taxpayers who accounted for more than 1 percent of all income in the United States in the year 2000 more than doubled their share from 8 years earlier, but their tax burden plummeted over that same period of time."

The article then goes on to say why, and then it says that "had President Bush's latest tax cuts been in effect in 2000, the average tax bill for the top 400 earners in the country would have been about $30.4 million, a savings of $8.3 million, or more than a fifth."

Now, when we are in tough times, we have to ask, in my judgment, who needs help the most. I think that decent military housing ought to come before $88,000 tax cuts for the most comfortable people in this society. We are not saying cut them out. We are simply saying shave them back by 5 percent.

Our problem is, we will not even be able to offer this amendment on the floor today because the Committee on Rules said, "No way, baby." So that means that once again, the Republican majority is able to hide behind its budget resolution which did not specify where the cuts would come from in order to pay for the tax cuts.

We have a serious problem in this House. The budget process is supposed to force the Congress to make choices, to recognize trade-offs, and explicitly make those choices in full view of the country. Instead, the budget process is being used in conjunction with the rules out of the Committee on Rules to deny the public the understanding of what the costs are from those tax cuts. So they get to think that they are cost-free.

They do not know, for instance, that they will cost the public an extra $27 billion in interest payments next year. If we could take just $10 billion of that extra interest payment, we could take care of the shortcomings in education, in health care, in military housing, and every other appropriation bill that comes before us. That is what we would do if we had any sense of common sense. That is what we would do if we had any sense of justice.

I urge you to vote against the previous question on the rule so that we can offer the amendment that I have just described.

[From the Army Times, June 30, 2003]

NOTHING BUT LIP SERVICE

In recent months, President Bush and the Republican-controlled Congress have missed no opportunity to heap richly deserved praise on the military. But talk is cheap—and getting cheaper by the day, judging from the nickel-and-dime treatment the troops are getting lately.

For example, the White House griped that various pay-and-benefits incentives added to the 2004 defense budget by Congress are wasteful and unnecessary—including a modest proposal to double the $6,000 gratuity paid to families of troops who die on active duty. This comes at a time when Americans continue to die in Iraq at a rate of about one a day.

Similarly, the administration announced that on Oct. 1 it wants to roll back recent modest increases in monthly imminent-danger pay (from $225 to $150) and family-separation allowance (from $250 to $100) for troops getting shot at in combat zones.

Then there's military tax relief—or the lack thereof. As Bush and Republican leaders in Congress preach the mantra of tax cuts, they can't seem to find time to make progress on minor tax provisions that would be a boon to military homeowners, reservists who travel long distances for training and parents deployed to combat zones, among others.

Incredibly, one of those tax provisions—easing residency rules for service members to qualify for capital-gains exemptions when selling a home—has been a homeless orphan in the corridors of power for more than five years now.

The chintz even extends to basic pay. While Bush's proposed 2004 defense budget would continue higher targeted raises for some ranks, he also proposed capping raises for E–1s, E–2s and O–1s at 2 percent, well below the average raise of 4.1 percent.

The Senate version of the defense bill rejects that idea, and would provide minimum 3.7 percent raises for all and higher targeted hikes for some. But the House version of the bill goes along with Bush, making this an issue still to be hashed out in upcoming negotiations.

All of which brings us to the latest indignity—Bush's $9.2 billion military construction request for 2004, which was set a full $1.5 billion below this year's budget on the expectation that Congress, as has become tradition in recent years, would add funding as it drafted the construction appropriations bill.

But Bush's tax cuts have left little elbow room in the 2004 federal budget that is taking shape, and the squeeze is on across the board.

The result: Not only has the House Appropriations military construction panel accepted Bush's proposed $1.5 billion cut, it voted to reduce construction spending by an additional $41 million next year.

Rep. David Obey, D-Wis., senior Democrat on the House Appropriations Committee, took a stab at restoring $1 billion of the $1.5 billion cut in Bush's construction budget. He proposed to cover that cost by trimming recent tax cuts for the roughly 200,000 Americans who earn more than $1 million a year. Instead of a tax break of $88,300, they would receive $83,500.

The Republican majority on the construction appropriations panel quickly shot Obey down. And so the outlook for making progress next year in tackling the huge backlog of work that needs to be done on crumbling military housing and other facilities is bleak at best.

Taken piecemeal, all these corner-cutting moves might be viewed as mere flesh wounds. But even flesh wounds are fatal if you suffer enough of them. It adds up to a troubling pattern that eventually will hurt morale—especially if the current breakneck operations tempo also rolls on unchecked and the tense situations in Iraq and Afghanistan do not ease.

Rep. Chet Edwards, D-Texas, who notes that the House passed a resolution in March pledging "unequivocal support" to service members and their families, puts it this way:

"American military men and women don't deserve to be saluted with our words and insulted by our actions."

Translation: Money talks—and we all know what walks.

Mr. McGOVERN. Mr. Speaker, I yield 6 minutes to the distinguished gentleman from Texas (Mr. EDWARDS), who has worked very hard on this bill.

Mr. EDWARDS. Mr. Speaker, several weeks ago, the gentleman from Texas (Mr. DELAY), the majority leader of this House, said that in time of war nothing is more important than tax cuts. Well, this bill proves it. Because of the tax cuts, including dividend tax cuts for the wealthiest Americans, because of the $88,000 tax cut that every American on average making over $1 million a year will receive, we now bring a bill to this House that should be an embarrassment to the Members of Congress who stood on this floor and said we should honor our servicemen and -women.

I noted the gentlewoman from North Carolina (Mrs. MYRICK) a few minutes ago said this bill is more than a signal to our servicemen and -women. Well, I agree. It is a flashing red light. It says that while we honor you with our words, we cut your quality of life programs with our deeds and with our votes. Yes, it is more than a signal. This bill is a slap in the face to every serviceman and -woman, every military child in America who this year and in years past has made tremendous sacrifices, including the sacrifice of life, to defend our country and our way of life.

The dollar figures in this bill are not the fault of the gentleman from Michigan (Mr. KNOLLENBERG), the great chairman of this subcommittee, of which I am the ranking member. He did the very best any human could do to fairly put together the highest list of priorities given the woefully inadequate funding in this bill; but let us tell the American people, Mr. Speaker, like it is. They deserve the truth and so do our servicemen and -women.

What this Republican leadership in Congress this year has said is that it is more important to give a person making more than $1 million dollar a year an $88,000 tax cut rather than an $83,000 tax cut. It is more important to do that than it is to provide adequate housing and day care and health clinics and training ranges for our brave servicemen and -women, many of whom are serving in Iraq today.

Let us be clear. What this House leadership is saying is that while we salute our troops as they get on the airplane to fly to Iraq or Afghanistan and risk their lives for us, we are handing them a slip saying the administration wants to cut their children's education funding and the IMPACT aid program; and on the very night of March 21 when we voted to salute our troops in Iraq, 8 minutes later the House Republican majority voted to cut those troops' future veterans benefits by $28 billion. There is a clear record here; and, yes, it is a clear signal to our servicemen and -women.

It is that we are going to cut your benefits, your housing, your children's education, your day care clinics, your health facilities in order to pay for the promise of the gentleman from Texas (Mr. DELAY), who said that in time of war, nothing is more important than tax cuts.

Unfortunately, the vast majority of the 44,000 Army soldiers that I have the privilege to represent at Fort Hood in Texas will not get anything or very little at all out of those tax cuts, while the millionaires will average, not the millionaires but the people making over $1 million a year will average more than $88,000 in tax cuts.

How serious is the housing problem for our servicemen and -women? Maybe they already have quality housing. Perhaps there is some Member of this House or some member of the public, Mr. Speaker, that has not visited our military installations recently. Maybe they think they live in the lap of luxury. Let me present the facts.

The fact is that there are 83,000 servicemen and -women living in inadequate barracks that do not even meet the lowest Department of Defense standards. The truth is that there are 128,860 military families, people that on this floor just a few minutes ago were called professional, the best, clearly dedicated, 128,000 of those families are now living in housing that does not meet very low DOD standards.

By the way, just for the record, let me point out what is defined as meeting the quality standard required by the Department of Defense. In the Navy that means that $15,000 could fix up your house where it could meet those lowest minimum DOD standards and you are living in adequate housing. Forget the fact that you may never get that $15,000 to fix your leaky roof or to fix the washer and dryer that are not working or to repair the damage to the structure of the house. If $15,000 would fix it, even if you never get that money to fix that house, you are living in adequate housing.

The truth is, as the gentlewoman from North Carolina said, we ask a lot from our servicemen and -women; and I stand in this House today to say that this bill, despite the tremendous, valiant efforts of the gentleman from Michigan (Mr. KNOLLENBERG) who did the best anybody could with the amount of money given to him, this bill is a slap in the face to our servicemen and -women; and just as the "Army Times" in its editorial recently said that our soldiers are in effect getting tired of lip service from Congress, this bill salutes them by insulting them.

It defines our rhetoric of appreciation with the reality of a $1.5 billion cut in important programs that would have meant a better quality of life, better training so that many of our troops might come home safely to the hugs of their families rather than in body bags.

What this House is saying, despite all the intentions that one might have, good or bad, what this House is saying with our votes is that we value more an $88,000 tax cut for millionaires, those making more than $1 million, more than them getting an $83,000 tax cut, we value that more than treating with respect our servicemen and -women.

We should oppose this rule, support the Obey amendment, and back up our rhetoric with our actions.

Mr. McGOVERN. Mr. Speaker, I yield myself such time as I may consume, and I will close for our side.

Mr. Speaker, first I want to thank the gentleman from Texas (Mr. EDWARDS) and the gentleman from Wisconsin (Mr. OBEY) for their eloquent and powerful words and for reminding us all how we are not living up to our promise to our uniformed men and women, and it is something that every single Member in this House should listen to very carefully; and we now have an opportunity to be able to do something about that.

Mr. Speaker, I will ask for a recorded vote on the previous question, and I will urge Members to vote "no" on the previous question. If the previous question is defeated, I will offer an amendment to the rule that will make in order the Obey amendment to restore funding for military construction programs. This amendment was submitted to the Committee on Rules and rejected by the Republican majority.

The bill provides $9.2 billion for military construction spending. That is $41 million below the level requested by the President, and $1.5 billion less than last year. As we have said over and over, even the gentleman from Michigan (Mr. KNOLLENBERG), the distinguished chairman of the subcommittee, called the bill woefully underfunded.

This amendment will help restore some of these desperately needed additional funds. It will provide an additional $958 million above the subcommittee's allocation. This would be offset by reducing the 2004 tax cut for 200,000 millionaires from $88,000 to $83,000. That is it.

Mr. Speaker, whether or not Members are Republicans or Democrats, they should be extremely concerned, in fact outraged, about the lack of adequate funding for the programs that help our men and women in the military. The Obey amendment would help fix that and do so with no additional cost to the deficit.

Our rhetoric is simply not enough, Mr. Speaker. If we want to honor our uniformed men and women then we should not be cutting their benefits and their programs. We should be providing them what they need.

So I will urge Members on both sides of the aisle to vote "no" on the previous question. Let me emphasize that a "no" vote will not stop the House from taking up the military construction appropriations bill. However, a "yes" vote will prevent the House from considering the Obey amendment to help restore funding for this important legislation.

Mr. Speaker, I ask unanimous consent to insert the text of the amendment and extraneous materials immediately prior to the vote on the previous question.

The SPEAKER pro tempore (Mr. LaTourette). Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

Mr. McGOVERN. Mr. Speaker, again, I urge my colleagues to vote "no" on the previous question, and I yield back the balance of my time.

The material previously referred to by the gentleman from Massachusetts is as follows:

Previous Question for H. Res. 298—Rule on H.R. 2559 Fiscal Year 2004 Military Construction Appropriations

At the end of the resolution, add the following:

"Sec. 2. Notwithstanding any other provision of this resolution, the amendment printed in section 3 shall be in order without intervention of any point of order and before any other amendment if offered by Representative Obey of Wisconsin or a designee. The amendment is not subject to amendment except for pro forma amendments or to a demand for a division of the question in the committee of the whole or in the House.

"Sec. 3. The amendment referred to in section 2 is as follows:

On page 2, line 13, under the heading "Military Construction, Army", delete the dollar amount and insert $1,726,660,000;

On page 3, line 13, under the heading "Military Construction, Navy", delete the dollar amount and insert $1,311,907,000;

On page 4, line 5, under the heading "Military Construction, Air Force", delete the dollar amount and insert $968,509,000;

On page 4, line 21, under the heading "Military Construction, Defense-Wide", delete the dollar amount and insert $872,110,000;

On page 5, line 20, under the heading "Military Construction, Army National Guard, delete the dollar amount and insert $231,860,000;

On page 6, line 3, under the heading "Military Construction Air National Guard", delete the dollar amount and insert $95,605,000;

On page 7, line 19, under the heading "Family Housing Construction, Army", delete the dollar amount and insert $601,191,000;

On page 8, line 13, under the heading "Family Housing Construction, Navy and Marine Corps", delete the dollar amount and insert $288,193,000;

And on page 9, line 6, under the heading "Family Housing Construction, Air Force", delete the dollar amount and insert $841,065,000.

At the end of the bill, add the following:

Section . In the case of taxpayers with adjusted gross income tax excess of $1,000,000 for the tax year beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 shall be reduced by five percent.

Mrs. MYRICK. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. McGOVERN. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for electronic voting, if ordered, on the question of adoption of the resolution.

The vote was taken by electronic device, and there were—yeas 220, nays 200, not voting 14, as follows:

[Roll No. 324]

YEAS—220

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (FL)

NAYS—200

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—14

Brown-Waite, Ginny
Cubin
Dooley (CA)
Evans
Gephardt
Herger
Jefferson
Lewis (CA)
McInnis
Paul
Smith (WA)
Stearns
Watson
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are advised 2 minutes remain in this vote.

☐ 1551

Mr. GORDON changed his vote from "yea" to "nay."

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

The resolution was agreed to.

A motion to reconsider was laid on the table.

PERMISSION FOR COMMITTEE ON APPROPRIATIONS TO HAVE UNTIL MIDNIGHT, JULY 3, 2003, TO FILE PRIVILEGED REPORT ON LEGISLATIVE BRANCH APPROPRIATIONS ACT, 2004

Mr. KINGSTON. Mr. Speaker, I ask unanimous consent that the Committee on Appropriations have until midnight, July 3, 2003, to file a privileged report, making appropriations for the Legislative Branch for the fiscal year ending September 30, 2004, and for other purposes.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

The SPEAKER pro tempore. Pursuant to clause 1 of rule XXI, all points of order are reserved on the bill.

GENERAL LEAVE

Mr. KNOLLENBERG. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks, and that I be permitted to include tabular and extraneous material on the bill, H.R. 2559.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2004

The SPEAKER pro tempore. Pursuant to House Resolution 298 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2559.

☐ 1553

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, with Mr. BASS in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Michigan (Mr. KNOLLENBERG) and the gentleman from Texas (Mr. EDWARDS) each will control 30 minutes.

The Chair recognizes the gentleman from Michigan (Mr. KNOLLENBERG).

Mr. KNOLLENBERG. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, it is my pleasure to present to the House H.R. 2559, the fiscal year 2004 military construction appropriations bill. This legislation provides funds for all types of construction projects on military installations here in the U.S. and abroad. Projects range from barracks and housing to training ranges and runways.

I would like to thank my ranking member, the gentleman from Texas (Mr. EDWARDS), for his advice and support and cooperation in producing this recommendation. He has been a good partner, and I appreciate having the gentleman there to work together on this bill.

I would also like to express my appreciation to all members of the subcommittee for their help in putting together this year's bill. I commend the good work done by the subcommittee staff, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldwin. This has made my transition to chairman an easy one. I want to thank my personal staff, Jeff Onizuk and Lieutenant Commander Scott Gray. I appreciate the long hours they have put in making this the best bill possible.

The bill presented today totals $9.196 billion, which complies with the 302(b) allocation for both budget authority and outlays. This recommendation is, however, $41 million below the President's request, a reduction of less than ½ of 1 percent. Excluding funds provided in response to the global war on terrorism and Operation Iraqi Freedom, the bill is $605 million or 6 percent below fiscal year 2003 enacted levels.

For the first time in recent memory, this subcommittee has produced a recommendation that is below the President's request. This is the hand that we were dealt under current budgetary constraints, and we have tried to deal with it in as fair a manner as possible.

I assure Members the committee did due diligence to find as much savings as possible for the bill, and I believe we left no stone unturned in this process. This bill continues the subcommittee's bipartisan tradition of quality of life first for our service men and women. This is our paramount goal, and I believe we have reached it.

As many Members are aware, the Department of Defense is undertaking a privatization effort for military housing. For those of us who have seen the results thus far, this is an exciting development. What it means for the family housing account of this bill is that less money does not mean less housing. It means that we are getting more bang for our buck. For example, take the Residential Communities Initiative at the Presidio of Monterey. Using only the basic allowance for housing, the BAH, 2,168 new homes will be built and 41 historic units will be renovated. In addition, the private contractor will build wider roads, playgrounds, amenities such as community centers and swimming pools, and so on. What had been substandard housing will become an enviable community for our military families, and it will come at no cost, no cost to the family housing account in this bill.

The bottom line is that the funding in this bill does not slow down the effort to revitalize our military family housing. In fact, that effort is accelerating because of this privatization initiative.

I would like to take a moment to highlight some key areas in the bill. First, $1.24 billion is provided for troop barracks. This is a $62 million increase from last year's level. This sends a positive message to our unaccompanied personnel stationed all around the world that their quality of life is a priority.

The bill includes $194 million for hospital and medical facilities, an increase of $25 million above last year's level. This is another positive quality-of-life message, one intended for all service members as well as their families.

$274 million is provided for community facilities, an increase of $45 million above the President's request. These facilities include child development centers, fire stations, schools, and physical fitness centers.

$465 million is provided for the Guard and Reserve components, an increase of $95 million above the President's request.

The bill fully funds the President's request of $1.2 billion for new family housing units and improvements to existing units, and $2.7 billion is provided for the operation and maintenance of existing family housing units.

☐ 1600

I would like to highlight the overseas military construction program for just one moment. In support of a global repositioning effort, the President's amended budget submission and the recommendation before Members today rescinds and/or reduces overseas construction requirements by $327 million. Of these reductions, $279 million has been applied to construction requirements in the United States. It is my opinion additional cuts will adversely impact the quality of life and mission readiness of our troops living overseas, including those who are fighting the war against terrorism and also in Operation Iraqi Freedom. Therefore, I cannot recommend additional cuts in this area to my colleagues.

We have worked closely with the authorization committee in producing this legislation. I would like to take this opportunity to thank the gentleman from Colorado (Mr. HEFLEY) and his staff for their assistance.

In conclusion, we have focused our efforts on programs that directly support the men and women in our Armed Forces. We would like to do more. We always have and always will. But in my opinion, the recommendations in this bill are solid and fully fund projects that are vital to the security of the United States. The bottom line is this: with this bill, we meet the military's mission critical infrastructure needs and enable its efforts to improve the quality of life for our men and women in the Armed Forces. This is a fair bill. I encourage all my colleagues to support it.

Mr. Chairman, I include the following tabular material for the RECORD:

BUDGET AUTHORITY FOR 2003 AND BUDGET REQUESTS AND AMOUNTS RECOMMENDED IN THE BILL FOR 2004
(Amounts in thousands) (H.R. 2559)

	FY 2003 Enacted	FY 2004 Request	Bill	Bill vs. Enacted	Bill vs. Request
Military construction, Army	1,472,022	1,602,060	1,533,660	+61,638	-68,400
Defense emergency response fund (DERF)	211,688	---	---	-211,688	---
Subtotal	1,683,710	1,602,060	1,533,660	-150,050	-68,400
Rescission	-49,376	-66,050	-183,615	-134,239	-117,565
Supplemental appropriations (P.L. 108-11)	2,000	---	---	-2,000	---
Total	1,636,334	1,536,010	1,350,045	-286,289	-185,965
Military construction, Navy	1,095,698	1,147,537	1,211,077	+115,379	+63,540
Defense emergency response fund (DERF)	209,430	---	---	-209,430	---
Subtotal	1,305,128	1,147,537	1,211,077	-94,051	+63,540
Rescission	-1,340	-14,679	-39,322	-37,982	-24,643
Supplemental appropriations (P.L. 108-11)	48,100	---	---	-48,100	---
Total	1,351,888	1,132,858	1,171,755	-180,133	+38,897
Military construction, Air Force	891,650	830,671	896,136	+4,486	+65,465
Defense emergency response fund (DERF)	188,597	---	---	-188,597	---
Subtotal	1,080,247	830,671	896,136	-184,111	+65,465
Rescission	-13,281	---	---	+13,281	---
Rescission (P.L. 108-7)	-18,600	---	---	+18,600	---
Supplemental appropriations (P.L. 108-11)	152,900	---	---	-152,900	---
Total	1,201,266	830,671	896,136	-305,130	+65,465
Military construction, Defense-wide	836,345	815,113	813,613	-22,732	-1,500
Defense emergency response fund (DERF)	33,300	---	---	-33,300	---
Subtotal	869,645	815,113	813,613	-56,032	-1,500
Rescissions	-2,976	-997	-32,680	-29,704	-31,683
Total	866,669	814,116	780,933	-85,736	-33,183
Total, Active components	5,056,157	4,313,655	4,198,869	-857,288	-114,786
Military construction, Army National Guard	241,377	168,298	208,033	-33,344	+39,735
Military construction, Air National Guard	194,880	60,430	77,105	-117,775	+16,675
Defense emergency response fund (DERF)	8,933	---	---	-8,933	---
Total	203,813	60,430	77,105	-126,708	+16,675
Military construction, Army Reserve	100,554	68,478	84,569	-15,985	+16,091
Military construction, Naval Reserve	67,804	28,032	38,992	-28,812	+10,960
Defense emergency response fund (DERF)	7,117	---	---	-7,117	---
Total	74,921	28,032	38,992	-35,929	+10,960

BUDGET AUTHORITY FOR 2003 AND BUDGET REQUESTS AND AMOUNTS RECOMMENDED IN THE BILL FOR 2004
(Amounts in thousands) (H.R. 2559)

	FY 2003 Enacted	FY 2004 Request	Bill	Bill vs. Enacted	Bill vs. Request
Military construction, Air Force Reserve	63,650	44,312	56,212	-7,438	+11,900
Defense emergency response fund (DERF)	3,576	---	---	-3,576	---
Subtotal	67,226	44,312	56,212	-11,014	+11,900
Miscellaneous appropriations (P.L. 108-7)	18,600	---	---	-18,600	---
Total	85,826	44,312	56,212	-29,614	+11,900
Total, Reserve components	706,491	369,550	464,911	-241,580	+95,361
Total, Military construction	5,762,648	4,683,205	4,663,780	-1,098,868	-19,425
Appropriations	(5,185,580)	(4,764,931)	(4,919,397)	(-266,183)	(+154,466)
Defense emergency response fund	(662,641)	---	---	(-662,641)	---
Rescissions	(-85,573)	(-81,726)	(-255,617)	(-170,044)	(-173,891)
North Atlantic Treaty Organization Security Investment Program	167,200	169,300	169,300	+2,100	---
Family housing construction, Army	280,356	409,191	409,191	+128,835	---
Rescission	-4,920	-52,300	-52,300	-47,380	---
Total	275,436	356,891	356,891	+81,455	---
Family housing operation and maintenance, Army	1,106,007	1,043,026	1,043,026	-62,981	---
Family housing construction, Navy and Marine Corps	376,468	184,193	184,193	-192,275	---
Rescission	-2,652	---	-3,585	-933	-3,585
Total	373,816	184,193	180,608	-193,208	-3,585
Family housing operation and maintenance, Navy and Marine Corps	861,788	852,778	852,778	-9,010	---
Family housing construction, Air Force	684,824	657,065	657,065	-27,759	---
Rescission	-8,782	-19,347	-29,039	-20,257	-9,692
Total	676,042	637,718	628,026	-48,016	-9,692
Family housing operation and maintenance, Air Force	833,419	834,468	826,074	-7,345	-8,394
Defense emergency response fund (DERF)	29,631	---	---	-29,631	---
Subtotal	863,050	834,468	826,074	-36,976	-8,394
Supplemental appropriations (P.L. 108-11)	1,800	---	---	-1,800	---
Total	864,850	834,468	826,074	-38,776	-8,394
Family housing construction, Defense-wide	5,480	350	350	-5,130	---
Family housing operation and maintenance, Defense-wide	42,395	49,440	49,440	+7,045	---
Department of Defense Family Housing Improvement Fund	2,000	300	300	-1,700	---
Total, Family housing	4,207,814	3,959,164	3,937,493	-270,321	-21,671
Base realignment and closure account	561,138	370,427	370,427	-190,711	---
General provision (sec. 118)	---	55,000	55,000	+55,000	---
Grand total:					
New budget (obligational) authority	10,698,800	9,237,096	9,196,000	-1,502,800	-41,096
Appropriations	(10,108,455)	(9,390,469)	(9,536,541)	(-571,914)	(+146,072)
Defense emergency response fund	(692,272)	---	---	(-692,272)	---
Rescissions	(-101,927)	(-153,373)	(-340,541)	(-238,614)	(-187,168)

Mr. Chairman, I reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am going to vote for this military construction bill for one reason and for one reason alone. I believe the gentleman from Michigan, the chairman of our committee, has worked very hard and in a fair and bipartisan manner from day one on this bill. He and his capable staff have worked diligently and professionally to deal with a $1.5 billion military construction cut. This grossly inadequate funding level was not the decision of the gentleman from Michigan or myself. The gentleman from Michigan has a deep and genuine commitment to supporting a high quality of life for our servicemen and -women and their families. I know that firsthand. This decision was made above his pay grade and above mine. As the chairman and the ranking member of the Subcommittee on Military Construction, our responsibility is to take whatever funding level is given to us and invest those resources in a way that will fund the highest possible military construction priorities. I believe that is what the gentleman from Michigan, our subcommittee, and I have done: and that is why I will vote for this bill.

However, Mr. Chairman, I would be remiss and I believe it would be the height of irresponsibility for me not to speak honestly to our colleagues about what I consider to be the serious implications of cutting military construction funding by $1.5 billion. By the way, that is before the consideration of inflation. In my opinion, cutting military quality of life and military training investments during a time of war breaks faith with America's servicemen and -women and their families. I am deeply disappointed that the administration and the House leadership would say in effect that it is okay to salute our troops with our words while cutting critical military quality-of-life programs with our deeds. I believe it is wrong to salute our servicemen and -women with words while insulting them with our deeds. It is wrong in a time of war in Afghanistan for the administration in a separate bill to want to cut military education funds for military children by $173 million and to cut funds for military family housing, health care, day care and training in this bill by $1.5 billion.

Mr. Chairman, we are starting to see a pattern of respect to our servicemen and -women in time of war with our rhetoric and disrespect with our priorities and our actions. Frankly, in my opinion, we are reflecting the values of the majority leader of the House, the gentleman from Texas (Mr. DELAY), who said during the Iraqi war that in time of war, nothing is more important than cutting taxes. I would like to invite the majority leader to my district to explain that statement and that value to the 44,000 soldiers I represent at Fort Hood, 20,000 of whom are overseas in Iraq today.

I believe it adds insult to injury to make these cuts in military quality-of-life programs to help pay for an $88,000 tax cut for people in America living here safely, comfortably at home, not fighting in war, people making over $1 million a year. It is not just wrong; it is outrageous. As public officials, our spending priorities are a better reflection of our values than our speeches and our rhetoric. What does it say about our values in Congress when we ask Americans to go into combat in Iraq and then the administration is trying to cut those very servicemen's and -women's children's education funding by 14 percent? What does it say about our values when a person making $1 million in dividend income this year just received a $200,000 tax cut while a soldier in Iraq must read that the House has voted to cut military housing, quality-of-life and training facility projects by $1.5 billion? By the way, the House has voted to cut their future veterans benefits by $28 billion, a vote cast on March 21 just 8 minutes after we had overwhelmingly voted for a resolution saluting the service of our servicemen and -women in Iraq.

Mr. Chairman, in my opinion that type of priority makes a mockery of the American ideals of fairness and shared sacrifice during time of war. What do these cuts mean? It means that tens and tens of thousands of servicemen and -women living in inadequate housing will have to continue to do so. We have 83,000 new barracks that are needed to meet minimum DOD standards for our single servicemen and -women. We have a need for 128,860 new housing units for military families who sacrifice so much for our country. This bill does not meet those needs. Why? Not because of the values or priorities of the gentleman from Michigan, but because the top leadership of this House and the administration decided that we must cut military construction by $1.5 billion to help pay for that massive tax cut that we have already signed into law.

There is a lot of good in this bill, and the committee should be proud of its work. There are a lot of important priority programs funded. I salute the chairman and his very professional staff for, under very difficult circumstances, having to cut out important programs in order to adequately fund the highest-priority programs. I salute the gentleman from Michigan, his staff and the professional staff on both sides. This bill was put together without partisanship. It was put together under trying circumstances, with a last-minute decision by someone, I do not know and I do not know how, someone who said, we are going to have to cut our spending by $560 million below the amount authorized just a few weeks ago.

I support this bill for the many good things in it and the good work that was done to produce it; but I say to my colleagues, Mr. Chairman, we should be ashamed that we are asking our servicemen and -women to have their housing, their quality of life, their day care, their health clinics, their training facility programs cut by $1.5 billion in time of war. We should salute our servicemen and -women and their families with our deeds, not just with our words.

Mr. Chairman, I reserve the balance of my time.

Mr. KNOLLENBERG. Mr. Chairman, it is a pleasure for me to yield 3 minutes to the gentleman from Florida (Mr. YOUNG), the chairman of the Committee on Appropriations.

Mr. YOUNG of Florida. Mr. Chairman, I thank the gentleman for yielding me this time, and I rise for two purposes: one, to express strong support for the bill and to compliment Chairman KNOLLENBERG and Ranking Member EDWARDS for producing as good a bill as they could with what they had to work with. We have heard today as we heard during the Homeland Security appropriations bill earlier and I predict, Mr. Chairman, we will hear it from the other 11 appropriations bills, that they need more money, that they did not get enough money; that, as in this particular case, the bill is below the President's budget request.

Mr. Chairman, the budget resolution that this committee is required to deal with was below the President's budget request. Somebody tell me how we can go above the President's budget request with a budget resolution that is below the President's budget request. That would take a little magic. The gentleman from Wisconsin and I have sat together many times trying to figure out that magic. We have not found the right magic wand yet. But the committees and the subcommittees are doing the best they can with what they have to work with, and they are producing good bills.

The second part of my interest today is to say to our colleagues that, although there was a substantial delay in getting past some budgetary issues that were above the jurisdiction of the Committee on Appropriations, that 2 weeks ago when those issues were finally settled, your Committee on Appropriations has responded well. The Homeland Security bill was marked up, sent to the House, and it has gone on to the Senate. The military construction bill has been marked up, sent to the House and will go to the Senate today. The defense appropriations bill has been marked up. The labor, health and human services bill has been marked up. The interior appropriations bill has been marked up. The agriculture appropriations bill has been marked up.

and the legislative branch bill has been marked up. So in that 2-week period, your committee has produced seven of the 13 bills. That is in addition to having completed 11 of last year's bills during this calendar year and one major wartime supplemental.

I am very proud of the Committee on Appropriations on both sides. I am proud of the subcommittees and their leadership. But you cannot have more money to spend than the budget resolution provides, whether it is with the President's number, above the President's number, or below the President's number. We are given that number, and that is what we have to deal with.

Mr. EDWARDS. Mr. Chairman, I yield myself 3 minutes.

Mr. Chairman, I want to thank the gentleman from Florida (Mr. YOUNG) for his comments. There is no Member of this House, Democrat or Republican, over the years who has been more committed to our servicemen and -women. As critical as I am of the funding level in this bill, I know if anyone will work hard to see if we can find more money to more adequately show our respect to our servicemen and -women with our dollars in military construction, the gentleman from Florida will be the person to fight that fight and to lead that fight.

Mr. Chairman, I want to say to my colleagues that my comments, my critical comments about the funding level of this bill, not the way it was put together because the gentleman from Michigan did an excellent job and a fair job in doing that, but I want people to know this criticism does not just come from one Member of Congress. I would like to read an editorial dated June 30 of the "Army Times." It says, "Nothing But Lip Service."

"In recent months, President Bush and the Republican-controlled Congress have missed no opportunity to heap richly deserved praise on the military. But talk is cheap and getting cheaper by the day, judging from the nickel-and-dime treatment the troops are getting lately."

It goes on to say this:

"All of which brings us to the latest indignity, Bush's $9.2 billion military construction request for 2004, which was set a full $1.5 billion below this year's budget on the expectation that Congress, as has become tradition in recent years, would add funding as it drafted the construction appropriations bill.

"But Bush's tax cuts have left little elbow room in the 2004 Federal budget that is taking shape, and the squeeze is on across the board.

"The result: not only has the House appropriations military construction panel accepted Bush's proposed $1.5 billion cut, it voted to reduce construction spending by an additional $41 million next year."

The editorial goes on after commending the gentleman from Wisconsin for his amendment to try to add nearly $1 billion to this bill to say this:

"Taken piecemeal, all these corner-cutting moves might be viewed as mere flesh wounds. But even flesh wounds are fatal if you suffer enough of them. It adds up to a troubling pattern that eventually will hurt morale, especially if the current breakneck operations tempo also rolls on unchecked and the tense situations in Iraq and Afghanistan do not ease."

Mr. Chairman, that is a statement not from a Democrat or Republican in this House, but from the "Army Times" editorial. I think we should listen to the words and spirit of that editorial. I do not think our servicemen and -women are going to accept lip service. They give us dedicated service, including the risking of their lives. It is time for us to give them more than lip service when it comes to committing to making tough choices, committing to ensure that they can have a better quality of life, live in decent housing, have day care for their children and quality schools for their families.

☐ 1615

Mr. KNOLLENBERG. Mr. Chairman, I have no further requests for time, and I reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I yield 6 minutes to the distinguished gentleman from Wisconsin (Mr. OBEY), the ranking Democrat on the full Committee on Appropriations who made an effort earlier this day to offer an amendment that was closed off by the Republican leadership to add nearly $1 billion of commitment to our servicemen and women's quality of life programs.

Mr. OBEY. Mr. Chairman, I thank the gentleman for yielding me this time.

I want to express my agreement with the comments made by the gentleman from Florida (Mr. YOUNG), the distinguished chairman of this committee.

And then I want to say this: Budgets are not just presentations of numbers. Budgets really reflect and define and exhibit our priorities and our values. And that is why this bill is such a sad commentary on the nature of this House.

When President Bush came into office, thanks to the fiscal discipline demonstrated by the previous administration, we expected to see at least $6 trillion worth of surpluses over the next decade. We were in the best shape that we had been fiscally in more than a generation. So the President decided that we could afford to provide very large tax cuts, and he estimated we would still have billions left over for other purposes, and the House passed those tax cuts.

My point is that then something happened that was totally unexpected. We got hit by 9/11 and the economic downturn that followed that. Any person of prudence in my view, having seen such a shocking change, would have been careful about the next step that they took, but this Congress and this White House, alas, was not. So despite the fact that the bottom was falling out of the economy and the bottom was falling out of Government revenues, the White House and this Congress decided they were going to push on with even larger tax cuts. They said that we needed to do it in order to create jobs.

But, not a single job has been created during the tenure of the Bush administration. In fact, we have lost almost 3 million jobs since President Bush took office. Part of that is not his responsibility; part of it in my view is, and the Congress's as well. My point is that when conditions change one would think that their approach and their remedies change, but they have not. We have gotten only one answer out of the administration in terms of dealing with the economy: Tax cuts, tax cuts, tax cuts, no matter how badly they are skewed to the upper reaches of the income ladders and no matter what they cost to the other people in this society. And this bill is one of the examples of what it costs.

When this House passes these tax cuts, it pretends that there is no cost to anyone else. Let me just spell out what some of the costs are. Those tax cuts mean that we will be paying $23 billion more in interest payments next year than we would otherwise be paying. Before these tax cuts play out we will be spending more on interest payments in the Federal budget than we will be spending on all domestic appropriation items reported by this committee, and it will be a gargantuan share of the Federal budget. We ought to be able to make better judgments than that.

But there are other costs as well. We passed the "No Child Left Behind Act" for education, sent mandates out to the States and said we would send cash out to help pay for those mandates. I've news for you, the appropriations bill that is going to come out will short sheet those education programs by $8 billion. Nobody knows that, but that is what is going to happen. And this is happening at a time when budget crunches all over the country are going to be squeezing States and squeezing schools. We are also having to squeeze down on what we provide in health care. There are thousands and thousands of families being pushed off health care in many States in the Union. And this bill represents what is going to happen to military families, because we are cutting $1.5 billion below the deliverable amount in the previous year's budget for military families under military construction. And we wind up making only token progress in improving the housing for military families and for single enlisted people.

The cost of the estate tax elimination, which this House just passed: For the cost of that money it took to take millionaires off the tax roll when we passed that estate tax change—that is going to cost $800 billion—for that $800 billion, we could close one-third of the gap in financing that will be existing in the Social Security system. We should have done that first. But we did not. We passed another huge tax cut for the high rollers.

So there are consequences, and there are costs to those tax cuts. The gentleman from Florida (Mr. YOUNG) is right. He cannot perform a miracle. Neither can the gentleman from Michigan (Mr. KNOLLENBERG). Appropriations are the table scraps that are left over after this House has decided to plunge ahead, promising all of these out-sized tax cuts to the American people with a huge share of those tax cuts going to the most well off, and then we see what happens to the rest.

So that is why I am not pleased with this bill, not because of the work of the gentleman from Michigan (Mr. KNOLLENBERG) or the staff but because this House made a basic bad judgment to begin with and it is being compounded and illustrated and demonstrated with every other bill we bring to the floor.

That is the problem. There are consequences. The budget process is being handled in this House to try to hide those consequences. It is our responsibility to try to lay out what those consequences are, and that is why we have gone through this operation this afternoon.

Mr. KNOLLENBERG. Mr. Chairman, I continue to reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I do not think there are any other speakers on this side. I yield myself 3 minutes.

Mr. Chairman, I never thought I in my 12 years in this House would come to the floor and speak out in favor of a military construction bill that cuts quality of life and training investments for servicemen and women even in time of war by $1.5 billion. I never thought I would ask my colleagues to vote for a bill that decreases Navy and Marine Corps family housing construction investment by $193 million compared to last year. I never thought I would ask my colleagues to vote for a bill that decreases family Air Force construction housing by $48 million compared to last year.

But I do ask my colleagues to vote for this bill because we had to do the best we could with the allocation given to us. Because of the needs, the important needs, military family needs that this bill meets, I will vote for it. Because of the needs that will remain unmet, I will not be proud that this House will go on record as saying in time of war to our servicemen and women thanks for risking their lives, thanks for fighting in Iraq, thanks for taking care of their children at home while they are wondering if their loved one will ever come home alive, while at the same time cutting their quality of life programs by $1.5 billion. I guess it is a testament to my respect for the gentleman from Michigan (Mr. KNOLLENBERG), his fairness, his dedication to our servicemen and women, his commitment to working as hard as any human could to see that we make the best with an unfair, horrible situation in this funding level, that I will vote for this bill. And I do want to pay a special thanks to the gentleman from Michigan (Mr. KNOLLENBERG) for standing up for people who often do not have someone speaking for them in this House, and that is our servicemen and women overseas, because I know there was an effort made to make additional cuts in some of those facilities. There is not much to be gained personally or politically by defending quality of life commitments overseas because those folks are not living in our districts at the time. The gentleman from Michigan (Mr. KNOLLENBERG) said no to that kind of cut because he knew that would have been the wrong thing to do. I salute him and I hope with his dedication and the gentleman from Florida's (Mr. YOUNG) and the gentleman from Wisconsin's (Mr. OBEY) and other Members of this House's dedication, we will see before this year ends we can pass a military construction bill that we can look our servicemen and women in the eye and say we are proud of them and we do salute them with more than just words.

So I ask my colleagues, despite my reservations, to support the tremendous effort and work of the gentleman from Michigan (Mr. KNOLLENBERG) and our subcommittee.

Mr. ORTIZ. Mr. Chairman, I rise this evening in support of our men and women in the Armed Services. For many weeks now, we have all declared our gratefulness to these warriors and their families of the sacrifices they have made on behalf of our Nation.

Besides their incredible efforts in fighting the War on Terrorism, these patriots and their families have had to learn to live without their fathers or mothers or spouses present on a daily basis because of numerous, long, and dangerous deployments, or even worse, if their loved one has paid the ultimate sacrifice. I, myself, have had more than my share of families in my district that have paid this price.

I have traveled extensively to our military facilities and have observed the substandard housing we force our military personnel and families to live in. We must address this situation.

We are all grateful for these sacrifices, but how will we show this gratefulness? Will we support the Ranking Member in his effort to scale back the tax cuts by a mere 5 percent for those who make over a million dollars a year, so we can restore funding and adequately house our forces?

Even though we are cutting military construction spending by $1.5 billion from last year's funding, we can still do the right thing at this time by voting for the Previous Question. We must support the Ranking Member's efforts and truly show our gratitude to our troops.

Mr. DICKS. Mr. Chairman, I would like to commend Chairman KNOLLENBERG and Ranking Member EDWARDS for their work on this bill. They have done their best with an unreasonable and unacceptable allocation. I know they share my deep disappointment over this level of funding, which is $1.5 billion less than was appropriated for Military Construction & Family Housing last year.

Unfortunately this cut makes a bad situation worse. When the Bush administration came into office, they found a Department of Defense where the recapitalization rates for facilities varied from 80 to over 100 years in the various services. They rightly condemned this situation. However, under this budget, the recapitalization rate for the active Air Force will increase to 183 years. The Navy recapitalization rate will increase to 140 years. The recapitalization rate for the Marines actually goes down, but is still an unacceptable 88 years. And the Army recapitalization rate in this budget increases to 144 years. The DOD goal is 67 years. I strongly support the effort by Mr. OBEY to increase funding for Military Construction and Family Housing in this bill by $1 billion. This funding, and much more, is sorely needed.

I would like to thank the Chairman and Ranking Member for working with me on the vital installations in Washington state. We will make a start in this bill on fixing a Navy pier at Puget Sound Naval Shipyard which today is not up to Navy standards for performing its mission, which is mooring nuclear powered aircraft carriers. And the bill includes several important projects to build barracks at Ft. Lewis, refurbish the Mission Support Center at McChord Air Force Base, and rebuild the service pier at Subase Bangor. Also, this bill continues to support the privatization of family housing at Ft. Lewis, WA. Mr. Chairman, beautiful new houses have been built and are under construction there, and this Congress can be proud about the new houses being built for military families through this innovative program.

I hope as this bill proceeds through the Congressional process, that additional funds can be found to make this a truly responsible piece of legislation. Having voiced my deep concerns, I will vote today in support of this bill in order to ensure that those important projects which do receive funding here are allowed to move forward.

Mr. SCHROCK. Mr. Chairman, America is indebted to the men and women of the armed forces. Their success in Iraq, Afghanistan and around the world give witness to their bravery and commitment. In order to maintain this dedicated, all-volunteer force and to ensure its readiness, we must be proactive in providing them adequate quality of life and training facilities.

The reality is that we are still correcting the spending deficiencies of the past. Even after years of funding plus-ups to the Department's military construction budget, service men and women continue to live and work in aging and inferior facilities. In fact, more than two-thirds of the services' current facilities are classified at "C–3" or "C–4" readiness levels. This signifies that their ability to carry out missions has been appreciably degraded.

I am glad that we are able to work across party lines to ensure that military construction is funded at the highest levels possible.

H.R. 2559 addresses many of the pressing construction and family housing needs facing the services. The bill would provide $1.2 billion for barracks, $16 million for child development centers, and $1.2 billion for new family housing units and improvements to existing ones.

I urge my colleagues to support H.R. 2559, because these new and improved facilities will enhance the quality of life for our service members while they are doing their jobs and training to defend America.

We must never let our military deteriorate as we have seen in the past, because, as recent events have demonstrated, we will never know when our nation's security will be challenged.

Mr. NUSSLE. Mr. Chairman, I rise today in support of H.R. 2559, the Military Construction Appropriations Act for Fiscal Year 2004. It is the second bill we are considering pursuant to the 302(b) allocations adopted by the Appropriations Committee on June 17th. I am pleased to report that it is consistent with the levels established in H. Con. Res. 95, the House concurrent resolution on the budget for fiscal year 2004, which Congress adopted on April 10. The budget resolution provided $400.1 billion in discretionary budget authority for national defense. This bill funds the military construction and family housing portion of that commitment to our men and women in uniform.

H.R. 2559 provides $9.196 billion in new budget authority and $10.282 billion in outlays for fiscal year 2004. It is therefore identical to its 302(b) allocation to the House Subcommittee on Military Construction Appropriations. It does not contain emergency-designated new BA. It does include $340.5 million in rescissions of previously enacted BA. Although budget authority in the bill declines by 12.8 percent from the previous year, it is $81 million above the President's request. This mainly because H.R. 2559 contains a procurement appropriation of $120 million that, according to CBO, was part of the administration's request for the Defense appropriation bill rather than this bill.

The bill complies with section 302(f) of the Budget Act, which prohibits consideration of bills in excess of an appropriations subcommittee's 302(b) allocation of budget authority and outlays established in the budget resolution.

H.R. 2559 represents this House's solemn commitment to the quality of life of those who put their lives on the line for freedom. It not only addresses the long-term infrastructure problems at military bases, it sustains barracks, family housing, medical facilities, and child support centers across the country and overseas. It also provides infrastructure funding for National Guard and Reserve troops who now find themselves on the front lines of the war against terrorism. Finally, it incorporates the results of real-world national security policy changes: The redeployment south of U.S. military forces away from the North Korean border to better-protected bases, and the gradual drawdown of troops from some Central European bases.

In conclusion, I express my support for H.R. 2559.

Mr. FRELINGHUYSEN. Mr. Chairman, I rise in strong support of H.R. 2559, making appropriations for military construction for fiscal 2004. This legislation is a strong product for tough times and I want to commend the Subcommittee Chairman, the gentleman from Michigan, Mr. KNOLLENBERG, and the Gentleman from Texas, Mr. EDWARDS.

This legislation provides $9.2 billion in funding for military construction and family housing projects across the country.

While no one is satisfied with the bottom line on this bill and we all wish that we could not do more, this is a solid product. It satisfies our obligation to ensure that our men and women in uniform live in, train at, and deploy from adequate facilities. This bill shows our commitment to our service members by constructing and upgrading military installations, and military family housing in the United States and overseas.

Improving the quality of life for our men and women in uniform throughout the world is critically important. If we are asking these brave men and women to protect our national security, then we must ensure that they have the tools and the facilities to protect themselves.

America's armed forces have been charged with developing the capabilities to fight jointly and with coalition partners to secure victory across the full spectrum of warfare while continuing the transition to a more flexible, more agile, lighter and more lethal force.

In this context, I am pleased the Committee has included funding for a state-of-the-art explosives loading facility at the Army's "Home of Lethality"—Picatinny Arsenal in New Jersey.

In Afghanistan and Iraq, the achievements of our young men and women in uniform are due in part to the incredible technological advances employed by our military, much of which has been researched and developed by Picatinny Arsenal—the only Army-owned, Army-operated facilities for the research and development of energetics materials (mines, armor, warheads, artillery, etc.) in the nation. The new facility will mark a substantial upgrade in safety, environmental protection and process controls that will benefit the other branches of the military that rely on Army research and development expertise.

Mr. Chairman, once again I commend Mr. KNOLLENBERG and Mr. YOUNG and I urge support for this bill.

Mr. FRANKS of Arizona. Mr. Chairman, today I urge your consideration of the authorization of $14.3 million for land acquisition to preserve access to the Barry M. Goldwater Range. This land acquisition would serve to prevent incompatible land uses and encroachment, and to increase the margin of safety in the Live Ordnance Departure Area located southwest of Luke Air Force Base.

The Barry M. Goldwater Range, a 2.7 million acre land and airspace area in southwest Arizona, is the crown jewel of all flight ranges, providing the Air Force with the space necessary to conduct live-fire training and simulating realistically the dimensions of a modern battlefield.

Luke Air Force Base-with its year-round idyllic weather-is the training home to the F–16 Fighting Falcon. With an average of 170 sorties flown each day, access to the Barry M. Goldwater Range is an essential part of the advanced training and practice required of the Air Force fighter pilots. The southern departure corridor from Luke Air Force Base is the only air corridor where live ordnance can be carried out by F–16 Fighters. The threat of advancement and increased pressure of residential development from what has traditionally been isolated farmland places the mission and the future of Luke Air Force Base at risk.

The Air Force has also made this $14.3 million request stating, "Continued residential development of the departure corridors could impair Luke [Air Force Base's] ability to support sorties carrying live ordnance and to fully utilize the [Barry M. Goldwater Range] . . . [and] further encumbering Luke [Air Force Base's] access to the [Barry M. Goldwater Range] may adversely impact Luke's mission and result in a degradation to the national security."

Mr. EDWARDS. Chairman, I yield back the balance of my time.

Mr. KNOLLENBERG. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the bill shall be considered for amendment under the 5-minute rule. During consideration of the bill for amendment, the Chair may accord priority in recognition to a Member offering an amendment that has been printed in the designated place in the CONGRESSIONAL RECORD. Those amendments will be considered read.

The Clerk will read.

The Clerk read as follows:

H.R. 2559

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated for military construction, family housing, and base realignment and closure functions administered by the Department of Defense, for the fiscal year ending September 30, 2004, and for other purposes, namely:

MILITARY CONSTRUCTION, ARMY

(INCLUDING RESCISSIONS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Army as currently authorized by law, including personnel in the Army Corps of Engineers and other personal services necessary for the purposes of this appropriation, and for construction and operation of facilities in support of the functions of the Commander in Chief, $1,533,660,000, to remain available until September 30, 2008: *Provided*, That of this amount, not to exceed $122,710,000 shall be available for study, planning, design, architect and engineer services, and host nation support, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor: *Provided further*, That of the funds appropriated for "Military Construction, Army" under

Public Law 107–249, $142,200,000 are rescinded: *Provided further*, That of the funds appropriated for "Military Construction, Army" under Public Law 107–64, $24,000,000 are rescinded: *Provided further*, That of the funds appropriated for "Military Construction, Army" under Public Law 106–246, $17,415,000 are rescinded.

AMENDMENT OFFERED BY MR. OBEY

Mr. OBEY. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. OBEY:

On page 2, line 13, under the heading "Military Construction, Army", delete the dollar amount and insert $1,726,660,000;

On page 3, line 13, under the heading "Military Construction, Navy", delete the dollar amount and insert $1,311,907,000;

On page 4, line 5, under the heading "Military Construction, Air Force", delete the dollar amount and insert $968,509,000;

On page 4, line 21, under the heading "Military Construction, Defense-Wide", delete the dollar amount and insert $872,110,000;

On page 5, line 20, under the heading "Military Construction, Army National Guard", delete the dollar amount and insert $231,860,000;

On page 6, line 3, under the heading "Military Construction, Air National Guard", delete the dollar amount and insert $95,605,000;

On page 7, line 19, under the heading "Family Housing Construction, Army", delete the dollar amount and insert $601,191,000;

On page 8, line 13, under the heading "Family Housing Construction, Navy and Marine Corps", delete the dollar amount and insert $288,193,000;

And on page 9, line 6, under the heading "Family Housing Construction, Air Force", delete the dollar amount and insert $841,065,000.

At the end of the bill, add the following:

Section . In the case of taxpayers with adjusted gross income in excess of $1,000,000 for the tax beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 shall be reduced by five percent.

Mr. OBEY (during the reading). Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. KNOLLENBERG. Mr. Chairman, I reserve a point of order.

The CHAIRMAN. The point of order is reserved.

Mr. OBEY. Mr. Chairman, I have already explained to the House what the intention of this amendment is. This amendment would reinstate the $160 million in cuts from the President's budget for hangers, maintenance shops, office space, physical fitness facilities for the military that even the White House thought were crucial. It adds $480 million for family housing to help at least 2,500 military families. There are 134,000 inadequate units that service those families to date. It would add $318 million for new barracks. It would help get 5,300 single service personnel into decent housing. The Pentagon says there is a need for over 83,000 unit fix-ups. And it would pay for that by reducing the expected tax cut for those with adjusted gross incomes of more than $1 million dollars annually. We would adjust their tax cuts from $88,000 to $83,000, thus enabling them to keep 95 percent of their tax cut. That would free up enough money to meet these military needs, and I would urge the House, despite the action of the Committee on Rules, to allow this amendment to go forward.

POINT OF ORDER

The CHAIRMAN. Does the gentleman from Michigan (Mr. KNOLLENBERG) insist on his point of order?

Mr. KNOLLENBERG. Mr. Chairman, I do. I make a point of order against the amendment because it proposes to change existing law and constitutes legislation in an appropriations bill and therefore violates clause 2 of rule XXI, which states in part "An amendment to a general appropriations bill shall not be in order if changing existing law."

At this time I ask for a ruling from the Chair.

Mr. OBEY. Mr. Chairman, I would like to be heard on the point of order.

The CHAIRMAN. The gentleman from Wisconsin is recognized.

Mr. OBEY. Mr. Chairman, what has been happening in this House is that the Committee on Rules has routinely been waiving points of orders for the majority but denying those same waivers to the minority. That puts us in an uneven position on the House floor. We are in that kind of position on this amendment. I want to simply say in conceding the point of order that I will continue to make this motion on this bill. I will have it in my motion to recommit. I will try at every stage of the process to get this matter before the House so we can make these priority judgments, and it is up to the majority whether it wants to knock them off the floor or not.

The CHAIRMAN. The gentleman's point of order is conceded and sustained.

The Clerk will read.

Mr. KNOLLENBERG. Mr. Chairman, I ask unanimous consent that the remainder of the bill, through page 19, line 19 be considered as read, printed in the RECORD and open to amendment at any point.

The CHAIRMAN. Is there objection to the gentleman from Michigan?

There was no objection.

The text of the remainder of the bill, from page 3, line 5, though page 19, line 19 is as follows:

MILITARY CONSTRUCTION, NAVY

(INCLUDING RESCISSIONS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, naval installations, facilities, and real property for the Navy as currently authorized by law, including personnel in the Naval Facilities Engineering Command and other personal services necessary for the purposes of this appropriation, $1,211,077,000, to remain available until September 30, 2008: *Provided*, That of this amount, not to exceed $65,612,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor: *Provided further*, That of the funds appropriated for "Military Construction, Navy" under Public Law 107–249, $27,213,000 are rescinded: *Provided further*, That of the funds appropriated for "Military Construction, Navy" under Public Law 107–64, $12,109,000 are rescinded.

MILITARY CONSTRUCTION, AIR FORCE

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Air Force as currently authorized by law, $896,136,000, to remain available until September 30, 2008: *Provided*, That of this amount, not to exceed $80,543,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, DEFENSE-WIDE

(INCLUDING RESCISSION AND TRANSFER OF FUNDS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, installations, facilities, and real property for activities and agencies of the Department of Defense (other than the military departments), as currently authorized by law, $813,613,000, to remain available until September 30, 2008: *Provided*, That such amounts of this appropriation as may be determined by the Secretary of Defense may be transferred to such appropriations of the Department of Defense available for military construction or family housing as he may designate, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation or fund to which transferred: *Provided further*, That of the amount appropriated, not to exceed $63,884,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor: *Provided further*, That of the funds appropriated for "Military Construction, Defense-wide" under Public Law 107–249, $32,680,000 are rescinded.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $208,033,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, AIR NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $77,105,000, to remain available until September 30, 2008.

Military Construction, Army Reserve

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $84,569,000, to remain available until September 30, 2008.

Military Construction, Naval Reserve

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the reserve components of the Navy and Marine Corps as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $38,992,000, to remain available until September 30, 2008.

Military Construction, Air Force Reserve

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air Force Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $56,212,000, to remain available until September 30, 2008.

North Atlantic Treaty Organization Security Investment Program

For the United States share of the cost of the North Atlantic Treaty Organization Security Investment Program for the acquisition and construction of military facilities and installations (including international military headquarters) and for related expenses for the collective defense of the North Atlantic Treaty Area as authorized in Military Construction Authorization Acts and section 2806 of title 10, United States Code, $169,300,000, to remain available until expended.

Family Housing Construction, Army

(INCLUDING RESCISSION)

For expenses of family housing for the Army for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $409,191,000, to remain available until September 30, 2008: *Provided*, That of the funds appropriated for "Family Housing Construction, Army" under Public Law 107–249, $52,300,000 are rescinded.

Family Housing Operation and Maintenance, Army

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $1,043,026,000.

Family Housing Construction, Navy and Marine Corps

(INCLUDING RESCISSION)

For expenses of family housing for the Navy and Marine Corps for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $184,193,000, to remain available until September 30, 2008: *Provided*, That of the funds appropriated for "Family Housing Construction, Navy and Marine Corps" under Public Law 107–249, $3,585,000 are rescinded.

Family Housing Operation and Maintenance, Navy and Marine Corps

For expenses of family housing for the Navy and Marine Corps for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $852,778,000.

Family Housing Construction, Air Force

(INCLUDING RESCISSIONS)

For expenses of family housing for the Air Force for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $657,065,000, to remain available until September 30, 2008: *Provided*, That of the funds appropriated for "Family Housing Construction, Air Force" under Public Law 107–249, $19,347,000 are rescinded: *Provided further*, That of the funds appropriated for "Family Housing Construction, Air Force" under Public Law 105–237, $9,692,000 are rescinded.

Family Housing Operation and Maintenance, Air Force

For expenses of family housing for the Air Force for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $826,074,000.

Family Housing Construction, Defense-Wide

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $350,000, to remain available until September 30, 2008.

Family Housing Operation and Maintenance, Defense-Wide

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for operation and maintenance, leasing, and minor construction, as authorized by law, $49,440,000.

Department of Defense Family Housing Improvement Fund

For the Department of Defense Family Housing Improvement Fund, $300,000, to remain available until expended, for family housing initiatives undertaken pursuant to section 2883 of title 10, United States Code, providing alternative means of acquiring and improving military family housing and supporting facilities.

Base Realignment and Closure Account

For deposit into the Department of Defense Base Closure Account 1990 established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991 (Public Law 101–510), $370,427,000, to remain available until expended.

GENERAL PROVISIONS

SEC. 101. None of the funds appropriated in Military Construction Appropriations Acts shall be expended for payments under a cost-plus-a-fixed-fee contract for construction, where cost estimates exceed $25,000, to be performed within the United States, except Alaska, without the specific approval in writing of the Secretary of Defense setting forth the reasons therefor.

SEC. 102. Funds appropriated to the Department of Defense for construction shall be available for hire of passenger motor vehicles.

SEC. 103. Funds appropriated to the Department of Defense for construction may be used for advances to the Federal Highway Administration, Department of Transportation, for the construction of access roads as authorized by section 210 of title 23, United States Code, when projects authorized therein are certified as important to the national defense by the Secretary of Defense.

SEC. 104. None of the funds appropriated in this Act may be used to begin construction of new bases inside the continental United States for which specific appropriations have not been made.

SEC. 105. No part of the funds provided in Military Construction Appropriations Acts shall be used for purchase of land or land easements in excess of 100 percent of the value as determined by the Army Corps of Engineers or the Naval Facilities Engineering Command, except: (1) where there is a determination of value by a Federal court; (2) purchases negotiated by the Attorney General or his designee; (3) where the estimated value is less than $25,000; or (4) as otherwise determined by the Secretary of Defense to be in the public interest.

SEC. 106. None of the funds appropriated in Military Construction Appropriations Acts shall be used to: (1) acquire land; (2) provide for site preparation; or (3) install utilities for any family housing, except housing for which funds have been made available in annual Military Construction Appropriations Acts.

SEC. 107. None of the funds appropriated in Military Construction Appropriations Acts for minor construction may be used to transfer or relocate any activity from one base or installation to another, without prior notification to the Committees on Appropriations.

SEC. 108. No part of the funds appropriated in Military Construction Appropriations Acts may be used for the procurement of steel for any construction project or activity for which American steel producers, fabricators, and manufacturers have been denied the opportunity to compete for such steel procurement.

SEC. 109. None of the funds available to the Department of Defense for military construction or family housing during the current fiscal year may be used to pay real property taxes in any foreign nation.

SEC. 110. None of the funds appropriated in Military Construction Appropriations Acts may be used to initiate a new installation overseas without prior notification to the Committees on Appropriations.

SEC. 111. None of the funds appropriated in Military Construction Appropriations Acts may be obligated for architect and engineer contracts estimated by the Government to exceed $500,000 for projects to be accomplished in Japan, in any NATO member country, or in countries bordering the Arabian Sea, unless such contracts are awarded to United States firms or United States firms in joint venture with host nation firms.

SEC. 112. None of the funds appropriated in Military Construction Appropriations Acts for military construction in the United States territories and possessions in the Pacific and on Kwajalein Atoll, or in countries bordering the Arabian Sea, may be used to award any contract estimated by the Government to exceed $1,000,000 to a foreign contractor: *Provided*, That this section shall not be applicable to contract awards for which the lowest responsive and responsible bid of a United States contractor exceeds the lowest responsive and responsible bid of a foreign contractor by greater than 20 percent: *Provided further*, That this section shall not apply to contract awards for military construction on Kwajalein Atoll for which the lowest responsive and responsible bid is submitted by a Marshallese contractor.

SEC. 113. The Secretary of Defense is to inform the appropriate committees of Congress, including the Committees on Appropriations, of the plans and scope of any proposed military exercise involving United States personnel 30 days prior to its occurring, if amounts expended for construction, either temporary or permanent, are anticipated to exceed $100,000.

SEC. 114. Not more than 20 percent of the appropriations in Military Construction Appropriations Acts which are limited for obligation during the current fiscal year shall be obligated during the last 2 months of the fiscal year.

(TRANSFER OF FUNDS)

SEC. 115. Funds appropriated to the Department of Defense for construction in prior years shall be available for construction authorized for each such military department by the authorizations enacted into law during the current session of Congress.

SEC. 116. For military construction or family housing projects that are being completed with funds otherwise expired or lapsed for obligation, expired or lapsed funds may be used to pay the cost of associated supervision, inspection, overhead, engineering and design on those projects and on subsequent claims, if any.

SEC. 117. Notwithstanding any other provision of law, any funds appropriated to a military department or defense agency for the construction of military projects may be obligated for a military construction project or contract, or for any portion of such a project or contract, at any time before the end of the fourth fiscal year after the fiscal year for which funds for such project were appropriated if the funds obligated for such project: (1) are obligated from funds available for military construction projects; and (2) do not exceed the amount appropriated for such project, plus any amount by which the cost of such project is increased pursuant to law.

(TRANSFER OF FUNDS)

SEC. 118. During the 5-year period after appropriations available to the Department of Defense for military construction and family housing operation and maintenance and construction have expired for obligation, upon a determination that such appropriations will not be necessary for the liquidation of obligations or for making authorized adjustments to such appropriations for obligations incurred during the period of availability of such appropriations, unobligated balances of such appropriations may be transferred into the appropriation "Foreign Currency Fluctuations, Construction, Defense" to be merged with and to be available for the same time period and for the same purposes as the appropriation to which transferred.

SEC. 119. The Secretary of Defense is to provide the Committees on Appropriations of the Senate and the House of Representatives with an annual report by February 15, containing details of the specific actions proposed to be taken by the Department of Defense during the current fiscal year to encourage other member nations of the North Atlantic Treaty Organization, Japan, Korea, and United States allies bordering the Arabian Sea to assume a greater share of the common defense burden of such nations and the United States.

(TRANSFER OF FUNDS)

SEC. 120. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, proceeds deposited to the Department of Defense Base Closure Account established by section 207(a)(1) of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100-526) pursuant to section 207(a)(2)(C) of such Act, may be transferred to the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to be merged with, and to be available for the same purposes and the same time period as that account.

(TRANSFER OF FUNDS)

SEC. 121. Subject to 30 days prior notification to the Committees on Appropriations, such additional amounts as may be determined by the Secretary of Defense may be transferred to the Department of Defense Family Housing Improvement Fund from amounts appropriated for construction in "Family Housing" accounts, to be merged with and to be available for the same purposes and for the same period of time as amounts appropriated directly to the Fund: *Provided*, That appropriations made available to the Fund shall be available to cover the costs, as defined in section 502(5) of the Congressional Budget Act of 1974, of direct loans or loan guarantees issued by the Department of Defense pursuant to the provisions of subchapter IV of chapter 169, title 10, United States Code, pertaining to alternative means of acquiring and improving military family housing and supporting facilities.

SEC. 122. None of the funds appropriated or made available by this Act may be obligated for Partnership for Peace Programs in the New Independent States of the former Soviet Union.

(TRANSFER OF FUNDS)

SEC. 123. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, amounts may be transferred from the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to the fund established by section 1013(d) of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3374) to pay for expenses associated with the Homeowners Assistance Program. Any amounts transferred shall be merged with and be available for the same purposes and for the same time period as the fund to which transferred.

SEC. 124. Notwithstanding this or any other provision of law, funds appropriated in Military Construction Appropriations Acts for operations and maintenance of family housing shall be the exclusive source of funds for repair and maintenance of all family housing units, including general or flag officer quarters: *Provided*, That not more than $35,000 per unit may be spent annually for the maintenance and repair of any general or flag officer quarters without 30 days advance prior notification to the appropriate committees of Congress, except that an after-the-fact notification shall be submitted if the limitation is exceeded solely due to costs associated with environmental remediation that could not be reasonably anticipated at the time of the budget submission: *Provided further*, That the Under Secretary of Defense (Comptroller) is to report annually to the Committees on Appropriations all operations and maintenance expenditures for each individual general or flag officer quarters for the prior fiscal year.

SEC. 125. None of the funds made available in this Act may be transferred to any department, agency, or instrumentality of the United States Government, except pursuant to a transfer made by, or transfer authority provided in, this Act or any other appropriation Act.

SEC. 126. None of the funds appropriated in this Act for the Department of the Army for military construction projects in the Republic of Korea may be obligated or expended for projects at Camp Humphreys in the Republic of Korea until the Secretary of Defense certifies and reports to the appropriate committees of Congress that the United States and the Republic of Korea have entered into an agreement on the availability and use of land sufficient for such projects. The certification must be presented to the committees no later than September 30, 2004, or the funds expire.

□ 1630

The CHAIRMAN. Are there any amendments?

If not, the Clerk will read.

The Clerk read as follows:

This Act may be cited as the "Military Construction Appropriations Act, 2004".

The CHAIRMAN. Are there further amendments?

If not, under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore, Mr. THORNBERRY, having assumed the chair, Mr. BASS, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, pursuant to House Resolution 298, he reported the bill back to the House.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. OBEY

Mr. OBEY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. OBEY. Without the motion to recommit, yes.

Mr. KNOLLENBERG. Mr. Speaker, I reserve a point of order against the motion to recommit.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. OBEY moves to recommit the bill, H.R. 2559, to the Committee on Appropriation with instructions to report the same forthwith with the following amendment:

On page 2, line 13, under the heading "Military Construction, Army", delete the dollar amount and insert $1,726,660,000;

On page 3, line 13, under the heading "Military Construction, Navy", delete the dollar amount and insert $1,311,907,000;

On page 4, line 5, under the heading "Military Construction, Air Force", delete the dollar amount and insert $968,509,000;

On page 4, line 21, under the heading "Military Construction, Defense-Wide", delete the dollar amount and insert $872,110,000;

On page 5, line 20, under the heading "Military Construction, Army National Guard, delete the dollar amount and insert $231,860,000;

On page 6, line 3, under the heading "Military Construction, Air National Guard", delete the dollar amount and insert $95,605,000;

On page 7, line 19, under the heading "Family Housing Construction, Army", delete the dollar amount and insert $601,191,000;

On page 8, line 13, under the heading "Family Housing Construction, Navy and Marine Corps", delete the dollar amount and insert $288,193,000;

And on page 9, line 6, under the heading "Family Housing Construction, Air Force", delete the dollar amount and insert $841,065,000.

At the end of the bill, add the following:

SECTION . In the case of taxpayers with adjusted gross income in excess of $1,000,000 for the tax year beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 shall be reduced by five percent.

Mr. OBEY (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Wisconsin (Mr. OBEY) on his motion to recommit.

Mr. OBEY. Mr. Speaker, I will not take the 5 minutes. This is simply the same motion I offered before. If this House were operating on the basis of any degree of fairness today, it would be before the House, and I would simply ask that the majority refrain from offering the point of order against it. I know they have their marching orders. They have to do what they have to do, and I have to do what I have to do.

POINT OF ORDER

Mr. KNOLLENBERG. Mr. Chairman, I make a point of order against the motion to recommit because it proposes to change existing law and constitutes legislation in an appropriations bill, and, therefore, violates clause 2 of rule XXI.

The rule states, in pertinent part, "An amendment to a general appropriation bill shall not be in order if changing existing law."

The amendment proposes to alter the application of existing law.

The SPEAKER pro tempore. Does the gentleman from Wisconsin wish to be heard on the point of order?

Mr. OBEY. Yes, I do, Mr. Speaker.

As I said earlier, this is the same motion I made before. What is happening here is that because of a technical difference in the way the rules are being applied to the majority and the minority, we are being prevented from offering a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society.

With that, I concede the point of order.

The SPEAKER pro tempore. The gentleman from Wisconsin concedes the point of order. The point of order is sustained.

MOTION TO RECOMMIT OFFERED BY MR. OBEY

Mr. OBEY. Mr. Chairman, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. OBEY. I am, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. OBEY moves to recommit the bill, H.R. 2559, to the Committee on Appropriations.

The SPEAKER pro tempore. The motion is not debatable.

The question is on the motion to recommit offered by the gentleman from Wisconsin (Mr. OBEY).

The motion was rejected.

The SPEAKER pro tempore. The question is on the passage of the bill.

Under clause 10 of rule XX, the yeas and nays are ordered.

Pursuant to clauses 8 and 9 of rule XX, this 15-minute vote on passage of H.R. 2559 will be followed by 5-minute votes on suspending the rules and adopting House Resolution 277 and on agreeing to the Speaker's approval of the Journal.

The vote was taken by electronic device, and there were—yeas 428, nays 0, not voting 6, as follows:

[Roll No. 325]

YEAS—428

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker

Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOT VOTING—6

Brown-Waite, Ginny
Cox
Gephardt
McInnis
Paul
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. THORNBERRY) (during the vote). Members are reminded less than 2 minutes remain in this vote.

□ 1654

Mr. ACKERMAN changed his vote from "nay" to "yea".

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

EXPRESSING SUPPORT FOR FREEDOM IN HONG KONG

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and agreeing to the resolution, H. Res. 277.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the resolution, H. Res. 277, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 426, nays 1, not voting 7, as follows:

[Roll No. 326]

YEAS—426

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—1

Paul

NOT VOTING—7

Brown-Waite, Ginny
Edwards
Gephardt
Herger
Jefferson
McInnis
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in the vote.

□ 1703

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

THE JOURNAL

The SPEAKER pro tempore (Mr. SWEENEY). Pursuant to clause 8 of rule XX, the pending business is the question of the Speaker's approval of the Journal of the last day's proceedings.

The question is on the Speaker's approval of the Journal, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 357, nays 68, not voting 9, as follows:

[Roll No. 327]

YEAS—357

Abercrombie
Ackerman
Akin
Alexander
Andrews
Baca
Bachus
Baker
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bereuter
Berkley
Berman
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Cox
Cramer
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Flake
Fletcher
Foley

Forbes
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gingrey
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Hall
Harman
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hill
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larson (CT)
Latham
LaTourette
Leach
Lee
Lewis (CA)
Lewis (KY)
Linder
Lipinski
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McHugh
McIntyre
McKeon
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mollohan
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Ortiz
Osborne
Ose
Owens
Oxley
Pallone
Pascrell
Paul
Payne
Pearce
Pelosi
Pence
Peterson (PA)
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stearns
Sullivan
Tancredo
Tanner
Tauscher
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Tierney
Turner (OH)
Turner (TX)
Udall (CO)
Upton
Van Hollen
Velazquez
Vitter
Walden (OR)
Walsh
Wamp
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Wexler
Whitfield
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Young (AK)
Young (FL)

NAYS—68

Aderholt
Allen
Baird
Baldwin
Bell
Berry
Brady (PA)
Brown (OH)
Brown, Corrine
Capuano
Costello
Crane
DeFazio
English
Filner
Ford
Gillmor
Gutknecht
Hastings (FL)
Hefley
Hinchey
Hulshof
Johnson, E. B.
Kennedy (MN)
Kennedy (RI)
Kucinich
Larsen (WA)
Levin
Lewis (GA)
LoBiondo
Markey
Marshall
Matheson
McDermott
McGovern
McNulty
Miller, George
Moore
Neal (MA)
Oberstar
Obey
Olver
Otter
Pastor
Peterson (MN)
Ramstad
Sabo
Sánchez, Linda T.
Schakowsky
Shadegg
Slaughter
Smith (MI)
Stark
Stenholm
Strickland
Stupak
Sweeney
Taylor (MS)
Thompson (CA)
Thompson (MS)
Toomey
Towns
Udall (NM)
Visclosky
Waters
Weller
Wicker
Wu

NOT VOTING—9

Brown-Waite, Ginny
Edwards
Gephardt
Gonzalez
Jefferson
McInnis
Petri
Smith (WA)
Wynn

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining.

□ 1711

So the Journal was approved.

The result of the vote was announced as above recorded.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 312. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

MAKING IN ORDER ON TUESDAY, JULY 8, 2003, CONSIDERATION OF DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2004

Mr. LEWIS of California. Mr. Speaker, I ask unanimous consent that it be in order on Tuesday, July 8, 2003, for the Speaker, as though pursuant to clause 2(b) of rule XVIII, to declare the House resolved into the Committee of the Whole House on the State of the Union for consideration of a bill reported pursuant to section 6 of House Resolution 299 making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, which shall proceed according to the following order:

The first reading of the bill shall be dispensed with.

All points of order against consideration of the bill are waived.

General debate shall be confined to the bill and shall not exceed 1 hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations.

After general debate, the bill shall be considered for amendment under the 5-minute rule.

Points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived.

During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the CONGRESSIONAL RECORD designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read.

At the conclusion of consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

Mr. THOMAS. Mr. Speaker, pursuant to House Resolution 299, I call up the bill (H.R. 2596) to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The text of H.R. 2596 is as follows:

H.R. 2596

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Savings and Affordability Act of 2003".

SEC. 2. HEALTH SAVINGS SECURITY ACCOUNTS AND HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 223 as section 225 and by inserting after section 222 the following new sections:

"SEC. 223. HEALTH SAVINGS SECURITY ACCOUNTS.

"(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a health savings security account of such individual.

"(b) LIMITATIONS.—

"(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

"(2) MONTHLY LIMITATION.—The monthly limitation for any month is $\frac{1}{12}$ of—

"(A) $2,000, in the case of an eligible individual who—

"(i) has self-only coverage under a minimum deductible plan as of the first day of such month, or "(ii) is uninsured as of the first day of such month and is not described in subparagraph (B)(ii) with respect to the taxable year which includes such month,

"(B) $4,000, in the case of an eligible individual who—

"(i) has family coverage under a minimum deductible plan as of the first day of such month, or

"(ii) is uninsured as of the first day of such month and, with respect to the taxable year which includes such month—

"(I) is entitled to a deduction for a dependent under section 151(c) (or would be so entitled but for paragraph (2) or (4) of section 152(e)), or

"(II) files a joint return, and

"(C) zero in any other case.

"(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—

"(A) IN GENERAL.—In the case of an individual who has attained the age of 55 before the close of the taxable year, paragraph (2) shall be applied by increasing the $2,000 amount in paragraph (2)(A) and the $4,000 amount in paragraph (2)(B) by the additional contribution amount.

"(B) ADDITIONAL CONTRIBUTION AMOUNT.—For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

"For taxable years beginning in:	The additional contribution amount is:
2004	$500
2005	$600
2006	$700
2007	$800
2008	$900
2009 and thereafter	$1,000.

"(4) LIMITATION BASED ON ADJUSTED GROSS INCOME.—

"(A) SELF-ONLY COVERAGE.—The dollar amount in paragraph (2)(A) (as increased under paragraph (3)) shall be reduced (but not below zero) by an amount which bears the same ratio to such dollar amount as—

"(i) the amount (if any) by which the taxpayer's adjusted gross income for such taxable year exceeds $75,000 ($150,000 in the case of a joint return), bears to

"(ii) $10,000 ($20,000 in the case of a joint return).

"(B) FAMILY COVERAGE.—The dollar amount in paragraph (2)(B) (as increased under paragraph (3)) shall be reduced (but not below zero) by an amount which bears the same ratio to such dollar amount as—

"(i) the amount (if any) by which the taxpayer's adjusted gross income for such taxable year exceeds $150,000, bears to

"(ii) $20,000.

"(C) NO REDUCTION BELOW $200 UNTIL COMPLETE PHASE-OUT.—No dollar amount shall be reduced below $200 under subparagraph (A) or (B) unless (without regard to this subparagraph) such limitation is reduced to zero.

"(D) ROUNDING.—Any amount determined under this paragraph which is not a multiple of $10 shall be rounded to the next lowest $10.

"(E) ADJUSTED GROSS INCOME.—For purposes of this paragraph, adjusted gross income shall be determined—

"(i) without regard to this section or section 911, and

"(ii) after application of sections 86, 135, 137, 219, 221, 222, and 469.

"(5) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

"(A) the aggregate amount paid during such taxable year to Archer MSAs of such individual,

"(B) the aggregate amount paid during such taxable year to health savings accounts of such individual, and

"(C) the aggregate amount paid during such taxable year to health savings security accounts of such individual by persons other than such individual.

"(6) SPECIAL RULES FOR MARRIED INDIVIDUALS, DEPENDENTS, AND MEDICARE ELIGIBLE INDIVIDUALS.—Rules similar to the rules of paragraphs (3), (6), and (7) of section 220(b) shall apply for purposes of this section.

"(c) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual unless such individual is covered, as of the first day of such month, under any health plan which is not a minimum deductible plan.

"(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A) shall be applied without regard to—

"(i) coverage for any benefit provided by permitted insurance, and

"(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

"(2) MINIMUM DEDUCTIBLE PLAN.—

"(A) IN GENERAL.—The term 'minimum deductible plan' means a health plan—

"(i) in the case of self-only coverage, which has an annual deductible which is not less than $500, and

"(ii) in the case of family coverage, which has an annual deductible which is not less than twice the dollar amount in clause (i) (as increased under subparagraph (B)).

"(B) COST-OF-LIVING ADJUSTMENT FOR ANNUAL DEDUCTIBLES.—

"(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2004, the $500 amount in subparagraph (A)(i) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.

"(ii) ROUNDING.—If any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(C) SPECIAL RULES.—

"(i) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

"(ii) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a minimum deductible plan by reason of failing to have a deductible for preventive care.

"(3) UNINSURED.—An individual shall be treated as uninsured if such individual is not covered by insurance which constitutes medical care. The preceding sentence shall be applied without regard to the coverage described in paragraph (1)(B).

"(4) PERMITTED INSURANCE.—The term 'permitted insurance' has the meaning given such term in section 220(c)(3).

"(5) FAMILY COVERAGE.—The term 'family coverage' has the meaning given such term in section 220(c)(5).

"(6) ARCHER MSA.—The term 'Archer MSA' has the meaning given such term in section 220(d).

"(7) HEALTH SAVINGS ACCOUNT.—The term 'health savings account' has the meaning given such term in section 224(d).

"(d) HEALTH SAVINGS SECURITY ACCOUNT.—For purposes of this section—

"(1) IN GENERAL.—The term 'health savings security account' means a trust created or organized in the United States as a health savings security account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a rollover contribution from an Archer MSA, or a health savings security account, which is not includible in gross income, no contribution will be accepted—

"(i) unless it is in cash and is contributed by—

"(I) the account beneficiary,

"(II) a member of the family of the account beneficiary, or

"(III) an employer of the account beneficiary, and

"(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the highest annual limitation which could apply to an individual under subsection (b) for a taxable year beginning in such calendar year.

"(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(E) The interest of an individual in the balance in his account is nonforfeitable.

"(2) MEMBER OF THE FAMILY.—The term 'member of the family' has the meaning given such term in section 2032A(e)(2).

"(3) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' has the meaning given such term in section 220(d)(2), except that—

"(A) subparagraph (B)(i) thereof shall not apply to—

"(i) insurance which constitutes a minimum deductible plan if no portion of the cost of such insurance is paid by an employer or former employer of the account beneficiary or the spouse of such beneficiary, and

"(ii) any health insurance (other than health insurance substantially all of its coverage is coverage described in subsection (c)(1)(B)) if the account beneficiary has attained age 65, and

"(B) subparagraph (C) thereof shall not apply for purposes of this section.

"(4) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual on whose behalf the health savings security account was established.

"(5) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

"(A) Section 219(d)(2) (relating to no deduction for rollovers).

"(B) Section 219(f)(3) (relating to time when contributions deemed made).

"(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

"(D) Section 408(g) (relating to community property laws).

"(E) Section 408(h) (relating to custodial accounts).

“(6) CONTRIBUTIONS FROM FLEXIBLE SPENDING ACCOUNTS TREATED AS MADE BY THE EMPLOYER.—Any contribution from a flexible spending account to a health savings security account which is not includible in the gross income of the employee by reason of section 125(h) shall be treated as a contribution made by the employer for purposes of this section.

“(e) TAX TREATMENT OF ACCOUNTS.—

“(1) IN GENERAL.—A health savings security account is exempt from taxation under this subtitle unless such account has ceased to be a health savings security account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

“(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings security accounts, and any amount treated as distributed under such similar rules shall be treated as not used to pay qualified medical expenses.

“(f) TAX TREATMENT OF DISTRIBUTIONS.—

“(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings security account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

“(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

“(A) IN GENERAL.—Any amount paid or distributed out of a health savings security account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary in the manner provided under section 72.

“(B) SPECIAL RULES FOR APPLYING SECTION 72.—For purposes of applying section 72 to any amount described in subparagraph (A)—

“(i) all health savings security accounts shall be treated as 1 contract,

“(ii) all distributions during any taxable year shall be treated as 1 distribution,

“(iii) the value of the contract, income on the contract, and investment in the contract shall be computed as of the close of the calendar year in which the taxable year begins, and

“(iv) such distributions shall be treated as made from contributions from members of the family of the account beneficiary to the extent that such distribution, when added to all previous distributions from the health savings security account taken into account under this clause, do not exceed the aggregate contributions from members of such family.

“(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

“(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any health savings security account of an individual, paragraph (2) shall not apply to distributions from the health savings security accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

“(i) such distribution is made on or before the last day prescribed by law (including extensions of time) for filing the account beneficiary's return for such taxable year,

“(ii) no deduction is allowed under this section with respect to such contribution,

“(iii) such distribution is accompanied by the amount of net income attributable to such excess contribution, and

“(iv) such distribution satisfies the requirements of subparagraph (B).

“(B) RULES RELATED TO ORDERING.—

“(i) DISTRIBUTIONS LIMITED TO CONTRIBUTIONS.—Subparagraph (A) shall apply to distributions to a person only to the extent of the contributions of such person to such accounts during such taxable year.

“(ii) CLASSES OF CONTRIBUTORS.—Subparagraph (A) shall apply only to distributions of such contributions which are made in the following order:

“(I) first, to members of the family of the account beneficiary,

“(II) second, to the account beneficiary,

“(III) third, to employers of the account beneficiary with respect to contributions under section 125(h), and

“(IV) fourth, to employers of the account beneficiary with respect to contributions under section 106(d).

“(iii) LAST-IN FIRST-OUT.—If distributions could be made to more than one person under any subclause of clause (ii), subparagraph (A) shall not apply to any such distribution unless such distribution is of the most recent excess contribution which has not been distributed to the contributor.

“(C) TREATMENT OF NET INCOME.—Any net income described in subparagraph (A)(iii) shall be included in the gross income of the person receiving the distribution for the taxable year in which received.

“(D) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term ‘excess contribution’ means any contribution (other than a rollover contribution from another health savings security account, or from an Archer MSA, which is not includible in gross income) to the extent such contribution results in the aggregate contributions to health savings security accounts of the account beneficiary for the taxable year to be in excess of the limitation under subsection (b) (determined without regard to paragraph (5)(C) thereof) which applies to such beneficiary for such year.

“(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

“(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings security account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 15 percent of the amount which is so includible.

“(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

“(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

“(5) ROLLOVER CONTRIBUTION.—

“(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings security account to the account beneficiary to the extent the amount received is paid into a health savings security account, or a health savings account, for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

“(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings security account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings security account which was not includible in the individual's gross income because of the application of this paragraph.

“(6) SPECIAL RULES.—Rules similar to the rules of paragraphs (6), (7), and (8) of section 220(f) shall apply for purposes of this section.

“(g) REPORTS.—The Secretary may require the trustee of a health savings security account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

“(h) REGULATIONS.—The Secretary may issue regulations to carry out the purposes of this section, including regulations regarding the proper treatment of distributions described in subsection (f)(3) and nondeductible contributions by members of the family of the account beneficiary.

“SEC. 224. HEALTH SAVINGS ACCOUNTS.

“(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a health savings account of such individual.

“(b) LIMITATIONS.—

“(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

“(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to $\frac{1}{12}$ of the annual deductible (as of the first day of such month) of the individual's coverage under the high deductible health plan.

“(3) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

“(A) the aggregate amount paid during such taxable year to Archer MSAs of such individual,

“(B) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

“(C) the aggregate amount paid during such taxable year to health savings accounts of such individual by persons other than such individual.

“(4) SPECIAL RULES FOR MARRIED INDIVIDUALS, DEPENDENTS, AND MEDICARE ELIGIBLE INDIVIDUALS.—Rules similar to the rules of paragraphs (3), (6), and (7) of section 220(b) shall apply for purposes of this section.

“(c) DEFINITIONS.—For purposes of this section—

“(1) ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, any individual if—

“(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

“(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

“(I) which is not a high deductible health plan, and

“(II) which provides coverage for any benefit which is covered under the high deductible health plan.

‘‘(B) Certain coverage disregarded.—Subparagraph (A)(ii) shall be applied without regard to—

‘‘(i) coverage for any benefit provided by permitted insurance, and

‘‘(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

‘‘(2) High deductible health plan.—

‘‘(A) In general.—The term ‘high deductible health plan’ means a health plan—

‘‘(i) in the case of self-only coverage, which has an annual deductible which is not less than $1,000 and not more than $2,250,

‘‘(ii) in the case of family coverage, which has an annual deductible which is not less than $2,000 and not more than $4,500, and

‘‘(iii) the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

‘‘(I) $3,000 for self-only coverage, and

‘‘(II) $5,500 for family coverage.

‘‘(B) Cost-of-living adjustment.—

‘‘(i) In general.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subparagraph (A) shall be increased by an amount equal to—

‘‘(I) such dollar amount, multiplied by

‘‘(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 1997’ for ‘calendar year 1992’ in subparagraph (B) thereof.

‘‘(ii) Special rules.—In the case of the $1,000 amount in subparagraph (A)(i) and the $2,000 amount in subparagraph (A)(ii), subclause (i)(II) shall be applied by substituting ‘calendar year 2002’ for ‘calendar year 1997’.

‘‘(iii) Rounding.—If any increase under clause (i) or (ii) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

‘‘(C) Special rules.—

‘‘(i) Exclusion of certain plans.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

‘‘(ii) Safe harbor for absence of preventive care deductible.— A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care.

‘‘(D) Treatment of network services.—

‘‘(i) In general.—In the case of a health plan which is a preferred provider organization plan and which would (without regard to services provided outside such organization's network of providers described in clause (iii)(I)) be a high deductible health plan, such plan shall not fail to be a high deductible health plan because—

‘‘(I) the annual deductible for services provided outside such network exceeds the applicable maximum dollar amount in clause (i) or (ii) of subparagraph (A), or

‘‘(II) the annual out-of-pocket expenses required to be paid for services provided outside such network exceeds the applicable dollar amount in subparagraph (A)(iii).

‘‘(ii) Annual deductible.—The annual deductible taken into account under subsection (b)(2) with respect to a plan which is a high deductible health plan by reason of clause (i) shall be the annual deductible for services provided within such network.

‘‘(iii) Preferred provider organization plan defined.—In this subparagraph, the term ‘preferred provider organization plan’ means a health plan that—

‘‘(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan,

‘‘(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers, and

‘‘(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

‘‘(3) Permitted insurance.—The term ‘permitted insurance’ has the meaning given such term in section 220(c)(3).

‘‘(4) Family coverage.—The term ‘family coverage’ has the meaning given such term in section 220(c)(5).

‘‘(5) Archer msa.—The term ‘Archer MSA’ has the meaning given such term in section 220(d).

‘‘(6) Health savings security account.—The term ‘health savings security account’ has the meaning given such term in section 223(d).

‘‘(d) Health Savings Account.—For purposes of this section—

‘‘(1) In general.—The term ‘health savings account’ means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

‘‘(A) Except in the case of a rollover contribution from an Archer MSA, a health savings security account, or a health savings account, which is not includible in gross income, no contribution will be accepted—

‘‘(i) unless it is in cash and is contributed by—

‘‘(I) the account beneficiary, or

‘‘(II) an employer of the account beneficiary, and

‘‘(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the highest annual limitation which could apply to an individual under subsection (b) for a taxable year beginning in such calendar year.

‘‘(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

‘‘(C) No part of the trust assets will be invested in life insurance contracts.

‘‘(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

‘‘(E) The interest of an individual in the balance in his account is nonforfeitable.

‘‘(2) Qualified medical expenses.—The term ‘qualified medical expenses’ has the meaning given such term in section 220(d)(2).

‘‘(3) Account beneficiary.—The term ‘account beneficiary’ means the individual on whose behalf the health savings account was established.

‘‘(4) Certain rules to apply.—Rules similar to the following rules shall apply for purposes of this section:

‘‘(A) Section 219(d)(2) (relating to no deduction for rollovers).

‘‘(B) Section 219(f)(3) (relating to time when contributions deemed made).

‘‘(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

‘‘(D) Section 408(g) (relating to community property laws).

‘‘(E) Section 408(h) (relating to custodial accounts).

‘‘(6) Contributions from flexible spending accounts treated as made by the employer.—Any contribution from a flexible spending account to a health savings account which is not includible in the gross income of the employee by reason of section 125(h) shall be treated as a contribution made by the employer for purposes of this section.

‘‘(e) Tax Treatment of Accounts.—

‘‘(1) In general.—A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

‘‘(2) Account terminations.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

‘‘(f) Tax Treatment of Distributions.—

‘‘(1) Amounts used for qualified medical expenses.—Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

‘‘(2) Inclusion of amounts not used for qualified medical expenses.—Any amount paid or distributed out of a health savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

‘‘(3) Excess contributions returned before due date of return.—

‘‘(A) In general.—If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

‘‘(i) such distribution is made on or before the last day prescribed by law (including extensions of time) for filing the account beneficiary's return for such taxable year,

‘‘(ii) no deduction is allowed under this section with respect to such contribution,

‘‘(iii) such distribution is accompanied by the amount of net income attributable to such excess contribution, and

‘‘(iv) such distribution satisfies the requirements of subparagraph (B).

‘‘(B) Rules related to ordering.—

‘‘(i) Distributions limited to contributions.—Subparagraph (A) shall apply to distributions to a person only to the extent of the contributions of such person to such accounts during such taxable year.

‘‘(ii) Classes of contributors.—Subparagraph (A) shall apply only to distributions of such contributions which are made in the following order:

‘‘(I) first, to the account beneficiary,

‘‘(II) second, to employers of the account beneficiary with respect to contributions under section 125(h), and

‘‘(III) third, to employers of the account beneficiary with respect to contributions under section 106(d).

‘‘(iii) Last-in first-out.—If distributions could be made to more than one person under any subclause of clause (ii), subparagraph (A) shall not apply to any such distribution unless such distribution is of the most recent excess contribution which has not been distributed to the contributor.

‘‘(C) Treatment of net income.—Any net income described in subparagraph (A)(iii) shall be included in the gross income of the person receiving the distribution for the taxable year in which received.

"(D) Excess contribution.—For purposes of subparagraph (A), the term 'excess contribution' means any contribution (other than a rollover contribution from another health savings account, from a health savings security account, or from an Archer MSA, which is not includible in gross income) to the extent such contribution results in the aggregate contributions to health savings accounts of the account beneficiary for the taxable year to be in excess of the limitation under subsection (b) (determined without regard to paragraph (3)(C) thereof) which applies to such beneficiary for such year.

"(4) Additional tax on distributions not used for qualified medical expenses.—

"(A) In general.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 15 percent of the amount which is so includible.

"(B) Exception for disability or death.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

"(C) Exception for distributions after medicare eligibility.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

"(5) Rollover contribution.—

"(A) In general.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

"(B) Limitation.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of this paragraph.

"(6) Special rules.—Rules similar to the rules of paragraphs (6), (7), and (8) of section 220(f) shall apply for purposes of this section.

"(g) Reports.—The Secretary may require the trustee of a health savings account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.".

(b) Deduction Allowed Whether or Not Individual Itemizes Other Deductions.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (18) the following new paragraphs:

"(19) Health savings security accounts.—The deduction allowed by section 223.

"(20) Health savings accounts.—The deduction allowed by section 224.".

(c) Coordination With Archer MSAs.—

(1) Rollovers from Archer MSAs permitted.—Subparagraph (A) of section 220(f)(5) of such Code (relating to rollover contribution) is amended by inserting ", a health savings security account (as defined in section 223(d)), or a health savings account (as defined in section 224(d))," after "paid into an Archer MSA".

(2) Reduction in Archer MSA limitation for contributions to health savings security accounts and health savings accounts.—Subsection (b) of section 220 of such Code (relating to limitations) is amended by adding at the end the following new paragraph:

"(8) Coordination with health savings security accounts and health savings accounts.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

"(A) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

"(B) the aggregate amount paid during such taxable year to health savings accounts of such individual.".

(d) Exclusions for Employer Contributions to Health Savings Security Accounts and Health Savings Accounts.—

(1) Exclusion from income tax.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsections:

"(d) Contributions to Health Savings Security Accounts.—

"(1) In general.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any health savings security account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

"(2) Special rules.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

"(3) Definitions.—For purposes of this subsection, the terms 'eligible individual' and 'health savings security account' have the respective meanings given to such terms by section 223.

"(4) Cross reference.—

"For penalty on failure by employer to make comparable contributions to the health savings security accounts of comparable employees, see section 4980G.

"(e) Contributions to Health Savings Accounts.—

"(1) In general.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any health savings account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 224(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

"(2) Special rules.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

"(3) Definitions.—For purposes of this subsection, the terms 'eligible individual' and 'health savings account' have the respective meanings given to such terms by section 224.

"(4) Cross reference.—

"For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.".

(2) Exclusion from employment taxes.—

(A) Railroad retirement tax.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

"(11) Health savings security account and health savings account contributions.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.".

(B) Unemployment tax.—Subsection (b) of section 3306 of such Code is amended by striking "or" at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting "; or", and by inserting after paragraph (17) the following new paragraph:

"(18) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.".

(C) Withholding tax.—Subsection (a) of section 3401 of such Code is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106."

(3) Employer contributions required to be shown on W-2.—Subsection (a) of section 6051 of such Code is amended by striking "and" at the end of paragraph (10), by striking the period at the end of paragraph (11) and inserting a comma, and by inserting after paragraph (11) the following new paragraphs:

"(12) the amount contributed to any health savings security account (as defined in section 223(d)) of such employee or such employee's spouse, and

"(13) the amount contributed to any health savings account (as defined in section 224(d)) of such employee or such employee's spouse.".

(4) Penalty for failure of employer to make comparable health savings account contributions.—

(A) In general.—Chapter 43 of such Code is amended by adding after section 4980F the following new section:

"SEC. 4980G. FAILURE OF EMPLOYER TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

"(a) General Rule.—In the case of an employer who makes a contribution to the health savings security account or the health savings account of any employee during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (b) for such calendar year.

"(b) Rules and Requirements.—Rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

"(c) Regulations.—The Secretary shall issue regulations to carry out the purposes of this section, including regulations providing special rules for employers who make contributions to more than one of the following types of accounts during the calendar year:

"(1) An Archer MSA.

"(2) A health savings security account.

"(3) A health savings account.".

(B) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding after the item relating to section 4980F the following new item:

"Sec. 4980G. Failure of employer to make comparable health savings account contributions.".

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to certain tax-favored accounts and annuities) is amended—

(1) by striking "or" at the end of paragraph (3) of subsection (a),

(2) by inserting after paragraph (4) of subsection (a) the following new paragraphs:

"(5) a health savings security account (within the meaning of section 223(d)), or

"(6) a health savings account (within the meaning of section 224(d))", and

(4) by adding at the end the following new subsections:

"(g) EXCESS CONTRIBUTIONS TO HEALTH SAVINGS SECURITY ACCOUNTS.—For purposes of this section, in the case of health savings security accounts (within the meaning of section 223(d)), the term 'excess contributions' means the sum of—

"(1) the aggregate amount contributed for the taxable year to the accounts (other than a rollover contribution from another health savings security account, or from an Archer MSA, which is not includible in gross income) which is in excess of the limitation under section 223(b) (determined without regard to paragraph (5)(C) thereof), and

"(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

"(A) the distributions out of the accounts which were included in gross income under section 223(f)(2), and

"(B) the excess (if any) of—

"(i) the sum of limitations described in paragraph (1), over

"(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the health savings security account in a distribution to which section 223(f)(3) applies shall be treated as an amount not contributed.

"(h) EXCESS CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—For purposes of this section, in the case of health savings accounts (within the meaning of section 224(d)), the term 'excess contributions' means the sum of—

"(1) the aggregate amount contributed for the taxable year to the accounts (other than a rollover contribution from another health savings account, a health savings security account, or from an Archer MSA, which is not includible in gross income) which is in excess of the limitation under section 224(b) (determined without regard to paragraph (3)(C) thereof), and

"(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

"(A) the distributions out of the accounts which were included in gross income under section 224(f)(2), and

"(B) the excess (if any) of—

"(i) the sum of limitations described in paragraph (1), over

"(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the health savings account in a distribution to which section 224(f)(3) applies shall be treated as an amount not contributed.".

(f) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraphs:

"(6) SPECIAL RULE FOR HEALTH SAVINGS SECURITY ACCOUNTS.—An individual for whose benefit a health savings security account (within the meaning of section 223(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health savings security account by reason of the application of section 223(e)(2) to such account.

"(7) SPECIAL RULE FOR HEALTH SAVINGS ACCOUNTS.—An individual for whose benefit a health savings account (within the meaning of section 224(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health savings account by reason of the application of section 224(e)(2) to such account.".

(2) Paragraph (1) of section 4975(e) of such Code is amended by redesignating subparagraphs (E) and (F) as subparagraphs (G) and (H), respectively, and by inserting after subparagraph (D) the following new subparagraphs:

"(E) a health savings security account described in section 223(d).

"(F) a health savings account described in section 224(d).".

(g) FAILURE TO PROVIDE REPORTS ON HEALTH SAVINGS ACCOUNTS.—Paragraph (2) of section 6693(a) of such Code (relating to reports) is amended by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (B) the following new subparagraphs:

"(C) section 223(g) (relating to health savings security accounts),

"(D) section 224(g) (relating to health savings accounts),".

(h) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) of such Code (defining specified insurance contract) is amended by striking "and" at the end of clause (iii), by striking the period at the end of clause (iv) and inserting a comma, and by adding at the end the following new clauses:

"(v) any contract which is a health savings security account (as defined in section 223(d)), and".

"(vi) any contract which is a health savings account (as defined in section 224(d)).".

(i) HEALTH SAVINGS SECURITY ACCOUNTS AND HEALTH SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Paragraph (2) of section 125(d) (relating to cafeteria plan defined) is amended by adding at the end the following new subparagraph:

"(D) EXCEPTION FOR HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) shall not apply to a plan to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a health savings security account, or a health savings account, established on behalf of the employee.".

(j) INFORMATION REPORTING BY PROVIDERS OF HEALTH INSURANCE.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end the following new section:

"SEC. 6050U. RETURNS RELATING TO PROVIDERS OF HEALTH INSURANCE.

"(a) REQUIREMENT OF REPORTING.—Under regulations prescribed by the Secretary, every person who provides any individual with coverage under a plan which constitutes medical care shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains such information as the Secretary prescribes.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

"(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.".

(k) CONFORMING AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

"Sec. 223. Health savings security accounts.
"Sec. 224. Health savings accounts.
"Sec. 225. Cross reference.".

(2)(A) Sections 86(b)(2)(A), 135(c)(4)(A), 137(b)(3)(A), 219(g)(3)(A)(ii), and 221(b)(2)(C)(i) are each amended by inserting "223," after "222,".

(B) Section 222(b)(2)(C)(i) is amended by inserting "223," before "911".

(C) Section 469(i)(3)(F)(iii) is amended by striking "and 222" and inserting "222, and 223".

(l) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

SEC. 3. DISPOSITION OF UNUSED HEALTH BENEFITS IN CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j), respectively, and by inserting after subsection (g) the following:

"(h) CONTRIBUTIONS OF CERTAIN UNUSED HEALTH BENEFITS.—

"(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan solely because qualified benefits under such plan include a health flexible spending arrangement under which not more than $500 of unused health benefits may be—

"(A) carried forward to the succeeding plan year of such health flexible spending arrangement, ‘‘(B) to the extent permitted by sections 223 and 224, contributed on behalf of the employee to a health savings security account (as defined in section 223(d)), or a health savings account (as defined in section 224(d)), maintained for the benefit of such employee, or

‘‘(C) contributed to a qualified retirement plan (as defined in section 4974(c)), or an eligible deferred compensation plan (as defined in section 457(b)) of an eligible employer described in section 457(e)(1)(A), but only to the extent such amount would not be allowed as a deduction under—

‘‘(i) section 223 if made directly by the employee to a health savings security account of the employee (determined without regard to any other contributions made by the employee), and

‘‘(ii) section 224 if made directly by the employee to a health savings account of the employee (determined without regard to any other contributions made by the employee).

‘‘(2) SPECIAL RULES FOR TREATMENT OF CONTRIBUTIONS TO RETIREMENT PLANS.—For purposes of this title, contributions under paragraph (1)(C)—

‘‘(A) shall be treated as elective deferrals (as defined in section 402(g)(3)) in the case of contributions to a qualified cash or deferred arrangement (as defined in section 401(k)) or to an annuity contract described in section 403(b),

‘‘(B) shall be treated as employer contributions to which the employee has a nonforfeitable right in the case of a plan (other than a plan described in subparagraph (A)) which is described in section 401(a) which includes a trust exempt from tax under section 501(a),

‘‘(C) shall be treated as deferred compensation in the case of contributions to an eligible deferred compensation plan (as defined in section 457(b)), and

‘‘(D) shall be treated in the manner designated for purposes of section 408 or 408A in the case of contributions to an individual retirement plan.

‘‘(3) HEALTH FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, the term ‘health flexible spending arrangement’ means a flexible spending arrangement (as defined in section 106(c)) that is a qualified benefit and only permits reimbursement for expenses for medical care (as defined in section 213(d)(1) (without regard to subparagraphs (C) and (D) thereof).

‘‘(4) UNUSED HEALTH BENEFITS.—For purposes of this subsection, with respect to an employee, the term ‘unused health benefits’ means the excess of—

‘‘(A) the maximum amount of reimbursement allowable to the employee during a plan year under a health flexible spending arrangement, taking into account any election by the employee, over

‘‘(B) the actual amount of reimbursement during such year under such arrangement.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2003.

SEC. 4. EXCEPTION TO INFORMATION REPORTING REQUIREMENTS RELATED TO CERTAIN HEALTH ARRANGEMENTS.

(a) IN GENERAL.—Section 6041 (relating to information at source) is amended by adding at the end the following new subsection:

‘‘(f) SECTION DOES NOT APPLY TO CERTAIN HEALTH ARRANGEMENTS.—This section shall not apply to any payment for medical care (as defined in section 213(d)) made under—

‘‘(1) a flexible spending arrangement (as defined in section 106(c)(2)), or

‘‘(2) a health reimbursement arrangement which is treated as employer-provided coverage under an accident or health plan for purposes of section 106.’’.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after December 31, 2002.

□ 1715

The SPEAKER pro tempore (Mr. SWEENEY). Pursuant to House Resolution 299, the gentleman from California (Mr. THOMAS) and the gentleman from New York (Mr. RANGEL) each will control 30 minutes.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

This is an important day regarding all Americans' health care needs. Most people are focused on our seniors and the Medicare legislation, which will be before us shortly. We have before us now the Health Savings and Affordability Act, and I first want to thank my colleague, the gentleman from Illinois (Mr. LIPINSKI), for working with us in producing a bipartisan piece of legislation, which is extremely important to seniors accompanying the Medicare legislation, but really to all Americans, and especially those Americans who, through no fault of their own, today have no health insurance available to them.

This legislation creates two new savings accounts, a health savings account and a health savings security account. The basic idea is that people ought to be able to put their own money away, individuals, relatives, or otherwise who wish to help them put money away, and in particular instances, employers who adopt particular kinds of health care plans for their employees assist in putting money away for health care needs. These accounts will accumulate tax free and can be expended for any health needs.

Here is the really exciting and important new twist. There is no age limit at which you have to make all of the contributions paid out of the health savings account. It is literally lifetime assistance. Why is that important? Because today, as we pass the new Medicare modernization with prescription drug program, we will add tremendous new benefits, but there are other costs associated with the bill, both in acquiring prescription drugs and in making sure that seniors can pay for those additional costs.

It is not right to say that every additional benefit provided to seniors should be paid for by taxpayers. We are already in the midst of the greatest intergenerational transfer of wealth in the history of the world. But it is also not fair to say to hardworking Americans that when they retire they should pay out of their own pockets if we have not provided an easily affordable method to accumulate those dollars.

That is exactly what we have in front of us today: A health savings account that has a multiple number of ways in which money can be placed in to be paid for health needs not only while you are working but when you retire. There is no absolute payout. And if there is money in it when the senior passes, then it becomes part of an estate and that money, in its transfer, is taxable. There is no possibility of gimmicking the system.

The real concern is that we have told Americans oftentimes that they have to pay for particular costs, and yet we do not provide an easy and affordable way for them to do so. One of the big concerns we have today is chronic or long-term care costs for seniors. Time value of money is the best way to address a problem that is going to face most Americans. That is exactly what health savings accounts allow you to do. It is clearly an affordable health care cost if you have planned for it.

Unfortunately, too often today's seniors did not plan. There was not a program convenient and easy for them to plan. This allows them, in a prudent way, to put money away. Oftentimes we may want to help our parents, senior children. This is a way, through a health savings account, that they can place money available for seniors to be readily used for health savings accounts that provide a positive, tax-free environment for accumulating those dollars.

In so many ways, Mr. Speaker, this particular program will blend not only with the Medicare changes that we are going to be making but in terms of meeting the needs of today's workers as well. It is completely portable, it is a fund that accumulates tax free, and it belongs to the individual. They can take it with them wherever they may want to work.

Mr. Speaker, I ask unanimous consent that the control of the balance of my time be by the gentleman from Wisconsin (Mr. RYAN).

The SPEAKER pro tempore. Without objection, the gentleman from Wisconsin (Mr. RYAN) will control the balance of the time.

There was no objection.

Mr. RYAN of Wisconsin. Mr. Speaker, I reserve the balance of my time.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

The chairman of the Committee on Ways and Means connected this bill with senior citizens' inability to plan for their future. Well, I am glad he is sending them a signal, because after what they intend to do with seniors with the Medicare bill, somebody might have planned for their futures.

I remember in the good old days when Republicans used to say that they were going to travel around the country and pull the Tax Code up by the roots. That meant they were going to close loopholes, get rid of shelters, and to have a system that people did not have to hire accountants and lawyers in order to know what their tax liability would be. I even volunteered to drive around with them on these buses to see just how they intended to put back a Code that was more equitable and fair and one could understand.

But while the gentleman from California (Mr. STARK) still thinks that some of them are on the level as relates to health, I asked for the opportunity to at least open up this debate just so that people who are not on the floor would understand that this has nothing to do with health. It has a heck of a lot to do with wealth and more to do with shelter. They have to find ways to make certain that the deficit gets larger and that there is no money in the Treasury to take care of the problems that we used to say was a Federal responsibility. How do you do it? Just being creative.

Why, they do not even need a chairman of a Committee on the Budget because there are no budget restrictions. Last night, this bill was supposed to be going over to the Committee on Rules at a cost of $71 billion over 10 years. What imagination. What creativity, when just overnight they found out that the bill really costs $171 billion. How can Republicans be so smart that just overnight, without hearings, without checking with Treasury, without talking with OMB they can find $100 billion?

Now, what is the cost of $171 billion? It is simple: It means that people who make up to $150,000 and are well do not have to pay taxes on storing away $4,000 in a tax shelter. So if you are working for someone and you make up to $150,000, you never have to pay taxes on the money, whether you are sick or whether or not you retire with the money. This is really just a tax-free grant to some of the people who are friendly to people on the other side.

But what about the people that do not have the $4,000? Now, that is the problem, because you are not eligible for this unless you do not have expenses that will be paid for for $1,000. So if an employer really cares for you and wants to have you eligible for this tax shelter, the best favor he can do for you is to take away your health insurance. And, of course, you make the killing on your savings by not paying taxes. And so once he does you this favor, he has to do it for the lesser-income people, and lo and behold, we will find that those who cannot afford to stash away this money, because they do not have disposable income, end up with no insurance and no savings account.

Oh, one might say this is cruel, but sensitivity never bothered the majority party, because at the end of the game they want to know how much of the people's money did you leave with them. Or to put it another way, how much did you take away from the Federal Government so that we cannot provide basic services.

So the gentleman from California (Mr. STARK) need not worry. This savings account has nothing to do with health. It has everything to do with shelter.

Mr. Speaker, I ask unanimous consent that the balance of my time be turned over to the gentleman from California (Mr. STARK) and that he be given the authority to allocate time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

The SPEAKER pro tempore. The gentleman from California (Mr. STARK) reserves the balance of his time.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just heard the ranking member say this is not a health bill, that this is a tax shelter. I beg to differ. Number one, what we are talking about here is really novel and revolutionary. We are saying that employers and employees can together contribute to their own savings account with pretax dollars, with tax- deductible dollars to purchase health care spending and to have a catastrophic plan.

The gentleman from New York said, what about the people who do not have $4,000 to put in their health security savings account? Well, their employer can put $4,000 into their account. The purpose of this reform, Mr. Speaker, is to get at some of the big issues that are really hurting this country, and that is the cost of health insurance, the affordability, and the accessibility of health insurance.

So what this reform does is it equips the individual in the family with the ability to go out into the health care marketplace with tax-deductible dollars to act like good consumers and buy their health insurance. It gives incentives. It actually requires, on health savings accounts, that employers provide catastrophic health insurance, or individuals who have their own health savings accounts have catastrophic health insurance. So it makes sure that people have health insurance if they really run into problems. But it allows people to manage their health care expenditures themselves.

You know, it is often said that we spend more time shopping for cars or computers than we do for our own health insurance. Well, the reforms in this bipartisan Thomas-Lipinski bill give us those incentives to act like good consumers so we can watch our health care dollars. Health care inflation is out of control. Health care spending is out of control. Premium increases facing small businesses and individuals are out of control. We need to give consumers the ability to get it under control. That is what this legislation does.

I am also interested in the argument that this is somehow fiscally irresponsible. I find that kind of a unique argument, given the fact that the gentleman from New York is about to bring a prescription drug substitute amendment to the floor that spends $600 billion more than the Republican plan does; a trillion dollar bill that spends a trillion dollars on his prescription drug bill versus the $400 billion that was paid for in the House budget resolution, as is this health savings account legislation.

Mr. Speaker, I reserve the balance of my time so that the other side can yield time.

Mr. STARK. Mr. Speaker, I yield myself 3 minutes.

Mr. STARK. Mr. Speaker, I will start with an apology to all my Republican colleagues. For, oh, at least the 30 years or so I have been here, I have been accusing the Republicans of not being inclusive, just dealing with the rich and forgetting about the minorities and the working people in this country. With this bill they have become broadly inclusive. Later on tonight, they are going to take the first step in destroying health care for seniors, and then, because they are being so inclusive with this bill, they are going to screw everybody. They are going to destroy health care for the employees who get their health insurance from employers.

As the distinguished ranking member of our committee pointed out, $100 billion was added to this in the middle of the night, and the bill will be funded by borrowing, by increasing the national debt and worsening deficits. And all it really does, if you cut through all the Mickey Mouse that they have talked about, high-deductible insurance, is that it creates some new tax-exempt savings accounts. Tax shelters for the wealthy and the healthy. And it advances the objective of undercutting employer-provided health coverage.

It is no secret that the distinguished chairman of the Committee on Ways and Means has expressed his desire to dismantle the employment-linked health insurance system, and he has noted that he believes it encourages overutilization of health care because individuals are shielded from knowing the true cost.

□ 1730

Now, the argument that the bill will assist the uninsured is not true. Most of the uninsured have incomes too low to be eligible for any tax benefits contained in H.R. 2596. And as was stated earlier, few, if any, have the $4,000 a year in additional savings required to utilize the benefits contained. There is nothing in this bill that requires the employers to give the employees any money to make up for that gap that will be created by the higher deductibles. It merely gives them the opportunity, if they have any money, to add to savings accounts.

Not surprisingly, the same 6 million families who were deliberately excluded by the Republicans from the recent tax bill for child tax credit are the same families that they are excluding from benefiting in this bill. So for families with insurance, it provides tax benefits only if the insurance requires them to pay the first thousand dollars; and employers will be encouraged by this nonsense to increase health insurance deductibles, which lowers their costs and lowers the benefits for most of their employees' health insurance.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. DUNN), a member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, I am very happy that we have this bill on the floor finally. I think it serves a real need, and it provides total flexibility to people who want to provide for the coverage of their health care expenses.

One particular provision that appeals to me is one that we used to refer to as a catch-up health savings account contribution. We now call it a health savings security account, and these are accounts that are designed particularly for people who are age 55 or older. It gives them the right to contribute additional dollars every year into their health savings accounts because of particular situations they might have faced in the past.

The flexibility of HSAs is widely known. These dollars can be used for any health-related expense as long as it is not reimbursed. For example, they can be used to pay for long-term care or for health coverage policy or doctors' bills or for prescription drugs; but what is special about the health savings security accounts is in the way it applies to people like me. Many people, particularly women, during their child-raising years took time away from the workplace and often did not add money into accounts like IRAs, or actually Social Security accounts, and ended up with big goose eggs when the time came to calculate their benefits.

In this case, the health savings accounts provide for folks who took time off during their child-raising years, or to look after an ill parent; and it allows them to add up to 25 percent in additional dollars each year to their health savings accounts. This will begin in operation as soon as this bill is enacted. An individual age 55 or older can contribute $500 a year in addition to the total health savings account. That amount will grow to $1,000 in 2009, and I think it is a very sensitively written provision to help folks who have been away from the workforce or need this additional provision.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. LEVIN), a member of the Committee on Ways and Means who understands that with this $174 billion that we are wasting in this bill, we could help States maintain Medicaid coverage as they weather their fiscal crisis.

Mr. LEVIN. Mr. Speaker, this came out of the wee hours of this morning, but I want Members to realize how radical a move this is. We are going to have later today a radical effort to dismantle Medicare. What this is is a radical effort to dismantle our employer-based system in this country. So now we are going to take a step toward a kind of voucher for health insurance in the form of a tax credit. That is what we are going to do.

Those who can afford to use the tax credit will have that voucher, and they will go out into the marketplace. The consumer, each individual one, is going to try to swim as best as they can. But for those who do not have the money to put in this account, who have no benefit from the tax credit, they are going to continue not to swim as an individual consumer, but to sink. That is what is going to happen. That is why this is so radical.

Now, the other side of the aisle said we want to add money into Medicare in the prescription drug proposal. They are darn right. We did not create this deep deficit. Their answer to a deficit that is deep is to dig it deeper. In the middle of the night or early morning, you add $100 billion to the deficit; and I want to quickly read what this looks like.

We were supposed to have with the March baseline a deficit of $377 billion. We added $484 billion through what was called a technical reestimate. Then through legislation, we added what was it, 700 to $800 billion. Now the projected deficit, $1.5 trillion, four times what was projected a few months ago, and this does not include the bill that is going to be brought up later or additional military expenditures. It does not include this $100 billion. I tell the gentleman from Wisconsin (Mr. RYAN), this is fiscally irresponsible. You Republicans have zero fiscal responsibility in your political veins. Zero. This is radical because it is going to dismantle the employer-based system.

PARLIAMENTARY INQUIRY

Mr. HAYWORTH. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore (Mr. SWEENEY). Does the gentleman from Michigan (Mr. LEVIN) yield for a parliamentary inquiry?

Mr. LEVIN. No, Mr. Speaker. I will not yield for a parliamentary inquiry.

Mr. Speaker, as I was saying, you are not only going to dismantle Medicare later as a first step, and now try to dismantle the employer-based health care system in this country; but what you are doing is digging a deeper, deeper hole of debt in this country. This is a radical proposal on all accounts, and it should be rejected.

PARLIAMENTARY INQUIRY

Mr. HAYWORTH. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. HAYWORTH. Mr. Speaker, is it appropriate for a Member to address his comments directly to another Member, or should those comments be directed through the Chair addressing the Member?

The SPEAKER pro tempore. All remarks should be directed through the Chair.

Mr. HAYWORTH. Was it true that the preceding gentleman addressed a Member directly?

The SPEAKER pro tempore. All remarks in debate should be directed to the Chair.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, to respond to a couple of comments from the last speaker, I would say, number one, we are going to keep hearing this rhetoric, that this undermines or destroys employer-sponsored health care. Actually, it is far from that. It is the opposite of that. This makes it easier for employers to offer health care to their employees. What this does is it makes it easier because employers can offer less-costly catastrophic coverage and give their employees money, pretax money in their accounts, to purchase health care. This will lower the cost of health insurance and make it cheaper for employers to offer health care.

Mr. Speaker, I yield 2½ minutes to the gentleman from Arizona (Mr. HAYWORTH), an esteemed member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, again, as we come to the well this evening, we see a very vast difference in our visions of health care and visions of America.

Our friends on the left who later tonight will offer a $1 trillion government command-and-control approach to prescription drugs now take strong objection, to put it diplomatically, about a plan that, yes, initially is expensive. I would grant Members that billions are real dollars here, but it substantially supplements and expands the ability of people to have health insurance.

As the gentleman from Wisconsin (Mr. RYAN) mentioned, it gives employers more options to provide that type of insurance by embracing catastrophic plans and freeing up dollars to go to employees, and as we see in the case of health savings security accounts, and this is the key, and I would urge my colleagues to understand this, as so many have come to the well of this House on both sides of the aisle and lamented the numbers of uninsured Americans, not the medically indigent with whom we try to deal through Medicaid, but those who are working people who do not have insurance, this provides an option to those people to embrace insurance. To realize savings, yes, does require a modicum of personal responsibility, undoubtedly.

But, Mr. Speaker, certainly we have not degenerated to the point where we absolutely forsake a notion of personal responsibility in savings. What we do is offer options that will supplement health care; and despite the cat calls and poisonous partisan rhetoric, it is worth noting that this is bipartisan legislation.

So again a cautionary note to my friends on the left. If you believe you are indicting one party, stop and think; many of your colleagues who share both the party label and broad-based philosophy, as my friends on the left share in many different areas, join with us in this legislation because they understand it opens opportunity for health insurance, it opens opportunity for individuals, it opens opportunity for employers, and it will lead to more people seeking the insurance we all want to see them have. Vote "yes" on this legislation.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. McDERMOTT) who realizes that with this $176 billion we could insure every one of the 9 million uninsured children in this country.

Mr. McDERMOTT. Mr. Speaker, I think it is important to realize that last night a miracle occurred in this body, a bill that left the committee costing $73 billion sometime after midnight suddenly became $173 billion. An actual miracle in the Committee on Rules.

The fact is Members have to understand why that happened. All Members make $150,000 a year. They were not covered by this bill. It only went up to $65,000; but in the Committee on Rules they said, let us put ourselves in this bill, so they raised it up to $150,000 so that we could take benefit of this. Now that was a thoughtful thing for them to be doing, but did they think about the people in your district?

My employees at Boeing, they get $65,000 a year. It is a pretty good paying job, and they get good benefits from their company. What is to stop their company tomorrow from saying, We are going to give you a $10,000 deductible policy, and we will put $500 into your account, you put $3,500 in, and you will have it all for yourself? They can do that. They can end a defined benefit package at Boeing tomorrow and give a defined contribution. Give employees a voucher, and say they are on their own. Do Members want them to strike over that?

Mr. Speaker, how about the woman making $30,000 teaching school. We all know those school teachers are rich people. You end the school program, the State governments are in trouble, they could say let us stop giving insurance to the teachers, let us just give them a $10,000 deductible policy, put $500 in their savings account and say to the $30,000-a-year teacher, they can come up with $3,500 to put into their account.

□ 1745

I love to hear people who make $150,000 talk about what it is like to be in this country making $30,000, which is the average pay. Or the people making $18,000. They work every day. They have no insurance. Do you think they have $3,500 to put into a savings account?

This is for rich people. That is why it went up $100 billion miraculously between a $65,000 income limit and $150,000. It only cost 74 for all the people at the bottom, but it cost 100 for us. This is a bad bill.

What it does, also, it says people are going to get out of the pool. People who are rich and healthy are going to get out of the pool, and they are going to leave the sick and the poor in the pool. And what happens to the premiums for the average person? They go up. The idea of insurance is to spread the risk, and you are letting the wealthy and healthy get out of the pool.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself 15 seconds to respond just briefly only to say that health care is voluntary by businesses. Mr. Speaker, Boeing could drop their health care right now, today, to their employees. And, Mr. Speaker, that is what is happening today. Millions of businesses are making those kinds of decisions to drop health care. We are trying to make it more affordable. We are trying to keep it so that businesses can still offer health insurance at an affordable price to their employees.

Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. ROYCE).

Mr. ROYCE. Mr. Speaker, I thank the gentleman for yielding me this time. This measure will make it easier for employers to offer health care to their employees. It is also going to help Americans save for their medical expenses, to gain greater access to quality health care. I particularly support the provision in this bill that would prevent a portion of the unused balances and flexible spending arrangements from being forfeited at the end of the year. Right now there is a use-it-or-lose-it provision that applies to workers. I have been working for several years to allow individuals to accumulate unused balances from their flexible spending arrangements to save for health care expenses. In this Congress I introduced H.R. 176 to allow individuals to accumulate $2,000 annually from these FSAs, as we call them.

Right now we have over 30 million workers in the United States that have these FSAs available to them. Employees and employers can set aside pretax money which can be used to pay for out-of-pocket health care expenses and copayments and deductibles. Under the current system, unfortunately, employees forfeit money not used at the end of the year. Currently, this encourages wasteful health care spending because employees, knowing that they will forfeit unused account balances, engage in end-of-the-year spending sprees on services they may not need like extra eyeglasses, shades or unnecessary exams. So eliminating the use-it-or-lose-it provision solves this problem because then the employee will be able to roll over the balance from year to year. That is the attempt in this bill on that provision.

Preventing some forfeiture also increases the savings rate by increasing the disposable income of those employees in the program, and it also empowers them to make their own health care decisions. I urge my colleagues to pass this legislation.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds. I have a couple of letters, one from the AFL-CIO which suggests that this legislation would establish an enormous tax shelter for wealthy individuals and at the same time undermine employer-based health coverage and shift costs onto workers. I have a letter from Families USA which, among other things, says that this bill also threatens the employer-provided health insurance system particularly among smaller employers who will be able to take deductions in the top brackets and who will then no longer be interested in providing coverage for their employees.

Mr. Speaker, I include both letters for the RECORD.

AMERICAN FEDERATION OF LABOR
AND CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington, DC, June 26, 2003.

DEAR REPRESENTATIVE: The AFL-CIO opposes H.R. 2351, the Health Savings Account Availability Act. This legislation would establish an enormous tax shelter for wealthy individuals and at the same time undermine employer-based health coverage and shift more cost onto workers. Despite proponents' claims, this bill would fail to expand coverage to the uninsured and would be especially harmful to those low-income, older and sicker workers who now have comprehensive coverage.

Under H.R. 2351, employers could offer Health Savings Accounts as long as they are provided in conjunction with high-deductible health insurance policies, defined as at least $500 for an individual policy and $1,000 for a family plan. This will encourage employers to abandon more generous coverage and offer instead less comprehensive policies that shift significant costs onto workers. The Joint Committee on Taxation has estimated that 30 million such accounts would be established by 2013 and the majority of employers would modify their health plans to meet the high-deductible guidelines of the legislation.

In addition, this shift in coverage would harm most those workers who need health care. Low-income workers who are the intended beneficiaries of these plans' preferred tax treatment are not likely to get back enough in taxes to offset the greater out-of-pocket costs they are likely to incur with these high-deductible plans.

Furthermore, those workers and other insured individuals who have traditional, more comprehensive coverage will see their premiums rise. Younger, healthier workers will likely choose the less-comprehensive coverage, leaving older and sicker workers and those who earn too little to pay taxes in traditional coverage. As a result, costs for this coverage will rise, leaving workers with no choice but to enroll in the high-deductible coverage this bill seeks to promote.

This legislation was slipped through the Ways and Means committee last week, and made worst late last night in the Rules Committee. Among the changes made in Rules, the income threshold has been raised to $175,000 for joint filers. The cost of the revised bill is estimated to be $174 over ten years—more than twice the estimated cost of the bill that passed Ways and Means last week—and makes clear that this legislation is first and foremost another tax shelter, not a bill to cover the uninsured.

H.R. 2351 was raised just last week with little notice and certainly without any hearings, despite the bill's far-reaching implications and significant cost. And now the House leadership has called for it to be joined with the Medicare prescription drug legislation before the House. I urge you to vote against H.R. 2351.

Sincerely,

WILLIAM SAMUEL,
Director, Department of Legislation.

FAMILIES USA
Washington, DC, June 26, 2003.

Hon. CHARLES RANGEL,
Rayburn House Office Building,
Washington, DC.

DEAR REPRESENTATIVE RANGEL. On behalf of Families USA, the national advocacy group for health care consumers, I am writing to oppose the Health Savings and Affordability act of 2003 (H.R. 2596). Implementation of the Health Savings Accounts (HSAs) and Health Savings Security Accounts (HSSAs) will do little to expand health insurance coverage to the 41 million Americans who are uninsured.

This bill creates two programs loosely modeled after existing Archer Medical Savings Accounts (MSAs). Rather than targeting limited federal funds to provide help for the lowest-income uninsured, this bill creates tax-free accounts, the HSSA's, which can be accessed by families with incomes up to $150,000 before starting to phase-out. The total cost of this bill is over $169 billion over ten years—a huge federal investment that will do little or nothing to cover the low-income uninsured. The people who deserved to be helped in any health legislation are being ignored by this legislation. If this huge commitment of resources were applied to an expansion of the Children's Health Insurance Program or to Medicaid, we could cover every uninsured child in America (about 8.5 million) with excellent care and have money left over to help their mothers! To casually, and with so little debate, spend these huge resources on so many higher-income individuals is a travesty of the legislative process.

This bill also threatens the employer-provided health insurance system, particularly among smaller employers who will be able to take deductions in the top brackets for their personal insurance and who will then no longer be interested in providing coverage for their employees.

We look forward to working under your leadership to reject this bill, and instead to work for real and meaningful mechanisms to expand coverage to the uninsured in this country. Thank you for your continued commitment to this issue and to reducing the number of uninsured Americans.

Sincerely,

RONALD E. POLLACK,
Executive Director.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Speaker, let me thank the gentleman from California for yielding me this time.

Mr. Speaker, I really do not know where to start, to start answering some of the critics and the proponents of this legislation. This bill started out about a week ago or so in the Committee on Ways and Means, which I serve on, and the cost was $14 billion. Then the day the bill came up, the cost rose to $72 billion. And then last night the cost went to $173 billion. Mr. Speaker, let us pass this bill quickly, because I am afraid it is going to continue to grow. But that does not make it a good bill.

What is going on here, my friends, is this is the demise of the employer-sponsored health care system in this country. The employers do not like it. They want to get out of it. Members of the committee, including the chairman, have indicated that their desire is to dismantle the employer-based health care system. This bill does it.

How does it do it? It gives the employer an option. It says, Mr. and Mrs. Employee, we are changing your health policy. I am going to give you one starting next month that will provide for a $2,000 deduction on your health care costs. Start saving, because the Congress passed a bill where you can save and then you pay the first $2,000.

It sounds fine in principle, but here is the problem, my friends. Working families in this country have to first of all pay the mortgage so they do not lose the home, pay for the car so he can get to work, feed the kids and clothe them and send them to school, and then this Congress has already told you that the past generation has been irresponsible, they did not plan for their future and you better. So put money away for your retirement in an IRA and a 401(k). And you say, yes, because Social Security probably will not be enough, I will do that. Then this Congress said, college education is going up, mom and dad, start saving for your kids' education. And so you say, yeah, I will put a couple of thousand away a year for Johnny's and Sally's education.

Now we are saying to you, after all this, we have got another one, start saving for your health care. Then you say, Mr. Republican Congressman, I am out of money. I do not make that much. I do not have any more disposable income. And so when your employer changes your health plan and you do not put the $2,000 or $4,000 away when you get sick, you are out of luck. That is what is going on here. Make no mistake about it.

Mr. STARK. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Texas (Mr. DOGGETT), a member of the Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, once again Republicans insist on a fiscally irresponsible bill that will benefit the wealthiest and in this case the healthiest at the cost of at least $174 billion added to our already soaring national debt.

Mr. Speaker, despite the bright sunshine outside, it really is a dark day for so many Americans who are working hard just to make ends meet. This bill is the natural companion to a measure written by the same folks that are presenting this bill, which previously denied a child tax credit to poor working folks. Tax cuts, no matter what the economic conditions, no matter how pressing are the other priorities we have in our country, such as protecting our families from terrorism, tax cuts, we are always told, can cure any ill in our society, unless of course you are poor and working, in which case your kids are not worthy of a child tax credit.

Thanks to the intransigence of the House Republican leadership, there are now 6 million working American families, they are folks like cafeteria workers and teachers' aides, nursing home employees, those working at our hospitals doing the tough work, they will receive no check for their children this year like other Americans. Their bid to gain a little economic independence, to share in the economic benefits of the American Dream, it will come and go on July 4 unfulfilled because of the refusal of this House Republican leadership and their desire to go on recess not only for July 4 but to continue their recess from reality.

For these same families that were deliberately excluded from the recent tax cut as well as for many other working families, House Republicans add more insult to injury by encouraging employers to terminate or to weaken any group health insurance coverage through which some of these employees may be covered. This bill is also the natural companion to the next bill that we are about to take up, the bill to repeal Medicare as we have known it, since President Lyndon B. Johnson signed it into law. We know this is not new. They have opposed Medicare since before President Johnson wrote his signature to make it a reality. Newt Gingrich wanted it to wither on the vine. Earlier this month, Mr. Gingrich declared, much as our colleagues are here today, using the very same words that they got from Newt Gingrich, that it was an "obsolete government monopoly."

Only yesterday we heard the same language from the sponsor of this measure: "To those who say that the bill would end Medicare as we know it, our answer is, 'We certainly hope so.'"

"Old-fashioned Medicare isn't very good," said Bill Thomas, the sponsor of this legislation and the companion measure to repeal Medicare tonight.

Some of us think old-fashioned Medicare has worked pretty well for the millions of Americans that it has served since 1965, and we want to strengthen it, not see it undermined through into privatization.

The bill before us this afternoon does something very similar to what the later bill proposes to do to Medicare and, that is, to weaken, at great cost to our Treasury, our employer-based health care system. By totally excluding employees unless they are in plans that deny any assistance on at least the first $1,000 or $2,000 in medical bill coverage, this bill will encourage even higher deductibles. And it will be a struggle for a cafeteria worker to pay their first $1,000 or their first $2,000 or more-thousand under these new high-deductible plans.

The same plans will encourage more small employers to stop providing coverage at all and to protect themselves individually through these MSAs and to terminate costly health insurance for their other employees. It will encourage group health plans to reduce covered services, increase copayments.

In short, through these three bills, we see Republican indifference from cradle to grave for children, for workers, for seniors.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. ENGLISH) to talk about this legislation that we are debating, health savings accounts.

Mr. ENGLISH. Mr. Speaker, I really wish more of the American public were watching this debate because they would be able to fully appreciate how marginal the left has become to any serious debate about the problems facing this country. What we are going to be doing tonight is not voting to repeal Medicare, but instead voting to pass this bill, which is a bill that would provide more medical security for uninsured Americans as well as many low- and middle-income workers.

This legislation actually creates two new instruments to meet health care needs by rewarding Americans who open either type of account with tax advantages and maximum flexibility, so as the other side has noted, even the healthy can have a greater role in managing their own health care. Encouraging individuals to enroll in these new savings vehicles has multiple benefits. First, this is a big step to make health insurance more affordable and help reduce the growing number of Americans without health insurance. The tax-preferred nature of the health savings security accounts offers a powerful incentive for uninsured workers to take advantage of these accounts. The contributions to the accounts are deductible; the investment earnings within the accounts tax-free; and the distributions are also tax-free when used for health insurance. Many, including the self-employed, would find this enormously valuable. This results in significant savings on health insurance, an economic benefit that is certain to encourage many uninsured Americans to utilize these accounts.

Second, insured workers with high-deductible plans will also see similar incentives. Both savings vehicles give individuals a potent incentive to save for health care costs that do not fit within their deductible, giving them another option and perhaps some peace of mind about unanticipated medical expenses. The medical expenses that qualify for tax-free distributions are very far reaching and include expenses from preventive care to long-term care. When individuals use their own hard-earned dollars for health care, they will ask more questions, further inform themselves, and become better consumers of health care products. This bill undoubtedly promotes an educated and wise consumer of health care services and will result in all-around better health care decisions.

Our current Tax Code puts a punitive burden on working families who save their own money for medical and other expenses. The health savings accounts ease that burden by providing two simple and flexible savings mechanisms for working families.

☐ 1800

This is commonsense legislation that makes health insurance and health care more affordable and tax advantaged for Americans. It does not destroy our health care system and it does not dismantle Medicare. Accordingly, I urge my colleagues to give workers control of their own health care and vote for the creation of health savings accounts.

The SPEAKER pro tempore (Mr. SWEENEY). The Chair advises Members that the gentleman from California (Mr. STARK) has 9 minutes remaining and the gentleman from Wisconsin (Mr. RYAN) has 12¼ minutes remaining.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE), who understands that we could cover the parents of low-income children who are eligible for Medicaid and CHIP with the same amount of money.

Mr. PALLONE. Mr. Speaker, I just do not know how many tricks or hoaxes the Republican leadership is going to play on us tonight and on the American people. It is unbelievable. I listened to the gentleman from Pennsylvania. He said there is going to be Medicare reform tonight. There is not going to be Medicare reform. It is just going to be an effort to kill Medicare and destroy Medicare. And then they say they are going to bring up a prescription drug benefit tonight that really is not any meaningful benefit that forces one into HMOs, that denies them of choices of doctors and hospitals. And now this one, the ultimate trick, which I guess we did not really even know about until today, that basically tries to undercut employer-based health insurance.

When does it end? When are the Republicans going to end what they are trying to do to destroy the health care system?

Mr. Speaker, although we would like to provide health coverage for those who are uninsured, this bill does little or nothing to help the low-income uninsured. Individuals eligible for the tax credit under the Thomas bill would have to be uninsured or in high deductible plans, but according to the bill, starting in 2004, those individuals could set aside up to $2,000 tax free into a new health savings account to supposedly help pay for health insurance. But the argument that the bill will assist the uninsured is simply not true. Most uninsured have incomes that are too low to owe Federal income tax liability, let alone have $2,000 to set aside for this purpose. In addition, self-employed individuals, the other large segment of the uninsured, may already deduct 100 percent of the health insurance costs.

The only consequence of this bill is to undercut the provision of employer-sponsored health care coverage by encouraging employers to raise deductibles or potentially drop their coverage and raise the cost of health care for low income, older and sick workers with higher co-payments and premiums.

And, lastly, as many of the speakers on our side have said, this legislation will cost the government over $173 billion, another in a series of fiscally irresponsible tax cuts passed by the House. The entire cost of the bill will be funded by borrowing, increasing the national debt.

Where does this end? We have a national debt 4-, $500 billion. Where is it going to end?

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentleman from Nebraska (Mr. TERRY).

Mr. TERRY. Mr. Speaker, when will it end? I am saddened by the arguments from the left that fail to recognize that there are more people in America that want to have choices. They do not want just the offering of a government program one size fits all. Not everyone thinks that the government is the answer to everything. So I am proud to support bills that allow the market to provide opportunities and choices, and that is what tonight is about. I am wondering sitting here listening to the debate what some of our Founding Fathers would think of today's debate. Think about the people that started this country that left their countries to set sail on a venture unknown to come to a new land for what? Freedom. Trying to escape the government powers that were controlling their lives. And now 200 or 300 years later from those first people that landed on our shores, our debate is how far government is going to control their health and their lives. Not everybody wants bureaucrats running their health care. So I am proud to stand in favor of the HSAs.

Mr. Speaker, in today's world us baby boomers, and, yes, I am on the tail-end, there are a few others that are nearing their entry into Medicare, but we are facing a crisis too. Our parents need help in today's world. At the same time that we worry about our parents' health and their futures and what our role is as their children will be in helping them in their golden years, we are also raising our children, trying to save for their college and their future. This is one pro-family tax item. It allows me, as the child of a father who had a stroke last October, to help my parents with their health care costs. So this is one great pro-family tax measure, and I urge my colleagues to support it.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Mr. Speaker, I thank my colleague from California for yielding me this time.

Earlier the speaker before me talked about choice. In the prescription drug debate we are having, I have talked about choice and I have an amendment, a bipartisan amendment, to offer people choice between generic versus name brand drugs that would reduce prices so people could pick cheaper drugs. Also part of the provision allows individuals, government, private sector, to buy medications anywhere in the G–8 countries and have competition so they can get drugs cheaper in Germany or France or Canada or Italy. That would drive prices down.

I too agree with competition. The free market would drive prices down. So those of us who embrace the free market wonder why sometimes our colleagues on the other side are so scared of the free market. I have seen that the benefits of the free market work. I would like to see it come to the discussion we have on a prescription drug bill because if we bring that competition of the free market to the debate about prescription drugs, we will make medications more affordable to all Americans of all ages.

The interesting thing is there are two issues that are driving health care inflation at 25, 30 percent for the public. One is the cost of prescription drugs. Two is the 42 million uninsured who show up in our emergency rooms, driving up hospital costs which insurance companies pass on to employers and employers pass on to employees. And if we wanted to insure the uninsured, we can do it for a lot less money than this. Expand Kid Care. In Illinois we have a program known as Kid Care, insurance for the children of working parents, that expands the kid care to family care.

What is most interesting about this debate is that we have a prescription drug bill coverage for Members of Congress that is far more generous than the one that we are about to provide for our elderly. Those are the wrong values. Those are not the values that we came here to represent.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 30 seconds to the gentleman from Louisiana (Mr. MCCRERY), from the committee.

Mr. MCCRERY. Mr. Speaker, the immediate preceding speaker, the gentleman from Illinois (Mr. EMANUEL), spoke about the free market and letting free market forces work with respect to prescription drugs, and his solution is either import drugs from other countries and sell them here of course at lower prices or let us adopt the prices that are paid in those other countries here in our country, and he calls that the free market.

What he failed to point out is those drugs and those prices that he would be importing or adopting the prices out here are set by government price controls, not the free market.

Mr. EMANUEL. Mr. Speaker, will the gentleman yield?

Mr. MCCRERY. I yield to the gentleman from Illinois.

Mr. EMANUEL. Mr. Speaker, the fact is we would have competition. It is a Gutknecht-Emanuel bill with a number of the gentleman's colleagues on his side and a number of colleagues on my side. The three provisions to this bill, A, allow generics to come to market quicker so name brand pharmaceutical companies could not be involved in frivolous lawsuits.

Mr. MCCRERY. Mr. Speaker, reclaiming my time, the issue of generics is addressed in the underlying bill that we will be debating later tonight, but the gentleman spoke about bringing drugs in from other countries and selling them at prices that have been imposed by governments, not by the free market.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I thank the gentleman from Wisconsin for yielding me this time.

H.R. 2596 will increase access to consumer-based health coverage to all Americans regardless of income. Under H.R. 2596 the availability of health savings accounts will assist those that live without health coverage and give Americans more options when it comes to their health. Health savings accounts will promote savings and more direct health purchasing.

The character of these accounts will also simplify the doctor-patient relationship. As a physician, I know firsthand the difficulty some patients have working through their insurance companies and trying to figure out what services are covered by their policies. With a health savings account, patients can focus their attention on their medical care. They can discuss their needs with their doctors frankly and honestly, and they can proceed with appropriate medical treatments that they need.

My colleagues on the other side of the aisle are more prepared to force people into a one-size-fits-all solution instead of giving individuals the choice or the purchasing power to make decisions for themselves.

I myself have had a medical saving account since 1997, that is, until I came to Congress, and it was coverage that I made available to everyone in my practice as a choice. It was not a requirement. If someone wanted the chance to be in charge of their medical decisions and a chance to build wealth in one of these accounts for future medical expenses, I thought it was only prudent as an employer to provide that opportunity.

Mr. Speaker, we talk about the evils of HMOs, and the Members on the other side of the aisle are frequently mentioning the evils of HMOs, but this is the anti-HMO. Put the purchasing power back in the hand of the patient.

These plans are centered on the concept of personal choice. These accounts make more money available to purchase health coverage. We need to be serious about the solutions when addressing the problems of the uninsured in this country. An individual will make rational decisions when they have the ability to spend their own money on their health services.

I ask my colleagues, I implore my colleagues, not to stand in the way. Give Americans the freedom to make this decision.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. INSLEE).

Mr. INSLEE. Mr. Speaker, in regard to the Medicare bill we will be considering this evening, I thought about coming down to the House and asserting that this bill was a Trojan horse, but I think it is worse than a Trojan horse. I do not think it would be fair to the Trojan horse metaphor to call this a Trojan horse. And the reason is, is when the Athenians sent the horse to the Trojans, they did not announce in advance that the horse was full of soldiers that were going to attack the city. They kind of kept that a secret. But the Republicans have not kept any secrets about this horse at all because if we look at what the gentleman from California (Mr. THOMAS) said, "To those who say that the Medicare bill would end Medicare as we know it, our answer is we certainly hope so."

If the Athenians had announced that the gift, the alleged gift, they were sending was going to destroy the city they were attacking, no one would have bought that old nag. And it is the same situation here. We should not buy this old nag of a bill with the expressed intent of destroying Medicare over the next 10 years. And, yes, it is complicated on how that is going to happen. And, yes, it is a little bit chaotic in explaining it. But the Members can rest assured that America's senior citizens are going to figure this out. They are going to figure out this is worse than a Trojan horse because they see it coming. We should reject this and adopt the Democratic substitute.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. HARRIS).

Ms. HARRIS. Mr. Speaker, today the House of Representatives stands at the threshold of passing landmark legislation that protects and improves Medicare while providing our seniors with a real prescription drug benefit. While the debate remains properly focused upon this moral obligation to our seniors, I wish to highlight another exciting component of health care reform that we will address today.

H.R. 2596, the Health Savings and Affordability Act of 2003, authorizes the creation of health savings accounts which will enable every American to pay their basic medical expenses from tax-free money. In almost every purchase of goods and services except health care, individuals bargain directly with vendors and providers.

□ 1815

Assuming an adequately competitive market, suppliers will not charge more than buyers are willing and able to pay for very long.

The structure of our current health care system pushes consumers to the sidelines. Big insurance companies negotiate prices with big health care conglomerates, producing a distorted market and more expensive health care, prescription drugs, and health insurance premiums for the uninsured and self-employed.

H.R. 2596 allows Americans, particularly Medicare-eligible seniors, to use health care savings accounts to pay for medical expenses, prescription drug costs, retiree health insurance expenses, long-term care service, and COBRA coverage. It permits family members and employers to make tax-free contributions to these accounts.

The nature and uncertainty of health care expenses will always require critical programs such as Medicare and an efficiently-operating insurance industry. That is why the reforms that we will adopt in H.R. 1 are so vital.

Nevertheless, through the magic of the free market, H.R. 2596 will reduce costs that many Americans pay for the most basic health care needs, while forcing our entire health care system to become more efficient.

Mr. STARK. Mr. Speaker, I am delighted to yield the balance of our time to the distinguished gentleman from California (Mr. GEORGE MILLER), the ranking member of the Committee on Education and the Workforce.

Mr. GEORGE MILLER of California. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, in the next few hours, the Republicans in the Congress will engage in the greatest raid and diminishment on middle-class health care benefits in the history of this country. Benefits that have been built up over the last 50 or 60 years in this country that have enabled middle-class individuals to have some health security, to have some access to prescription drugs, to have access to the health care that they and their families need, will come under assault. It begins with this legislation, medical savings accounts, where millions of Americans who now have good health care plans, where they share the payment of those plans with their employers, between employers and employees, will find out that those plans are going to be substituted by high-threshold, high-cost, high-deductible plans, and the theory is that they can pay for that out of their medical savings accounts.

Millions of Americans are going to wake up and find out that the health care plans that they have available to them today will not be available to them tomorrow.

Just as with the passage of the Medicare bill, the prescription drug bill that we will do later tonight, some 30 percent of the people who have prescription drug benefits will wake up and find out that they will get a lesser benefit under the Medicare prescription drug benefit than they are currently getting today. Millions of senior citizens will discover that they have lost their prescription drug benefit as they know it, and they will have to accept something much less than that.

When we come back from the Fourth of July break, we will complete this trifecta assault on middle-class health care plans when the Committee on Education and the Workforce reports out the Association Health Care Plan proposal. Because the CBO, the Congressional Budget Office tells us that over 8 million Americans will lose the health care they have today, and what will be substituted will be a health care plan that is much less comprehensive than they have today. Mr. Speaker, 8 million Americans, 8 million middle-class Americans. And the answer that the Republicans suggest to us is we can all just save and pay for that ourselves.

Well, if we look who is paying into 401(k)s, we know that most Americans do not have that disposable income. That is why they have employer-based health care systems.

But starting tonight, that employer-based health care system, that system that has done so much to keep people healthy, to keep people out of poverty, to keep them from losing their homes, is about to be shredded; and the assault is complete and it's comprehensive, and it runs from the seniors to new and young families trying to raise children. All of these people will find out. If my colleagues do not think it is going to happen, just look at the employers who are announcing that these cutbacks are going to come who are supporting the association health care plans, who are supporting medical savings accounts, these health savings accounts tonight, and who are supporting prescription drugs. Because they are lining up to get rid of their obligations for prescription drugs, for health care for young families, health care for older families, all in the name of their cost savings. But that will dramatically change the middle class in this country and what they have come to know as health care security.

But for the elderly it is going to be even more dramatic. When we look at the prescription drug benefit, it is interesting that the largest elderly group in the country, AARP, everything that they say is essential to protect senior citizens, and a prescription drug benefit is not in this bill. Read their letter. It is not in this bill. They wish it was, they hope it will be, but it is not here tonight.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself the remaining time.

I would like to begin my closing by saying that the gentleman from California is a person who has worked in health care for many, many years; and I know that he is sincere in trying to do what he thinks is best to give access to people who need health care. I believe everyone who came to the floor and into the well who spoke on this bill today cares about health care.

Mr. Speaker, I am relatively new to this body; but one thing I have learned is that if you are running out of arguments, the oldest trick in the book is to impugn the other person's motives. Tell them that all we want to do is help the rich and hurt the poor, that what we are trying to do is destroy employer-sponsored health care.

Well, Mr. Speaker, two of the Nation's leading organizations who represent small employers, the people who are really facing these high premium hikes, the National Association of Manufacturers, the National Federation of Independent Businesses, this is one of their key priorities. They endorse this bill.

What this does, Mr. Speaker, is it makes it easier for employers to offer health care to their employees. It helps us continue employer-sponsored health care.

Another thing that we have been hearing, that this is fiscally irresponsible and adds to the deficit.

Mr. Speaker, what is fiscally irresponsible is the substitute prescription drug bill that the minority is bringing to the floor which costs $600 billion more than the budget resolution allows. The budget resolution that passed this House balances the budget within the term of the budget resolution, within 10 years. And this is paid for and budgeted for in the budget resolution.

Mr. Speaker, at the end of the day, after we have heard all of these arguments, it kind of comes down to two things, two different philosophies: socialism versus consumerism. They want socialized medicine. They want power to go to Washington where Washington can allocate the benefits, where Washington can ration the health care. We want power to go to the people. We want power to go to the consumers. We want people to have more choices. They want to restrict those choices.

This does not take anything away from anybody, Mr. Speaker. This gives people more choices. This says to people, if you are having a hard time saving for your health care, we are going to make it easier for you to do that. If you are a small business and you cannot afford health care for your employees right now, we are giving you a new option to do just that.

We are going to give employers the ability to say, look, you can put money in an account that you can deduct it from in your employee's name. Your employees contribute to this account. If you do it, you have to buy catastrophic health care coverage for them. So we are making sure with health care savings accounts that there is health insurance. And the beautiful part of this proposal, Mr. Speaker, is that this is the employee's money; it is their money that is at stake when they go out and buy health care. They are going to act like real consumers. They can take this money with them when they leave their job and go to another job. They can take this money with them into retirement throughout the rest of their life; and when they die, this money can go to their spouse. This money becomes the individual's money.

One of the big problems we have in health care today is we do not act like consumers. We have third-party payers paying the bills, and so when we go and pay for health care, someone else is paying the bills, so we really do not care how much it costs. That is one of the reasons why the costs of health care are going up through the roof.

This puts in place 280 million brains on behalf of bringing down health care costs and 280 million sets of eye balls watching this industry to make sure that doctors are charging the right kinds of prices, that hospitals are not overcharging, and that they are getting the best quality for their dollar.

Mr. Speaker, it is about giving power to consumers versus giving power to bureaucrats in Washington. Let us give Americans more freedom, let us give consumers more power, and let us help bring down health care costs.

Mr. Speaker, I urge passage of this bill.

Ms. JACKSON-LEE of Texas. Mr. Speaker, it used to be that the most challenging part of my job here was finding meaningful ways of improving quality of life for the people in my district. Now it seems the most challenging part is trying to figure out how the Republican leadership will next try to deny those same people the lives they and their families deserve. Today's bill is one of the more creative approaches I have seen by the Republicans to advance their goals of giving their rich political donors big tax cuts, and denying the poor and middle classes healthcare and the services they need.

This bill serves no one that really needs it, and will actually undermine the health insurance benefits received by millions of Americans now. It is confusing and complex, and makes a mess of a system that needs to be fine-tuned, not destroyed. The majority of Americans now receive health insurance through employers. This bill will offer a tax break to people who do not have health insurance coverage, and those whose coverage has a deductible of over $1,000. It sounds good, until you think about it. This bill will serve to encourage businesses to cut their health insurance programs, or raise deductibles on their employees. Low- to moderate-income employees and those who are uninsured pay all kinds of taxes: payroll taxes, sales taxes, property taxes. However, they tend to not pay enough income taxes to take advantage of this new Republican-give-to-the-rich scheme. So the exact people who are not being left out of our healthcare system, and who need relief, are being left out of this bill.

The underlying goal of this bill is to dismantle the employer-based health insurance system that the Chairman of the Ways and Means Committee hates. He has stated that he does not like employer-based health insurance because it shields people from the cost of healthcare and thus enables people to use healthcare too much. I don't see that Americans have made themselves too healthy. I want to increase access to care not decrease it, so I will vote against this bill.

Not only is this a bad bill, it is an expensive one. It will cost $71 billion over the next ten years—all money borrowed from our children and grandchildren. In the later years of the budget window, this bill will cost in excess of $10 billion per year, and will accelerate just at the time when the baby boom generation retires, denying resources to meet our commitments to the Social Security and Medicare systems.

Again, it seems this bill was crafted to specifically target and destroy the elements of our healthcare system that people know and trust: Medicare and Employer-sponsored coverage—and use the savings to give to CEOs, the healthy, and the wealthy. It is not surprising to find that due to the structure of this bill, the same people whose children were denied the benefits of a child tax credit, will also not receive any benefits from this bill.

Of course they will be allowed to help pay the interest on the booming debt that it adds to.

I will oppose this bill and encourage my colleagues to do the same.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. SWEENEY). All time for debate has expired.

Pursuant to House Resolution 299, the bill is considered read for amendment and the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. STARK. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 237, nays 191, not voting 7, as follows:

[Roll No. 328]

YEAS—237

Aderholt
Akin
Alexander
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Berkley
Biggert
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardoza
Carter
Case
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dooley (CA)
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hooley (OR)
Hostettler
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)

Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Scott (GA)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

NAYS—191

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berman
Berry
Bishop (NY)
Blumenauer
Boswell
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Castle
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Houghton
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—7

Brown-Waite, Ginny
Gephardt
McInnis
Ros-Lehtinen
Smith (WA)
Vitter
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. Sweeney) (during the vote). Members are advised that there are 2 minutes remaining in this vote.

□ 1855

Mr. STRICKLAND and Mr. GUTIERREZ changed their vote from ``yea'' to ``nay.''

Mr. BISHOP of Georgia changed his vote from ``nay'' to ``yea.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

EXTENDING AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that the Committee on Energy and Commerce be discharged from further consideration of the bill (H.R. 531) to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP), and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. Sweeney). Is there objection to the request of the gentleman from Louisiana?

There was no objection.

The Clerk read the bill, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENDING AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001.

(a) Retained and Redistributed Allotments for Fiscal Years 1998 and 1999.—Paragraphs (2)(A)(i) and (2)(A)(ii) of section 2104(g) of the Social Security Act (42 U.S.C. 1397dd(g)) are each amended by striking ``fiscal year 2002'' and inserting ``fiscal year 2004''.

(b) Extension and Revision of Retained and Redistributed Allotments for Fiscal Year 2000.—

(1) Permitting and extending retention of portion of fiscal year 2000 allotment.—Paragraph (2) of such section 2104(g) is amended—

(A) in the heading, by striking ``AND 1999'' and inserting ``THROUGH 2000''; and

(B) by adding at the end of subparagraph (A) the following:

``(iii) Fiscal year 2000 allotment.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004.''.

(2) Redistributed allotments.—Paragraph (1) of such section 2104(g) is amended—

(A) in subparagraph (A), by inserting ``or for fiscal year 2000 by the end of fiscal year 2002,'' after ``fiscal year 2001,'';

(B) in subparagraph (A), by striking ``1998 or 1999'' and inserting ``1998, 1999, or 2000'';

(C) in subparagraph (A)(i)—

(i) by striking ``or'' at the end of subclause (I),

(ii) by striking the period at the end of subclause (II) and inserting ``; or''; and

(iii) by adding at the end the following new subclause:

``(III) the fiscal year 2000 allotment, the amount specified in subparagraph (C)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (C)(ii) for the State to the amount specified in subparagraph (C)(iii).'';

(D) in subparagraph (A)(ii), by striking ``or 1999'' and inserting ``, 1999, or 2000'';

(E) in subparagraph (B), by striking ``with respect to fiscal year 1998 or 1999'';

(F) in subparagraph (B)(ii)—

(i) by inserting ``with respect to fiscal year 1998, 1999, or 2000,'' after ``subsection (e),''; and

(ii) by striking ``2002'' and inserting ``2004''; and

(G) by adding at the end the following new subparagraph:

``(C) Amounts used in computing redistributions for fiscal year 2000.—For purposes of subparagraph (A)(i)(III)—

``(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2000, less the total amount remaining available pursuant to paragraph (2)(A)(iii);

``(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b); and

``(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2000, of the amounts specified in clause (ii).''.

(3) Conforming amendments.—Such section 2104(g) is further amended—

(A) in its heading, by striking ``AND 1999'' and inserting ``, 1999, AND 2000''; and

(B) in paragraph (3)—

(i) by striking ``or fiscal year 1999'' and inserting ``, fiscal year 1999, or fiscal year 2000''; and

(ii) by striking ``or November 30, 2001'' and inserting ``November 30, 2001, or November 30, 2002'', respectively.

(c) Extension and Revision of Retained and Redistributed Allotments for Fiscal Year 2001.—

(1) Permitting and extending retention of portion of fiscal year 2001 allotment.—Paragraph (2) of such section 2104(g), as amended in subsection (b)(1)(B), is further amended—

(A) in the heading, by striking ``2000'' and inserting ``2001''; and

(B) by adding at the end of subparagraph (A) the following:

``(iv) Fiscal year 2001 allotment.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year

2003, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2005.".

(2) Redistributed allotments.—Paragraph (1) of such section 2104(g), as amended in subsection (b)(2), is further amended—

(A) in subparagraph (A), by inserting "or for fiscal year 2001 by the end of fiscal year 2003," after "fiscal year 2002,";

(B) in subparagraph (A), by striking "1999, or 2000" and inserting "1999, 2000, or 2001";

(C) in subparagraph (A)(i)—

(i) by striking "or" at the end of subclause (II),

(ii) by striking the period at the end of subclause (III) and inserting "; or"; and

(iii) by adding at the end the following new subclause:

"(IV) the fiscal year 2001 allotment, the amount specified in subparagraph (D)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (D)(ii) for the State to the amount specified in subparagraph (D)(iii).";

(D) in subparagraph (A)(ii), by striking "or 2000" and inserting "2000, or 2001";

(E) in subparagraph (B)—

(i) by striking "and" at the end of clause (ii);

(ii) by redesignating clause (iii) as clause (iv); and

(iii) by inserting after clause (ii) the following new clause:

"(iii) notwithstanding subsection (e), with respect to fiscal year 2001, shall remain available for expenditure by the State through the end of fiscal year 2005; and"; and

(F) by adding at the end the following new subparagraph:

"(D) Amounts used in computing redistributions for fiscal year 2001.—For purposes of subparagraph (A)(i)(IV)—

"(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2001, less the total amount remaining available pursuant to paragraph (2)(A)(iv);

"(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); and

"(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2001, of the amounts specified in clause (ii).".

(3) Conforming amendments.—Such section 2104(g) is further amended—

(A) in its heading, by striking "and 2000" and inserting "2000, and 2001"; and

(B) in paragraph (3)—

(i) by striking "or fiscal year 2000" and inserting "fiscal year 2000, or fiscal year 2001"; and

(ii) by striking "or November 30, 2002," and inserting "November 30, 2002, or November 30, 2003,", respectively.

(d) Effective Date.—This section, and the amendments made by this section, shall be effective as if this section had been enacted on September 30, 2002, and amounts under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) from allotments for fiscal years 1998 through 2000 are available for expenditure on and after October 1, 2002, under the amendments made by this section as if this section had been enacted on September 30, 2002.

The bill was ordered to be engrossed and read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 531, the bill just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

Mr. THOMAS. Mr. Speaker, pursuant to House Resolution 299, I call up the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. LaHood). Pursuant to House Resolution 299, the bill is considered read for amendment.

The text of H.R. 1 is as follows:

H.R. 1

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the "Medicare Prescription Drug and Modernization Act of 2003".

(b) Amendments to Social Security Act.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; Secretary.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106-554.

(2) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

(d) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.

"Part D—Voluntary Prescription Drug Benefit Program

"Sec. 1860D-1. Benefits; eligibility; enrollment; and coverage period.
"Sec. 1860D-2. Requirements for qualified prescription drug coverage.
"Sec. 1860D-3. Beneficiary protections for qualified prescription drug coverage.
"Sec. 1860D-4. Requirements for and contracts with prescription drug plan (PDP) sponsors.
"Sec. 1860D-5. Process for beneficiaries to select qualified prescription drug coverage.
"Sec. 1860D-6. Submission of bids and premiums.
"Sec. 1860D-7. Premium and cost-sharing subsidies for low-income individuals.
"Sec. 1860D-8. Subsidies for all medicare beneficiaries for qualified prescription drug coverage.
"Sec. 1860D-9. Medicare Prescription Drug Trust Fund.
"Sec. 1860D-10. Definitions; application to medicare advantage and EFFS programs; treatment of references to provisions in part C.

Sec. 102. Offering of qualified prescription drug coverage under Medicare Advantage and enhanced fee-for-service (EFFS) program.
Sec. 103. Medicaid amendments.
Sec. 104. Medigap transition.
Sec. 105. Medicare prescription drug discount card and assistance program.
Sec. 106. Disclosure of return information for purposes of carrying out medicare catastrophic prescription drug program.
Sec. 107. State Pharmaceutical Assistance Transition Commission.
Sec. 108. Additional requirements for annual financial report and oversight on medicare program, including prescription drug spending.

TITLE II—MEDICARE ENHANCED FEE-FOR-SERVICE AND MEDICARE ADVANTAGE PROGRAMS; MEDICARE COMPETITION

Sec. 200. Medicare modernization and revitalization.

Subtitle A—Medicare Enhanced Fee-for-Service Program

Sec. 201. Establishment of enhanced fee-for-service (EFFS) program under medicare.

"Part E—Enhanced Fee-for-Service Program

"Sec. 1860E-1. Offering of enhanced fee-for-service plans throughout the United States.
"Sec. 1860E-2. Offering of enhanced fee-for-service (EFFS) plans.
"Sec. 1860E-3. Submission of bids; beneficiary savings; payment of plans.
"Sec. 1860E-4. Premiums; organizational and financial requirements; establishment of standards; contracts with EFFS organizations.

Subtitle B—Medicare Advantage Program

Chapter 1—Implementation Of Program

Sec. 211. Implementation of medicare advantage program.
Sec. 212. Medicare advantage improvements.

Chapter 2—Implementation Of Competition Program

Sec. 221. Competition program beginning in 2006.

Chapter 3—Additional Reforms

Sec. 231. Making permanent change in medicare advantage reporting deadlines and annual, coordinated election period.
Sec. 232. Avoiding duplicative State regulation.

Sec. 233. Specialized medicare advantage plans for special needs beneficiaries.
Sec. 234. Medicare MSAs.
Sec. 235. Extension of reasonable cost contracts.
Sec. 236. Extension of municipal health service demonstration projects.
Sec. 237. Study of performance-based payment systems.

Subtitle C—Application of FEHBP-Style Competitive Reforms

Sec. 241. Application of FEHBP-style competitive reform beginning in 2010.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

Sec. 301. Medicare secondary payor (MSP) provisions.
Sec. 302. Competitive acquisition of certain items and services.
Sec. 303. Competitive acquisition of covered outpatient drugs and biologicals.
Sec. 304. Demonstration project for use of recovery audit contractors.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

Sec. 401. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 402. Immediate establishment of uniform standardized amount in rural and small urban areas.
Sec. 403. Establishment of essential rural hospital classification.
Sec. 404. More frequent update in weights used in hospital market basket.
Sec. 405. Improvements to critical access hospital program.
Sec. 406. Redistribution of unused resident positions.
Sec. 407. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under prospective payment system for hospital outpatient department services.
Sec. 408. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 409. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 410. Improvement in payments to retain emergency capacity for ambulance services in rural areas.
Sec. 411. Two-year increase for home health services furnished in a rural area.
Sec. 412. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 413. GAO study of geographic differences in payments for physicians' services.
Sec. 414. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 415. Extension of telemedicine demonstration project.
Sec. 416. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.
Sec. 417. Medicare incentive payment program improvements for physician scarcity.
Sec. 418. Rural hospice demonstration project.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 501. Revision of acute care hospital payment updates.
Sec. 502. Recognition of new medical technologies under inpatient hospital PPS.
Sec. 503. Increase in Federal rate for hospitals in Puerto Rico.
Sec. 504. Wage index adjustment reclassification reform .
Sec. 505. MedPAC report on specialty hospitals.

Subtitle B—Other Provisions

Sec. 511. Payment for covered skilled nursing facility services.
Sec. 512. Coverage of hospice consultation services.
Sec. 513. Correction of Trust Fund holdings.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

Sec. 601. Revision of updates for physicians' services.
Sec. 602. Studies on access to physicians' services.
Sec. 603. MedPAC report on payment for physicians' services.
Sec. 604. Inclusion of podiatrists and dentists under private contracting authority.
Sec. 605. Establishment of floor on work geographic adjustment.

Subtitle B—Preventive Services

Sec. 611. Coverage of an initial preventive physical examination.
Sec. 612. Coverage of cholesterol and blood lipid screening.
Sec. 613. Waiver of deductible for colorectal cancer screening tests.
Sec. 614. Improved payment for certain mammography services.

Subtitle C—Other Services

Sec. 621. Hospital outpatient department (HOPD) payment reform.
Sec. 622. Payment for ambulance services.
Sec. 623. Renal dialysis services.
Sec. 624. One-year moratorium on therapy caps; provisions relating to reports.
Sec. 625. Adjustment to payments for services furnished in ambulatory surgical centers.
Sec. 626. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
Sec. 627. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 628. Part B deductible.
Sec. 629. Extension of coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
Sec. 630. Medicare coverage of diabetes laboratory diagnostic tests.
Sec. 631. Demonstration project for coverage of certain prescription drugs and biologics.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 701. Update in home health services.
Sec. 702. Establishment of reduced copayment for a home health service episode of care for certain beneficiaries.
Sec. 703. MedPAC study on medicare margins of home health agencies.
Sec. 704. Demonstration project to clarify the definition of homebound.

Subtitle B—Direct Graduate Medical Education

Sec. 711. Extension of update limitation on high cost programs.

Subtitle C—Chronic Care Improvement

Sec. 721. Voluntary chronic care improvement under traditional fee-for-service.
Sec. 722. Chronic care improvement under medicare advantage and enhanced fee-for-service programs.
Sec. 723. Institute of Medicine report.
Sec. 724. MedPAC report.

Subtitle D—Other Provisions

Sec. 731. Modifications to medicare payment advisory commission (MedPAC).
Sec. 732. Demonstration project for medical adult day care services.
Sec. 733. Improvements in national and local coverage determination process to respond to changes in technology.
Sec. 734. Treatment of certain physician pathology services.
Sec. 735. Clinical investigation of medicare pancreatic islet cell transplants.
Sec. 736. Demonstration project for consumer-directed chronic outpatient services.

TITLE VIII—MEDICARE BENEFITS ADMINISTRATION

Sec. 801. Establishment of Medicare Benefits Administration.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

Sec. 901. Construction; definition of supplier.
Sec. 902. Issuance of regulations.
Sec. 903. Compliance with changes in regulations and policies.
Sec. 904. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

Sec. 911. Increased flexibility in medicare administration.
Sec. 912. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

Sec. 921. Provider education and technical assistance.
Sec. 922. Small provider technical assistance demonstration program.
Sec. 923. Medicare Provider Ombudsman; Medicare Beneficiary Ombudsman.
Sec. 924. Beneficiary outreach demonstration program.
Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

Sec. 931. Transfer of responsibility for medicare appeals.
Sec. 932. Process for expedited access to review.
Sec. 933. Revisions to medicare appeals process.

Sec. 934. Prepayment review.
Sec. 935. Recovery of overpayments.
Sec. 936. Provider enrollment process: right of appeal.
Sec. 937. Process for correction of minor errors and omissions without pursuing appeals process.
Sec. 938. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle V—Miscellaneous Provisions

Sec. 941. Policy development regarding evaluation and management (E & M) documentation guidelines.
Sec. 942. Improvement in oversight of technology and coverage.
Sec. 943. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
Sec. 944. EMTALA improvements.
Sec. 945. Emergency Medical Treatment and Active Labor Act (EMTALA) technical advisory group.
Sec. 946. Authorizing use of arrangements to provide core hospice services in certain circumstances.
Sec. 947. Application of OSHA bloodborne pathogens standard to certain hospitals.
Sec. 948. BIPA-related technical amendments and corrections.
Sec. 949. Conforming authority to waive a program exclusion.
Sec. 950. Treatment of certain dental claims.
Sec. 951. Furnishing hospitals with information to compute dsh formula.
Sec. 952. Revisions to reassignment provisions.
Sec. 953. Other provisions.
Sec. 954. Temporary suspension of OASIS requirement for collection of data on non-medicare and non-medicaid patients.

TITLE X—MEDICAID

Sec. 1001. Medicaid disproportionate share hospital (DSH) payments.
Sec. 1002. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Subtitle A—Access to Affordable Pharmaceuticals

Sec. 1101. 30-month stay-of-effectiveness period.
Sec. 1102. Forfeiture of 180-day exclusivity period.
Sec. 1103. Bioavailability and bioequivalence.
Sec. 1104. Conforming amendments.

Subtitle B—Ability of Federal Trade Commission to Enforce Antitrust Laws

Sec. 1111. Definitions.
Sec. 1112. Notification of agreements.
Sec. 1113. Filing deadlines.
Sec. 1114. Disclosure exemption.
Sec. 1115. Enforcement.
Sec. 1116. Rulemaking.
Sec. 1117. Savings clause.
Sec. 1118. Effective date.

Subtitle C—Importation of Prescription Drugs

Sec. 1121. Importation of prescription drugs.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) In General.—Title XVIII is amended—

(1) by redesignating part D as part F; and

(2) by inserting after part C the following new part:

"Part D—Voluntary Prescription Drug Benefit Program

"SEC. 1860D-1. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

"(a) Provision of Qualified Prescription Drug Coverage Through Enrollment in Plans.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860D-2(a)) as follows:

"(1) Medicare-related plans.—

"(A) Medicare advantage.—If the individual is eligible to enroll in a Medicare Advantage plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in such plan and obtain coverage through such plan.

"(B) EFFS plans.—If the individual is eligible to enroll in an EFFS plan that provides qualified prescription drug coverage under part E under section 1860E-2(d), the individual may enroll in such plan and obtain coverage through such plan.

"(C) MA-EFFS plan; MA-EFFS Rx plan.—For purposes of this part, the term 'MA-EFFS plan' means a Medicare Advantage plan under part C and an EFFS plan under part E and the term 'MA-EFFS Rx plan' means a MA-EFFS plan insofar as such plan provides qualified prescription drug coverage.

"(2) Prescription drug plan.—If the individual is not enrolled in a MA-EFFS plan, the individual may enroll under this part in a prescription drug plan (as defined in section 1860D-10(a)(5)).

Such individuals shall have a choice of such plans under section 1860D-5(d).

"(b) General Election Procedures.—

"(1) In general.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a MA-EFFS Rx plan under part C or part E, and to change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1809(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

"(2) Election periods.—

"(A) In general.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare Advantage and EFFS programs under section 1851(e), including—

"(i) annual coordinated election periods; and

"(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of an election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

"(B) Initial election periods.—

"(i) Individuals currently covered.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of October 1, 2005, there shall be an initial election period of 6 months beginning on that date.

"(ii) Individual covered in future.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

"(C) Additional special election periods.—The Administrator shall establish special election periods—

"(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

"(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B;

"(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Administrator may provide; and

"(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

"(3) Information on plans.—Information described in section 1860D-3(b)(1) on prescription drug plans and MA-EFFS Rx plans shall be made available during election periods.

"(4) Additional information.—In order to promote the efficient marketing of prescription drug plans and MA-EFFS plans, the Administrator may provide information to the sponsors and organizations offering such plans about individuals eligible to enroll in such plans.

"(c) Guaranteed Issue; Community Rating; and Nondiscrimination.—

"(1) Guaranteed issue.—

"(A) In general.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or MA-EFFS Rx plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

"(B) Medicare advantage limitations permitted.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

"(2) Community-rated premium.—

"(A) In general.—In the case of an individual who enrolls under a prescription drug plan or in a MA-EFFS Rx plan during the individual's initial enrollment period under this part or maintains (as determined under subparagraph (C)) continuous prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or entity offering a prescription drug plan or MA-EFFS Rx plan and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or vary or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

"(B) Late enrollment penalty.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or an entity offering a MA-EFFS Rx plan may (notwithstanding any provision in this title) adjust the premium otherwise applicable with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4). The Administrator shall provide a mechanism for assisting such sponsors and entities in identifying eligible individuals who have (or have not) maintained such continuous prescription drug coverage.

“(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

“(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MA-EFFS RX PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a MA-EFFS Rx plan.

“(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, or through a demonstration project under part C that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

“(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860D–8(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

“(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2006, and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

“(v) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

“(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

“(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

“(E) DISCLOSURE.—

“(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (iii), (iv), (v), or (vi) of subparagraph (C) shall provide for disclosure, consistent with standards established by the Administrator, of whether such coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

“(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately informed that such coverage did not provide such level of benefits.

“(F) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a MA-EFFS Rx plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

“(3) NONDISCRIMINATION.—A PDP sponsor that offers a prescription drug plan in an area designated under section 1860D–4(b)(5) shall make such plan available to all eligible individuals residing in the area without regard to their health or economic status or their place of residence within the area.

“(d) EFFECTIVE DATE OF ELECTIONS.—

“(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator provides that similar elections under section 1851(e) take effect under section 1851(f).

“(2) NO ELECTION EFFECTIVE BEFORE 2006.—In no case shall any election take effect before January 1, 2006.

“(3) TERMINATION.—The Administrator shall provide for the termination of an election in the case of—

“(A) termination of coverage under both part A and part B; and

“(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

“SEC. 1860D–2. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

“(a) REQUIREMENTS.—

“(1) IN GENERAL.—For purposes of this part and part C and part E, the term ‘qualified prescription drug coverage’ means either of the following:

“(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

“(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if it is approved by the Administrator, as provided under subsection (c).

“(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

“(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

“(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C or E. If the Administrator finds, in the case of a qualified prescription drug coverage under a prescription drug plan or a MA-EFFS Rx plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C or E.

“(3) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

“(b) STANDARD COVERAGE.—For purposes of this part, the ‘standard coverage’ is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

“(1) DEDUCTIBLE.—The coverage has an annual deductible—

“(A) for 2006, that is equal to $250; or

“(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

“(2) 80:20 BENEFIT STRUCTURE.—

“(A) 20 PERCENT COINSURANCE.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is—

“(i) equal to 20 percent; or

“(ii) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

“(B) USE OF TIERS.—Nothing in this part shall be construed as preventing a PDP sponsor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

“(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes—

“(A) for 2006, that is equal to $2,000; or

“(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

“(4) CATASTROPHIC PROTECTION.—

“(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with no cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B).

“(B) ANNUAL OUT-OF-POCKET THRESHOLD.—

“(i) IN GENERAL.—For purposes of this part, the ‘annual out-of-pocket threshold’ specified in this subparagraph is equal to $3,500 (subject to adjustment under clause (ii) and subparagraph (D)).

"(ii) INFLATION INCREASE.—For a year after 2006, the dollar amount specified in clause (i) shall be increased by the annual percentage increase described in paragraph (5) for the year involved. Any amount determined under the previous sentence that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

"(C) APPLICATION.—In applying subparagraph (A)—

"(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

"(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860D-7, under title XIX, or under a State pharmaceutical assistance program and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such title or such program) for such costs.

"(D) ADJUSTMENT OF ANNUAL OUT-OF-POCKET THRESHOLDS.—

"(i) IN GENERAL.—Subject to clause (vii), for each enrollee in a prescription drug plan or in a MA-EFFS Rx plan whose adjusted gross income exceeds the income threshold as defined in clause (ii) for a year, the annual out-of-pocket threshold otherwise determined under subparagraph (B) for such year shall be increased by an amount equal to the percentage specified in clause (iii), multiplied by the lesser of—

"(I) the amount of such excess; or

"(II) the amount by which the income threshold limit exceeds the income threshold.

Any amount determined under the previous sentence that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

"(ii) INCOME THRESHOLD.—For purposes of clause (i)—

"(I) IN GENERAL.—Subject to subclause (II), the term 'income threshold' means $60,000 and the term 'income threshold limit' means $200,000.

"(II) INCOME INFLATION ADJUSTMENT.—In the case of a year beginning after 2006, each of the dollar amounts in subclause (I) shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) of the Internal Revenue Code of 1986 for such year, determined by substituting 'calendar year 2005' for 'calendar year 1992'. If any amount increased under the previous sentence is not a multiple of $100, such amount shall be rounded to the nearest multiple of $100.

"(iii) PERCENTAGE.—The percentage specified in this clause for a year is a fraction (expressed as a percentage) equal to—

"(I) the annual out-of-pocket threshold for a year under subparagraph (B) (determined without regard to this subparagraph), divided by

"(II) the income threshold under clause (ii) for that year.

If any percentage determined under the previous sentence that is not a multiple of 1/10th of 1 percentage point, such percentage shall be rounded to the nearest multiple of 1/10th of 1 percentage point.

"(iv) USE OF MOST RECENT RETURN INFORMATION.—For purposes of clause (i) for an enrollee for a year, except as provided in clause (v), the adjusted gross income of an individual shall be based on the most recent information disclosed to the Secretary under section 6109(l)(19) of the Internal Revenue Code of 1986 before the beginning of that year.

"(v) INDIVIDUAL ELECTION TO PRESENT MOST RECENT INFORMATION REGARDING INCOME.—The Secretary shall provide, in coordination with the Secretary of the Treasury, a procedure under which, for purposes of applying this subparagraph for a calendar year, instead of using the information described in clause (iv), an enrollee may elect to use more recent information, including information with respect to a taxable year ending in such calendar year. Such process shall—

"(I) require the enrollee to provide the Secretary with a copy of the relevant portion of the more recent return to be used under this clause;

"(II) provide for the Medicare Beneficiary Ombudsman (under section 1810) offering assistance to such enrollees in presenting such information and the toll-free number under such section being a point of contact for beneficiaries to inquire as to how to present such information;

"(III) provide for the verification of the information in such return by the Secretary of the Treasury under section 6103(l)(19) of the Internal Revenue Code of 1986; and

"(IV) provide for the payment by the Secretary (in a manner specified by the Secretary) to the enrollee of an amount equal to the excess of the benefit payments that would have been payable under the plan if the more recent return information were used, over the benefit payments that were made under the plan.

In the case of a payment under subclause (III) for an enrollee under a prescription drug plan, the PDP sponsor of the plan shall pay to the Secretary the amount so paid, less the applicable reinsurance amount that would have applied under section 1860D-8(c)(1)(B) if such payment had been treated as an allowable cost under such section. Such plan payment shall be deposited in the Treasury to the credit of the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund (under section 1841).

"(vi) DISSEMINATION OF INFORMATION ON PROCESS.—The Secretary shall provide, through the annual medicare handbook under section 1804(a), for a general description of the adjustment of annual out-of-pocket thresholds provided under this subparagraph, including the process for adjustment based upon more recent information and the confidentiality provisions of subparagraph (F), and shall provide for dissemination of a table for each year that sets forth the amount of the adjustment that is made under clause (i) based on the amount of an enrollee's adjusted gross income.

"(vii) ENROLLEE OPT-OUT.—The Secretary shall provide a procedure whereby, if an enrollee elects to have the maximum annual out-of-pocket threshold applied under this subparagraph for a year, the Secretary shall not request any information regarding the enrollee under subparagraph (E) for that year.

"(E) REQUESTING INFORMATION ON ENROLLEES.—

"(i) IN GENERAL.—The Secretary shall, periodically as required to carry out subparagraph (D), transmit to the Secretary of the Treasury a list of the names and TINs of enrollees in prescription drug plans (or in MA-EFFS Rx plans) and request that such Secretary disclose to the Secretary information under subparagraph (A) of section 6103(l)(19) of the Internal Revenue Code of 1986 with respect to those enrollees for a specified taxable year for application in a particular calendar year.

"(ii) DISCLOSURE TO PLAN SPONSORS.—In the case of a specified taxpayer (as defined in section 6103(l)(19)(B) of the Internal Revenue Code of 1986) who is enrolled in a prescription drug plan or in an MA-EFFS Rx plan or an individual who makes an election under subparagraph (D)(vii), the Secretary shall disclose to the entity that offers the plan the annual out-of-pocket threshold applicable to such individual under subparagraph (D).

"(F) MAINTAINING CONFIDENTIALITY OF INFORMATION.—

"(i) IN GENERAL.—The amount of any increase in an annual out-of-pocket threshold under subparagraph (D) may not be disclosed by the Secretary except to a PDP sponsor or entity that offers a MA-EFFS Rx plan to the extent necessary to carry out this part.

"(ii) CRIMINAL AND CIVIL PENALTIES FOR UNAUTHORIZED DISCLOSURE.—A person who makes an unauthorized disclosure of information disclosed under section 6103(l)(19) of the Internal Revenue Code of 1986 (including disclosure of any increase in an annual out-of-pocket threshold under subparagraph (D)) shall be subject to penalty to the extent provided under—

"(I) section 7213 of such Code (relating to criminal penalty for unauthorized disclosure of information);

"(II) section 7213A of such Code (relating to criminal penalty for unauthorized inspection of returns or return information);

"(III) section 7431 of such Code (relating to civil damages for unauthorized inspection or disclosure of returns and return information);

"(IV) any other provision of the Internal Revenue Code of 1986; or

"(V) any other provision of law.

"(iii) APPLICATION OF ADDITIONAL CIVIL MONETARY PENALTY FOR UNAUTHORIZED DISCLOSURES.—In addition to any penalty otherwise provided under law, any person who makes an unauthorized disclosure of such information shall be subject to a civil monetary penalty of not to exceed $10,000 for each such unauthorized disclosure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"(G) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the sponsors and organization that offer the plans in which such individuals are enrolled about such reimbursement arrangements. A PDP sponsor or Medicare Advantage or EFFS organization may also periodically ask individuals enrolled in a prescription drug plan or MA-EFFS Rx plan offered by the sponsor or organization whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D–1(d)(3).

"(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous year.

"(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or MA-EFFS Rx plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the Administrator determines (based on an actuarial analysis approved by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

"(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

"(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (e)) is at least equal to the actuarial value (as so determined) of standard coverage.

"(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the subsidy payments under section 1860D–8 with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the product of—

"(i) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the deductible described in subsection (b)(1); and

"(ii) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(i).

"(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

"(d) ACCESS TO NEGOTIATED PRICES.—

"(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or an entity offering a MA-EFFS Rx plan, the sponsor or entity shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX to a beneficiary enrolled under such title and under a prescription drug plan or MA-EFFS Rx plan for a drug based on the prices negotiated by a prescription drug plan or MA-EFFS Rx plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated by a prescription drug plan under this part, by a MA-EFFS Rx plan with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860D–8(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(2) DISCLOSURE.—The PDP sponsor or entity offering a MA-EFFS Rx plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates or other remuneration or price concessions made available to the sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

"(3) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D–4(b)(3)(C), the Administrator may periodically audit the financial statements and records of PDP sponsor or entities offering a MA-EFFS Rx plan.

"(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

"(1) PROCESSES.—For purposes of this section, the Administrator shall establish processes and methods—

"(A) for determining the actuarial valuation of prescription drug coverage, including—

"(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860D–8;

"(ii) the use of generally accepted actuarial principles and methodologies; and

"(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

"(B) for determining annual percentage increases described in subsection (b)(5).

Such methods for determining actuarial valuation shall take into account effects of alternative coverage on drug utilization.

"(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and entities offering MA-EFFS Rx plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

"(f) COVERED OUTPATIENT DRUGS DEFINED.—

"(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term 'covered outpatient drug' means—

"(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

"(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary)

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(2) EXCLUSIONS.—

"(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D–3(f)(2).

"(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or MA-EFFS Rx plan may exclude from qualified prescription drug coverage any covered outpatient drug—

"(A) for which payment would not be made if section 1862(a) applied to part D; or

"(B) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–3(f).

"SEC. 1860D–3. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) GUARANTEED ISSUE, COMMUNITY-RATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860D–1(c)(1), 1860D–1(c)(2), 1860D–2(d), and 1860D–6(b), respectively.

"(b) DISSEMINATION OF INFORMATION.—

"(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

"(A) Access to specific covered outpatient drugs, including access through pharmacy networks.

"(B) How any formulary used by the sponsor functions, including the drugs included in the formulary.

"(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

"(D) Grievance and appeals procedures.

Such information shall also be made available upon request to prospective enrollees.

"(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

"(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

“(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to each enrollee in a form easily understandable to such enrollees an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and the annual out-of-pocket threshold applicable to such enrollee for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

“(c) ACCESS TO COVERED BENEFITS.—

“(1) ASSURING PHARMACY ACCESS.—

“(A) PARTICIPATION OF ANY WILLING PHARMACY.—A PDP sponsor and an entity offering a MA-EFFS Rx plan shall permit the participation of any pharmacy that meets terms and conditions that the plan has established.

“(B) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—A prescription drug plan and a MA-EFFS Rx plan may, notwithstanding subparagraph (A), reduce coinsurance or copayments for its enrolled beneficiaries below the level otherwise provided for covered outpatient drugs dispensed through in-network pharmacies, but in no case shall such a reduction result in an increase in payments made by the Administrator under section 1860D–8 to a plan.

“(C) CONVENIENT ACCESS FOR NETWORK PHARMACIES.—The PDP sponsor of the prescription drug plan and the entity offering a MA-EFFS Rx plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (consistent with rules of the Administrator). The Administrator shall establish convenient access rules under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TRICARE Retail Pharmacy (TRRx) program. Such rules shall include adequate emergency access for enrolled beneficiaries.

“(D) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, with any differential in charge paid by such enrollees.

“(E) NOT REQUIRED TO ACCEPT INSURANCE RISK.—The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

“(2) USE OF STANDARDIZED TECHNOLOGY.—

“(A) IN GENERAL.—The PDP sponsor of a prescription drug plan and an entity offering a MA-EFFS Rx plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to negotiated prices under section 1860D–2(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the plan.

“(B) STANDARDS.—

“(i) DEVELOPMENT.—The Administrator shall provide for the development or utilization of uniform standards relating to a standardized format for the card or other technology referred to in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

“(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommendations to the Administrator under such subsection regarding the standards developed under clause (i).

“(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan or an entity offering a MA-EFFS Rx plan uses a formulary, the following requirements must be met:

“(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor or entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one practicing physician and at least one practicing pharmacist independent and free of conflict with respect to the committee both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

“(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall—

“(i) base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate; and

“(ii) shall take into account whether including in the formulary particular covered outpatient drugs has therapeutic advantages in terms of safety and efficacy.

“(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (although not necessarily for all drugs within such categories and classes). In establishing such classes, the committee shall take into account the standards published in the United States Pharmacopeia-Drug Information. The committee shall make available to the enrollees under the plan through the Internet or otherwise the bases for the exclusion of coverage of any drug from the formulary.

“(D) PROVIDER AND PATIENT EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary.

“(E) NOTICE BEFORE REMOVING DRUG FROM FORMULARY FOR CHANGING PREFERRED OR TIER STATUS OF DRUG.—Any removal of a covered outpatient drug from a formulary and any change in the preferred or tier cost-sharing status of such a drug shall take effect only after appropriate notice is made available to beneficiaries and physicians.

“(F) PERIODIC EVALUATION OF PROTOCOLS.—In connection with the formulary, a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and procedures.

“(G) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

“(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

“(1) IN GENERAL.—The PDP sponsor or entity offering a MA-EFFS Rx plan shall have in place, directly or through appropriate arrangements, with respect to covered outpatient drugs—

“(A) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

“(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including side-effects, and improve medication use, including a medication therapy management program described in paragraph (2) and for years beginning with 2007, an electronic prescription program described in paragraph (3); and

“(C) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a PDP sponsor or entity from utilizing cost management tools (including differential payments) under all methods of operation.

“(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

“(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that may be furnished by a pharmacy provider and that is designed to assure, with respect to beneficiaries at risk for potential medication problems, such as beneficiaries with complex or chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use and reduce the risk of adverse events, including adverse drug interactions. Such programs may distinguish between services in ambulatory and institutional settings.

“(B) ELEMENTS.—Such program may include—

“(i) enhanced beneficiary understanding to promote the appropriate use of medications by beneficiaries and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, case management, disease state management programs, and other appropriate means;

“(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other compliance programs and other appropriate means; and

“(iii) detection of patterns of overuse and underuse of prescription drugs.

“(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

“(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program and an entity offering a MA-EFFS Rx plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program. Each such sponsor or entity shall disclose to the Administrator upon request the amount of any such management or dispensing fees and such fees shall be confidential in the same manner as provided under section 1927(b)(3)(D) for information disclosed under section 1927(b)(3)(A).

“(3) ELECTRONIC PRESCRIPTION PROGRAM.—

“(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a program that includes at least the following components, consistent with uniform standards established under subparagraph (B):

“(i) Electronic transmittal of prescriptions.—Prescriptions must be written and transmitted electronically (other than by facsimile), except in emergency cases and other exceptional circumstances recognized by the Administrator.

“(ii) Provision of information to prescribing health care professional.—The program provides for the electronic transmittal to the prescribing health care professional of information that includes—

“(I) information (to the extent available and feasible) on the drug or drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

“(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

“(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

“(B) Standards.—

“(i) Development.—The Administrator shall provide for the development of uniform standards relating to the electronic prescription drug program described in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

“(ii) Advisory task force.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives of physicians, hospitals, pharmacies, beneficiaries, pharmacy benefit managers, individuals with expertise in information technology, and pharmacy benefit experts of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

“(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

“(II) The extent to which such standards and systems reduce medication errors and can be readily implemented by physicians, pharmacies, and hospitals.

“(III) Efforts to develop uniform standards and a common software platform for the secure electronic communication of medication history, eligibility, benefit, and prescription information.

“(IV) Efforts to develop and promote universal connectivity and interoperability for the secure electronic exchange of such information.

“(V) The cost of implementing such systems in the range of hospital and physician office settings and pharmacies, including hardware, software, and training costs.

“(VI) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

“(iii) Deadlines.—

“(I) The Administrator shall constitute the task force under clause (ii) by not later than April 1, 2004.

“(II) Such task force shall submit recommendations to Administrator by not later than January 1, 2005.

“(III) The Administrator shall provide for the development and promulgation, by not later than January 1, 2006, of national standards relating to the electronic prescription drug program described in clause (ii). Such standards shall be issued by a standards organization accredited by the American National Standards Institute (ANSI) and shall be compatible with standards established under part C of title XI.

“(4) Treatment of accreditation.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug plans under this part with respect to the following requirements, in the same manner as they apply to plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

“(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

“(B) Subsection (c)(1) (relating to access to covered benefits).

“(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

“(5) Public disclosure of pharmaceutical prices for equivalent drugs.—Each PDP sponsor and each entity offering a MA-EFFS Rx plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost available generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

“(e) Grievance Mechanism, Coverage Determinations, and Reconsiderations.—

“(1) In general.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

“(2) Application of coverage determination and reconsideration provisions.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an organization with respect to benefits it offers under a plan under part C.

“(3) Request for review of tiered formulary determinations.—In the case of a prescription drug plan offered by a PDP sponsor or a MA-EFFS Rx plan that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a non-preferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

“(f) Appeals.—

“(1) In general.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs (including a determination related to the application of tiered cost-sharing described in subsection (e)(3)) in the same manner as such requirements apply to an organization with respect to benefits it offers under a plan under part C.

“(2) Formulary determinations.—An individual who is enrolled in a prescription drug plan offered by a PDP sponsor or in a MA-EFFS Rx plan may appeal to obtain coverage for a covered outpatient drug that is not on a formulary of the sponsor or entity offering the plan if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

“(g) Confidentiality and Accuracy of Enrollee Records.—A PDP sponsor that offers a prescription drug plan shall meet the requirements of section 1852(h) with respect to enrollees under the plan in the same manner as such requirements apply to an organization with respect to enrollees under part C. A PDP sponsor shall be treated as a business associate for purposes of the provisions of subpart E of part 164 of title 45, Code of Federal Regulations, adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S. C. 1320d-2 note).

“SEC. 1860D–4. REQUIREMENTS FOR AND CONTRACTS WITH PRESCRIPTION DRUG PLAN (PDP) SPONSORS.

“(a) General Requirements.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

“(1) Licensure.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

“(2) Assumption of financial risk for unsubsidized coverage.—

“(A) In general.—Subject to subparagraph (B) and section 1860D–5(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860D–8.

“(B) Reinsurance permitted.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrollee.

“(3) Solvency for unlicensed sponsors.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Administrator under subsection (d).

“(b) Contract Requirements.—

“(1) In general.—The Administrator shall not permit the election under section 1860D–1 of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860D–7 or 1860D–8, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

“(2) Negotiation regarding terms and conditions.—The Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860D–6(a)(2), the Administrator shall take into account the subsidy payments under section 1860D–8.

“(3) Incorporation of certain Medicare Advantage contract requirements.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

‘‘(A) Minimum enrollment.—Paragraphs (1) and (3) of section 1857(b), except that the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

‘‘(B) Contract period and effectiveness.—Paragraphs (1) through (3) and (5) of section 1857(c).

‘‘(C) Protections against fraud and beneficiary protections.—Section 1857(d).

‘‘(D) Additional contract terms.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

‘‘(i) such section shall be applied separately to costs relating to this part (from costs under part C and part E);

‘‘(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

‘‘(iii) no fees shall be applied under this subparagraph with respect to MA-EFFS Rx plans.

‘‘(E) Intermediate sanctions.—Section 1857(g).

‘‘(F) Procedures for termination.—Section 1857(h).

‘‘(4) Rules of application for intermediate sanctions.—In applying paragraph (3)(E)—

‘‘(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

‘‘(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

‘‘(5) Service area requirement.—For purposes of this part, the Administrator shall designate at least 10 areas covering the entire United States and to the extent practicable shall be consistent with EFFS regions established under section 1860E–1(a)(2).

‘‘(c) Waiver of Certain Requirements to Expand Choice.—

‘‘(1) In general.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) have been met.

‘‘(2) Grounds for approval.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

‘‘(3) Application of waiver procedures.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

‘‘(4) Licensure does not substitute for or constitute certification.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

‘‘(5) References to certain provisions.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

‘‘(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

‘‘(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

‘‘(d) Solvency Standards for Non-Licensed Sponsors.—

‘‘(1) Establishment.—The Administrator shall establish, by not later than October 1, 2004, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

‘‘(2) Compliance with standards.—Each PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

‘‘(e) Relation to State Laws.—

‘‘(1) In general.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency, except as provided in subsection (d)) with respect to prescription drug plans which are offered by PDP sponsors under this part.

‘‘(2) Prohibition of state imposition of premium taxes.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Administrator under this part.

“SEC. 1860D–5. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

‘‘(a) In General.—The Administrator shall establish a process for the selection of the prescription drug plan or MA-EFFS Rx plan through which eligible individuals elect qualified prescription drug coverage under this part.

‘‘(b) Elements.—Such process shall include the following:

‘‘(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860D–1(b)(2).

‘‘(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-Federal entities.

‘‘(3) Coordination of elections through filing with the entity offering a MA-EFFS Rx plan or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

‘‘(4) Informing each enrollee before the beginning of each year of the annual out-of-pocket threshold applicable to the enrollee for that year under section 1860D–2(b)(4) at such time.

‘‘(c) MA-EFFS Rx Enrollee May Only Obtain Benefits Through the Plan.—An individual who is enrolled under a MA-EFFS Rx plan may only elect to receive qualified prescription drug coverage under this part through such plan.

‘‘(d) Assuring Access to a Choice of Qualified Prescription Drug Coverage.—

‘‘(1) Choice of at least two plans in each area.—

‘‘(A) In general.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

‘‘(B) Requirement for different plan sponsors.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or one entity that offers a MA-EFFS Rx plan offers all the qualifying plans in the area.

‘‘(2) Guaranteeing access to coverage.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator may provide partial underwriting of risk for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

‘‘(3) Limitation on authority.—In exercising authority under this subsection, the Administrator—

‘‘(A) shall not provide for the full underwriting of financial risk for any PDP sponsor; and

‘‘(B) shall seek to maximize the assumption of financial risk by PDP sponsors or entities offering a MA-EFFS Rx plan.

‘‘(4) Reports.—The Administrator shall, in each annual report to Congress under section 1809(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

‘‘(5) Qualifying plan defined.—For purposes of this subsection, the term ‘qualifying plan’ means a prescription drug plan or a MA-EFFS Rx plan.

“SEC. 1860D–6. SUBMISSION OF BIDS AND PREMIUMS.

‘‘(a) Submission of Bids, Premiums, and Related Information.—

‘‘(1) In general.—Each PDP sponsor shall submit to the Administrator the information described in paragraph (2) in the same manner as information is submitted by an organization under section 1854(a)(1).

‘‘(2) Information submitted.—The information described in this paragraph is the following:

‘‘(A) Coverage provided.—Information on the qualified prescription drug coverage to be provided.

‘‘(B) Actuarial value.—Information on the actuarial value of the coverage.

‘‘(C) Bid and premium.—Information on the bid and the premium for the coverage, including an actuarial certification of—

‘‘(i) the actuarial basis for such bid and premium;

‘‘(ii) the portion of such bid and premium attributable to benefits in excess of standard coverage;

‘‘(iii) the reduction in such bid resulting from the reinsurance subsidy payments provided under section 1860D–8(a)(2); and

‘‘(iv) the reduction in such premium resulting from the direct and reinsurance subsidy payments provided under section 1860D–8.

‘‘(D) Additional information.—Such other information as the Administrator may require to carry out this part.

"(3) Review of information; negotiation and approval of premiums.—

"(A) In general.—Subject to subparagraph (B), the Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D–4(b)(2) (relating to using OPM-like authority under the FEHBP). The Administrator, using the information provided (including the actuarial certification under paragraph (2)(C)) shall approve the premium submitted under this subsection only if the premium accurately reflects both (i) the actuarial value of the benefits provided, and (ii) the 73 percent average subsidy provided under section 1860D–8 for the standard benefit. The Administrator shall apply actuarial principles to approval of a premium under this part in a manner similar to the manner in which those principles are applied in establishing the monthly part B premium under section 1839.

"(B) Exception.—In the case of a plan described in section 1851(a)(2)(C), the provisions of subparagraph (A) shall not apply and the provisions of paragraph (5)(B) of section 1854(a), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and proportion referred to in subparagraph (A).

"(b) Uniform Bid and Premium.—

"(1) In general.—The bid and premium for a prescription drug plan under this section may not vary among enrollees in the plan in the same service area.

"(2) Construction.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860D–1(c)(2)(B).

"(c) Collection.—

"(1) Beneficiary's option of payment through withholding from social security payment or use of electronic funds transfer mechanism.—In accordance with regulations, a PDP sponsor shall permit each enrollee, at the enrollee's option, to make payment of premiums under this part to the sponsor through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839 or through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account) or otherwise. All premium payments that are withheld under this paragraph shall be credited to the Medicare Prescription Drug Trust Fund and shall be paid to the PDP sponsor involved.

"(2) Offsetting.—Reductions in premiums for coverage under parts A and B as a result of a selection of a MA-EFFS Rx plan may be used to reduce the premium otherwise imposed under paragraph (1).

"(d) Acceptance of Reference Premium Amount as Full Premium for Subsidized Low-Income Individuals if No Standard (or Equivalent) Coverage in an Area.—

"(1) In general.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860D–7 and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any entity offering a MA-EFFS Rx plan in the area) shall accept the reference premium amount (under paragraph (3)) as payment in full for the premium charge for qualified prescription drug coverage.

"(2) Standard prescription drug coverage defined.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

"(3) Reference premium amount defined.—For purposes of this subsection, the term 'reference premium amount' means, with respect to qualified prescription drug coverage offered under—

"(A) a prescription drug plan that—

"(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the plan's PDP premium; or

"(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the plan's PDP premium multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage;

"(B) an EFFS plan, the EFFS monthly prescription drug beneficiary premium (as defined in section 1860E–4(a)(3)(B)); or

"(C) a Medicare Advantage, the Medicare Advantage monthly prescription drug beneficiary premium (as defined in section 1854(b)(2)(B)).

For purposes of subparagraph (A), the term 'PDP premium' means, with respect to a prescription drug plan, the premium amount for enrollment under the plan under this part (determined without regard to any low-income subsidy under section 1860D–7 or any late enrollment penalty under section 1860D–1(c)(2)(B)).

"SEC. 1860D–7. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

"(a) Income-Related Subsidies for Individuals With Income Below 150 Percent of Federal Poverty Level.—

"(1) Full premium subsidy and reduction of cost-sharing for individuals with income below 135 percent of federal poverty level.—In the case of a subsidy eligible individual (as defined in paragraph (4)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

"(A) to an income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

"(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860D–2(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

"(2) Sliding scale premium subsidy for individuals with income above 135, but below 150 percent, of federal poverty level.—In the case of a subsidy eligible individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

"(3) Construction.—Nothing in this section shall be construed as preventing a PDP sponsor or entity offering a MA-EFFS Rx plan from reducing to 0 the cost-sharing otherwise applicable to generic drugs.

"(4) Determination of eligibility.—

"(A) Subsidy eligible individual defined.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

"(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

"(ii) has income below 150 percent of the Federal poverty line; and

"(iii) meets the resources requirement described in subparagraph (D).

"(B) Determinations.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

"(C) Income determinations.—For purposes of applying this section—

"(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

"(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(D) Resource standard applied to be based on three times SSI resource standard.—The resource requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

"(i) for 2006 three times the maximum amount of resources that an individual may have and obtain benefits under that program; and

"(ii) for a subsequent year the resource limitation established under this clause for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any resource limitation established under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(E) Treatment of territorial residents.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

"(F) Treatment of conforming medigap policies.—For purposes of this section, the term 'qualified prescription drug coverage' includes a medicare supplemental policy described in section 1860D–8(b)(4).

"(5) Indexing dollar amounts.—

"(A) For 2007.—The dollar amounts applied under paragraphs (1)(B) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860D–2(b)(5) for 2007.

"(B) For subsequent years.—The dollar amounts applied under paragraph (1)(B) for a year after 2007 shall be the amounts (under this paragraph) applied under paragraph (1)(B) for the preceding year increased by the annual percentage increase described in section 1860D–2(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

"(b) PREMIUM SUBSIDY AMOUNT.—

"(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark premium amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the MA-EFFS Rx plan in which the individual is enrolled.

"(2) BENCHMARK PREMIUM AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark premium amount' means, with respect to qualified prescription drug coverage offered under—

"(A) a prescription drug plan that—

"(i) provides standard coverage (or alternative prescription drug coverage the actuarial value of which is equivalent to that of standard coverage), the premium amount for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860D–1(c)(2)(B)); or

"(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the premium amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

"(B) a MA-EFFS Rx plan, the portion of the premium amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

"(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

"(1) IN GENERAL.—In applying subsection (a)(1)(B), nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

"(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B), the PDP sponsor or entity offering a MA-EFFS Rx plan may not charge more than $5 per prescription.

"(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(5) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B).

"(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a MA-EFFS Rx plan—

"(1) the Administrator provides for a notification of the PDP sponsor or the entity offering the MA-EFFS Rx plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

"(2) the sponsor or entity involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

"(3) the Administrator periodically and on a timely basis reimburses the sponsor or entity for the amount of such reductions.

The reimbursement under paragraph (3) with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

"(e) RELATION TO MEDICAID PROGRAM.—

"(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

"(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX consistent with section 1935(d)(1).

"(3) COORDINATION.—The Administrator shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

"SEC. 1860D–8. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries consistent with an overall subsidy level of 73 percent, to reduce adverse selection among prescription drug plans and MA-EFFS Rx plans, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

"(1) DIRECT SUBSIDY.—In the case of an enrollee enrolled for a month in a prescription drug plan or a MA-EFFS Rx plan, a direct subsidy equal to 43 percent of the national average monthly bid amount (computed under subsection (g)) for that month.

"(2) SUBSIDY THROUGH REINSURANCE.—In the case of an enrollee enrolled for a month in a prescription drug plan or a MA-EFFS Rx plan, the reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of the total payments made by qualifying entities for standard coverage under the respective plan, for excess costs incurred in providing qualified prescription drug coverage—

"(A) for enrollees with a prescription drug plan under this part; and

"(B) for enrollees with a MA-EFFS Rx plan.

"(3) EMPLOYER AND UNION FLEXIBILITY.—In the case of an individual who is a participant or beneficiary in a qualified retiree prescription drug plan (as defined in subsection (f)(1)) and who is not enrolled in a prescription drug plan or in a MA-EFFS Rx plan, the special subsidy payments under subsection (f)(3).

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

"(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

"(1) A PDP sponsor offering a prescription drug plan under this part.

"(2) An entity that offers a MA-EFFS Rx plan.

"(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

"(c) REINSURANCE PAYMENT AMOUNT.—

"(1) IN GENERAL.—Subject to subsection (d)(1)(B) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in paragraph (5)) for a coverage year (as defined in subsection (h)(2)) is equal to the sum of the following:

"(A) REINSURANCE BETWEEN INITIAL REINSURANCE THRESHOLD AND THE INITIAL COVERAGE LIMIT.—For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds the initial reinsurance threshold specified in paragraph (4), but does not exceed the initial coverage limit specified in section 1860D–2(b)(3), an amount equal to 20 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

"(B) REINSURANCE ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860D-2(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

"(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

"(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

"(4) INITIAL REINSURANCE THRESHOLD.—The initial reinsurance threshold specified in this paragraph—

"(A) for 2006, is equal to $1,000; or

"(B) for a subsequent year, is equal to the payment threshold specified in this paragraph for the previous year, increased by the annual percentage increase described in section 1860D–2(b)(5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(5) QUALIFYING COVERED INDIVIDUAL DEFINED.—For purposes of this subsection, the term 'qualifying covered individual' means an individual who—

"(A) is enrolled with a prescription drug plan under this part; or

"(B) is enrolled with a MA-EFFS Rx plan.

"(d) ADJUSTMENT OF PAYMENTS.—

"(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REINSURANCE.—

"(A) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

"(i) the total payments to be made (without regard to this subsection) during a year under subsections (a)(2) and (c); and

"(ii) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

"(B) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) and (c) for a coverage year in such manner so that the total of the payments made under such subsections for the year is equal to 30 percent of the total payments described in subparagraph (A)(ii).

"(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments made under such subsection.

"(e) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

"(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Trust Fund.

"(f) RULES RELATING TO QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

"(1) DEFINITION.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (4)(A)) if, with respect to an individual who is a participant or beneficiary under such coverage and is eligible to be enrolled in a prescription drug plan or a MA-EFFS Rx plan under this part, the following requirements are met:

"(A) ACTUARIAL EQUIVALENCE TO STANDARD COVERAGE.—The Administrator determines (based on an actuarial analysis approved by the Administrator) that coverage provides at least the same actuarial value as standard coverage. Such determination may be made on an annual basis.

"(B) AUDITS.—The sponsor (or the administrator, if designated by the sponsor) and the plan shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made.

"(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860D–1(c)(2)(D).

"(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to a participant or beneficiary in a qualified retiree prescription drug plan unless the individual is—

"(A) is covered under the plan; and

"(B) is eligible to obtain qualified prescription drug coverage under section 1860D–1 but did not elect such coverage under this part (either through a prescription drug plan or through a MA-EFFS Rx plan).

"(3) EMPLOYER AND UNION SPECIAL SUBSIDY AMOUNTS.—

"(A) IN GENERAL.—For purposes of subsection (a), the special subsidy payment amount under this paragraph for a qualifying covered retiree (as defined in paragraph (6)) for a coverage year (as defined in subsection (h)) enrolled in a qualifying entity described in subsection (b)(3) under a qualified retiree prescription drug plan is, for the portion of the individual's gross covered prescription drug costs for the year that exceeds the deductible amount specified in subparagraph (B), an amount equal to, subject to subparagraph (D), 28 percent of the allowable costs attributable to such gross covered prescription drug costs, but only to the extent such costs exceed the deductible under subparagraph (B) and do not exceed the cost limit under such subparagraph in the case of any such individual for the plan year.

"(B) DEDUCTIBLE AND COST LIMIT APPLICABLE.—Subject to subparagraph (C)—

"(i) the deductible under this subparagraph is equal to $250 for plan years that end in 2006; and

"(ii) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

"(C) INDEXING.—The deductible and cost limit amounts specified in subparagraphs (B) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible under section 1860D–2(b)(1) is annually adjusted under such section.

"(4) RELATED DEFINITIONS.—As used in this section:

"(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals eligible to enroll in a prescription drug plan or MA-EFFS Rx plan under this part (or for such individuals and their spouses and dependents) under a group health plan (including such a plan that is established or maintained under or pursuant to one or more collective bargaining agreements or that is offered under chapter 89 of title 5, United States Code) based on their status as retired participants in such plan.

"(B) QUALIFYING COVERED RETIREE.—The term 'qualifying covered retiree' means an individual who is eligible to obtain qualified prescription drug coverage under section 1860D–1 but did not elect such coverage under this part (either through a prescription drug plan or through a MA-EFFS Rx plan) but is covered under a qualified retiree prescription drug plan.

"(C) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"(5) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) precluding an individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in a MA-EFFS plan;

"(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under such a prescription drug plan or MA-EFFS plan on behalf of such an individual; or

"(C) preventing such employment-based retiree health coverage from providing coverage for retirees—

"(i) who are covered under a qualified retiree prescription plan that is better than standard coverage; or

"(ii) who are not covered under a qualified retiree prescription plan but who are enrolled in a prescription drug plan or a MA-EFFS Rx plan, that is supplemental to the benefits provided under such prescription drug plan or MA-EFFS Rx plan, except that any such supplemental coverage (not including payment of any premium referred to in subparagraph (B)) shall be treated as primary coverage to which section 1862(b)(2)(A)(i) is deemed to apply.

"(g) COMPUTATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT.—

"(1) IN GENERAL.—For each year (beginning with 2006) the Administrator shall compute a national average monthly bid amount equal to the average of the benchmark bid amounts for each prescription drug plan and for each MA-EFFS Rx plan (as computed under paragraph (2), but excluding plans described in section 1851(a)(2)(C))) adjusted under paragraph (4) to take into account reinsurance payments.

"(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark bid amount' means, with respect to qualified prescription drug coverage offered under—

"(A) a prescription drug plan that—

"(i) provides standard coverage (or alternative prescription drug coverage the actuarial value of which is equivalent to that of standard coverage), the PDP bid; or

"(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the PDP bid multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

"(B) a MA-EFFS Rx plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

For purposes of subparagraph (A), the term 'PDP bid' means, with respect to a prescription drug plan, the bid amount for enrollment under the plan under this part (determined without regard to any low-income subsidy under section 1860D–7 or any late enrollment penalty under section 1860D–1(c)(2)(B)).

"(3) WEIGHTED AVERAGE.—

"(A) IN GENERAL.—The monthly national average monthly bid amount computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

"(B) SPECIAL RULE FOR 2006.—For purposes of applying this subsection for 2006, the Administrator shall establish procedures for determining the weighted average under subparagraph (A) for 2005.

"(4) ADJUSTMENT TO ADD BACK IN VALUE OF REINSURANCE SUBSIDIES.—The adjustment under this paragraph, to take into account reinsurance payments under subsection (c) making up 30 percent of total payments, is such an adjustment as will make the national average monthly bid amount represent 100 percent, instead of representing 70 percent, of average payments under this part.

"(h) COVERAGE YEAR DEFINED.—For purposes of this section, the term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

"SEC. 1860D–9. MEDICARE PRESCRIPTION DRUG TRUST FUND.

"(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Prescription Drug Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

"(b) Payments From Trust Fund.—

"(1) In general.—The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Administrator certifies are necessary to make—

"(A) payments under section 1860D–7 (relating to low-income subsidy payments);

"(B) payments under section 1860D–8 (relating to subsidy payments); and

"(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

"(2) Transfers to medicaid account for increased administrative costs.—The Managing Trustee shall transfer from time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

"(c) Deposits Into Trust Fund.—

"(1) Low-income transfer.—There is hereby transferred to the Trust Fund, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

"(2) Appropriations to cover government contributions.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

"(d) Relation to Solvency Requirements.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

"SEC. 1860D–10. DEFINITIONS; APPLICATION TO MEDICARE ADVANTAGE AND EFFS PROGRAMS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

"(a) Definitions.—For purposes of this part:

"(1) Covered outpatient drugs.—The term 'covered outpatient drugs' is defined in section 1860D–2(f).

"(2) Initial coverage limit.—The term 'initial coverage limit' means such limit as established under section 1860D–2(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

"(3) Medicare prescription drug trust fund.—The term 'Medicare Prescription Drug Trust Fund' means the Trust Fund created under section 1860D–9(a).

"(4) PDP sponsor.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

"(5) Prescription drug plan.—The term 'prescription drug plan' means health benefits coverage that—

"(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Administrator and the sponsor under section 1860D–4(b);

"(B) provides qualified prescription drug coverage; and

"(C) meets the applicable requirements of the section 1860D–3 for a prescription drug plan.

"(6) Qualified prescription drug coverage.—The term 'qualified prescription drug coverage' is defined in section 1860D–2(a).

"(7) Standard coverage.—The term 'standard coverage' is defined in section 1860D–2(b).

"(8) Insurance risk.—The term 'insurance risk' means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.

"(b) Offer of Qualified Prescription Drug Coverage Under Medicare Advantage and EFFS Programs.—

"(1) As part of medicare advantage plan.—Medicare Advantage organizations are required to offer Medicare Advantage plans that include qualified prescription drug coverage under part C pursuant to section 1851(j).

"(2) As part of EFFS plan.—EFFS organizations are required to offer EFFS plans that include qualified prescription drug coverage under part E pursuant to section 1860E–2(d).

"(c) Application of Part C Provisions Under this Part.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

"(1) any reference to a Medicare Advantage or other plan included a reference to a prescription drug plan;

"(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

"(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–4(b); and

"(4) any reference to part C included a reference to this part.

"(d) Report on Pharmacy Services Provided to Long-Term Care Facility Patients.—

"(1) Review.—Within 6 months after the date of the enactment of this section, the Secretary shall review the current standards of practice for pharmacy services provided to patients in nursing facilities and other long-term care facilities.

"(2) Evaluations and recommendations.—Specifically in the review under paragraph (1), the Secretary shall—

"(A) assess the current standards of practice, clinical services, and other service requirements generally utilized for pharmacy services in the long-term care setting;

"(B) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care; and

"(C) recommend (in the Secretary's report under paragraph (3)) necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities and other long-term care facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

"(3) Report.—The Secretary shall submit a report to the Congress on the Secretary's findings and recommendations under this subsection, including a detailed description of the Secretary's plans to implement this part in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of patients of nursing facilities and other long-term care facilities.".

(b) Additional Conforming Changes.—

(1) Conforming references to previous part D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(2) Conforming amendment permitting waiver of cost-sharing.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.".

(3) Submission of legislative proposal.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this subtitle.

(c) Study on Transitioning Part B Prescription Drug Coverage.—Not later than January 1, 2005, the Medicare Benefits Administrator shall submit a report to Congress that makes recommendations regarding methods for providing benefits under part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE AND ENHANCED FEE-FOR-SERVICE (EFFS) PROGRAM.

(a) Medicare Advantage.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

"(j) Availability of Prescription Drug Benefits and Subsidies.—

"(1) Offering of qualified prescription drug coverage.—A Medicare Advantage organization on and after January 1, 2006—

"(A) may not offer a Medicare Advantage plan described in section 1851(a)(2)(A) in an area unless either that plan (or another Medicare Advantage plan offered by the organization in that area) includes qualified prescription drug coverage; and

"(B) may not offer the prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare Advantage plan, unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

"(2) Requirement for election of part D coverage to obtain qualified prescription drug coverage.—For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860D–1(b) shall be treated as being ineligible to enroll in a Medicare Advantage plan under this part that offers such coverage.

"(3) Compliance with certain additional beneficiary protections for prescription drug coverage.—With respect to the offering of qualified prescription drug coverage by a Medicare Advantage organization under this part on and after January 1, 2006, the organization and plan shall meet the requirements of subsections (a) through (d) of section 1860D–3 in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860D–6(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

"(4) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES.—In the case of low-income individuals who are enrolled in a Medicare Advantage plan that provides qualified prescription drug coverage, premium and cost-sharing subsidies are provided for such coverage under section 1860D–7.

"(5) AVAILABILITY OF DIRECT AND REINSURANCE SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—Medicare Advantage organizations are provided direct and reinsurance subsidy payments for providing qualified prescription drug coverage under this part under section 1860D–8.

"(6) CONSOLIDATION OF DRUG AND NON-DRUG PREMIUMS.—In the case of a Medicare Advantage plan that includes qualified prescription drug coverage, with respect to an enrollee in such plan there shall be a single premium for both drug and non-drug coverage provided under the plan.

"(7) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2006 shall be the 6-month period beginning with November 2005.

"(8) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860D–2.

"(9) SPECIAL RULES FOR PRIVATE FEE-FOR-SERVICE PLANS.— With respect to a Medicare Advantage plan described in section 1851(a)(2)(C) that offers qualified prescription drug coverage—

"(A) REQUIREMENTS REGARDING NEGOTIATED PRICES.—Subsections (a)(1) and (d)(1) of section 1860D–2 shall not be construed to require the plan to negotiate prices or discounts but shall apply to the extent the plan does so.

"(B) MODIFICATION OF PHARMACY PARTICIPATION REQUIREMENT.—If the plan provides access, without charging additional copayments, to all pharmacies without regard to whether they are participating pharmacies in a network, section 1860D-3(c)(1)(A)(iii) shall not apply to the plan.

"(C) DRUG UTILIZATION MANAGEMENT PROGRAM NOT REQUIRED.—The requirements of section 1860D-3(d)(1)(A) shall not apply to the plan.

"(D) NON-PARTICIPATING PHARMACY DISCLOSURE EXCEPTION.—If the plan provides coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D-3(d)(5) shall not apply to the plan.".

(b) APPLICATION TO EFFS PLANS.—Subsection (d) of section 1860E–2, as added by section 201(a), is amended to read as follows:

"(d) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS AND SUBSIDIES.—

"(1) OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—An EFFS organization—

"(A) may not offer an EFFS plan in an area unless either that plan (or another EFFS plan offered by the organization in that area) includes qualified prescription drug coverage; and

"(B) may not offer the prescription drug coverage (other than that required under parts A and B) to an enrollee under an EFFS plan, unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

"(2) REQUIREMENT FOR ELECTION OF PART D COVERAGE TO OBTAIN QUALIFIED PRESCRIPTION DRUG COVERAGE.—For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860D–1(b) shall be treated as being ineligible to enroll in an EFFS plan under this part that offers such coverage.

"(3) COMPLIANCE WITH CERTAIN ADDITIONAL BENEFICIARY PROTECTIONS FOR PRESCRIPTION DRUG COVERAGE.—With respect to the offering of qualified prescription drug coverage by an EFFS organization under this part, the organization and plan shall meet the requirements of subsections (a) through (d) of section 1860D–3 in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860D–6(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

"(4) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES.—In the case of low-income individuals who are enrolled in an EFFS plan that provides qualified prescription drug coverage, premium and cost-sharing subsidies are provided for such coverage under section 1860D–7.

"(5) AVAILABILITY OF DIRECT AND REINSURANCE SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—EFFS organizations are provided direct and reinsurance subsidy payments for providing qualified prescription drug coverage under this part under section 1860D–8.

"(6) CONSOLIDATION OF DRUG AND NON-DRUG PREMIUMS.—In the case of an EFFS plan that includes qualified prescription drug coverage, with respect to an enrollee in such plan there shall be a single premium for both drug and non-drug coverage provided under the plan.

"(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860D–2.".

(c) CONFORMING AMENDMENTS.—Section 1851 (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)—

(A) by inserting "(other than qualified prescription drug benefits)" after "benefits";

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

"and may elect qualified prescription drug coverage in accordance with section 1860D–1."; and

(2) in subsection (g)(1), by inserting "and section 1860D–1(c)(2)(B)" after "in this subsection".

(d) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2006.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking "and" at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting "; and"; and

(C) by inserting after paragraph (65) the following new paragraph:

"(66) provide for making eligibility determinations under section 1935(a).".

(2) NEW SECTION.—Title XIX is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

"SPECIAL PROVISIONS RELATING TO MEDICARE
PRESCRIPTION DRUG BENEFIT

"SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

"(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860D–7;

"(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

"(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–7).

"(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

"(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows (but in no case shall the rate as so increased exceed 100 percent):

"(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 6-⅔ percent of the percentage otherwise payable (but · for this subsection) by the State.

"(B)(i) For expenditures attributable to costs incurred during 2006 and each subsequent year through 2018, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

"(ii) For purposes of clause (i), the 'applicable percent' for—

"(I) 2006 is 13-⅓ percent; or

"(II) a subsequent year is the applicable percent under this clause for the previous year increased by 6-⅔ percentage points.

"(C) For expenditures attributable to costs incurred after 2018, the otherwise applicable Federal matching rate shall be increased to 100 percent.

"(2) COORDINATION.—The State shall provide the Administrator with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.".

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(c)(1) for the State and the quarter".

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

“(c) Federal Assumption of Medicaid Prescription Drug Costs for Dually-Eligible Beneficiaries.—

“(1) In general.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

“(A) Medicare subsidies.—The total amount of payments made in the quarter under section 1860D–7 (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

“(B) State matching rate.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

“(C) Phase-out proportion.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

“(2) Phase-out proportion.—For purposes of paragraph (1)(C), the ‘phase-out proportion’ for a calendar quarter in—

“(A) 2006 is 93⅓ percent;

“(B) a subsequent year before 2021, is the phase-out proportion for calendar quarters in the previous year decreased by 6-⅔ percentage points; or

“(C) a year after 2020 is 0 percent.”.

(c) Medicaid Providing Wrap-Around Benefits.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

“(d) Additional Provisions.—

“(1) Medicaid as secondary payor.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a MA-EFFS Rx plan under part C or E of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title (other than for copayment amounts specified in section 1860D–7(a)(1)(B), notwithstanding section 1916) for prescribed drugs to the extent payment is not made under the prescription drug plan or MA-EFFS Rx plan selected by the individual.

“(2) Condition.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860D–1.”.

(d) Treatment of Territories.—

(1) In general.—Section 1935, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting “subject to subsection (e)” after “section 1903(a)”;

(B) in subsection (c)(1), by inserting “subject to subsection (e)” after “1903(a)(1)”; and

(C) by adding at the end the following new subsection:

“(e) Treatment of Territories.—

“(1) In general.—In the case of a State, other than the 50 States and the District of Columbia—

“(A) the previous provisions of this section shall not apply to residents of such State; and

“(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

“(2) Plan.—The plan described in this paragraph is a plan that—

“(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860D–2(f)) to low-income medicare beneficiaries; and

“(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

“(3) Increased amount.—

“(A) In general.—The amount specified in this paragraph for a State for a year is equal to the product of—

“(i) the aggregate amount specified in subparagraph (B); and

“(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

“(B) Aggregate amount.—The aggregate amount specified in this subparagraph for—

“(i) 2006, is equal to $25,000,000; or

“(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860D–2(b)(5) for the year involved.

“(4) Report.—The Administrator shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Administrator deems appropriate.”.

(2) Conforming amendment.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting “and section 1935(e)(1)(B)” after “Subject to subsection (g)”.

(e) Amendment to Best Price.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking “and” at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting “; and”; and

(3) by adding at the end the following new subclause:

“(V) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by a MA-EFFS Rx plan under part C or E of such title with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860D–8(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.”.

SEC. 104. MEDIGAP TRANSITION.

(a) In General.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(v) Coverage of Prescription Drugs.—

“(1) In general.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2006, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs. Nothing in this subsection shall be construed as preventing the policy holder of a medicare supplemental policy issued before January 1, 2006, from continuing to receive benefits under such policy on and after such date.

“(2) Issuance of substitute policies for beneficiaries enrolled with a plan under part D.—

“(A) In general.—The issuer of a medicare supplemental policy—

“(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’, ‘F’, or ‘G’ (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

“(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

“(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

“(B) Individual covered.—An individual described in this subparagraph is an individual who—

“(i) enrolls in a prescription drug plan under part D; and

“(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ‘H’, ‘I’, or ‘J’ under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

“(C) Enforcement.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

“(3) New standards.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Prescription Drug and Modernization Act of 2003, with respect to policies issued to individuals who are enrolled in a plan under part D, the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that may provide for coverage of cost-sharing (other than the prescription drug deductible) with respect to qualified prescription drug coverage under such part. The two benefit packages shall be consistent with the following:

“(A) First new policy.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

“(i) Coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

“(ii) No coverage of the part B deductible.

“(iii) Coverage for all hospital coinsurance for long stays (as in the current core benefit package).

“(iv) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

“(B) Second new policy.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

“(i) Substitute ‘75 percent’ for ‘50 percent’ in clause (i) of such subparagraph.

“(ii) Substitute ‘$2,000’ for ‘$4,000’ in clause (iv) of such subparagraph.

“(4) Construction.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met through the offering of other coverage under this subsection.”.

(b) NAIC Report to Congress on Medigap Modernization.—The Secretary shall request the National Association of Insurance Commissioners to submit to Congress, not later than 18 months after the date of the enactment of this Act, a report that includes recommendations on the modernization of coverage under the medigap program under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND ASSISTANCE PROGRAM.

(a) In General.—Title XVIII is amended by inserting after section 1806 the following new sections:

“MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT AND ASSISTANCE PROGRAM

“Sec. 1807. (a) Establishment of Program.—

“(1) In general.—The Secretary shall establish a program—

“(A) to endorse prescription drug discount card programs (each such program referred to as an ‘endorsed program’) that meet the requirements of this section in order to provide access to prescription drug discounts through eligible entities for medicare beneficiaries throughout the United States; and

“(B) to provide for prescription drug accounts and public contributions into such accounts.

The Secretary shall make available to medicare beneficiaries information regarding endorsed programs and accounts under this section.

“(2) Limited period of operation.—The Secretary shall begin—

“(A) the card endorsement part of the program under paragraph (1)(A) as soon as possible, but in no case later than 90 days after the date of the enactment of this section; and

“(B) the prescription drug account part of the program under paragraph (1)(B) as soon as possible, but in no case later than September 2004.

“(3) Transition.—The program under this section shall continue through 2005 throughout the United States. The Secretary shall provide for an appropriate transition and termination of such program on January 1, 2006.

“(4) Voluntary nature of program.—Nothing in this section shall be construed as requiring an eligible beneficiary to enroll in the program under this section.

“(b) Eligible Beneficiary; Eligible Entity; Prescription Drug Account.—For purposes of this section:

“(1) Eligible beneficiary.—The term ‘eligible beneficiary’ means an individual who is eligible for benefits under part A or enrolled under part B and who is not enrolled in a Medicare Advantage plan that offers qualified prescription drug coverage.

“(2) Eligible entity.—The term ‘eligible entity’ means any entity that the Secretary determines to be appropriate to provide the benefits under this section, including—

“(A) pharmaceutical benefit management companies;

“(B) wholesale and retail pharmacy delivery systems;

“(C) insurers;

“(D) Medicare Advantage organizations;

“(E) other entities; or

“(F) any combination of the entities described in subparagraphs (A) through (E).

“(3) Prescription drug account.—The term ‘prescription drug account’ means, with respect to an eligible beneficiary, an account established for the benefit of that beneficiary under section 1807A.

“(c) Enrollment in Endorsed Plan.—

“(1) Establishment of process.—

“(A) In general.—The Secretary shall establish a process through which an eligible beneficiary may make an election to enroll under this section with an endorsed program.

“(B) Requirement of enrollment.—An eligible beneficiary must enroll under this section for a year in order to be eligible to receive the benefits under this section for that year.

“(C) Limitation on enrollment.—

“(i) In general.—Except as provided under this subparagraph and under such exceptional circumstances as the Secretary may provide, an eligible individual shall have the opportunity to enroll under this section during an initial, general enrollment period as soon as possible after the date of the enactment of this section and annually thereafter. The Secretary shall specify the form, manner, and timing of such election but shall permit the exercise of such election at the time the individual is eligible to enroll. The annual open enrollment periods shall be coordinated with those provided under the Medicare Advantage program under part C.

“(ii) Reelection after termination of enrollment in a medicare advantage plan.—In the case of an individual who is enrolled under this section and who subsequently enrolls in a Medicare Advantage plan that provides qualified prescription drug coverage under part C, the individual shall be given the opportunity to reenroll under this section at the time the individual discontinues the enrollment under such part.

“(iii) Late enrollment.—The Secretary shall permit individuals to elect to enroll under this section at times other than as permitted under the previous provisions of this paragraph.

“(D) Termination of enrollment.—An enrollee under this section shall be disenrolled—

“(i) upon enrollment in a Medicare Advantage plan under part C that provides qualified prescription drug coverage;

“(ii) upon failure to pay the applicable enrollment fee under subsection (f);

“(iii) upon termination of coverage under part A or part B; or

“(iv) upon notice submitted to the Secretary in such form, manner, and time as the Secretary shall provide.

Terminations of enrollment under this subparagraph shall be effective as specified by the Secretary in regulations.

“(2) Enrollment periods.—

“(A) In general.—Except as provided under this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

“(B) Open enrollment period for current beneficiaries.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this section and shall end not earlier than 3 months later, during which any eligible beneficiary may enroll under this section.

“(C) Special enrollment period in case of termination of coverage under a group health plan.—The Secretary shall provide for a special enrollment period under this section in the same manner as is provided under section 1837(i) with respect to part B, except that for purposes of this subparagraph any reference to ‘by reason of the individual's (or the individual's spouse's) current employment status’ shall be treated as being deleted.

“(3) Period of coverage.—

“(A) In general.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this section shall be effective for the period provided under section 1838, as if that section applied to the program under this section.

“(B) Enrollment during open and special enrollment.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this section under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this section beginning on the first day of the month following the month in which such enrollment occurs.

“(d) Selection of an Eligible Entity for Access to Negotiated Prices.—

“(1) Process.—

“(A) In general.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this section shall select any eligible entity, that has been awarded a contract under this section and serves the State in which the beneficiary resides, to provide access to negotiated prices under subsection (i).

“(B) Rules.—In establishing the process under subparagraph (A), the Secretary shall use rules similar to the rules for enrollment and disenrollment with a Medicare Advantage plan under section 1851 (including the special election periods under subsection (e)(4) of such section), including that—

“(i) an individual may not select more than one eligible entity at any time; and

“(ii) an individual shall only be permitted (except for unusual circumstances) to change the selection of the entity once a year.

In carrying out clause (ii), the Secretary may consider a change in residential setting (such as placement in a nursing facility) to be an unusual circumstance.

“(C) Default selection.—In establishing such process, the Secretary shall provide an equitable method for selecting an eligible entity for individuals who enroll under this section and fail to make such a selection.

“(2) Competition.—Eligible entities with a contract under this section shall compete for beneficiaries on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

“(e) Providing Enrollment, Selection, and Coverage Information to Beneficiaries.—

“(1) Activities.—The Secretary shall provide for activities under this section to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this section, the selection of eligible entities, and the prescription drug coverage made available by eligible entities with a contract under this section.

“(2) Special rule for first enrollment under the program.—To the extent practicable, the activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in subsection (c).

“(f) Enrollment Fee.—

“(1) Amount.—Except as provided in paragraph (3), enrollment under the program under this section is conditioned upon payment of an annual enrollment fee of $30. Such fee for 2004 shall include any portion of 2003 in which the program is implemented under this section.

“(2) Collection of enrollment fee.—The annual enrollment fee shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840, except that it shall be collected only 1 time per year.

“(3) Payment of enrollment fee by state for certain beneficiaries.—

“(A) In general.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all low income enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State and shall not be collected under paragraph (2). In carrying out this paragraph, the Secretary may apply procedures similar to that applied under state agreements under section 1843.

“(B) No federal matching available under medicaid or schip.—Expenditures made by a State described in subparagraph (A) shall not be treated as State expenditures for purposes of Federal matching payments under titles XIX and XXI insofar as such expenditures are for an enrollment fee under this subsection.

“(4) Distribution of portion of enrollment fee.—Of the enrollment fee collected by the Secretary under this subsection with respect to a beneficiary, ⅔ of that fee shall be made available to the eligible entity selected by the eligible beneficiary.

“(g) Issuance of Card and Coordination.—Each eligible entity shall—

“(1) issue, in a uniform standard format specified by the Secretary, to each enrolled beneficiary a card and an enrollment number that establishes proof of enrollment and that can be used in a coordinated manner—

“(A) to identify the eligible entity selected to provide access to negotiated prices under subsection (i); and

“(B) to make deposits to and withdrawals from a prescription drug account under section 1807A; and

“(2) provide for electronic methods to coordinate with the accounts established under section 1807A.

“(h) Enrollee Protections.—

“(1) Guaranteed issue and nondiscrimination.—

“(A) Guaranteed issue.—

“(i) In general.—An eligible beneficiary who is eligible to select an eligible entity under subsection (b) for prescription drug coverage under this section at a time during which selections are accepted under this section with respect to the coverage shall not be denied selection based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor and may not be charged any selection or other fee as a condition of such acceptance.

“(ii) Medicare advantage limitations permitted.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to selection of eligible entities under this paragraph.

“(B) Nondiscrimination.—An eligible entity offering prescription drug coverage under this section shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

“(C) Coverage of all portions of a state.—If an eligible entity with a contract under this section serves any part of a State it shall serve the entire State.

“(2) Dissemination of information.—

“(A) General information.—An eligible entity with a contract under this section shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary who has selected the entity to provide access to negotiated prices under this section at the time of selection and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage. Such information includes the following (in a manner designed to permit and promote competition among eligible entities):

“(i) Summary information regarding negotiated prices (including discounts) for covered outpatient drugs.

“(ii) Access to such prices through pharmacy networks.

“(iii) How any formulary used by the eligible entity functions.

“(B) Disclosure upon request of general coverage, utilization, and grievance information.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such beneficiary.

“(C) Response to beneficiary questions.—Each eligible entity offering prescription drug coverage under this section shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices, including discounts) to individuals who have selected the entity. The entity shall make available, through an Internet website and in writing upon request, information on specific changes in its formulary.

“(D) Coordination with prescription drug account benefits.—Each such eligible entity shall provide for coordination of such information as the Secretary may specify to carry out section 1807A.

“(3) Access to covered benefits.—

“(A) Ensuring pharmacy access.—The provisions of subsection (c)(1) of section 1860D-3 (other than payment provisions under section 1860D–8 with respect to sponsors under such subsection) shall apply to an eligible entity under this section in the same manner as they apply to a PDP sponsor under such section.

“(B) Access to negotiated prices for prescription drugs.—For requirements relating to the access of an eligible beneficiary to negotiated prices (including applicable discounts), see subsection (i).

“(C) Requirements on development and application of formularies.—Insofar as an eligible entity with a contract under this part uses a formulary, the entity shall comply with the requirements of section 1860D–3(c)(3), insofar as the Secretary determines that such requirements can be implemented on a timely basis.

“(4) Cost and utilization management; quality assurance; medication therapy management program.—

“(A) In general.—For purposes of providing access to negotiated benefits under subsection (i), the eligible entity shall have in place the programs and measure described in section 1860D–3(d), including an effective cost and drug utilization management program, quality assurance measures and systems, and a program to control fraud, abuse, and waste, insofar as the Secretary determines that such provisions can be implemented on a timely basis.

“(B) Treatment of accreditation.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to the requirements for an endorsed program under this section with respect to the following requirements, in the same manner as they apply to Medicare Advantage plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

“(i) Paragraph (3)(A) (relating to access to covered benefits).

“(ii) Paragraph (7) (relating to confidentiality and accuracy of enrollee records).

“(5) Grievance mechanism.—Each eligible entity shall provide meaningful procedures for hearing and resolving grievances between the organization consistent with the requirements of section 1860D–3(e) insofar as they relate to PDP sponsors of prescription drug plans.

“(6) Beneficiary services.—An eligible entity shall provide for its enrollees pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

“(7) Coverage determinations and reconsiderations.—An eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug coverage it offers under this section in the same manner as such requirements apply to a Medicare Advantage organization with respect to benefits it offers under a Medicare Advantage plan under part C.

“(8) Confidentiality and accuracy of enrollee records.—An eligible entity shall meet the requirements of section 1852(h) with respect to enrollees under this section in the same manner as such requirements apply to a Medicare Advantage organization with respect to enrollees under part C. The eligible entity shall implement policies and procedures to safeguard the use and disclosure of enrollees' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996. The eligible entity shall be treated as a covered entity for purposes of the provisions of subpart E of part 164 of title 45, Code of Federal Regulations, adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S. C. 1320d-2 note).

“(9) Periodic reports and oversight.—The eligible entity shall submit to the Secretary periodic reports on performance, utilization, finances, and such other matters as the Secretary may specify. The Secretary shall provide appropriate oversight to ensure compliance of eligible entities with the requirements of this subsection, including verification of the discounts and services provided.

“(10) Additional beneficiary protections.—The eligible entity meets such additional requirements as the Secretary identifies to protect and promote the interest of enrollees, including requirements that ensure that enrollees are not charged more than the lower of the negotiated retail price or the usual and customary price.

"(i) BENEFITS UNDER THE PROGRAM THROUGH SAVINGS TO ENROLLEES THROUGH NEGOTIATED PRICES.—

"(1) IN GENERAL.—Subject to paragraph (2), each eligible entity with a contract under this section shall provide each eligible beneficiary enrolled with the entity with access to negotiated prices (including applicable discounts). For purposes of this paragraph, the term 'prescription drugs' is not limited to covered outpatient drugs, but does not include any over-the-counter drug that is not a covered outpatient drug. The prices negotiated by an eligible entity under this paragraph shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(2) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for prescription drugs shall only be available for drugs included in such formulary.

"(3) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The negotiated prices under this subsection shall apply to prescription drugs that are available other than solely through mail order.

"(4) PROHIBITION ON CHARGES FOR REQUIRED SERVICES.—An eligible entity (and any pharmacy contracting with such entity for the provision of a discount under this section) may not charge a beneficiary any amount for any services required to be provided by the entity under this section.

"(5) DISCLOSURE.—The eligible entity offering the endorsed program shall disclose to the Secretary (in a manner specified by the Secretary) the extent to which discounts or rebates or other remuneration or price concessions made available to the entity by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Secretary under this paragraph in the same manner as such provisions apply to information disclosed under such section.

"(6) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug in connection with its endorsed program shall inform the enrollee in that program at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost available generic drug covered under the program that is therapeutically equivalent and bioequivalent.

"(j) CONTRIBUTION INTO PRESCRIPTION DRUG ACCOUNT.—

"(1) IN GENERAL.—In the case of an individual enrolled under this section, the Secretary shall—

"(A) establish a prescription drug account for the individual under section 1807A; and

"(B) subject to paragraph (5), deposit into such account on a monthly or other periodic basis an amount that, on an annual basis, is equivalent to the annual Federal contribution amount specified in paragraph (2) for the enrollee involved.

"(2) ANNUAL FEDERAL CONTRIBUTION AMOUNT.—Subject to paragraph (3), in the case of an accountholder whose income is—

"(A) not more than 135 percent of the poverty line, the annual Federal contribution amount for a year is $800;

"(B) more than 135 percent, but not more than 150 percent, of the poverty line, the annual Federal contribution amount for a year is $500; or

"(C) more than 150 percent of the poverty line, the annual Federal contribution amount for a year is $100.

"(3) INCOME ELIGIBILITY DETERMINATIONS.—The determination of whether an individual residing in a State is a eligible for a contribution under paragraph (1) shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Secretary. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this paragraph.

"(4) PARTIAL YEAR.—Insofar as the provisions of this subsection and section 1807A are not implemented for all months in 2004, the annual contribution amount under this subsection for 2004 shall be prorated to reflect the portion of that year in which such provisions are in effect.

"(5) RESTRICTION ON CONTRIBUTIONS.—There shall only be an annual Federal contribution under paragraph (1) for an individual if the individual is not eligible for coverage of, or assistance for, outpatient prescription drugs under any of the following:

"(A) A medicaid plan under title XIX (including under any waiver approved under section 1115).

"(B) Enrollment under a group health plan or health insurance coverage.

"(C) Enrollment under a medicare supplemental insurance policy.

"(D) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

"(E) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

"(F) Enrollment under a plan under chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

"(G) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

"(6) APPROPRIATION TO COVER NET PROGRAM EXPENDITURES.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this section exceed the sum of the portion of the enrollment fees retained by the Secretary.

"(k) DEFINITIONS.—In this part and section 1807A:

"(1) COVERED OUTPATIENT DRUG.—

"(A) IN GENERAL.—Except as provided in this paragraph, for purposes of this section, the term 'covered outpatient drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

"(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary),

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—

"(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this section shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this section shall not be so considered under an endorsed program if the eligible entity offering the program excludes the drug under a formulary and a review of such exclusion is not successfully resolved under subsection (h)(5).

"(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—An eligible entity offering an endorsed program may exclude from qualified prescription drug coverage any covered outpatient drug—

"(i) for which payment would not be made if section 1862(a) applied to part D; or

"(ii) which are not prescribed in accordance with the program or this section.

Such exclusions are determinations subject to review pursuant to subsection (h)(5).

"(2) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section and section 1807A.

"(e) INTERIM, FINAL REGULATORY AUTHORITY.—In order to carry out this section and section 1807A in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

"PRESCRIPTION DRUG ACCOUNTS

"SEC. 1807A. "(a) ESTABLISHMENT OF ACCOUNTS.—

"(1) IN GENERAL.—The Secretary shall establish and maintain for each eligible beneficiary who is enrolled under section 1807 at the time of enrollment a prescription drug account (in this section and section 1807 referred to as an 'account').

"(2) RESERVE ACCOUNTS.—In cases described in subsections (b)(3)(A), (b)(3)(B)(i), and (b)(3)(B)(ii)(I), the Secretary shall establish and maintain for each surviving spouse who is not enrolled under section 1807 a reserve prescription drug account (in this section referred to as an 'reserve account').

"(3) ACCOUNTHOLDER DEFINED.—In this section and section 1807A, the term 'accountholder' means an individual for whom an account or reserve account has been established under this section.

"(4) EXPENDITURES FROM ACCOUNT.—Nothing in this section shall be construed as requiring the Federal Government to obligate funds for amounts in any account until such time as a withdrawal from such account is authorized under this section.

"(b) USE OF ACCOUNTS.—

"(1) APPLICATION OF ACCOUNT.—Except as provided in this subsection, amounts credited to an account shall only be used for the purchase of covered outpatient drugs for the accountholder. Any amounts remaining at the end of a year remain available for expenditures in succeeding years.

"(2) Account rules for public and private contributions.—The Secretary shall establish a ongoing process for the determination of the amount in each account that is attributable to public and private contributions (including spousal rollover contributions) based on the following rules:

"(A) Treatment of expenditures.—Expenditures from the account shall—

"(i) first be counted against any public contribution; and

"(ii) next be counted against private contributions.

"(B) Treatment of spousal rollover contributions.—With respect to any spousal rollover contribution, the portions of such contribution that were attributable to public and private contributions at the time of its distribution under subsection (b)(3) shall be treated under this paragraph as if it were a direct public or private contribution, respectively, into the account of the spouse.

"(3) Death of accountholder.—In the case of the death of an accountholder, the balance in any account (taking into account liabilities accrued before the time of death) shall be distributed as follows:

"(A) Treatment of public contributions.—If the accountholder is married at the time of death, the amount in the account that is attributable to public contributions shall be credited to the account (if any) of the surviving spouse of the accountholder (or, if the surviving spouse is not an eligible beneficiary, into a reserve account to be held for when that spouse becomes an eligible beneficiary).

"(B) Treatment of private contributions.—The amount in the account that is attributable to private contributions shall be distributed as follows:

"(i) Designation of distributee.—If the accountholder has made a designation, in a form and manner specified by the Secretary, for the distribution of some or all of such amount, such amount shall be distributed in accordance with the designation. Such designation may provide for the distribution into an account (including a reserve account) of a surviving spouse.

"(ii) Absence of designation.—Insofar as the accountholder has not made such a designation—

"(I) Surviving spouse.—If the accountholder was married at the time of death, the remainder shall be credited to an account (including a reserve account) of the accountholder's surviving spouse.

"(II) No surviving spouse.—If the accountholder was not so married, the remainder shall be distributed to the estate of the accountholder and distributed as provided by law.

"(4) Use of account for premiums for enrollment in a medicare advantage plan.—During any period in which an accountholder is enrolled in a Medicare Advantage plan under part C, the balance in the account may be used and applied only to reimburse the amount of the premium (if any) established for enrollment under the plan.

"(5) Application to medicaid expenses in certain cases.—

"(A) In general.—Except as provided in this paragraph, an account shall be treated as an asset for purposes of establishing eligibility for medical assistance under title XIX.

"(B) Application towards spenddown.—In the case of an accountholder who is applying for such medical assistance and who would, but for the application of subparagraph (A), be eligible for such assistance—

"(i) subparagraph (A) shall not apply; and

"(ii) the account shall be available (in accordance with a procedure established by the Secretary) to the State to reimburse the State for any expenditures made under the plan for such medical assistance.

"(c) Amounts Credited in Account.—The Secretary shall credit to a prescription drug account of an eligible beneficiary the following amounts:

"(1) Public contributions.—The following contributions (each referred to in this section as a 'public contribution'):

"(A) Federal contributions.—Federal contributions provided under subsection (d).

"(B) State contributions.—Contributions made by a State under subsection (f).

"(2) Spousal rollover contribution.—A distribution from a deceased spouse under subsection (b)(3) (referred to in this section as a 'spousal rollover contribution').

"(3) Private contributions.—The following contributions (each referred to in this section as a 'private contribution'):

"(A) Employer and individual contributions.—Contributions made under subsection (e).

"(B) Other individual contributions.—Contributions made by accountholder other than under subsection (e).

"(C) Contributions by nonprofit organizations.—Contributions made by a charitable, not-for-profit organization (that may be a religious organization).

Except as provided in this subsection, no amounts may be contributed to, or credited to, a prescription drug account.

"(d) Federal Contribution.—For Federal contributions in the case of accountholders, see section 1807(j).

"(e) Employer and Individual Contributions.—

"(1) Employment-related contribution.—

"(A) In general.—In the case of any accountholder who is a beneficiary or participant in a group health plan (including a multi-employer plan), whether as an employee, former employee or otherwise, including as a dependent of an employee or former employee, the plan may make a contribution into the accountholder's account (but not into a reserve account of the accountholder).

"(B) Limitation.—The total amount that may be contributed under subparagraph (A) under a plan to an account during any year may not exceed $5,000.

"(C) Condition.—A group health plan may condition a contribution with respect to an accountholder under this paragraph on the accountholder's enrollment under section 1807 with an eligible entity that is recognized or approved by that plan.

"(2) Other individuals.—

"(A) In general.—Any individual may also contribute to the account of that individual or the account of any other individual under this subsection.

"(B) Limitation.—The total amount that may be contributed to an account under subparagraph (A) during any year may not exceed $5,000, regardless of who makes such contribution.

"(3) No contribution permitted to reserve account.—No contribution may be made under this subsection to a reserve account.

"(4) Form and manner of contribution.—The Secretary shall specify the form and manner of contributions under this subsection.

"(f) State Contributions.—

"(1) In general.—A State may enter into arrangements with the Secretary for the crediting of amounts for accountholders.

"(2) Form and manner of contribution.—The Secretary shall specify the form and manner of contributions under this subsection.

"(3) Medicaid treatment.—Amounts credited under this subsection shall not be treated as medical assistance for purposes of title XIX or child health assistance for purposes of title XXI for individuals who are not qualifying low income enrollees.".

(b) Exclusion of Costs From Determination of Part B Monthly Premium.—Section 1839(g) (42 U.S.C. 1395r(g)) is amended—

(1) by striking "attributable to the application of section" and inserting "attributable to—

"(1) the application of section";

(2) by striking the period and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(2) the Voluntary Medicare Outpatient Prescription Drug Discount and Security Program under sections 1807 and 1807A.".

(c) State Eligibility Determinations.—Section 1935, as added by section 103(a)(2), is amended—

(1) in subsection (a)(1), by inserting "and of eligibility for an annual Federal contribution amount under section 1807A(j)(2)" before the semicolon; and

(2) in subsection (a)(3), by inserting "and sections 1807 and 1807A" after "1860D–7)".

(d) Report on Progress in Implementation of Prescription Drug Benefit.—Not later than March 1, 2005, the Administrator shall submit a report to Congress on the progress that has been made in implementing the prescription drug benefit under this title. The Administrator shall include in the report specific steps that have been taken, and that need to be taken, to ensure a timely start of the program on January 1, 2006.

SEC. 106. DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT MEDICARE CATASTROPHIC PRESCRIPTION DRUG PROGRAM.

(a) Disclosure.—

(1) In general.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

"(19) Disclosure of return information for purposes of carrying out medicare catastrophic prescription drug program.—

"(A) In general.—The Secretary may, upon written request from the Secretary of Health and Human Services under section 1860D–2(b)(4)(E)(i) of the Social Security Act, disclose to officers and employees of the Department of Health and Human Services with respect to a specified taxpayer for the taxable year specified by the Secretary of Health and Human Services in such request—

"(i) the taxpayer identity information with respect to such taxpayer, and

"(ii) the adjusted gross income of such taxpayer for the taxable year (or, if less, the income threshold limit specified in section 1860D–2(b)(4)(D)(ii) for the calendar year specified by such Secretary in such request).

"(B) Specified taxpayer.—For purposes of this paragraph, the term 'specified taxpayer' means any taxpayer who—

"(i) is identified by the Secretary of Health and Human Services in the request referred to in subparagraph (A), and

"(ii) either—

"(I) has an adjusted gross income for the taxable year referred to in subparagraph (A) in excess of the income threshold specified in section 1860D–2(b)(4)(D)(ii) of such Act for the calendar year referred to in such subparagraph, or

"(II) is identified by such Secretary under subparagraph (A) as being an individual who elected to use more recent information under section 1860D–2(b)(4)(D)(v) of such Act.

"(C) JOINT RETURNS.—In the case of a joint return, the Secretary shall, for purposes of applying this paragraph, treat each spouse as a separate taxpayer having an adjusted gross income equal to one-half of the adjusted gross income determined with respect to such return.

"(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of Health and Human Services only for the purpose of administering the prescription drug benefit under title XVIII of the Social Security Act. Such officers and employees may disclose the annual out-of-pocket threshold which applies to an individual under such part to the entity that offers the plan referred to in section 1860D–2(b)(4)(E)(ii) of such Act in which such individual is enrolled. Such sponsor may use such information only for purposes of administering such benefit.".

(2) JOINT RETURN PERMITTED IN CASE OF SURVIVING SPOUSES.—Under section 6103(a)(3) of the Internal Revenue Code of 1986, a surviving spouse may file a joint return for the taxable year in which one spouse dies.

(b) CONFIDENTIALITY.—Paragraph (3) of section 6103(a) of such Code is amended by striking "or (16)" and inserting "(16), or (19)".

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Subsection (p)(4) of section 6103 of such Code is amended by striking "any other person described in subsection (l)(16) or (17)" each place it appears and inserting "any other person described in subsection (l)(16), (17), or (19)".

(d) UNAUTHORIZED DISCLOSURE.—Paragraph (2) of section 7213(a) of such Code is amended by striking "or (16)" and inserting "(16), or (19)".

(e) UNAUTHORIZED INSPECTION.—Subparagraph (B) of section 7213A(a)(1) of such Code is amended by inserting "or (19)" after "subsection (l)(18)".

SEC. 107. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established, as of the first day of the third month beginning after the date of the enactment of this Act, a State Pharmaceutical Assistance Transition Commission (in this section referred to as the "Commission") to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the medicare prescription drug program under part D of title XVIII of the Social Security Act.

(2) DEFINITIONS.—For purposes of this section:

(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term "State pharmaceutical assistance program" means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act assistance to low-income medicare beneficiaries for the purchase of prescription drugs.

(B) PROGRAM PARTICIPANT.—The term "program participant" means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(b) COMPOSITION.—The Commission shall include the following:

(1) A representative of each governor of each State that the Secretary identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under part D of title XVIII of the Social Security Act.

(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

(4) Representatives of Medicare Advantage organizations and other private health insurance plans, as appointed by the Secretary.

(5) The Secretary (or the Secretary's designee) and such other members as the Secretary may specify

The Secretary shall designate a member to serve as chair of the Commission and the Commission shall meet at the call of the chair.

(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

(2) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this title.

(3) Principles of medicare modernization provided under title II of this Act.

(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and the Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

SEC. 108. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM, INCLUDING PRESCRIPTION DRUG SPENDING.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND, THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, AND MEDICARE PRESCRIPTION DRUG TRUST FUND.—

"(1) IN GENERAL.—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund, the Federal Supplementary Medical Insurance Trust Fund established under section 1841, and the Medicare Prescription Drug Trust Fund under section 1860D–9(a) (in this subsection collectively referred to as the 'Trust Funds'). Such report shall included the following information:

"(A) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds for payment for benefits covered under this title, stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year.

"(B) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in subparagraph (A).

"(C) 10-YEAR AND 75-YEAR PROJECTIONS.—An estimate of total amounts referred to in subparagraph (A) required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 75-year period beginning with the succeeding fiscal year.

"(D) RELATION TO GDP GROWTH.—A comparison of the rate of growth of the total amounts referred to in subparagraph (A) to the rate of growth in the gross domestic product for the same period.

"(2) PUBLICATION.—Each report submitted under paragraph (1) shall be published jointly by the Committee on Ways and Means and the Committee on Energy and Commerce as a public document and shall be made available by such Committees on the Internet.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of the enactment of this Act.

TITLE II—MEDICARE ENHANCED FEE-FOR-SERVICE AND MEDICARE ADVANTAGE PROGRAMS; MEDICARE COMPETITION

SEC. 200. MEDICARE MODERNIZATION AND REVITALIZATION.

This title provides for—

(1) establishment of the medicare enhanced fee-for-service (EFFS) program under which medicare beneficiaries are provided access to a range of enhanced fee-for-service (EFFS) plans that may use preferred provider networks to offer an enhanced range of benefits;

(2) establishment of a Medicare Advantage program that offers improved managed care plans with coordinated care; and

(3) competitive bidding, in the style of the Federal Employees Health Benefits program (FEHBP), among enhanced fee-for-service plans and Medicare Advantage plans in order to promote greater efficiency and responsiveness to medicare beneficiaries.

Subtitle A—Medicare Enhanced Fee-for-Service Program

SEC. 201. ESTABLISHMENT OF ENHANCED FEE-FOR-SERVICE (EFFS) PROGRAM UNDER MEDICARE.

(a) IN GENERAL.—Title XVIII, as amended by section 101(a), is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

"PART E—ENHANCED FEE-FOR-SERVICE PROGRAM

"OFFERING OF ENHANCED FEE-FOR-SERVICE PLANS THROUGHOUT THE UNITED STATES

"SEC. 1860E–1. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Administrator shall establish under this part beginning January 1, 2006, an enhanced fee-for-service program under which enhanced fee-for-service plans (as defined in subsection (b)) are offered to EFFS-eligible individuals (as so defined) in EFFS regions throughout the United States.

"(2) EFFS REGIONS.—For purposes of this part the Administrator shall establish EFFS regions throughout the United States by dividing the entire United States into at least 10 such regions. Before establishing such regions, the Administrator shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established. The regions shall be established in a manner to take into consideration maximizing full access for all EFFS-eligible individuals, especially those residing in rural areas.

"(b) DEFINITIONS.—For purposes of this part:

"(1) EFFS ORGANIZATION.—The 'EFFS organization' means an entity that the Administrator certifies as meeting the requirements and standards applicable to such organization under this part.

"(2) ENHANCED FEE-FOR-SERVICE PLAN; EFFS PLAN.—The terms 'enhanced fee-for-service plan' and 'EFFS plan' mean health benefits coverage offered under a policy, contract, or plan by an EFFS organization pursuant to and in accordance with a contract pursuant to section 1860E–4(c), but only if the plan provides either fee-for-service coverage described in the following subparagraph (A) or preferred provider coverage described in the following subparagraph (B):

"(A) FEE-FOR-SERVICE COVERAGE.—The plan—

"(i) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

"(ii) does not vary such rates for such a provider based on utilization relating to such provider; and

"(iii) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

"(B) PREFERRED PROVIDER COVERAGE.—The plan—

"(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; and

"(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers.

"(3) EFFS ELIGIBLE INDIVIDUAL.—The term 'EFFS eligible individual' means an eligible individual described in section 1851(a)(3).

"(4) EFFS REGION.—The term 'EFFS region' means a region established under subsection (a)(2).

"(c) APPLICATION OF CERTAIN ELIGIBILITY, ENROLLMENT, ETC. REQUIREMENTS.—The provisions of section 1851 (other than subsection (h)(4)(A)) shall apply to EFFS plans offered by an EFFS organization in an EFFS region, including subsection (g) (relating to guaranteed issue and renewal).

"OFFERING OF ENHANCED FEE-FOR-SERVICE (EFFS) PLANS

"SEC. 1860E–2. (a) PLAN REQUIREMENTS.—No EFFS plan may be offered under this part in an EFFS region unless the requirements of this part are met with respect to the plan and EFFS organization offering the plan.

"(b) AVAILABLE TO ALL EFFS BENEFICIARIES IN THE ENTIRE REGION.—With respect to an EFFS plan offered in an EFFS region—

"(1) IN GENERAL.—The plan must be offered to all EFFS-eligible individuals residing in the region.

"(2) ASSURING ACCESS TO SERVICES.—The plan shall comply with the requirements of section 1852(d)(4).

"(c) BENEFITS.—

"(1) IN GENERAL.—Each EFFS plan shall provide to members enrolled in the plan under this part benefits, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

"(A) for the items and services described in section 1852(a)(1);

"(B) that are uniform for the plan for all EFFS eligible individuals residing in the same EFFS region;

"(C) that include a single deductible applicable to benefits under parts A and B and include a catastrophic limit on out-of-pocket expenditures for such covered benefits; and

"(D) that include benefits for prescription drug coverage for each enrollee who elects under part D to be provided qualified prescription drug coverage through the plan.

"(2) DISAPPROVAL AUTHORITY.—The Administrator shall not approve a plan of an EFFS organization if the Administrator determines (pursuant to the last sentence of section 1852(b)(1)(A)) that the benefits are designed to substantially discourage enrollment by certain EFFS eligible individuals with the organization.

"(d) OUTPATIENT PRESCRIPTION DRUG COVERAGE.—For rules concerning the offering of prescription drug coverage under EFFS plans, see the amendment made by section 102(b) of the Medicare Prescription Drug and Modernization Act of 2003.

"(e) OTHER ADDITIONAL PROVISIONS.—The provisions of section 1852 (other than subsection (a)(1)) shall apply under this part to EFFS plans. For the application of chronic care improvement provisions, see the amendment made by section 722(b).

"SUBMISSION OF BIDS; BENEFICIARY SAVINGS; PAYMENT OF PLANS

"SEC. 1860E–3. (a) SUBMISSION OF BIDS.—

"(1) REQUIREMENT.—

"(A) EFFS MONTHLY BID AMOUNT.—For each year (beginning with 2006), an EFFS organization shall submit to the Administrator an EFFS monthly bid amount for each EFFS plan offered in each region. Each such bid is referred to in this section as the 'EFFS monthly bid amount'.

"(B) FORM.—Such bid amounts shall be submitted for each such plan and region in a form and manner and time specified by the Administrator, and shall include information described in paragraph (3)(A).

"(2) UNIFORM BID AMOUNTS.—Each EFFS monthly bid amount submitted under paragraph (1) by an EFFS organization under this part for an EFFS plan in an EFFS region may not vary among EFFS eligible individuals residing in the EFFS region involved.

"(3) SUBMISSION OF BID AMOUNT INFORMATION BY EFFS ORGANIZATIONS.—

"(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

"(i) The EFFS monthly bid amount for provision of all items and services under this part, which amount shall be based on average costs for a typical beneficiary residing in the region, and the actuarial basis for determining such amount.

"(ii) The proportions of such bid amount that are attributable to—

"(I) the provision of statutory non-drug benefits (such portion referred to in this part as the 'unadjusted EFFS statutory non-drug monthly bid amount');

"(II) the provision of statutory prescription drug benefits; and

"(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

"(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

"(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

"(i) The term 'statutory non-drug benefits' means benefits under section 1852(a)(1).

"(ii) The term 'statutory prescription drug benefits' means benefits under part D.

"(iii) The term 'statutory benefits' means statutory prescription drug benefits and statutory non-drug benefits.

"(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—The Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)), and for such purpose, the Administrator has negotiation authority that the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).

"(D) CONTRACT AUTHORITY.—The Administrator may, taking into account the unadjusted EFFS statutory non-drug monthly bid amounts accepted under subparagraph (C), enter into contracts for the offering of EFFS plans by up to 3 EFFS organizations in any region.

"(b) PROVISION OF BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

"(1) BENEFICIARY REBATE RULE.—

"(A) REQUIREMENT.—The EFFS plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (2) applicable to the plan and year involved.

"(B) FORM OF REBATE.—A rebate required under this paragraph shall be provided—

"(i) through the crediting of the amount of the rebate towards the EFFS monthly prescription drug beneficiary premium (as defined in section 1860E–4(a)(3)(B)) and the EFFS monthly supplemental beneficiary premium (as defined in section 1860E–4(a)(3)(C));

"(ii) through a direct monthly payment (through electronic funds transfer or otherwise); or

"(iii) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.

"(2) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(A), the average per capita monthly savings referred to in such paragraph for an EFFS plan and year is computed as follows:

"(A) DETERMINATION OF REGION-WIDE AVERAGE RISK ADJUSTMENT.—

"(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006), for each EFFS region the average of the risk adjustment factors described in subsection (c)(3) to be applied to enrollees under this part in that region. In the case of an EFFS region in which an EFFS plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied under subsection (c)(3) in that region in a previous year.

"(ii) TREATMENT OF NEW REGIONS.—In the case of a region in which no EFFS plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable EFFS regions or applied on a national basis.

"(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each EFFS plan offered in an EFFS region, the Administrator shall—

"(i) adjust the EFFS region-specific non-drug monthly benchmark amount (as defined in paragraph (3)) by the applicable average risk adjustment factor computed under subparagraph (A); and

"(ii) adjust the unadjusted EFFS statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

"(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

"(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

"(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

"(3) COMPUTATION OF EFFS REGION-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term 'EFFS region-specific non-drug monthly benchmark amount' means, with respect to an EFFS region for a month in a year, an amount equal to 1/12 of the average (weighted by number of EFFS eligible individuals in each payment area described in section 1853(d)) of the annual capitation rate as calculated under section 1853(c)(1) for that area.

"(c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

"(1) NON-DRUG BENEFITS.—Under a contract under section 1860E–4(c) and subject to section 1853(g) (as made applicable under subsection (d)), the Administrator shall make monthly payments under this subsection in advance to each EFFS organization, with respect to coverage of an individual under this part in an EFFS region for a month, in an amount determined as follows:

"(A) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in subsection (b)(2)(C), the payment under this subsection is equal to the unadjusted EFFS statutory non-drug monthly bid amount, adjusted under paragraphs (3) and (4), plus the amount of the monthly rebate computed under subsection (b)(1)(A) for that plan and year.

"(B) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in subsection (b)(2)(C), the payment amount under this subsection is equal to the EFFS region-specific non-drug monthly benchmark amount, adjusted under paragraphs (3) and (4).

"(2) FOR FEDERAL DRUG SUBSIDIES.—In the case in which an enrollee who elects under part D to be provided qualified prescription drug coverage through the plan, the EFFS organization offering such plan also is entitled—

"(A) to direct subsidy payment under section 1860D–8(a)(1);

"(B) to reinsurance subsidy payments under section 1860D–8(a)(2); and

"(C) to reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–7(c)(3).

"(3) DEMOGRAPHIC RISK ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust under paragraph (1)(A) the unadjusted EFFS statutory non-drug monthly bid amount and under paragraph (1)(B) the EFFS region-specific non-drug monthly benchmark amount for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under section 1853(a)(3) (as applied under subsection (d)), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

"(4) ADJUSTMENT FOR INTRA-REGIONAL GEOGRAPHIC VARIATIONS.—The Administrator shall also adjust such amounts in a manner to take into account variations in payments rates under part C among the different payment areas under such part included in each EFFS region.

"(d) APPLICATION OF ADDITIONAL PAYMENT RULES.—The provisions of section 1853 (other than subsections (a)(1)(A), (d), and (e)) shall apply to an EFFS plan under this part, except as otherwise provided in this section.

"PREMIUMS; ORGANIZATIONAL AND FINANCIAL REQUIREMENTS; ESTABLISHMENT OF STANDARDS; CONTRACTS WITH EFFS ORGANIZATIONS

"SEC. 1860E–4. (a) PREMIUMS.—

"(1) IN GENERAL.—The provisions of section 1854 (other than subsections (a)(6)(C) and (h)), including subsection (b)(5) relating to the consolidation of drug and non-drug beneficiary premiums and subsection (c) relating to uniform bids and premiums, shall apply to an EFFS plan under this part, subject to paragraph (2).

"(2) CROSS-WALK.—In applying paragraph (1), any reference in section 1854(b)(1)(A) or 1854(d) to—

"(A) a Medicare Advantage monthly basic beneficiary premium is deemed a reference to the EFFS monthly basic beneficiary premium (as defined in paragraph (3)(A));

"(B) a Medicare Advantage monthly prescription drug beneficiary premium is deemed a reference to the EFFS monthly prescription drug beneficiary premium (as defined in paragraph (3)(B)); and

"(C) a Medicare Advantage monthly supplemental beneficiary premium is deemed a reference to the EFFS monthly supplemental beneficiary premium (as defined in paragraph (3)(C)).

"(3) DEFINITIONS.—For purposes of this part:

"(A) EFFS MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'EFFS monthly basic beneficiary premium' means, with respect to an EFFS plan—

"(i) described in section 1860E–3(c)(1)(A) (relating to plans providing rebates), zero; or

"(ii) described in section 1860E–3(c)(1)(B), the amount (if any) by which the unadjusted EFFS statutory non-drug monthly bid amount exceeds the EFFS region-specific non-drug monthly benchmark amount (as defined in section 1860E–3(b)(3)).

"(B) EFFS MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term 'EFFS monthly prescription drug beneficiary premium' means, with respect to an EFFS plan, the portion of the aggregate monthly bid amount submitted under clause (i) of section 1860E–3(a)(3)(A) for the year that is attributable under such section to the provision of statutory prescription drug benefits.

"(C) EFFS MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'EFFS monthly supplemental beneficiary premium' means, with respect to an EFFS plan, the portion of the aggregate monthly bid amount submitted under clause (i) of section 1860E–3(a)(3)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.

"(b) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS.—The provisions of section 1855 shall apply to an EFFS plan offered by an EFFS organization under this part.

"(c) STANDARDS.—The provisions of paragraphs (1), (3), and (4) of section 1856(b) shall apply to an EFFS plan offered by an EFFS organization under this part.

"(d) CONTRACTS WITH EFFS ORGANIZATIONS.—The provisions of section 1857 shall apply to an EFFS plan offered by an EFFS organization under this part, except that any reference in such section to part C is deemed a reference to this part.".

(b) APPLICATION OF MEDIGAP PROVISIONS TO EFFS PLANS.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) shall be administered as if any reference to a Medicare+Choice organization offering a Medicare+Choice plan under part C of title XVIII of such Act were a reference both to a Medicare Advantage organization offering a Medicare Advantage plan under such part and an EFFS organization offering an EFFS plan under part E of such title.

Subtitle B—Medicare Advantage Program

CHAPTER 1—IMPLEMENTATION OF PROGRAM

SEC. 211. IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act, as amended by this title.

(b) REFERENCES.—Any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to "Medicare+Choice" is deemed a reference to "Medicare Advantage".

SEC. 212. MEDICARE ADVANTAGE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERVICE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by adding at the end the following:

"(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

"(i) IN GENERAL.—For 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare Advantage payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare Advantage under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

"(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.".

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking “or (C)” and inserting “(C), or (D)”.

(b) CHANGE IN BUDGET NEUTRALITY FOR BLEND.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), by inserting “(for a year other than 2004)” after “multiplied”; and

(2) in paragraph (5), by inserting “(other than 2004)” after “for each year”.

(c) INCREASING MINIMUM PERCENTAGE INCREASE TO NATIONAL GROWTH RATE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended—

(A) in subparagraph (A), by striking “The sum” and inserting “For a year before 2005, the sum”;

(B) in subparagraph (B)(iv), by striking “and each succeeding year” and inserting “, 2003, and 2004”;

(C) in subparagraph (C)(iv), by striking “and each succeeding year” and inserting “and 2003”; and

(D) by adding at the end of subparagraph (C) the following new clause:

“(v) For 2004 and each succeeding year, the greater of—

“(I) 102 percent of the annual Medicare Advantage capitation rate under this paragraph for the area for the previous year; or

“(II) the annual Medicare Advantage capitation rate under this paragraph for the area for the previous year increased by the national per capita Medicare Advantage growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.”.

(2) CONFORMING AMENDMENT.—Section 1853(c)(6)(C) (42 U.S.C. 1395w–23(c)(6)(C)) is amended by inserting before the period at the end the following: “, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004”.

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (E)”, and

(2) by adding at the end the following new subparagraph:

“(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.”.

(e) EXTENDING SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS TO REHABILITATION HOSPITALS.—

(1) IN GENERAL.—Section 1853(g) (42 U.S.C. 1395w–23(g)) is amended—

(A) by inserting “or from a rehabilitation facility (as defined in section 1886(j)(1)(A))” after “1886(d)(1)(B))”; and

(B) in paragraph (2)(B), by inserting “or section 1886(j), as the case may be,” after “1886(d)”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contract years beginning on or after January 1, 2004.

(f) MEDPAC STUDY OF AAPCC.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) as applied under section 1853(c)(1)(A) of such Act (as amended by subsection (a)). Such study shall include an examination of—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment under the Medicare Advantage program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

(g) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS.—Not later than July 1, 2006, the Medicare Benefits Administrator shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and BIPA) on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(h) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare Advantage capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2004, revised in accordance with the provisions of this section.

CHAPTER 2—IMPLEMENTATION OF COMPETITION PROGRAM

SEC. 221. COMPETITION PROGRAM BEGINNING IN 2006.

(a) SUBMISSION OF EFFS-LIKE BIDDING INFORMATION BEGINNING IN 2006.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(1) by amending the section heading to read as follows:

“PREMIUMS AND BID AMOUNT”;

(2) in subsection (a)(1)(A)—

(A) by striking “(A)” and inserting “(A)(i) if the following year is before 2006,”; and

(B) by inserting before the semicolon at the end the following: “or (ii) if the following year is 2006 or later, the information described in paragraph (3) or (6)(A) for the type of plan involved”; and

(3) by adding at the end of subsection (a) the following:

“(6) SUBMISSION OF BID AMOUNTS BY MEDICARE ADVANTAGE ORGANIZATIONS.—

“(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

“(i) The monthly aggregate bid amount for provision of all items and services under this part, which amount shall be based on average costs for a typical beneficiary residing in the area, and the actuarial basis for determining such amount.

“(ii) The proportions of such bid amount that are attributable to—

“(I) the provision of statutory non-drug benefits (such portion referred to in this part as the ‘unadjusted Medicare Advantage statutory non-drug monthly bid amount’);

“(II) the provision of statutory prescription drug benefits; and

“(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

“(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

“(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

“(i) The term ‘statutory non-drug benefits’ means benefits under section 1852(a)(1).

“(ii) The term ‘statutory prescription drug benefits’ means benefits under part D.

“(iii) The term ‘statutory benefits’ means statutory prescription drug benefits and statutory non-drug benefits.

“(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—

“(i) IN GENERAL.—Subject to clause (ii)—

“(I) the Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)), and for such purpose and subject to such clause, the Administrator has negotiation authority that the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code; and

“(II) the Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).

“(ii) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(C), the provisions of clause (i) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and proportion referred to in subparagraph (A).”.

(b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

(1) IN GENERAL.—Section 1854(b) (42 U.S.C. 1395w–24(b)) is amended—

(A) by adding at the end of paragraph (1) the following new subparagraph:

“(C) BENEFICIARY REBATE RULE.—

“(i) REQUIREMENT.—The Medicare Advantage plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3) applicable to the plan and year involved.

“(iii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided—

“(I) through the crediting of the amount of the rebate towards the Medicare Advantage monthly supplementary beneficiary premium or the premium imposed for prescription drug coverage under part D;

“(II) through a direct monthly payment (through electronic funds transfer or otherwise); or

“(III) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.”; and

(B) by adding at the end the following new paragraphs:

“(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for a Medicare Advantage plan and year is computed as follows:

“(A) DETERMINATION OF STATE-WIDE AVERAGE RISK ADJUSTMENT.—

“(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006), for each State the average of the risk adjustment factors to be applied under section 1853(a)(1)(A) to payment for enrollees in that State. In the case of a State in which a Medicare Advantage plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied in that State in a previous year.

“(ii) TREATMENT OF NEW STATES.—In the case of a State in which no Medicare Advantage plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable States or applied on a national basis.

“(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each Medicare Advantage plan offered in a State, the Administrator shall—

“(i) adjust the Medicare Advantage area-specific non-drug monthly benchmark amount (as defined in subsection (j)) by the applicable average risk adjustment factor computed under subparagraph (A); and

“(ii) adjust the unadjusted Medicare Advantage statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

“(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

“(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

“(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

“(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.

“(4) BENEFICIARY'S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a Medicare Advantage organization shall permit each enrollee, at the enrollee's option, to make payment of premiums under this part to the organization indirectly through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839 or through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account) or otherwise. All premium payments that are withheld under this paragraph that are credited to the Federal Supplementary Medical Insurance Drug Trust Fund shall be paid to the Medicare Advantage organization involved.”.

(2) PROVISION OF SINGLE CONSOLIDATED PREMIUM.—Section 1854(b) (42 U.S.C. 1395w–24(b)), as amended by paragraph (1), is further amended by adding at the end the following new paragraph:

“(5) SINGLE CONSOLIDATED PREMIUM.—In the case of an enrollee in a Medicare Advantage plan who elects under part D to be provided qualified prescription drug coverage through the plan, the Administrator shall provide a mechanism for the consolidation of the beneficiary premium amount for non-drug benefits under this part with the premium amount for prescription drug coverage under part D provided through the plan.”.

(3) COMPUTATION OF MEDICARE ADVANTAGE AREA-SPECIFIC NON-DRUG BENCHMARK.—Section 1853 (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

“(j) COMPUTATION OF MEDICARE ADVANTAGE AREA-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term ‘Medicare Advantage area-specific non-drug montnly benchmark amount’ means, with respect to a Medicare Advantage payment area for a month in a year, an amount equal to $\frac{1}{12}$ of the annual Medicare Advantage capitation rate under section 1853(c)(1) for the area for the year.”.

(c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

(1) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking “in an amount” and all that follows and inserting the following: “in an amount determined as follows:

“(i) PAYMENT BEFORE 2006.—For years before 2006, the payment amount shall be equal to $\frac{1}{12}$ of the annual Medicare Advantage capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iv).

“(ii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2006.—For years beginning with 2006—

“(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment under this subsection is equal to the unadjusted Medicare Advantage statutory non-drug monthly bid amount, adjusted under clause (iv), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

“(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage area-specific non-drug monthly benchmark amount, adjusted under clause (iv).

“(iii) FOR FEDERAL DRUG SUBSIDIES.—In the case in which an enrollee who elects under part D to be provided qualified prescription drug coverage through the plan, the Medicare Advantage organization offering such plan also is entitled—

“(I) to direct subsidy payment under section 1860D–8(a)(1);

“(II) to reinsurance subsidy payments under section 1860D–8(a)(2); and

“(III) to reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–7(c)(3).

“(iv) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the unadjusted Medicare Advantage statutory non-drug monthly bid amount under clause (ii)(I), and the Medicare Advantage area-specific non-drug monthly benchmark amount under clause (ii)(II) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.”.

(d) CONFORMING AMENDMENTS.—

(1) PROTECTION AGAINST BENEFICIARY SELECTION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w–22(b)(1)(A)) is amended by adding at the end the following: “The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare Advantage eligible individuals with the organization.”.

(2) CONFORMING AMENDMENT TO PREMIUM TERMINOLOGY.—Section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) is amended by redesignating subparagraph (C) as subparagraph (D) and by striking subparagraphs (A) and (B) and inserting the following:

“(A) MEDICARE ADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term ‘Medicare Advantage monthly basic beneficiary premium’ means, with respect to a Medicare Advantage plan—

“(i) described in section 1853(a)(1)(A)(ii)(I) (relating to plans providing rebates), zero; or

“(ii) described in section 1853(a)(1)(A)(ii)(II), the amount (if any) by which the unadjusted Medicare Advantage statutory non-drug monthly bid amount exceeds the Medicare Advantage area-specific non-drug monthly benchmark amount.

“(B) MEDICARE ADVANTAGE MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term ‘Medicare Advantage monthly prescription drug beneficiary premium’ means, with respect to a Medicare Advantage plan, that portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of statutory prescription drug benefits.

“(C) MEDICARE ADVANTAGE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term ‘Medicare Advantage monthly supplemental beneficiary premium’ means, with respect to a Medicare Advantage plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.”.

(3) REQUIREMENT FOR UNIFORM PREMIUM AND BID AMOUNTS.—Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended to read as follows:

“(c) UNIFORM PREMIUM AND BID AMOUNTS.—The Medicare Advantage monthly bid amount submitted under subsection (a)(6), the Medicare Advantage monthly basic, prescription drug, and supplemental beneficiary premiums, and the Medicare Advantage monthly MSA premium charged under subsection (b) of a Medicare Advantage organization under this part may not vary among individuals enrolled in the plan.”.

(4) PERMITTING BENEFICIARY REBATES.—

(A) Section 1851(h)(4)(A) (42 U.S.C. 1395w–21(h)(4)(A)) is amended by inserting “except as provided under section 1854(b)(1)(C)” after “or otherwise”.

(B) Section 1854(d) (42 U.S.C. 1395w–24(d)) is amended by inserting “, except as provided under subsection (b)(1)(C),” after “and may not provide”.

(5) OTHER CONFORMING AMENDMENTS RELATING TO BIDS.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) in the heading of subsection (a), by inserting “AND BID AMOUNTS” after “PREMIUMS”; and

(B) in subsection (a)(5)(A), by inserting “paragraphs (2), (3), and (4) of” after “filed under”.

(e) ADDITIONAL CONFORMING AMENDMENTS.—

(1) ANNUAL DETERMINATION AND ANNOUNCEMENT OF CERTAIN FACTORS.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)) is amended by striking ‘‘the respective calendar year’’ and all that follows and inserting the following: ‘‘the calendar year concerned with respect to each Medicare Advantage payment area, the following:

‘‘(A) PRE-COMPETITION INFORMATION.—For years before 2006, the following:

‘‘(i) MEDICARE ADVANTAGE CAPITATION RATES.—The annual Medicare Advantage capitation rate for each Medicare Advantage payment area for the year.

‘‘(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

‘‘(B) COMPETITION INFORMATION.—For years beginning with 2006, the following:

‘‘(i) BENCHMARK.—The Medicare Advantage area-specific non-drug benchmark under section 1853(j).

‘‘(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iv) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).’’.

(2) REPEAL OF PROVISIONS RELATING TO ADJUSTED COMMUNITY RATE (ACR).—

(A) IN GENERAL.—Subsections (e) and (f) of section 1854 (42 U.S.C. 1395w–24) are repealed.

(B) CONFORMING AMENDMENTS.—(i) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ‘‘, and to reflect’’ and all that follows and inserting a period.

(ii) Section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)) is amended by striking ‘‘title XI’’ and all that follows and inserting the following: ‘‘title XI those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan.’’.

(iii) Section 1857(d)(1) (42 U.S.C. 1395w–27(d)(1)) is amended by striking ‘‘, costs, and computation of the adjusted community rate’’ and inserting ‘‘and costs’’.

(f) REFERENCES UNDER PART E.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

‘‘(f) APPLICATION UNDER PART E.—In the case of any reference under part E to a requirement or provision of this part in the relation to an EFFS plan or organization under such part, except as otherwise specified any such requirement or provision shall be applied to such organization or plan in the same manner as such requirement or provision applies to a Medicare Advantage private fee-for-service plan (and the Medicare Advantage organization that offers such plan) under this part.’’.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for months beginning with January 2006.

CHAPTER 3—ADDITIONAL REFORMS

SEC. 231. MAKING PERMANENT CHANGE IN MEDICARE ADVANTAGE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD.

(a) CHANGE IN REPORTING DEADLINE.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by section 532(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ‘‘2002, 2003, and 2004 (or July 1 of each other year)’’ and inserting ‘‘2002 and each subsequent year’’.

(b) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking ‘‘and after 2005’’; and

(2) by striking ‘‘, 2004, and 2005’’ and inserting ‘‘and any subsequent year’’.

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking ‘‘and after 2005’’; and

(2) by striking ‘‘and 2005’’ and inserting ‘‘and each subsequent year’’.

(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended by inserting before the period the following: ‘‘to the extent such information is available at the time of preparation of materials for the mailing’’.

SEC. 232. AVOIDING DUPLICATIVE STATE REGULATION.

(a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w–26(b)(3)) is amended to read as follows:

‘‘(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare Advantage plans which are offered by Medicare Advantage organizations under this part.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 233. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: ‘‘Specialized Medicare Advantage plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.’’.

(b) SPECIALIZED MEDICARE ADVANTAGE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraph:

‘‘(4) SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

‘‘(A) IN GENERAL.—The term ‘specialized Medicare Advantage plan for special needs beneficiaries’ means a Medicare Advantage plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

‘‘(B) SPECIAL NEEDS BENEFICIARY.—The term ‘special needs beneficiary’ means a Medicare Advantage eligible individual who—

‘‘(i) is institutionalized (as defined by the Secretary);

‘‘(ii) is entitled to medical assistance under a State plan under title XIX; or

‘‘(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare Advantage plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.’’.

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

‘‘(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare Advantage plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.’’.

(d) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MEDICARE ADVANTAGE PLANS.—In promulgating regulations to carry out the last sentence of section 1851(a)(2)(A) of the Social Security Act (as added by subsection (a)) and section 1859(b)(4) of such Act (as added by subsection (b)), the Secretary may provide (notwithstanding section 1859(b)(4)(A) of such Act) for the offering of specialized Medicare Advantage plans by Medicare Advantage plans that disproportionately serve special needs beneficiaries who are frail, elderly medicare beneficiaries.

(e) REPORT TO CONGRESS.—Not later than December 31, 2005, the Medicare Benefits Administrator shall submit to Congress a report that assesses the impact of specialized Medicare Advantage plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect upon the date of the enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 6 months after the date of the enactment of this Act, the Secretary shall issue interim final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 234. MEDICARE MSAS.

(a) EXEMPTION FROM REPORTING ENROLLEE ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C. 1395w–22(e)(1)) is amended by inserting ‘‘(other than MSA plans)’’ after ‘‘plans’’.

(2) CONFORMING AMENDMENTS.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(A) in subsection (c)(1)(I), by inserting before the period at the end the following: ‘‘if required under such section’’; and

(B) in subparagraphs (A) and (B) of subsection (e)(2), by striking ‘‘, a non-network MSA plan,’’ and ‘‘, NON-NETWORK MSA PLANS,’’ each place it appears.

(b) MAKING PROGRAM PERMANENT AND ELIMINATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended—

(1) in the heading, by striking ‘‘ON A DEMONSTRATION BASIS’’;

(2) by striking the first sentence of subparagraph (A); and

(3) by striking the second sentence of subparagraph (C).

(c) APPLYING LIMITATIONS ON BALANCE BILLING.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting ‘‘or with an organization offering a MSA plan’’ after ‘‘section 1851(a)(2)(A)’’.

(d) ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A) (42 U.S.C. 1395w–21(e)(5)(A)) is amended—

(1) by adding ‘‘or’’ at the end of clause (i);

(2) by striking ‘‘, or’’ at the end of clause (ii) and inserting a semicolon; and

(3) by striking clause (iii).

SEC. 235. EXTENSION OF REASONABLE COST CONTRACTS.

Subparagraph (C) of section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is amended to read as follows:

"(C)(i) Subject to clause (ii), may be extended or renewed under this subsection indefinitely.

"(ii) For any period beginning on or after January 1, 2008, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area, during the entire previous year, was within the service area of 2 or more plans which were coordinated care Medicare Advantage plans under part C or 2 or more enhanced fee-for-service plans under part E and each of which plan for that previous year for the area involved meets the following minimum enrollment requirements:

"(I) With respect to any portion of the area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area, 5,000 individuals.

"(II) With respect to any other portion of such area, 1,500 individuals.".

SEC. 236. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, section 4017 of BBA, section 534 of BBRA (113 Stat. 1501A–390), and section 633 of BIPA, is amended by striking "December 31, 2004" and inserting "December 31, 2009".

SEC. 237. STUDY OF PERFORMANCE-BASED PAYMENT SYSTEMS.

(a) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to—

(1) conduct a study that reviews and evaluates public and private sector experiences in establishing performance measures and payment incentives under the medicare program and linking performance to payment; and

(2) submit a report to the Secretary and Congress, not later than 18 months after the date of the enactment of this Act, regarding such study.

(b) STUDY.—The study under subsection (a)(1) shall—

(1) include a review and evaluation of incentives that have been or could be used to encourage quality performance, including those aimed at health plans and their enrollees, providers and their patients, and other incentives that encourage quality-based health care purchasing and collaborative efforts to improve performance; and

(2) examine how these measures and incentives might be applied in the Medicare Advantage program, the Enhanced Fee-For-Service (EFFS) program, and traditional fee-for-service programs.

(c) REPORT RECOMMENDATIONS.—The report under subsection (a)(2) shall—

(1) include recommendations regarding appropriate performance measures for use in assessing and paying for quality; and

(2) identify options for updating performance measures.

Subtitle C—Application of FEHBP-Style Competitive Reforms

SEC. 241. APPLICATION OF FEHBP-STYLE COMPETITIVE REFORM BEGINNING IN 2010.

(a) IDENTIFICATION OF COMPETITIVE EFFS REGIONS; COMPUTATION OF COMPETITIVE EFFS NON-DRUG BENCHMARKS UNDER EFFS PROGRAM.—

(1) IN GENERAL.—Section 1860E–3, as added by section 201(a), is amended by adding at the end the following new subsection:

"(e) APPLICATION OF COMPETITION.—

"(1) DETERMINATION OF COMPETITIVE EFFS REGIONS.—

"(A) IN GENERAL.—For purposes of this part, the term 'competitive EFFS region' means, for a year beginning with 2010, an EFFS region that the Administrator finds—

"(i) there will be offered in the region during the annual, coordinated election period under section 1851(e)(3)(B) (as applied under section 1860E–1(c)) before the beginning of the year at least 2 EFFS plans (in addition to the fee-for-service program under parts A and B), each offered by a different EFFS organization and each of which met the minimum enrollment requirements of paragraph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of March of the previous year; and

"(ii) during March of the previous year at least the percentage specified in subparagraph (C) of the number of EFFS eligible individuals who reside in the region were enrolled in an EFFS plan.

"(B) PERCENTAGE SPECIFIED.—

"(i) IN GENERAL.—For purposes of subparagraph (A), subject to clause (ii), the percentage specified in this subparagraph for a year is equal the lesser of 20 percent or to the sum of—

"(I) the percentage, as estimated by the Administrator, of EFFS eligible individuals in the United States who are enrolled in EFFS plans during March of the previous year; and

"(II) the percentage, as estimated by the Administrator, of Medicare Advantage eligible individuals in the United States who are enrolled in Medicare Advantage plans during March of the previous year.

"(ii) EXCEPTION.—In the case of an EFFS region that was a competitive EFFS region for the previous year, the Medicare Benefits Administrator may continue to treat the region as meeting the requirement of subparagraph (A)(ii) if the region would meet such requirement but for a de minimis reduction below the percentage specified in clause (i).

"(2) COMPETITIVE EFFS NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term 'competitive EFFS non-drug monthly benchmark amount' means, with respect to an EFFS region for a month in a year and subject to paragraph (8), the sum of the 2 components described in paragraph (3) for the region and year. The Administrator shall compute such benchmark amount for each competitive EFFS region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which it is designated as such a region.

"(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for an EFFS region and a year are the following:

"(A) EFFS COMPONENT.—The product of the following:

"(i) WEIGHTED AVERAGE OF PLAN BIDS IN REGION.—The weighted average of the EFFS plan bids for the region and year (as determined under paragraph (4)(A)).

"(ii) NON-FFS MARKET SHARE.—1 minus the fee-for-service market share percentage determined under paragraph (5) for the region and the year.

"(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

"(i) FEE-FOR-SERVICE REGION-SPECIFIC NON-DRUG AMOUNT.—The fee-for-service region-specific non-drug amount (as defined in paragraph (6)) for the region and year.

"(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage (determined under paragraph (5)) for the region and the year.

"(4) DETERMINATION OF WEIGHTED AVERAGE EFFS PLAN BIDS FOR A REGION.—

"(A) IN GENERAL.—For purposes of paragraph (3)(A)(i), the weighted average of EFFS plan bids for an EFFS region and a year is the sum of the following products for EFFS plans described in subparagraph (C) in the region and year:

"(i) UNADJUSTED EFFS STATUTORY NON-DRUG MONTHLY BID AMOUNT.—The unadjusted EFFS statutory non-drug monthly bid amount (as defined in subsection (a)(3)(A)(ii)(I)) for the region and year.

"(ii) PLAN'S SHARE OF EFFS ENROLLMENT IN REGION.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all EFFS plans described in subparagraph (C) for that region and year.

"(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each EFFS plan described in subparagraph (C) for an EFFS region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during March of the previous year.

"(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an EFFS region and year, the EFFS plans described in this subparagraph are plans that are offered in the region and year and were offered in the region in March of the previous year.

"(5) COMPUTATION OF FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year and an EFFS region, the proportion (in this subsection referred to as the 'fee-for-service market share percentage') of the EFFS eligible individuals who are residents of the region during March of the previous year, of such individuals who were not enrolled in an EFFS plan or in a Medicare Advantage plan (or, if greater, such proportion determined for individuals nationally).

"(6) FEE-FOR-SERVICE REGION-SPECIFIC NON-DRUG AMOUNT.—

"(A) IN GENERAL.—For purposes of paragraph (3)(B)(i) and section 1839(h)(2)(A), subject to subparagraph (C), the term 'fee-for-service region-specific non-drug amount' means, for a competitive EFFS region and a year, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for such region for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under this part who are not enrolled in an EFFS plan under part E or a Medicare Advantage plan under part C for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

"(B) USE OF FULL RISK ADJUSTMENT TO STANDARDIZE FEE-FOR-SERVICE COSTS TO TYPICAL BENEFICIARY.—In determining the adjusted average per capita cost for a region and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under subsection (c)(3) so that such per capita costs reflect the average costs for a typical beneficiary residing in the region.

"(C) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under subparagraph (A) for a year, such cost shall be adjusted to include the Administrator's estimate, on a per capita basis, of the amount of additional payments that would have been made in the region involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

“(7) APPLICATION OF COMPETITION.—In the case of an EFFS region that is a competitive EFFS region for a year, for purposes of applying subsections (b) and (c)(1) and section 1860E–4(a), any reference to an EFFS region-specific non-drug monthly benchmark amount shall be treated as a reference to the competitive EFFS non-drug monthly benchmark amount under paragraph (2) for the region and year.

“(8) PHASE-IN OF BENCHMARK FOR EACH REGION.—

“(A) USE OF BLENDED BENCHMARK.—In the case of a region that has not been a competitive EFFS region for each of the previous 4 years, the competitive EFFS non-drug monthly benchmark amount shall be equal to the sum of the following:

“(i) NEW COMPETITIVE COMPONENT.—The product of—

“(I) the weighted average phase-in proportion for that area and year, as specified in subparagraph (B); and

“(II) the competitive EFFS non-drug monthly benchmark amount for the region and year, determined under paragraph (2) without regard to this paragraph.

“(ii) OLD COMPETITIVE COMPONENT.—The product of—

“(I) 1 minus the weighted average phase-in proportion for that region and year; and

“(II) the EFFS region-specific non-drug benchmark amount for the region and the year.

“(B) COMPUTATION OF WEIGHTED AVERAGE PHASE-IN PROPORTION.—For purposes of this paragraph, the ‘weighted average phase-in proportion’ for an EFFS region for a year shall be determined as follows:

“(i) FIRST YEAR (AND REGION NOT COMPETITIVE REGION IN PREVIOUS YEAR).—If the area was not a competitive EFFS region in the previous year, the weighted average phase-in proportion for the region for the year is equal to ⅕.

“(ii) COMPETITIVE REGION IN PREVIOUS YEAR.—If the region was a competitive EFFS region in the previous year, the weighted average phase-in proportion for the region for the year is equal to the weighted average phase-in proportion determined under this subparagraph for the region for the previous year plus ⅕, but in no case more than 1.”.

(2) CONFORMING AMENDMENTS.—

(A) Such section 1860E–3 is further amended—

(i) in subsection (b), by adding at the end the following new paragraph:

“(4) APPLICATION IN COMPETITIVE REGIONS.—For special rules applying this subsection in competitive EFFS regions, see subsection (e)(7).”;

(ii) in subsection (c)(1), by inserting “and subsection (e)(7)” after “(as made applicable under subsection (d))”; and

(iii) in subsection (d) , by striking “and (e)” and inserting “(e), and (k) ”.

(B) Section 1860E–4(a)(1), as inserted by section 201(a)(2), is amended by inserting “, except as provided in section 1860E–3(e)(7)” after “paragraph (2)”.

(b) IDENTIFICATION OF COMPETITIVE MEDICARE ADVANTAGE AREAS; APPLICATION OF COMPETITIVE MEDICARE ADVANTAGE NON-DRUG BENCHMARKS UNDER MEDICARE ADVANTAGE PROGRAM.—

(1) IN GENERAL.—Section 1853, as amended by section 221(b)(3), is amended by adding at the end the following new subsection:

“(k) APPLICATION OF COMPETITION.—

“(1) DETERMINATION OF COMPETITIVE MEDICARE ADVANTAGE AREAS.—

“(A) IN GENERAL.—For purposes of this part, the terms ‘competitive Medicare Advantage area’ and ‘CMA area’ mean, for a year beginning with 2010, an area (which is a metropolitan statistical area or other area with a substantial number of Medicare Advantage enrollees) that the Administrator finds—

“(i) there will be offered during the annual, coordinated election period under section 1851(e)(3)(B) under this part before the beginning of the year at least 2 Medicare Advantage plans (in addition to the fee-for-service program under parts A and B), each offered by a different Medicare Advantage organization and each of which met the minimum enrollment requirements of paragraph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of March of the previous year with respect to the area; and

“(ii) during March of the previous year at least the percentage specified in subparagraph (B) of the number of Medicare Advantage eligible individuals who reside in the area were enrolled in a Medicare Advantage plan.

“(B) PERCENTAGE SPECIFIED.—

“(i) IN GENERAL.—For purposes of subparagraph (A), subject to clause (ii), the percentage specified in this subparagraph for a year is equal the lesser of 20 percent or to the sum of—

“(I) the percentage, as estimated by the Administrator, of EFFS eligible individuals in the United States who are enrolled in EFFS plans during March of the previous year; and

“(II) the percentage, as estimated by the Administrator, of Medicare Advantage eligible individuals in the United States who are enrolled in Medicare Advantage plans during March of the previous year.

“(ii) EXCEPTION.—In the case of an area that was a competitive area for the previous year, the Medicare Benefits Administrator may continue to treat the area as meeting the requirement of subparagraph (A)(ii) if the area would meet such requirement but for a de minimis reduction below the percentage specified in clause (i).

“(2) COMPETITIVE MEDICARE ADVANTAGE NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term ‘competitive Medicare Advantage non-drug monthly benchmark amount’ means, with respect to a competitive Medicare Advantage area for a month in a year subject to paragraph (8), the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive Medicare Advantage area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which it is designated as such an area.

“(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for a competitive Medicare Advantage area and a year are the following:

“(A) MEDICARE ADVANTAGE COMPONENT.—The product of the following:

“(i) WEIGHTED AVERAGE OF MEDICARE ADVANTAGE PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (4)(A)).

“(ii) NON-FFS MARKET SHARE.—1 minus the fee-for-service market share percentage, determined under paragraph (5) for the area and year.

“(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

“(i) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—The fee-for-service area-specific non-drug amount (as defined in paragraph (6)) for the area and year.

“(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage, determined under paragraph (5) for the area and year.

“(4) DETERMINATION OF WEIGHTED AVERAGE MEDICARE ADVANTAGE BIDS FOR AN AREA.—

“(A) IN GENERAL.—For purposes of paragraph (3)(A)(i), the weighted average of plan bids for an area and a year is the sum of the following products for Medicare Advantage plans described in subparagraph (C) in the area and year:

“(i) MONTHLY MEDICARE ADVANTAGE STATUTORY NON-DRUG BID AMOUNT.—The unadjusted Medicare Advantage statutory non-drug monthly bid amount.

“(ii) PLAN'S SHARE OF MEDICARE ADVANTAGE ENROLLMENT IN AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all Medicare Advantage plans described in subparagraph (C) for that area and year.

“(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each Medicare Advantage plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during March of the previous year.

“(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the Medicare Advantage plans described in this subparagraph are plans described in the first sentence of section 1851(a)(2)(A) that are offered in the area and year and were offered in the area in March of the previous year.

“(5) COMPUTATION OF FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year and a competitive Medicare Advantage area, the proportion (in this subsection referred to as the ‘fee-for-service market share percentage’) of Medicare Advantage eligible individuals residing in the area who during March of the previous year were not enrolled in a Medicare Advantage plan or in an EFFS plan (or, if greater, such proportion determined for individuals nationally).

“(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—

“(A) IN GENERAL.—For purposes of paragraph (3)(B)(i) and section 1839(h)(1)(A), subject to subparagraph (C), the term ‘fee-for-service area-specific non-drug amount’ means, for a competitive Medicare Advantage area and a year, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for such area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under this part who are not enrolled in a Medicare Advantage plan under part C or an EFFS plan under part E for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

“(B) USE OF FULL RISK ADJUSTMENT TO STANDARDIZE FEE-FOR-SERVICE COSTS TO TYPICAL BENEFICIARY.—In determining the adjusted average per capita cost for an area and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under subsection (a)(1)(A)(iv) so that such per capita costs reflect the average costs for a typical beneficiary residing in the area.

"(C) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under subparagraph (A) for a year, such cost shall be adjusted to include the Administrator's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

"(7) APPLICATION OF COMPETITION.—In the case of an area that is a competitive Medicare Advantage area for a year, for purposes of applying subsection (a)(1)(A)(ii) and sections 1854(b)(2)(A)(ii) and 1854(b)(3)(B)(i), any reference to a Medicare Advantage area-specific non-drug monthly benchmark amount shall be treated as a reference to the competitive Medicare Advantage non-drug monthly benchmark amount under paragraph (2) for the area and year.

"(8) PHASE-IN OF BENCHMARK FOR EACH AREA.—

"(A) USE OF BLENDED BENCHMARK.—In the case of an area that has not been a competitive Medicare Advantage area for each of the previous 4 years, the competitive Medicare Advantage non-drug monthly benchmark amount shall be equal to the sum of the following:

"(i) NEW COMPETITIVE COMPONENT.—The product of—

"(I) the weighted average phase-in proportion for that area and year, as specified in subparagraph (B); and

"(II) the competitive Medicare Advantage non-drug monthly benchmark amount for the area and year, determined under paragraph (2) without regard to this paragraph.

"(ii) OLD COMPETITIVE COMPONENT.—The product of—

"(I) 1 minus the weighted average phase-in proportion for that area and year; and

"(II) the Medicare Advantage area-wide non-drug benchmark amount for the area and the year.

"(B) COMPUTATION OF WEIGHTED AVERAGE PHASE-IN PROPORTION.—For purposes of this paragraph, the 'weighted average phase-in proportion' for a Medicare Advantage payment area for a year shall be determined as follows:

"(i) FIRST YEAR (AND AREA NOT COMPETITIVE AREA IN PREVIOUS YEAR).—If the area was not a Medicare Advantage competitive area in the previous year, the weighted average phase-in proportion for the area for the year is equal to ⅕.

"(ii) COMPETITIVE AREA IN PREVIOUS YEAR.—If the area was a competitive Medicare Advantage area in the previous year, the weighted average phase-in proportion for the area for the year is equal to the weighted average phase-in proportion determined under this subparagraph for the area for the previous year plus ⅕, but in no case more than 1.

"(C) MEDICARE ADVANTAGE AREA-WIDE NON-DRUG BENCHMARK AMOUNT.—For purposes of subparagraph (A)(ii)(II), the term 'Medicare Advantage area-wide non-drug benchmark amount' means, for an area and year, the weighted average of the amounts described in section 1853(j) for Medicare Advantage payment area or areas included in the area (based on the number of traditional fee-for-service enrollees in such payment area or areas) and year.".

(2) APPLICATION.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) in subsection (b)(1)(C)(i), as added by section 221(b)(1)(A), by striking "(i) REQUIREMENT.—The" and inserting "(i) REQUIREMENT FOR NON-COMPETITIVE AREAS.—In the case of a Medicare Advantage payment area that is not a competitive Medicare Advantage area designated under section 1853(k)(1), the";

(B) in subsection (b)(1)(C), as so added, by inserting after clause (i) the following new clause:

"(ii) REQUIREMENT FOR COMPETITIVE MEDICARE ADVANTAGE AREAS.—In the case of a Medicare Advantage payment area that is designated as a competitive Medicare Advantage area under section 1853(k)(1), if there are average per capita monthly savings described in paragraph (6) for a Medicare Advantage plan and year, the Medicare Advantage plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings."; and

(C) by adding at the end of subsection (b), as amended by sections 221(b)(1)(B) and 221(b)(2), the following new paragraph:

"(6) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE MEDICARE ADVANTAGE AREAS.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings referred to in such paragraph for a Medicare Advantage plan and year shall be computed in the same manner as the average per capita monthly savings is computed under paragraph (3) except that the reference to the Medicare Advantage area-specific non-drug monthly benchmark amount in paragraph (3)(B)(i) (or to the benchmark amount as adjusted under paragraph (3)(C)(i)) is deemed to be a reference to the competitive Medicare Advantage non-drug monthly benchmark amount (or such amount as adjusted in the manner described in paragraph (3)(B)(i)).".

(3) ADDITIONAL CONFORMING AMENDMENTS.—

(A) PAYMENT OF PLANS.—Section 1853(a)(1)(A)(ii), as amended by section 221(c)(1), is amended—

(i) in subclauses (I) and (II), by inserting "(or, insofar as such payment area is a competitive Medicare Advantage area, described in section 1854(b)(6))" after "section 1854(b)(3)(C)"; and

(ii) in subclause (II), by inserting "(or, insofar as such payment area is a competitive Medicare Advantage area, the competitive Medicare Advantage non-drug monthly benchmark amount)" after "Medicare Advantage area-specific non-drug monthly benchmark amount"; and

(B) DISCLOSURE OF INFORMATION.—Section 1853(b)(1)(B), as amended by section 221(e)(1), is amended to read as follows:

"(B) COMPETITION INFORMATION.—For years beginning with 2006, the following:

"(i) BENCHMARKS.—The Medicare Advantage area-specific non-drug benchmark under section 1853(j) and, if applicable, the competitive Medicare Advantage non-drug benchmark under section 1853(k)(2), for the year and competitive Medicare Advantage area involved and the national fee-for-service market share percentage for the area and year.

"(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iv) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).

"(iii) CERTAIN BENCHMARKS AND AMOUNTS.—In the case of a competitive Medicare Advantage area, the Medicare Advantage area-wide non-drug benchmark amount (as defined in subsection (k)(8)(C)) and the fee-for-service area-specific non-drug amount (as defined in section 1853(k)(6)) for the area.

"(iv) INDIVIDUALS.—The number of individuals counted under subsection (k)(4)(B) and enrolled in each Medicare Advantage plan in the area.".

(C) DEFINITION OF MONTHLY BASIC PREMIUM.—Section 1854(b)(2)(A)(ii), as amended by section 221(d)(2), is amended by inserting "(or, in the case of a competitive Medicare Advantage area, the competitive Medicare Advantage non-drug monthly benchmark amount or, in applying this paragraph under part E in the case of a competitive EFFS region, the competitive EFFS non-drug monthly benchmark amount)" after "benchmark amount".

(c) PREMIUM ADJUSTMENT.—

(1) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(h)(1)(A) In the case of an individual who resides in a competitive Medicare Advantage area under section 1853(k)(1) (regardless of whether such area is in a competitive EFFS region under section 1860E–3(e)) and who is not enrolled in a Medicare Advantage plan under part C or in an EFFS plan under part E, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this subsection) shall be adjusted as follows: If the fee-for-service area-specific non-drug amount (as defined in section 1853(k)(6)) for the competitive Medicare Advantage area in which the individual resides for a month—

"(i) does not exceed the competitive Medicare Advantage non-drug benchmark (as determined under paragraph (2) of section 1853(k), without regard to paragraph (8) thereof) for such area, the amount of the premium for the individual for the month shall be reduced by an amount equal to the product of the adjustment factor under subparagraph (C) and 75 percent of the amount by which such competitive benchmark exceeds such fee-for-service area-specific non-drug amount; or

"(ii) exceeds such competitive Medicare Advantage non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure, subject to subparagraph (B), that—

"(I) the sum of the amount of the adjusted premium and the competitive Medicare Advantage non-drug benchmark for the area, is equal to

"(II) the sum of the unadjusted premium plus amount of the fee-for-service area-specific non-drug amount for the area.

"(B) In no case shall the actual amount of an adjustment under subparagraph (A)(ii) exceed the product of the adjustment factor under subparagraph (C) and the amount of the adjustment otherwise computed under subparagraph (A)(ii) without regard to this subparagraph.

"(C) The adjustment factor under this subparagraph for an area for a year is equal to—

"(i) the number of consecutive years (in the 5-year period ending with the year involved) in which such area was a competitive Medicare Advantage area; divided by

"(ii) 5.

"(2)(A) In the case of an individual who resides in an area that is within a competitive EFFS region under section 1860E–3(e) but is not within a competitive Medicare Advantage area under section 1853(k)(1) and who is not enrolled in a Medicare Advantage plan under part C or in an EFFS plan under part E, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this subsection) shall be adjusted as follows: If the fee-for-service region-specific non-drug amount (as defined in section 1860E–3(e)(6)) for a region for a month—

"(i) does not exceed the competitive EFFS non-drug monthly benchmark amount (as determined under paragraph (2) of section 1860E–3(e), without regard to paragraph (8) thereof) for such region, the amount of the premium for the individual for the month shall be reduced by an amount equal to the product of the adjustment factor under subparagraph (C) and 75 percent of the amount by which such competitive benchmark amount exceeds such fee-for-service region-specific non-drug benchmark amount; or

"(ii) exceeds such competitive EFFS non-drug monthly benchmark amount, the amount of the premium for the individual for the month shall be adjusted to ensure, subject to subparagraph (B), that—

"(I) the sum of the amount of the adjusted premium and the competitive EFFS non-drug monthly benchmark amount for the region, is equal to

"(II) the sum of the unadjusted premium plus the amount of the EFFS region-specific non-drug monthly bid for the region.

"(B) In no case shall the actual amount of an adjustment under subparagraph (A)(ii) exceed the product of the adjustment factor under subparagraph (C) and the amount of the adjustment otherwise computed under subparagraph (A)(ii) without regard to this subparagraph.

"(C) The adjustment factor under this subparagraph for an EFFS region for a year is equal to—

"(i) the number of consecutive years (in the 5-year period ending with the year involved) in which such region was a competitive EFFS region; divided by

"(ii) 5.

"(3) Nothing in this subsection shall be construed as preventing a reduction under paragraph (1)(A) or paragraph (2)(A) in the premium otherwise applicable under this part to zero or from requiring the provision of a rebate to the extent such premium would otherwise be required to be less than zero.

"(4) The adjustment in the premium under this subsection shall be effected in such manner as the Medicare Benefits Administrator determines appropriate.

"(5) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

"(A) at the beginning of each year, the name, social security account number, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

"(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.".

(2) No change in Medicare's defined benefit package.—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(3) Conforming amendment.—Section 1844(c) (42 U.S.C. 1395w(c)) is amended by inserting "and without regard to any premium adjustment effected under section 1839(h)" before the period at the end.

(d) Effective Date.—The amendments made by this section shall take effect on January 1, 2010.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

SEC. 301. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SEC. 302. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) In General.—Section 1847 (42 U.S.C. 1395w–3) is amended to read as follows:

"COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

"Sec. 1847. (a) Establishment of Competitive Acquisition Programs.—

"(1) Implementation of programs.—

"(A) In general.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

"(B) Phased-in implementation.—The programs shall be phased-in—

"(i) among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

"(I) at least ⅓ of such areas in 2005; and

"(II) at least ⅔ of such areas in 2006; and

"(ii) among items and services in a manner such that the programs apply to the highest cost and highest volume items and services first.

"(C) Waiver of certain provisions.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

"(2) Items and services described.—The items and services referred to in paragraph (1) are the following:

"(A) Durable medical equipment and medical supplies.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), including items used in infusion and drugs and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

"(B) Other equipment and supplies.—Items, equipment, and supplies (as described in section 1842(s)(2)(D) other than enteral nutrients).

"(C) Off-the-shelf orthotics.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

"(3) EXCEPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

"(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

"(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

"(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF DURABLE MEDICAL EQUIPMENT.—In the case of a covered item for which payment is made on a rental basis under section 1834(a), the Secretary shall establish a process by which rental agreements for the covered items entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1834(a).

"(5) PHYSICIAN AUTHORIZATION.—The Secretary may establish a process under which a physician may prescribe a particular brand or mode of delivery of an item or service if the item or service involved is clinically more appropriate than other similar items or services.

"(6) APPLICATION.—For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1834(a).

"(b) PROGRAM REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

"(2) CONDITIONS FOR AWARDING CONTRACT.—

"(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

"(i) The entity meets quality and financial standards specified by the Secretary or developed by the Program Advisory and Oversight Committee established under subsection (c).

"(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

"(iii) Beneficiary access to a choice of multiple suppliers in the area is maintained.

"(iv) Beneficiary liability is limited to 20 percent of the applicable contract award price, except in such cases where a supplier has furnished an upgraded item and has executed an advanced beneficiary notice.

"(B) DEVELOPMENT OF QUALITY STANDARDS FOR DME PRODUCTS.—

"(i) IN GENERAL.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. Not later than July 1, 2004, the Secretary shall establish new quality standards for products subject to competitive acquisition under this section. Such standards shall be applied prospectively and shall be published on the website of the Department of Health and Human Services.

"(ii) CONSULTATION WITH PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—The Secretary shall consult with the Program Advisory and Oversight Committee (established under subsection (c)) to review (and advise the Secretary concerning) the quality standards referred to in clause (i).

"(iii) CONSTRUCTION.—Nothing in this subparagraph shall be construed as delaying the effective date of the implementation of the competitive acquisition program under this section.

"(3) CONTENTS OF CONTRACT.—

"(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

"(B) TERM OF CONTRACTS.—The Secretary shall recompete contracts under this section not less often than once every 3 years.

"(4) LIMIT ON NUMBER OF CONTRACTORS.—

"(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

"(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

"(5) PAYMENT.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on the bids submitted and accepted under this section for such items and services.

"(6) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

"(A) the contractor has submitted a bid for such items and services under this section; and

"(B) the Secretary has awarded a contract to the contractor for such items and services under this section.

In this section, the term 'bid' means a request for a proposal for an item or service that includes the cost of the item or service, and where appropriate, any services that are attendant to the provision of the item or service.

"(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary shall consider the similarity of the clinical efficiency and value of specific codes and products, including products that may provide a therapeutic advantage to beneficiaries, before delineating the categories and products that will be subject to bidding.

"(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries and monitoring quality of services with respect to the program.

"(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

"(1) ESTABLISHMENT.—There is established a Program Advisory and Oversight Committee (hereinafter in this section referred to as the 'Committee').

"(2) MEMBERSHIP; TERMS.—The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

"(3) DUTIES.—

"(A) TECHNICAL ASSISTANCE.—The Committee shall provide advice and technical assistance to the Secretary with respect to the following functions:

"(i) The implementation of the program under this section.

"(ii) The establishment of requirements for collection of data.

"(iii) The development of proposals for efficient interaction among manufacturers and distributors of the items and services and providers and beneficiaries.

"(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

"(4) INAPPLICABILITY OF FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

"(d) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in beneficiary cost-sharing, access to and quality of items and services, and beneficiary satisfaction.

"(e) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

"(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

"(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

"(B) which are furnished by entities that did not have a face-to-face encounter with the individual.

"(2) TERMS AND CONDITIONS.—Such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2).

"(3) REPORT.—The Secretary shall submit to Congress—

"(A) an initial report on the project not later than December 31, 2005; and

"(B) such progress and final reports on the project after such date as the Secretary determines appropriate.".

(b) CONFORMING AMENDMENTS.—

(1) DURABLE MEDICAL EQUIPMENT; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(A) in paragraph (1)(B), by striking "The payment basis" and inserting "Subject to subparagraph (E)(i), the payment basis";

(B) in paragraph (1)(C), by striking "This subsection" and inserting "Subject to subparagraph (E)(ii), this subsection";

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(E) APPLICATION OF COMPETITIVE ACQUISITION; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of covered items and services that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

"(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and "(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied."; and

(D) in paragraph (10)(B), by inserting "in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(E)" after "under this subsection".

(2) Off-the-shelf orthotics; elimination of inherent reasonableness authority.—Section 1834(h) (42 U.S.C. 1395m(h)) is amended—

(A) in paragraph (1)(B), by striking "and (E)" and inserting ", (E), and (H)(i)";

(B) in paragraph (1)(D), by striking "This subsection" and inserting "Subject to subparagraph (H)(ii), this subsection";

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(H) Application of competitive acquisition to orthotics; elimination of inherent reasonableness authority.—In the case of orthotics described in paragraph (2)(B) of section 1847(a) that are included in a competitive acquisition program in a competitive acquisition area under such section—

"(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

"(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.".

(c) Report on Activities of Suppliers.—The Secretary shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act, as amended by subsection (a), are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability.

(d) GAO Study on Safe and Effective Home Infusion and Inhalation Therapy; Standards.—

(1) Study.—The Comptroller General of the United States shall conduct a study of the standards, professional services, and related functions necessary for the provision of safe and effective home infusion therapy and home inhalation therapy.

(2) Report.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(3) Use of findings in developing standards.—In promulgating regulations to carry out section 1847 of the Social Security Act, as amended by subsection (a), the Secretary shall ensure that quality standards developed under subsection (b)(2)(B) of such section reflect the findings of the Comptroller General set forth in the report under paragraph (2).

SEC. 303. COMPETITIVE ACQUISITION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS.

(a) Adjustment to Physician Fee Schedule.—

(1) Adjustment in practice expense relative value units.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking "The adjustments" and inserting "Subject to clause (iv), the adjustments"; and

(ii) by adding at the end of subparagraph (B), the following new clause:

"(iv) Exception to budget neutrality.—The additional expenditures attributable to clauses (ii) and (iii) of subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2005."; and

(B) by adding at the end the following new subparagraph:

"(H) Adjustments in practice expense relative value units for 2005.—

"(i) In general.—As part of the annual process of establishing the physician fee schedule under subsection (b) for 2005, the Secretary shall increase the practice expense relative value units for 2005 consistent with clauses (ii) and (iii).

"(ii) Use of supplemental survey data.—For 2005 for any specialty that submitted survey data that included expenses for the administration of drugs and biologicals for which payment is made under section 1842(o) (or section 1847A), the Secretary shall use such supplemental survey data in carrying out this subparagraph insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and insofar as such data are submitted to the Secretary by December 31, 2004.

"(iii) Provisions for appropriate reporting and billing for physicians' services associated with the administration of covered outpatient drugs and biologicals.—

"(I) Evaluation of codes.—The Secretary shall promptly evaluate existing codes for physicians' services associated with the administration of covered outpatient drugs and biologicals (as defined in section 1847A(a)(2)(A)) to ensure accurate reporting and billing for such services.

"(II) Use of existing processes.—In carrying out subclause (I), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

"(III) Implementation.—In carrying out subclause (I), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1847A or section 1847B, and shall take such steps within the Secretary's authority to expedite such considerations under subclause (II).

"(iv) Subsequent, budget neutral adjustments permitted.—Nothing in this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under (and consistent with) subparagraph (B) for years after 2005.

"(v) Consultation.—Before publishing the notice of proposed rulemaking to carry out this subparagraph, the Secretary shall consult with the Comptroller General of the United States and with groups representing the physician specialties involved.

"(vi) Treatment as change in law and regulation in sustainable growth rate determination.—The enactment of subparagraph (B)(iv) and this subparagraph shall be treated as a change in law for purposes of applying subsection (f)(2)(D).".

(2) Prohibition of administrative and judicial review.—Section 1848(i)(1) (42 U.S.C. 1395w-4(i)(1)) is amended—

(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(F) adjustments in practice expense relative value units for 2005 under subsection (c)(2)(H).".

(3) Treatment of other services currently in the non-physician work pool.—The Secretary shall make adjustments to the non-physician work pool methodology (as such term is used in the regulations promulgated by the Secretary in the Federal Register as of December 31, 2002) for determination of practice expense relative value units under the physician fee schedule described in section 1848(c)(2)(C)(ii) of the Social Security Act so that the practice expense relative value units for services determined under such methodology are not affected relative to the practice expense relative value units of other services not determined under such non-physician work pool methodology, as the result of amendments made by paragraph (1).

(b) Payment Based on Competition.—Title XVIII is amended by inserting after section 1847 (42 U.S.C. 1395w-3), as amended by section 302, the following new sections:

"COMPETITIVE ACQUISITION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS

"Sec. 1847A. (a) Implementation of Competitive Acquisition.—

"(1) Implementation of program.—

"(A) In general.—The Secretary shall establish and implement a competitive acquisition program under which—

"(i) competitive acquisition areas are established throughout the United States for contract award purposes for acquisition of and payment for categories of covered outpatient drugs and biologicals (as defined in paragraph (2)) under this part;

"(ii) each physician is given the opportunity annually to elect to obtain drugs and biologicals under the program or under section 1847B; and

"(iii) each physician who elects to obtain drugs and biologicals under the program makes an annual selection under paragraph (5) of the contractor through which drugs and biologicals within a category of drugs and biologicals will be acquired and delivered to the physician under this part.

"(B) Implementation.—The Secretary shall implement the program so that the program applies to—

"(i) the oncology category beginning in 2005; and

"(ii) the non-oncology category beginning in 2006.

This section shall not apply in the case of a physician who elects section 1847B to apply.

"(C) Waiver of certain provisions.—In order to promote competition, efficient service, and product quality, in carrying out the program the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

"(D) Exclusion authority.—The Secretary may exclude covered outpatient drugs and biologicals (including a class of such drugs and biologicals) from the competitive bidding system under this section if the drugs or biologicals (or class) are not appropriate for competitive bidding due to low volume of utilization by beneficiaries under this part or a unique mode or method of delivery or similar reasons.

"(2) COVERED OUTPATIENT DRUGS AND BIOLOGICALS, CATEGORIES, PROGRAM DEFINED.—For purposes of this section—

"(A) COVERED OUTPATIENT DRUGS AND BIOLOGICALS DEFINED.—The term 'covered outpatient drugs and biologicals' means drugs and biologicals to which section 1842(o) applies and which are not covered under section 1847 (relating to competitive acquisition for items of durable medical equipment). Such term does not include the following:

"(i) Blood clotting factors.

"(ii) Drugs and biologicals furnished to individuals in connection with the treatment of end stage renal disease.

"(iii) Radiopharmaceuticals.

"(iv) Vaccines.

"(B) 2 CATEGORIES.—Each of the following shall be a separate category of covered outpatient drugs and biologicals, as identified by the Secretary:

"(i) ONCOLOGY CATEGORY.—A category (in this section referred to as the 'oncology category') consisting of those covered outpatient drugs and biologicals that, as determined by the Secretary, are typically primarily billed by oncologists or are otherwise used to treat cancer.

"(ii) NON-ONCOLOGY CATEGORIES.—Such numbers of categories (in this section referred to as the 'non-oncology categories') consisting of covered outpatient drugs and biologicals not described in clause (i), and appropriate subcategories of such drugs and biologicals as the Secretary may specify.

"(C) PROGRAM.—The term 'program' means the competitive acquisition program under this section.

"(D) COMPETITIVE ACQUISITION AREA; AREA.—The terms 'competitive acquisition area' and 'area' mean an appropriate geographic region established by the Secretary under the program.

"(E) CONTRACTOR.—The term 'contractor' means an entity that has entered into a contract with the Secretary under this section.

"(3) APPLICATION OF PROGRAM PAYMENT METHODOLOGY.—With respect to covered outpatient drugs and biologicals which are supplied under the program in an area and which are prescribed by a physician who has not elected section 1847B to apply—

"(A) the claim for such drugs and biologicals shall be submitted by the contractor that supplied the drugs and biologicals;

"(B) collection of amounts of any deductible and coinsurance applicable with respect to such drugs and biologicals shall be the responsibility of such contractor and shall not be collected unless the drug or biological is administered to the beneficiary involved; and

"(C) the payment under this section (and related coinsurance amounts) for such drugs and biologicals—

"(i) shall be made only to such contractor;

"(ii) shall be conditioned upon the administration of such drugs and biologicals; and

"(iii) shall be based on the average of the bid prices for such drugs and biologicals in the area, as computed under subsection (d).

The Secretary shall provide a process for recoupment in the case in which payment is made for drugs and biologicals which were billed at the time of dispensing but which were not actually administered.

"(4) CONTRACT REQUIRED.—

"(A) IN GENERAL.—Payment may not be made under this part for covered outpatient drugs and biologicals prescribed by a physician who has not elected section 1847B to apply within a category and a competitive acquisition area with respect to which the program applies unless—

"(i) the drugs or biologicals are supplied by a contractor with a contract under this section for such category of drugs and biologicals and area; and

"(ii) the physician has elected such contractor under paragraph (5) for such category and area.

"(B) PHYSICIAN CHOICE.—Subparagraph (A) shall not apply for a category of drugs for an area if the physician prescribing the covered outpatient drug in such category and area has elected to apply section 1847B instead of this section.

"(5) CONTRACTOR SELECTION PROCESS.—

"(A) IN GENERAL.—The Secretary shall provide a process for the selection of a contractor, on an annual basis and in such exigent circumstances as the Secretary may provide and with respect to each category of covered outpatient drugs and biologicals for an area, by physicians prescribing such drugs and biologicals in the area of the contractor under this section that will supply the drugs and biologicals within that category and area. Such selection shall also include the election described in section 1847B(a).

"(B) INFORMATION ON CONTRACTORS.—The Secretary shall make available to physicians on an ongoing basis, through a directory posted on the Department's Internet website or otherwise and upon request, a list of the contractors under this section in the different competitive acquisition areas.

"(C) SELECTING PHYSICIAN DEFINED.—For purposes of this section, the term 'selecting physician' means, with respect to a contractor and category and competitive acquisition area, a physician who has not elected section 1847B to apply and has selected to apply under this section such contractor for such category and area.

"(b) PROGRAM REQUIREMENTS.—

"(1) CONTRACT FOR COVERED OUTPATIENT DRUGS AND BIOLOGICALS.—The Secretary shall conduct a competition among entities for the acquisition of a covered outpatient drug or biological within each HCPCS code within each category for each competitive acquisition area.

"(2) CONDITIONS FOR AWARDING CONTRACT.—

"(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in a competitive acquisition area pursuant to paragraph (1) with respect to the acquisition of covered outpatient drugs and biologicals within a category unless the Secretary finds that the entity meets all of the following with respect to the contract period involved:

"(i) CAPACITY TO SUPPLY COVERED OUTPATIENT DRUG OR BIOLOGICAL WITHIN CATEGORY.—

"(I) IN GENERAL.—The entity has sufficient arrangements to acquire and to deliver covered outpatient drugs and biologicals within such category in the area specified in the contract at the bid price specified in the contract for all physicians that may elect such entity.

"(II) SHIPMENT METHODOLOGY.—The entity has arrangements in effect for the shipment at least 5 days each week of covered outpatient drugs and biologicals under the contract and for the timely delivery (including for emergency situations) of such drugs and biologicals in the area under the contract.

"(ii) QUALITY, SERVICE, FINANCIAL PERFORMANCE AND SOLVENCY STANDARDS.—The entity meets quality, service, financial performance, and solvency standards specified by the Secretary, including—

"(I) the establishment of procedures for the prompt response and resolution of physician and beneficiary complaints and inquiries regarding the shipment of covered outpatient drugs and biologicals; and

"(II) a grievance process for the resolution of disputes.

"(B) ADDITIONAL CONSIDERATIONS.—The Secretary may refuse to award a contract under this section, and may terminate such a contract, with an entity based upon—

"(i) the suspension or revocation, by the Federal Government or a State government, of the entity's license for the distribution of drugs or biologicals (including controlled substances); or

"(ii) the exclusion of the entity under section 1128 from participation under this title.

"(C) APPLICATION OF MEDICARE PROVIDER OMBUDSMAN.—For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 1868(b), as added by section 923 of the Medicare Prescription Drug and Modernization Act of 2003.

"(3) AWARDING MULTIPLE CONTRACTS FOR A CATEGORY AND AREA.—In order to provide a choice of at least 2 contractors in each competitive acquisition area for a category of drugs and biologicals, the Secretary may limit (but not below 2) the number of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

"(A) The bid prices for covered outpatient drugs and biologicals within the category and area.

"(B) Bid price for distribution of such drugs and biologicals.

"(C) Ability to ensure product integrity.

"(D) Customer service.

"(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

"(F) Such other factors as the Secretary may specify.

"(4) TERMS OF CONTRACTS.—

"(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify consistent with this section.

"(B) PERIOD OF CONTRACTS.—A contract under this section shall be for a term of 2 years, but may be terminated by the Secretary or the entity with appropriate, advance notice.

"(C) INTEGRITY OF DRUG AND BIOLOGICAL DISTRIBUTION SYSTEM.—The Secretary—

"(i) shall require that for all drug and biological products distributed by a contractor under this section be acquired directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer; and

"(ii) may require, in the case of such products that are particularly susceptible to counterfeit or diversion, that the contractor comply with such additional product integrity safeguards as may be determined to be necessary.

"(D) IMPLEMENTATION OF ANTI-COUNTERFEITING, QUALITY, SAFETY, AND RECORD KEEPING REQUIREMENTS.—The Secretary shall require each contractor to implement (through its officers, agents, representatives, and employees) requirements relating to the storage and handling of covered outpatient drugs and biologicals and for the establishment and maintenance of distribution records for such drugs and biologicals. A contract under this section may include requirements relating to the following:

"(i) Secure facilities.

"(ii) Safe and appropriate storage of drugs and biologicals.

"(iii) Examination of drugs and biologicals received and dispensed.

"(iv) Disposition of damaged and outdated drugs and biologicals.

"(v) Record keeping and written policies and procedures.

"(vi) Compliance personnel.

"(E) COMPLIANCE WITH CODE OF CONDUCT AND FRAUD AND ABUSE RULES.—Under the contract—

"(i) the contractor shall comply with a code of conduct, specified or recognized by the Secretary, that includes standards relating to conflicts of interest; and

"(ii) the contractor shall comply with all applicable provisions relating to prevention of fraud and abuse, including compliance with applicable guidelines of the Department of Justice and the Inspector General of the Department of Health and Human Services.

"(F) DIRECT DELIVERY OF DRUGS AND BIOLOGICALS TO PHYSICIANS.—Under the contract the contractor shall only supply covered outpatient drugs and biologicals directly to the selecting physicians and not directly to beneficiaries, except under circumstances and settings where a beneficiary currently receives a drug or biological in the beneficiary's home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon receipt of a prescription for such drugs and biologicals, and such necessary data as may be required by the Secretary to carry out this section. This section does not—

"(i) require a physician to submit a prescription for each individual treatment; or

"(ii) change a physician's flexibility in terms of writing a prescription for drugs for a single treatment or a course of treatment.

"(5) PERMITTING ACCESS TO DRUGS AND BIOLOGICALS.—The Secretary shall establish rules under this section under which drugs and biologicals which are acquired through a contractor under this section may be used to resupply inventories of such drugs and biologicals which are administered consistent with safe drug practices and with adequate safeguards against fraud and abuse. The previous sentence shall apply if the physicians can demonstrate to the Secretary all of the following:

"(A) The drugs or biologicals are required immediately.

"(B) The physician could not have reasonably anticipated the immediate requirement for the drugs or biologicals.

"(C) The contractor could not deliver to the physician the drugs or biologicals in a timely manner.

"(D) The drugs or biologicals were administered in an emergency situation.

"(6) CONSTRUCTION.—Nothing in this section shall be construed as waiving applicable State requirements relating to licensing of pharmacies.

"(c) BIDDING PROCESS.—

"(1) IN GENERAL.—In awarding a contract for a category of drugs and biologicals in an area under the program, the Secretary shall consider with respect to each entity seeking to be awarded a contract the prices bid to acquire and supply the covered outpatient drugs and biologicals for that category and area and the other factors referred to in subsection (b)(3).

"(2) PRICES BID.—The prices bid by an entity under paragraph (1) shall be the prices in effect and available for the supply of contracted drugs and biologicals in the area through the entity for the contract period.

"(3) REJECTION OF CONTRACT OFFER.—The Secretary shall reject the contract offer of an entity with respect to a category of drugs and biologicals for an area if the Secretary estimates that the prices bid, in the aggregate on average, would exceed 100 percent of the average sales price (as determined under section 1847B).

"(4) BIDDING ON A NATIONAL OR REGIONAL BASIS.—Nothing in this section shall be construed as precluding a bidder from bidding for contracts in all areas of the United States or as requiring a bidder to submit a bid for all areas of the United States.

"(5) UNIFORMITY OF BIDS WITHIN AREA.—The amount of the bid submitted under a contract offer for any covered outpatient drug or biological for an area shall be the same for that drug or biological for all portions of that area.

"(6) CONFIDENTIALITY OF BIDS.—The provisions of subparagraph (D) of section 1927(b)(3) shall apply to a bid submitted in a contract offer for a covered outpatient drug or biological under this section in the same manner as it applies to information disclosed under such section, except that any reference—

"(A) in that subparagraph to a 'manufacturer or wholesaler' is deemed a reference to a 'bidder' under this section;

"(B) in that section to 'prices charged for drugs' is deemed a reference to a 'bid' submitted under this section; and

"(C) in clause (i) of that section to 'this section', is deemed a reference to 'part B of title XVIII'.

"(7) INCLUSION OF COSTS.—The bid price submitted in a contract offer for a covered outpatient drug or biological shall—

"(A) include all costs related to the delivery of the drug or biological to the selecting physician (or other point of delivery); and

"(B) include the costs of dispensing (including shipping) of such drug or biological and management fees, but shall not include any costs related to the administration of the drug or biological, or wastage, spillage, or spoilage.

"(8) PRICE ADJUSTMENTS DURING CONTRACT PERIOD; DISCLOSURE OF COSTS.—Each contract awarded shall provide for—

"(A) disclosure to the Secretary the contractor's reasonable, net acquisition costs for periods specified by the Secretary, not more often than quarterly, of the contract; and

"(B) appropriate price adjustments over the period of the contract to reflect significant increases or decreases in a contractor's reasonable, net acquisition costs, as so disclosed.

"(d) COMPUTATION OF AVERAGE BID PRICES FOR A CATEGORY AND AREA.—

"(1) IN GENERAL.—For each year or other contract period for each covered outpatient drug or biological and area with respect to which a competition is conducted under the program, the Secretary shall compute an area average of the bid prices submitted, in contract offers accepted for the category and area, for that year or other contract period.

"(2) SPECIAL RULES.—The Secretary shall establish rules regarding the use under this section of the alternative payment amount provided under section 1847B to the use of a price for specific covered outpatient drugs and biologicals in the following cases:

"(A) NEW DRUGS AND BIOLOGICALS.—A covered outpatient drug or biological for which an average bid price has not been previously determined.

"(B) OTHER CASES.—Such other exceptional cases as the Secretary may specify in regulations, such as oral drugs under section 1861(s)(2)(Q) and immmunosuppressives under section 1861(s)(2)(J).

"(e) COINSURANCE.—

"(1) IN GENERAL.—Coinsurance under this part with respect to a covered outpatient drug or biological for which payment is payable under this section shall be based on 20 percent of the payment basis under this section.

"(2) COLLECTION.—Such coinsurance shall be collected by the contractor that supplies the drug or biological involved and, subject to subsection (a)(3)(B), in the same manner as coinsurance is collected for durable medical equipment under this part.

"(f) SPECIAL PAYMENT RULES.—

"(1) IN GENERAL.—The Secretary may not provide for an adjustment to reimbursement for covered outpatient drugs and biologicals unless adjustments to the practice expense payment adjustment are made on the basis of supplemental surveys under section 1848(c)(2)(H)(ii) of the Social Security Act, as added by subsection (a)(1)(B).

"(2) USE IN EXCLUSION CASES.—If the Secretary excludes a drug or biological (or class of drugs or biologicals) under subsection (a)(1)(D), the Secretary may provide for reimbursement to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1847B.

"(3) COORDINATION RULES.—The provisions of section 1842(h)(3) shall apply to a contractor with respect to covered outpatients drugs and biologicals supplied by that contractor in the same manner as they apply to a participating supplier. In order to administer this section, the Secretary may condition payment under this part to a person for the administration of a drug or biological supplied under this section upon person's provision of information on such administration.

"(4) APPLICATION OF REQUIREMENT FOR ASSIGNMENT.—For provision requiring assignment of claims for covered outpatient drugs and biologicals, see section 1842(o)(3).

"(5) PROTECTION FOR BENEFICIARY IN CASE OF MEDICAL NECESSITY DENIAL.—For protection of beneficiaries against liability in the case of medical necessity determinations, see section 1842(b)(3)(B)(ii)(III).

"(6) PHYSICIAN ROLE IN APPEALS PROCESS.—The Secretary shall establish a procedure under which a physician who prescribes a drug or biological for which payment is made under this section has appeal rights that are similar to those provided to a physician who prescribes durable medical equipment or a laboratory test.

"(g) ADVISORY COMMITTEE.—The Secretary shall establish an advisory committee that includes representatives of parties affected by the program under this section, including physicians, specialty pharmacies, distributors, manufacturers, and beneficiaries. The committee shall advise the Secretary on issues relating to the effective implementation of this section.

"(h) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual report in each of 2005, 2006, and 2007, on the program. Each such report shall include information on savings, reductions in cost-sharing, access to covered outpatient drugs and biologicals, the range of choices of contractors available to providers, and beneficiary and provider satisfaction.

"OPTIONAL USE OF AVERAGE SALES PRICE PAYMENT METHODOLOGY

"SEC. 1847B. (a) IN GENERAL.—

"(1) ELECTION.—In connection with the annual election made by a physician under section 1847A(a)(5), the physician may elect to apply this section to the payment for covered outpatient drugs and biologicals instead of the payment methodology under section 1847A.

"(2) IMPLEMENTATION.—This section shall be implemented with respect to categories of covered outpatient drugs and biologicals described in section 1847A(a)(2)(B).

"(3) COVERED OUTPATIENT DRUGS AND BIOLOGICALS DEFINED.—For purposes of this section, the term 'covered outpatient drugs and biologicals' has the meaning given such term in section 1847A(a)(2)(A).

"(b) COMPUTATION OF PAYMENT AMOUNT.—

"(1) IN GENERAL.—If this section applies with respect to a covered outpatient drug or biological, the amount payable for the drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

"(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 100 percent (or in the case of covered outpatient drugs and biologicals furnished during 2005 and 2006, 112 percent) of the amount determined under paragraph (3); or

"(B) in the case of a single source drug (as defined in subsection (c)(6)(D)), 100 percent (or in the case of covered outpatient drugs and biologicals furnished during 2005 and 2006, 112 percent) of the amount determined under paragraph (4).

"(2) SPECIFICATION OF UNIT.—

"(A) SPECIFICATION BY MANUFACTURER.—The manufacturer of a covered outpatient drug shall specify the unit associated with each National Drug Code as part of the submission of data under section 1927(b)(3)(A)(iii).

"(B) UNIT DEFINED.—In this section, the term 'unit' means, with respect to a covered outpatient drug, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids.

"(3) MULTIPLE SOURCE DRUG.—For all drug products included within the same multiple source drug, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1927(b)(3)(A)(iii) computed as follows:

"(A) Compute the sum of the products (for each national drug code assigned to such drug products) of—

"(i) the manufacturer's average sales price (as defined in subsection (c)); and

"(ii) the total number of units specified under paragraph (2) sold, as reported under section 1927(b)(3)(A)(iii).

"(B) Divide the sum computed under subparagraph (A) by the sum of the total number of units under subparagraph (A)(ii) for all national drug codes assigned to such drug products.

"(4) SINGLE SOURCE DRUG.—The amount specified in this paragraph for a single source drug is the lesser of the following:

"(A) MANUFACTURER'S AVERAGE SALES PRICE.—The manufacturer's average sales price for a national drug code, as computed using the methodology applied under paragraph (3).

"(B) WHOLESALE ACQUISITION COST (WAC).—The wholesale acquisition cost (as defined in subsection (c)(6)(B)) reported for the single source drug.

"(5) BASIS FOR DETERMINATION.—The payment amount shall be determined under this subsection based on information reported under subsection (e) and without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

"(c) MANUFACTURER'S AVERAGE SALES PRICE.—

"(1) IN GENERAL.—For purposes of this subsection, subject to paragraphs (2) and (3), the manufacturer's 'average sales price' means, of a covered outpatient drug for a NDC code for a calendar quarter for a manufacturer for a unit—

"(A) the manufacturer's total sales (as defined by the Secretary in regulations for purposes of section 1927(c)(1)) in the United States for such drug in the calendar quarter; divided by

"(B) the total number of such units of such drug sold by the manufacturer in such quarter.

"(2) CERTAIN SALES EXEMPTED FROM COMPUTATION.—In calculating the manufacturer's average sales price under this subsection, the following sales shall be excluded:

"(A) SALES EXEMPT FROM BEST PRICE.—Sales exempt from the inclusion in the determination of 'best price' under section 1927(c)(1)(C)(i).

"(B) SALES AT NOMINAL CHARGE.—Such other sales as the Secretary identifies by regulation as sales to an entity that are nominal in price or do not reflect a market price paid by an entity to which payment is made under this section.

"(3) SALE PRICE NET OF DISCOUNTS.—In calculating the manufacturer's average sales price under this subsection, such price shall be determined taking into account volume discounts, prompt pay discounts, cash discounts, the free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under section 1927), that result in a reduction of the cost to the purchaser. A rebate to a payor or other entity that does not take title to a covered outpatient drug shall not be taken into account in determining such price unless the manufacturer has an agreement with the payor or other entity under which the purchaser's price for the drug is reduced as a consequence of such rebate.

"(4) AUTHORITY TO DISREGARD AVERAGE SALES PRICE DURING FIRST QUARTER OF SALES.—In the case of a covered outpatient drug during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug is not sufficiently available from the manufacturer to compute an average sales price for the drug, the Secretary may determine the amount payable under this section for the drug without considering the manufacturer's average sales price of that manufacturer for that drug.

"(5) FREQUENCY OF DETERMINATIONS.—

"(A) IN GENERAL ON A QUARTERLY BASIS.—The manufacturer's average sales price, for a covered outpatient drug of a manufacturer, shall be determined by such manufacturer under this subsection on a quarterly basis. In making such determination insofar as there is a lag in the reporting of the information on rebates and chargebacks under paragraph (3) so that adequate data are not available on a timely basis, the manufacturer shall apply a methodology established by the Secretary based on a 12-month rolling average for the manufacturer to estimate costs attributable to rebates and chargebacks.

"(B) UPDATES IN RATES.—The payment rates under subsection (b)(1) and (b)(2)(A) shall be updated by the Secretary on a quarterly basis and shall be applied based upon the manufacturer's average sales price determined for the most recent calendar quarter.

"(C) USE OF CONTRACTORS; IMPLEMENTATION.—The Secretary may use a carrier, fiscal intermediary, or other contractor to determine the payment amount under subsection (b). Notwithstanding any other provision of law, the Secretary may implement, by program memorandum or otherwise, any of the provisions of this section.

"(6) DEFINITIONS AND OTHER RULES.—In this section:

"(A) MANUFACTURER.—The term 'manufacturer' means, with respect to a covered outpatient drug, the manufacturer (as defined in section 1927(k)(5)) whose national drug code appears on such drug.

"(B) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' means, with respect to a covered outpatient drug, the manufacturer's list price for the drug to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug pricing data.

"(C) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' means, for a calendar quarter, a covered outpatient drug for which there are 2 or more drug products which—

"(i) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'),

"(ii) except as provided in subparagraph (E), are pharmaceutically equivalent and bioequivalent, as determined under subparagraph (F) and as determined by the Food and Drug Administration, and

"(iii) are sold or marketed in the United States during the quarter.

"(D) SINGLE SOURCE DRUG.—The term 'single source drug' means a covered outpatient drug which is not a multiple source drug and which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application, or which is a biological.

"(E) EXCEPTION FROM PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE REQUIREMENT.—Subparagraph (C)(ii) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (C)(i), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (F).

"(F) DETERMINATION OF PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE.—For purposes of this paragraph—

"(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

"(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

"(G) INCLUSION OF VACCINES.—In applying provisions of section 1927 under this section, 'other than a vaccine' is deemed deleted from section 1927(k)(2)(B).

"(d) Authority To Use Alternative Payment in Response to Public Health Emergency.—In the case of a public health emergency under section 319 of the Public Health Service Act in which there is a documented inability to access covered outpatient drugs and biologicals, and a concomitant increase in the price, of a drug or biological which is not reflected in the manufacturer's average sales price for one or more quarters, the Secretary may use the wholesale acquisition cost (or other reasonable measure of drug price) instead of the manufacturer's average sales price for such quarters and for subsequent quarters until the price and availability of the drug or biological has stabilized and is substantially reflected in the applicable manufacturer's average sales price.

"(e) Reports.—

"(1) Quarterly report on average sales price.—For requirements for reporting the manufacturer's average sales price (and, if required to make payment, the manufacturer's wholesale acquisition cost) for the covered outpatient drug or biological, see section 1927(b)(3).

"(2) Annual report to congress.—The Secretary shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on the operation of this section. Such report shall include information on the following:

"(A) Trends in average sales price under subsection (b).

"(B) Administrative costs associated with compliance with this section.

"(C) Total value of payments made under this section.

"(D) Comparison of the average manufacturer price as applied under section 1927 for a covered outpatient drug or biological with the manufacturer's average sales price for the drug or biological under this section.

"(f) Restriction on administrative and judicial review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of manufacturer's average sales price under subsection (c).".

(c) Continuation of Payment Methodology for Radiopharmaceuticals.—Nothing in the amendments made by this section shall be construed as changing the payment methodology under part B of title XVIII of the Social Security Act for radiopharmaceuticals, including the use by carriers of invoice pricing methodology.

(d) Conforming Amendments.—

(1) In general.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(A) in paragraph (1), by inserting ", subject to section 1847A and 1847B," before "the amount payable for the drug or biological"; and

(B) by adding at the end of paragraph (2) the following: "This paragraph shall not apply in the case of payment under section 1847A or 1847B.".

(2) No change in coverage basis.—Section 1861(s)(2)(A) (42 U.S.C. 1395x(s)(2)(A)) is amended by inserting "(or would have been so included but for the application of section 1847A or 1847B)" after "included in the physicians' bills".

(3) Payment.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting "(or, if applicable, under section 1847A or 1847B)" after "1842(o)".

(4) Consolidated reporting of pricing information.—Section 1927 (42 U.S.C. 1396r-8) is amended—

(A) in subsection (a)(1), by inserting "or under part B of title XVIII" after "section 1903(a)";

(B) in subsection (b)(3)(A)—

(i) in clause (i), by striking "and" at the end;

(ii) in clause (ii), by striking the period and inserting "; and"; and

(iii) by adding at the end the following new clause:

"(iii) for calendar quarters beginning on or after April 1, 2004, in conjunction with reporting required under clause (i) and by national drug code (NDC)—

"(I) the manufacturer's average sales price (as defined in section 1847B(c)) and the total number of units specified under section 1847B(b)(2)(A);

"(II) if required to make payment under section 1847B, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

"(III) information on those sales that were made at a nominal price or otherwise described in section 1847B(c)(2)(B), which information is subject to audit by the Inspector General of the Department of Health and Human Services;

for a covered outpatient drug or biological for which payment is made under section 1847B.";

(C) in subsection (b)(3)(B)—

(i) in the heading, by inserting "AND MANUFACTURER'S AVERAGE SALES PRICE" after "PRICE"; and

(ii) by inserting "and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment" after "manufacturer prices"; and

(D) in subsection (b)(3)(D)(i), by inserting "and section 1847B" after "this section".

(e) GAO Study.—

(1) Study.—The Comptroller General of the United States shall conduct a study to assess the impact of the amendments made by this section on the delivery of services, including their impact on—

(A) beneficiary access to drugs and biologicals for which payment is made under part B of title XVIII of the Social Security Act; and

(B) the site of delivery of such services.

(2) Report.—Not later than 2 years after the year in which the amendment made by subsection (a)(1) first takes effect, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(f) MedPAC Recommendations on Blood Clotting Factors.—The Medicare Payment Advisory Commission shall submit to Congress, in its annual report in 2004, specific recommendations regarding a payment amount (or amounts) for blood clotting factors and its administration under the medicare program.

(g) Establishment of Pharmaceutical Management Fee Where Drugs Provided Through a Contractor.—Section 1848(a) (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

"(5) Recognition of pharmaceutical management fee in certain cases.—In establishing the fee schedule under this section, the Secretary shall provide for a separate payment with respect to physicians' services consisting of the unique administrative and management costs associated with covered drugs and biologicals which are furnished to physicians through a contractor under section 1847A (compared with such costs if such drugs and biologicals were acquired directly by such physicians).".

(h) Study on Codes for Non-oncology Codes.—

(1) Study.—The Secretary shall conduct a study to determine the appropriateness of establishing and implementing separate codes for non-oncology infusions that are based on the level of complexity of the administration and resource consumption.

(2) Report.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study. To the extent the Secretary determines it to be appropriate, the Secretary may implement appropriate changes in the payment methodology for such codes.

SEC. 304. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) In General.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A or part B of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) Scope and Duration.—

(1) Scope.—The project shall cover at least 2 States that are among the States with—

(A) the highest per capita utilization rates of medicare services, and

(B) at least 3 contractors.

(2) Duration.—The project shall last for not longer than 3 years.

(c) Waiver.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) Qualifications of Contractors.—

(1) In general.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) Ineligibility of certain contractors.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) Preference for entities with demonstrated proficiency.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the medicaid program under title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

SEC. 401. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) DOUBLING THE CAP.—

(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

"(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2003, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

"(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 10 percent for a hospital that is not classified as a rural referral center under subparagraph (C).".

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting "subject to clause (xiv) and" before "for discharges occurring";

(B) in clause (viii), by striking "The formula" and inserting "Subject to clause (xiv), the formula"; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "Subject to clause (xiv), for purposes".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to discharges occurring on or after October 1, 2003.

SEC. 402. IMMEDIATE ESTABLISHMENT OF UNIFORM STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS.

(a) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

(1) in clause (iv), by inserting "and ending on or before September 30, 2003," after "October 1, 1995,"; and

(2) by redesignating clauses (v) and (vi) as clauses (vii) and (viii), respectively, and inserting after clause (iv) the following new clauses:

"(v) For discharges occurring in the fiscal year beginning on October 1, 2003, the average standardized amount for hospitals located in areas other than a large urban area shall be equal to the average standardized amount for hospitals located in a large urban area.".

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "IN DIFFERENT AREAS";

(B) in the matter preceding clause (i), by striking ", each of";

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking "and" after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking the period at the end and inserting "; and"; and

(E) by adding at the end the following new clause:

"(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

"(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.".

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting ", for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting ", for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region,".

SEC. 403. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

(a) CLASSIFICATION.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended—

(1) in the heading by adding "ESSENTIAL RURAL HOSPITALS" at the end; and

(2) by adding at the end the following new paragraphs:

"(4)(A) The term 'essential rural hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is located in a rural area (as defined for purposes of section 1886(d)), has more than 25 licensed acute care inpatient beds, has applied to the Secretary for classification as such a hospital, and with respect to which the Secretary has determined that the closure of the hospital would significantly diminish the ability of medicare beneficiaries to obtain essential health care services.

"(B) The determination under subparagraph (A) shall be based on the following criteria:

"(i) HIGH PROPORTION OF MEDICARE BENEFICIARIES RECEIVING CARE FROM HOSPITAL.—(I) A high percentage of such beneficiaries residing in the area of the hospital who are hospitalized (during the most recent year for which complete data are available) receive basic inpatient medical care at the hospital.

"(II) For a hospital with more than 200 licensed beds, a high percentage of such beneficiaries residing in such area who are hospitalized (during such recent year) receive specialized surgical inpatient care at the hospital.

"(III) Almost all physicians described in section 1861(r)(1) in such area have privileges at the hospital and provide their inpatient services primarily at the hospital.

"(IV) The hospital inpatient score for quality of care is not less than the median hospital score for qualify of care for hospitals in the State, as established under standards of the utilization and quality control peer review organization under part B of title XI or other quality standards recognized by the Secretary.

"(ii) SIGNIFICANT ADVERSE IMPACT IN ABSENCE OF HOSPITAL.—If the hospital were to close—

"(I) there would be a significant amount of time needed for residents to reach emergency treatment, resulting in a potential significant harm to beneficiaries with critical illnesses or injuries;

"(II) there would be an inability in the community to stablize emergency cases for transfers to another acute care setting, resulting in a potential for significant harm to medicare beneficiaries; and

"(III) any other nearby hospital lacks the physical and clinical capacity to take over the hospital's typical admissions.

"(C) In making such determination, the Secretary may also consider the following:

"(i) Free-standing ambulatory surgery centers, office-based oncology care, and imaging center services are insufficient in the hospital's area to handle the outpatient care of the hospital.

"(ii) Beneficiaries in nearby areas would be adversely affected if the hospital were to close as the hospital provides specialized knowledge and services to a network of smaller hospitals and critical access hospitals.

"(iii) Medicare beneficiaries would have difficulty in accessing care if the hospital were to close as the hospital provides significant subsidies to support ambulatory care in local clinics, including mental health clinics and to support post acute care.

"(iv) The hospital has a committment to provide graduate medical education in a rural area.

A hospital classified as an essential rural hospital may not change such classification and a hospital so classified shall not be treated as a sole community hospital, medicare dependent hospital, or rural referral center for purposes of section 1886.".

(b) PAYMENT BASED ON 102 PERCENT OF ALLOWED COSTS.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

"(11) In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for inpatient hospital services for discharges occurring during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this paragraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under part A or as waiving any requirement for billing for such services.".

(2) HOSPITAL OUTPATIENT SERVICES.—Section 1833(t)(13) (42 U.S.C. 1395l(t)(13)) is amended by adding at the end the following new subparagraph:

"(B) SPECIAL RULE FOR ESSENTIAL RURAL HOSPITALS.—In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for covered OPD services during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this subparagraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under this part or as waiving any requirement for billing for such services.".

(c) Effective Date.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2004.

SEC. 404. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) More Frequent Updates in Weights.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) Report.—Not later than October 1, 2004, the Secretary shall submit a report to Congress on the frequency established under subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) Increase in Payment Amounts.—

(1) In general.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l); 1395m(g)(1); 42 U.S.C. 1395tt(a)(3)) are each amended by inserting "equal to 102 percent of" before "the reasonable costs".

(2) Effective date.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after October 1, 2003.

(b) Coverage of Costs for Certain Emergency Room On-Call Providers.—

(1) In general.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services" and inserting "services covered under this title".

(2) Effective date.—The amendment made by paragraph (1) shall apply with respect to costs incurred for services provided on or after January 1, 2004.

(c) Modification of the Isolation Test for Cost-Based CAH Ambulance Services.—

(1) In general.—Section 1834(l)(8) (42 U.S.C. 1395m(l)), as added by section 205(a) of BIPA (114 Stat. 2763A-482), is amended by adding at the end the following: "The limitation described in the matter following subparagraph (B) in the previous sentence shall not apply if the ambulance services are furnished by such a provider or supplier of ambulance services who is a first responder to emergencies in accordance with local protocols (as determined by the Secretary).".

(2) Effective date.—The amendment made by paragraph (1) shall apply to ambulances services furnished on or after the first cost reporting period that begins after the date of the enactment of this Act.

(d) Reinstatement of Periodic Interim Payment (PIP).—

(1) In general.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting ", in the cases described in subparagraphs (A) through (D)" after "1986"; and

(B) by striking "and" at the end of subparagraph (C);

(C) by adding "and" at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

(2) Development of alternative methods of periodic interim payments.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

(3) Reinstatement of pip.—The amendments made by paragraph (1) shall apply to payments made on or after January 1, 2004.

(e) Condition for Application of Special Physician Payment Adjustment.—

(1) In general.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

"The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.".

(2) Effective date.—The amendment made by paragraph (1) shall be effective as if included in the enactment of section 403(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A-371).

(f) Flexibility in Bed Limitation for Hospitals.—Section 1820 (42 U.S.C. 1395i-4) is amended—

(1) in subsection (c)(2)(B)(iii), by inserting "subject to paragraph (3)" after "(iii) provides";

(2) by adding at the end of subsection (c) the following new paragraph:

"(3) Increase in maximum number of beds for hospitals with strong seasonal census fluctuations.—

"(A) In general.—Subject to subparagraph (C), in the case of a hospital that demonstrates that it meets the standards established under subparagraph (B) and has not made the election described in subsection (f)(2)(A), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

"(B) Standards.—The Secretary shall specify standards for determining whether a critical access hospital has sufficiently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A)."; and

(3) in subsection (f)—

(A) by inserting "(1)" after "(f)"; and

(B) by adding at the end the following new paragraph:

"(2)(A) A hospital may elect to treat the reference in paragraph (1) to '15 beds' as a reference to '25 beds', but only if no more than 10 beds in the hospital are at any time used for non-acute care services. A hospital that makes such an election is not eligible for the increase provided under subsection (c)(3)(A).

"(B) The limitations in numbers of beds under the first sentence of paragraph (1) are subject to adjustment under subsection (c)(3).".

(4) Effective date.—The amendments made by this subsection shall apply to designations made before, on, or after January 1, 2004.

(g) Additional 5-Year Period of Funding for Grant Program.—

(1) In general.—Section 1820(g) (42 U.S.C. 1395i-4(g)) is amended by adding at the end the following new paragraph:

"(4) Funding.—

"(A) In general.—Subject to subparagraph (B), payment for grants made under this subsection during fiscal years 2004 through 2008 shall be made from the Federal Hospital Insurance Trust Fund.

"(B) Annual aggregate limitation.—In no case may the amount of payment provided for under subparagraph (A) for a fiscal year exceed $25,000,000.".

(2) Conforming amendment.—Section 1820 (42 U.S.C. 1395i-4) is amended by striking subsection (j).

SEC. 406. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) In General.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting "subject to subparagraph (I)," after "October 1, 1997,";

(2) in subparagraph (H)(i), by inserting "subject to subparagraph (I)," after "subparagraphs (F) and (G),"; and

(3) by adding at the end the following new subparagraph:

"(I) Redistribution of unused resident positions.—

"(i) Reduction in limit based on unused positions.—

"(I) In general.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2004, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

"(II) Reference periods defined.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2002.

"(III) Reference resident level.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

"(IV) Adjustment process.—Upon the timely request of a hospital, the Secretary shall adjust (subject to audit) the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2003.

"(V) Affiliation.—With respect to hospitals which are members of the same affiliated group (as defined by the Secretary under subparagraph (H)(ii)), the provisions of this section shall be applied with respect to such an affiliated group by deeming the affiliated group to be a single hospital.

"(ii) Redistribution.—

"(I) In general.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

"(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2004, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2005.

"(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

"(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

"(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

"(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

"(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

"(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

"(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.".

(b) CONFORMING AMENDMENT TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: "The provisions of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection.".

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

SEC. 407. TWO-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking "SMALL" and inserting "CERTAIN";

(B) by inserting "or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area" after "100 beds"; and

(C) by striking "2004" and inserting "2006".

(2) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply with respect to payment for OPD services furnished on and after January 1, 2004.

(b) STUDY; ADJUSTMENT.—

(1) STUDY.—The Secretary shall conduct a study to determine if, under the prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), costs incurred by rural providers of services by ambulatory payment classification groups (APCs) exceed those costs incurred by urban providers of services.

(2) ADJUSTMENT.—Insofar as the Secretary determines under paragraph (1) that costs incurred by rural providers exceed those costs incurred by urban providers of services, the Secretary shall provide for an appropriate adjustment under such section 1833(t) to reflect those higher costs by January 1, 2005.

SEC. 408. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C. 1395yy(e)(2)(A)) is amended—

(1) in clause (i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

(2) by adding at the end the following new clause:

"(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

"(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

"(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were not furnished by an individual affiliated with a rural health clinic or a Federally qualified health center.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2004.

SEC. 409. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting "or nurse practitioner (as defined in subsection (aa)(5))" after "the physician (as defined in subsection (r)(1))".

(b) CLARIFICATION OF HOSPICE ROLE OF NURSE PRACTITIONERS.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting "(which for purposes of this subparagraph does not include a nurse practitioner)" after "attending physician (as defined in section 1861(dd)(3)(B))".

SEC. 410. IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A-486), as paragraph (9); and

(2) by adding at the end the following new paragraph:

"(10) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW MEDICARE POPULATION DENSITY AREAS.—

"(A) IN GENERAL.—In the case of ground ambulance services furnished on or after January 1, 2004, for which the transportation originates in a qualified rural area (as defined in subparagraph (B)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for the base rate in the lowest quartile as compared to the average cost for the base rate for such services that is in the highest quartile of all rural county populations.

"(B) QUALIFIED RURAL AREA DEFINED.—For purposes of subparagraph (A), the term 'qualified rural area' is a rural area (as defined in section 1886(d)(2)(D)) with a population density of medicare beneficiaries residing in the area that is in the lowest quartile of all rural county populations.".

SEC. 411. TWO-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) during 2004 and 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a-7(b)(3)), as amended by section 101(b)(2), is amended—

(1) in subparagraph (F), by striking "and" after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(H) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.".

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) In general.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) Factors to consider.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) Interim final effect.—No later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 413. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) Study.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions; and

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component.

(b) Report.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 414. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) In General.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

"(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.".

(b) Effective Date.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 415. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking "4-year" and inserting "8-year"; and

(2) in subsection (d)(3), by striking "$30,000,000" and inserting "$60,000,000".

SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) In General.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking "Wage levels.—The Secretary" and inserting "Wage levels.—

"(i) In general.—Except as provided in clause (ii), the Secretary"; and

(2) by adding at the end the following new clause:

"(ii) Alternative proportion to be adjusted beginning in fiscal year 2004.—

"(I) In general.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2003, the Secretary shall substitute the '62 percent' for the proportion described in the first sentence of clause (i).

"(II) Hold harmless for certain hospitals.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.".

(b) Waiving Budget Neutrality.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: "The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Medicare Prescription Drug and Modernization Act of 2003 had not been enacted.".

SEC. 417. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) Additional Bonus Payment for Certain Physician Scarcity Areas.—

(1) In general.—Section 1833 (42 U.S.C. 1395*l*) is amended by adding at the end the following new subsection:

"(u) Incentive Payments for Physician Scarcity Areas.—

"(1) In general.—In the case of physicians' services furnished in a year—

"(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

"(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

"(2) Determination of ratios of physicians to medicare beneficiaries in area.—Based upon available data, the Secretary shall periodically determine, for each county or equivalent area in the United States, the following:

"(A) Number of physicians practicing in the area.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

"(i) primary care physicians; or

"(ii) physicians who are not primary care physicians.

"(B) Number of medicare beneficiaries residing in the area.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both.

"(C) Determination of ratios.—

"(i) Primary care ratio.—The ratio (in this paragraph referred to as the 'primary care ratio') of the number of primary care physicians (determined under subparagraph (A)(i)), to number of medicare beneficiaries determined under subparagraph (B).

"(ii) Specialist care ratio.—The ratio (in this paragraph referred to as the 'specialist care ratio') of the number of other physicians (determined under subparagraph (A)(ii)), to number of medicare beneficiaries determined under subparagraph (B).

"(3) Ranking of counties.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

"(4) Identification of counties.—The Secretary shall identify—

"(A) those counties and areas (in this paragraph referred to as 'primary care scarcity counties') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph; and

"(B) those counties and areas (in this subsection referred to as 'specialist care scarcity counties') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph.

There is no administrative or judicial review respecting the identification of a county or area or the assignment of a specialty of any physician under this paragraph.

"(5) Rural census tracks.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

"(6) Physician Defined.—For purposes of this paragraph, the term 'physician' means a physician described in section 1861(r)(1) and the term 'primary care physician' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

"(7) Publication of list of counties.—In carrying out this subsection for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a primary care scarcity county or specialist care scarcity county under this subsection for the year involved.”.

(2) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to physicians' services furnished or after January 1, 2004.

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(A) by inserting “(1)” after “(m)”; and

(B) by adding at the end the following new paragraphs:

“(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).

“(3) In carrying out paragraph (1) for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a health professional shortage area under paragraph (1) for the year involved.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to physicians' services furnished or after January 1, 2004.

SEC. 418. RURAL HOSPICE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the home for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act; and

(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act.

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 501. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by striking “and” at the end of subclause (XVIII);

(2) by striking subclause (XIX); and

(3) by inserting after subclause (XVIII) the following new subclauses:

“(XIX) for each of fiscal years 2004 through 2006, the market basket percentage increase minus 0.4 percentage points for hospitals in all areas; and

“(XX) for fiscal year 2007 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.”.

SEC. 502. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

“(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.”.

(b) ELIGIBILITY STANDARD FOR TECHNOLOGY OUTLIERS.—

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

(A) by inserting “(I)” after “(vi)”; and

(B) by adding at the end the following new subclause:

“(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of specific discharges in which the service or technology has been used.”.

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting “(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved)” after “is inadequate”.

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following subclause:

“(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority review has been provided under section 515(d)(5) of such Act. Nothing in this subclause shall be construed as effecting the authority of the Secretary to determine whether items and services are medically necessary and appropriate under section 1862(a)(1).”.

(4) PROCESS FOR PUBLIC INPUT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by paragraph (1), is amended—

(A) in clause (i), by adding at the end the following: “Such mechanism shall be modified to meet the requirements of clause (viii).”; and

(B) by adding at the end the following new clause:

“(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

“(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

“(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

“(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.”.

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further amended by adding at the end the following new clause:

“(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).”.

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after “the estimated average cost of such service or technology” the following: “(based on the marginal rate applied to costs under subparagraph (A))”.

(e) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL INPATIENT TECHNOLOGY.—

(1) IN GENERAL.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking “subject to paragraph (4)(C)(iii).”.

(2) NOT BUDGET NEUTRAL.—There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2005.

(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2004 THAT ARE DENIED.—In the

case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 503. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking “for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)” and inserting “the applicable Puerto Rico percentage (specified in subparagraph (E))”; and

(B) in clause (ii), by striking “for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)” and inserting “the applicable Federal percentage (specified in subparagraph (E))”; and

(2) by adding at the end the following new subparagraph:

“(E) For purposes of subparagraph (A), for discharges occurring—

“(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

“(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

“(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 41 percent and the applicable Federal percentage is 59 percent;

“(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 33 percent and the applicable Federal percentage is 67 percent; and

“(v) on or after October 1, 2005, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.”.

SEC. 504. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM .

(a) In General.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

“(11)(A) In order to recognize commuting patterns among Metropolitan Statistical Areas and between such Areas and rural areas, the Secretary shall establish a process, upon application of a subsection (d) hospital that establishes that it is a qualifying hospital described in subparagraph (B), for an increase of the wage index applied under paragraph (3)(E) for the hospital in the amount computed under subparagraph (D).

“(B) A qualifying hospital described in this subparagraph is a subsection (d) hospital—

“(i) the average wages of which exceed the average wages for the area in which the hospital is located; and

“(ii) which has at least 10 percent of its employees who reside in one or more higher wage index areas.

“(C) For purposes of this paragraph, the term ‘higher wage index area’ means, with respect to a hospital, an area with a wage index that exceeds that of the area in which the hospital is located.

“(D) The increase in the wage index under subparagraph (A) for a hospital shall be equal to the percentage of the employees of the hospital that resides in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

“(i) the difference between (I) the wage index for such area, and (II) the wage index of the area in which the hospital is located (before the application of this paragraph); and

“(ii) the number of employees of the hospital that reside in such higher wage index area divided by the total number of such employees that reside in all high wage index areas.

“(E) The process under this paragraph shall be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10) with respect to data submitted by hospitals to the Board on the location of residence of hospital employees and wages under the applicable schedule established for geographic reclassification.

“(F) A reclassification under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

“(G) A hospital that is reclassified under this paragraph for a period is not eligible for reclassification under paragraphs (8) or (10) during that period.

“(H) Any increase in a wage index under this paragraph for a hospital shall not be taken into account for purposes of—

“(i) computing the wage index for the area in which the hospital is located or any other area; or

“(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).”.

(b) Effective Date.—The amendment made by subsection (a) shall first apply to the wage index for discharges occurring on or after October 1, 2004.

SEC. 505. MEDPAC REPORT ON SPECIALTY HOSPITALS.

(a) MedPAC Study.—The Medicare Payment Advisory Commission shall conduct a study of specialty hospitals compared with other similar general acute care hospitals under the medicare program. Such study shall examine—

(1) whether there are excessive self-referrals;

(2) quality of care furnished;

(3) the impact of specialty hospitals on such general acute care hospitals; and

(4) differences in the scope of services, medicaid utilization, and uncompensated care furnished.

(b) Report.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include any recommendations for legislation or administrative change as the Secretary determines appropriate.

Subtitle B—Other Provisions

SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) Adjustment to RUGs for AIDS Residents.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

“(12) Adjustment for residents with AIDS.—

“(A) In general.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

“(B) Sunset.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.”.

(b) Effective Date.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) Coverage of Hospice Consultation Services.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking “and” at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting “; and”; and

(3) by inserting after paragraph (4) the following new paragraph:

“(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

“(A) an evaluation of the individual's need for pain and symptom management;

“(B) counseling the individual with respect to end-of-life issues and care options; and

“(C) advising the individual regarding advanced care planning.”.

(b) Payment.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

“(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.”.

(c) Conforming Amendment.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: “and services described in section 1812(a)(5)”.

(d) Effective Date.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 513. CORRECTION OF TRUST FUND HOLDINGS.

(a) In General.—Within 120 days after the effective date of this section, the Secretary of the Treasury shall take the actions described in subsection (b) with respect to the Federal Hospital Insurance Trust Fund (in this section referred to as the “Trust Fund”) with the goal being that, after the actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary, the obligations that would have been held by the trust fund if the clerical error had not occurred.

(b) Obligations Issued and Redeemed.—The Secretary of the Treasury shall—

(1) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates as the obligations that—

(A) would have been issued to the Trust Fund if the clerical error had not occurred; or

(B) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(2) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) Appropriation to Trust Fund.—Within 120 days after the effective date of this section, there is hereby appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the trust fund through the date of credit by reason of the clerical error.

(d) Clerical Error Defined.—For purposes of this section, the term "clerical error" means the failure to have transferred the correct amount from the general fund to the Trust Fund, which failure occurred on April 15, 2001.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 601. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) Update for 2004 and 2005.—

(1) In general.—Section 1848(d) (42 U.S.C. 1395w-4(d)) is amended by adding at the end the following new paragraph:

"(5) Update for 2004 and 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.".

(2) Conforming amendment.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting "and paragraph (5)" after "subparagraph (D)".

(3) Not treated as change in law and regulation in sustainable growth rate determination.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)).

(b) Use of 10-Year Rolling Average in Computing Gross Domestic Product.—

(1) In general.—Section 1848(f)(2)(C) (42 U.S.C. 1395w-4(f)(2)(C)) is amended—

(A) by striking "projected" and inserting "annual average"; and

(B) by striking "from the previous applicable period to the applicable period involved" and inserting "during the 10-year period ending with the applicable period involved".

(2) Effective date.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2003.

SEC. 602. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO Study on Beneficiary Access to Physicians' Services.—

(1) Study.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(B) an examination of changes in the use by beneficiaries of physicians' services over time;

(C) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(2) Report.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

(b) Study and Report on Supply of Physicians.—

(1) Study.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) Report to Congress.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

(c) GAO Study of Medicare Payment for Inhalation Therapy.—

(1) Study.—The Comptroller General of the United States shall conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the medicare program.

(2) Report.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 603. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

(a) Practice Expense Component.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w-4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

(b) Volume of Physician Services.—The Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1848(f) of the Social Security Act).

(2) An examination of the relative growth of volume in physician services between medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

(4) An examination of the impact on volume of demographic changes.

(5) An examination of shifts in the site of service of services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have affected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

SEC. 604. INCLUSION OF PODIATRISTS AND DENTISTS UNDER PRIVATE CONTRACTING AUTHORITY.

Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is amended by striking "section 1861(r)(1)" and inserting "paragraphs (1), (2), and (3) of section 1861(r)".

SEC. 605. ESTABLISHMENT OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT.

(a) Minimum Index.—Section 1848(e)(1) (42 U.S.C. 1395w-4(e)(1)) is amended by adding at the end the following new subparagraph:

"(E) Floor at 1.0 on work geographic index.—

"(i) In general.—Subject to clause (ii), after calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2006, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

"(ii) Secretarial discretion.—Clause (i) shall have no force or effect in law if the Secretary determines, taking into account the report of the Comptroller General under section 605(b)(2) of the Medicare Prescription Drug and Modernization Act of 2003, that there is no sound economic rationale for the implementation of that clause.".

(b) GAO Report.—

(1) Evaluation.—As part of the study on geographic differences in payments for physicians' services conducted under section 413, the Comptroller General of the United States shall evaluate the following:

(A) Whether there is a sound economic basis for the implementation of the adjustment of the work geographic index under section 1848(e)(1) of the Social Security Act under subsection (a) in those areas in which the adjustment applies.

(B) The effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade.

(C) The appropriateness of establishing a floor of 1.0 for the work geographic index.

(2) Report.—By not later than September 1, 2004, the Comptroller General shall submit to Congress and to the Secretary a report on the evaluation conducted under paragraph (1).

Subtitle B—Preventive Services

SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) Coverage.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) an initial preventive physical examination (as defined in subsection (ww));".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Initial Preventive Physical Examination

"(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services (excluding clinical laboratory tests), as determined by the Secretary, consistent with the recommendations of the United States Preventive Services Task Force.".

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking "and" before "(6)", and

(B) by inserting before the period at the end the following: ", and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))".

(2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in clause (N), by inserting "(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))" after "80 percent"; and

(B) in clause (O), by inserting "(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))" after "80 percent".

(d) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting "(2)(W)," after "(2)(S),".

(e) OTHER CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) by striking "and" at the end of subparagraph (H);

(B) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(J) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;"; and

(2) in paragraph (7), by striking "or (H)" and inserting "(H), or (J)".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only for individuals whose coverage period begins on or after such date.

SEC. 612. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 611(a), is amended—

(1) in subparagraph (V), by striking "and" at the end;

(2) in subparagraph (W), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(X) cholesterol and other blood lipid screening tests (as defined in subsection (XX));".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 611(b), is amended by adding at the end the following new subsection:

"Cholesterol and Other Blood Lipid Screening Test

"(xx)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

"(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 611(e), is amended—

(1) by striking "and" at the end of subparagraph (I);

(2) by striking the semicolon at the end of subparagraph (J) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1861(xx)(1)), which is performed more frequently than is covered under section 1861(xx)(2).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 613. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.

(a) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 611(c)(1), is amended—

(1) by striking "and" before "(7)"; and

(2) by inserting before the period at the end the following: ", and (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))".

(b) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are each amended—

(1) by striking "DEDUCTIBLE AND" in the heading; and

(2) in subclause (I), by striking "deductible or" each place it appears.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services furnished on or after Janaury 1, 2004.

SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

Subtitle C—Other Services

SEC. 621. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) PAYMENT FOR DRUGS.—

(1) MODIFICATION OF AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(A) by redesignating paragraph (13) as paragraph (14); and

(B) by inserting after paragraph (12) the following new paragraph:

"(13) DRUG APC PAYMENT RATES.—

"(A) IN GENERAL.—With respect to payment for covered OPD services that includes a specified covered outpatient drug (defined in subparagraph (B)), the amount provided for payment for such drug under the payment system under this subsection for services furnished in—

"(i) 2004, 2005, or 2006, shall in no case—

"(I) exceed 95 percent of the average wholesale price for the drug; or

"(II) be less than the transition percentage (under subparagraph (C)) of the average wholesale price for the drug; or

"(ii) a subsequent year, shall be equal to the average price for the drug for that area and year established under the competitive acquisition program under section 1847A as calculated and applied by the Secretary for purposes of this paragraph.

"(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

"(i) IN GENERAL.—In this paragraph, the term 'specified covered outpatient drug' means, subject to clause (ii), a covered outpatient drug (as defined in 1927(k)(2), that is—

"(I) a radiopharmaceutical; or

"(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

"(ii) EXCEPTION.—Such term does not include—

"(I) a drug for which payment is first made on or after January 1, 2003, under paragraph (6); or

"(II) a drug for a which a temporary HCPCS code has not been assigned.

"(C) TRANSITION TOWARDS HISTORICAL AVERAGE ACQUISITION COST.—The transition percentage under this subparagraph for drugs furnished in a year is determined in accordance with the following table:

For the year—	The transition percentage for—		
	Single source drugs are—	Innovator multiple source drugs are—	Generic drugs are—
2004	83%	81.5%	46%
2005	77%	75%	46%
2006	71%	68%	46%

"(D) PAYMENT FOR NEW DRUGS UNTIL TEMPORARY HCPCS CODE ASSIGNED.—With respect to payment for covered OPD services that includes a covered outpatient drug (as defined in 1927(k)) for a which a temporary HCPCS code has not been assigned, the amount provided for payment for such drug under the payment system under this subsection shall be equal to 95 percent of the average wholesale price for the drug.

"(E) CLASSES OF DRUGS.—For purposes of this paragraph, each of the following shall be treated as a separate class of drugs:

"(i) SOLE SOURCE DRUGS.—A sole source drug which for purposes of this paragraph means a drug or biological that is not a multiple source drug (as defined in subclauses (I) and (II) of section 1927(k)(7)(A)(i)) and is not a drug approved under an abbreviated new drug application under section 355(j) of the Federal Food, Drug, and Cosmetic Act.

"(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—Innovator multiple source drugs (as defined in section 1927(k)(7)(A)(ii)).

"(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—Noninnovator multiple source drugs (as defined in section 1927(k)(7)(A)(iii)).

"(F) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION FACTORS.—Additional expenditures resulting from this paragraph and paragraph (14)(C) in a year shall not be taken into account in establishing the conversion factor for that year.".

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(14), as redesignated by paragraph (1)(A), is amended by adding at the end the following new subparagraph:

"(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs to $50 per administration.’’.

(3) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

‘‘(E) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory procedure codes established separately for drugs.’’.

(4) PAYMENT FOR PASS THROUGH DRUGS.—Clause (i) of section 1833(t)(6)(D) (42 U.S.C. 1395l(t)(6)(D)) is amended by inserting after ‘‘under section 1842(o)’’ the following: ‘‘(or if the drug is covered under a competitive acquisition contract under section 1847A for an area, an amount determined by the Secretary equal to the average price for the drug for that area and year established under such section as calculated and applied by the Secretary for purposes of this paragraph)’’.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2004.

(b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

(1) IN GENERAL.—Section 1833(t)(14), as so redesignated and amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

‘‘(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost.’’.

(2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2) is amended—

(A) in subparagraph (F), by striking ‘‘and’’ at the end;

(B) in subparagraph (G), by striking the period at the end and inserting ‘‘; and’’; and

(C) by adding at the end the following new subparagraph:

‘‘(H) with respect to devices of brachytherapy, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.’’.

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(13)(B) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

(c) APPLICATION OF FUNCTIONAL EQUIVALENCE TEST.—

(1) IN GENERAL.—Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

‘‘(F) LIMITATION ON APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—The Secretary may not apply a ‘functional equivalence’ payment standard (including such standard promulgated on November 1, 2002) or any other similar standard in order to deem a particular product to be functionally equivalent (or a similar standard) unless the Commissioner of Food and Drugs establishes a functional equivalence standard and certifies, under such standards, that the two products are functionally equivalent. If the Commissioner makes such a certification with respect to two or more products, the Secretary may, after complying with applicable rulemaking requirements, implement such standard with respect to such products under this subsection.’’.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of the enactment of this Act, unless such application was being made to such drug or biological prior to June 13, 2003.

(d) HOSPITAL ACQUISITION COST STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the costs incurred by hospitals in acquiring covered outpatient drugs for which payment is made under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(2) DRUGS COVERED.—The study in paragraph (1) shall not include those drugs for which the acquisition costs is less than $50 per administration.

(3) REPRESENTATIVE SAMPLE OF HOSPITALS.—In conducting the study under paragraph (1), the Secretary shall collect data from a statistically valid sample of hospitals with an urban/rural stratification.

(4) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations with respect to the following:

(A) Whether the study should be repeated, and if so, how frequently.

(B) Whether the study produced useful data on hospital acquisition cost.

(C) Whether data produced in the study is appropriate for use in making adjustments to payments for drugs and biologicals under section 1847A of the Social Security Act.

(D) Whether separate estimates can be made of overhead costs, including handling and administering costs for drugs.

SEC. 622. PAYMENT FOR AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 410(a), is amended—

(1) in paragraph (2)(E), by inserting ‘‘consistent with paragraph (11)’’ after ‘‘in an efficient and fair manner’’; and

(2) by adding at the end the following new paragraph:

‘‘(11) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

‘‘(A) For 2004, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

‘‘(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

‘‘(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

‘‘(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

‘‘(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.’’.

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

‘‘(12) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to such miles.’’.

(c) GAO REPORT ON COSTS AND ACCESS.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under section 1834(l) of the Social Security Act, as amended by this section). Not later than December 31, 2007, the Comptroller General shall submit to Congress a final report on such access and supply.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulance services furnished on or after January 1, 2004.

SEC. 623. RENAL DIALYSIS SERVICES.

(a) DEMONSTRATION OF ALTERNATIVE DELIVERY MODELS.—

(1) USE OF ADVISORY BOARD.—In carrying out the demonstration project relating to improving care for people with end-stage renal disease through alternative delivery models (as published in the Federal Register of June 4, 2003), the Secretary shall establish an advisory board comprised of representatives described in paragraph (2) to provide advice and recommendations with respect to the establishment and operation of such demonstration project.

(2) REPRESENTATIVES.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The medicare payment advisory commission, established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(D) The National Kidney Foundation.

(E) The National Institute of Diabetes and Digestive and Kidney Diseases of National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(I) Providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking "and (C)" and inserting ", (C), and (D)";

(B) in subparagraph (B), by striking "In the case" and inserting "Subject to subparagraph (D), in the case"; and

(C) by adding at the end the following new subparagraph:

"(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.".

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)), as amended by subsection (b), is further amended by striking "Until" and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and until".

(c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent.

SEC. 624. ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 1-YEAR MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking "and 2002" and inserting "2002, and 2004".

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2003, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) IDENTIFICATION OF CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps under section 1833(g)(4) of the Social Security Act (42 U.S.C. 1395l(g)(4)).

(2) REPORTS TO CONGRESS.—

(A) PRELIMINARY REPORT.—Not later than July 1, 2004, the Secretary shall submit to Congress a preliminary report on the conditions and diseases identified under paragraph (1).

(B) FINAL REPORT.—Not later than September 1, 2004, the Secretary shall submit to Congress a final report on such conditions and diseases.

(C) RECOMMENDATIONS.—Not later than October 1, 2004, the Secretary shall submit to Congress a recommendation of criteria, with respect to such conditions and disease, under which a waiver of the therapy caps would apply.

(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL THERAPIST SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access to physical therapist services in States authorizing such services without a physician referral and in States that require such a physician referral. The study shall—

(A) examine the use of and referral patterns for physical therapist services for patients age 50 and older in States that authorize such services without a physician referral and in States that require such a physician referral;

(B) examine the use of and referral patterns for physical therapist services for patients who are medicare beneficiaries;

(C) examine the potential effect of prohibiting a physician from referring patients to physical therapy services owned by the physician and provided in the physician's office;

(D) examine the delivery of physical therapists' services within the facilities of Department of Defense; and

(E) analyze the potential impact on medicare beneficiaries and on expenditures under the medicare program of eliminating the need for a physician referral and physician certification for physical therapist services under the medicare program.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

SEC. 625. ADJUSTMENT TO PAYMENTS FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended in the last sentence by inserting "and each of fiscal years 2004 through 2008" after "In each of the fiscal years 1998 through 2002".

SEC. 626. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE FOR ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—Section 1833(o) (42 U.S.C. 1395l(o)) is amended—

(1) in paragraph (1), by striking "no more than the limits established under paragraph (2)" and inserting "no more than the amount of payment applicable under paragraph (2)"; and

(2) in paragraph (2), to read as follows:

"(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

"(B) The Secretary or a carrier may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

"(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.".

(b) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting "(and includes shoes described in section 1861(s)(12))" after "in section 1861(s)(9)".

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 2004.

SEC. 627. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2004. The Secretary of Health and Human Services shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 628. PART B DEDUCTIBLE.

Section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking "1991 and" and inserting "1991,"; and

(2) by striking "and subsequent years" and inserting "and each subsequent year through 2003, and for a subsequent year after 2003 the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1)".

SEC. 629. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611(a) and 612(a) is amended—

(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraph (W);

(B) by adding "and" at the end of subparagraph (X); and

(C) by adding at the end the following new subparagraph:

“(Y) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (yy));”; and

(2) by adding at the end the following new subsection:

“Intravenous Immune Globulin

“(yy) The term ‘intravenous immune globulin’ means an approved pooled plasma derivative for the treatment in the patient’s home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient’s home is medically appropriate.”.

(b) Payment as a Drug or Biological.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting “(including intravenous immune globulin (as defined in section 1861(yy)))” after “with respect to drugs and biologicals”.

(c) Effective Date.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 630. MEDICARE COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.

(a) Coverage.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by sections 611 and 612, is amended—

(1) in subparagraph (W), by striking “and” at the end;

(2) in subparagraph (X), by adding “and” at the end; and

(3) by adding at the end the following new subparagraph:

“(Y) diabetes screening tests and services (as defined in subsection (yy));”.

(b) Services Described.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611 and 612, is further amended by adding at the end the following new subsection:

“Diabetes Screening Tests and Services

“(yy)(1) The term ‘diabetes screening tests’ means diagnostic testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

“(A) a fasting plasma glucose test; and

“(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

“(2) For purposes of paragraph (1), the term ‘individual at risk for diabetes’ means an individual who has any, a combination of, or all of the following risk factors for diabetes:

“(A) A family history of diabetes.

“(B) Overweight defined as a body mass index greater than or equal to 25 kg/m2.

“(C) Habitual physical inactivity.

“(D) Belonging to a high-risk ethnic or racial group.

“(E) Previous identification of an elevated impaired fasting glucose.

“(F) Identification of impaired glucose tolerance.

“(G) Hypertension.

“(H) Dyslipidemia.

“(I) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

“(J) Polycystic ovary syndrome.

“(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.”.

(c) Frequency.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by sections 611 and 612, is amended—

(1) by striking “and” at the end of subparagraph (J);

(2) by striking the semicolon at the end of subparagraph (K) and inserting “; and”; and

(3) by adding at the end the following new subparagraph:

“(L) in the case of a diabetes screening tests or service (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3).”.

(d) Effective Date.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

SEC. 631. DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICS.

(a) Demonstration Project.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for drugs or biologics that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q))), or both, for which payment is made under such part.

(b) Demonstration Project Sites.—The project established under this section shall be conducted in 3 States selected by the Secretary.

(c) Duration.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act, but in no case may the project extend beyond December 31, 2005.

(d) Limitation.—Under the demonstration project over the duration of the project, the Secretary may not provide—

(1) coverage for more than 10,000 patients; and

(2) more than $100,000,000 in funding.

(e) Report.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to reduced physicians' services and hospital outpatient departments services for administration of the biological.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 701. UPDATE IN HOME HEALTH SERVICES.

(a) Change to Calender Year Update.—

(1) In general.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking “each fiscal year (beginning with fiscal year 2002)” and inserting “fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)”; and

(ii) by inserting “or year” after “the fiscal year”;

(B) in paragraph (3)(B)(ii)(II), by striking “any subsequent fiscal year” and inserting “2004 and any subsequent year”;

(C) in paragraph (3)(B)(iii), by inserting “or year” after “fiscal year” each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting “or year” after “fiscal year” each place it appears; and

(ii) by inserting “or years” after “fiscal years”; and

(E) in paragraph (5), by inserting “or year” after “fiscal year”.

(2) Transition rule.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2003, shall be such amount (or amounts) for the previous calendar quarter.

(b) Changes in Updates for 2004, 2005, and 2006.—Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B), is amended—

(1) by striking “or” at the end of subclause (I);

(2) by redesignating subclause (II) as subclause (III);

(3) in subclause (III), as so redesignated, by striking “2004” and inserting “2007”; and

(4) by inserting after subclause (I) the following new subclause:

“(II) each of 2004, 2005, and 2006 the home health market basket percentage increase minus 0.4 percentage points; or”.

SEC. 702. ESTABLISHMENT OF REDUCED COPAYMENT FOR A HOME HEALTH SERVICE EPISODE OF CARE FOR CERTAIN BENEFICIARIES.

(a) Part A.—

(1) In general.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

“(5)(A)(i) Subject to clause (ii), the amount payable for home health services furnished to the individual under this title for each episode of care beginning in a year (beginning with 2004) shall be reduced by a copayment equal to the copayment amount specified in subparagraph (B)(ii) for such year.

“(ii) The copayment under clause (i) shall not apply—

“(I) in the case of an individual who has been determined to be entitled to medical assistance under section 1902(a)(10)(A) or 1902(a)(10)(C) or to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), a specified low-income medicare beneficiary described in section 1902(a)(10)(E)(iii), or a qualifying individual described in section 1902(a)(10)(E)(iv)(I); and

“(II) in the case of an episode of care which consists of 4 or fewer visits.

“(B)(i) The Secretary shall estimate, before the beginning of each year (beginning with 2004), the national average payment under this title per episode for home health services projected for the year involved.

“(ii) For each year the copayment amount under this clause is equal to 1.5 percent of the national average payment estimated for the year involved under clause (i). Any amount determined under the preceding sentence which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

“(iii) There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of average payment under clause (i).”.

(2) Timely implementation.—Unless the Secretary of Health and Human Services otherwise provides on a timely basis, the copayment amount specified under section 1813(a)(5)(B)(ii) of the Social Security Act (as added by paragraph (1)) for 2004 shall be deemed to be $40.

(b) Conforming Provisions.—

(1) Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) is amended by inserting “less the copayment amount applicable under section 1813(a)(5)” after “1895”.

(2) Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(A) by striking “or coinsurance” and inserting “, coinsurance, or copayment”; and

(B) by striking "or (a)(4)" and inserting "(a)(4), or (a)(5)".

SEC. 703. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) Study.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) Report.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

SEC. 704. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) Demonstration Project.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) Medicare Beneficiary Described.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if—

(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) the beneficiary requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) the beneficiary requires skilled nursing services on a permanent basis and the skilled nursing is more than medication management;

(4) either (A) an attendant is needed during the day to monitor and treat the beneficiary's medical condition, or (B) the beneficiary needs daily skilled nursing on a permanent basis and the skilled nursing is more than medication management; and

(5) the beneficiary requires technological assistance or the assistance of another person to leave the home.

(c) Demonstration Project Sites.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) Limitation on Number of Participants.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) Data.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) Report to Congress.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) Construction.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) Authorization of Appropriations.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) Definitions.—In this section:

(1) Medicare beneficiary.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) Home health services.—The term "home health services" has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) Activities of daily living defined.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

(4) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

Subtitle B—Direct Graduate Medical Education

SEC. 711. EXTENSION OF UPDATE LIMITATION ON HIGH COST PROGRAMS.

Section 1886(h)(2)(D)(iv) (42 U.S.C. 1395ww(h)(2)(D)(iv)) is amended—

(1) in subclause (I)—

(A) by inserting "AND 2004 THROUGH 2013" after "AND 2002"; and

(B) by inserting "or during the period beginning with fiscal year 2004 and ending with fiscal year 2013" after "during fiscal year 2001 or fiscal year 2002"; and

(2) in subclause (II)—

(A) by striking "fiscal year 2004, or fiscal year 2005," and

(B) by striking "For a" and inserting "For the".

Subtitle C—Chronic Care Improvement

SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

Title XVIII, as amended by section 105(a), is amended by inserting after section 1807 the following new section:

"CHRONIC CARE IMPROVEMENT

"Sec. 1808. (a) In General.—

"(1) In general.—The Secretary shall establish a process for providing chronic care improvement programs in each CCIA region for medicare beneficiaries who are not enrolled under part C or E and who have certain chronic conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, prostate and colon cancer, hypertension, or other disease as identified by the Secretary as appropriate for chronic care improvement. Such a process shall begin to be implemented no later than 1 year after the date of the enactment of this section.

"(2) Terminology.—For purposes of this section:

"(A) CCIA region.—The term 'CCIA region' means a chronic care improvement administrative region delineated under subsection (b)(2).

"(B) Chronic care improvement program.—The terms 'chronic care improvement program' and 'program' means such a program provided by a contractor under this section.

"(C) Contractor.—The term 'contractor' means an entity with a contract to provide a chronic care improvement program in a CCIA region under this section.

"(D) Individual plan.—The term 'individual plan' means a chronic care improvement plan established under subsection (c)(5) for an individual.

"(3) Construction.—Nothing in this section shall be construed as expanding the amount, duration, or scope of benefits under this title.

"(b) Competitive Bidding Process.—

"(1) In general.—Under this section the Secretary shall award contracts to qualified entities for chronic care improvement programs for each CCIA region under this section through a competitive bidding process.

"(2) Process.—Under such process—

"(A) the Secretary shall delineate the United States into multiple chronic care improvement administrative regions; and

"(B) the Secretary shall select at least 2 winning bidders in each CCIA region on the basis of the ability of each bidder to carry out a chronic care improvement program in accordance with this section, in order to achieve improved health and financial outcomes.

"(3) Eligible contractor.—A contractor may be a disease improvement organization, health insurer, provider organization, a group of physicians, or any other legal entity that the Secretary determines appropriate.

"(c) Chronic Care Improvement Programs.—

"(1) In general.—Each contract under this section shall provide for the operation of a chronic care improvement program by a contractor in a CCIA region consistent with this subsection.

"(2) Identification of prospective program participants.—Each contractor shall have a method for identifying medicare beneficiaries in the region to whom it will offer services under its program. The contractor shall identify such beneficiaries through claims or other data and other means permitted consistent with applicable disclosure provisions.

“(3) Initial contact by secretary.—The Secretary shall communicate with each beneficiary identified under paragraph (2) as a prospective participant in one or more programs concerning participation in a program. Such communication may be made by the Secretary (or on behalf of the Secretary) and shall include information on the following:

“(A) A description of the advantages to the beneficiary in participating in a program.

“(B) Notification that the contractor offering a program may contact the beneficiary directly concerning such participation.

“(C) Notification that participation in a program is voluntary.

“(D) A description of the method for the beneficiary to select the single program in which the beneficiary wishes to participate and for declining to participate and a method for obtaining additional information concerning such participation.

“(4) Participation.—A medicare beneficiary may participate in only one program under this section and may terminate participation at any time in a manner specified by the Secretary.

“(5) Individual chronic care improvement plans.—

“(A) In general.—For each beneficiary participating in a program of a contractor under this section, the contractor shall develop with the beneficiary an individualized, goal-oriented chronic care improvement plan.

“(B) Elements of individual plan.—Each individual plan developed under subparagraph (A) shall include a single point of contact to coordinate care and the following, as appropriate:

“(i) Self-improvement education for the beneficiary (such as education for disease management through medical nutrition therapy) and support education for health care providers, primary caregivers, and family members.

“(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

“(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

“(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

“(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

“(C) Contractor responsibilities.—In establishing and carrying out individual plans under a program, a contractor shall, directly or through subcontractors—

“(i) guide participants in managing their health, including all their co-morbidities, and in performing activities as specified under the elements of the plan;

“(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

“(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

“(6) Additional requirements.—The Secretary may establish additional requirements for programs and contractors under this section.

“(7) Accreditation.—The Secretary may provide that programs that are accredited by qualified organizations may be deemed to meet such requirements under this section as the Secretary may specify.

“(c) Contract Terms.—

“(1) In general.—A contract under this section shall contain such terms and conditions as the Secretary may specify consistent with this section. The Secretary may not enter into a contract with an entity under this section unless the entity meets such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the population to be served.

“(2) Use of subcontractors permitted.—A contractor may carry out a program directly or through contracts with subcontractors.

“(3) Budget neutral payment condition.—In entering into a contract with an entity under this subsection, the Secretary shall establish payment rates that assure that there will be no net aggregate increase in payments under this title over any period of 3 years or longer, as agreed to by the Secretary. Under this section, the Secretary shall assure that medicare program outlays plus administrative expenses (that would not have been paid under this title without implementation of this section), including contractor fees, shall not exceed the expenditures that would have been incurred under this title for a comparable population in the absence of the program under this section for the 3-year contract period.

“(4) At risk relationship.—For purposes of section 1128B(b)(3)(F), a contract under this section shall be treated as a risk-sharing arrangement referred to in such section.

“(5) Performance standards.—Payment to contractors under this section shall be subject to the contractor's meeting of clinical and financial performance standards set by the Secretary.

“(6) Contractor outcomes report.—Each contractor offering a program shall monitor and report to the Secretary, in a manner specified by the Secretary, the quality of care and efficacy of such program in terms of—

“(A) process measures, such as reductions in errors of treatment and rehospitalization rates;

“(B) beneficiary and provider satisfaction;

“(C) health outcomes; and

“(D) financial outcomes.

“(7) Phased in implementation.—Nothing in this section shall be construed as preventing the Secretary from phasing in the implementation of programs.

“(d) Biannual Outcomes Reports.—The Secretary shall submit to the Congress biannual reports on the implementation of this section. Each such report shall include information on—

“(1) the scope of implementation (in terms of both regions and chronic conditions);

“(2) program design; and

“(3) improvements in health outcomes and financial efficiencies that result from such implementation.

“(e) Clinical Trials.—The Secretary shall conduct randomized clinical trials, that compare program participants with medicare beneficiaries who are offered, but decline, to participate, in order to assess the potential of programs to—

“(1) reduce costs under this title; and

“(2) improve health outcomes under this title.

“(f) Authorization of Appropriations.—There are authorized to be appropriated to the Secretary, in appropriate part from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for contracts with chronic care improvement programs under this section.

“(g) Limitation on Funding.—In no case shall the funding under this section exceed $100,000,000 over a period of 3 years.”.

SEC. 722. CHRONIC CARE IMPROVEMENT UNDER MEDICARE ADVANTAGE AND ENHANCED FEE-FOR-SERVICE PROGRAMS.

(a) Under Medicare Advantage Program.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(1) by amending subsection (e) to read as follows:

“(e) Implementation of Chronic Care Improvement Programs for Beneficiaries with Multiple or Sufficiently Severe Chronic Conditions.—

“(1) In general.—Each Medicare Advantage organization with respect to each Medicare Advantage plan it offers shall have in effect, for enrollees with multiple or sufficiently severe chronic conditions, a chronic care improvement program that is designed to manage the needs of such enrollees and that meets the requirements of this subsection.

“(2) Enrollee with multiple or sufficiently severe chronic conditions.—For purposes of this subsection, the term ‘enrollee with multiple or sufficiently severe chronic conditions’ means, with respect to an enrollee in a Medicare Advantage plan of a Medicare Advantage organization, an enrollee in the plan who has one or more chronic conditions, such as congestive heart failure, diabetes, COPD, stroke, prostate and colon cancer, hypertension, or other disease as identified by the organization as appropriate for chronic care improvement.

“(3) General requirements.—

“(A) In general.—Each chronic care improvement program under this subsection shall be conducted consistent with this subsection.

“(B) Identification of enrollees.—Each such program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet the organization's criteria for participation under the program.

“(C) Development of plans.—For an enrollee identified under subparagraph (B) for participation in a program, the program shall develop, with the enrollee's consent, an individualized, goal-oriented chronic care improvement plan for chronic care improvement.

“(D) Elements of plans.—Each chronic care improvement plan developed under subparagraph (C) shall include a single point of contact to coordinate care and the following, as appropriate:

“(i) Self-improvement education for the enrollee (such as education for disease management through medical nutrition therapy) and support education for health care providers, primary caregivers, and family members.

“(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

“(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

“(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

“(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

“(E) Organization responsibilities.—In establishing and carrying out chronic care improvement plans for participants under this paragraph, a Medicare Advantage organization shall, directly or through subcontractors—

"(i) guide participants in managing their health, including all their co-morbidities, and in performing the activities as specified under the elements of the plan;

"(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

"(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

"(3) Additional requirements.—The Secretary may establish additional requirements for chronic care improvement programs under this section.

"(4) Accreditation.—The Secretary may provide that chronic care improvement programs that are accredited by qualified organizations may be deemed to meet such requirements under this subsection as the Secretary may specify.

"(5) Outcomes report.—Each Medicare Advantage organization with respect to its chronic care improvement program under this subsection shall monitor and report to the Secretary information on the quality of care and efficacy of such program as the Secretary may require."; and

(2) by amending subparagraph (I) of subsection (c)(1) to read as follows:

"(I) Chronic care improvement program.—A description of the organization's chronic care improvement program under subsection (e).".

(b) Application Under Enhanced Fee-for-Service Program.—Section 1860E–2(c)(3), as inserted by section 201(a), is amended by inserting ", including subsection (e) (relating to implementation of chronic care improvement programs)" after "The provisions of section 1852".

(c) Effective Date.—The amendments made by this section shall apply for contract years beginning on or after 1 year after the date of the enactment of this Act.

SEC. 723. INSTITUTE OF MEDICINE REPORT.

(a) Study.—

(1) In general.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a study of the barriers to effective integrated care improvement for medicare beneficiaries with multiple or severe chronic conditions across settings and over time and to submit a report under subsection (b).

(2) Specific items.—The study shall examine the statutory and regulatory barriers to coordinating care across settings for medicare beneficiaries in transition from one setting to another (such as between hospital, nursing facility, home health, hospice, and home). The study shall specifically identify the following:

(A) Clinical, financial, or administrative requirements in the medicare program that present barriers to effective, seamless transitions across care settings.

(B) Policies that impede the establishment of administrative and clinical information systems to track health status, utilization, cost, and quality data across settings.

(C) State-level requirements that may present barriers to better care for medicare beneficiaries.

(3) Consultation.—The study under this subsection shall be conducted in consultation with experts in the field of chronic care, consumers, and family caregivers, working to integrate care delivery and create more seamless transitions across settings and over time.

(b) Report.—The report under this subsection shall be submitted to the Secretary and Congress not later than 18 months after the date of the enactment of this Act.

SEC. 724. MEDPAC REPORT.

(a) Evaluation.—shall conduct an evaluation that includes a description of the status of the implementation of chronic care improvement programs under section 1808 of the Social Security Act, the quality of health care services provided to individuals in such program, the health status of the participants of such program, and the cost savings attributed to implementation of such program.

(b) Report.—Not later than 2 years after the date of implementation of such chronic care improvement programs, the Commission shall submit a report on such evaluation.

Subtitle D—Other Provisions

SEC. 731. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) Examination of Budget Consequences.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

"(8) Examination of budget consequences.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.".

(b) Consideration of Efficient Provision of Services.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting "the efficient provision of" after "expenditures for".

(c) Application of Disclosure Requirements.—

(1) In general.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following: "Members of the Commission shall be treated as employees of the Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

(d) Additional Reports.—

(1) Data needs and sources.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services. The Commission shall examine data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens.

(2) Use of tax-related returns.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) Establishment.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the "demonstration project") under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) Payment.—

(1) In general.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) Budget neutrality for demonstration project.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) Demonstration Project Sites.—The project established under this section shall be conducted in not more than 5 States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) Duration.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) Voluntary Participation.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) Preference in Selecting Agencies.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day care services.

(g) Waiver Authority.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) Evaluation and Report.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later 30 months after the commencement of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) Definitions.—In this section:

(1) Home health agency.—The term "home health agency" has the meaning given such

term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) Medical adult day care facility.—The term "medical adult day care facility" means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) Medical adult day care services.—The term "medical adult day care services" means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) Medicare beneficiary.—The term "medicare beneficiary" means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 733. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) National and Local Coverage Determination Process.—

(1) In general.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting "consistent with subsection (k)" after "the Secretary shall ensure"; and

(B) by adding at the end the following new subsection:

"(k) National and Local Coverage Determination Process.—

"(1) Factors and evidence used in making national coverage determinations.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

"(2) Timeframe for decisions on requests for national coverage determinations.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

"(3) Process for public comment in national coverage determinations.—At the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

"(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

"(B) provide a 30-day period for public comment on such draft;

"(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

"(D) include in such final decision summaries of the public comments received and responses thereto;

"(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

"(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coding change.

"(4) Consultation with outside experts in certain national coverage determinations.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

"(5) Local coverage determination process.—With respect to local coverage determinations made on or after January 1, 2004—

"(A) Plan to promote consistency of coverage determinations.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

"(B) Consultation.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

"(C) Dissemination of information.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

"(6) National and local coverage determination defined.—For purposes of this subsection, the terms 'national coverage determination' and 'local coverage determination' have the meaning given such terms in paragraphs (1)(B) and (2)(B), respectively, of section 1869(f).".

(2) Effective date.—The amendments made by paragraph (1) shall apply to national and local coverage determinations as of January 1, 2004.

(b) Medicare Coverage of Routine Costs Associated With Certain Clinical Trials.—

(1) In general.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(2) Rule of construction.—Nothing in this subsection shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement paragraph (1)).

(3) Effective date.—This subsection shall apply to clinical trials begun before, on, or after the date of the enactment of this Act and to items and services furnished on or after such date.

(c) Issuance of Temporary National Codes.—Not later than January 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act.

SEC. 734. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

(a) In General.—Section 1848(i) (42 U.S.C. 1395w-4(i)) is amended by adding at the end the following new paragraph:

"(4) Treatment of certain inpatient physician pathology services.—

"(A) In general.—With respect to services furnished on or after January 1, 2004, and before January 1, 2009, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary shall treat such component as a service for which payment shall be made to the laboratory under this section and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) or as a hospital outpatient service for which payment is made to the hospital under section 1833(t).

"(B) Definitions.—In this paragraph:

"(i) Covered hospital.—

"(I) In general.—The term 'covered hospital' means, with respect to an inpatient or outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a carrier with a contract under section 1842 and not to the hospital.

"(II) Change in ownership does not affect determination.—A change in ownership with respect to a hospital on or after the date referred to in subclause (I) shall not affect the determination of whether such hospital is a covered hospital for purposes of such subclause.

"(ii) Fee-for-service medicare beneficiary.—The term 'fee-for-service medicare beneficiary' means an individual who is entitled to benefits under part A, or enrolled under this part, or both, but is not enrolled in any of the following:

"(I) A Medicare+Choice plan under part C.

"(II) A plan offered by an eligible organization under section 1876.

"(III) A program of all-inclusive care for the elderly (PACE) under section 1894.

"(IV) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).".

(b) Conforming Amendment.—Section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–550), as enacted into law by section 1(a)(6) of Public Law 106–554, is repealed.

(c) Effective Dates.—The amendments made by this section shall take effect as if included in the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

SEC. 735. CLINICAL INVESTIGATION OF MEDICARE PANCREATIC ISLET CELL TRANSPLANTS.

The Secretary shall authorize payment under title XVIII of the Social Security Act for the routine costs for items and services for medicare beneficiaries received as part of a clinical investigation of pancreatic islet cell transplants conducted by the National Institutes of Health.

SEC. 736. DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUTPATIENT SERVICES.

(a) Establishment.—

(1) In general.—Subject to the succeeding provisions of this section, the Secretary shall establish demonstration projects (in this section referred to as "demonstration projects") under which the Secretary shall evaluate methods that improve the quality of care provided to medicare beneficiaries with chronic conditions and that reduce expenditures that would otherwise be made under the medicare program on behalf of such individuals for such chronic conditions, such methods to include permitting those beneficiaries to direct their own health care needs and services.

(2) Medicare beneficiaries with chronic conditions defined.—In this section, the term "medicare beneficiaries with chronic conditions" means an individual entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, but who is not enrolled under part C of such title who is diagnosed as having one or more chronic conditions (as defined by the Secretary), such as diabetes.

(b) Design of Projects.—

(1) In general.—In establishing the demonstration projects under this section, the Secretary shall evaluate practices employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act that permit patients to self-direct the provision of personal care services.

(2) Scope of services.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

(c) Voluntary Participation.—Participation of medicare beneficiaries in the demonstration projects shall be voluntary.

(d) Demonstration Projects Sites.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall conduct no fewer than 3 demonstration projects established under this section. Of those demonstration projects, the Secretary shall conduct at least one in each of the following areas:

(1) An urban area.

(2) A rural area.

(3) An area that the Secretary determines has a medicare population with rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

(e) Evaluation and Report.—

(1) Evaluations.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

(2) Reports.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the projects as compared to such outcomes and costs to other beneficiaries for the same health conditions.

(B) Evaluation of patient satisfaction under the demonstration projects.

(C) Such recommendations regarding the extension, expansion, or termination of the projects as the Secretary determines appropriate.

TITLE VIII—MEDICARE BENEFITS ADMINISTRATION

SEC. 801. ESTABLISHMENT OF MEDICARE BENEFITS ADMINISTRATION.

(a) In General.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by sections 105 and 721, is amended by inserting after 1808 the following new section:

"MEDICARE BENEFITS ADMINISTRATION

"Sec. 1809. (a) Establishment.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

"(b) Administrator; Deputy Administrator; Chief Actuary.—

"(1) Administrator.—

"(A) In general.—The Medicare Benefits Administration shall be headed by an administrator to be known as the 'Medicare Benefits Administrator' (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

"(B) Compensation.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

"(C) Term of office.—The Administrator shall be appointed for a term of 4 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) General authority.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

"(E) Rulemaking authority.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code. The Administrator shall provide for the issuance of new regulations to carry out parts C, D, and E.

"(F) Authority to establish organizational units.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except as specified in this section.

"(G) Authority to delegate.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

"(2) Deputy administrator.—

"(A) In general.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

"(B) Compensation.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(C) Term of office.—The Deputy Administrator shall be appointed for a term of 4 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) Duties.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

"(3) Chief actuary.—

"(A) In general.—There is established in the Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary may be removed only for cause.

"(B) Compensation.—The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

"(C) Duties.—The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

"(4) Secretarial coordination of program administration.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

"(c) Duties; Administrative Provisions.—

"(1) Duties.—

"(A) General duties.—The Administrator shall carry out parts C, D, and E, including—

"(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare Advantage plans under part C and EFFS plans under part E, including the offering of qualified prescription drug coverage under such plans; and

"(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

"(B) Other duties.—The Administrator shall carry out any duty provided for under part C, part D, or part E, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), medicare cost contractors under section 1876(h), and through a Medicare Advantage project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

"(C) PRESCRIPTION DRUG CARD.—The Administrator shall carry out section 1807 (relating to the medicare prescription drug discount card endorsement program).

"(D) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

"(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

"(ii) interfere in any way with negotiations between PDP sponsors and Medicare Advantage organizations and EFFS organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

"(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

"(E) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C, D, and E during the previous fiscal year.

"(2) STAFF.—

"(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3102 through 3108, 3110 through 3113, 3136m and 3151, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

"(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

"(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) of such title (relating to classification and schedule pay rates).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of the enactment of this Act.

"(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

"(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

"(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

"(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

"(d) OFFICE OF BENEFICIARY ASSISTANCE.—

"(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to coordinate functions relating to outreach and education of medicare beneficiaries under this title, including the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

"(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

"(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate, directly or through contract, to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through a toll-free telephone number, information with respect to the following:

"(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C, D, and E.

"(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare Advantage plans under part C and EFFS plans under part E.

"(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare Advantage program under part C, the Voluntary Prescription Drug Benefit Program under part D, and the Enhanced Fee-for-Service program under part E.

"(e) MEDICARE POLICY ADVISORY BOARD.—

"(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C, D, and E, including the review of payment policies under such parts.

"(2) REPORTS.—

"(A) IN GENERAL.—With respect to matters of the administration of parts C, D, and E the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

"(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

"(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C, D, and E for services furnished to medicare beneficiaries.

"(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C, D, and E, and the program for enrollment under the title.

"(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare Advantage organizations offering Medicare Advantage plans (and the corresponding payment provisions under part E) that accounts for variations in per capita costs based on health status, geography, and other demographic factors.

"(iv) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C, D, and E in rural areas.

"(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

"(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

"(4) MEMBERSHIP.—

"(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of seven members to be appointed as follows:

"(i) Three members shall be appointed by the President.

"(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairmen and the ranking minority members of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

"(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

"(B) Qualifications.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

"(C) Prohibition on inclusion of federal employees.—No officer or employee of the United States may serve as a member of the Board.

"(5) Compensation.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(6) Terms of office.—

"(A) In general.—The term of office of members of the Board shall be 3 years.

"(B) Terms of initial appointees.—As designated by the President at the time of appointment, of the members first appointed—

"(i) one shall be appointed for a term of 1 year;

"(ii) three shall be appointed for terms of 2 years; and

"(iii) three shall be appointed for terms of 3 years.

"(C) Reappointments.—Any person appointed as a member of the Board may not serve for more than 8 years.

"(D) Vacancy.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

"(7) Chair.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

"(8) Meetings.—The Board shall meet at the call of the Chair, but in no event less than three times during each fiscal year.

"(9) Director and staff.—

"(A) Appointment of director.—The Board shall have a Director who shall be appointed by the Chair.

"(B) In general.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

"(C) Flexibility with respect to compensation.—

"(i) In general.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

"(ii) Maximum rate.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(D) Assistance from the administrator of the medicare benefits administration.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

"(10) Contract authority.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

"(f) Funding.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.".

(b) Effective Date.—

(1) In general.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) Duties with respect to eligibility determinations and enrollment.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out parts C and E of such title for years beginning or after January 1, 2006.

(3) Transition.—Before the date the Administrator of the Medicare Benefits Administration is appointed and assumes responsibilities under this section and section 1807 of the Social Security Act, the Secretary of Health and Human Services shall provide for the conduct of any responsibilities of such Administrator that are otherwise provided under law.

(c) Miscellaneous Administrative Provisions.—

(1) Administrator as member of the board of trustees of the medicare trust funds.—Section 1817(b) and section 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking "and the Secretary of Health and Human Services, all ex officio," and inserting "the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,".

(2) Increase in grade to executive level III for the administrator of the centers for medicare & medicaid services; level for medicare benefits administrator.—

(A) In general.—Section 5314 of title 5, United States Code, by adding at the end the following:

"Administrator of the Centers for Medicare & Medicaid Services.

"Administrator of the Medicare Benefits Administration.".

(B) Conforming amendment.—Section 5315 of such title is amended by striking "Administrator of the Health Care Financing Administration.".

(C) Effective date.—The amendments made by this paragraph take effect on January 1, 2004.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

SEC. 901. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) Construction.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) Definition of Supplier.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

"Supplier

"(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.".

SEC. 902. ISSUANCE OF REGULATIONS.

(a) Regular Timeline for Publication of Final Rules.—

(1) In general.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

"(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

"(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

"(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(b) Limitations on New Matter in Final Regulations.—

(1) In general.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to final

regulations published on or after the date of the enactment of this Act.

SEC. 903. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(a), is amended by adding at the end the following new subsection:

"(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

"(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

"(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

"(2)(A) If—

"(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

"(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claims to the contractor in writing; and

"(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

"(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 904. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than one year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 2(a), is amended by adding at the end the following new subsection:

"(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

Subtitle B—Contracting Reform

SEC. 911. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function;

"(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

"(C) the entity has sufficient assets to financially support the performance of such function; and

"(D) the entity meets such other requirements as the Secretary may impose.

"(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

“(F) Provider education and technical assistance.—Performing the functions relating to provider education, training, and technical assistance.

“(G) Additional functions.—Performing such other functions as are necessary to carry out the purposes of this title.

“(5) Relationship to MIP contracts.—

“(A) Nonduplication of duties.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

“(B) Construction.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

“(6) Application of Federal acquisition regulation.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

“(b) Contracting Requirements.—

“(1) Use of competitive procedures.—

“(A) In general.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

“(B) Renewal of contracts.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

“(C) Transfer of functions.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

“(D) Incentives for quality.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

“(2) Compliance with requirements.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

“(3) Performance requirements.—

“(A) Development of specific performance requirements.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

“(B) Consultation.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

“(C) Inclusion in contracts.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

“(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

“(ii) shall be used for evaluating contractor performance under the contract; and

“(iii) shall be consistent with the written statement of work provided under the contract.

“(4) Information requirements.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

“(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

“(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

“(5) Surety bond.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

“(c) Terms and Conditions.—

“(1) In general.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

“(2) Prohibition on mandates for certain data collection.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

“(d) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) Certifying officer.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

“(2) Disbursing officer.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

“(3) Liability of medicare administrative contractor.—

“(A) In general.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

“(B) Relationship to false claims act.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ‘False Claims Act’).

“(4) Indemnification by secretary.—

“(A) In general.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

“(B) Conditions.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

“(C) Scope of indemnification.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

“(D) Written approval for settlements.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

“(E) Construction.—Nothing in this paragraph shall be construed—

“(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or "(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.".

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services," in the matter preceding clause (i); and

(II) by striking "carrier" and inserting "medicare administrative contractor" in clause (i);

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,"; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking "carrier" and inserting "medicare administrative contractor"; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2010.

(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of the enactment of this Act and before the date specified under subparagraph (A), the Secretary may enter into new agreements under section 1816 of the Social Security Act (42 U.S.C. 1395h) without regard to any of the provider nomination provisions of such section.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) Status of implementation.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) In General.—Section 1874A, as added by section 911(a)(1), is amended by adding at the end the following new subsection:

"(e) Requirements for Information Security.—

"(1) Development of information security program.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

"(2) Independent audits.—

"(A) Performance of annual evaluations.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

"(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

"(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

"(B) Deadline for initial evaluation.—

"(i) New contractors.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

"(ii) Other contractors.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

"(C) Reports on evaluations.—

"(i) To the Department of Health and Human Services.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

"(ii) To congress.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

"(iii) Agency reporting.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.".

(b) Application of Requirements to Fiscal Intermediaries and Carriers.—

(1) In general.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) Deadline for initial evaluation.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 921. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) Coordination of Education Funding.—

(1) In general.—Title XVIII is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"Sec. 1889. (a) Coordination of Education Funding.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) Report.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) Incentives To Improve Contractor Performance.—

(1) In general.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a), is amended by adding at the end the following new subsection:

"(f) Incentives To Improve Contractor Performance in Provider Education and Outreach.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.".

(2) Application to fiscal intermediaries and carriers.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO report on adequacy of methodology.—Not later than October 1, 2004, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) Report on use of methodology in assessing contractor performance.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) Provision of Access to and Prompt Responses From Medicare Administrative Contractors.—

(1) In general.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a) and subsection (b), is further amended by adding at the end the following new subsection:

"(g) Communications with Beneficiaries, Providers of Services and Suppliers.—

"(1) Communication strategy.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

"(2) Response to written inquiries.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

"(3) Response to toll-free lines.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) MONITORING OF CONTRACTOR RESPONSES.—

"(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) DEVELOPMENT OF STANDARDS.—

"(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2004.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

"(b) ENHANCED EDUCATION AND TRAINING.—

"(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2005 and 2006 and such sums as may be necessary for succeeding fiscal years.

"(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

"(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

"(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

"(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

"(A) a provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a supplier with fewer than 10 full-time-equivalent employees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

"(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

"(1) provides answers in an easily accessible format to frequently asked questions, and

"(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

"(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

"(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term "small providers of services or suppliers" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of

Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2005, $1,000,000, and

(2) for fiscal year 2006, $6,000,000.

SEC. 923. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; MEDICARE PROVIDER OMBUDSMAN";

(2) by inserting "PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)" after "(a)";

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

"(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

"(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.".

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII, as previously amended, is amended by inserting after section 1809 the following new section:

"MEDICARE BENEFICIARY OMBUDSMAN

"SEC. 1810. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

"(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

"(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

"(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

"(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary;

"(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

"(C) assistance to such individuals in presenting information under section 1860D–2(b)(4)(D)(v); and

"(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

"(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.".

(c) DEADLINE FOR APPOINTMENT.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(d) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by adding at the end the following: "The Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.".

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free number 1-800–MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 924. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and

shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 925. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) In General.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) Inclusion of Information in Certain Hospital Discharge Plans.—

(1) In general.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking "hospice services" and inserting "hospice care and post-hospital extended care services"; and

(B) by inserting before the period at the end the following: "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides".

(2) Effective date.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) Transition Plan.—

(1) In general.—Not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) GAO evaluation.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) Transfer of Adjudication Authority.—

(1) In general.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) Assuring independence of judges.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another other officer of the Department.

(3) Geographic distribution.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) Hiring authority.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) Financing.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) Shared resources.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) Increased Financial Support.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) Conforming Amendment.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA (114 Stat. 2763A–543), is amended by striking "of the Social Security Administration".

SEC. 932. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) Expedited Access to Judicial Review.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision";

(2) in paragraph (1)(F)—

(A) by striking clause (ii);

(B) by striking "PROCEEDING" and all that follows through "DETERMINATION" and inserting "DETERMINATIONS AND RECONSIDERATIONS"; and

(C) by redesignating subclauses (I) and (II) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

(3) by adding at the end the following new paragraph:

"(2) Expedited access to judicial review.—

"(A) In general.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

"(B) Prompt determinations.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

"(C) Access to judicial review.—

"(i) In general.—If the appropriate review panel—

"(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) Deadline for filing.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) Venue.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

"(iv) Interest on amounts in controversy.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

"(D) Review panels.—For purposes of this subsection, a 'review panel' is a panel consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection (c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.".

(b) Application to Provider Agreement Determinations.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) Effective Date.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

(d) Expedited Review of Certain Provider Agreement Determinations.—

(1) Termination and certain other immediate remedies.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases of termination.

(2) Increased financial support.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year 2005 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

(e) Process for Reinstatement of Approval of Certain Snf Training Programs.—

(1) In general.—In the case of a termination of approval of a nurse aide training program described in paragraph (2) of a skilled nursing facility, the Secretary shall develop and implement a process for the reinstatement of approval of such program before the end of the mandatory 2 year disapproval period if the facility and program is certified by the Secretary, in coordination with the applicable State survey and certification agency and after public notice, as being in compliance with applicable requirements and as having remedied any deficiencies in the facility or program that resulted in noncompliance.

(2) Termination of approval described.—A termination of approval of a training program described in this paragraph is a mandatory 2-year disapproval provided for under section 1819(f)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(B)(iii)) if the only basis for the mandatory disapproval was the assessment of a civil money penalty of not less than $5,000.

SEC. 933. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) Requiring Full and Early Presentation of Evidence.—

(1) In general.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 932(a), is further amended by adding at the end the following new paragraph:

"(3) Requiring full and early presentation of evidence by providers.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(b) Use of Patients' Medical Records.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

(c) Notice Requirements for Medicare Appeals.—

(1) Initial determinations and redeterminations.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by BIPA, is amended by adding at the end the following new paragraphs:

"(4) Requirements of notice of determinations.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

"(A) the written notice on the determination shall include—

"(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

"(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

"(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section; and

"(B) the person provided such notice may obtain, upon request, the specific provision of the policy, manual, or regulation used in making the determination.

"(5) Requirements of notice of redeterminations.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

"(A) the written notice on the redetermination shall include—

"(i) the specific reasons for the redetermination;

"(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

"(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

"(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

"(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

"(C) the person provided such notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.".

(2) Reconsiderations.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting "be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)" after "in writing, "; and

(B) by inserting "and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section" after "such decision,".

(3) Appeals.—Section 1869(d) (42 U.S.C. 1395ff(d)), as amended by BIPA, is amended—

(A) in the heading, by inserting "; Notice" after "Secretary"; and

(B) by adding at the end the following new paragraph:

"(4) Notice.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

"(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

"(B) the procedures for obtaining additional information concerning the decision; and

"(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.".

(4) Submission of record for appeal.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking "prepare" and inserting "submit" and by striking "with respect to" and all that follows through "and relevant policies".

(d) Qualified Independent Contractors.—

(1) Eligibility requirements of qualified independent contractors.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking "sufficient training and expertise in medical science and legal matters" and inserting "sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing"; and

(B) by adding at the end the following new subparagraph:

“(K) INDEPENDENCE REQUIREMENTS.—

“(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

“(I) is not a related party (as defined in subsection (g)(5));

“(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

“(III) does not otherwise have a conflict of interest with such a party.

“(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

“(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.”.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

“(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).”; and

(B) by adding at the end the following new subsection:

“(g) QUALIFICATIONS OF REVIEWERS.—

“(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

“(A) each individual conducting a review shall meet the qualifications of paragraph (2);

“(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

“(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a ‘reviewing professional’), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

“(2) INDEPENDENCE.—

“(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

“(i) not be a related party (as defined in paragraph (5));

“(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

“(iii) not otherwise have a conflict of interest with such a party.

“(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

“(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

“(I) the individual is not involved in the provision of items or services in the case under review;

“(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

“(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

“(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

“(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term ‘participation agreement’ means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

“(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

“(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

“(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

“(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

“(5) RELATED PARTY DEFINED.—For purposes of this section, the term ‘related party’ means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

“(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

“(B) The individual (or authorized representative).

“(C) The health care professional that provides the items or services involved in the case.

“(D) The institution at which the items or services (or treatment) involved in the case are provided.

“(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

“(F) Any other party determined under any regulations to have a substantial interest in the case involved.”.

(3) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking “not fewer than 12 qualified independent contractors under this subsection” and inserting “with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection”.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

(5) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 934. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by sections 912(b), 921(b)(1), and 921(c)(1), is further amended by adding at the end the following new subsection:

“(h) CONDUCT OF PREPAYMENT REVIEW.—

“(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

“(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

“(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

“(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

“(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term ‘random prepayment review’ means a demand for the production’ of records or documentation absent cause with respect to a claim.

“(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

“(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

“(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.”.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after

the date of the enactment of this Act) as the Secretary shall specify.

(c) Application to Fiscal Intermediaries and Carriers.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 935. RECOVERY OF OVERPAYMENTS.

(a) In General.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

“(f) Recovery of Overpayments.—

“(1) Use of repayment plans.—

“(A) In general.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

“(B) Hardship.—

“(i) In general.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

“(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

“(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

“(ii) Rule of application.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

“(iii) Treatment of previous overpayments.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

“(C) Exceptions.—Subparagraph (A) shall not apply if—

“(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

“(ii) there is an indication of fraud or abuse committed against the program.

“(D) Immediate collection if violation of repayment plan.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

“(E) Relation to no fault provision.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

“(2) Limitation on recoupment.—

“(A) In general.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

“(B) Collection with interest.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

“(C) Medicare contractor defined.—For purposes of this subsection, the term ‘medicare contractor’ has the meaning given such term in section 1889(g).

“(3) Limitation on use of extrapolation.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

“(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

“(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

“(4) Provision of supporting documentation.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

“(5) Consent settlement reforms.—

“(A) In general.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

“(B) Opportunity to submit additional information before consent settlement offer.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

“(i) communicate to the provider of services or supplier—

“(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

“(II) the nature of the problems identified in such evaluation; and

“(III) the steps that the provider of services or supplier should take to address the problems; and

“(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

“(C) Consent settlement offer.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

“(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

“(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

“(I) the opportunity for a statistically valid random sample; or

“(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

“(D) Consent settlement defined.—For purposes of this paragraph, the term ‘consent settlement’ means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

“(6) Notice of over-utilization of codes.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

“(7) Payment audits.—

“(A) Written notice for post-payment audits.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

“(B) Explanation of findings for all audits.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

“(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

“(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

“(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

“(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

“(C) Exception.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

“(8) Standard methodology for probe sampling.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.".

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: "; ENROLLMENT PROCESSES"; and

(2) by adding at the end the following new subsection:

"(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) ENROLLMENT PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

"(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

"(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

"(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.".

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 937. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) CLAIMS.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) PERMITTING USE OF CORRECTED AND SUPPLEMENTARY DATA.—

(1) IN GENERAL.—Section 1886(d)(10)(D)(vi) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

"Notwithstanding subclause (I), a hospital may submit, and the Secretary may accept upon verification, data that corrects or supplements the data described in such subclause without regard to whether the corrected or supplementary data relate to a cost report that has been settled.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to fiscal years beginning with fiscal year 2004.

(3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS PERMITTED FOR FISCAL YEAR 2004.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a hospital may submit (or resubmit) an application for a change described in section 1886(d)(10)(C)(i)(II) of the Social Security Act for fiscal year 2004 if the hospital demonstrates on a timely basis to the satisfaction of the Secretary that the use of corrected or supplementary data under the amendment made by paragraph (1) would materially affect the approval of such an application.

(B) APPLICATION OF BUDGET NEUTRALITY.—If one or more hospital's applications are approved as a result of paragraph (1) and subparagraph (A) for fiscal year 2004, the Secretary shall make a proportional adjustment in the standardized amounts determined under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) for fiscal year 2004 to assure that approval of such applications does not result in aggregate payments under section 1886(d) of such Act that are greater or less than those that would otherwise be made if paragraph (1) and subparagraph (A) did not apply.

SEC. 938. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 933(d)(2)(B), is further amended by adding at the end the following new subsection:

"(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

"(1) ESTABLISHMENT OF PROCESS.—

"(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

"(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

"(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

"(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

"(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

"(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

"(3) REQUEST FOR PRIOR DETERMINATION.—

"(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

"(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

"(4) RESPONSE TO REQUEST.—

"(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

"(i) the item or service is so covered;

"(ii) the item or service is not so covered; or

"(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

"(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

"(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

"(5) EFFECT OF DETERMINATIONS.—

"(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

"(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

"(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

"(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

"(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

"(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

"(6) LIMITATION ON FURTHER REVIEW.—

"(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

"(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

"(i) decides not to seek a prior determination under this subsection with respect to items or services; or

"(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

"(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.".

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term "advance beneficiary notice" means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

Subtitle V—Miscellaneous Provisions

SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for, or clinical examples of, evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term "rural area" has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term "teaching settings" are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 942. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 921(a), is amended by adding at the end the following new subsection:

"(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

"(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.".

(b) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

"(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

"(B) Determinations under subparagraph (A) shall be made only after the Secretary—

"(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) PROCESS FOR ADOPTION OF ICD CODES AS DATA STANDARD.—Section 1172(f) (42 U.S.C.

1320d-1(f)) is amended by inserting after the first sentence the following: "Notwithstanding the first sentence of this subsection, if the National Committee on Vital and Health Statistics has not made a recommendation to the Secretary, within 1 year after the date of the enactment of this sentence, with respect to the adoption of the International Classification of Diseases, 10th Revision, Procedure Coding System ('ICD–10–PCS') and the International Classification of Diseases, 10th Revision, Clinical Modification ('ICD–10–CM') as a standard under this part, then the Secretary may adopt ICD–10–PCS and ICD–10–CM as such a standard.".

SEC. 943. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) In General.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) Reference Laboratory Services Described.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 944. EMTALA IMPROVEMENTS.

(a) Payment for EMTALA-Mandated Screening and Stabilization Services.—

(1) In general.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

"(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

"(4) Notice upon closing an investigation.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.".

(c) Prior Review by Peer Review Organizations in EMTALA Cases Involving Termination of Participation.—

(1) In general.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting "or in terminating a hospital's participation under this title" after "in imposing sanctions under paragraph (1)"; and

(B) by adding at the end the following new sentences: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.".

(2) Effective date.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

(d) Modification of Requirment for Medical Screening Examinations for Patients Not Requesting Emergency Department Services.—

(1) In general.—Section 1867(a) (42 U.S.C. 1395dd(a)) is amended—

(A) by designating all that follows "(a) Medical Screening Requirement.—" as paragraph (1) with the heading "In general.—";

(B) by aligning such paragraph with the paragraph added by paragraph (3); and

(C) by adding at the end the following new paragraph:

"(2) Exception for certain cases.—The requirement for an appropriate medical screening examination under paragraph (1) shall not apply in the case of an individual who comes to the emergency department and neither the individual, nor another person on the individual's behalf, requests examination or treatment for an emergency medical condition (such as a request solely for preventive services, such as blood pressure screening or non-emergency laboratory and diagnostic tests).".

(2) Effective date.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 945. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) Establishment.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term "EMTALA" refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) Membership.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) General Responsibilities.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) Administrative Matters.—

(1) Chairperson.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) Meetings.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) Termination.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) Waiver of Administrative Limitation.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 946. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) In General.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

"(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.".

(b) Conforming Payment Provision.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(c) Effective Date.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 947. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) In General.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking "and" at the end:

(B) in subparagraph (S), by striking the period at the end and inserting ", and"; and

(C) by inserting after subparagraph (S) the following new subparagraph:

"(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated)."; and

(2) by adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

"(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

"(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.".

(b) Effective Date.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 948. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) Technical Amendments Relating to Advisory Committee under BIPA Section 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking "established under section 1114(f)"; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking "under subsection (f)"; and

(ii) by striking "section 1862(a)(1)" and inserting "subsection (a)(1)".

(b) Terminology Corrections.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking "policy" and inserting "determination"; and

(B) in subclause (IV), by striking "medical review policies" and inserting "coverage determinations".

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C)) is amended by striking "policy" and "POLICY" and inserting "determination" each place it appears and "DETERMINATION", respectively.

(c) Reference Corrections.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking "subclause (I), (II), or (III)" and inserting "clause (i), (ii), or (iii)";

(2) in subparagraph (B), by striking "clause (i)(IV)" and "clause (i)(III)" and inserting "subparagraph (A)(iv)" and "subparagraph (A)(iii)", respectively; and

(3) in subparagraph (C), by striking "clause (i)", "subclause (IV)" and "subparagraph (A)" and inserting "subparagraph (A)", "clause (iv)" and "paragraph (1)(A)", respectively each place it appears.

(d) Other Corrections.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c-3(e)) is amended by striking paragraph (5).

(e) Effective Date.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 949. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a-7(c)(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.".

SEC. 950. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) In General.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

"(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

"(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.".

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 951. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 952. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) In General.—Section 1842(b)(6)(A) (42 U.S.C. 1395u(b)(6)(A)) is amended by striking "or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service," and inserting "or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such other program integrity and other safeguards as the Secretary may determine to be appropriate,".

(b) Conforming Amendment.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "except to an employer or facility" and inserting "except to an employer, entity, or other person".

(c) Effective Date.—The amendments made by section shall apply to payments made on or after the date of the enactment of this Act.

SEC. 953. OTHER PROVISIONS.

(a) GAO Reports on the Physician Compensation.—

(1) Sustainable Growth Rate and Updates.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w-4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) Physician compensation generally.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w-4).

(b) Annual Publication of List of National Coverage Determinations.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c) GAO Report on Flexibility in Applying Home Health Conditions of Participation to Patients Who Are Not Medicare Beneficiaries.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to such recipients.

(d) OIG Report on Notices Relating to Use of Hospital Lifetime Reserve Days.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.

SEC. 954. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) In General.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) Period of Suspension.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) Report.—

(1) Study.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) Report.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) Construction.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

TITLE X—MEDICAID

SEC. 1001. MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1923(f)(3) (42 U.S.C. 1396r-4(f)(3)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraphs:

"(C) Special, Temporary Increase in Allotments on a One-time, Non-cumulative Basis.—The DSH allotment for any State—

"(i) for fiscal year 2004 is equal to 120 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

"(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

"(D) Fiscal year specified.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.".

SEC. 1002. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) In General.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r-8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: "(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)".

(b) Anti-Diversion Protection.—Section 1927(c)(1)(C) (42 U.S.C. 1396r-8(c)(1)(C)) is amended by adding at the end the following:

"(iii) Application of auditing and recordkeeping requirements.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.".

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Subtitle A—Access to Affordable Pharmaceuticals

SEC. 1101. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) Abbreviated New Drug Applications.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraph (B) and inserting the following:

"(B) Notice of opinion that patent is invalid or will not be infringed.—

"(i) Agreement to give notice.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

"(ii) Timing of notice.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

"(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(iii) Recipients of notice.—An applicant required under this subparagraph to give notice shall give notice to—

"(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(II) the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(iv) Contents of notice.—A notice required under this subparagraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(B) by adding at the end the following subparagraph:

"(D)(i) An applicant may not amend or supplement an application to seek approval of a drug referring to a different listed drug from the listed drug identified in the application as submitted to the Secretary.

"(ii) With respect to the drug for which an application is submitted, nothing in this subsection prohibits an applicant from amending or supplementing the application to seek approval of a different strength."; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking "under the following" and inserting "by applying the following to each certification made under paragraph (2)(A)(vii)"; and

(ii) in clause (iii)—

(I) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted."; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

"(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(aa) the date on which the court enters judgment reflecting the decision; or

"(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(bb) by striking subclause (II) and inserting the following:

"(II) if before the expiration of such period the district court decides that the patent has been infringed—

"(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

"(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(cc) in subclause (III), by striking "on the date of such court decision." and inserting "as provided in subclause (I); or";

(dd) by inserting after subclause (III) the following:

"(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II)."; and

(ee) in the matter after and below subclause (IV) (as added by item (dd)), by striking "Until the expiration" and all that follows;

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

"(C) Civil action to obtain patent certainty.—

"(i) Declaratory judgment absent infringement action.—

"(I) In general.—No action may be brought under section 2201 of title 28, United States Code, by an applicant under paragraph (2) for a declaratory judgment with respect to a patent which is the subject of the certification referred to in subparagraph (B)(iii) unless the forty-five day period referred to in such subparagraph has expired, and unless, if the notice provided under paragraph (2)(B) relates to noninfringement, the notice was accompanied by a document described in subclause (II). Any such action shall be brought in the judicial district where the defendant has its principal place of business or a regular and established place of business.

"(II) Right of confidential access to application.—For purposes of subclause (I), the document described in this subclause is a document providing a right of confidential access to the application of the applicant under paragraph (2) for the purpose of determining whether an action referred to in subparagraph (B)(iii) should be brought. The document providing the right of confidential access shall contain such restrictions as to persons entitled to access, and on the use and disposition of any information accessed, as would apply had a protective order been entered for the purpose of protecting trade secrets and other confidential business information. Any person provided a right of confidential access shall review the application for the sole and limited purpose of evaluating possible infringement of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV) and for no other purpose, and may not disclose information of no relevance to any issue of patent infringement to any person other than a person provided a right of confidential access. Further, the application may be redacted by the applicant to remove any information of no relevance to any issue of patent infringement.

"(ii) Counterclaim to infringement action.—

"(I) In general.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) No independent cause of action.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) No damages.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).".

(b) Applications Generally.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b)—

(A) by striking paragraph (3) and inserting the following:

"(3) Notice of opinion that patent is invalid or will not be infringed.—

"(A) Agreement to give notice.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

"(B) Timing of notice.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

"(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(C) Recipients of notice.—An applicant required under this paragraph to give notice shall give notice to—

"(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) Contents of notice.—A notice required under this paragraph shall—

"(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(B)(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following paragraph:

"(4)(A) An applicant may not amend or supplement an application referred to in paragraph (2) to seek approval of a drug that is a different drug than the drug identified in the application as submitted to the Secretary.

"(B) With respect to the drug for which such an application is submitted, nothing in this subsection or subsection (c)(3) prohibits an applicant from amending or supplementing the application to seek approval of a different strength."; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking "under the following" and inserting "by applying the following to each certification made under subsection (b)(2)(A)(iv)";

(B) in subparagraph (C)—

(i) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.";

(ii) in the second sentence—

(I) by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(II) by striking clause (i) and inserting the following:

"(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(I) the date on which the court enters judgment reflecting the decision; or

"(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(III) by striking clause (ii) and inserting the following:

"(ii) if before the expiration of such period the district court decides that the patent has been infringed—

"(I) if the judgment of the district court is appealed, the approval shall be made effective on—

"(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(II) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(IV) in clause (iii), by striking "on the date of such court decision." and inserting "as provided in clause (i); or";

(V) by inserting after clause (iii), the following:

"(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii)."; and

(VI) in the matter after and below clause (iv) (as added by subclause (V)), by striking "Until the expiration" and all that follows; and

(iii) in the third sentence, by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

"(D) Civil action to obtain patent certainty.—

"(i) Declaratory judgment absent infringement action.—

"(I) In general.—No action may be brought under section 2201 of title 28, United States Code, by an applicant referred to in subsection (b)(2) for a declaratory judgment with respect to a patent which is the subject of the certification referred to in subparagraph (C) unless the forty-five day period referred to in such subparagraph has expired, and unless, if the notice the applicant provided under subsection (b)(3) relates to noninfringement, the notice was accompanied by a document described in subclause (II). Any such action shall be brought in the judicial district where the defendant has its principal place of business or a regular and established place of business.

"(II) Right of confidential access to application.—For purposes of subclause (I), the document described in this subclause is a document providing a right of confidential access to the application of the applicant referred to in subsection (b)(2) for the purpose of determining whether an action referred to in subparagraph (C) should be brought. The document providing the right of confidential access shall contain such restrictions as to persons entitled to access, and on the use and disposition of any information accessed, as would apply had a protective order been entered for the purpose of protecting trade secrets and other confidential business information. Any person provided a right of confidential access shall review the application for the sole and limited purpose of evaluating possible infringement of the patent that is the subject of the certification under subsection (b)(2)(A)(iv) and for no other purpose, and may not disclose information of no relevance to any issue of patent infringement to any person other than a person provided a right of confidential access. Further, the application may be redacted by the applicant to remove any information of no relevance to any issue of patent infringement.

"(ii) Counterclaim to infringement action.—

"(I) In general.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) No independent cause of action.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) No damages.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).".

(c) Applicability.—

(1) In general.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) Notice of opinion that patent is invalid or will not be infringed.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) Effective date of approval.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 1102. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) In General.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 1101) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

"(iv) 180-day exclusivity period.—

"(I) Definitions.—In this paragraph:

"(aa) 180-day exclusivity period.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

"(bb) First applicant.—As used in this subsection, the term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

"(cc) Substantially complete application.—As used in this subsection, the term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

"(dd) Tentative approval.—

"(AA) In general.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

"(BB) Limitation.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

"(II) Effectiveness of application.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant."; and

(2) by inserting after subparagraph (C) the following:

"(D) Forfeiture of 180-day exclusivity period.—

"(i) Definition of forfeiture event.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

"(I) Failure to market.—The first applicant fails to market the drug by the later of—

"(aa) the earlier of the date that is—

"(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

"(BB) 30 months after the date of submission of the application of the first applicant; or

"(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

"(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

"(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

"(CC) The patent expires.

"(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

"(II) Withdrawal of application.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

"(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

"(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

"(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

"(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

"(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

"(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

"(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

"(II) no applicant shall be eligible for a 180-day exclusivity period.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term "decision of a court" as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 1103. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

"(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

"(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action."; and

(2) by adding at the end the following:

"(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.".

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 1104. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking "(j)(5)(D)(ii)" each place it appears and inserting "(j)(5)(F)(ii)";

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking "(j)(5)(D)" each place it appears and inserting "(j)(5)(F)"; and

(3) in subsections (e) and (l), by striking "505(j)(5)(D)" each place it appears and inserting "505(j)(5)(F)".

Subtitle B—Federal Trade Commission Review

SEC. 1111. DEFINITIONS.

In this subtitle:

(1) ANDA.—The term "ANDA" means an abbreviated drug application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act.

(2) BRAND NAME DRUG.—The term "brand name drug" means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, including an application referred to in section 505(b)(2) of such Act.

(3) BRAND NAME DRUG COMPANY.—The term "brand name drug company" means the party that holds the approved application referred to in paragraph (2) for a brand name drug that is a listed drug in an ANDA, or a party that is the owner of a patent for which information is submitted for such drug under subsection (b) or (c) of section 505 of the Federal Food, Drug, and Cosmetic Act.

(4) COMMISSION.—The term "Commission" means the Federal Trade Commission.

(5) GENERIC DRUG.—The term "generic drug" means a drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act is approved.

(6) GENERIC DRUG APPLICANT.—The term "generic drug applicant" means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act.

(7) LISTED DRUG.—The term "listed drug" means a brand name drug that is listed under section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act.

SEC. 1112. NOTIFICATION OF AGREEMENTS.

(a) AGREEMENT WITH BRAND NAME DRUG COMPANY.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(A)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act and a brand name drug company that enter into an agreement described in paragraph (2) shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of the generic drug that is the subject of the ANDA.

(2) SUBJECT MATTER OF AGREEMENT.—An agreement described in this paragraph between a generic drug applicant and a brand name drug company is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the listed drug in the ANDA involved;

(B) the manufacture, marketing, or sale of the generic drug for which the ANDA was submitted; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) AGREEMENT WITH ANOTHER GENERIC DRUG APPLICANT.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(A)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act with respect to a listed drug and another generic drug applicant that has submitted an ANDA containing such a certification for the same listed drug shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of either of the generic drugs for which such ANDAs were submitted.

(2) SUBJECT MATTER OF AGREEMENT.—An agreement described in this paragraph between two generic drug applicants is an agreement regarding the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to the ANDAs with which the agreement is concerned.

(c) FILING.—

(1) AGREEMENT.—The parties that are required in subsection (a) or (b) to file an agreement in accordance with this subsection shall file with the Commission the text of any such agreement, except that such parties are not required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

(2) OTHER AGREEMENTS.—The parties that are required in subsection (a) or (b) to file an agreement in accordance with this subsection shall file with the Commission the text of any agreements between the parties that are not described in such subsections and are contingent upon, provide a contingent condition for, or are otherwise related

to an agreement that is required in subsection (a) or (b) to be filed in accordance with this subsection.

(3) DESCRIPTION.—In the event that any agreement required in subsection (a) or (b) to be filed in accordance with this subsection has not been reduced to text, each of the parties involved shall file written descriptions of such agreement that are sufficient to disclose all the terms and conditions of the agreement.

SEC. 1113. FILING DEADLINES.

Any filing required under section 1112 shall be filed with the Commission not later than 10 business days after the date the agreements are executed.

SEC. 1114. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Commission pursuant to this subtitle shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. 1115. ENFORCEMENT.

(a) CIVIL PENALTY.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this subtitle shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this subtitle. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) COMPLIANCE AND EQUITABLE RELIEF.—If any brand name drug company or generic drug applicant fails to comply with any provision of this subtitle, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Commission.

SEC. 1116. RULEMAKING.

The Commission, by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this subtitle—

(1) may define the terms used in this subtitle;

(2) may exempt classes of persons or agreements from the requirements of this subtitle; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this subtitle.

SEC. 1117. SAVINGS CLAUSE.

Any action taken by the Commission, or any failure of the Commission to take action, under this subtitle shall not at any time bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant, or any agreement between generic drug applicants, under any other provision of law, nor shall any filing under this subtitle constitute or create a presumption of any violation of any competition laws.

SEC. 1118. EFFECTIVE DATE.

This subtitle shall—

(1) take effect 30 days after the date of enactment of this Act; and

(2) shall apply to agreements described in section 1112 that are entered into 30 days after the date of enactment of this Act.

Subtitle C—Importation of Prescription Drugs

SEC. 1121. IMPORTATION OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

“SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

“(a) DEFINITIONS.—In this section:

“(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

“(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

“(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

“(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

“(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

“(C) an infused drug (including a peritoneal dialysis solution);

“(D) an intravenously injected drug;

“(E) a drug that is inhaled during surgery; or

“(F) a drug which is a parenteral drug, the importation of which pursuant to subsection (b) is determined by the Secretary to pose a threat to the public health, in which case section 801(d)(1) shall continue to apply.

“(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

“(5) WHOLESALER.—

“(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

“(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

“(b) REGULATIONS.—The Secretary shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

“(c) LIMITATION.—The regulations under subsection (b) shall—

“(1) require that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with all other applicable requirements of this Act;

“(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e);

“(3) require that any prescription drug from Canada imported by a domestic pharmacist or wholesaler under this section be contained in packaging which the Secretary has determined to be reasonably certain to be tamper-resistant and not capable of counterfeiting;

“(4) require that all prescription drugs from Canada imported by a domestic pharmacist or a wholesaler under this section contain a statement designed to inform the end-user of such drug that such drug has been imported from a foreign seller other than a manufacturer;

“(5) require that only prescription drugs which have not left the possession of the first Canadian recipient of such prescription drugs after receipt from the manufacturer of such prescription drugs be eligible for importation into the United States under this section;

“(6) require, if determined appropriate by the Secretary, that all prescription drugs imported from Canada under this section by domestic pharmacists and wholesalers enter the United States through ports of entry designated by the Secretary for purposes of this section;

“(7) contain any additional provisions determined by the Secretary to be appropriate to protect the public health; and

“(8) contain any additional provisions determined by the Secretary to be appropriate to facilitate the importation of prescription drugs that do not jeopardize the public health.

“(d) INFORMATION AND RECORDS.—

“(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

“(A) The name and quantity of the active ingredient of the prescription drug.

“(B) A description of the dosage form of the prescription drug.

“(C) The date on which the prescription drug is shipped.

“(D) The quantity of the prescription drug that is shipped.

“(E) The point of origin and destination of the prescription drug.

“(F) The price paid and the price charged by the importer for the prescription drug.

“(G) Documentation from the foreign seller specifying—

“(i) the original source of the prescription drug; and

“(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

“(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

“(I) The name, address, telephone number, and professional license number (if any) of the importer.

“(J)(i) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

“(ii) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

“(iii) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

“(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

“(i) is approved for marketing in the United States and is not adulterated or misbranded; and

“(ii) meets all labeling requirements under this Act.

“(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

“(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

``(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

``(2) Maintenance by the Secretary.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

``(e) Testing.—The regulations under subsection (b) shall require—

``(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

``(2) if the tests are conducted by the importer—

``(A) that information needed to—

``(i) authenticate the prescription drug being tested; and

``(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

``(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing under this section; and

``(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

``(f) Registration of Foreign Sellers.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment and the name of the United States agent for the establishment.

``(g) Suspension of Importation.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

``(h) Approved Labeling.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

``(i) Charitable Contributions.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

``(j) Waiver Authority for Importation by Individuals.—The Secretary may, for drugs being imported from a licensed Canadian pharmacy, grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate. Such conditions shall include conditions that such drug or device be—

``(1) in the possession of an individual when the individual enters the United States;

``(2) imported by such individual from a licensed pharmacy for personal use by the individual, not for resale, in quantities that do not exceed a 90-day supply, which individual will use the drug or device (or for a family member of such individual);

``(3) accompanied by a copy of a valid prescription;

``(4) imported from Canada, from a seller registered with the Secretary;

``(5) a prescription drug approved by the Secretary under chapter V that is not adulterated or misbranded;

``(6) in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

``(7) imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

``(k) Studies; Reports.—

``(1) By the Institute of Medicine of the National Academy of Sciences.—

``(A) Study.—

``(i) In general.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

``(I) importations of prescription drugs made under the regulations under subsection (b); and

``(II) information and documentation submitted under subsection (d).

``(ii) Requirements.—In conducting the study, the Institute of Medicine shall—

``(I) evaluate the compliance of importers with the regulations under subsection (b);

``(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

``(III) consult with the Secretary to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

``(B) Report.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

``(2) By the Comptroller General.—

``(A) Study.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

``(B) Report.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

``(l) Construction.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

``(m) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

``(n) Conditions.—This section shall become effective only if the Secretary demonstrates to the Congress that the implementation of this section will—

``(1) pose no additional risk to the public's health and safety; and

``(2) result in a significant reduction in the cost of prescription drugs to the American consumer.''.

(b) Conforming Amendments.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking ``covered product in violation of section 804'' and inserting ``prescription drug in violation of section 804''; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking ``covered product pursuant to section 804(a)'' and inserting ``prescription drug under section 804(b)''.

The SPEAKER pro tempore. After 3 hours of debate on the bill, it shall be in order to consider the amendment printed in House Report 108–181, if offered by the gentleman from New York (Mr. Rangel) or his designee, which shall be considered read, and shall be debatable for 1 hour, equally divided and controlled by the proponent and an opponent.

The gentleman from California (Mr. Thomas), the gentleman from New York (Mr. Rangel), the gentleman from Louisiana (Mr. Tauzin), and the gentleman from Michigan (Mr. Dingell) each will control 45 minutes of debate on the bill.

The Chair recognizes the gentleman from California (Mr. Thomas).

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

As we begin the 3 hours of debate on the primary bill and an additional hour on the substitute, I do want to indicate that this day, in my opinion, has been too long in coming.

I want to thank President Bush for his position during the campaign that Medicare needed to be modernized and we were overdue for putting prescription drugs in Medicare.

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I believe he has continued to be firm in his resolve that both the House, and the Senate now for the first time, pass legislation so that we can conference a common bill and send it to him for his signature.

I also want to thank the Speaker of the House. The gentleman from Illinois (Mr. Hastert) was involved in these discussions prior to our becoming the majority and, of course, prior to his becoming Speaker. If you examine H.R. 1, you will find that the Speaker has been willing to be the lead author. I think it is entirely proper and appropriate that the Speaker of the House lead the House through the most fundamental and important change in Medicare since its inception.

I especially want to thank my colleague and friend and chairman of the Committee on Energy and Commerce, the gentleman from Louisiana (Mr. Tauzin). In this institution, where jurisdictions are guarded with a pretty vicious willingness to have turf wars whenever necessary to hang on to your jurisdiction, the working relationship with the shared jurisdiction of the Committee on Energy and Commerce and the Committee on Ways and Means has been a very pleasant experience, and the working relationship between the staff, of which I will have more to say a little bit later, could not have been better.

And, frankly, the product we have before us, although the gentleman from Louisiana (Mr. TAUZIN) joined me in the initial sponsorship of legislation, we could not have gotten it through both committees and back together again in the Committee on Rules to present to you here today as H.R. 1 without complete and open and very comradely behavior between the chairman of the Committee on Energy and Commerce and this committee, and I thank him for that.

I especially thank the gentlewoman from Connecticut (Mrs. JOHNSON), who is the chairman of the Subcommittee on Health of the Committee on Ways and Means. The members of that committee have been very, very helpful in holding the hearings and continuing to shape this legislation. This bill, as it rightly should be, is the best piece of legislation that we have offered this House, notwithstanding the fact that twice previously we have passed Medicare modernization with prescription drugs.

And let me say that I do want to single out two members of the Committee on Ways and Means, the gentleman from Iowa (Mr. NUSSLE), who also happens to be the chairman of the Committee on the Budget, and the gentleman from North Dakota (Mr. POMEROY), who offered together a bipartisan amendment which was very significant in helping us redress the failure to provide those Americans especially in middle America but in principally rural areas with a fair and equitable Medicare program.

I want to thank, and I do not want to go through every staff member, but I do want to thank the chief of our Subcommittee on Health staff John McManus for the enormous number of hours he and the staff have put in. You cannot produce as complex and difficult a piece of legislation as you have in front of you without the dedicated staff. And I mean not just on the committees, but the Congressional Budget Office, and I will mention from Leg Counsel Ed Grossman, who is an institutional glue. He is the one who spends the hours to make sure that the language makes sense in the legislative language that we have before us. He is absolutely indispensable to the functioning of this institution, and I want to personally thank him once again for the hours of commitment that he has put in to produce this piece of legislation.

There are organizations and associations who have very strong feelings about the direction of Medicare and the changes that might be made, and I want to thank all of them for their openness and willingness to present comments upon which we reacted. Most recently, I think one of the more prominent organizations, formerly known as the American Association of Retired Persons, now AARP, and I am indebted to my colleague, the gentlewoman from California (Mrs. CAPPS), for circulating the letter from AARP, because I think it is very instructive. It provides us with an example of how these organizations point with pride and view with alarm some of the changes that are being made.

For example, the opening paragraph in the letter addressed to me says, and I quote, "AARP is encouraged by the advancement in the House of legislation to add prescription drug coverage to Medicare. Relief from the high cost of drugs is long overdue. Our members and all older Americans and their families expect and need legislation this year. We appreciate your efforts and leadership toward this end."

But they go on to say in the letter, in terms of a number of additional points, that they think certain areas need to be strengthened and perhaps some changes need to be made. For example, under low-income protections, they say, "We are encouraged by the bill's inclusion of all Medicare beneficiaries, including dual eligibles." We spend $43 billion over the next decade picking up these low-income seniors. We believe they should be classified as seniors first in the Federal Medicare program and not low-income first, as they currently are today.

But they go on to say that they are concerned because eligibility is limited by a restrictive assets test. And we took that letter to heart and we have examined that provision, notwithstanding the fact that the original bill doubled the assets provision under the SSI, Social Security provisions for low-income eligibility. The bill had doubled it. We examined it, we determined that perhaps we should go that extra mile. Under the bill before you today we have tripled it. We have tripled the SSI standards in terms of low-income protections. These are the kinds of exchanges that improved this legislation as we move forward.

And let me say lastly that I am very pleased that the Senate, I believe, will pass legislation and join the House finally in conference to craft a piece of legislation that will become law. Mr. Speaker, I understand the rules of the House in terms of the very narrow line we must tread, and I am not allowed to mention a Senator, but just let me say that a senior Senator, who has been a leader in health care debate for a number of years, frankly needs to be commended, because without his courageous step forward I do not believe the Senate would have moved as quickly or as rapidly as they have to a conclusion on their legislation.

I have enjoyed my conversations that I have had with him over the years, obviously more frequently as I have moved into a position to help effect adding prescription drugs to Medicare. Although we have profound differences in terms of our view oftentimes of the role of the Federal Government and assistance, we have never ever left the focus of policy, and although we may differ, the differences have always been over policy.

Never, ever has he mentioned Jim Jones, Kool-aid, mass suicide. Never, ever in our discussions has he mentioned the Holocaust. Never, ever has he mentioned blacks or slavery. He has always carried on the discussion on the basis of substance and the differences that we have on substance and the fact that in this society, in this civil society, the debate ought to be over choices of a legislative nature rather than trying to create an atmosphere of fear. For that I am grateful for his friendship and the fact that we will meet in conference and, finally, seniors, who are the last bastion of paying the price of retail for drugs, that will no longer be the case. And for that, all of us will be grateful. Policy will have triumphed over politics.

Mr. Speaker, I reserve the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHOOD). Although it is permissible to refer to a Senator as the sponsor of legislation, other personal references are not permitted.

Mr. RANGEL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Speaker, I would just like to state for the record that the Senator from Massachusetts referred to is my father, and I rise in opposition to H.R. 1.

Mr. Speaker, I rise in opposition to the Republican prescription drug bill.

Our seniors know that Democrats have worked to provide them with universal, affordable, and reliable drug coverage.

And they know that THIS bill is just another Republican attempt to dismantle Medicare.

This bill won't help seniors . . . in fact, there is no guaranteed backstop to ensure that there will be drug coverage in their area. Indeed, seniors may end up without ANY drug coverage . . . or forced into an HMO that they do not want to be in.

And the problems with the bill today will only increase in 2010, when premium support and competitive bidding kicks in.

Republicans divide this issue between helping our Nation's elderly now or helping our young in the future, but we can help both.

James, a Boy Scout from Lincoln, Rhode Island, wrote to me because he is worried about his two grandmothers who cannot afford their medications.

I hope he doesn't grow up only to realize that we passed a bill in Congress that actually made it worse for his loved ones.

We should not disappoint James, his family, or the forty million Medicare beneficiaries in this Nation.

Vote "no" on H.R. 1.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I think this is one of those days that we will never forget as legislators. This is one of those days that I think as legislators we will never forget. And even though we have some people who have not studied the bill that are so anxious to believe that they are going to get prescription drug relief, I think at the end of the day that they might be able to see that this is the first step that has been specifically designed not to reform the Medicare system as we know it but to dissolve it.

There are some people who are honest enough, at least outside of this hallway, to admit that that is exactly what they would want to do, to dissolve the Medicare. Many of the people on the other side of the aisle, and perhaps a handful on our side, believe that health care should not be an entitlement, Social Security should not be an entitlement; that the free marketplace should be able to work its will; that government should not be involved in providing these type of services.

Ultimately, I do believe that when the bill is studied and they see that the transfer of the ability to determine how much prescription drugs will cost, which prescriptions would be filled, what is the recipient entitled to, when does the bill lock into place, and at the year 2010 what do they do with the voucher if we do not have Medicare, all of these things, I think, will be answered at some time, but I really hope that they are answered today.

We have many people that have worked hard on this bill: certainly the gentleman from Michigan (Mr. DINGELL) has been a champion for health care for decades; the gentleman from California (Mr. STARK), who will be handling the remainder of this bill, the gentleman from New Jersey (Mr. PALLONE), the gentleman from Ohio (Mr. BROWN), and so many others. But as I have said so many times publicly, at some point in time people will be asking, when they were moving to dissolve Medicare, where were you and what were you doing?

I think, as so many votes in the past, that people will remember this vote. And those of us who oppose this piece of legislation will be giving our colleagues an opportunity on voting for legislation that provides all of the coverage that the letter requested from AARP, and while parts of the letter were read, I think it is safe to say that the objections that were raised to the bill or the questions that they had hoped that would be changed, that that is handled in the substitute.

Mr. Speaker, I ask unanimous consent to allocate the remainder of my time to the gentleman from California (Mr. STARK), with the understanding that he be permitted to allocate the rest of the remaining time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. FOLEY), a member of the Committee on Ways and Means.

Mr. FOLEY. Mr. Speaker, I thank the chairman for yielding me this time, and to both chairmen who have brought this bill to the floor, I congratulate them for this landmark legislation.

During the rule debate, it was a little depressing to me to hear so many people refer to the fact that our seniors would not be able to figure these programs out. These people we are talking about survived the Depression, they fought in World War II and Korea, they taught us how to read and write, they taught us how to ride our bikes and drive our cars. They are our parents. They are smart enough to figure this out.

I come from a district in Florida, the fifth largest population of Medicare recipients in the Nation, the fifth largest Medicare recipients in the Nation. When I go to town hall meetings, they do not ask for anything free. They want a break. They want a discount. They want an opportunity to shop. They want freedom in the marketplace. But they want security to know they will not go broke. This bill provides that.

The bill provides for a discount card that I helped author, along with Senator HAGEL, which provides immediate access to discount pharmaceutical prices. Real reforms in Medicare allowing generics, something I have heard about on this floor repeatedly from the other side of the aisle. We have to get generics to the market place sooner, faster, quicker, cheaper. That is in this bill.

This bill provides for increased rural funding for hospitals, which is an incredibly important thing for people in my community and rural communities like Glades, Okeechobee, Hendry, and Highlands County. These are Medicare reforms that will save billions of dollars.

□ 1915

Yes, this is an historic night, not one to be celebrating fear and animosity or negative pessimism about our seniors, but rejoicing in the fact that we are helping them provide for themselves and their families.

Yes, there is a phenomenal opportunity tonight to pass a bill that will help seniors in my community. And the instructions they gave me when I first ran for office and have continued to give me is do not make it free, do not make it cheap, do not make it for political purposes, make it so it works. This bill works, and I applaud the leadership for giving us a chance to make history tonight on the floor of the House.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, it is difficult to know where to begin to warn the seniors in this country about this sham of a bill and the beginning of the destruction of Medicare, as the Republicans have wanted to do for a number of years. There is no question that this is a major move toward privatizing Medicare. By the calculations that we have from the last feeble attempt to do this, of course Health and Human Services refuses to give us the most recent actuarial computations, but using the last ones, the Medicare premium for B in this drug benefit would rise to $142 a month if the premium could hold at $35.

By 2010, all Medicare will be privatized and immediately there will be a means test, the first time ever, an attempt to turn a government program into a welfare program, and the interesting thing is that every senior's income data will be turned over to any insurance company in the United States that requests it. So seniors, so much for their privacy. Every one of those people that calls on the phone to sell you some hokey insurance is going to have complete data on your income courtesy of the Republicans.

Mr. Speaker, the sad part even further is that the Republicans would like to turn this over to private companies to operate it, and it is very interesting that one of the largest and best known private companies, Medco, a subsidiary of Merck, was just indicted, or as they say, essentially indicted, by the U.S. Attorney in Philadelphia for a series of crimes committed on our Federal employees' health insurance benefits. This company that the Republicans would turn the management of this drug benefit over to was indicted for canceling, deleting and destroying patients mail order prescriptions to avoid penalties for late filing and mailing; shortchanging patients on the number of pills paid for; making false statements to the insurance plan they were contracted with about compliance with mailing timelines; calling and inducing physicians to authorize switching to higher cost medications while representing that this would save money for the insurance company, which was untrue; fabricating records of calls by pharmacists to physicians, and the list goes on.

This is the type of company who supports the Republicans, and they in turn are paying back that favor by offering Medco and Merck and their ilk the opportunity to provide a so-called benefit to seniors. I say so-called benefit because the next cruel hoax in this bill is there is no benefit defined in the bill. Nowhere in the bill does it define a premium, nowhere in the bill does it define a copay, and nowhere in the bill does it define a benefit. Now, we can all do some math and the CBO actuaries tell us that the actuarial value of a suggested benefit might be $1,360. It is important to add that our actuarial benefit for our health employees' benefit plan is probably closer to $3,000, but there is nothing that states in this law that the U.S. Government shall create, provide, or require a benefit of any type. In other words, if the insurance companies cannot be induced or bribed into offering a benefit, there will not be any. This is a nothing bill. It does not provide a benefit.

Now, I guess perhaps Members may not want to just take my word for it, so I think it is important to note what many others might say about the bill.

Mr. Speaker, the Arizona Daily Star says that "the Democratic bill is better in every respect," and that the House drug bill is "awful" and "repulsive."

The Chicago Tribune says the Medicare debate "has more to do with campaign 2004 than providing a prescription drug benefit."

The Long Island Newsday said that "the proposals racing through the House are a mess. Unless they improve dramatically en route to passage, doing nothing would be better than enacting such flawed laws."

The Evansville Courier & Press says the "ridiculously complex Medicare reform now being considered by Congress may be one of the more irresponsible measures in the long history of cradle-to-grave legislation."

The Akron Beacon Journal says that while the Medicare reform bills would address the lack of drug coverage in Medicare, beneficiaries might be "no better off with the benefit than they are at present" because "on the key issues of affordability, the structure of premiums, deductibles and copayments, both versions follow an elaborate path to disappointment." The list goes on.

In North Carolina, the Raleigh News Observer says the bill's actual benefit does not begin to outweigh the drawbacks of its so-called reforms.

The Roanoke Times and World News says even if the drug bill passes, seniors still will have to fear the possibility they will face crushing drug bills.

In Kansas, the Windfield Courier says the doughnut hole "hurts many seniors when they need the help the most." "The majority Republicans are at risk of passing a Medicare bill that looks, walks and talks like a political campaign creature."

Washington State, the Seattle Post-Intelligencer says what Congress finally sends to the White House will surely be a disappointment.

The Oregonian says it is difficult to see the congressional proposals for Medicare drug coverage as much more than a big letdown. They are thin in coverage and convoluted in delivery.

Mr. Speaker, I think we can sum this all up, people will say this is drug coverage for old folks. The truth is this bill is nothing but political coverage for the Republicans.

Mr. Speaker, I reserve the balance of my time.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, Members will find periodically during this 3-hour debate that we will take a very short segment of time to make sure that when an outlandish, outrageous, untrue statement has been made, we will correct the record immediately.

Mr. Speaker, I yield 1 minute to the gentlewoman from Connecticut (Mrs. JOHNSON), the chairman of the Subcommittee on Health for the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, this bill does not allow the IRS to share your income information with insurance companies. The bill very clearly protects the confidentiality of your information, and there are criminal and civil penalties for violating those provisions. Violators can go to jail.

It is true that for 5 percent of the seniors, they will have a higher threshold for catastrophic coverage. I personally do not believe that someone with a $200,000 income living in a gated community should have exactly the same subsidy as someone struggling along on $25,000 or $30,000 of income. I think that is a strength of this bill. But if someone does not want the government to tell you what your catastrophic threshold is, you can opt out and just take the highest threshold. That is your right. But only 5 percent will fall above the threshold, and we think that is progressive. We think we need to target this benefit at those who need it the most, and that is what we do.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. CRANE), chairman of the Subcommittee on Trade, a long time member of the Committee on Ways and Means.

Mr. CRANE. Mr. Speaker, I rise in support of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. As a member of the Committee on Ways and Means' Subcommittee on Health, I can say with confidence that this bill is a fair and balanced approach towards providing millions of America's seniors with prescription drug coverage.

Congress is long overdo in helping our seniors with the skyrocketing costs of their prescription medication. Seniors are struggling and we need to help them. But we cannot ignore that the current program without an expensive new drug benefit is not financially stable. The Medicare program is already struggling to provide a finite number of health services to nearly 41 million elderly and disabled. It is imperative that this House takes action before the retirement of the baby boom generation, which will add another 36 million beneficiaries to the Medicare roll. Simply adding a new drug benefit is not the answer.

I support H.R. 1 because it includes a number of reforms that will ensure the long-term fiscal integrity of Medicare through modernization. This legislation gives seniors the same range of private health insurance plans available to Members of Congress and other Federal employees. If seniors do not want to enroll in a private plan, they have the option of staying in traditional fee-for-service.

The time has come for Congress to work together to move past political rhetoric and provide prescription drug coverage for seniors. More importantly, it is time to institute reforms to ensure that future generations will have the security of knowing that Medicare will be there when they retire. I urge my colleagues on both sides of the aisle to support H.R. 1.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. MATSUI), a member of the Committee on Ways and Means.

Mr. MATSUI. Mr. Speaker, I thank the gentleman for yielding me this time.

I have to first of all say that I am extremely disappointed that my colleagues on the other side of the aisle have put this bill before us. It is a shame because if they would have thought through the matter better and instead of bringing up those tax cuts, particularly the dividend tax cut and the capital gains tax cut, we could have gotten a bill on the floor that all Americans could be proud of, and every senior citizen in this country would not only be proud of, but would have an adequate benefit.

I think this bill is a sham and I think instead of covering senior citizens, what we are doing is giving my Republican colleagues cover, political cover that eventually the senior citizens will lift and begin to understand what this bill is really all about. I guarantee Members by the fall of this year, senior citizens in America will understand this bill and they will be very, very unhappy with a vote in favor of this legislation.

When we think about it for a minute, this bill does not do much at all. If a senior citizen has $5,000 worth of prescription drug coverage in any given year, the senior citizen will have to pay $4,000 immediately, $4,000 of the first $5,000 of coverage before they can even get $1 of Federal government benefit. They have to have $670 that they have to pay out in the form of monthly premiums, in the form of copayments.

□ 1930

And so this bill is not a good bill for senior citizens.

In addition to that, this bill will ultimately in the next 5 years begin the erosion of Medicare as we know it. Newt Gingrich had said when he became Speaker of the House a few years ago that he wanted to see Medicare wither on the vine. We had the gentleman from California (Mr. THOMAS) just the other day say on national television, "Those who say that the bill would end Medicare as we know it, our answer is, 'We certainly hope so.'" Because what they really want to do is privatize Medicare, make it so that insurance companies could increase premiums to whatever they want to do and only insure the healthy senior citizen so that the chronically ill will ultimately wither on the vine.

This system that is being put forward today is one that will in fact do major damage to the Medicare system in America. Why did we have Medicare in 1964 in the first place? Because we knew senior citizens could not get coverage because seniors by their very nature are the ones that get ill and the ones that ultimately go into very, very difficult physical situations. And so ultimately what we are going to have is going back to 1964 with this legislation. That is their intent, because they want to see Medicare wither on the vine.

This bill is a bad bill and we need to vote "no" on it so the American public understands exactly what my colleagues on the other side of the aisle are attempting to do.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

This is the first mention of the quote that I made, and it is not surprising that the quote is certainly truncated. Perhaps a journalism spot on The New York Times might be available to some of my colleagues given their ability to take reality and distort it. Here is my quote:

"Some of our friends on the other side of the aisle are saying that if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, We certainly hope so. Why should seniors be the last group that pays retail prices for drugs?" We have not heard that from the other side.

"Old-fashioned Medicare isn't very good. Why should the insurance for seniors be called MediGap? I think that indicates just how good the insurance is." We have not heard that from the other side.

But what I did say was, you will hear scare tactics. But seniors with extremely high drug costs when this becomes law will save more than 60 percent of their current costs if they spend $10,000 a year on prescription drugs today. That is real change. That is real progress, making Medicare a real day-to-day benefit. I would say to my colleagues, if you really think that current Medicare should not end, why in the world did you put up such a fit to have a substitute so that if we accept your bill, current Medicare as we know it will end as well? Half quotes are not going to get it done. Try the full quote, because if you do, you will vote "yes" on this bill.

Mr. Speaker, it is my pleasure to yield to the gentleman from Pennsylvania (Mr. GERLACH) to enter into a colloquy.

Mr. GERLACH. Mr. Speaker, I thank the gentleman from California for his dedication to adding a prescription drug benefit to Medicare. Members of the Pennsylvania delegation have some concerns as to whether State pharmaceutical assistance programs like PACE and PACENET in Pennsylvania will be able to fully coordinate their programs with Medicare drug plans to provide a seamless transition for beneficiaries and States that already have prescription drug plans.

Mr. THOMAS. I will tell the gentleman from Pennsylvania that we have a generous amount, and we believe it will be appropriate; but certainly as we get to conference, our intent is to provide a seamless transition for beneficiaries and States and that will be done.

Mr. GERLACH. I thank the gentleman.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from Pennsylvania (Mr. ENGLISH), a member of the Committee on Ways and Means.

Mr. ENGLISH. Mr. Speaker, I rise in strong support of the bill before the House today. This bill is the most historic and significant addition to Medicare in the program's history. This Medicare bill offers enormous benefits for all of Pennsylvania's seniors while saving the Commonwealth hundreds of millions of dollars. The Medicare Prescription Drug and Modernization Act provides all seniors with a thorough, flexible, and voluntary prescription drug plan while at the same time augmenting Pennsylvania's PACE plan. Importantly, for the nearly 2 million seniors in Pennsylvania, this bill would allow PACE to wrap around the Federal benefit which would largely supplant and build on PACE's current benefits. And to ensure that Pennsylvania's seniors get maximum drug coverage, this Medicare bill would allow PACE to pay for beneficiaries' copays under Medicare while at the same time counting those contributions toward out-of-pocket expenditures to more rapidly trigger catastrophic coverage.

Our seniors have waited too long to receive the benefits that they deserve. This flexible, voluntary, and affordable plan would provide seniors with dependable benefits. This is a huge benefit for seniors in the roughly 10 States that have a significant State plan already in place.

Mr. Speaker, this bill also provides real help to America's rural health providers to allow them to deliver the highest quality care to seniors and meet the demanding fiscal challenges that they currently face. In many rural areas like my own district of western Pennsylvania, inequities in Medicare's wage reimbursements and payments for hospitals often drive workers, especially skilled nurses, to look for jobs in higher-paying metropolitan hospitals and contribute to staffing shortages in many local communities.

Several provisions in this bill mirror legislation I introduced earlier this year to help alleviate those high costs by increasing Medicare's salary reimbursements to our hospitals. These two provisions would pump $13.3 billion into the struggling rural health systems, and I am pleased to note that hospitals in my district alone would receive approximately $65 million as part of this fix. I ask for support for the bill.

Mr. STARK. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Michigan (Mr. LEVIN).

Mr. LEVIN. Mr. Speaker, the Republican bill contains a ticking time bomb, a ticking time bomb of Medicare privatization set to go off in 2010. Under this bill, starting in 2010, seniors, in essence, would receive a voucher instead of Medicare's guaranteed benefits, instead of open access to doctors and hospitals and predictable costs.

Seniors who cannot afford to pay more than they do right now would have to leave Medicare and join HMOs. This so-called benefit for prescription drugs in the Republican bill serves as a decoy, but it is not a very good one.

The Republican drug plan is insurance without assurance. No assured premium, no assured deductible, no assured size of the gap between the basic coverage and stop-loss, no assured list of drugs, no assured list of pharmacies, no assured plan from one year to the next. It could change from year to year.

From the very beginning, Republicans have wanted to use prescription drugs as leverage to end Medicare. The President said earlier to seniors, we will give you some prescription drug help depending on whether you leave Medicare and join an HMO. And now what this Republican bill is doing is using a very inferior drug insurance plan in 2006, not until then, to make everything except HMOs unaffordable for seniors in 2010. The chairman did say just a few days ago, "Old-fashioned Medicare isn't very good," and I quote his quote. What Republicans call old-fashioned Medicare is the system of guaranteed benefits, set premiums and deductibles and access to doctors and hospitals that have served seniors so well since 1965. Republicans want to end all that, but current and future Medicare beneficiaries do not. And we Democrats intend to keep fighting for those good aspects of old-fashioned Medicare. Indeed, it has been very, very, very good.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume. If it has been very, very good, why did the Democrats fight for a substitute which will change the structure significantly?

Mr. Speaker, I yield 1 minute to the gentlewoman from Connecticut (Mrs. JOHNSON) to point out once again an absolutely outrageous statement that cannot go unchallenged.

Mrs. JOHNSON of Connecticut. Mr. Speaker, scare tactics have no place in this debate. There are no vouchers in this bill. In 2010, a senior that wants to be in the Medicare program will be in the Medicare program exactly as they are now. They will be in that Medicare program and have that choice of the Medicare program in 2010, in 2011, in 2012, in 2013. They will never receive a voucher. That word is not in this legislation. It is used rhetorically to scare seniors. I want to assure the seniors listening that this bill represents the most dramatic expansion of benefits under Medicare since the program was founded, not only prescription drugs but additional preventive benefits and a whole system to support seniors with chronic illness.

Mr. STARK. Mr. Speaker, I am happy to yield 3 minutes to the gentleman from Maryland (Mr. CARDIN). The gentleman from Maryland understands that with proponents like THOMAS and JOHNSON, the seniors do not need any scaring from us.

Mr. CARDIN. Mr. Speaker, I oppose the passage of this bill. The passage will make it much more difficult for Congress to enact a meaningful prescription drug benefit for our Nation's seniors. Let me give you five reasons why.

Reason number one. There is no guaranteed benefit in this bill. Unlike seeing a doctor or going to a hospital, we cannot tell our seniors that their prescription drugs will be covered. It will be different in different parts of the country. Mr. Speaker, I tried to correct that by offering an amendment in the Committee on Ways and Means, and it was rejected by the Republicans. I tried to give this body an opportunity to vote on it, but the Committee on Rules would not make that amendment in order.

Reason number two. We are set on a course to privatize Medicare. Only private insurance can participate in the prescription drug coverage. Private insurance only has to offer a 1-year commitment. Mr. Speaker, my citizens of Maryland remember when we had Medicare+Choice; 100,000 Marylanders lost their coverage when all eight HMOs left Maryland. It is irresponsible to claim that private insurance companies are eager to return to a market that they have abandoned in the past.

Reason number three. This bill will jeopardize coverage for seniors who have good private retiree prescription drug coverage today. CBO has estimated that 30 percent of our seniors who currently have their own private coverage for prescription drugs through their prior employment will lose those benefits as a result of the enactment of this legislation.

Reason number four. We are missing an opportunity to bring down drug prices. The legislation specifically prohibits our government from using the purchasing power of 40 million beneficiaries to lower drug prices just like the Canadians do.

Reason number five. The benefits are inadequate. The Republicans project that this bill will provide for a $35 a month premium, $250 deductible, then some help up to $2,000, but then our seniors are on their own for the next $2,900. Our seniors are expected to pay a $35-a-month premium when they are not entitled to any benefit for a good part of the year. I think that is unrealistic.

My Republican friends say, well, you only have $400 billion. We offered alternatives within $400 billion that would provide real benefits. I offered a substitute that said, look, if you cannot afford all drugs, let us at least cover drugs for those illnesses such as high blood pressure and coronary artery disease and diabetes and severe depression. But, no, the Committee on Rules would not allow this body to decide whether that would be a better package and a guaranteed benefit package.

Mr. Speaker, I cannot support a bill that provides no guaranteed benefit, relies solely on the whim of private insurance companies, causes harm to seniors who currently have adequate prescription drug coverage, will not do enough to bring down the cost of prescription drugs, and provides inadequate benefits. Therefore, I will vote "no" on the Republican bill.

Mr. THOMAS. Mr. Speaker, I yield myself 1 minute.

You know, it just kind of makes you wonder what the Democrats did for 30 years when they were the majority, because, you know, when Republicans became the majority in 1995, there was literally no prevention and wellness in Medicare. We are the ones that are supposed to be destroying Medicare? We are the ones that added diabetes. We are the ones that added osteoporosis. We are the ones that added prostate and colorectal screening. We are the ones that added the mammography. In fact, in this bill that they continue to speak against, we provide for the first time every new beneficiary should have a physical.

□ 1945

I want to underscore that. Every new beneficiary should have a physical. In addition to that, we believe that cholesterol screening has now been advanced, and it should be provided as well.

I find it amazing that they go back to the same old scare statements.

Read the bill. It is an enhanced and an improved Medicare. What in the world were you doing for 30 years? The fact of the matter is you did not have a competent challenge.

What we have done is provide real change, and they are afraid those old frayed bumper stickers will not work anymore.

Mr. Speaker, I yield 3 minutes to the gentlewoman from Washington (Ms. DUNN), a very valued member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, I for one am very proud that the President in his State of the Union address directed the Congress to put together a program that will cost about $400 billion to provide prescription drugs for seniors because I think it is time to keep our promise to the people we represent and provide a comprehensive and voluntary prescription drug benefit for all seniors.

We have all heard stories of seniors paying too much for prescription drugs. This problem is even more acute among low-income seniors, especially for women who comprise half of Medicare beneficiaries with annual incomes below 150 percent of the poverty level. In this bill we help seniors on fixed incomes and those with high drug costs. A woman, for example, with an income of less than $14,400 today, which is 150 percent of poverty, will receive assistance from the Federal Government for prescription drugs. While all seniors will benefit, nearly 11 million or 34 percent of Medicare beneficiaries will qualify for additional assistance when this bill is fully implemented.

Improving Medicare is not only about providing a drug benefit, but it is also about giving seniors access to doctors, hospitals, Medicare HMOs, and other services they need. To ensure access to doctors, we address the low reimbursements that they are receiving. We also increase funding for rural hospitals so that seniors can get the health care service they need right in their community.

For Medicare HMOs, this bill requires Medicare to accurately account for military retirees in the formula and that means higher Medicare+Choice reimbursements in areas with military facilities. Strengthening Medicare also means improving the quality of life for every senior. For this reason I am very happy that we were able to provide preventative services like cholesterol screening, initial physical exams and chronic care management to help those seniors with serious diseases.

Seniors will also have access to innovative treatments to deal with rheumatoid arthritis and other chronic diseases. This bill provides seniors immediate access to self-injectable biologics. Besides providing the choice of which drug works best for rheumatoid arthritis, these self-injectable treatments will allow seniors to receive treatments right in their homes instead of going to the hospital or to a physician's office and will take the burden off those hospitals, clinics and doctors.

This is a real prescription drug plan, Mr. Speaker. It is one that provides up to 25 percent in drug discounts for manufacturers. It covers seniors to participate in the drug program, and it protects those with very high drug costs. It strengthens Medicare's future without compromising the benefits seniors enjoy today. I ask my colleagues to support a real prescription drug by passing this legislation.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. McDERMOTT), a member of the Committee on Ways and Means, who understands that seniors are going to have to pay 4,000 bucks for the first $5,000 of drugs regardless.

Mr. McDERMOTT. Mr. Speaker, well the rubber stamp Congress is ready tonight. The drug companies, after they contributed and got the President elected, gave him this bill, and they said this is what we want. The President brought it up here. We are rubber stamping it out of here. Can you believe that the Senate, excuse me, in another part of this building they are considering something like 400 amendments, but we cannot have one because when you are using a rubber stamp, you cannot have one single amendment in here. Nothing can be improved in this bill. Can you believe it? It is like the Ten Commandments. It is perfect. It came down from God or somewhere, or the White House.

This bill was put together by drug companies, 10 of them. They had $38 billion in profit last year. That is 50 percent of the profit of the Fortune 500. If the Members think they did not have an impact on this bill, why do they want to privatize? Why do they want to give no guaranteed benefit? Why do they want to have all openness in the world? And why do they put the one line in there that says that the Secretary cannot negotiate on behalf of 40 million people, soon to be 80 million people? They want it all broken up into little different pieces so they can divide and conquer. This little agency will get so much. But a little bit bigger one, we will give them a little bit higher benefit. They are going to divide and conquer the American people. This is a sham.

In Canada they get their price reduced very simply by saying let us make the Canadian price the average of the G–7. The United States is way up here and Canada is way down there. Why could we not pass a little amendment in here that said let us give the average of the G–7? I do not know. In my State everybody goes across the border to Canada or they mail across the border. They do it in Vermont. They do it in New Hampshire. They do it in Maine. They do it in New York State. Why? Because everybody knows the Canadians have got a better deal than we. But you say no, no, we cannot make one change. When we are sent in here with our rubber stamp to approve of everything George Bush does, we have to give him the bill exactly as he sent it over here.

The idea that you could come out here with a bill and say that we have a perfect piece of legislation, the seniors are like Abraham Lincoln. Do you remember, the founder of the Republican Party? He said, You can fool some people all of the time and all of the people some of the time, but you cannot fool all the people all of the time.

I know the President is going to raise $200 billion for ads in this campaign to say this, I got this from that rubber-stamped Congress and it is good for you, and he is going to give the tax cuts and the child never left behind, and he is going to give this stuff, and every one of those is phony. The child never left behind? He puts a budget out here $17 billion short to fund it, and the people are going to figure it out.

Counting on believing that the American people are stupid is not a good political way to go. Vote against this bill because the rubber stamp is wrong.

Mr. THOMAS. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. SHAW), a valued member of the Committee on Ways and Means.

Mr. SHAW. Mr. Speaker, I thank the chairman for yielding me this time.

This is probably, I think without question, one of the most important sessions that this Congress has had regarding Medicare since its inception. We have heard a lot of argument about old fashioned Medicare and new Medicare and the changes, and the truth be known, both political parties understand that medical treatment has changed in the last 40 some years since Medicare first came on line. We know that. Drugs are more important to keep the seniors out of hospitals, to keep them mobile, to keep their quality of life moving. So this is a very important thing, and it is important that we put this in the Medicare law. And it is very important that we make it where the seniors can afford it.

Florida has the seven most heavily used Medicare congressional districts in the country. I have seen on more than one occasion, while standing in line waiting for a prescription to be filled, somebody going up. I have a very vivid memory of the last one I saw, this elderly lady coming up and finding out what her prescription drugs was going to cost and looking at this bottle and that bottle and then handing that bottle back. She was low income. This bill will take care of her. She will be taken care of under this bill, and she will not have to give that bottle back because she needs it. These are prescription medicines, these are what control her quality of life, and this is a good bill.

The Republican bill looks after the low-income people first, and it also takes care of those who are the heavy drug users because of the illnesses that they are suffering from. Obviously we can sweeten the pie by increasing the expenditures, but we heard tonight one of the Members from the other side was saying that we are letting it wither on the vine. We are putting $400 billion into Medicare. We are propping it up. We are putting some reforms in there, we are putting some cost containments in there that is going to make it a better deal. The price of drugs because of the Republican bill will come down, and the people that need it most, the heavy users and the low income, will be taken care of.

This is a very good bill. It is one that the Congress should definitely, definitely pass. H.R. 1, its time has come and it is time for this Congress to act. I compliment the chairman and all of those who did this very complex bill and put it together. It is a good bill and it is one this Congress should pass.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Wisconsin (Mr. KLECZKA), a member of the Committee on Ways and Means, who, unlike the authors of this bill, did not spend his entire life in the public trough but actually worked in private enterprise; so he understands what privatization is.

Mr. KLECZKA. Mr. Speaker, I worked for an insurance company before I was elected to the legislature.

So with that as an opening, Mr. Speaker, let me say to the body that in my view this is the beginning of the end of the Medicare program. For 38 years Medicare has provided seniors with quality health care, a defined benefit, and whether one lived in California, Alaska, Maine, or Florida, the premium was the same, they knew what the benefit was, and they knew what the services were, and it has worked.

So there are those in this House who say there has been a change in the way we deliver medicine today, and that is called drug therapy. Let us add that coverage to the Medicare program and we can use the purchasing power of the Federal Government to get the best deal on drugs for in excess of 40 million people. And there are those on the other side of the aisle who say no, we do not want to do that, and the reason is because that is going to cut into the drug profits of their friends, the drug companies. But know full well, Mr. Speaker, we do it for the VA and it works and it works well.

So instead of doing a benefit connected to the Medicare program, what we are doing is we are going to send our seniors out to the private insurance market, we are going to tell them go shop for a drug-only policy. The policy that is being offered in this bill has one big problem, and that is once one spends $2,000 on drugs in any one year coverage stops until their expenditures total $4,900. Know full well during that period they are paying 100 percent of their drug cost. Their premiums go on. They are paying premiums and getting no benefit. There is something wrong with that system, and that is why this bill is very bad in that respect.

The other problem with the bill is we had this program for a couple years now called Medicare+Choice, and we are going to show those seniors that the private market who did not want them 35 years ago wants them now. They are holding their arms open. We want the seniors because we know they have a lot of drug costs and a lot of health care costs. So the Committee on Ways and Means and this Congress go along with this Medicare+Choice. What it is, is a private insurance company selling policies to seniors. Milwaukee, where I come from, has four of these companies and they were peddling these policies and offering the sun and the moon and all of a sudden bingo, three of them go belly up, the seniors have to scurry to get back into some type of Medicare program, and today we have one left. One left.

□ 2000

And the reimbursement for that one Medicare+Choice program is 110 percent of the Medicare rate. So clearly, we are not saving a heck of a lot of money with that Medicare choice plan.

Well, it is a failed experiment, Mr. Speaker. So what are we doing in this bill? We are changing the name. We are going to call it Medicare Advantage, and it is supposed to look and smell better; but, my friends, it is the same thing that has failed in the past. It will fail again.

Mr. Speaker, I urge a "no" vote on this legislation.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, well, I guess, if all of the innovations are going to fail, what will be left is the current Medicare. I find it interesting that one of the reasons the gentleman from Wisconsin (Mr. KLECZKA), my friend, is going to vote against the bill is because there is no government ultimate negotiation of the price.

Let me tell my colleagues a story, and I believe before I give my colleagues the punch line, they will know the story. We have government negotiation of price. And as is typically the case, currently, in law, in the Medicaid program, it is called "best price." That is where government determines how much the drug is going to cost. It is going to be the best price.

When we looked at ways to change Medicare, we looked at the "best price" concept. Guess what? We sat down with the Congressional Budget Office and we said, what would happen if we did not use best price? They sat down and calculated and they said, you know, if you actually had competition for the drugs, instead of putting in the government phony floor of "best price," you could save $18 billion. Do my colleagues know why we do not have government negotiating the price? It would cost us tens of billions of dollars over a real negotiation on drugs. Yet, here we are, hearing the same old same old: I am going to vote "no" because we do not have government dictating the price. That is what has gotten us into the problem in the first place.

Mr. Speaker, it is my real pleasure to yield 3 minutes to the gentleman from Illinois (Mr. WELLER), a member of the Committee on Ways and Means.

Mr. WELLER. Mr. Speaker, tonight we hear some partisan political rhetoric, particularly from the other side of the aisle, who began this process by announcing they were going to oppose the bill. It does not matter what is in it; they are going to oppose it.

So I think the important question that we really should ask is: What does this mean, this modernization of Medicare? What does it mean that we are modernizing Medicare for the 21st century? What does it mean that we are investing $400 billion in modernizing Medicare with prescription drugs?

When I think of prescription drug coverage, I think of the seniors who I have met over the 9 years I have had the privilege of serving in this body. They are men and women who I have talked with in their homes who sit there and they sit in that easy chair and right next to their chair, they have that tray, a tray full of pill bottles, and they talked and shared with me the choices they have had to make, whether or not they go to the drugstore, the grocery store that particular week because of the expenses they are facing because of rising prescription drug costs.

Well, those are the people that are the primary beneficiaries of this legislation. Because we have a plan before us that helps those who are truly needy, low-income, by ensuring they pay no premiums; and for others, they pay a pretty affordable premium. This plan would cost a senior about $35 a month, $1 a day. Think about that. A dollar a day for a senior participating in this plan. And if you qualify for Medicare today and you are going to be eligible tomorrow, you qualify and are able to take advantage of this new prescription drug plan. But for a dollar a day, it is projected you could save anywhere from 30 to 70 percent of your prescription drug costs.

Think about that. When you think of that elderly man or woman who you have had the opportunity to talk with in their home and sit there while they are seated in that chair, perhaps they are home-bound, they have that tray of pill bottles, and they are, frankly, very concerned because they cannot do much else, other than buy their drugs and hopefully get to the grocery store, they are going to really benefit from this plan. It is affordable. It is available for all seniors.

We also give seniors choices. It is affordable, a dollar a day, $35 a month; it provides real savings, 30 to 70 percent that is projected by nonpartisan analysts who look at this and say, what does it really mean, is the question they ask. To qualify for Medicare, you qualify for this program, and you are going to have choice. You do not have to pick the one-size-fits-all that some of my friends on the other side of the aisle want to have and say, seniors, you only get one choice, and we are going to tell you what it is.

Mr. Speaker, we are going to give seniors more than one choice so they can find a plan that best fits them. Think about that. That is what this really means. We are helping seniors who need help with their prescription drug costs. We are modernizing Medicare for the 21st century. We have a plan that is almost 50 years old that has not changed. We are going to modernize it. The most important choice that seniors face today is, of course, the availability and affordability of prescription drug costs.

Mr. Speaker, this is a commonsense plan. It deserves bipartisan support. I hope my friends on the other side of the aisle will do the right thing. I recognize that they set out today with a decision to oppose the bill, regardless of what is in it. Well, let us work together. Let us provide a bipartisan vote to provide prescription drug coverage that will help every senior in America.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume, because I do not intend to let unsubstantiated remarks go unchallenged either.

We do not oppose this bill because of what is in it, because there is nothing in it. There are no benefits in it. There is nothing in the bill except to spend money to get private insurance companies, if they decide to come.

Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. LEWIS), who recognizes that.

Mr. LEWIS of Georgia. Mr. Speaker, here we are once again debating Medicare. Thirty-eight years ago, the Republicans did not like Medicare, and they do not like it now. In 1965, 88 percent of Republicans voted against Medicare. And here they are, once again, trying to privatize prescription drugs for seniors, just like they tried to privatize Medicare.

This is just another scheme by the Republicans to entice older voters. Not last week, not last year, but just yesterday, the gentleman from California (Mr. THOMAS), the Republican chairman of the Committee on Ways and Means, made it crystal clear when he said, "To those who say that the bill would end Medicare as we know it, our answer is: We hope so." He went on to say, "Old-fashioned Medicare is not very good." Tell my mother. Tell your mother that old-fashioned Medicare is not good. Tell your grandmother, tell your grandfather that old-fashioned Medicare was not good. It was good in 1965. It was good yesterday. It was good then, and it is still good right now. We do not need to destroy Medicare. We need to save and strengthen Medicare.

Mr. Speaker, this bill is just another Republican scheme to deceive our seniors, to deceive our elderly. That is not right. That is not fair. I want my Republican colleagues to tell the American people the truth. We must tell our seniors that the Republican bill does not offer our seniors the basic right to affordable prescription drugs. We must and we will tell the American people that the Republicans want to privatize Medicare.

We must tell the American people the truth. This is no time to play partisan politics with the lives of our seniors.

The clock is running. Time is running out. My Republican colleagues, you still have time to do the right thing. Do not turn your back on our seniors, on the elderly. This is a matter of life and death.

I beg, I plead with my colleagues to vote against the Republican bill, not just for our parents, our grandparents, our children, but also for generations yet unborn. Old-fashioned Medicare was like a bridge over troubled waters. It was reliable. It was dependable then, and it is still dependable.

Ask the seniors, ask the old people who live on fixed incomes in our cities and rural areas. I say to my Republican colleagues, follow the dictates of your conscience. You have a moral obligation, a mission, and a mandate to uphold the legislation of 1965 when Lyndon Johnson signed the Medicare bill.

I urge my colleagues to vote against this unreliable bill.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I will tell my friend from Georgia, we do not intend to turn our backs on seniors. Indeed, we intend to reach out our hand. If someone wants to stay in yesterday's Medicare, they can tomorrow. We want to make sure of that, because in 1965 and yesterday, there were no drugs, there was no preventive care, there was no disease management, that by passage of this legislation, tomorrow there will be.

But Mr. Speaker, as we have carried on this debate about improving Medicare, and I know that to my friends on the other side of the aisle $400 billion does not look like much to them. I understand they are going to offer a substitute that proposes spending $1 trillion, rather than the $400 billion.

But at some point in this debate, we ought to realize that we are in the middle of the greatest intergenerational transfer of wealth in the history of the world. Because while we strive to provide a decent and appropriate health program for seniors, we all know someone else is going to be paying for it. And so we really ought to focus on what we are trying to do to make sure that the young people who are going to be carrying this bill understand that while we are providing additional benefits to seniors, we want to make sure that the program stays within the reasonable bounds of the $400 billion that we are proposing to add to Medicare.

Mr. Speaker, to insist on focusing on that, it is my real pleasure to yield 4 minutes to the gentleman from Louisiana (Mr. McCRERY), the chairman of the Subcommittee on Select Revenue of the Committee on Ways and Means.

Mr. McCRERY. Mr. Speaker, I rise in support of this legislation which reforms Medicare and adds prescription drugs to the program; but I arrived at this position of support haltingly, grudgingly, reluctantly. I will tell my colleagues why.

I was reluctant to support this bill because I believe the current Medicare program as it is structured is financially unsustainable. I believe it is only a matter of time before, as the financial experts tell us, Medicare, one of the two fastest growing programs in the Federal Government, consumes an ever-larger and larger share of our national income; an ever-larger and larger share of our Federal budget, with the potential to crowd out spending on other government priorities. And, as we all know, there are numerous, very important priorities of government. Health care is not the only one. I believe, Mr. Speaker, that as that occurred and as policymakers in Congress realized that Medicare was crowding out other spending, causing us to reduce our commitment to other priorities, we would do as most other countries that have similar programs have done: we would start to ration health care for our seniors. I do not want to do that.

So, Mr. Speaker, I was reluctant to add to the current program, which is going to go belly up or bust the budget, a new entitlement program, prescription drugs, which would exacerbate that situation, which would make it worse, which would get us to that point where we would have to start rationing health care faster. Yes, I was reluctant to do that.

But as I studied the bill and listened to those who put together the components of the bill, I realized that the reforms contained in the bill, particularly those beginning in the year 2010, which give us a chance to move Medicare into a form much like the FEHBP program, the premium support model that the Medicare Commission recommended several years ago, then I realized that this is maybe our last best chance to save Medicare in a way that we can afford it as a society, and deliver quality health care for our seniors.

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So, Mr. Speaker, I am here after much thought and consideration and yes, reluctantly arriving here, but I am here because I do believe this is our best chance to save Medicare, to make it a truly viable program that will not bust the budget, and if we do not take advantage of this opportunity and I want to speak, Mr. Speaker, through you to the conservatives out there on both sides of the aisle about supporting this bill, do not blow this opportunity. If you are a conservative, if you are concerned about the cost of the Medicare program, do not miss this opportunity to give us the best chance to reform it in a way that can save costs over the long term, that can keep us from rationing health care, not only for our seniors, but I believe eventually for all of our society.

Mr. Speaker, I urge everyone to support this bill tonight and hope and pray that the reforms contained therein work.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, how short memories are. It was just an hour ago that we threw away $174 billion on useless medical savings accounts and over the last year or two we gave $800 billion in inheritance tax relief to an average of 10,000 people a year so we could punish a hundred million people a year by destroying their Medicare. They just do not remember. But the gentleman from Massachusetts, the distinguished member of the Committee on Ways and Means (Mr. NEAL) remembers.

Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts (Mr. NEAL).

Mr. NEAL of Massachusetts. Mr. Speaker, let me thank the gentleman from California (Mr. STARK) for yielding me time.

Only in this Chamber over the last few months could we have written $2 trillion out of our tax system irresponsibly over the next decade and then say that the cost of Medicare is unsustainable. Only in this Chamber could we have this debate from a political party who says, let us not take a truncated quotation. Let us not take a scare tactic. But you know what? You cannot truncate history.

When I came to this House 15 years ago, the Republican leader in the Senate, Bob Dole, had voted against the establishment of Medicare. The Republican leader in this House, Bob Michel, wonderful human being, had voted against the establishment of Medicare. And they say, do not use these quotes because they are not true. They are not for real.

Speaker Gingrich said, in time we would let Medicare wither on the vine.

The third ranking Republican in the United States in the other body down the hallway, said recently, I believe the standard benefit, the traditional Medicare program, has to be phased out. And they say, but trust us on Medicare. Do not be skeptical of our intentions. We have come to love Medicare.

There is not anybody on that side of the aisle that believes that tonight and there certainly is not anybody on this side of the aisle that believes that tonight as well. And then they argue, well, we have improved Medicare. Think of what we might have done without those tax cuts over the last 2 years.

A predictable, carefully defined benefit would have been in place for Medicare recipients. It is the closest thing, Medicare, that this Nation has ever had to universal health care. It is an extraordinary achievement for those who turn 65 years old, and they refer to it as old-fashioned Medicare and we are to trust them. But let us talk about Medicare+Choice where I live in Massachusetts, the private sector's answer to the problems of Medicare.

Well, they are all gone and the ones that are not gone have jacked premiums through the roof. They do not want to take care of the most vulnerable and whether we have a debate about government tonight and its role or not, that in the end is what government does. It takes care of those who are outside the mainstream of this economic life. Not the top 1 percent of the wage earners in this country, not those who benefit from the repeal of an estate tax. It is government that does that.

Medicare is a legacy and an amendment to the Social Security program, the greatest achievement domestically in this Nation's history. And that amendment in Medicare is a greatchild and a success of a determined Congress and an enlightened President, Lyndon Johnson. Tonight let us stand with history, stand with Roosevelt and stand with Lyndon Johnson on what Medicare has done to make us a much more equitable society. What a great achievement it is.

Reject the notion tonight of where they are going to take us, and that is down the road to privatization of Medicare.

Mr. STARK. Mr. Speaker, may I inquire of the time remaining?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from California (Mr. THOMAS) has 7 minutes remaining. The gentleman from California (Mr. STARK) has 12 minutes remaining.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. DOGGETT), a member of the Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, since President Lyndon B. Johnson signed Medicare into law over massive Republican resistance, Republicans have never ceased in their determination to end Medicare. We all remember the partner of the gentleman from California (Mr. THOMAS), former House Speaker Newt Gingrich, who insisted that Medicare should be allowed "to wither on the vine." He has been chattering again this month, that Medicare is an "obsolete government monopoly."

The gentleman from California (Mr. THOMAS) joined him yesterday by declaring, "To those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so." "Old fashioned Medicare isn't very good," he added.

The gentleman may not like reporters, especially if they report, but really there is nothing new or inconsistent in this statement and many that he has made for years. He just referred a few moments ago to Medicare as "yesterday's Medicare," denigrating and deriding it. "Yesterday's Medicare," "old fashioned Medicare" has served millions of Americans pretty well.

The one problem we have with it is not the result of a defective Medicare. Rather the failure to deal with the outrageous, predatory pricing of prescription drugs has resulted from the sustained collusion of House Republicans and pharmaceutical manufacturers. We can do something meaningful about that, but this bill is not it.

What of this plan that seniors are finally offered tonight? It is basically a "pay a lot and get a little" plan. If you are a senior and you have been hoping and praying we would finally be able to overcome this Republican resistance and deal with prescription drugs, what do you get from this bill according to its own clear language? Well, this year you get nothing. Next year you get nothing. The year after that you get nothing. Oh, yes, you are entitled to a discount card. It is as valuable as one of those cards you pull out of a cereal box. With it and a dollar or two you can get a cup of coffee, but it does not guarantee you a cent of reduction in the cost of your medications.

Finally, in 2006 you get all their much ballyhooed help. If you have $4,900 in drug bills, and that is mighty easy to get at today's outrageous prices, you pay $3,500, and you get $1,400 paid for you, and that is only if you also pay an unknown premium, already estimated at least $35 per month. And such incomplete coverage at such a cost tells us what this initiative is really all about. This is a plan to eliminate Medicare and force seniors out into inadequate private insurance plans. This is not a prescription drug. This is a prescription for disaster.

I hope that our Republican colleagues continue holding up this poster about "strengthening Medicare" that they have been showing here because it looks like the type of solicitation scams that so many seniors receive weekly. Their poster shows seniors out frolicking on the beach because of all the benefits they will get, when in fact seniors will be denied the very protection they so desperately need on their prescription drugs. That is because those who are proposing this bill are the same folks, who tried to undermine Medicare from the time Democrats and Lyndon Johnson got it passed through Congress in 1965, and they have not relented until this very moment.

Mr. THOMAS. Mr. Speaker, I ask unanimous consent to place in the RECORD an exchange of letters between myself as chairman of the Committee on Ways and Means and the gentleman from Virginia (Mr. DAVIS), chairman of the Committee on Government Reform.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, June 25, 2003.

Hon. TOM DAVIS,
Chairman, Committee on Government Reform,
House of Representatives, Washington, DC.

DEAR CHAIRMAN DAVIS: Thank you for your letter regarding H.R. 2473, the "Medicare Prescription Drug and Modernization Act of 2003."

As you have noted, the Committee on Ways and Means has ordered favorably reported, as amended, H.R. 2473. The general text of this legislation will be incorporated into H.R. 1, the "Medicare Prescription Drug and Modernization Act of 2003." I appreciate your agreement to expedite the passage of this legislation despite affecting programs within the jurisdiction of Committee on Government Reform. I acknowledge your decision to forego further action on the bill was based on the understanding that it will not prejudice the Committee on Government Reform with respect to the appointment of conferees or its jurisdictional prerogatives on this or similar legislation.

Finally, I will include in the Congressional Record a copy of our exchange of letters on this matter during floor consideration of H.R. 1. Thank you for your assistance and cooperation. We look forward to working with you in the future.

Best regards,

BILL THOMAS,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC, June 25, 2003.

Hon. WILLIAM M. THOMAS,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR CHAIRMAN THOMAS: I am writing to confirm our mutual understanding with respect to the consideration of H.R. 2473, the Medicare Prescription Drug and Modernization Act of 2003, which was referred to the Committees on Ways and Means and Energy and Commerce. I am writing specifically regarding Sections 302 and 303, which waive provisions of the Federal Acquisition Regulation and exempts a newly established advisory committee from the Federal Advisory Committee Act (FACA). As you know, the Federal Acquisition Regulation and the Federal Advisory Committee Act are within the jurisdiction of the Committee on Government Reform.

I have concerns regarding the appropriateness of waiving FACA, as it would pertain to the Program Advisory and Oversight Commit proposed in section 302. I would welcome the opportunity to work with you and Chairman Tauzin to address the applicability of FACA to this proposed committee.

In the interests of moving this important legislation forward, I do not intend to ask for sequential referral of this bill. However, I do so only with the understanding that this procedural route should not be construed to prejudice the Committee on Government Reform's jurisdictional interest and prerogatives on these provisions or any other similar legislation and will not be considered as precedent for consideration of matters of jurisdictional interest to my Committee in the future. Furthermore, should these provisions or similar provisions be considered in a conference with the Senate, I would expect Members of the Committee on Government Reform be appointed as outside conferees on those provisions.

Finally, I would ask that you include a copy of our exchange of letters on this matter in the Congressional Record during House debate of the bill. If you have questions regarding this matter, please do not hesitate to call me. I thank you for your consideration.

Sincerely,

TOM DAVIS,
Chairman.

I also include for the RECORD a quote:

Some of our friends on the other side of the aisle are saying that if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so. Why should seniors be the last group that pays retail prices for drugs? Old-fashioned Medicare is not very good . . . You're going to hear scare tactics . . . but seniors with extremely high drug costs, when this becomes law, will save more than 60 percent of current costs, that's real change, real progress, making Medicare a real day-to-day benefit.—Bill Thomas, Chairman, Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, I ask unanimous consent to place in the RECORD the report from NBC news correspondent Norah O'Donnell entitled "Prescription Drug Benefit Imminent" from yesterday's MSNBC.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

PRESCRIPTION DRUG BENEFIT IMMINENT

(By Norah O'Donnell)

After years of promising a prescription drug benefit for seniors, Congress is on the verge of a breakthrough. This week, the House and Senate are expected to pass bills that for the first time will allow seniors to sign up for a prescription drug plan in which the government helps pay their drug bills. The policy and political consequences are enormous.

Congress had agreed to spend $400 billion, which in effect means the biggest expansion of Medicare since its creation nearly four decades ago. Critics charge that the bill's passage is the largest expansion of a federal entitlement since Lyndon Johnson's Great Society, with huge costs to American taxpayers when the Baby Boomers enter the Medicare program.

Passions surrounding the Medicare reform bill are reaching a crescendo heading into votes in both the House and the Senate by the end of this week, perhaps as early as Thursday.

"To those who say that (the bill) would end Medicare as we know it, our answer is: We certainly hope so," declared Ways and Means Chairman Bill Thomas, R-Calif., Wednesday morning. "Old-fashioned Medicare isn't very good," he added.

House Speaker Dennis Hastert, R-Ill., echoed the sense around Capitol Hill that this is indeed the year that it gets done. "We are at the point now where politics and policy have to be married up," he said.

Health and Human Services Secretary Tommy Thompson appeared with Thomas and other GOP leaders Wednesday morning to release figures that purport to show what seniors would save on some popular drugs. For example, Thompson said that seniors are now paying $108.65 for 30 tablets of Lipitor. Under the system, he projects that the cost would come down to $86.92. Seniors would have to pay only 20% as co-pay ($17.38). That's a savings of $91.27, according to his figures.

But House Minority Leader Nancy Pelosi and other House Democrats fought back Wednesday, saying Thompson has forbidden Health and Human Services actuary Rick Foster from releasing his analysis of how much Part B premiums would go up under the House GOP plan. Part B is the existing program that insures seniors for medical services other than prescriptions.

They suspect the figures would show that the premium would rise substantially. A similar bill in 2000 would have resulted in a rise in Part B premiums of 47 percent. Pelosi and Rep. Pete Stark, D–Calif., say that Foster is being threatened with termination if he reveals the figures this time.

Once the measure passes, congressional Republicans and President George W. Bush will declare victory on an issue that Democrats have traditionally championed. "This could be transformational in terms of the image of the Republican Party among seniors," Bill McInturff, a Republican pollster, said.

Seniors or older voters have historically favored Democrats when it comes to the issue of Medicare and prescription drugs. But a recent survey by the Kaiser Family Foundation found older voters now trust Republicans and Democrats equally.

Older Americans are the nation's most reliable voters. Two-thirds of them go to the polls. And with a large number of seniors living in big swing states that are expected to decide the presidential election in 2004, the issue could be pivotal.

As a quick example, George W. Bush lost the state of Pennsylvania to Al Gore by five points in the year 2000. He lost among older voters by a whopping 17 points. If the president improves his standing among older voters, he could close the margin of victory in such a state.

But the potential political windfall could be stymied once seniors get a closer look at the details of the plan. After conducting polls and focus groups, Republican strategists are warning fellow party members that seniors who've done the kitchen-table test are not happy.

In fact, according to an internal Republican memo by McInturff, obtained by NBC News, the pollster warns that, in focus groups, seniors ere very disappointed: "The current drug coverage plan is not as generous as the private coverage two-thirds of seniors already enjoy. It's clear most seniors are first evaluating this plan in comparison to their current, private coverage, then deciding it's not as generous and certainly not a replacement for that coverage, so some are reacting unfavorably."

McInturff is advising Republican lawmakers and the president that they can overcome deficiencies with the bill, stressing rhetorically that the plan provides seniors with additional choices in coverage.

GAPS IN COVERAGE

The nation's largest lobby for seniors, the American Association of Retired Persons, or AARP, has warned Congress that it is deeply concerned about huge benefit gaps in the plan. "People are disappointed that there isn't more of a benefit here," said John Rother, policy director for the AARP. "And sometimes they're mad, and sometimes they think, 'Well, at least it's a first step.' But everyone is disappointed."

That's especially true for seniors like 77-year-old Pat Roussous of Madison, Conn. She suffers from arthritis, diabetes and high blood pressure. Her out-of-pocket drug costs are as much as $6,500 a year. "It's only a start. And I'm not convinced it's going to go very far," she said.

Roussous is one of an estimated 10 million seniors who will fall into a benefit gap, because, under the Senate plan, the government will pay for half of drug costs up to $4,500. But, there's a huge gap for the next $1,300, where the beneficiary must pay for all of their drug costs.

Catastrophic coverage does not kick in until one's drug costs exceed $5,800. Then the government will pay 90 percent of drug cost over that amount.

"I think, the gap—where people are required to pay for the drug themselves—I can't imagine that working," said Roussous. "Because those are the people who actually need to have the help."

Still, the AARP will not use its political might to block the plan. "This year, 'something' in prescription drugs is better than 'nothing,'" said Rother.

The bulk of the proposed assistance in the prescription drug plan will not be enacted until 2006. Until then, seniors will receive a discount card that will provide them with 10 to 15 percent off their drug costs. Low-income seniors will get an annual $600 credit.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

I see the gentleman from Texas (Mr. DOGGETT) had two quotes connected with a description of myself, rather than the continuation of the real quote, and I can understand why he would fabricate the quote in that way. Because what I said was, why should seniors be the last group that pays retail prices for drugs? That really did not fit the intention of the gentleman's thrust, but that is simply the truth.

Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSLE), the chairman of the Committee on Budget, but I proudly say also a member of Committee on Ways and Means.

Mr. NUSSLE. Mr. Speaker, I thank the gentleman for yielding me time and for his partnership and hard work on this bill.

The Democrats are living in 1965. Boy, we have heard a lot about that tonight. We have heard about Bob Dole and Lyndon Baines Johnson. Well, that is great but it is not 1965. Medicare is going bankrupt. Tax cuts did not cause that. Health care costs are out of control. The reimbursement system under

Medicare is broken and it is not paying the bills. Hospitals are closing. Doctors are leaving rural areas or not taking Medicare patients at all. Cost shifting is running rampant onto the private pay side, and as a result, problems are running rampant within our health care system.

Benefits have not improved. We do not have drugs. We do not have prevention. We do not have disease management. We have a sick care system, and the Democrats have done nothing about it for the past 30 years since they did pass Medicare in 1965.

Doing nothing tonight is not an option, and that is why in the budget we put $400 billion to improve Medicare, increasing Medicare by $400 billion, hardly withering on anybody's vine, because doing nothing is not an option. Tonight, H.R. 1 is the choice. It modernizes Medicare, saves it from bankruptcy, controls costs, modernizes benefits, fixes the Iowa and other rural reimbursement problems, keeps these hospitals open and viable so that they can pay the bills as a result of amendments that have been passed in both the Committee on Ways and Means and the Committee on Energy and Commerce.

Quality health care will be available in rural areas on into the future as a result of what we have done tonight. Inaction is not an option.

But there is one other choice. The Democrats will offer a $1 trillion Medicare drug benefit tonight; one that CBO says costs $1 trillion. Guess what? That not only busts the Republican budget, but it busts the Democratic budget and it busts both of our budgets combined. Do not bankrupt Medicare. Save it by passing H.R. 1.

Mr. STARK. Mr. Speaker, I yield 2¼ minutes to the gentlewoman from Ohio (Mrs. JONES), a member of the Committee on Ways and Means who understands that the Republican bill does not extend the life of the Medicare Trust Fund at all. In fact, it probably reduces it some.

Mrs. JONES of Ohio. Mr. Speaker, I will begin with a quote. "Seniors face a confusing hodgepodge of co-payments and deductibles in Medicare. The system is irrational and difficult to navigate. Simplifying and modernizing cost sharing will make coverage easier to understand and will strengthen the Medicare program over the long term. I believe we can better design both Medicare and Medigap so that seniors and people with disabilities get the most of the health care dollars they spent."

That is a quote from a Republican colleague. But let me report from Howard Brown, 77 years old, from Cleveland, Ohio. He complained about the complexity of the program that will involve choosing a plan, tracking out-of-pocket expenses, and knowing when the coverage kicks in, lapses and then resumes in severe cases, all according to a sliding scale of benefit.

Mr. BROWN said, "I am too old to try to figure all this out. Make it simple. Make it plain so I can understand it."

The people in the United States, the seniors who are on Medicare, they want a defined benefit giving them an entitlement and a guarantee. They want it to be affordable with reasonable premiums and deductibles. They want it to be designed to significantly reduce the price of their prescriptions, and they want a meaningful Medicare prescription drug bill that provides absolutely no gaps and no separate privatized ambulance.

□ 2030

But we have not heard any Republican get up tonight and define what the gap is. They have not explained to seniors across this country that there will be a gap in coverage, and it will not be Medicare improved for prescription drugs.

Truly, 35 years ago we did not think about prescriptions as being part of Medicare; but it is, in fact, a part of Medicare today, and our seniors do not want to wait till 2006 and then find out that after paying premiums all year that they do not get any coverage in this gap of coverage. Explain the gap Mr. and Mrs. Republican on the Republican side.

What about the new preventive? Every new beneficiary gets an opportunity, but what about the old folks? It is like Mrs. Ruby Bogus from Cleveland, Ohio, said. She was annoyed that the program would not begin until 2006, and do my colleagues know what she told her friends. Well, girls, I guess we will just have to live a little bit longer to get a prescription drug benefit.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

If the gentlewoman would go to page 260, line 19, from the legislation before us now, I quote, "Nothing in this part or the amendments made by this part shall be construed as changing the entitlement to defined benefits under part A and B of title XVIII of the Social Security Act."

Mr. STARK. Mr. Speaker, if the Chairman could explain the gap, but obviously he cannot. So I am happy to yield 2 minutes to the gentleman from Texas (Mr. SANDLIN), a member of the Committee on Ways and Means.

Mr. SANDLIN. Mr. Speaker, it is the old bait and switch. The Republican leadership has used smoke and mirrors to trick seniors into thinking they are getting a Medicare prescription drug plan when in reality they are forcing them to seek medication from private insurance companies, not Medicare.

Mr. Speaker, this is not an entitlement Medicare plan for seniors. All this is is an entitlement to ask to be able to make an offer, to make a purchase from a reluctant, profit-seeking insurance company who may or may not accept that offer. Importantly, not a single insurance company in the United States of America has volunteered or agreed to take part in this program, not one, nada, zip, zilch. This plan is nothing more than a mere vapor.

What has history shown us about what happens when private insurance companies get involved in Medicare? Medicare+Choice, the great managed care experiment on our Nation's seniors, should have been named Medicare Minus Choice. After all, it has been a total disaster for seniors. Between 1998 and 2003 the number of Medicare+Choice plans dropped by more than half. In my home State of Texas, 313,000 Medicare+Choice seniors have been dropped by insurance companies just since 1999.

Question: Who sets the price of the drugs in the Republican insurance company plan? The Republican insurance company plan allows HMOs and pharmaceutical companies to determine how much to charge and what coverage to offer.

Mr. Speaker, I would like to take a vote, what do my colleagues think the insurance companies will choose, more coverage or less coverage? What will the pharmaceutical companies charge, more money or less money? The answer is clear.

The other day the President said, "When the government determines which drugs are covered and which illnesses are treated, patients face delays and inflexible limits on coverage." And yet the Republican private insurance company bill wants to turn over these decisions to an insurance company who has financial interest in denying coverage. The more insurance companies deny, the more money they keep. Now, is that not special?

Mr. THOMAS. Mr. Speaker, I have one speaker to close.

Mr. STARK. Mr. Speaker, I am delighted to yield 1 minute to the gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT of Georgia. Mr. Speaker, let us get right to the chase of it. What the Republican plan is designed to do is end Medicare as we know it today. Make no mistake about it. I have the quote right here and it says, "To those who say that the bill would end Medicare as we know it, our answer is: We certainly hope so." Bill Thomas, chairman of the Committee on Ways and Means, MSNBC News, on 6/25/2003.

It was stated, to back that up, the chairman of the Senate Republican conference said this, "I believe the standard benefit, the traditional Medicare program, has to be phased out."

That is what we are faced with today, and that is what the American people need to understand, and that is what the Democratic Party is doing in here today, to pull these covers off. We are talking about people who cannot afford it. Medicare was designed to help people, to help the least of us, to help those senior citizens who cannot afford the medicine. Government is there for something. They do not want it privatized.

Mr. Speaker, let me just say this from one of my constituents, and I want to read this note. He said: "I am a 74-year-old retired senior on Medicare and this Medicare drug prescription plan is just a stone's throw away from privatization of Medicare. That should not be allowed to happen." Let us not let it happen.

SNELLVILLE, GA,
June 14, 2003.

Representative DAVID SCOTT,
Jonesboro, GA.

DEAR REPRESENTATIVE SCOTT: I'm a 74 year old retired senior that's on Medicare at home recovering from a massive heart attack and bladder infection so I am very concerned about what course of action Congress is presently taking on the Medicare Drug Prescription Plan.

When the news first came out that Congress was finally going to add prescription drugs to Medicare in order to provide financial relief for seniors that are paying way too much for their medication versus their meaner yearly income from Social Security and if they have one, their pension fund and any life savings they may have. At that time I heard that Congress would be working on such a plan Medicare beneficiaries would be given a choice if they needed and wanted their prescription drugs covered by Medicare. If they did all they had to do is sign up for it and pay whatever the cost of the plan covers. For the rest of us who are happy staying with Medicare and our present secondary insurance coverage that provides better prescription drug coverage at a lower cost would not have to participate in any Medicare prescription drug plan.

Seniors that don't have prescription drug coverage should be covered by this plan as a matter of choice, however; I feel it is unfair for Congress to make it a mandatory requirement for all seniors to pay for this plan which would override their own secondary insurance plan for their prescription drug plan. It just isn't fair. Why should we have to give up our plan and end up paying far more than what we are presently paying? I'm sure if all seniors were aware of what really is going on they would want to make it a matter of choice also.

Representative Scott please give us Medicare beneficiaries a choice to join or not to join the Medicare prescription drug coverage. Even though I'm not in your district I'm asking you to please support us many seniors by making sure this choice provision will get covered in the final bill that is sent to President Bush. If this choice does not become part of this Medicare Drug Prescription plan it is just a stone's throw away from the privatization of Medicare and that should not be allowed to happen. Please remember when you vote whatever the outcome is on this plan it will affect all Americans nation wide and in some way or other I'm sure it will have some sort of a bearing on the outcome of the 2004 elections.

May God Bless you and may God Bless America.

Sincerely yours,

RICHARD MCGRAW.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. WEXLER).

Mr. WEXLER. Mr. Speaker, I am privileged to represent the oldest district in this country, and I thought it was important to hear from some of those seniors who fought in World War II and Korea and who rebuilt this country after the depression.

Mr. and Mrs. Robert Moore of Lantana, Florida: "Why do we worry about tax cuts for the rich while so many older folks have to choose between food and medicine?"

Speaking directly to the Republican plan, Mr. Arthur Taubman of Delray Beach, Florida: "I prefer nothing instead of a botched up Republican plan."

Mrs. Elaine Schwartz from Boynton Beach: "It is very disappointing to me that I live in this wonderful country and senior citizens who have contributed for so many years supporting this country have been forgotten."

Mrs. Schwartz has got it right, forgotten benefits. Drug benefits for seniors, forgotten; lower drug costs for seniors, forgotten by the Republican plan. American seniors by the Republican plan, forgotten.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BELL).

Mr. BELL. Mr. Speaker, the gentleman from Texas (Mr. DELAY), the majority leader, has stated that the Democratic strategy on his Medicare bill is obstruction, obstruction, obstruction; but when the best that the GOP can do is create a plan that destroys Medicare, we should all rise in opposition.

I want to point out that the Republicans blocked every attempt at a Democratic substitute, sound proposals that would protect Medicare and provide comprehensive coverage for all seniors, regardless of the size of their bank accounts. The AARP, a trusted voice on this subject, says the Republican plan is not good public policy because it has too many coverage gaps.

Why do the Republicans oppose better plans without gaps for seniors? Well, the gentleman from Iowa says one of the plans is too expensive. It was not too expensive for them to pass the largest tax cut in American history, only to create the largest deficit this country has ever seen. It is just when it comes to providing our seniors with the most basic ability to protect their health the cost is too high.

It does seem to me to be a simple matter of priorities. So do we intend to obstruct the gentleman from Texas (Mr. DELAY) and the Republican's plan to destroy Medicare? Absolutely.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I did not want this historic debate to leave without my words in opposition to a plan that does nothing to serve the needs of seniors in America. The reason? Because I am proud that President Lyndon Baines Johnson in 1965 extended the lives of American senior citizens, but today we have a plan that will be shoved through on this floor that denies the preservation of Medicare, denies the real Medicare benefit. Lower prices are denied. Full coverage is denied. Choice of drugs is denied because when a sick senior citizen gets to a certain amount of their prescription drug benefit, then they drop through the doughnut hole; and if they survive, if they live through the gap between when we start paying for it, then they may be able to hit again when the amount of the prescriptions go up to $5,000.

The doughnut and privatization are two items in this particular legislation that I will stand against, and again, Medicare denied, real Medicare benefits denied, lower prices denied, full coverage denied, choice of drugs denied. This is a historic debate. Vote "no" and stand on the side of saving lives of America's senior citizens.

Mr. Speaker, when we look at the health care system for our seniors in the United States today, we see good news and bad news. The bad news is that drug costs are outrageously high. The good news is that Medicare is an effective and efficient program that is working well for our seniors, and that senior trust. I have never met a senior that disagree with these two facts: that drug costs are too high and need to be brought down, and that Medicare is a good program that needs to be protected.

So it is outrageous to me that the Prescription Drugs Bill that the Republicans are shoving through Congress today without opportunity for amendment or time for debate, is preserving the bad—the high cost of drugs—and is dismantling the good—Medicare.

We Democrats have been fighting for years for a Medicare prescription drug program that is (1) affordable; (2) available to all seniors and Medicare beneficiaries with disabilities; (3) offers meaningful benefits; and (4) is available in the Medicare program—the tried and true program that seniors trust.

And now it seems that we have the political momentum to make a good prescription drug benefit a reality. The President says he wants it. Both parties, both sides of the Capitol—everyone has declared their commitment to getting affordable prescription drugs to our nation. So why is it that the only Medicare prescription drug "plan" the Republicans have to offer is a terrible bill full of holes, and gifts to the HMOs, and protections for pharmaceuticals companies. Every time we get a chance to take a closer look at the Republican drug scheme, it becomes more obvious that it is just another piece of the Republican machine that is trying to dismantle Medicare and turn our federal commitment to our nation's seniors, over to HMOs and the private insurance industry.

The Republican plan would be run by HMOs, not Medicare. HMOs would design the new prescription drug plans, decide what to charge, and even decide which drugs seniors would get. Plus, HMOs would only have to promise to stay in the program for one year. That means that seniors might have to change plans, change doctors, change pharmacies, and even change the drugs they take every twelve months. Medicare expert Marilyn Moon told the Senate Finance Committee on Friday that "There will be a lot of confused and angry consumers in line at their local pharmacies in the fall," if the Republican approach is not changed. She's right.

The Republican plan provides poor benefits, and has a giant gap in coverage. Under the House Republican plan, many seniors would be required to pay high premiums even when they don't receive benefits. Reportedly, under the House GOP plan, Medicare beneficiaries have a high $250 deductible. After they reach that deductible, they would then be required to pay a portion of their first $2,000 in drug costs—that is a fairly normal system. But, after a senior's costs hit $2000 for a year—that is when it becomes obvious just how bad this plan is. Once a senior's drug costs hit $2000, the Republican plan cuts them off. Even though they must continue to pay premiums, they get no assistance in paying their drug costs at all until their costs reach $5,100. Let me say that again. It seems so crazy, it is almost unbelievable. The sickest of our seniors, the ones on the most medications—once their costs reach the $2000 mark—they fall into the Republican gap. They are left to pay the next $3000 out of their own pockets, while continuing to pay premiums. Almost half of seniors would be affected by this gap in coverage. They will be outraged, and our offices will be hearing about it. Already we are hearing that 4 out of 5 seniors, the people we are trying to help, are against this plan.

I have attended hundreds of health care briefings, and have read everything I can get my hands on, on the subject of improving Medicare and getting good health insurance to the American people. And I have never heard anyone say that a hallmark of a smart health insurance program is to have a giant gap in coverage for those who need help the most. Why would our Republican colleagues put in this ditch in the road to health for seniors? Because they wasted all of our nation's hard earned money, on massive tax breaks for the rich, and an unnecessary war.

So now they have placed an arbitrary budget cap on vital programs, pushed by President Bush, in order to compensate for the irresponsible Republican tax cut they jammed through this Congress and last Congress. The way they are dealing with the mess that they have made is by throwing bad policy after bad policy. To remain within their own arbitrary budget cap, they are pitching a bill that will provide a confusing, insubstantial benefit to the majority of seniors.

If the Republicans wanted to save money, they could have put in a provision that I and many Democrats have pushed for—and that is to allow the Secretary of the HHS to negotiate with the pharmaceutical to get fairer prices for the American people. I believe that the American pharmaceuticals industry is the best in the world. They make good products that benefit the world. But Americans are now paying double the cost for drugs than their counterparts in other rich nations such as Germany, Canada, Great Britain, or Japan. I am glad our companies are making money. But as we enact a prescription drug benefit under Medicare, access to drugs will rise—and drug company profits will rise as well. It is only fair that the Secretary should have the power to negotiate a good price for American consumers, to make sure we get the best returns possible on our federal investment.

Not only did the Republicans not put in a provision to allow such negotiations, they went out of their way to forbid the Secretary from trying to get better prices for Americans. Why? Because they value the profits of their corporate sponsors at Pharma, more than they do the well-being of our nation's seniors. American consumers are now subsidizing the drug costs of the rest of the world. The Canadians, British, Germans, Japanese—the rich nations of the world—still pay half of what we pay for drugs. We need to bring leaders in the Pharmaceutical companies to the table. They want to sell their products to more Americans, and we want more Americans to have access to their products. Surely, the Secretary should be able work with the industry to negotiate a compromise that serves all Americans well.

Similarly, the Republican plan's design wastes billions in kickbacks for HMOs—instead of using that money to bring down the premiums and out-of-pocket costs that seniors and the disabled are forced to pay.

The Republican plan is to privatize Medicare starting in 2010. The whole reason that Medicare was developed in the first place, was that private industry would not rise to the challenge of taking care of our nation's seniors the way they deserve.

The Republican plan is a risky scheme only an HMO could love. The Bush Administration's Medicare Administrator has called traditional Medicare "dumb" and "a disaster," highlighting Republicans' disdain for a program that Democrats have been fighting for since 1965. While Democrats have worked to modernize Medicare with prescription drugs, preventive care and other new benefits, Republicans are insisting on a riskier course even the Wall Street Journal calls a business and social "experiment."

The Republican plan destroys Employer Retiree coverage. The Congressional Budget Office has concluded that about one third of private employers will drop their retiree drug coverage under a proposal like the one being contemplated. In order to lower its cost, the House Republican plan stipulates that any dollar an employer pays for an employee's drug costs would not count towards the employee's $3,700 out-of-pocket catastrophic cap. This would therefore disadvantage seniors with employer retiree coverage because it would be almost impossible for them to ever reach the $3,700 catastrophic cap, over which Medicare would pay 100 percent of their drug costs. The practical effect of this is that employers will stop offering retiree coverage. That is a step in the wrong direction.

We can do better. The House Democrats' legislation, that I am a proud cosponsor of, is designed to help seniors and people with disabilities, not HMOs and the pharmaceuticals industry. Under the Democratic proposal, the new Medicare prescription drug program would be affordable for seniors and Americans with disabilities and available to all no matter where they lived. It offers a meaningful benefit with a guaranteed low premium; and would be available as a new "Medicare Part D" within the traditional Medicare program that seniors know and trust.

I am committed to getting seniors the prescription medications that their doctors deem they need. I want to work with our Colleagues on the other side of the aisle, and the Administration to make that happen. But unless I see a plan without a gap—with a consistent benefit—with some smart cost-controls—and some protections for Medicare, an excellent program for Americans, I cannot support this Republican drug scheme.

This bill is a sham. Our seniors have been looking forward to getting relief from the high cost of drugs. They will be waiting with anticipation until after the next elections, when this bill conveniently kicks in. When it does, they will be furious. Let's do better.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair would remind the gentleman from California (Mr. STARK) that he has 30 seconds remaining.

Mr. STARK. Mr. Speaker, I yield myself the remaining time and will use it to sum up because that is about all the time it will take to explain what is in the Republican bill, which is nothing. It privatizes Medicare, and it promises a benefit as good as we Members of Congress get, and it does not get a third of the way there.

It is a hoax. It is phony. It is a fig leaf. It only gives coverage to the Republicans because there is nothing, absolutely nothing in this bill that requires anybody to provide a drug benefit to the seniors, and perhaps they will give the Republicans enough campaign money or promises and favors of other sorts to get them to change this in the future; but right now, sexual favors will not do it, nothing will do it. We are not giving the seniors anything but a hoax.

The SPEAKER pro tempore. All time for the gentleman from California (Mr. STARK) has expired.

The gentleman from California (Mr. THOMAS) has 4½ minutes remaining.

Mr. THOMAS. Mr. Speaker, I yield the remaining time to the gentlewoman from Connecticut (Mrs. JOHNSON), to close for our side, to continue to talk about the bill that for the first time in the history of Medicare provides low-income help, and she is the chairwoman of the Subcommittee on Health of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman for yielding me the time.

Today, is an historic day for America's seniors. Congress is about to fulfill the promise and the potential of Medicare, which has been one of our greatest success stories in our history; but when Medicare was created in 1965, prescription drugs were few and far between. Instead, painful and invasive surgeries were standard treatment; but now, with the health security of our seniors tied directly to medicines,

medicines that extend life and restore hope, we must add prescription drugs to Medicare for all our seniors.

A Medicare program without a drug benefit is a false promise in the 21st century. I am proud to stand here on this House floor and bring prescription drugs to Medicare for all of our seniors and a benefit that is simple, generous, and fair.

It is simple because it pays 80 percent of the first $2,000 of drug costs; and it guarantees the peace of mind of our seniors, protecting them against catastrophic drug costs, covering all costs above $3,500.

It is generous because the average senior spends $1,200 on prescription drugs every year. Yet in this bill we cover 80 percent of the cost up to $2,000.

It is fair because it helps the low-income seniors more than any other group. It not only helps the very poor, below 150 percent of poverty, but for the first time, by allowing State subsidies to help seniors toward that threshold of catastrophic coverage, we help the next income group to have that security that seniors depend on in their retirement.

In addition, there is fairness at both ends of this bill. Should someone with a $200,000 income have the same level of catastrophic protection as a low-income senior? Of course not.

But modernizing Medicare cannot be just about prescription drugs, as important as prescription drugs are. It must also be about addressing the most crippling threat to our seniors' well-being and their retirement. It must address chronic illness.

□ 2045

Current Medicare is an old-fashioned illness treatment program. This bill will provide seniors with chronic illnesses a chance to have truly progressive care, whose goal it is to prevent the progression of chronic illness. Our goal must be to be sure that if you have diabetes, you do not end up on dialysis.

Disease management is the new frontier in medicine. It will slow, interrupt or reverse disease. It requires more sophisticated technology. It requires greater patient involvement in their own care. But it results in higher quality health care and much improved quality of life and lower costs for hospital care, emergency room care, and doctors' visits.

Mr. Speaker, this bill will bring the cutting edge of medical science and modern technology to the service of our seniors and disabled veterans. With over half of our seniors suffering from five or more chronic illnesses and using 80 percent of Medicare's resources, we must bring chronic disease management to the service of our seniors. And no bill to this point has ever done that. So I am proud to say that this bill brings both prescription drugs and preventive health care programs to Medicare and will provide unprecedented vitality to our Medicare program.

In conclusion, let me remind us all that this bill will revitalize our Medicare Choice plans and provide that reliable high-quality care year after year after year that seniors depend on, a more holistic integrated care than fee-for-service can provide. So I ask my colleagues tonight to support wholeheartedly and enthusiastically H.R. 1. It is historic. It brings prescription drugs into Medicare and it prepares Medicare to provide 21st century medicine to our seniors in the years to come.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). All time allocated to the Committee on Ways and Means has expired. The gentleman from Louisiana (Mr. TAUZIN) is recognized for 45 minutes.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, when the chairman of the Committee on Ways and Means, the gentleman from California (Mr. THOMAS), opened this debate tonight in presenting H.R. 1 to the floor, he acknowledged the extraordinary cooperation and the spirit by which our two committees, the venerable Committee on Ways and Means and the venerable Committee on Energy and Commerce, of the House have worked together on this bill again this Congress, with the kind of harmony and dedication to accomplishing a good purpose for this country that is seldom seen between committees that often fight and juggle for jurisdiction. I want to commend him for that statement and acknowledge my personal gratitude for him and the entire membership of the Committee on Ways and Means and their great staff for the spirit in which they worked with the Committee on Energy and Commerce to accomplish this historic moment for our country.

I also want to thank the gentlewoman from Connecticut (Mrs. JOHNSON) of the Committee on Ways and Means for the extraordinary work she has personally given to this effort and the way in which she has worked with members of the Committee on Energy and Commerce, so many long hours, to accomplish this bill.

It is important also that I highlight, while not acknowledging all the staff who contributed so many hours, the head of our health care staff of the Committee on Energy and Commerce, Mr. Pat Morrisey, who has done Herculean work once again on behalf of this effort. And I want to acknowledge and thank, again, Mr. Ed Grossman, who is a legend in the Legislative Counsel's office, in terms of his contribution to this entire body and the work we do in preparing legislation for the floor.

When we began this effort 2½ years ago to create once again an opportunity for this House to pass a prescription drug benefit for Medicare and, at the same time, to modernize a system that is in deep trouble, we announced that the entire effort in health care would be dedicated to a theme of patients first; the idea that everything we did should be designed to make sure that patients in America continue to have the best health care delivery system in our country and, importantly in this area, that seniors get something they desperately need; and that is that every senior get access to prescription drug coverage and that the Medicare system itself, which has long been absent of that important product in the arsenal of products that keep our seniors healthy and long living in our country, that prescription drugs be added to this system, this important new element of health care in our country that has long been missing from the program.

At the same time, we recognize that the worst thing that can happen to any citizen is to be forced to go to a single store, whether it is a government-run store or a private-run store. We know when there is only one store in town, generally you get bad products and bad services and often bad attitudes. No matter what store it is, no matter who runs it, when more than one store is available, when we have choice, whether it is choice between a government store or a privately-run store, all of a sudden prices become better, products become better, attitudes become better, and service becomes better.

We know that Medicare is described by so many members of the Committee on Ways and Means as being in deep trouble. We know it is on a path toward insolvency. And Medicare, a system by which so many citizens have depended on for years for their health care, is absent this vital asset of prescription drug coverage. So we began our efforts to make sure we could add that coverage to the bill. We have been doing this over several Congresses now, and every year we battle over what is the right number to fund this program and how best to fund it.

I want to point out that we owe a great debt of gratitude to the chairman of the Committee on the Budget, the gentleman from Iowa (Mr. NUSSLE), for including this year $400 billion for us to fund this effort. In last year's budget, we dealt with considerably less. In fact, in the Democratic budget that was prepared for the year 2002, our friends on the other side allocated only $330 billion to their effort to fund prescription drugs. This year, our Committee on the Budget provided us with $70 billion more than even the Democrats did when they prepared their budget for the year 2002. And I want to thank the Committee on the Budget and Chairman NUSSLE for that great effort.

With that amount of money available, we have been able to construct this year, as the gentleman from California (Mr. THOMAS) and his team have so adequately described, a much better bill, a bill richer in benefits, more secure in the texture of its structure, to make sure that seniors would, in fact, have more choices. Those like my mother, who want to stay in Medicare, cannot only stay in Medicare but enjoy a prescription drug benefit now; and those who might enter their senior years knowing about choice, liking choice, preferring choice, having the availability of different plans offered in the private sector that they could choose their prescription drug benefit from.

That is the kind of world we hope to create when we pass this bill tonight, a bill that historically modernizes the Medicare system and, at the same time, brings some more stores to town and makes sure that every store, the government store and the private stores, all have the products that seniors need so desperately, and that is prescription drugs.

In this bill this year, we do a number of other things. We address the concerns of many of our health care providers in terms of their lack of proper reimbursement from the government, and we add reimbursements to hospitals and physicians and caregivers across America. We have an excellent, and I thank the Committee on Ways and Means again for their work on this, we have an excellent rural package that will provide $27.2 billion of assistance to rural health care givers and hospitals to beef up care in America where care is desperately short and, unfortunately, hospitals are closing and doctors are leaving their practices.

Indeed, because this bill adds to the mix of choices that seniors will have in the future, there are predictions from CBO that Medicare will get back on its feet, will not necessarily have to go insolvent. It will have a chance to be one of the options that seniors wish to choose for a long time in the future.

These benefits are going to benefit all Americans. I know there is some talk about how the plan has coverage and then there is a donut hole and there is coverage again for catastrophic coverage. The discounts provided to seniors in this bill will be available at all stages of prescription drug coverage, at all stages of prescription drug use and purchase throughout the bill. Seniors will see lower drug expenses in this bill. CBO estimates, in many cases, by as much as 50 to 70 percent. All seniors will benefit.

And for the seniors who live below 135 percent of poverty, and there are thousands and millions of those seniors living across America, this bill provides a 100 percent subsidy, 100 percent coverage for the drugs they are going to need under this prescription drug plan. And that is a pretty good effort and that is a pretty good reform of our system.

Indeed, we are also going to do some interesting things. We are concerned about the high prices of drugs. And like the Senate, we include reforms in the Hatch-Waxman laws that will speed the approval of generic drugs into the marketplace. And we reformed that awful, that awful wholesale price system that the government currently uses with phony wholesale prices that force seniors to pay 20 percent of phony prices whenever they suffer cancer and have to endure cancer therapies and urinary tract therapies and respiratory therapies. In short, we are going to lower the cost of drugs to America across the board, and we are going to increase the availability of drug coverage for every senior in this country and build new options for seniors to choose from. That is a pretty good package.

I want to again congratulate all who worked on it and all in the two committees who contributed so much to it. In the House Committee on Energy and Commerce we had 65 amendments, I think 29 recorded votes, over 22½ hours of debate again this year. Are we ready for this vote tonight? You bet we are. Are seniors ready for the debate to end? You bet they are. Are seniors ready for us to really do it this year? You know it. Are seniors ready for this House, the Senate, and the President to come together and actually sign a law that gives them these benefits, instead of constantly just debating the issue? You know that is true.

This is a historic moment, and this is our time to get it done.

Mr. Speaker, I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) is recognized for 45 minutes.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, three things: One, this is a bad bill. Two, it is not the Senate bill. And, three, it destroys Medicare as we now know it.

And if you do not believe it, take the words of my good friend, the chairman of the Committee on Ways and Means, who says, "To those who say this bill would end Medicare as we know it. Our answer is, we certainly hope so. Old-fashioned Medicare isn't very good."

Well, it is a safety net that has preserved and protected the health and the well-being of Americans for 38 years. It has been a fabulous system for the protection of the health and the welfare of the people.

This thought echoes the words of Speaker Gingrich, who wanted Medicare to wither on the vine.

Well, it is a fraud upon the American people. It provides very little for most people who are looking for the benefit of receiving prescription pharmaceuticals. What it does is it subsidizes the insurance companies. It does not control prices. It does not stimulate competition. It affords to the senior citizens a situation where they wait 2 years. And after they wait 2 years, what do they get? An enormous donut hole into which they fall after they have spent $2,000, during which period, for a period of about $2,900, they get no additional help from their government, but during which time they have to pay more money, more money, to not draw any benefits.

And it should be noted there is no requirement whatsoever, none in this legislation, that requires the insurance companies, who will begin getting subsidized enormously in just 2 years after the enactment, to do a single thing to provide for prescription pharmaceuticals for the benefit of their subscribers. Indeed, most insurance companies have said they do not want to participate in the pharmaceutical-only care benefit that would be offered by this legislation. So they have set up this wonderful situation where there will be enormous boundless subsidies to try to induce somebody to come in and set up HMOs which will serve the people in the area or provide prescription pharmaceuticals to them.

The Democrats have a simple, easy-to-understand piece of legislation, one which builds upon the practices which we have used in Medicare with such great success and so efficiently for so long to see to it that the people get the benefit on the payments of a modest sum and a modest deductible and then they get their benefits. No donut hole during which they do not gain benefits.

And I would note that, by an interesting circumstance, many people under this wonderful Republican bill will pay a lot more than they will get out of this legislation. It is a piece of legislation which can best and most kindly be defined as a fraud upon a group of people who have high hopes that their Congress is going to take care of them.

□ 2100

Well, this Congress is going to take care of them; it is going to give them a deceitful piece of legislation which benefits them very little, if at all.

Mr. Speaker, less than 2 weeks ago, the House Republicans divorced themselves from the Senate bipartisan legislation and unveiled their lengthy and complicated proposal to make sweeping changes in Medicare. After taking months to develop more than 300 pages of fine print in secret consultation with selected corporate allies, they rammed the bill through committees last week and are ramming it through the House today under a rule developed in the wee hours this morning. No hearings, no significant opportunity for public comment, no concessions—just the way the House Republican leadership wants things.

But the Republican leadership is playing with fire. Not content merely to privatize a watered-down drug benefit, this bill, H.R. 1 privatizes the entire program in 7 years. As Chairman THOMAS said yesterday, "[t]o those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so. * * * Old fashioned Medicare isn't very good." And a Republican Senate leader was quoted last month as saying that "I believe the standard benefit, the traditional Medicare program, has to be phased out," echoing Speaker Gingrich's 1995 prediction that traditional Medicare would "wither on the vine." The list goes on. Former Majority Leader Dick Armey said, also in 1995, that Medicare was "a program I would have no part of in a free world." Most recently, the Bush administration official in charge of Medicare, Tom Scully, 2 months ago called Medicare an "unbelievable disaster" and a "dumb system." And, of course, I was here in 1965 to witness the overwhelming majority of Republicans vote for the motion to recommit the legislation that created Medicare.

How will seniors react when told they will be forced to pay more to see their family doctor, or accept whatever doctors and benefits a private plan chooses to give them? How will seniors react when traditional fee-for-service Medicare is no longer a trusted safety net? How will seniors react when given a voucher and told to fend for themselves in the insurance marketplace—the same marketplace that failed them before Medicare? They should, and will, be outraged.

Seniors will also be angry when they learn that the Republican drug benefit helps insurance companies more than them. Democrats propose a true benefit provided under Medicare, with set premiums and benefits. Republicans propose payments to insurers to offer uncertain benefits, with uncertain premiums. The only certainty in the Republican plan is a huge coverage gap, when seniors will continue to pay premiums after substantial out-of-pocket expenses, and yet receive no benefit. And drug costs will continue to rise, because the Republicans prevent bargaining by Medicare to make prescription drugs more affordable to seniors.

Other nasty surprises will hurt seniors as well. Cuts in payments to hospital, when many are closing down. Inadequate payments to doctors, when seniors' access already is jeopardized. Increasing seniors' costs by $8.3 billion for their Part B coverage. These are shortsighted acts of extraordinary callousness.

I urge my colleagues to reject this dangerous Republican plan. Our senior citizens deserve better than to be guinea pigs for risky ideological experimentation.

Mr. Speaker, I reserve the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise in support of H.R. 1, and I urge my colleagues to lend their support to this very important bill. We have before us a historic opportunity to provide our constituents with a meaningful prescription drug benefit that our Nation can afford. While the bill before us certainly is not perfect, it targets the $400 billion available under our budget resolution towards areas where it can do the most good.

Our bill provides a great deal of assistance to our lower-income seniors for whom we waive a deductible and coinsurance requirements. These seniors, those with incomes below 150 percent of the poverty level, which in 2002 was $13,290 for an individual and $17,910 for a married couple, will only be responsible for a small copayment per prescription.

In addition, the bill targets the prescription drug benefit towards where the need is greatest. Beneficiaries are only responsible for 20 percent of their drug costs between a $250 deductible and a $2,000 initial coverage limit. When we consider that the 2003 median drug costs for Medicare beneficiaries are estimated to be $1,390, it is clear that our bill provides a very good, upfront benefit.

Finally, the bill ensures that seniors will have the peace of mind of knowing that their annual drug costs will be capped at no more than $3,500 out of pocket. While that number does rise for some wealthier seniors, I would note that 95 percent of seniors will qualify for the $3,500 figure. Our bill makes other improvements to the Medicare program, and includes some Medicare payment modifications to ensure that beneficiaries will still have access to high-quality health care.

I would like to close by noting my great disappointment with my colleagues on the other side of the aisle, who for 30 years when they controlled this House did not do a thing for Medicare. I had to sit through a 3-day markup where my intentions and those of my colleagues were constantly questioned. Republicans were often accused of not being willing to commit adequate resources to a Medicare prescription drug benefit. I find that odd since in 2001, 2 years ago, the Democratic substitute to the budget resolution included only $330 billion for a new drug benefit. Republicans added $70 billion to that number only 2 years later, and still our colleagues accuse us of underfunding that benefit.

Mr. Speaker, all this tells me is that most Democrats only care about engaging in a reckless bidding war with Republicans and not about developing a reasonable, affordable benefit. H.R. 1 is a good bill, and its passage today will move us one step closer to a law which will provide real help to tens of millions of Medicare beneficiaries.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from Ohio (Mr. BROWN), the ranking member of the Subcommittee on Health.

Mr. BROWN of Ohio. Mr. Speaker, for years Republicans have tried to frighten seniors by telling them that Medicare was going broke. The media in this country scolded the Republicans for their Mediscare tactics. Well tonight, Republicans have graduated from using Mediscare tactics to a new level, and that is scam.

Mediscam number one: my Republican colleagues tout H.R. 1 as the largest expansion of Medicare since the program's inception calling their plan generous. But under H.R. 1, seniors will be required to pay $4,000 out of pocket to receive $5,000 in benefits. That is not generous; that is not even insurance.

Mediscam number two: my Republican colleagues say we should pass H.R. 1 because seniors deserve better coverage options like those available to Members of Congress, yet this bill's drug coverage is less generous than the least generous coverage available to Members of Congress. That is not treating seniors like Members of Congress; that is treating seniors for suckers.

Mediscam number three: my Republican colleagues say H.R. 1 gives seniors coverage they can trust. It is an expansion of the old, failed Medicare+Choice program which has dropped coverage for 2 million seniors outright. H.R. 1 is not coverage you can trust; H.R. 1 is coverage that cashes the check, then leaves seniors hanging.

Mediscam number four: my Republican colleagues say H.R. 1 will enhance the security of America's retirees, but the nonpartisan Congressional Budget Office says about one-third of employers will drop their retiree benefits if H.R. 1 becomes law. In other words, H.R. 1 will force seniors out of the drug coverage they now have. It will force seniors out of the drug coverage they now have.

Mediscam number five: my Republican colleagues say H.R. 1 will bring prices down through the magic of competition. How could that be? The drug industry wrote this legislation; the insurance industry wrote this legislation. They do not want lower prices, they want higher prices, and that is why my Republican colleagues took out any ability for the Secretary of Health and Human Services to lower drug prices. In fact, the drug companies gave $85 million to my Republican friends for their reelection in 2002 and tens of millions of dollars to President Bush.

Mediscam number six: my Republican colleagues say forcing seniors into private health insurance will reduce health care costs because private plans are more efficient. My Republican friends know that private insurance plans actually operate less efficiently than Medicare with administrative costs five times higher than Medicare.

Mr. Speaker, it is irresponsible to spend tax dollars bribing HMOs. It is irresponsible to provoke employers into dropping retiree health coverage. Vote "no" on H.R. 1.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, the Mediscam bill that the gentleman just described is patterned after H.R. 1495, authored by the gentleman from California (Mr. STARK), the gentleman from Michigan

(Mr. DINGELL), the gentleman from California (Mr. WAXMAN), and the gentleman from Ohio (Mr. BROWN) just a few sessions ago in the 106th Congress.

It provided a $220 deductible, 20 percent cost share up to $1,700, a doughnut hole with a $3,000 catastrophic coverage, and no defined premiums. Does that sound familiar? The bill we wrote today is patterned after a bill written by my friends on the other side of the aisle back then, and they complain today that it is Mediscam.

Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. STEARNS), the chairman of the Subcommittee on Commerce, Trade and Consumer Protection.

Mr. STEARNS. Mr. Speaker, we have heard from the Democrats that this is a plan that will not work and is a fraud. We had 2 days of hearing, and I never heard a plan from the gentleman from Michigan (Mr. DINGELL) or the gentleman from Ohio (Mr. BROWN). We had 64 amendments.

PARLIAMENTARY INQUIRY

Mr. BROWN of Ohio. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Will the gentleman yield for a parliamentary inquiry?

Mr. STEARNS. Mr. Speaker, I do not yield.

The SPEAKER pro tempore. The gentleman from Florida (Mr. STEARNS) controls the time.

Mr. STEARNS. Mr. Speaker, what we have here is a plan that the Republicans have been on their knees trying to come up with to try and solve this problem. It is voluntary. It brings choice, everything that the Federal employees health benefit plan has, the same program that all these folks have.

Joshua Hammond wrote a book called "The 7 Cultural Forces," which defines who we are as Americans; and one of those cultural forces is we are ready, fire, aim. That is, sometimes we do not get it perfect. We do the best we can, and that has been our history for 230 years. Is this bill perfect? No. In fact, the people on this side will argue back and forth, but all of us know this bill is not perfect. However, we have carefully balanced the needs and resources from home health to physical therapy.

This bill contains the long-overdue addition of a prescription drug benefit. Our seniors and disabled beneficiaries have waited many years, particularly true in Florida; and I am pleased to be part of the solution and part of that markup that we did for 2 days.

Now the folks on this side of the aisle say they have a bill. Their bill is for $1 trillion. Ours meets the budget demands of $400 billion. If we could spend all we want in the world, that would be the Democrat's plan.

But at long last Medicare beneficiaries will have available the same options that the President of the United States has, the Senate and the House and the staff here in Congress, a choice to choose the plan that best meets their needs.

Mr. Speaker, I am very happy that part of this plan that we have here has a demonstration project in consumer directed care for chronic conditions such as folks with diabetes. It is analogous to the successful consumer-directed care demonstration and evaluation projects, known as cash and counseling in Florida, Arkansas and New Jersey. It is consumer-directed, and in fact this type of plan is part of the American Postal Workers Union. It has a consumer-directed option. So what we have with Medicaid, we are going to have with Medicare. I am glad that is part of the solution we have.

So I would conclude by saying to my colleagues who are wondering what to do on this side of the aisle, come along with us. It is a start. It is not perfect. We can move it to the Senate, have a conference on it, and improve it. In fact, the gentleman from Louisiana (Mr. TAUZIN) in the markup amended the bill with a GAO study of the impact of this new cost regime. It is my hope that this will provide an objective, balanced approach and give us a proper understanding of how much this whole thing is going to cost. I commend the chairman every step of the way trying to be balanced, listening to the Democrats' amendments, many of which were accepted, many we defeated.

Mr. Speaker, thank you for bringing this package of Medicare additions, updates and reforms here to the Floor today. There is much here to applaud. We have carefully balanced needs and resources varying from home health to the physical therapy cap. Most significantly, this bill contains the long-overdue addition of a prescription drug benefit to Medicare. Our seniors and disabled beneficiaries have waited for this for many years now, and I am pleased to be part of the solution. At long last, Medicare's beneficiaries will have available to them the same options that we, and the Senators, and all of our staff and employees have: a choice of selections from which to choose the plan that best meets their needs.

Leading off with "choice," I am pleased that my provision for a voluntary, small-scale, controlled demonstration project in consumer-directed care for Medicare beneficiaries with chronic conditions, my particular interest is diabetes, is included in H.R. 1 as Section 736.

This would be an analog to the successful Consumer-Directed Care Demonstration and Evaluation Projects, known nationally as "Cash and Counseling," in Medicaid in Florida, Arkansas, and New Jersey. the Energy and Commerce Committee held a hearing June 5 on Consumer-Directed Care, and every single Member praised that demonstration's progress, but many cautioned not to overreach expanding its application. I agree. To that end, at markup I agreed to language from my friend, the ranking Member of the Committee, the gentleman of Michigan, Mr. DINGELL, tightening some boundaries for the demonstration project. The Consumer-Directed Care demo is working, let's expand the elements of Consumer-Directed Care that have been successful in a voluntary, incremental fashion and see how the demonstration in Medicare might be evaluated down the road.

Section 736 will direct the Secretary to design a demonstration project allowing for participating Medicare beneficiaries to cash out the value of certain services. They then, with the assistance of a designated "counselor" of their choosing, and government-provided fiscal intermediary, would have some flexibility in making decisions directing care for their condition.

Furthermore, Consumer-Directed Care type models are now offered in major health plans in the private sector: in 2003, the American Postal Workers Union (APWU–AFL–CIO) are the very first Federal employee group with a Consumer-Directed Care plan available to them. Do our Medicare beneficiaries deserve any less choice?

At the June 5 hearing, the National Director of Cash and Counseling, Dr. Kevin Mahoney, outlined that there are generally three characteristics of a condition that make it a good fit for the consumer-directed care model. Disabilities fit these three, and I believe diabetes does, too: (1) It is chronic, and one of the most self-managed diseases; (2) it follows a relatively predictable course of treatment; and (3) there is room for choice, in tailoring a treatment plan to the individual.

I remind my colleagues that under the Medicaid demonstration, satisfaction has been in the high 90 percentage, no adverse health outcomes have occurred (in some measures it has improved), and fraud has been virtually zero.

From that, I must turn to other provisions of the bill. I do not stand here without some reservations. For example, the reform of reimbursement for oncologists. No one, no Member, no oncologist, and no patient wishes for the accounting mismatch of Average Wholesale Price (AWP), to perpetuate, and we should never let dialogue about AWP degrade into accusations about gaming the system. It is true that H.R. 1 eliminates the current overpayment on Medicare-covered drugs, while concurrently increasing the practice expense reimbursement to appropriate levels that reflect their costs. But my understanding is that this is still a net decrease for the practice. I ask that the negotiations continue in good faith. In Energy and Commerce, Chairman TAUZIN amended the bill with a GAO study of the impact of this new cost regime, and it is my hope that this will provide an objective, accepted arbiter on true proper costs of administering total community-based cancer care.

Further, I harbor concerns that this bill not become a runaway money train. We have budgeted $400 billion over 10 years: is that a ceiling, or a floor? It is a logical modernization to add prescription drug coverage to the Medicare program; none of us would choose a health plan in FEHBP (Federal Employee Health Benefits Program) that lacked drug coverage. And, through economies of scale, both the traditional fee-for-service program and the participating private sector plans will have the purchasing power to contain costs.

However, there always runs the risk of this exploding beyond our control. We have a responsibility for the fiscal health of this nation, and it is essential that proper cost containment be addressed in conference, as I understand the Speaker has assured.

Mr. TAUZIN. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, just to correct the record, the Democrats did offer a substitute plan in our committee which was defeated, and I think it is pretty close to the substitute plan we will see later tonight.

Mr. Speaker, I yield 10 seconds to the gentleman from Florida (Mr. STEARNS).

Mr. STEARNS. Mr. Speaker, if the Democrats' plan is for $1 trillion and ours is for $400 billion, we cannot say they offered a plan that met the budget requirements. I would like to ask the Democrats tonight: Do you have a plan that is under $400 billion like the Republicans?

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. DEUTSCH).

Mr. DEUTSCH. Mr. Speaker, the House bill in front of us, as the ranking Democrat of our full committee has ably quoted the chairman of the Committee on Ways and Means in his own words, "To those who say the bill would end Medicare as we know it, the answer is we certainly hope so."

This bill is a nonstarter. The Republicans in the Senate oppose it. It will not happen. It destroys Medicare. I am going to take my 2 minutes and even talk about that.

Mr. Speaker, I am going to talk about the disingenuous nature of the proposal that the Republicans are fostering at this point as a final product. And I say disingenuous because both this bill and that proposal does absolutely nothing about cost containment. How can they have a prescription drug bill that does nothing on cost containment? It is totally disingenuous.

For real seniors, and I would encourage all of my colleagues to talk to seniors because one of the things that is going on in America today is we do not know the number. We just had the FDA in our committee again several times. We do not know the number of how many seniors are availing themselves of purchases through Canada by the Internet, but it is easily 10 million seniors. We have 10 million seniors who are purchasing drugs in Canada where the benefits of purchasing drugs in Canada far exceed any proposal the Republicans have made. Just because people are old, just because they are sick does not mean they are stupid. They are going to continue to purchase them. So this bill for most seniors, for probably over 95 percent of the seniors in America, does absolutely nothing.

□ 2115

What it does is even worse, though. In a Congress, in a country, in a society that is facing the largest budget deficits in the history of the world, we take $400 billion out of working Americans, give it to seniors, but effectively take that $400 billion and flush it down the toilet and we get absolutely nothing from my Republican colleagues' proposal.

Mr. TAUZIN. Mr. Speaker, I first want to take 15 seconds, if I may, to point out that the bill before us does now contain the drug reimportation provisions similar to the Senate provisions and adds language directing the FDA to conduct rulemaking to make sure that there is safe packaging, to make sure when we do get drugs under any such program, that they are safe and effective.

Mr. Speaker, I yield 4 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), distinguished chairman of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, our grand inquisitor.

Mr. GREENWOOD. I thank the gentleman for yielding me this time.

Mr. Speaker, my parents, my mother and father, are 81 years of age, alive and well, and I would like to dedicate all the work that I have put into this bill to them and I know it will benefit them immensely. My father used to say when I was a young lad, "Jim, there are three kinds of people in this world. There are shirkers, there are workers and there are jerkers. The shirkers are the people who just don't do anything. They don't contribute. They don't help. The workers are the people who roll up their sleeves and get the job done. The jerkers are the ones that all the time the workers are working they keep tugging at them, pulling at them, jerking them around trying to interfere with the work."

I would submit that the Democratic Party, in all due respect, between 1965 and 1994, when they lost control of the House, were shirkers when it came to the issue of a prescription drug benefit, for they did nothing. They did not provide a big plan, a little plan, a medium-sized plan, they did not provide a plan with a doughnut, without a doughnut. They did not provide a plan of any kind. They did nothing. We have been the worker party. We have passed a prescription drug bill in this House year after year since we have had control. That is hard to do. That is hard to do because mature legislators have to figure out how to strike a balance.

We have people in this House who do not want to vote for this bill. They do not want to vote for this bill because they think it is too liberal. They think it is a big new entitlement program that will bankrupt the country. They are against it because it is too liberal. There are a whole lot of people in this House who cannot vote for this and will not vote for it because it is too conservative; it does not spend enough money; it is not big government enough; it uses private sector factors, influences to curb prices. If you want to get 218 votes for a bill to provide a prescription drug benefit to the elderly and the disabled in this country, you have to work very hard with very complex issues and strike a political balance down the center through the eye of the needle to get the job done, and that is what this bill before the House of Representatives stands for. That is what it results from.

Now we have got the jerkers. We are trying to get this carefully balanced, incredibly complicated piece of work that our staff on both sides of the aisle have labored over for years to get done, want to try to move it through the House today, get it over to Senate, we have got some bipartisan support here, we have got some bipartisan support in the Senate, and we are going to get it done. And at the end of the day when the little old ladies and the little old men in my district and your districts who have been writing us letters and saying, with tears rolling down their cheeks, I have got a prescription for cholesterol drugs, I have got a prescription for antidepressants, I have got a prescription for my arthritis, I have got a prescription for this and for that and I can't afford them, what am I going to do. We have all been getting those letters for years and years. And when this year is over and when we stand with the President of the United States and he signs these bills, we will say to the little old men and the little old ladies and the disabled people of all ages in our district, we got the job done, when nobody else could or nobody else would. Whether the shirkers did not do their job or the jerkers tried to get in the way, the workers will get the job done and this will be an historic year for the Medicare program of this United States.

I am proud of everyone on either side of the aisle who actually rolled up their sleeves and contributed to the product.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. I thank the distinguished ranking member of the committee for yielding me this time.

Mr. Speaker, for those that are listening in this evening, besides the vote that some Members of Congress have had to take on going to war, I consider this the most important vote in the House of Representatives. Tonight we debate a bill where there is only one thing that the two parties agree on, and that is that our seniors deserve prescription drug coverage.

For 38 years, there has been a gold standard for those that are 65 years and older and it was named Medicare. How dare my colleagues on this side of the aisle say that the Democrats have not done a damn thing. I regret those words in the RECORD. We love Medicare. We put it on the books, and we have defended it ever since then. And we want a policy in Medicare that is ennobling and recognizes what senior citizens are.

The advertisers are very busy, but beware. Beware of the advertising. Read the bill. If your insurance salesman comes to you, the first thing you say is, how much is this going to cost a month? Read the bill. There is no premium cost in the bill. It says choice. Yes, there will be choice of insurance companies but not choices of doctors.

By 2010, every senior citizen that is listening in, you will be forced, you will be mandated to go into a private insurance program. That is what our friends have written.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from the great State of Nebraska (Mr. OSBORNE).

Mr. OSBORNE. Mr. Speaker, rural health care is struggling. The hospitals are closing and many doctors are leaving. If you are in a small community and the doctor leaves or the hospital closes, the whole community begins to unravel. H.R. 1 addresses the troubles that we see currently in rural health care. Number one, it lowers the labor share of the wage index for rural hospitals. This allows them to be more competitive with urban areas in terms of salary scale.

Number two, H.R. 1 increases Medicare reimbursement for rural doctors. Sixty percent of the patient load in my district and many other rural districts are Medicare patients. Doctors simply cannot afford to treat Medicare patient loads of this size because on many Medicare patients they lose money. As a result, they cut back Medicare patients or sometimes leave the area.

Thirdly, H.R. 1 provides a full and permanent equalization of Medicare payments to rural hospitals. An appendectomy is not cheaper in a small hospital than in a large urban hospital. In some cases it is actually more expensive. Also, H.R. 1 provides additional home health care payments and provides provision for rural ambulance.

Mr. Speaker, the reason I want to come to the floor tonight is simply to thank the gentleman from Louisiana for all that he has done for rural health care. This is probably, as far as I am concerned, the most important part of the bill. I would also like to say I represent a rural area. Many retirees in my area live on fixed incomes. Most of these people are making 15, $20,000 a year. Most of them are spending 30, 40, 50 percent of their income on prescription drugs. And so the number one concern that I see in rural America is the prescription drug bill. This bill offers considerable help to these people.

Again, I would like to thank the gentleman from Louisiana, the gentleman from California (Mr. THOMAS) and also the gentleman from Iowa (Mr. NUSSLE). I urge the passage of H.R. 1.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New York (Mr. ENGEL).

Mr. ENGEL. I thank my friend for yielding me this time.

Mr. Speaker, I rise in strong opposition to this bill. This bill is a cruel hoax perpetrated on America's seniors. This bill is not about helping seniors. It is all about privatizing Medicare. This is not the Senate bill. This bill is a wolf in sheep's clothing. It purports to help seniors. All it does is create a goal that many people on the other side of the aisle have wanted for years, the privatization of Medicare. This bill drains the lifeblood out of the Medicare program and breaks the promise we made to seniors 38 years ago when Medicare was created.

I wish this Congress could have come together for an historic moment that would finally provide seniors with the type of prescription drug coverage they need and deserve. Unfortunately, we are doing a disservice to our seniors by shortchanging them with a woefully inadequate drug benefit. Why is it inadequate? Let us face it, there is not enough money in this bill because my friends on the other side of the aisle have bankrupted this government with huge tax cuts, huge tax cuts to benefit the rich, huge tax cuts which make it impossible to help entitlement programs like Medicare. When the leaders over there said they wanted Medicare to wither on the vine, they were speaking the truth and that is what is happening today. With the enactment of this bill, Medicare is withering on the vine.

When I came to Congress 15 years ago, my goal was to provide meaningful prescription drug benefits. My bill and others, 1045, would keep the promise of Medicare, which was created to prevent seniors from having their life savings ravaged by health care costs. Today we are considering no such thing. The legislation before us is not a promise kept to seniors, it is a promise kept to HMOs and insurance companies. This is not the Senate bill. The Senate bill was a starting point to improve upon. This bill bankrupts Medicare, privatizes it by the year 2010. American seniors will not have Medicare as they know it by 2010. Again, when you have tax cuts for the rich and you do it to help your rich friends and you want to strangle social programs and entitlement programs, you do not have an adequate bill.

This bill should be rejected.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maryland (Mr. WYNN).

Mr. WYNN. Mr. Speaker, I thank the gentleman for yielding me this time. I rise in strong opposition to the Republican plan. This Medicare reform plan is woefully inadequate. Everyone agrees that a real prescription drug plan would cost between $600 and $800 billion. This plan only provides $400 billion. Why? My Republican colleagues will say, well, this is because that's all we can afford. The truth of the matter is that is all we can afford because of their big tax cuts. But keep in mind, you did not get a big tax cut. The wealthy got a big tax cut. Mr. and Mrs. Average American got cuts in service, cuts in benefits and cuts in quality. What we have here this evening is an attempt by the Republicans to do prescription drug coverage on the cheap.

There are three problems with this. First, in their plan, there are no guaranteed drug benefits. The private insurers determine what drugs are going to be available to you, not your needs. So that if your drugs are not covered, then you have to pay the full price. This is no prescription drug benefit. Second, there are no fixed premiums. You hear the Republicans tell you, well, it's going to be $35 a month. Wait a minute. $35 a month is nowhere in their bill. These premiums could rise to as much as $85 a month. You will drive seniors into bankruptcy with that.

The third problem with this plan is the hole in the doughnut, the gap. Under the Republican plan, this plan they are talking about tonight, after the first $2,000 of prescription drug costs, you have to pay the rest up to $5,000. That is a gap of $3,000. Again, that would drive seniors into bankruptcy. The neediest, sickest seniors do not get the benefits when they need it, the consequence of doing prescription drug coverage on the cheap. Forty-eight percent of Medicare beneficiaries will fall into this gap. This is not a true prescription drug plan.

Second, this bill contains something called Medicare reform. That is another name for privatizing and destroying Medicare as we know it. Plans will have to compete. Medicare will compete against private plans and our seniors will be forced out of a plan that they have come to trust. This plan will not work, will not provide the benefits as a safety net for our seniors. I urge its rejection.

Mr. TAUZIN. Mr. Speaker, I yield myself 10 seconds to ask a question. If this plan funded at $400 billion is prescription drugs on the cheap, what do you call the $330 billion that was allotted by the Democratic budget for the year 2002?

☐ 2130

Mr. Speaker, I yield 3 minutes to the gentleman from North Carolina (Mr. BURR), the distinguished vice chairman of the Committee on Energy and Commerce.

Mr. BURR. Mr. Speaker, I am here tonight to thank the chairman of the Committee on Energy and Commerce and the gentleman from Michigan (Mr.

DINGELL), ranking member, our colleagues on the House Committee on Ways and Means, the leadership of the House for having the foresight to move forward with legislation to recognize that there is a problem in America, a problem that we have ignored for a decade, the need to add a prescription drug plan. I did not come here to argue with anybody. I came here because I believe we can do better. I believe we can do better than the bill we have proposed. I believe we can do better than the substitute that is offered.

America understands why we have not solved this because all they need to do is listen to us. We talk about each other's bills in a way that we point out things that we think are bad. We forget that we are talking about a population that has nothing. I wish we could have started with something smaller, but something that was targeted to people who are faced with the decision every day of do I buy drugs or do I buy food? But we have been convinced by this town that our only action has to be something comprehensive, something that includes everybody, something that includes those who have a minimal income and those who have an income of $1 million a year. We have not excluded anybody. We will not exclude them over here and we will not exclude them over here, because there are associations and groups that represent seniors, and they have never met those seniors, but we have.

Mr. Speaker, we owe our constituents more than to sit on this floor and tear up each other's legislation. We have to be for something. To get up here and debate that we are against this and we are against that and it is bad, it is inadequate is only a suggestion that we are not good enough to serve here, that they ought to look for replacements. I would challenge all of us.

I do not know what the outcome of tonight would be. I will vote no on both proposals that come up. I do not suggest on either side of the aisle that Members do that. That is what I am going to do. I have come to the conclusion, but never forget if we want a real solution to this, a real solution that affects real people, then we have got to put our heads together and work together and remember who it is that we are trying to provide for in this bill. I reluctantly say that I will vote against this.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, following the gentleman from North Carolina, my good friend, it is frustrating because I feel the same thing, that we were given a plan and even though we spent 3 days and a long night debating it in committee we did not really get to legislate because we really had a plan given to us and it was either take it or leave it. But this is the most important issue that we will consider this year not only for our seniors but for everyone. I know a lot of my colleagues feel that we should support any legislation because it is a step in the right direction or maybe it is like the Senate bill.

This is not the Senate bill. The Senate has a better idea. It is not as good as I would like, but it is better than what we have on the floor today.

This legislation would require Medicare to move to a competitive program by 2010. A lot of different terms are used to describe the model in this bill, whether it is called defined contribution, voucher, premium support, or something else, but it abolishes Medicare as we know it. The bottom line is it is privatization of Medicare. It will take the responsibility of providing meaningful, affordable, quality health insurance away from the government, like 1965, and shift the burden onto the shoulders of our seniors. The legislation relies entirely on private insurance plans to provide drug benefits for seniors. No government fall-back plan, no safety nets for seniors living in areas where drug plans do not offer coverage. It places blind faith in private drug plans that they will sign people up. That is the ultimate in faith-based policy making. There is a huge gap in this coverage that will disproportionately hurt individuals who need drug coverage. Those with the highest drug costs, they will fall into this doughnut hole. Once one has a little over $3,000 a year up to a little over $5,000, they fall in this hole.

I talked to a senior this evening who has a little over $300 a month in prescription drug cost. They will still pay their $35 plus a month, but they will not get one dime of benefits because they will be in this doughnut hole.

The ultimate anti-competitive part is that this bill prohibits the Secretary from negotiating lower drug costs. The VA does it, Medicare does it, private insurance does it, but we are prohibiting in this bill the Secretary of Health and Human Services to reduce costs for our seniors. That is why it is outrageous.

The substitute, on the other hand, is the kind of benefit that seniors support. It is affordable, comprehensive, and will actually help drive down the costs of prescription drugs.

Yes, it's more expensive than the base bill, but you cannot provide a prescription drug benefit on the cheap.

Finally, there's one issue that I'd like to raise about a provision that would limit the ability of physicians to refer patients to specialty hospitals in which they have a financial interest.

There is language in the Senate bill which could hurt some innovative practices that are occurring in specialty hospitals.

Patients need access to a broad range of facilities, and should be able to choose a hospital that has expertise in their specific health needs.

I know that some have suggested limiting the percentage profit that physicians can enjoy under these arrangements, or to limit the percentage of physician ownership and I hope that both sides can sit down and reach a solution to this problem.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Missouri (Ms. MCCARTHY).

Ms. MCCARTHY of Missouri. Mr. Speaker, the Republican Medicare bill fails to provide seniors with meaningful prescription drug coverage and is an attempt to end Medicare as we know it. With their plan seniors will have no assurance from 1 year to the next on what plan will be available to them, what drugs will cost them nor what doctors will serve them. Under their plan many seniors will have to pay a premium without receiving any assistance with their drug costs.

Seniors deserve affordable prescription drugs without gaps in coverage. Our seniors should not be forced to pay more to keep their choice of doctors. Not only would the plan before us limit or charge extra for choice, it would force seniors to go to a primary care physician before seeing a specialist.

The Republicans have produced a plan that fails to make prescription drugs more affordable and, disturbingly, ends the Medicare system that has been an irreplaceable safety net to millions of people for the past four decades. Instead they are creating a plan that costs seniors a lot and gives them very little.

Mr. Speaker, I urge my colleagues to oppose H.R. 1, the so-called Medicare Prescription Drug and Modernization Act of 2003, and to support the Democratic motion to recommit which will preserve Medicare and provide our seniors with the affordable prescription drugs they need.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. FERGUSON), one of our newer members on the Committee on Energy and Commerce.

Mr. FERGUSON. Mr. Speaker, I thank the chairman and ranking member and members of the committee who have worked so hard on this bill.

I rise in strong support of H.R. 1. It includes an amendment that I offered in the Committee on Energy and Commerce which will assist our most vulnerable seniors by allowing State drug spending to count towards a senior's catastrophic limit. Especially in States like New Jersey, this provision is going to dramatically reduce seniors' out-of-pocket spending while saving our States $5 billion.

About a year ago I stood in the well of this House when we debated the drug bill last year and I told the Members about my mom who has been battling cancer and who is only alive today by the grace of God and because she has had access to great medical care and the prescription drugs which have quite literally saved her life. I am proud that my State of New Jersey is home to thousands of researchers and scientists and companies which have spent their entire lives and billions of dollars on research to find the cures of tomorrow. This very day, today, they are working on finding the cures to cancers and diabetes and AIDS and Alzheimer's.

What are we here to do tonight? We are here to make these great products more affordable and more available to more people.

As much as I love my mom, her situation is not unique. She is like millions of other Americans who depend on prescription drugs for their quality of life. Our responsibility today is to pass this generous and responsible bill, to make the miracle cures of tomorrow available to people like my mom. Just as importantly, though, we have to do so in a way which values and encourages the incredible research and innovation which will create the cures of tomorrow because I do not only love my mom, but my wife and I love and treasure our three young children and it is they who will benefit as well because the lives of our children and our children's children will be better and stronger and more fulfilling because of the new cures that will be found and the fact that they will be affordable because of this plan. That is our charge. That is our responsibility. Let us pass this plan tonight.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Maryland (Mr. HOYER), the very able and respected minority whip.

Mr. HOYER. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, if truth in advertising applies to legislation, we would have a duty to warn America's seniors, beware, the Republicans' prescription drug bill could be hazardous to your health. This bill is nothing less than an historic betrayal of America's seniors. The GOP pretends that it is merely extending Medicare, but in fact the bill is the most dangerous attempt yet to dismantle the most popular health care program in history.

The Republicans fought the adoption of Medicare in 1965. Their majority leader said that Medicare should not exist in a free society. Yesterday the chairman of the Committee on Ways and Means, the architect of this bill, said on television, and the Members can read it here, "To those who say that [the bill] would end Medicare as we know it, our answer is we certainly hope so."

This bill would drive seniors out of Medicare and into the arms of private insurers. There is no guaranteed monthly premium. There is no defined benefit for seniors. There is no guaranteed access to drugs seniors must have. The only guarantee in this bill is that it would leave a huge gap in coverage. Seniors would pay a $250 deductible, $420 a year in premiums, and all costs between $2,000 and $5,100 in drug expenses. That is $3,100 left to seniors to pay. This bill even prohibits the government from negotiating lower drug prices for seniors.

In contrast, the Democratic substitute offered by the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL) would provide a prescription drug benefit that guarantees affordable, universal and voluntary Medicare coverage for prescription drugs. There are no gaps in coverage. Seniors would pay $25 a month, $100 deductible, and then 20 percent coinsurance. Their out-of-pocket expenses would be limited to $2,000 a year. That is 1,100 under the gap that exists in the Republican bill.

The Republican plan also does not give the Secretary of Health and Human Services the authority to negotiate prices. Our bill does. I would ask the Members to vote for this substitute which guarantees prescription drug coverage for seniors.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I am always happy to accommodate the gentleman from Louisiana (Mr. TAUZIN), my dear friend, even when he is pushing an outrageous piece of legislation under an appallingly constrictive rule.

Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Massachusetts (Mr. MARKEY), and I ask the chairman from the Committee on Energy and Commerce to listen closely.

Mr. MARKEY. Watch out, Grandma. Watch out, Grandpa. The GOP is selling snake oil off the back of a wagon, and, boy, do they have a prescription for you.

Mr. Speaker, every senior citizen gets a bottle with three bitter pills. Bitter pill number one is a lethal dose of privatization poison. The Republicans are diverting Medicare funds into private drug plans with no maximum premiums, no guaranteed coverage, and a cynical drive to destroy the Medicare program.

Bitter pill number two is a dose of crushing costs. Incredibly the Republican bill injects $400 billion into Medicare but spends it in such a tangled, convoluted, copay-riddled, incomprehensible, doughnut-hole-hollowed maze of bureaucracy and lacks any effective effort to keep prescription drug prices from continuing to soar, that Grandma is actually going to spend more under this proposal than if we had just left well enough alone.

□ 2145

Bitter pill number three is a privacy piracy pill in the form of income tax forms. The Republicans require senior citizens to hand over to corporations sensitive personal information from income tax returns and the most intimate details of their medical care as a condition of qualifying for any catastrophic coverage. This information will then be turned against seniors in marketing schemes intended to cherry-pick the most desirable recruits into private plans, further weakening the foundation of Medicare for the seniors who need it most.

This is a black day for Medicare. Mr. Speaker, GOP used to stand for Grand Old Party. Now it stands for Forget Old People.

Mr. TAUZIN. Mr. Speaker, now that we have heard from the doctor of showmanship, we are going to hear from a real OB-GYN doctor.

Mr. Speaker, I yield 2½ minutes to the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY. Mr. Speaker, I thank the gentleman from Louisiana for yielding me this time.

Mr. Speaker, as a physician Member of this body, I rise in strong support of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

I do not take lightly voting for a Federal program that expends $400 billion of the taxpayers' money. Being responsible with that money is a burden that I take very seriously. As appropriators of the people's revenue, we must assure that each dollar is spent wisely. That is a high hurdle, but I believe the Medicare Modernization Act clears that hurdle.

This act is an investment that brings Medicare into the 21st century. We will save money as we expand the focus of Medicare spending to include preventive care. Seniors who take the right drugs at the right time are more likely to stay healthy; and they are less likely to need expensive, prolonged hospitalizations, painful and complicated surgical procedures and, sometimes, yes, extended nursing home stays. For that reason, I do not think that this program will really cost $400 billion over 10 years. It will only cost that much if it does not work.

My experience as a physician for more than 28 years teaches that a prescription drug program for preventive care will pay dividends and increase health and a better quality of life. It is true what they say: an ounce of prevention is worth a pound of cure. And it is a lot less expensive.

This Congress has a great opportunity to expand the coverage for seniors, particularly our needy seniors, while, at the same time, strengthening the system so that it will be around to serve the baby boom generation as it moves into retirement. We will serve tomorrow's seniors as we are serving today's.

Some of our friends on the other side of the aisle insisted today that this bill could be the death of Medicare. They were even grandstanding around with black arm bands. That is interesting, Mr. Speaker, because their Democratic alternative would cost nearly $1 trillion, threatening to slam the entire Medicare system onto the rocks of financial insolvency long before 2030.

The plan that we will vote on tonight provides a good, strong benefit for our seniors; but just as important, it provides a sustainable benefit that will be there for future generations of seniors.

I encourage my colleagues on both sides of the aisle to bring Medicare into the 21st century. Vote for the Medicare Prescription Drug and Modernization Act tonight and deliver on your promise to our beloved seniors.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Ohio (Mr. STRICKLAND).

Mr. STRICKLAND. Mr. Speaker, I would just like to point out to my friend, the gentleman who just spoke, my understanding is that he voted recently to give $800 billion to about 200,000 people. Surely to God we can do a little better than that for our 40 million senior citizens.

Make no mistake about it. This bill will provide no stable, affordable prescription drug benefit for our seniors, but I will tell my colleagues what it will do. It will ultimately destroy Medicare's social insurance structure, a structure that has provided successful services to our seniors since 1965.

Let me give a clear example of how this bill will fail. The Republicans claim that premiums offered by the private plans will be about $35 a month. But there is no provision in this bill that will guarantee a $35 monthly premium or even a range of premiums near $35. Despite what we have heard, despite what we have heard, understand this: there is nothing in this bill to keep the private plans from charging any premium they choose to charge.

Now, in fact, Nevada is the only place this model has been tried; and in Nevada, the premiums were $85 a month. Furthermore, premiums will be different from State to State, from county to county, even from ZIP code to ZIP code.

Finally, private plans will be able to increase their premiums each year without any regulation, leaving seniors subject to the possibility of wildly fluctuating premiums.

Now, I offered a simple amendment in the Committee on Energy and Commerce last week that would have corrected this problem and guaranteed seniors a $35 monthly premium, regardless of which drug plan they chose to enroll in or where they lived. Every single Republican voted against that amendment. Last night, I asked the Committee on Rules. On a party line vote, they denied me the right to offer this amendment.

Republicans continue to say their bill will cost $35 a month. It is not true. They ought to stop saying it.

Mr. TAUZIN. Mr. Speaker, what is absolutely true is that 529,000 citizens of Ohio are given free coverage under this bill because they live under 135 percent of poverty.

Mr. Speaker, I yield 3 minutes to the gentleman from Rockwall, Texas (Mr. HALL), a Democrat and my dear friend.

Mr. HALL. Mr. Speaker, I rise in support of this bill because I am for a bill. I want to see a bill passed. I want a bill that can pass this House. I want a bill that can get to the conference committee. I want a bill that we can consider along with the Senate bill and get the best of both bills for the best people of this country.

Almost 40 years ago when I was in the Texas senate, Members of this Congress came to Texas, came to the Texas house and the senate, touting two great programs that they were going to introduce and pass. They named them Medicare and Medicaid. And they said by 1990, Medicare could cost $9 billion a year. And as I remember, they said Medicaid could cost almost $1 billion a year. They told us that we really needed to monitor the program closely or the costs could double.

Well, my colleagues know what has happened to the cost, what has happened to Medicaid and Medicare. There is an awful lot to do, and we need to be doing it.

There is no doubt that Medicare has helped millions of seniors escape dire poverty and live fuller lives. There is also no doubt that medical costs have far outstripped inflation due to a number of factors, including expansion of benefits, increased use, and coverage of the disabled population. Our seniors are staring into their pocketbooks to find the money they need for their care. We desperately need to do something to save a great program for people in their golden years.

Mr. Speaker, Medicare needs to be modernized to include a meaningful provision for drug coverage. In my lifetime, we have seen how prescription drugs have greatly improved and extended the lives of Americans. We have also seen how the cost of those life-providing drugs can trouble families every day. Unfortunately, Congress has almost been timid in seeking parity between the prices drug companies have charged domestic dispensers compared to the nondomestic dispensers just across our borders.

While American drug companies need added alliance for research and development, and I am willing to give them that, for 10 key drugs for seniors, Americans pay an average of 150 percent more for the drugs than Canadians. This is unacceptable. I do not like price controls. The marketplace provides the competition necessary to deliver the best price for the people in need. We have to lower the cost of prescription drugs, and my hope is that we can all work together, including drug companies, to come up with new, better, and more creative ways to achieve affordable prescription drugs.

As we look at introducing new competition among providers for services, we should consider provisions that respect the choices available to current Medicare beneficiaries. These seniors and the disabled have paid for and have come to expect a traditional Medicare system and the safety net that it provides them, and they should be able to retain their current plans if they continue to be pleased with them. The Senate improved upon this provision, and I hope that is included in the final bill.

The Senate and the House bills have good provisions to achieve our goal. Like many people, I am not completely satisfied with this bill, but I am very hopeful that we can pass a bill.

I am particularly pleased that we are introducing long-overdue Medicare reforms that will bring health care into the 21st century; namely—regulatory reforms and provider reimbursement issues. We are all aware that providers nationwide, including our rural providers, have been diminishing in the face of increasing costs and decreasing reimbursement. We simply must confront this issue because without access, the rest of the program is meaningless.

Like many people,I am not completely satisfied with this bill, but I am also not satisfied to see this program collapse. We are closer than we have ever been to making some meaningful reforms and providing a prescription drug benefit to seniors. I am hopeful that we will improve this bill in the conference committee as we seek to find a bipartisan solution to our common problem. This is just a first step in an ongoing process of reform to ensure that our seniors get the care that they deserve. Congress, through its oversight and yearly appropriations process, will continue to monitor the program—making necessary changes and improvements to guarantee healthy years for our Medicare population.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I thank my distinguished ranking member for yielding me this time.

Mr. Speaker, the Medicare bill before us is not a good bill. The coverage it provides is unreliable and insufficient. After a senior has used $2,000 in medications, they get no more help until they have spent another $2,900 out of pocket without help and while continuing to pay premiums. And that is only if a private plan chooses to come into their area. This bill turns Medicare into a voucher, handing it over to the insurance companies and forcing seniors to pay more. It reneges on a promise that we have made to America's seniors by ending Medicare as they know it.

In addition, the bill before us cuts cancer care by hundreds of millions of dollars, jeopardizing access to cancer care for seniors who face this dreaded diagnosis. If this bill passes, many cancer centers will close. Others will curtail their services, admit fewer patients, and lay off oncology nurses and critical support staff. This bill is supposed to make it easier for patients to get health care, but it will actually make it harder for cancer patients to get the care they need.

It is true that Medicare beneficiaries are paying too much for their oncology medications. We all agree we must fix this. But Medicare also pays way too little for essential oncology services, and so the overpayment for oncology drugs has been used to pay for treatments oncologists provide to cancer patients. We must fix both parts of this problem, but this bill still cuts hundreds of millions of dollars from cancer care. And it still risks the lives of cancer patients.

We will all go home after passing a Medicare bill, and we will face our constituents. I, for one, do not want to tell the cancer patients in my district that Congress has decided to curtail their treatment and endanger their care.

We can do better. We must. I urge my colleagues to vote against this bill.

Mr. TAUZIN. Mr. Speaker, I yield myself 10 seconds. I want to point out our bill provides 430 million new dollars to oncologists in America, twice that provided to any other specialist for nonpractice expenses, twice as much as any other specialist.

Mr. Speaker, I am pleased to yield 3 minutes to the distinguished gentleman from Texas (Mr. BARTON), the chairman of the Subcommittee on Energy of the Committee on Energy and Commerce.

Mr. BARTON of Texas. Mr. Speaker, first, I want to commend my chairman, the gentleman from Louisiana (Mr. TAUZIN), for his work in this noble effort, and I want to thank him for allowing the reform group that I have been a part of in his committee the opportunity to present an alternative and to try to make that a part of the package. I really appreciate that.

I would say to my friends on the Democratic side of the aisle, as they have talked about privatizing Medicare, that the first thing that we need to do is preserve Medicare. I would point out that if we do nothing to the existing Medicare program, the projections are that within the next 5 to 10 years, there will be no Medicare, because doctors and hospitals will opt out of the system because they are not able to be reimbursed adequately for the services they are providing.

So the first thing that we need to do is to preserve the current Medicare system, and the bill before us does that with such things as competitive bidding for durable medical equipment and other reforms.

The second thing I would like to point out is that we understand that seniors need a prescription drug benefit.

□ 2200

And my reform group was able to get into this bill a transition program that if this bill becomes law within 90 days of enactment, 17 million seniors in this country will begin to get a prescription drug benefit immediately. They will get a prescription drug card, and if they are low income those drug cards will have $800 of benefits on them; and if they are moderate income, they will have $500; and if they are upper income, they will have $100. Their families and employers can add money to those cards, up to $5,000, and within 90 days of enactment there will be a prescription drug benefit. Not 3 years from now, not 4 years from now but within 90 days. And that drug benefit will not require a deductible, and it will not require any paperwork. It will not have any doughnuts.

It will require a modest co-pay, but then you get your prescription drugs plus any discounts that the prescription drug benefit card allows you. And I think that is important that we as a country say to our senior citizens, not that we want to get old people but that we want to give our parents and our grandparents a break. We want to give them a benefit and we want to do it sooner rather than later.

I think the most important thing about this bill is that there is an acknowledgment and a guarantee that there will be a benefit, there will be a prescription drug benefit.

Now, we can debate and we will debate whether it is adequate or it needs to be more generous or whether it needs to be more universal or whether it needs to be more targeted to the people that need it the most, but the important step is we are giving the benefit, we are adding the benefit and we are doing it now. And our transition program will kick in within 90 days of enactment, no later than September of 2004. So I will vote for this bill and hope we can perfect it as we go through the process.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Pennsylvania (Mr. DOYLE).

Mr. DOYLE. Mr. Speaker, I represent Allegheny County, Pennsylvania, the second oldest county in the country. And this is indeed a sad day for seniors in Allegheny County because instead of providing our seniors with an affordable prescription drug plan under Medicare, instead, tonight we will give seniors a Medicare+Choice style drug plan.

Now, we all remember in Pennsylvania what Medicare+Choice is. That is the HMOs trying to provide Medicare, the same companies that left hundreds of thousands of Pennsylvanians high and dry, not only in my State but all across this country, when they pulled out of their plans.

This plan is nothing more than a huge subsidy to drug companies and will eventually lead to the privatization of Medicare. Do not just take our work for it. The AARP, which represents more senior citizens than any other organization in this country, says, The provisions that would establish a premium support structure beginning in 2010 could destabilize the traditional Medicare program and lead to much higher costs for beneficiaries. Rather than expand choice, this provision could limit choice by leading to a substantially higher cost for beneficiaries who want to stay in the traditional Medicare program. Those who choose not to enroll in private plans should not be put at a financial disadvantage.

The other part of this plan that I just find unbelievable right here in title VIII, section 801 is we prohibit the administrator of the program from negotiating better prices from the drug companies on behalf of taxpayers. We are going to spend $400 billion of taxpayers' money, and we always hear from our friends, let us run government like a business. Well, what business does not negotiate for more favorable prices? But not this plan.

Our government is prohibited from negotiating lower prices on behalf of senior citizens. I watch seniors in Pittsburg get on buses every month and drive to Canada to buy their drugs, because they cannot afford them in this country, for half the price of what they have to pay for in the United States. And now when we finally have an opportunity to take the buying power of all these senior citizens and negotiate more favorable prices from the drug companies, this bill specifically prohibits us from doing that.

Mr. Speaker, this is a bad bill. We should vote it down.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. BURNS).

Mr. BURNS. Mr. Speaker, I appreciate the chairman for yielding me time.

Mr. Speaker, we have a bill before us tonight that will improve and it will preserve Medicare. This bill will continue to provide seniors with fundamental health care they so desperately need but provide something more. It provides something that my constituents want and need in affordable prescription drug plan for all Americans and seniors.

Mr. Speaker, I am a co-sponsor of H.R. 1 for one simple reason: Because seniors in my home State of Georgia must have an improved Medicare system. They must have prescription drug coverage. They do not want excuses. They want action. They want it now. The time for stale ideas and old systems and gimmickry are over.

H.R. 1 is legislation we can support because it preserves a system our seniors know and love, while it addresses the issues of increased coverage and solvency of a program for baby boom generations. Make no mistake, we are far from finished in our efforts to fix our Nation's health care challenges, but this is the first step into a new world of advanced health care. Through H.R. 1, seniors in Georgia can decide the coverage plan that best fits their needs. Seniors in Georgia will be able to decide which prescription drug plan through Medicare is the best option. For those who have no coverage and pay exorbitant prices for their drugs out of their own pocket, these benefits are real. We are providing them with real savings and real choices.

Mr. Speaker, it is time for Congress to step up to the plate and ensure Medicare's future for all Americans.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maine (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, the Republican prescription drug bill transforms Medicare into Maybe care. Depending on where you live, maybe you get your traditional Medicare and maybe you do not. Depending on what plan you have, maybe you keep your doctor or maybe you do not. Depending on what year it is, maybe you keep a good package of benefits or maybe you pay very high prices for a low, low package of benefits.

And the Republicans are here tonight saying choices, choices, choices. We are giving America's seniors choice. Well, what kind of choice are they giving America's seniors? Well, not a choice of doctors and not a choice of hospitals. What they are saying is we are going to give you a choice of insurance plans. Well, no one in my State of Maine has ever come up to me and said, You know what I really want is not a choice of doctors or hospitals, I want to see different brochures, different insurance brochures. Please have some insurance agents call me and talk about their different plans.

What is happening in Maine, in the private sector with this wonderful competition for the employed market is every year 20 percent increases, 30 percent increases, higher payments, lower benefits. That is competition and choice and what the Republicans are saying is that is what America's seniors need. It is unbelievable. Every senior I talk to says we want lower prices. Please give us lower prices. We are buying from Canada. We are taking buses to Canada, and this bill prevents the administrator from negotiating lower prices for America's seniors.

This bill is never likely to work in my opinion, but if it did, you ought to follow the money. Who gains from this bill? The insurance companies will make millions, hundreds of millions of dollars. The pharmaceutical industry will be able to keep charging the highest prices in the world. America's seniors lose. You follow the money to the insurance companies and the pharmaceutical industry and you can tell who wins under this bill.

This bill is a nightmare for America's seniors. Reject this bill and support the Democratic substitute.

Mr. TAUZIN. Mr. Speaker, how much time remains on each side?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 8 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 14½ minutes remaining.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Louisiana (Mr. JOHN).

Mr. JOHN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I strongly support a drug benefit in Medicare. And in some aspects, the Democrats have won because it has not been that long ago, just a few short years, that the Republicans wanted to take a privatized outside-of-Medicare, a drug benefit. But now all of the debate is about it being a part of Medicare. So in that aspect, I think that we have won as Democrats. But I do believe that what they have done with this bill is continue to try to privatize Medicare and the benefits that are in it.

An entire generation of baby boomers are upon us, Mr. Speaker, and in just a few years away we are going to have to deal with this. Unfortunately, this bill falls short of what our seniors deserve as it has holes in it that the Republicans refuse to plug.

Perhaps the $174 billion bill that we passed just previous to this debate could have been used for the doughnut to be plugged. Efforts to fix this problem were denied us through the amendment process in this body on this debate. I offered amendments to try to bring some certainty with 2 years for our seniors to try to provide our rural ambulance services, our rural home health care and our rural doctors a fair reimbursement. In particular, I believe this bill falls short in addressing the needs of rural seniors and rural Americans. In fact, our previous experience should tell us that it has not worked. It is not profitable to offer plans to seniors in rural areas. In southwest Louisiana we have no Medicare+Choice plans.

I urge Members to vote against this, and I urge the other side to work, as the Senate did, in a bipartisan fashion to fashion a bill that our seniors can use.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Florida (Mr. DAVIS).

Mr. DAVIS of Florida. Mr. Speaker, one of the things that Democrats and Republicans ought to be able to agree upon tonight is that we owe our seniors truthfulness. We should be very clear and honest with them and ourselves as to exactly what is happening. Our failure to do so is a cardinal sin because it is ultimately to disrespect our seniors.

This bill offered by the House Republicans is based on a remarkable fixation with private insurance companies. Private insurance companies throughout the country in Washington have said once again they do not want the money that is being offered under this bill to write these private insurance plans.

The distinguished chairman of the committee's response to that is we will subsidize 99 percent of this cost as necessary to get private insurance companies to sell this benefit. How often in Washington, D.C. do you hear somebody turn down that type of money the government is offering them? Something is wrong with this plan.

I salute the Republicans on the committee who acknowledge they were concerned about whether private insurance companies would offer this benefit to seniors. Some of them are going to vote against the bill tonight based on that concern. A number of Democrats have said to those Republicans and others, we will work with you on a bill that fits within our budget constraints but let us have a traditional Medicare benefit that provides drug coverage.

What does this bill do? It does not set any maximum premium. It does not set any maximum deductible. It has a doughnut hole that almost 50 percent of seniors will experience after they have spent $2,000 on drug costs. During that time period they will be forced to pay a premium for basically nothing.

I would like to bring a chart up here to also show you just how complicated this plan will be that is being foisted on seniors. This represents a relatively detailed description of what this bill attempts to do.

Would somebody on the majority please explain to me how this bill works and how any senior at home, Democrat, Republican or Independent, is expected to understand how to use this drug benefit?

Mr. Speaker, I ask unanimous consent for 2 additional hours to explain the chart.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

Mr. TAUZIN. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. WHITFIELD), a distinguished member of the Committee on Energy and Commerce.

Mr. WHITFIELD. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, tonight is the culmination of 4 or 5 years of debate of a prescription drug benefit for our senior citizens here in America. I hear a lot of the criticism and I have heard it all day today about private insurance companies being involved in this program that we are submitting tonight. Yet, I would remind those on the other side of the aisle that private insurance companies are involved in Medicare as it exists today and has been for some time because it is the private companies that are responsible for the reimbursement of our health care.

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So private companies are already very much involved in our Medicare system today.

I would also say, what benefit are seniors going to get from this program? First of all, if they are 135 percent of the poverty level and below, and I can tell my colleagues, in my district that is about 60 percent of them, they are not going to have to pay anything. The government's going to pay their premium for them. The only thing that they will have to pay is a $2 small copay for a generic drug and a $5 copay for a name-brand drug. What is wrong with a program that provides free medicines for seniors who today cannot get them?

I would also say that in addition to that tremendous benefit, and we provide catastrophic coverage for them as well, but in addition to that tremendous benefit, we have a rural health package in this bill that is going to help rural America, rural health providers. It is going to provide $27 billion over 10 years for our rural areas, and the disproportionate share payment for our rural hospitals, children's hospitals around the country, urban hospitals that treat our citizens on Medicaid, our hospitals over the next 10 years are going to get $3.8 billion for those who treat the neediest in our society.

This is a program that we should all be supporting, and certainly we should not support the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Ms. SOLIS).

Ms. SOLIS. Mr. Speaker, I thank our ranking member for yielding me the time.

I rise tonight in opposition to this bill. We have heard a lot tonight about how this bill is going to help our seniors from the other side of the aisle. Well, I want to talk about the seniors that I represent in my hometown in the San Gabriel Valley in East Los Angeles, California.

In my congressional district, I represent nearly 6,000, 6,000 seniors in poverty, making less than $11,000 a year. For them the cost of prescription drugs is so overwhelming that they often have to forgo between paying their medicine or having a meal or paying a phone bill. That is what it means to seniors in my district.

This is a choice that no senior citizen should have to make. Yet the Republican bill does nothing to reduce the cost of prescription drugs. It does not allow us to use the purchasing power of Medicare beneficiaries to negotiate lower drug prices. How ironic, just like we do for the Veterans Administration.

So what do we tell Grandma, living alone on a fixed income who cannot afford her medicine? Sorry, but Medicare has a new drug benefit, but it is not for you? Sorry, but Medicare is raising part B deductibles by eight times as much as our Social Security cost-of-living increase?

Only the Democratic alternative that we will debate later on tonight will do what I think my senior citizens want to hear, and it will provide them with the guaranteed, affordable, easy-to-use drug benefit that is part of Medicare.

Let us be clear tonight. For our seniors, for our grandmothers, our uncles, our fathers and our mothers, there is only one thing to talk about tonight and it is about medicine. This should not be about privatization or insurance companies or anything else. Let us give our senior citizens the help they need to pay for that medicine.

Let us oppose this proposal being put forward tonight by the Republicans and support the Democratic prescription drug bill.

Mr. TAUZIN. Mr. Speaker, how much time remains on each side?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 6 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 8½ minutes remaining.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I thank the distinguished gentleman from Michigan for yielding me the time, and I appreciate his leadership on this and all other matters before this House.

Mr. Speaker, one thing we understand is the Republicans are in the majority. They are in charge. You can do whatever you want to do. You have got the Senate. You have got the White House. Now, you may talk more trash than a $3 radio, but you are in charge.

The difference in these two plans is very simple. The Democrats would offer you the best plan, the best price, and we will pay 80 percent and let the patient, the Medicare beneficiary, pay 20 percent. The Republicans only, on the other hand, will allow the pharmaceutical companies, by law, statutorily, to continue to rob our senior citizens, charge them the highest price and let them pay 80 percent; and they will pay 20 percent of the bill, if you are lucky enough to live long enough.

They come to the floor repeatedly this evening and talk about this bill is not perfect. Boy, you have got that right. I will agree with you on that one.

They say it is historic, and they are right. Never before in the history of this Republic has there been such an outrageous attempt to provide the ability to insurance companies, as if they needed any help, to rob and deceive and cheat our senior citizens. Never before have they been presented with an opportunity, the pharmaceutical companies, to cheat and continue to rob our senior citizens.

It is indeed historic by their own admission. The chairman of the Committee on Ways and Means says we want to end Medicare as you know it. I suggest you all get you a buckeye. It will bring you good luck and keep rheumatism away. That is all you are going to get through this Medicare program.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I thank the chairman for yielding me the time, and certainly I want to acknowledge the great leadership of our chairman and the gentleman from Texas (Mr. BARTON), as well, who proposed the prescription drug card.

I rise tonight to support H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

Mr. Speaker, this debate is about taking care of America. This debate is about making a guarantee to senior citizens that they will have access to quality medical care which includes prescription drugs. This debate is about ensuring the future of Medicare. This debate is about delivering better outcomes at lower cost.

H.R. 1 is a strong solution to these serious problems. Providing prescription drugs for America's seniors is the right thing to do. I cannot picture what medicine would look like today if pharmaceuticals were not an available treatment option. Physicians and other providers would have no option but to resort to seriously invasive treatments when confronted with acute medical conditions.

There is no doubt that Americans have benefited from the development of new and innovative medicines. New drugs can improve and extend lives. New drugs exist that can dramatically reduce cholesterol, fight cancer, alleviate debilitating arthritis.

An entirely new class of medicines, collectively known as selective estrogen receptor modulators, are available for reducing breast cancer mortality rates, and one day may see an expanded role in preventing this disease.

Unfortunately, Medicare has been deeply rooted in the medicine of 1965, not the medicine of today; and this has negatively impacted the health of our senior citizens.

Tonight, the House of Representatives will take a bold step to improve the lives of senior citizens. Not only will seniors have greater access to prescription drugs, but built-in reforms will hold down the cost of these medications.

In a report released today by Secretary Tommy Thompson, seniors will save substantially through upfront drug discounts under the House plan. The Medicare actuary estimates seniors will see an immediate savings of 25 percent off their current prescription drug costs.

On the other side of the aisle, those who were wearing the arm bands earlier today, where were those arm bands in 1998 and 1999? Where were those arm bands when that administration refused to even open the book and look at the Medicare commission, bipartisan commission?

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Michigan (Ms. KILPATRICK).

Ms. KILPATRICK. Mr. Speaker, I thank the ranking member for yielding me the time in this most difficult discussion, but what a sham we have today for our seniors of America who built this country. Not only do you not have a prescription drug benefit, but this one you will not get till 2006, if you get it at all. It will privatize Medicare by the year 2010.

What most people want in America, including seniors, is to contain the high costs of prescription drugs. This bill prohibits the Secretary of Health and Human Services from negotiating lower prices for prescription drugs. That in itself is enough to say vote "no" on this bill. What a sham for the seniors who built this country.

This plan will destroy the retirement benefits that companies in my district like General Motors, like Daimler Chrysler already are giving to their retirees. This plan is a disincentive for them to keep giving that. Vote "no" on this plan. It is unfortunate I do not have any more time. Vote "no."

Mr. Speaker, I rise today to express my disappointment and opposition to H.R. 1. We, in Congress, over the last few years, have repeatedly pledged to provide seniors with the prescription drug coverage they so desperately need—and deserve. My Republican colleagues have touted this day as a "historical day." Unfortunately, for Democrats, who support a meaningful, universal, and comprehensive drug plan under Medicare, this day is not a "historical day" in the positive sense but a day when we failed on our promise to come through for our seniors. What this bill does do is afford the Republicans the ability to say to seniors, "We came through on our pledge." Unfortunately, their rhetoric does not match up to the emptiness that will be felt in our seniors' pocketbooks. Nor does it match up in providing seniors with real choice and a meaningful, comprehensive prescription drug program.

The GOP Prescription Drug Plan is a flawed plan, period. It would put the power in the hands of private insurers—those same insurers who have abandoned seniors in providing essential health care services in the past. Why our Republican colleagues want to give even more power to HMOs and private insurers is a question I cannot answer. However, the consequences of such actions will be felt by the most vulnerable in our society.

The majority of seniors across our nation live on fixed monthly incomes. With so many seniors today living longer, this also means that they need to save as much money as they can to ensure their survival over the years. They cannot afford to pay exorbitant costs for their drugs. Moreover, seniors need security. What they do not need is to be forced into private managed care plans that are able to opt-out of coverage for seniors at their free will. Seniors deserve better—they deserve a universal, comprehensive, affordable, and meaningful drug plan under Medicare.

The House Republican prescription drug bill is even worse than the one considered by Congress last year and goes much further in privatizing Medicare. Seniors would need to use private insurance companies for drug coverage and these private insurance companies and managed care plans would design the new prescription drug plans. These insurance plans would also need to commit to the program for only one year. What does this mean? It means that seniors can be dropped from their plan year-to-year. They would have to change their plan, their doctor, and the drugs they take every 12 months. This puts seniors at the mercy of private insurance companies, rather than giving them an option that provides them with the security and stability they need. Seniors do not want to be forced into an HMO. In fact, 72 percent of seniors polled say they do not want to be forced into getting coverage through an HMO. We need to listen to those we are trying to serve.

The GOP plan also receives an "F" on the affordability scale. Under their plan, seniors would be required to pay high premiums even if they are not receiving coverage. The Republican plan would deny assistance to those seniors with drug costs between $2,000 and $4,900. Nearly half of Medicare beneficiaries would fall into this "coverage gap" every year; however, they would still be expected to pay the monthly premium. Seniors would be asked to continue paying for a service they are not receiving—a service that does not honor seniors with meaningful support in the first place.

Another glitch in the Republican bill is its inability to deal with the underlying problem—the rising costs of prescription drugs. Seniors want help in curbing the increasing costs of prescription drugs. In fact, seniors prefer cost control measures by a vote of two to one. While seniors want help in purchasing their medicines, they also want solutions in curbing the rising costs. The Republican bill does not do this. It neglects to include an important provision supported by Democrats to provide the Secretary of Health and Human Services with the authority to negotiate for lower prices like the Veterans' Administration has done. Including cost-control provisions is the right and responsible thing to do; however, our Republican friends do not see the benefit of this. How unfortunate.

The Democratic Substitute, which I proudly support, is the coverage that will fulfill our pledge to seniors. It provides them with real assistance within Medicare and includes provisions to curb the high cost of prescription drugs. Seniors do not need to worry about paying more in the future if they decide to stay in the traditional Medicare program. They do need to worry about this with the Republican bill, since the "competitive bidding" provision would force seniors to pay more for their prescription drugs than they do now. Seniors want a plan that is straight up, no-nonsense, and significant. That is what Democrats have provided in the substitute measure.

I want to do right by the seniors in my district and for seniors all across the nation who are struggling to pay for the prescription drugs they need to live fulfilling and healthy lives. H.R. 1 was constructed with the interests of pharmaceutical companies and private insurance companies at heart. The voice of seniors was nothing but a faint echo in the rooms where this bill was constructed and their best interests have been left in the dust. For these reasons, I vote against passage of H.R. 1. We need to safeguard our nation's seniors, not private insurance companies.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. Mr. Speaker, I really suggest that the other side go to see the movie, it is an old movie, "Thelma and Louise." Thelma turns to Louise and says, "Do not settle, Louise."

You have settled. You blew it. In fact, the seniors already are angry. The plan does not even go into effect until 2006. Why are they angry? They are angry because this is a question of values. Just when you need it most, the plan ends.

The second reason why they are angry is you are going to force them into HMOs. Look what happened in New Jersey on Medicare+Choice. Now you are going to call it Medicare plus advantage. Bill Safire would have a picnic on this.

This is a joke and a sham, and you know it. Look at that record that you have provided, that we provided, all of us in the State of New Jersey, where they lost 100,000 people. What we are going to do, as the gentleman from Pennsylvania said just a few moments ago, is subsidize insurance plans. That is what we are going to do.

The third reason why they are ticked off is that there is no control over prices. Boy, are they angry. You blew it.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from California (Ms. WATERS).

Ms. WATERS. Mr. Speaker, last night we debated the Homeland Security appropriations bill. The Republicans made excuses about not spending enough money to truly secure our homeland. Tonight, the Republicans are crying broke and claiming we do not have enough money to fund credible prescription drug coverage for our seniors.

This bill provides no coverage when a senior's prescription drug costs are between $2,000 and $4,900 per year. This huge coverage gap affects 47 percent of Medicare beneficiaries.

This bill is also a giveaway to pharmaceutical companies, as it prohibits the Secretary of Health and Human Services from negotiating lower drug prices. The primary beneficiaries of this bill are not the beneficiaries of Medicare. They are the wealthy special interests and the pharmaceutical industry and the insurance industry that give huge campaign contributions to the Republicans.

Mr. Speaker, the Republicans have given huge tax cuts to the wealthy, promised the Iraqis a universal health care plan. They are spending millions attempting to buy the loyalty of warlords in Afghanistan, and the President just gave Musharraf $3 billion.

Seniors, call your Republican Members and ask them why they do not take care of the seniors of this country.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the gentleman from Arkansas (Mr. ROSS).

Mr. ROSS. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL), the ranking member, for yielding me the time.

As the owner of a small-town family pharmacy, I got sick and tired of seeing seniors who could not afford their medicine or could not afford to take it properly. That is why back in 2000 I decided to run for the United States House of Representatives.

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But tonight, what we are debating is nothing more than a false promise for our seniors. Seniors need an accountant to figure out this plan.

I put a calculator to it, and here is what the Republican national leadership plan offers our seniors. Seniors will pay the first $2,520 of the first $3,500 worth of medicine they need every year. Now, let us contrast that a moment to a health care plan provided for Members of Congress, those who wrote this plan. Guess what they pay? Seven hundred dollars of the first $3,500 worth of medicine.

They want to provide seniors with little help while continuing to take care of Members of Congress. It is simply wrong. This is not a seniors bill, this is a bill written by the big drug manufacturers for one reason only. To privatize Medicare. To privatize Medicare so that Medicare cannot command discounts.

Mr. DINGELL. Mr. Speaker, I would inform the gentleman from Louisiana at this time that I have one speaker remaining.

Mr. TAUZIN. Mr. Speaker, who has the right to close?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana has the right to close.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time and the right to close.

Mr. DINGELL. Mr. Speaker, I yield the balance of my time to the distinguished gentlewoman from California (Ms. PELOSI), the minority leader, to close.

Ms. PELOSI. Mr. Speaker, I thank the distinguished gentleman from Michigan for yielding me this time and for his tremendous leadership. He has been fighting this fight for America's seniors for access to quality health care for all Americans and an affordable prescription drug benefit for America's seniors. We are all in your debt.

Mr. Speaker, today is a sad day for America's seniors. Another sad day, late at night in the Chamber of the House of Representatives, where the budget priorities of our country should be debated to their fullest extent, but where the limitation on time is placed so that the American people can never really get the full story. This prescription drug benefit bill discussion is an historic occasion for our country because it does indeed, it does indeed give us the opportunity to expand Medicare to provide a guaranteed affordable defined benefit for our seniors. The Senate has taken up the bill for the past 2 weeks. They have considered 30 amendments to the bill. Thirty amendments. The House is considering the bill this evening with no opportunity for amendment.

I do want to commend the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL), the ranking member on the Committee on Ways and Means, for the proposal that they will be putting forth tonight, which is a real prescription drug benefit for seniors. I commend the gentleman from California (Mr. DOOLEY) for his limited opportunity but great product that he put forth on the previous question on the rule earlier. Another excellent proposal. And I commend the Blue Dogs, the gentleman from California (Mr. THOMPSON) and the gentleman from Arkansas (Mr. BERRY), for their hard work on our motion to recommit, which we hope will be allowed on the floor tonight.

Any one of these would be far superior to the proposal that is being put forth by the Republicans today. Why it is so sad is because we are supposed to honor our parents. Our senior citizens built our country. They raised our families, the backbone of America. They fought our wars. Some of them are part of the greatest generation. Some of them lived through the New Deal, many of them the Fair Deal, and tonight they are getting a raw deal. What makes it so sad is that we had the opportunity to do it right, and one of those opportunities we will hear about next, the Dingell-Rangel/Rangel-Dingell Democratic proposal, of which we are very proud.

Nearly 40 years ago, when Medicare came into existence, it came at a time when many, many seniors had no access to health care, and now almost every senior in America has access to quality health care. At the time, there was no prescription drug benefit included in the package. That was unfortunate. Today, it is imperative that we have a prescription drug benefit in the package. The advances to science have been so miraculous. Seniors today, if they have a prescription drug benefit, would be able to self-administer drugs, which would not only be an adjunct to physician or hospital care but be a supplement for it. It would be a substitute for it.

So think of what it means to the quality of life for our seniors in order for them to have that independence and to be able to know that it is guaranteed, defined, and dependable. Think of what it means to the taxpayer in the reduction of cost in medical services to seniors because they can have access to prescription drug benefits. That is what makes this such a tragedy. It makes it such a tragedy.

So tonight, instead of honoring our parents and our seniors, we are foisting a hoax upon them, at least the Republicans are. And a cruel hoax it is indeed. In doing so, the Republicans insult the intelligence, they insult the intelligence of America's seniors. Many of you are blessed to still have your parents with you, and some of us are even bordering on being seniors ourselves, but any of you who have your parents or dear relatives who are older know that they are into stats. They know their statistics. They know their blood count, they know their blood pressure, they know their bank account balance, they know the cost of everything, many of them, because many of them are on fixed incomes and the slightest change has an impact on their economic security.

So I want those seniors who are so sensitive to changes in cost to take a look at this chart, which was in the New York Times this morning, and it says, "Under House GOP Bill Seniors' Out-of-pocket Drug Costs Remain Staggering." Remain staggering. The average cost that seniors will pay in drug costs in 2006 is reported to be $3,155. So let us take the $3,000 line for the Republican hoax on seniors. If the beneficiary's annual drug costs are $3,000, seniors out there, if you are paying about $3,000, under the House bill your deductible will be $250. Your premium will be $420. The share of initial coverage is $350. Gap in coverage, here is where you fall into the gap, $1,000.

So of that $3,000 worth of drug cost, you, America's seniors, will be paying $2,020 out-of-pocket. Where is the benefit? And this is the best case scenario. These prices that you see here are suggestions to the HMOs. The prices could be much more, and your out-of-pocket cost could be much more.

I do not know how many of you think the hole is the most delicious part of the donut, but seniors, when they fall into this donut hole where they get no coverage, they still pay the premium. They are paying a premium for something that is not there. It is not there. And of course, if they pay $4,500 in drug costs, they are paying $3,520 out-of-pocket. A cruel hoax on America's seniors. And they call that modernization. I call it humiliation. I call that insulting the intelligence of America's seniors.

It was interesting, in this same article today one senior who was quoted on the subject said, "Do you think anybody in Washington, D.C. has any idea what people on a limited income have to do to live?" Clearly, the Republicans do not. They are just too busy giving the biggest tax breaks to the highest-end people in our country. They are just too busy giving those tax breaks that they cannot write a decent prescription drug benefit for seniors.

In fact, I might add seniors and children. Where, oh where did the child tax credit go in all of this, as we adjourn tomorrow? Tax cuts instead of child tax credits. Tax cuts instead of prescription drug benefits. At the beginning of life; toward the end of life. It is a cruel hoax.

And so, my colleagues, no matter what the Republicans tell you about their bill, the euphemism that it is a modernization of Medicare is really a laugh. It is an elimination of Medicare. Because no matter what they tell you, the facts are these: The Republicans do not provide a guaranteed defined benefit for seniors. The Republican bill does not reduce the high cost of prescription drugs.

Indeed, the hardest to explain to anyone is that the bill prohibits the Secretary of Health and Human Services from negotiating for best prices. I repeat: Not only does the bill not bring down the cost of drugs, it prohibits the Secretary of HHS from negotiating for the best prices. Every business in America, indeed the VA, does that. Volume gives you leverage; gives you opportunity. Except in this bill it is prohibited.

And at this point I want to say that the proposal put forth by the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL), the cost of it would be cut in half, cut in half, if the Secretary had the authority, which our bill calls for, and indeed took that responsibility to negotiate for best prices.

What the bill does also, instead of modernizing Medicare, is to unravel not only Medicare, and I hope seniors are listening, not only the prescription drug benefit, but part A and part B along with the prescription drug benefit, forcing seniors to compete and pay more to stay in Medicare, the Medicare they know and trust. I repeat: When this bill, in 2010, comes to fruition, seniors will have to pay more to stay in Medicare for part A, part B, and prescription drug benefits.

And this is really a sad one in their bill. The employer piece. The employer piece. There are many businesses in America who honor their responsibility to their retirees. The CBO, the Congressional Budget Office, estimates that under the Republican bill one-third of all retirees who get their benefits from their employers will lose their coverage. Millions of seniors will be worse off.

So that is why I say this is really a tragedy. It is a missed opportunity. It could be so good. It could be bipartisan. It could be what seniors expect and deserve. Democrats have a better idea. The Rangel-Dingell/Dingell-Rangel proposal, the two distinguished gentlemen who have spent a lifetime in public policy promoting access to quality health care, whose credentials are impeccable in this regard, they support Medicare. They have promoted a bill that is worthy of the seniors whom we respect. It is a guaranteed defined benefit under Medicare. It does give the authority to the Secretary to negotiate for best prices. It protects seniors' options in terms of their employers giving them benefits; not making millions of seniors be worse off.

America's seniors deserve a benefit that is affordable, with reasonable premiums and deductibles. America's seniors deserve a benefit that is available to all seniors and disabled Americans, including Americans in rural areas.

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Ms. PELOSI. Mr. Speaker, the Democratic plan does just that. This Republican bill, I repeat, is not guaranteed. It is not affordable. It is not a defined prescription drug benefit under Medicare that our seniors want and deserve. The Republican plan is a plan to end Medicare. I urge my colleagues to reject this raw deal for America's seniors and vote no on the Republican bill and yes on the very excellent Democratic proposal.

Mr. TAUZIN. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, when we test the arguments made on the floor of the House on a major piece of legislation such as this, it is important to test the credibility of those arguments. The best way to test that credibility is to first of all tell Members a fairy tale.

Once upon a time Bill Clinton proposed Medicare prescription drug coverage for America. Once upon a time my Democratic friends, the gentleman from California (Mr. STARK), the gentleman from Michigan (Mr. DINGELL), the gentleman from California (Mr. WAXMAN), the gentleman from New York (Mr. RANGEL), the gentleman from Ohio (Mr. BROWN), and many others introduced a bill, H.R. 1495.

Once upon a time Democrats recommended a bill with a $200 deductible, 80 percent cost sharing by the government up to $1,700 of drug expenses, a doughnut hole, and then $3,000 out-of-pocket catastrophic coverage with no defined premium. And guess what, once upon a time their bill provided that the benefits would be provided through a PBM. Members might ask how would the PBM be selected: By competitive bidding.

Members might further ask how would the contracts be awarded under this privatization of Medicare, and the answer in a fairy tale world would be shared risk capitation of performance. But the truth is this is not a fairy tale. It happens to be the truth. That was the Democratic proposal on Medicare prescription drugs, but tonight Democrats have come to the floor one after the other and criticized this plan because it contained many of those same features. Different, however, in some respects because this plan provides better coverage for seniors on the bottom. In fact, while some of my friends came to the floor and called this a sad day and said how sorry they were for the citizens of California, this bill we proposed would put 1.4 million California senior citizens in plans that would cost them no premiums, no deductibles, free entry for drugs in California for 1.4 million senior citizens, half a million in Indiana, half a million in Ohio, half a million in Pennsylvania, almost a million in Texas, and so on and so forth, free drug coverage under this plan, and yet the fantasy plan offered by the Clinton administration just a few years ago containing many of the same elements is somehow forgotten. It is somehow put away in a closet. It is somehow not to be remembered, and this plan is to be attacked. When we test credibility of arguments on the floor of the House, test them against the reality of the plan offered by the Democrats and the reality of the plan offered today.

I want to thank the gentleman from Michigan (Mr. DINGELL) for the courtesies and the respect and the statesmanship he has always shown me in debates in committee and on the floor of the House. The gentleman is a dear friend. I wish I could say that about all Members all the time. But let me say something. I am offended that anyone would come to this floor and accuse anyone in this House of wanting to get old people. Do Members think for a second they love their moms and dads any more than we love ours?

I ask the gentleman from California (Mr. STARK), do you really believe that? God bless them. That is the sort of unstatesmanship that should never enter the halls of this House.

There is nobody in this House that loves their mother more than I love my mother. I challenge Members on that. She is a three-time cancer survivor, she is 84 years old, and she won first place at the Senior Olympics this year in shotput, and if you give her trouble, I will sic her on you.

There are Members who have come to the floor and said seniors cannot understand choice. Let me tell Members something, I grew up in a poverty family. My mom and dad never earned above poverty. They made hard choices all their life for us. They sent three out of their four children to college. They fed and clothed us and gave us a great education and a chance for me to come to Congress. I love that woman and I loved my dad as long as I had him. How dare anyone suggest otherwise. We love our parents and grandparents the same.

We differ on how to structure this program today. Apparently we did not a few years ago, but we do now. That is a legitimate debate and that is worthy of this House, but to suggest that any of us care less about old people, to suggest that any of us love those citizens who gave so much and made those hard choices for us any less than we do is a shame. My parents made hard choices. My mother knows how to make hard choices. If we give her choices, she will make the right ones, just like she did all her life. I trust her and I trust seniors in America. We are going to give them drug coverage in Medicare and we are going to give them other choices, too, if they want to make those choices. And if Members do not want to help us do it today, I suggest in a month from now when the conference committee report is back after a compromise with the Senate, you might want to join us then.

Mr. ISTOOK. Mr. Speaker, this bill will hasten the day when Medicare will go bankrupt, and it also threatens to unravel our children's future.

Medicare is already on shaky financial legs, and this will add enormous extra expenses that will make it worse. Do we expect our children to pay a lifetime of higher taxes, and still find there's nothing left for them when they retire? That is what we face.

I would like to add prescription drug benefits, but it's wrong to promise something we cannot pay for.

I want to preserve what's good about Medicare, not destroy it by making extravagant promises for political gain.

The enormous extra spending under this bill will be far more than projected. Because today's Medicare is a huge price control system, many doctors already refuse to see Medicare patients. In just a few years this will make it worse, including price controls that will destroy the incentives for companies to create new medicines.

What should we be doing?

Since 76 percent of seniors already have drug coverage, we could focus on helping those who don't. But this bill undoes the coverage for those 76 percent, and puts them in a confusing new medical experiment.

We should be stabilizing Medicare, so it can keep the promises already made, not making new promises that we don't have the money to keep.

We should address the reasons why drug prices and healthcare costs are so high. By banning re-imported drugs, we're forcing Americans to subsidize far lower drug prices in other countries. We should change our policies so Americans only pay the lower world price, not a higher price.

We should end the 130,000 pages of federal regulations that have driven the costs of medicine and healthcare through the roof. On average, for every hour they spend with a patient, doctors and nurses spend another half-hour doing government paperwork.

We should stress personal responsibility in healthcare, just as we did in welfare reform, so government resources are focused on those who cannot care for themselves, not on those who can.

Bit by bit, Congress is undoing the principles of welfare reform and undercutting basic American principles in the process. Both political parties are making extravagant promises today, trying to outbid each other to win votes. Unfortunately, they are bidding with taxpayers' own money, and our children's hopes will be crushed by the bills they will inherit.

Mr. UDALL of New Mexico. Mr. Speaker, for far too long, as I traveled around the state of New Mexico, seniors have told me their heartbreaking stories of being forced to choose between purchasing their medicine and purchasing groceries as a result of the exploding costs of prescription drugs. Today we have an excellent opportunity to address this tragic situation by providing a prescription drug benefit for Medicare beneficiaries and put an end to the outrageous dilemma facing our seniors throughout the country. In addition, we have an historic opportunity to modernize the incredibly important Medicare program, including updating formulas for our health care providers in rural areas—an issue that is of particular importance to my constituents and me.

Thankfully, H.R. 1 does address the latter concern, but unfortunately falls far short on the critically important issue of prescription drug coverage. The prescription drug benefit provided under H.R. 1 would be the first step toward privatizing one of the most successful government programs in history, leaves seniors at the mercy of insurance companies, forces seniors into HMOs, has an incredible gap in coverage, and does nothing to control the exploding costs of prescription drugs. As such, I am forced to vote against H.R. 1.

Under this bill, seniors and disabled Medicare beneficiaries can obtain their prescription drug coverage only from HMOs and private insurance companies. Given the history of HMOs and other private health plans in rural areas, I have serious concerns about this approach. In fact, in 1997 in the state of New Mexico, HMOs dropped approximately 18,000 individuals because of rising costs. These individuals were left with nowhere to turn.

H.R. 1 would put beneficiaries at a similar risk by relying on untested private drug-only plans, which can decide whether or not to serve rural areas, and they can decide to leave every 12 months. Further contributing to the risk of this provision is the fact that there is no fallback option to allow traditional Medicare to provide prescription drug coverage if private plans decline to provide coverage in rural areas. Because much of my district is rural, this legislation would put the seniors in my district at particular risk. I cannot support this.

This is greatly disappointing to me given the several major rural healthcare provisions that are included in this legislation. The labor share revision, the geographic physician payment adjustment, equalizing the Medicare disproportionate share payments, increasing home health services furnished in rural areas, critical access hospital improvements—these are all incredibly important provisions that I strongly support in order to help strengthen the health care system in rural areas. I cannot, however, vote in support of H.R. 1 with the extremely flawed prescription drug benefit included with these strong rural health provisions.

Mr. Speaker, I strongly support adding a voluntary prescription drug benefit to Medicare. I strongly believe that we must take action to provide relief for our nation's seniors. I simply do not believe, however, that H.R. 1 is the most effective way to do so. Tonight I will be voting in support of the substitute being offered by Mr. RANGEL and Mr. DINGELL.

In addition to including stronger rural provisions than those included in the Majority's bill, the substitute includes a guaranteed benefit of a $25 premium, a $100 deductible, 20% co-insurance, and a $2,000 catastrophic protection. The substitute also allows for lower drug prices by granting the Secretary of Health and Human Services the authority to use the collective purchasing power of Medicare's 40 million beneficiaries to negotiate lower drug prices. Also, the substitute grants access to generic drugs, and allows the safe re-importation of pharmaceuticals, providing further tools to seniors for gaining access to cheaper prescription drugs.

Perhaps most importantly, the substitute will not force seniors to leave traditional Medicare to get drug coverage. Nor will they be forced to join a private insurance plan that will restrict access to needed drugs, deny coverage for the medicine their doctor prescribes, or force them to change pharmacies.

Mr. Speaker, our seniors deserve a real prescription drug benefit, not the flawed benefit included in H.R. 1. I urge my colleagues to vote against H.R. 1 and support the substitute. Our seniors should not be forced into the unconscionable position of being forced to choose between medications and groceries any longer, and, unfortunately, H.R. 1 will not adequately address this situation.

Mr. SHAYS. Mr. Speaker, I rise in support of H.R. 1, the Medicare Modernization and Prescription Drug Act. I want to begin by appreciating the incredible time and energy that my colleague, NANCY JOHNSON, has put into crafting what I consider to be a good product, and thank her for her efforts.

When Medicare was created in 1965, the program's principal purpose was to help seniors pay for their hospital costs. Since that time, Medicare has not kept pace with how health care is delivered. Today, we are bringing this program into the 21st Century by including coverage for prescription drugs.

Our seniors need and deserve prescription drug coverage under Medicare. This legislation will give them tremendous assistance. After a $250 deductible, seniors will get 80 percent of their first $2,000 paid for by the program, catastrophic protection from any cost over $3,700, and a discount on all their pharmaceutical costs from an Rx Drug Discount Card. The card will save beneficiaries between 10 and 25 percent on every purchase.

I believe this bill takes a positive step towards injecting competition into Medicare, but I regret we did not go further in reforming the program to ensure its solvency for future generations.

I also believe anything free, even health care, is overutilized. I support the House proposal to add a small co-payment to home health care and to index Part B deductibles to inflation, and I support the Senate proposal to have seniors pay a portion of their catastrophic costs. This way, seniors have a greater incentive to get care because they need it, not just because it is offered.

Finally, we must be concerned with what this program will ultimately cost. It could go well over the $400 billion we budgeted and accelerate the program's financial demise if we are not vigilant.

There is a lot to like in the bill we hope to pass tonight, and the Senate has already passed a plan I can support. My hope is the House and Senate conferees will draft a final bill that takes the best approaches from each chamber and that we can ultimately send the President a Medicare prescription drug bill supported by both sides of the aisle. I urge my colleagues to support H.R. 1.

Mr. DAVIS of Illinois. Mr. Speaker, late last night, the House Rules Committee sent a terrible message to our Nation's seniors and hospitals. Two amendments I proposed were not allowed to pass onto the House floor. The first amendment would have stricken the language regarding the "market basket" index. Under the current bill hospitals would lose $12 billion over the next ten years. My amendment would have kept the funding streams toward hospitals level so that hospitals would not be forced to make difficult cuts in services and jeopardize patient care.

My second amendment would have assured that the prescription drug benefits we members of Congress enjoy would be comparable to those of Medicare beneficiaries. My colleagues in the Senate passed such an amendment, but the Members of the House Rules Committee seem reluctant to subject themselves to the very same benefits they would give our Nation's seniors. They have sent the clear message that these benefits are not good enough for them, the relatively young and healthy, but are adequate for our Nation's seniors and disabled persons.

Once again this Congress has proven that the Democratic process is not working. Not only are the voices of America's seniors not being heard, but neither are those of Members of Congress. As we go home to celebrate our Nation's independence, we will have to explain to our seniors that yes, a prescription drug bill passed, but it will not benefit them. It will not benefit middle America, it will not benefit the poor, it will not benefit those who are already struggling to buy their prescription drugs. It will only benefit those who can currently afford their drugs, afford to pay more for hospital services, and afford to pass this bill. Mr. Speaker, I oppose this rule and I oppose the underlying bill.

Mr. HOLT. Mr. Speaker, for forty years, the federal government has kept a promise to our nation's seniors. That promise is called Medicare, and it means that every senior will receive affordable, reliable health care in their later years.

Four years ago, I came to this Congress having made a promise to the seniors in my Congressional district—that I would work to bring Medicare into the twenty-first century by including coverage for prescription drugs. Coverage that, like the original Medicare program, is comprehensive, voluntary, universal, and reliable—without hampering the innovation that has brought us so many miraculous drugs over the past few decades.

Today I am voting to keep that promise by opposing a bill that would undermine the Medicare program itself. H.R. 1 purports to offer seniors coverage for the prescription drugs they rely on every day. Unfortunately, it falls far short when held up to the spirit and practice of Medicare.

The most distressing aspect of this bill, to me, to my constituents, and to the AARP, is that it takes the entire Medicare program down a short road to privatization. By the year 2010, Medicare would be converted to a voucher program with competition between managed care plans and traditional fee-for-service—only the deck would be stacked against the traditional plans. Seniors would find themselves forced to enroll in managed care programs like the Medicare+Choice programs that have failed so miserably in central New Jersey.

Rather than giving seniors what they want and deserve—a reliable, affordable drug benefit under Medicare, this provision, glibly called "premium support," will destabilize the program and lead to substantially higher costs for seniors who want to stay in traditional Medicare.

Yet another element of confusion comes from the bizarre "donut hole" in coverage under this bill. Seniors would find themselves paying 20 percent of drug costs up to $2000 in drug costs—then having no coverage until they reach $4900 in drug costs, when a catastrophic cap finally kicks in. Not only is this extremely convoluted, it ends up leaving seniors with a very paltry benefit. A beneficiary with $5000 in annual drug costs would pay nearly $4000 out of their own pocket!

This may be alarming to seniors who currently have no drug coverage. There are millions out there, however, who may think this debate won't really affect them because they already have coverage under their company's retiree benefit packages. I want them to know that the Republicans have quite a surprise in store for them.

If this bill passes, nearly one-third of employers currently offering retiree drug benefits—covering 11 million seniors—would drop that coverage. Retiree benefits would not count towards the beneficiary's out-of-pocket limit, making it almost impossible for seniors with retiree coverage to ever reach the catastrophic cap. So the bill actually discriminates against seniors with existing coverage and will have the practical effect of employers ending their benefits. This provision makes no sense—why on earth do we want to have less private sector drug coverage?

While I am disappointed with the underlying bill, I am pleased to see that the Rules Committee made the Dingell-Rangel substitute bill in order. This legislation would go a long way to fulfilling the promise I mentioned—it would provide a reliable, stable benefit under Medicare. Beneficiaries know exactly what they would pay—20 percent of drug costs up to $2000 in out-of-pocket costs with a defined premium of $25 per month and a defined deductible of $100.

Tonight, in this body, by passing H.R. 1 we could be bringing about the end of a program that served seniors so well. Instead, we should pass the Dingell-Rangel substitute. That is what seniors need and deserve.

Ms. CHRISTENSEN. Mr. Speaker, I rise in strong opposition to the Republican prescription drug bill, and in favor of the Dingell/Rangel Substitute.

We have been talking about a Medicare drug benefit for at least as long as I have been here—seven years. It is time to deliver. We owe it to our seniors who need it because their lives depend on it.

I have longed for the day when all people living in this country have reliable, comprehensive insurance coverage. Today we can bring this within the reach of every person on Medicare.

About 25 percent of my patients when I was in practice were on Medicare. Many could not get a full month's supply of medication because they could not afford it on their fixed income. We would try to make it up with samples, with medication that might not have been as effective but was within their price range, and better than nothing, and with a lot of prayer. It is probably the latter which got them through.

The bill, H.R. 1, as usual comes with a good sounding name, but true to form it does nothing good at all. Instead, it misleads the older Americans who have been looking to us for help.

We need a benefit that is truly a benefit—one that is affordable and fair—through a program they know, have used all along and trust.

It needs to be available to all benies without having to navigate through the maze of managed care.

And we need to make it reliable—no holes to fall through when they might need it most.

Not dropping them like hot potatoes like happened with Medicare+Choice.

Finally tonight, we have such a bill in the Democratic, Rangel/Dingell substitute.

In this bill, there are no slight of hands. What you see is what you get.

And our plan strengthens Medicare, while the Republican plan would slowly kill it.

No tricky numbers, no fancy words, just a simple, Medicare prescription drug plan. That is what the senior and disabled citizens have been asking for and that is what they deserve. It is what God-willing; I hope I would have when I am on Medicare.

I want for Medicare beneficiaries, who have played an important role in making this country what it is, and paved the way for all of us, and those who have special needs, what I want for my family and myself.

The Democratic substitute, developed under the leadership of JOHN DINGELL and CHARLES RINGELL, is the only bill before either body, which honors our seniors' gift to all of us.

Let us do the right thing. Reject the Republican bill and pass the Democratic substitute.

Mr. HINOJOSA. Mr. Speaker, I rise today in opposition to the Republican prescription drug bill. For years, our seniors have been begging for help to obtain affordable prescription drugs. Unfortunately, however, the bill before us today gives relief not to our vulnerable seniors, but to the large drug companies.

It forces Medicare patients into multiple private drug plans and out of Medicare. It undercuts seniors' collective purchasing power and enables the drug industry to maintain its unjustifiably high prices.

Seniors who live in rural and undeserved areas will find themselves without any coverage because insurance companies will not be required to serve them and are given no incentives to provide coverage. Because of a large coverage gap, over half of all seniors will still be required to pay thousands of dollars a year for prescription drugs as well as the program premiums.

Hidden in this bill is also another provision that will change the way cancer patients are treated and subject them to delays and reduced access to care.

By contrast, the Democratic plan offered by Mr. RANGEL would provide voluntary prescription drug coverage for all Medicare beneficiaries. The plan curbs drug costs by allowing this Secretary to use the collective bargaining power of Medicare's 40 million beneficiaries to negotiate lower drug prices.

I urge my colleagues to oppose the sham Republican proposal and support the Rangel substitute that provides real benefit to our Nation's seniors.

Ms. MILLENDER-MCDONALD. Mr. Speaker, I stand here with my colleagues tonight to talk about the need for affordable prescription drug coverage for women. Because women suffer more from chronic illnesses requiring medication than men do, they pay more out of pockets for medicine though their financial resources are often limited.

The proposed House bill would fail to offer meaningful prescription drug coverage to the millions of low-income women with incomes below the 135 percent poverty level who do not meet the requirements of asset tests. Also, the House bill would raise the amount of copayments that our country's poorest women Medicare beneficiaries are forced to pay.

Unlike the House bill, the Senate proposal, while not perfect, would be far more helpful to elderly women who range from 74 to 160 percent of the poverty level. Under the House bill, the out-of-pocket costs paid by elderly women will still make it difficult for them to get their much-needed prescriptions filled. If the House bill is enacted, our struggling women seniors who are in greatest need of assistance will receive up to 40 percent fewer prescriptions than those seniors who are able to afford private insurance. Our elderly women, who are among our most vulnerable citizens, deserve far better treatment than this. It is critical that as Members of Congress, we help women and all seniors by expanding Medicare to offer a prescription drug benefit that is universal, affordable, dependable, and voluntary. We can do no less than to offer elderly women access to adequate healthcare that they can afford and easily access.

Our Republican colleagues are offering a plan that gives no real guarantees or assistance to those who need quality prescription drug coverage the most.

Furthermore, the House plan would force seniors to purchase their own private insurance, a tactic that will benefit insurance companies, and not seniors. This is a catastrophe we can avoid if we craft the right policy to benefit our elderly now. When it comes to our elderly women, we know that:

Women make up 58 percent of the Medicare population at age 65, and 71 percent of the Medicare population at age 85.

Overall, elderly women have more chronic health problems than elderly men do.

On average, women live another 19 years after retirement, while men typically live another 15 years after retiring.

Due to the obstacles they face in enrolling, almost half of elderly women with incomes under the poverty limit are not enrolled in Medicare.

As compared to married women, widows are four times as likely, and divorced or single women are five times as likely to live in poverty upon retiring.

Many elderly women survive on fixed incomes. Over half of the older women age 65 and above earn less than $10,000 annually, and three out of four earn under $15,000 yearly. In contrast to elderly men, older women age 65 and above earned $14,820 as compared to $26,543 for men in the same age group.

Once retired, women earn less than men because:

Women tend to save less than men do throughout their lives which decreases their lifetime earnings.

Elderly women usually have smaller Social Security benefits and pension incomes than men do.

Minority women are much more likely to earn less and live in poverty than are White women. Even when they have similar educational backgrounds, minority women tend to earn less money and own fewer assets.

The sad fact is, the older and poorer a woman is, the higher her out-of-pocket health care costs will be, and the more help an elderly woman requires, the less likely she is to receive assistance. As a nation, though we are facing a great economic crisis, we are still obligated to provide assistance to our most needy citizens. Let us take good care of our elderly women and men by not enacting a prescription drug policy that will force them to choose between either buying food or paying for necessary medication.

Mr. COSTELLO. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. I recently informed over 70,000 seniors in my district that I would not support legislation that would fundamentally change the nature of Medicare and provide a prescription drug benefit that relies solely on insurance companies. I am opposing the bill because it does just that.

Medicare has been a success because it provides guaranteed coverage for all elderly and disabled Americans. H.R. 1 would end Medicare as we know it and may particularly harm rural areas that depend on the traditional Medicare program. Beginning in 2010, H.R. 1 would force the Medicare fee-for-service program for doctors and hospitals visits to compete with private insurance plans. People who wanted to remain in traditional Medicare would find their premiums going up as other beneficiaries opted for bargain private insurance coverage. Seniors and the disabled would essentially be forced out of the traditional fee-for-service program and into some form of managed care.

In addition, the Republican approach does not guarantee the same benefits for all seniors. Seniors who live where hospitals and doctors negotiate lucrative contracts with managed care plans would have to pay more; seniors with higher incomes would have to pay more; seniors in rural areas would have fewer choices of doctors and pharmacies; and seniors with low incomes but with assets such as a savings account might get nothing at all. These provisions violate the central promise of Medicare: to provide a consistent, guaranteed benefit that allows everyone, no matter where they live, how much they have, or how sick they are, access to quality medical care.

Finally, H.R. 1 is flawed because it offers seniors an inadequate prescription drug benefit. I support a voluntary prescription drug benefit paid for by Medicare. I am committed to providing a comprehensive benefit that is affordable and dependable for all beneficiaries with no gaps or gimmicks in its coverage. The Senate is currently working on a prescription drug bill that provides a government fallback provision, providing Americans with more of a reliable, consistent benefit. The Senate is moving in the right direction and I am hopeful, progress will continue to be made when this legislation goes to conference.

H.R. 1 relies too heavily on the insurance industry to bring drug costs down and does not guarantee seniors access to the medicine prescribed by their doctor or that they can get prescriptions filled at their local pharmacy. Seniors deserve fair drug prices and a real, affordable prescription drug plan.

Mr. Speaker, for these reasons, I oppose H.R. 1. I urge my colleagues to do the same.

Mr. FILNER. Mr. Speaker, I rise today to discuss the prescription drug benefit proposal that my colleagues on the other side of the aisle have rammed through the legislative process. I rise to decry this bill because it does not give seniors what they deserve. It seems pretty simple to me: a prescription drug benefit under Medicare ought to work the same way that Medicare has always worked. That is, it is a guaranteed benefit for all seniors, no matter where they live, how ill they are, or what kind of illness they have.

This bill proposes to turn the prescription drug benefit over to HMOs and the private insurance industry. That means, for one thing, that premium prices are not guaranteed—the insurance industry would be able to charge what ever they wanted for the premium. In addition, it would be the insurance companies that get to decide which drugs would be covered. What this means for seniors is that there will not be a consistent, reliable program for all seniors is that there will not be a consistent, reliable program for all seniors across the country. Seniors in my district might pay higher premiums and get less coverage than their counterparts in other areas of the country. Or, they may get better coverage for lower premiums. We just don't know because it will be left up to the private insurance companies and the HMOs.

This bill also raises out-of-pocket costs for those who need the protection that Medicare had traditionally provided: the sickest and the poorest beneficiaries. In addition to the "mystery" premium, seniors will have to pay for the first $250 worth of drugs without any help from the Federal Government. After they have paid $250, they must pay 20 percent of all their drug costs. Once they reach $2,000 worth of medications, they must pay all of their drug costs until they reach $4,900 worth of drug costs. So, once they get to $2,000, in addition to the premium, the $250, the 20 percent copay, they must cover all of their prescription costs until they get to $4,900. That is quite a lot of money.

Allowing HMOs and private insurance companies to take over the Medicare Prescription Drug benefit also presents a problem for rural areas. A very large portion of my district is rural. Everyone knows that for private companies, the bottom line rules. Rural areas aren't as profitable for insurance companies, so there is less incentive for them to offer benefits in those area. This means that there will be fewer choices—if any choices at all—for seniors in rural areas.

In one fell swoop, this bill takes the great success story that is Medicare: Universal healthcare for all beneficiaries, and crushes it. Under this Republican bill, your benefits and your costs depend on your income, where you live and the whim of the insurance company or HMO that is running the program in your area.

Mr. Speaker, I have received many letters and calls from my constituents who are worried about this proposal. They know that this proposal will cost them more money, may not even be available to them if they live in rural areas, and will not cover all their medication needs—especially for those with diabetes or even cancer. I will read one example from my constituent, Edna Monk:

> Dear Sir, I am writing my Senators and Representatives to plead our case regarding Medicare proposals that could endanger patent access to chemotherapy. I am a lung cancer survivor, age 71, and my husband, age 78, is now undergoing chemo. for liver cancer. Chemo drugs are required for my husband's quality of life now and MRF's have shown the tumors have diminished in size, so "it's working!"

She goes on to say, "We in the cancer community want one thing: for all critical cancer services, including chemotherapy and patient care services to be covered fully and fairly by Medicare."

Mrs. Monk makes a good point. Services must be covered fully and fairly by Medicare. It does seniors no good to have unequal coverage of medications! That is why I cannot support the Republican bill and I urge my colleagues to vote against this poison pill for Medicare!

Mr. PASTOR. Mr. Speaker, I rise today in opposition to the Medicare Prescription Drug and Modernization Act. This bill, long heralded by the Republicans and the Administration as a comprehensive overhaul of the Medicare system, will do nothing to alleviate the harsh effect on our seniors of the high cost of prescription drugs. It only will continue to aggravate the cause of health care inflation.

Despite all Republican claims to the contrary, the bill, which calls for private drug-only plans, would not make drugs affordable. It has no mechanism for keeping prices down, no negotiation for acceptable terms, no guarantee of defined and stable costs. Seniors would be at the mercy of private plans. They would lose their choice of doctors. They would be at risk of continuous coverage.

Private plans would only have to promise to stay in the program for one year. We've had these problems before with the Medicare Plus Choice program which failed to deliver its expanded benefits, leaving millions of seniors out on a limb.

Seniors have voiced their concerns. They fear the absence of provisions to limit drug prices and the lack of certainty about the future cost and coverage provided. Many seniors in rural areas are worried because they have no access to private plans and would have no "fallback" to offer coverage. Seniors are particularly concerned with the "gap-in-coverage" that means no coverage at all for drug spending between $2,000 and $5,100.

Instead of passing this plan which would privatize Medicare, we should support a plan that would establish a real Medicare prescription drug benefit within the Medicare program. The plan should be available to everyone regardless of income or place of residence. It should be voluntary and comprehensive. And, most importantly, it should be affordable.

The Medicare Prescription Drug and Modernization Act fills none of these requirements. Therefore, Mr. Speaker, I vote "no" on H.R. 1.

Ms. WOOLSEY. Mr. Speaker, this debate is a question of priorities, and it's a question of values. Under the Republican plan, after seniors have incurred $2,000 in prescription drug benefits, they will still pay a premium, but they better not expect anything in return. And why is that?

It's because just last week, the Republican leadership decided that they would rather eliminate estate taxes for millionaires than help seniors afford prescription drugs. They insisted on spending a total of $820 billion to help 8,000 millionaires. For almost the same cost, we could give millions of seniors a real prescription drug benefit.

Millionaires or millions of seniors? The Republicans give new meaning to the phrase "better off dead." If you're rich and dead, Republicans don't want you to lose a dime. But if you're alive and can't afford the high cost of prescription drugs—well, good luck.

You might want to be dead. I dare my Republican colleagues to tell their mothers what they're doing to Medicare.

My priority is giving every American senior a real prescription drug benefit, like the one in the Democratic alternative. Oppose the Republican bill, support the Democratic alternative.

Mr. OBERSTAR. Mr. Speaker, Medicare, the most successful social service program since Social Security, will be dramatically transformed and, in the long run, unraveled by this Republican bill we are debating tonight.

Their plan will convert Medicare from a defined benefit plan to a defined contribution voucher plan. In plain English, it means that seniors will lose the guaranteed coverage and the security of knowing which benefits are covered. Instead of having predictability about Medicare premiums and copayments, seniors will essentially receive a voucher for services to cover the lowest-cost private insurance plan. If this plan does not pay for the services they need, seniors will have to cover the difference—which could be a big figure—out of their own meager income.

As a result, this untested, speculative health care experiment threatens to abandon all seniors, especially rural seniors. The Republican bill replaces Medicare with an illusory promise that private health insurance companies will offer health insurance polices in rural America. Under current law, health insurance companies have found it unprofitable to offer policies in rural America; worse, the Republican plan does not guarantee that rural seniors will have access to the same benefits as seniors in metropolitan areas enjoy.

Not only does this bill undermine Medicare, it fails to provide an affordable prescription drug benefit. I don't understand how the majority, on the one hand can justify trillion dollar tax cuts, and in the other hand, impose an arbitrary limit on Medicare and prescription drug benefits. To comply with this artificial limitation, the Republican plan offers a complicated and untested prescription drug benefit, with an enormous gap in coverage.

The Republican plan is difficult to explain, but let me try: it begins with uncertain private health insurance premiums; then, seniors must pay a $250 deductible before they receive any assistance, and there is a large coverage gap, the "hole" in the doughnut, where seniors will be paying premiums but receiving no assistance at all. Seniors first have to spend $250 a year, then they will pay 20 percent co-insurance for up to $2,000 in drug costs. However, no assistance would be provided between $2,000 and $5,100 in drug spending, forcing seniors to pay $3,100 out-of-pocket in drug costs. This plan is as unfair as it is complicated and costly to older Americans living on fixed incomes.

In contrast, the Democratic plan is guaranteed, defined, dependable, and understandable. It sets a premium of $25 a month; a $100 per year deductible; a 20 percent co-insurance payment for beneficiaries, with Medicare paying 80 percent; and a limit of $2,000 in out-of-pocket costs per beneficiary per year.

Health care is essential in greater Minnesota. The hospitals in many small communities throughout northern and northeastern Minnesota are the major employer in town, and the health care they offer is critical for economic development and tourism. The Rangel/Dingell bill offers a substantial improvement in payments to the hospitals and doctors in rural Minnesota who provide those critical health care services.

In particular, I am pleased that the Democratic Substitute includes numerous provisions to improve reimbursement for rural providers. The increased funding for low-volume, "critical access" and "sole community" hospitals, rural home health and ambulance providers, and rural physicians adds up to very significant improvements for hospitals in my district, and will assure their continued viability for years to come.

To be specific, the Democratic bill eliminates the 35-mile rule presently in place for Critical Access Hospital ambulance services. That improvement would save the hospital in Ely, Minnesota, and would strengthen ambulance services at nine other Critical Access Hospitals in my district.

The Democratic plan would provide an additional $6 billion for all rural ambulance providers by increasing payments for ambulance services. The increases we propose would ensure the financial solvency of St. Mary's Life Flight, enabling it to continue assisting, for example, people who are injured while vacationing in the Boundary Waters Canoe Area Wilderness.

On the whole, rural health care providers plan are better served, better funded, and treated more fairly under the Democratic plan, which also has the advantage of preserving Medicare. For that reason, I will be supporting the Rangel/Dingell bill.

Mr. BURR. Mr. Speaker, as vice chairman of the Energy and Commerce Committee and a member of the Health Subcommittee, I have worked on Medicare prescription drug legislation for more than four years. The House has passed Medicare prescription drug legislation twice and I voted for both bills.

Mr. Speaker, I will not vote for this bill.

The $400 billion allocated for the Medicare drug benefit is not being spent widely under this legislation. High-income Medicare beneficiaries like Warren Buffett are subsidized 73 percent by the Federal government for their drug-only insurance plans. Low-income seniors who are not dually eligible have no cost-sharing assistance for their drug spending between $2,000 and $3,500. The Secretary is commanded to negotiate with insurance companies who will game the system to receive a 99.99-percent subsidy when 73 percent would have been fine. Mr. Speaker, that's not a negotiation—the insurance company will hold all of the cards. No money is being spent on a fallback plan. Seniors in rural areas of North Carolina will not have drug coverage if insurance companies refuse to offer a plan, even when the companies are bribed with an almost no-risk contract. This bill would benefit insurance companies, not extend a benefit to our Nation's seniors.

Yet insurance companies do not want any part of this legislation. For four years insurance companies have been telling Congress that they do not want to insure Medicare beneficiaries' drug expenditures, but we keep throwing money at them in the hope that they will finally say yes. The premium subsidy used to be 67 percent, now it is 73 percent and Congress demands that it grow to 99.99 percent if need be. At the end of the day, who are we kidding? Of course it will be 99.99 percent.

Our problem is that the Congressional Budget Office has written this bill. The last time I checked, Mr. Speaker, it was not the job of the Congressional Budget Office to write highly technical and important health care legislation. But policymakers are so convinced that a purely insurance-based product will work that they are willing to follow CBO's instructions and tweak the product one thousand different ways—and cut provider payments at the same time—to fit it under some magical budget ceiling. If CBO is wrong in its estimate, and this drug benefit costs more than $400 billion, our entire health care system will be at risk. This is not wise health care policy.

Where do my colleagues think the extra money is going to come from? When CBO realizes that their estimated insurance penetration rate was off by 10 percent that money will come out of future physician, hospital, nursing home, and home health care reimbursement rates. If only 85 percent of seniors sign up for drug coverage and plans' subsidies skyrocket, that money will come out of Food and Drug Administration modernization efforts, National Institutes of Health research, and bioterrorism preparedness. Congress is working with a limited pot of money, but we are promising a defined benefit. Obviously, the experiences of the private sector have taught us nothing.

If Congress listened to the private sector, we would mirror the success of defined contribution plans and individual empowerment by offering choice. Seniors could choose between twenty different discount drug cards based on the cards' formularies, pharmacy networks, and drug discounts. The government would set up accounts and contribute money to those accounts based on the seniors' needs. Seniors, their family members, friends, and former employers could put money into the accounts and receive a tax deduction. And insurance companies would offer catastrophic coverage that is subsidized by the federal government for low-income seniors. Unfortunately, that plan is not on the floor today.

Mr. Speaker, I wanted to be able to come to the floor today and vote for a good Medicare prescription drug benefit because of the bills passed by the House in the last 3 years this one has the greatest chance of actually becoming law. But not only does this bill contain a bad drug benefit, it also contains a cut in the overall hospital market basket update, a new home health copayment, multiple reimportation provisions that will harm our Nation's drug supply, and a reduction in the overall reimbursement rate for physicians such as oncologists and rheumatologists who administer Part B drugs. It also constitutes a threat to the very future of our health care system.

I can only compare my feelings today to my experience in 1997, when I voted against the Balanced Budget Act. I was one of only 32 Republicans who opposed that bill. I came to Congress to balance the federal budget, but in the end I could not vote for the legislation because of the drastic and thoughtless cuts in Medicare reimbursements. Since 1997, Congress has done nothing substantive in Medicare except try to fix the damage done under the BBA. I cannot support this legislation that builds on and magnifies those 6-year-old mistakes.

I regret that I cannot and will not vote for this legislation.

Mr. UDALL of Colorado. Mr. Speaker, I want to support a Medicare prescription drug bill, but I can't support the one we are considering today. It is inadequate, unreliable, will force seniors into HMOs, and will endanger drug benefits that many seniors get through their retirement plans. In fact, instead of drafting a Medicare drug benefit bill, the Republican Majority has used this opportunity to try to end Medicare as we know it.

I have long believed that Congress should act to help seniors with their prescription drug expenses. Nearly everyone agrees that Medicare should be updated with a drug benefit; it is the right and sensible thing to do. How we design that benefit is where the rub is. I had hoped that we would vote on a bill similar to the one in the Senate because I think it's a good start toward building a workable, financially sound prescription drug benefit. But the House bill is not the same as the Senate bill.

First, I think Congress should give seniors greater choice in coverage, however, it should provide an equal prescription drug benefit to all beneficiaries, regardless of whether they enroll in a private health plan or traditional fee-for-service Medicare. We shouldn't force seniors into managed care, which I believe this bill will do by opening the traditional Medicare program up to competitive bidding against private insurers in 2010.

Second, the House bill does not include an important "fallback" provision that requires that traditional Medicare would step in as a backup if private insurers show no interest in selling drug plans in a particular area. Currently, private plans don't exist in many parts of the country, including many smaller cities, rural and mountain areas in Colorado. I've heard from many seniors in my district who have been dropped from their Medicare HMO and are now having trouble finding a doctor. In addition, 88 percent of all Medicare beneficiaries are enrolled in traditional Medicare. So, without this "fallback" safety net provision, seniors would have no coverage in regions where insurers say it's unprofitable to provide it, especially rural areas.

Taken together, I think these provisions undermine the traditional Medicare program. By opening traditional Medicare to competitive bidding and with no fallback mechanism, I fear that our country will revert to the time before Medicare was established in 1965 when private insurers wouldn't provide affordable coverage to seniors. That's a step backward, not a step forward, in fixing Medicare.

I also have problems with the home health copayment provision in the bill, which I believe will discourage seniors from accessing home health care, which is more cost effective than accessing treatment an emergency room or a skilled nursing facility. And I am concerned that opening durable medical equipment to competitive bidding will give seniors less choice and put many small businesses out of business.

On top of everything, this 692-page bill was introduced at midnight last night. How can anyone know what's in it, except the people who wrote it? Our seniors deserve greater respect.

Mr. Speaker, it is misguided at best that Medicare will pay for a senior's care following a stroke but will not pay for the anti-hypertension drugs that prevent them. The time is ripe to pass a Medicare prescription drug benefit, but not this one. I regret I can't support it. I hope that a bill can be worked out in conference that I can support. We need to put ideological and partisan politics aside and get it done this year.

Mr. CROWLEY. Mr. Speaker, I rise in support of the Democratic substitute because this bill meets the 4 basic tenets that any prescription drug plan under Medicare should absolutely provide for.

First, it means lower drug prices. The House Democratic bill allows HHS to negotiate lower drug prices. The Republican bill, unfortunately, does not.

Second, this bill guarantees coverage under Medicare.

Because of this, a senior knows what his premium, cost-sharing level, and catastrophic coverage is. The Republican bill has no such guarantees.

Third, this bill provides coverage for all drugs prescribed by a doctor. Under the Republican bill, a payer could deny coverage for a drug if the payer decides to not include it in its formulary.

Fourth, this bill has no gaps in coverage. Under the Democratic plan, when a senior has spent $2,000 on drugs, the government picks up the remaining costs.

When a senior has spent $2,000 under the Republican plan, they're dropped. They get zero coverage until they've spent $4,900.

The Republican bill does not simply have one big problem. It has several huge problems.

Only the Democratic substitute provides seniors in my district guaranteed, quality coverage. I urge an "aye" vote.

Mr. BUYER. Mr. Speaker, I rise in opposition to the bill, H.R. 1, the Medicare Prescription Drug and Modernization Act.

I fully support the effort to provide prescription drug coverage to Medicare beneficiaries. The successes in modern medicine that we see today can be partly attributed to the advent of safer and more effective pharmaceutical drug therapy. Illnesses and serious diseases that often required hospitalization 40 years ago, when Medicare was created, can now be treated with outpatient care and pharmaceuticals. This is a testament to the many scientists in numerous companies that toil daily to find compounds to treat and manage disease. The pharmaceutical industry is a testament to the free market system of the United States that rewards hard work, initiative, and enterprise. As the great minds of the world push the bounds of modern science, new discoveries in pharmacology lead to the betterment of mankind.

While H.R. 1 has some positive features, including addressing medical doctor and dentist provider reimbursement concerns and regulatory impediments, an insurance product built and guaranteed by the government is not the approach to provide a drug benefit under Medicare.

And, make no mistake, we MUST get it right. I have serious levels of concern.

First, the legislation before us has the government assuming 73 percent of the risk of offering the insurance, 43 percent of the initial benefit and 30 percent of reinsurance retrospectively. This is the floor! We must all understand that the taxpayer's exposure to risk can only increase. The bill permits the government to assume more risk, up to 99.9 percent if it is necessary to entice an insurance product into a region. And this is an unknown factor. We simply do not, nor cannot, know what this provision will cost the taxpayers.

Today, Medicare already consumes nearly 12 percent of the federal budget. It is expected to be 30 percent or 35 percent of the federal budget in 2030 without the addition of prescription drugs, or any other benefit. It is irresponsible of this Congress to simply add a prescription drug benefit without also addressing the budgetary impact of this benefit. H.R. 1 leaves the federal budget and the taxpayers exposed to unknown expenditure levels in the future. I do not believe that this drug bill will remain within the proposed budget of $400 billion over the next 10 years.

Second, there is no provision in the House bill on how to provide a benefit to seniors in areas where two insurance products are not available in January 2006. It is simply neither realistic, nor fair, for seniors in one region to have products available and seniors in another region to not have choice because two plans have not been forthcoming.

Furthermore, I am adamantly opposed to the proposal by some, especially in the other body, that the government provide this coverage. This will only lead to the government determining what prescription drugs a senior can have and ultimately the imposition of price controls that will have a chilling effect upon research and development of pharmaceutical therapies.

Third, the premium charged to seniors for the drug-only insurance plan is estimated to be $35 per year initially. This premium number is not found in the bill—it is an estimate by the Congressional Budget Office. What if it is more? Will seniors decide that this premium is worth the benefit they will receive under a drug insurance plan? There will be a great deal of kitchen table math being done by seniors in 2005 to decide whether this new benefit meets their drug needs and their wallet realities.

I am also concerned about a number of modifications made under the bill to reimbursement for providers and to the last minute inclusion of language regarding the Patent Term Restoration Act, the so-called Hatch-Waxman legislation. Although some very necessary provider reimbursement changes were made in the bill, particurlary regarding doctors and rural areas, nonetheless, I am concerned about the changes to the market basket update for hospitals, as well as the changes to skilled nursing facilities and home health care providers. In addition, I share the concern of others regarding the sufficiency of the reimbursement to oncologists. It is very true that the Congress needed to address the use of the "average wholesale price," which was neither average nor wholesale, and left Medicare beneficiaries paying 20 percent of an inflated drug price, but oncologists need to be reasonably compensated for the level of care they provide to Medicare patients. I am not convinced that this has been sufficiently addressed.

I also have grave reservations over the inclusion of provisions regarding patent term and generic drugs, the changes to the Hatch-Waxman law. Initiating more litigation of patent rights is not conducive to encouraging innovation in pharmaceuticals. Unfortunately, this is exactly what this provision will do.

The vast majority of seniors have drug coverage today through either an existing government program or through the private sector. However, 27 percent of seniors have nothing. These seniors pay the highest prices when they go to the pharmacy because they have no means to bargain for lower costs. These seniors also tend to be those between 100 percent and 175 percent of the federal poverty level (FPL). A Medicare drug benefit should not displace existing coverage and should address the needs of those seniors who do not have coverage.

The government should encourage employers, families and others to help seniors with the purchase of expensive prescription drugs. It is time that we admit that no proposal that comes to the House floor that meets the budget requirements will fully address all the prescription drug requirements of seniors. Every plan will have a "so-called donut hole." There should be a way to tackle this without putting our heads in the sand and expecting it to simply "work out."

We live by a system of checks and balances. We run into the limitations with everything that we do. How can we then create a system that is dependent upon the unknown? The government's assistance to beneficiaries should be a defined contribution. This type of benefit would be manageable and known.

I am committed to providing a prescription drug benefit for seniors. Seniors should have access to the same mechanisms that are available in the private sector to drive down costs and improve health care services.

Along with four of my colleagues on the Energy and Commerce Committee, we submitted legislation, that would address these issues and provide a prescription drug benefit under Medicare. I testified before the Rules Committee to request a vote on our bill. The request was denied. This benefit would have been delivered through a prescription drug discount, or value, card that would be available to all seniors on a voluntary basis for an annual $30 fee. This is an approach that has been recommended by the President.

Any entity qualified by the Centers for Medicare and Medicaid Services could offer a drug value card to seniors. Card issuers would negotiate with pharmaceutical manufacturers for discounts on drug utilizing the same techniques that are found in the marketplace today. These discounts would range from 15 percent to 35 percent of current retail prices. The competition among these card issuers would result in attractive offerings to beneficiaries.

Recognizing that some beneficiaries need financial assistance to pay for prescription drugs, this legislation would tie the drug value card to an account to which the federal government would provide assistance related to the income of the beneficiary. Others could add contributions on a tax preferred basis up to $5,000 for a beneficiary and family; and $5,000 for an employer. Non-profit organizations, like local churches, and State pharmaceutical assistance programs could add contributions to the accounts. Contributions on the accounts would roll over from year to year.

Protection from catastrophic drug expenses would also be offered at $10,000 through the private sector, with federal subsidies on the premium for those with low incomes.

In my opinion, this delivery mechanism for a prescription drug benefit works best for the beneficiary, and best for the taxpayers. Beneficiaries would have access to negotiated discounts and some financial assistance to buy drugs. The taxpayers would have a defined contribution that could be planned from year to year in the federal budget.

My colleagues, this has been a long road for us all. But, it is nothing compared to what could happen if Congress gets this wrong. Please be mindful of our obligations to our nation, not just to seniors.

It is my opinion that Congress needs to grasp this opportunity to provide a prescription drug benefit with a full appreciation of the duty and responsibility this nation has to our seniors, taxpayers, and future generations. To do anything less, we break the trust of all Americans.

Because the margin for error is so thin, my hope is that the majority is right. However, my intellect and instincts tell me that this bill will not fulfill the desired result. I must vote against final passage of this measure.

Mr. PAUL. Mr. Speaker, while there is little debate about the need to update and modernize the Medicare system to allow seniors to use Medicare funds for prescription drugs, there is much debate about the proper means to achieve this end. However, much of that debate is phony, since neither H.R. 1 nor the alternative allows seniors the ability to control their own health care. Both plans give a large bureaucracy the power to determine which prescription drugs senior citizens can receive. Under both plans, federal spending and control over health care will rise dramatically. The only difference is that the alternative puts seniors under the total control of the federal bureaucracy, while H.R. 1 shares this power with "private" health maintenance organizations and insurance companies. No wonder supporters of nationalized health care are celebrating the greatest expansion of federal control over health care since the Great Society.

I am pleased that the drafters of H.R. 1 incorporate regulatory relief legislation, which I have supported in the past, into the bill. This will help relieve some of the tremendous regulatory burden imposed on health care providers by the Federal Government. I am also pleased that H.R. 1 contains several good provisions addressing the congressionally-created crisis in rural health and attempts to ensure that physicians are fairly reimbursed by the Medicare system.

However, Mr. Speaker, at the heart of this legislation is a fatally flawed plan that will fail to provide seniors access to the pharmaceuticals of their choice. H.R. 1 provides seniors a choice between staying in traditionally Medicare or joining an HMO or a Preferred Provider Organization (PPO). No matter which option the senior selects, choices about which pharmaceuticals are available to seniors will be made by a public or private sector bureaucrat. Furthermore, the bureaucrats will have poor to determine the aggregate prices charged to the plans. Being forced to choose between types of bureaucrats is not choice.

Thus, in order to get any help with their prescription drug costs, seniors have to relinquish their ability to choose the type of prescriptions that meet their own individual needs! The inevitable result of this process will be rationing, as Medicare and/or HMO bureaucrats attempt to control costs by reducing the reimbursements paid to pharmacists to below-market levels (thus causing pharmacists to refuse to participate in Medicare), and restricting the type of pharmacies seniors may use in the name of "cost effectiveness." Bureaucrats may even go so far as to forbid seniors from using their own money to purchase Medicare-covered pharmaceuticals. I remind my colleagues that today the federal government prohibits seniors from using their own money to obtain health care services that differ from those "approved" of by the Medicare bureaucracy!

This bill is even more pernicious when one realizes that this plan provides a perverse incentive for private plans to dump seniors into the government plans. In what is likely to be a futile effort to prevent this from happening, H.R. 1 extends federal subsidies to private insurers to bribe them to keep providing private drug coverage to senior citizens. However, the Joint Economic Committee has estimated that nearly 40 percent of private plans that currently provide prescription drug coverage to seniors will stop providing such coverage if this plan is enacted. This number is certain to skyrocket once the pharmaceutical companies begin passing on any losses caused by Medicare price controls to private plans.

Furthermore, these private plans will be subject to government regulations. Thus, even seniors who are able to maintain their private coverage will fall under federal control. Thus, H.R. 1 will reduce the access of many seniors to the prescription drugs of their choice!

Setting up a system where by many of those currently receiving private coverage are hired into the government program exacerbates one of the major problems with this bill: it hastens the bankruptcy of the Medicare program and the federal government. According to Medicare Trustee, and professor of economics at Texas A&M University, Tom Saving, the costs of this bill could eventually amount to two-thirds of the current public-held debt of $3.8 trillion! Of course, estimates such as this often widely underestimate the costs of government programs. For example, in 1965, the government estimate that the Medicare Part B hospitalization program would cost $9 billion in 1990, but Medicare Part B costs $66 billion in 1990!

This new spending comes on top of recent increases in spending for "homeland security," foreign aid, federal education programs, and new welfare initiatives, such as those transforming churches into agents of the welfare state. In addition we have launched a seemingly endless program of global reconstruction to spread "democratic capitalism." The need to limit spending is never seriously discussed: it is simply assumed that Congress can spend whatever it wants and rely on the Federal Reserve to bail us out of trouble. This is a prescription for disaster.

At the least, we should be debating whether to spend on warfare or welfare and choosing between corporate welfare and welfare for the poor instead of simply increasing spending on every program. While I would much rather spend federal monies on prescription drugs then another unconstitutional war, increasing spending on any program without corresponding spending reductions endangers our nation's economic future.

Congress further exacerbates the fiscal problems created by this bill by failing to take any steps to reform the government policies responsible for the skyrocketing costs of prescription drugs. Congress should help all Americans by reforming federal patent laws and FDA policies, which provide certain large pharmaceutical companies a government-granted monopoly over pharmaceutical products. Perhaps the most important thing Congress can do to reduce pharmaceutical policies is liberalize the regulations surrounding the reimportation of FDA-Approved pharmaceuticals.

As a representative of an area near the Texas-Mexico border, I often hear from angry constituents who cannot purchase inexpensive quality imported pharmaceuticals in their local drug store. Some of these constituents regularly travel to Mexico on their own to purchase pharmaceuticals. It is an outrage that my constituents are being denied the opportunity to benefit from a true free market in pharmaceuticals by their own government.

Supporters of H.R. 1 claim that this bill does liberalize the rules governing the importation of prescription drugs. However, H.R. 1's importation provision allows the Secretary of Health and Human Services to arbitrarily restrict the ability of American consumers to import prescription drugs—and HHS Secretary Thompson has already gone on record as determined to do all he can to block a free trade in pharmaceuticals! Thus, the importation language in H.R. 1 is a smokescreen designed to fool the gullible into thinking Congress is acting to create a free market in pharmaceuticals.

The alternative suffers from the same flaws, and will have the same (if not worse) negative consequences for seniors as will H.R. 1. There are only two differences between the two: First, under the alternative, seniors will not be able to choose to have a federally subsidized HMO bureaucrat deny them their choice of prescription drugs; instead, seniors will have to accept the control of bureaucrats at the Center for Medicare and Medicaid Services (CMS). Second, the alternative is even more fiscally irresponsible than H.R. 1.

Mr. Speaker, our seniors deserve better than a "choice" between whether a private or a public sector bureaucrat will control their health care. Meaningful prescription drug legislation should be based on the principles of maximum choice and flexibility for senior citizens. For example, my H.R. 1617 provides seniors the ability to use Medicare dollars to cover the costs of prescription drugs in a manner that increases seniors' control over their own health care.

H.R. 1617 removes the numerical limitations and sunset provisions in the Medicare Medical Savings Accounts (MSA) program. Medicare MSAs consist of a special saving account containing Medicare funds for seniors to use for their routine medical expenses, including prescription drug costs. Unlike the plans contained in H.R. 4504, and the Democratic alternative, Medicare MSAs allow seniors to use Medicare funds to obtain the prescription drugs that fit their unique needs. Medicare MSAs also allow seniors to use Medicare funds for other services not available under traditional Medicare, such as mammograms.

Medicare MSAs will also ensure that seniors have access to a wide variety of health care services by minimizing the role of the federal bureaucracy. As many of my colleagues know, an increasing number of health care providers have withdrawn from the Medicare program because of the paperwork burden and constant interference with their practice by bureaucrats from the Center for Medicare and Medicaid Services. The MSA program frees seniors and providers from this burden, thus making it more likely that quality providers will remain in the Medicare program!

There are claims that this bill provides seniors access to MSAs. It is true that this bill lifts the numerical caps on Medicare MSAs; however, it also imposes price controls and bureaucratic requirements on MSA programs. Thus, the MSAs contained in this bill do nothing to free seniors and health care providers from third party control of health care decisions!

Mr. Speaker, seniors should not be treated like children by the federal government and told what health care services they can and cannot have. We in Congress have a duty to preserve and protect the Medicare trust fund. We must keep the promise to America's seniors and working Americans, whose taxes finance Medicare, that they will have quality health care in their golden years. However, we also have a duty to make sure that seniors can get the health care that suits their needs, instead of being forced into a cookie cutter program designed by Washington, DC-based bureaucrats! Medicare MSAs are a good first step toward allowing seniors the freedom to control their own health care.

Finally, Mr. Speaker, I would like to comment on the procedure under which this bill was brought before the House. Last week, the committees with jurisdiction passed two separate, but similar Medicare prescription drug bills. In the middle of last night, the two bills were merged to produce H.R. 1. The bills reported out of Committee were each less than 400 pages, yet the bill we are voting on today is 692 pages. So in the middle of the night, the bill mysteriously doubled in size! Once again, members are asked to vote on a significant piece of legislation with far reaching effects on the American people without having had the chance to read, study, or even see major portions of the bill.

In conclusion, Mr. Speaker, both H.R. 1 and the alternative force seniors to cede control over which prescription medicines they may receive. The only difference between them is that H.R. 1 gives federally funded HMO bureaucrats control over seniors' prescription drugs, whereas the alternative gives government functionaries the power to tell seniors which prescription drug they can (and can't) have. Congress can, and must, do better for our Nation's seniors, by rejecting this command-and-control approach. Instead, Congress should give seniors the ability to use Medicare funds to pay for the prescription drugs of their choice by passing my legislation that gives all seniors access to Medicare Medical Savings Accounts.

Mr. THORNBERRY. Mr. Speaker, health care is an important but complex issue for Congress and for America's seniors. Two facts, however, seem clear:

One fact is that Medicare is currently headed toward financial collapse. The last report of the Medicare trustees shows that in nine years the income of the Medicare trust fund will not be enough to cover its expenses. After that, the problem gets much worse with the retirement of the baby boom generation.

A second clear fact is that Medicare was enacted in 1965 and has been largely unchanged since then. It does not reflect modern medical practices, including our reliance upon prescription drugs. If we were designing a new federal health care program for seniors today—rather than in 1965 when Medicare was created—we would unquestionably include some form of prescription drug coverage.

Our objective then should be to update and strengthen Medicare so that it does a better job of providing health care for seniors and at the same time put Medicare on a sound financial footing so that it can be sustained through the baby boom generation retirement.

This bill takes some steps in that direction. It contains some reforms that improve Medicare and give beneficiaries more control over their health care. It also adds prescription drug coverage, and there are too many seniors in my district who are not able to afford the prescription medicines they need, forcing them either to do without and become sick or to sacrifice other necessities of life.

I am gravely concerned, however, that the reforms take too long to implement and that the new drug benefit will cost far more than expected. Without changes, this bill may add a major new benefit to Medicare but, at the same time, hasten the day of its financial collapse.

At the same time if we do nothing, we are guaranteeing that Medicare will not survive for long. The alternative proposals are far more expensive and are fiscally irresponsible.

I have other concerns with this bill, such as the reductions in payments for cancer treatments. Today, however, I will vote to send the House bill to conference with the Senate. I strongly urge that improvements be made to ensure Medicare solvency and to improve the quality of health care for America's seniors. We can do better. If improvements are not made, I will not be able to support the final conference report.

Mr. KIND. Mr. Speaker, providing affordable Medicare prescription drug coverage for our nation's seniors is one of the most pressing issues facing our country today. Even though the elderly use the most prescriptions, more than 75 percent of seniors on Medicare lack reliable drug coverage. It is time to modernize Medicare to reflect our current health care delivery system. The use of prescription medications is as important today as the use of hospital beds was in 1965 when Medicare was created.

I have heard from a number of seniors in western Wisconsin regarding the problems they have paying for prescription drugs. One woman from Deer Park, Wisconsin, a small town in my district, wrote to me and said:

> My medication is $135.00 per month. Fortunately my husband is not on any medication. If we both were not working part-time, I guess that we would have to make a choice between food and Medication—does one eat to survive or take the medication for a "long and happy life"?

What is to happen to this couple if the husband falls ill and has high drug costs too?

The cost of prescription medicines should not place financial strains on seniors that would force them to choose between buying drugs and buying food. We need to make prescription medicines affordable and accessible to all of our seniors.

I came to Congress to work toward a real solution to this problem. Unfortunately, today's debate is a sham. We will not have the opportunity to discuss this issue in a fair and open process. There were several alternatives presented at the Rules Committee late last night and they should be debated on the floor today. The majority, however, chose to dedicate only one day to this debate and allowed only one alternative and no amendments to be made in order. Our Nation's seniors deserve better. They deserve an open process, but the Republican leadership has failed to deliver this.

The Leadership has also failed seniors with their prescription drug proposal. The Republican plan is doomed to fail because the plan relies on health insurance companies to offer drug only policies which they have said they won't offer. Further, there is no fall back option. So, if insurance companies won't offer these policies, how will seniors actually obtain prescription drug coverage under the leadership plan?

Providing a drug benefit through private plans could be problematic, specifically for folks living in rural and small communities. There are no requirements as to what has to be covered and the coverage may vary from area to area depending on the plan. Because is there is no guaranteed benefit, Wisconsin may end up on the short end of the stick like we have in the past under Medicare.

The biggest problem with the leadership bill is the fact that it will fully privatize Medicare in 2010. This is a radical provision that will be the demise of the traditional Medicare program on which our seniors have depended for nearly 40 years. In 2010, seniors will be given a lump sum to purchase health isuurance, including traditional Medicare. There is concern that the healthy seniors will leave traditional Medicare and the premiums will increase dramatically, up to 47 percent. In addition, under the leadership bill, each local area will have a different premium for fee-for-service Medicare. For example, seniors in Wisconsin might have to pay more to enroll in fee-for-service Medicare than seniors in Florida. This is a drastic departure from Medicare's fundamental principle that seniors across the country pay the same premium for the fee-for-service benefit.

We must provide a real solution to the problem of prescription drug coverage for our seniors. The Republican plan falls woefully short.

All of the Democratic alternatives offered at the Rules Committee would be better than the leadership bill. One proposal, the Medicare Rx NOW Act, is a simple straightforward plan that provides assistance to the seniors most in need, those with low incomes and seniors with high drug costs. This proposal builds on the Medicare program seniors know and provides them with a guaranteed benefit for no additional premium.

Another proposal put forward by the Blue Dogs is based on the bipartisan Senate bill.

Unlike the House bill, this proposal includes a fall back provision to ensure that all seniors would have access to a prescription drug plan. In addition, this bill does not include the privatization components of the leadership plan.

In addition, both of these alternatives provide substantial improvements to Medicare payments for rural providers. Both pieces of legislation include equalizing the disproportionate share hospital payments for rural hospitals, an increase in the bed limit for critical access hospitals, and a geographic adjustment for rural physicians. None of these provisions are included in the leadership's bill.

It is unfortunate that the Republican leadership has squandered an excellent opportunity to try and solve the problem of prescription drug coverage in a bipartisan fashion. Instead they have steamrolled ahead and present our nation's seniors with an unworkable solution to a grave problem. I urge my colleagues to reject this flawed proposal.

Mr. RAMSTAD. Mr. Speaker, I rise in strong support of the Medicare Prescription Drug and Modernization Act.

Today is an historic day. Congress is finally delivering on our promise to create a meaningful and long overdue prescription drug benefit for Medicare seniors and people with disabilities.

This bill means seniors will no longer have to choose between purchasing life-savings drugs or the basic necessities of food and housing.

In addition to this important new prescription drug benefit, the bill modernizes and improves Medicare to give seniors better choices and greater access to state-of-the-art health care.

I am grateful for the many important provisions in this package from my Medicare Innovation Responsiveness Act (H.R. 941), which will increase seniors' access to lifesaving medical technology.

As founder and co-chair of the Medical Technology Caucus, I have seen first-hand the incredible advances that medical technology and prescription drugs have made to treat and cure debilitating conditions. The current Medicare system is crying out for reform with its failure to incorporate these critical improvements.

Currently, seniors and people with disabilities face unconscionable delays of up to five years before Medicare provides access to technology that can literally be a matter of life or death.

The bill before us incorporates many of the reforms I have proposed in Medicare's coverage, coding and payment process that will speed access to lifesaving technology.

Thanks to this legislation, we are finally tearing down barriers that discourage innovation and deny America's seniors the medical technologies they desperately need. Seniors have waited too long for access to the same treatment options as other Americans.

In addition to the excellent work and leadership of Chairman THOMAS and Chairman JOHNSON, I want to thank two unsung staff heroes—John McManus and Deb Williams—who have worked so tirelessly on these provisions.

I am also pleased the bill includes H.R. 841, legislation I introduced with Mr. CARDIN to break down regulatory barriers facing specialized Medicare+Choice plans that serve the frail elderly.

Mr. Speaker, this package of reforms will improve the lives of our seniors and generations to come who count on Medicare. I urge my colleagues to support this landmark legislation and deliver on our promise to modernize and strengthen Medicare.

Mr. BACA. Mr. Speaker, I rise in opposition to H.R. 1, the Medicare Prescription Drug & Modernization Act of 2003.

This Republican plan is bad for seniors! It's bad for Hispanics! And it's simply bad for the American people!

For millions of Americans, this plan will replace traditional Medicare with vouchers that won't guarantee benefits.

It forces seniors into risky HMO plans and new private fee-for-service plans that will not cover all of seniors' costs!

Forty-seven percent of seniors in Medicare will have a $1,900 gap in their drug coverage. How are our seniors supposed to make up for that gap?

How are our parents and grandparents going to afford that! Most seniors are on fixed incomes with nothing to spare!

Forty percent of poor and disabled seniors won't get the additional help they need to pay deductibles and premiums. 40 percent.

This plan will not give taxpaying pregnant women and children benefits!

It will not help the twenty million Hispanics without Health insurance!

And it will not help our parents and grandparents pay for their medicines!

We must take care of our seniors! We must not gamble with their health and well-being. Seniors deserve to be protected in a safe and fair healthcare plan.

In my district, San Bernardino, California, seniors are boarding buses to Tijuana so they can afford to buy prescription drugs.

Our seniors have to go all the way to Mexico to get the life-saving medicine they need. Mexico!

This is not safe and it is not fair.

I am angered when I think about all of the people that the Republicans are leaving behind in this plan!

Why are we letting this happen to our abuelos? Our parents and grandparents? How can we be so heartless?

When I think about this plan, I think about all of the seniors who can't afford life saving prescription drugs.

I think about the senior who has glaucoma and prostate cancer and makes only $8,000 a year.

Like 750,000 other Hispanics, he won't get help paying for his prescription drugs, because he is lucky enough to have assets and owns a car.

According to Republicans, that is wealthy!

They will give tax breaks to millionaires, but under their plan, a man who makes $8,000 a year and is lucky enough to own a car, is too wealthy to get medicines that will ease his pain and save his life!

This is an outrage!

Under the Republican plan he would have to sell his car and pass an assets test to be poor enough to receive aide for low-income seniors.

When I think about this plan, I think about the senior who might make $10,000 a year.

That senior will pay one-fifth of his or her income to cover the Republican coverage gap.

One-fifth! This won't get him off the bus to Tijuana!

Like 63 percent of Americans, seniors in my district want and need the security of Medicare.

Under the Republican plan they may start in Medicare.

But after a couple of years, Medicare will only be a voucher program and where will seniors be?

In an HMO plan and still in a pharmacy in Tijuana buying medicine.

My constituents deserve better than the Republican plan!

They deserve more!

They deserve the Democratic plan that we have been fighting for for years!

A plan that cares about the health and safety of America's seniors!

A plan that actually works for America's seniors!

A plan that offers coverage to all seniors—even Hispanics!

It's time to take seniors off the bus to Tijuana!

Mr. MICHAUD. Mr. Speaker, tonight the House of Representatives considered a plan that would supposedly create a Medicare prescription drug benefit. While some touted the plan as an innovative approach, the fact is that when you look past the smoke and mirrors, it turns out to be a very bad deal for Maine's seniors. In fact, the House plan could make the current situation for seniors a lot worse: it will do nothing to control rising prescription costs, it will jeopardize the traditional Medicare fee-for-service plan that seniors enjoy right now, it has a large gap in coverage that will force seniors to pay thousands of dollars out of their pockets, and it may cause employers to drop their health coverage.

We all know that drug prices are spiraling out of control. Maine seniors are forced to take bus trips to Canada to buy affordable prescription drugs. Our best hope for getting affordable medicines to people is to lower prices—that is why Maine passed the innovative Maine Rx law, and that's why I introduced a national version of the bill called America Rx. Yet, the House legislation does nothing to control rising costs. In fact, this plan expressly prohibits the Secretary of Health and Human Services from ever negotiating with drug companies for better prices. Pharmaceutical companies are reaping huge profits while seniors are often forced to choose between medicine and food.

Furthermore, this plan doesn't guarantee a prescription benefit for seniors and it actually jeopardizes current Medicare coverage. The proposed benefit is entirely run by the private insurance industry and has no fallback provision of areas with no private plan. Without a fallback provision, there is no guarantee that private plans will be established in largely rural areas like Maine—so our seniors will be left in the cold. This has happened before with Medicare Plus Choice, and it is very likely to happen again, meaning that Maine's seniors would get nothing from this bill.

In addition, this bill also contains a "premium assistance" provision that aims to phase out traditional fee-for-service Medicare and replace it with a voucher program. This is just another step toward total privatization of Medicare and the elimination of the only plan available to seniors in areas such as Maine—the traditional Medicare plan. Forcing seniors into private plans, and making them give up Medicare, is not the right approach—but that's what this bill would do.

This bill also has a very large gap in coverage seniors would have to continue to pay a monthly premium, but would receive absolute no benefit fro drug costs between $2,000–$4,900. Having this kind of a gap in coverage is like telling people that their auto insurance doesn't cover accidents in June, July and August.

Finally, and perhaps worst of all, there is a provision in this bill that does not allow for retiree coverage to count toward the out-of-pocket spending cap. It has been estimated that the bill passed by the House would result in up to ⅓ of employers dropping their retiree coverage, the seniors who enjoy these plans would be forced into a Medicare plan with fewer benefits. The House should not pass a plan that forces seniors to lose what benefits they have.

For all these reasons, groups from AARP to the National Committee to Preserve Social Security and Medicare have sharply criticized this plan. I supported a number of alternative bills that would address the problems with this plan and vastly improve the benefit available to seniors. Unfortunately, the leadership of the House was more concerned about pushing any bill through as quickly as possible than with providing a quality benefit for seniors, and they weren't willing to fix the serious flaws in the bill that could hurt seniors. In fact, the House leadership refused to allow even one real amendment to the legislation.

I want to pass a real prescription drug benefit—but I would not vote for a plan that hurts Maine's seniors. I am disappointed with the legislation that was passed by the House, however the fight for a real Medicare benefit is not over. It is my hope that this legislation will be improved in the upcoming conference with the Senate. I will continue to fight to make sure that all Maine seniors receive an affordable and real Medicare prescription benefit.

Mr. LANGEVIN. Mr. Speaker, I rise in opposition to H.R. 1, the Medicare Prescription Drug & Modernization Act. Like many of my colleagues, I held sincere hope that the 108th Congress would overcome the inaction that has plagued this issue, at the expense of America's senior citizens, for many years. I am extremely disappointed that the bill before the House this week not only fails to offer a structurally sound prescription drug benefit for Medicare beneficiaries, but also contains provisions that threatens the stability of the program that has provided health benefits for millions of elderly people and younger adults with disabilities for the past 38 years.

In particular, I want to call attention to the fact that this bill does nothing to address the rapidly rising costs of prescription drugs. It not only fails to address this crisis, it contains a "noninterference" clause prohibiting the agents of the Department of Health & Human Services from using the bulk purchasing power of Medicare beneficiaries to negotiate for lower prices for senior citizens. Without taking measures to curb the escalating prices of the medications our seniors need to stay alive, the benefit is rendered meaningless. Seniors will pay more out of pocket in 2007 with the prescription drug benefit than they are paying in 2003 without it.

I urge my colleagues to pay careful attention to the details of the Medicare Prescription Drug & Modernization Act and to think critically about the effect—or lack thereof—it will have on the seniors in their districts.

Mr. ISRAEL. Mr. Speaker, I am proud to be a Democratic Member of this body. I have always been proud to be a Democrat. And always will be.

But I came to Congress 2½ years ago with a promise to my constituents that I would work hard to break through partisan gridlock. I promised that when I agreed with the Republicans I would vote with them; and when I disagreed I would vote against them. But that I would always work to develop consensus and move our country forward.

That is what brings me here today, Mr. Speaker.

In those 2½ years, I have focused on a health care crisis for seniors on Long Island. We used to have 12 Medicare HMOs in my communities. Now we have two left. Eighty-five thousand seniors have been tossed out of their Medicare HMOs. One out of five is skipping their medication because they can't afford them.

And in those 2½ years, I have listened to Republicans blame Democrats for this crisis; Democrats blame Republicans; the House blame the Senate; the Senate blame the House; Congress blame the White House; the White House blame Congress; and everyone blame the insurance companies.

There is plenty of blame to go around. But all the blame in the world isn't going to help a single senior citizen get their prescription drugs at a more affordable price.

It's time to stop blaming. It's time to stop finger pointing. It's time for conservatives to stop railing against a $400 billion prescription drug plan because it's too liberal. It's time for liberals to stop railing against a $400 billion prescription drug plan because it's too conservative. It's time for everyone to stop rejecting the imperfect because we can't get the perfect. It's time to move this process forward.

Mr. Speaker, I believe the Democrats are right. It will take at least $800 billion to provide America's seniors with a truly comprehensive, voluntary prescription drug plan.

Is an $800 billion prescription drugs program better than a $400 billion program that's before us today? Of course. $400 billion is only half as good as $800 billion . . . but it is $400 billion better than nothing. And nothing is exactly what we will leave our seniors if we reject this proposal today.

To reject the largest expansion of Medicare in its 38-year history because it's $400 billion instead of $800 billion just doesn't make sense to me.

Mr. Speaker, only a short time ago, President Bush argued for a $190 billion prescription drug plan. My side of the aisle proposed an $800 billion plan. Some say we have ended up at a $400 billion plan.

I disagree. I think we are beginning with a $400 billion plan. It is the largest expansion of Medicare in its 38-year history. It is, in my view, a down payment. An investment.

Is this plan flawed? I believe it is. I believe the Senate plan, supported by TED KENNEDY, is much better. But we can't get near that plan unless we go to a House-Senate conference. And we can't go to a House-Senate conference unless we pass this bill today.

Yesterday at the White House, I listened carefully to President Bush. He said clearly we must move this process forward and pledged to work on a bipartisan basis to develop a final bill that represents consensus.

But there's no hope for consensus, no hope for a penny of prescription drug spending, if we slam the brakes on the process today by killing this bill today.

Mr. Speaker, of particular importance to me and the constituents I represent is that this bill contains the Greenwood-Israel-Fossella amendment, which ends the economic discrimination in federal reimbursement formulas to suburban Medicare HMOs that have forced 85,000 of my constituents out of their prescription drug plans.

Those seniors are watching us today. They are tired of blame, tired of gridlock, tired of excuses. They don't care whether it's a Democratic solution or a Republican solution, as long as it's a good solution.

This is not a perfect solution. But it is a good start. It is the largest expansion of Medicare in its 38-year history. It ends the price discrimination on Long Island and other suburbs around the nation.

Mr. Speaker, let me close by repeating this: $400 billion is only half as good as $800 billion . . . but it is $400 billion better than nothing. And nothing is exactly what we will leave our seniors if we reject this proposal today. In the spirit of advancing the process, I will support this bill. I reserve the right, however, to vote against a bill that emerges from Conference that does not address the significant flaws in the legislation before us tonight.

Mr. EVANS. Mr. Speaker, this Republican Medicare bill falls well short of what our country's retirees deserve. And I believe, that if this Congress and this President had not squandered the budget surplus we could afford to give our seniors a benefit they deserve.

It is well past time to assist with our seniors prescription drug costs. The Democratic substitute provides a reliable and affordable benefit to America's seniors. This voluntary prescription drug coverage costs only $25 a month with a $100 deductible and provides a $2000 stop-loss protection with no gaps in coverage. There are also special provisions to help the poorest seniors with either full payment or assistance on a sliding fee scale.

The Democratic substitute I support also allows the Secretary of Health and Human Services to wield the collective bargaining power of the 40 million Medicare beneficiaries to negotiate lower drug prices. And as the ranking member on the Veterans' Affairs Committee, I was proud to help craft a similar plan which has helped our nation's veterans lower their out of pocket drug costs.

As a member representing a rural district, I also want to highlight the rural health care provisions included in the Democratic substitute. These provisions are essential to create equity in the reimbursement system between urban and rural hospital. They allow fair payments to hospitals that have a disproportionate share of low-income patients, increases payments to rural home health providers without requiring a co-pay, and adjusts low-volume payments for small hospitals. It also takes into account the physician shortage crisis in rural areas by finally correcting the huge disparity between urban rural hospitals, that drives providers from our small towns.

All of these reasons make the Democratic alternative to H.R. 1 the right answer to the spiraling costs for prescription drugs for seniors. Medicare works for America's seniors but, I oppose the GOP's efforts to privatize this system and provide a second-rate prescription drug benefit. I proudly support the Democratic substitute and I urge my colleagues to vote down H.R. 1 and vote Yes on the substitute.

Mr. CUMMINGS. Mr. Speaker, I rise today to speak against the inadequate Medicare prescription drug bill being considered today, H.R. 2473 and in support of the Rangel/Dingell Substitute.

With over 40 million elderly and disabled persons covered under the 38-year-old Medicare entitlement, Congress' chief objective should be to ensure that these Americans have access to quality health care coverage. However, today we consider legislation that will do more harm than good because it is the first step in privatizing the Medicare program and as former Speaker Gingrich predicted, causing it to "wither on the vine". Passage of this legislation will cause many of our seniors to wither right along with the Medicare program—which will no longer be seen as the social compact with our seniors that this nation embraces.

Medicare is the nation's second largest social welfare program. As an entitlement program, it is imperative to realize that with the implementation of H.R. 2473, fee-for-service Medicare payments would naturally increase. This will result in many seniors facing the horrible prospect of being unable to afford the increasing payments. I think many of my colleagues would agree that this is a very troubling proposition and a totally unnecessary result.

Additionally, with the establishment of the Voluntary Prescription Drug Benefit Program, seniors again would lose because of the lack of negotiated prices for the prescription drugs. Also, although federal subsidies would be provided to encourage participation, the bill would increase the annual out-of-pocket threshold for many beneficiaries. Once again a pseudo-solution of adding a prescription drug benefit while increasing the cost for persons who need the benefit but will not be able to afford its costs.

Furthermore, the use of health maintenance organizations (HMOs) and other private organizations to obtain prescription drugs would deter many seniors from getting the benefit. As Rep. Charles B. Rangel, Ranking Democrat on the Committee on Ways and Means stated, "to get prescription drug coverage, seniors would have to go to an HMO by another name. Then, all the choices would belong to the private insurance provider—which drugs are covered, which pharmacies you can choose, who your doctor is, etc." Mr. Speaker, this bill is an empty pillbox—it is a paltry solution to the problem of providing adequate prescription drug coverage to our seniors; rather, it is creating an inadequate system—based on a provider concept that does not currently exist and will not likely work in practice.

A better alternative to H.R. 2473 is The Medicare RX Drug Benefit an Discount Act (H.R. 1199) offered by my friend CHARLIE RANGEL of New York. This prescription drug plan would guarantee that every Medicare beneficiary, no matter where they live, could have a benefit with a $25 monthly premium, $100 annual deductible, 20 percent co-insurance and $2000 out-of-pocket limit. The bill would also:

Lower prescription drug cost for all Americans, regardless of whether they are covered by Medicare;

Give all Medicare beneficiaries the option of a reasonably priced guaranteed prescription benefit under Medicare;

Ensure that senior citizens and people with disabilities receive coverage for the drug that their doctor prescribes; and

Provide additional assistance for low-income beneficiaries such that many seniors would pay nothing for their prescription drugs.

Unlike the proposal put forth by the Bush Administration and endorsed and worsened by the House GOP Leadership, H.R. 1199 would not require seniors to join an HMO or similar private plan in order to get a prescription drug benefit. In fact, Medicare beneficiaries would be guaranteed a prescription drug benefit rather than offered a marginal, voluntary plan under H.R. 2473. This plan would ensure that we keep our social compact with our seniors. The Republican plan fails to do that.

Since its inception in 1965, Medicare has provided important protection for millions of aged and disabled persons. H.R. 2473 would be a detriment to improving and securing this system. I lend my voice in opposition and urge my colleagues to vote against H.R. 4273 and to support H.R. 1199.

Ms. WATERS. Mr. Speaker, I rise to oppose this Medicare privatization plan, which is masquerading as a prescription drug bill.

This bill would force seniors who want prescription drug coverage to get it from private insurance companies. It provides no guarantee that insurance plans will be available, and when they are, premiums and benefits will vary widely. The bill also provides no coverage when a senior's prescription drug costs are between $2,000 and $4,900 per year. This huge coverage gap affects 47 percent of Medicare beneficiaries.

This bill is also a give-away to pharmaceutical companies, as it prohibits the Secretary of Health and Human Services from negotiating lower drug prices. The primary beneficiaries of this bill are not the beneficiaries of Medicare. They are the wealthy special interests in the pharmaceutical industry and the insurance industry that give campaign contributions to Republicans.

However, the most outrageous aspect of this bill is what it does to traditional Medicare. The bill would increase seniors' cost for visits to the doctor's office by raising the Medicare Part B deductible and indexing it for inflation. This could cost American seniors an estimated $8 billion. While this may seem like a tiny fraction of the Republicans' $350 billion tax-cut-for-the-rich, it is a huge expense for senior citizens, many of whom live on limited incomes.

This bill also divides Medicare into 10 or more regional plans in 2006 and then converts the entire Medicare program into a voucher program depending upon private insurance companies in 2010. If the Republicans really want to privatize Medicare, they should be honest with the American people and call this plan what it is, the Medicare Privatization Act.

The Democrats alternative prescription drug plan on the other hand provides prescription drug coverage under Medicare with guaranteed and affordable premiums and benefits for all American seniors and no gaps in coverage. It is time for Congress to make prescription drugs available to all seniors who need them.

I urge my colleagues to oppose the Republican Medicare Privatization Act and support the Democratic alternative.

Mr. ISTOOK. Mr. Speaker, this bill will hasten the day when Medicare will go bankrupt, and it also threatens to unravel our children's future.

Medicare is already on shaky financial legs, and this will add enormous extra expenses that will make it worse. Do we expect our children to pay a lifetime of higher taxes, and still find there's nothing left for them when they retire? That is what we face.

I would like to add prescription drug benefits, but it's wrong to promise something we cannot pay for.

I want to preserve what's good about Medicare, not destroy it by making extravagant promises for political gain.

The enormous extra spending under this bill will be far more than projected. Because today's Medicare is a huge price control system, many doctors already refuse to see Medicare patients. In just a few years this will make it worse, including price controls that will destroy the incentives for companies to create new medicines.

What should we be doing?

Since 76 percent of seniors already have drug coverage, we could focus on helping those who don't. But this bill undoes the coverage for those 76 percent, and puts them in a confusing new medical experiment.

We should be stabilizing Medicare, so it can keep the promises already made, not making new promises that we don't have the money to keep.

We should address the reasons why drug prices and healthcare costs are so high. By banning re-imported drugs, we're forcing Americans to subsidize far-lower drug prices in other countries. We should change our policies so Americans only pay the lower world price, not a higher price.

We should end the 130,000 pages of federal regulations that have driven the costs of medicine and healthcare through the roof. On average, for every hour they spend with a patient, doctors and nurses spend another half-hour to a full hour doing government paperwork.

We should stress personal responsibility in healthcare, just as we did in welfare reform, so government resources are focused on those who cannot care for themselves, not on those who can.

Bit-by-bit, Congress is undoing the principles of welfare reform, and undercutting basic American principles in the process. Both political parties are making extravagant promises today, trying to outbid each other to win votes. Unfortunately, they are bidding with taxpayers' own money, and our children's hopes will be crushed by the bills they inherit.

Mr. PORTMAN. Mr. Speaker, I rise to speak in supper of provisions in H.R. 1, The Medicare Prescription Drug and Modernization Act, that are designed to address the special pharmacy needs of beneficiaries residing in nursing homes.

Nursing home residents are not in a position to fill prescriptions like everyone else. They cannot simply walk into a pharmacy and have their prescription filled. Many nursing home residents, because of their physical or mental condition, are not able to take their prescription drugs on their own, especially if they have to take multiple medications throughout the day. Their unique circumstances require specialized pharmacy care that retail and mail order pharmacies do not provide. Long-term care pharmacies meet these special needs. They contract with nursing homes to provide specialized packaging, 24-hour delivery, infusion therapy services, geriatric-specific formularies, clinical consultation and other services that are critical to a nursing home. Importantly, long-term pharmacies play a critical role in preventing medication errors that add to the cost of care and suffering of Medicare patients. In fact, one study estimates $3.6 billion in medication errors have been avoided as a result of long term pharmacy care. I believe it makes sense to preserve specialty pharmacies' ability to perform these vital services for nursing home residents, and I want to point out how H.R. 1 does this.

First, the bill requires the Secretary of Health and Human Services to review the current standards of practice for pharmacy services provide to patients in nursing facilities. Prior to implementation of the prescription drug benefit, the Secretary will submit its findings to Congress on how long-term pharmacy services will be available to nursing home residents, including appropriate reimbursement levels for the specialty pharmacies that currently serve these nursing home residents. The Secretary's report is to include a detailed description of its plans to implement the provisions of this legislation in a manner consistent with state and federal laws designed to protect the safety and quality of care of nursing facility patients.

Second, H.R. 1 directs plan sponsors to implement medication therapy management programs as a tool to reduce medication errors and improve patient outcomes. Long-term care pharmacies currently employ such initiatives to meet the complex medication needs of nursing facility patients, and the bill appropriately allows plan sponsors' programs to distinguish between services provided in ambulatory and institutional settings.

Finally, the bill includes provisions to ensure that beneficiaries are guaranteed access to pharmacy services, including emergency services. These provisions are vitally important to maintain the high standard of care for all beneficiaries, but particularly for patients in nursing facilities, who receive specialized pharmacy services 25 hours-a-day, seven days-a-week, through networks of long-term care pharmacies that contract with nursing facilities to meet their patients' needs.

Mr. Speaker, I believe these long-term pharmacy provisions take a significant step toward ensuring that our nation's most frail and elderly citizens will have affordable, appropriate prescription drugs and delivery services.

Mr. BASS. Mr. Speaker, as a member of the Energy and Commerce Committee, I am extremely pleased to have had the opportunity to develop a strong Medicare modernization package that will significantly improve this critical government program.

The seniors of New Hampshire have long clamored for a prescription drug benefit under Medicare, as is the case in the rest of the nation. I am pleased to represent those same seniors today as we pass this bill and take one giant step closer toward our goal of creating a new and voluntary prescription drug benefit that makes lifesaving medications more accessible.

This benefit is the product of years of research, study, testimony, and compromise. I have no doubt whatsoever that each of us might wish for a slightly different version of this bill. We represent different regions with different demographics.

And, I am sure we all wish lifesaving drugs were more affordable for our families, friends, and constituents. The goal is formulating a fiscally responsible plan that will remain solvent in years to come, is easily accessible, and increasingly beneficial to seniors of all regions and means, was a daunting one.

Yet, the bill makes a number of Medicare improvements for care providers in New Hampshire. This proposal represents one of the most generous rural packages ever contemplated by the House. Notably, after several years of efforts on the part of the rural medical community, uniform standards for Medicare reimbursements will be established for rural and small urban facilities.

Beginning October 1, Medicare reimbursements to rural areas would finally mirror those for large urban ones. Having lamented for a number of years over the inequity of this provision within the Medicare reimbursement system, I am particularly pleased that this is being addressed in the bill.

A drug benefit for seniors and a rejuvenation of the Medicare system are essential to seniors and their caretakers. The delivery of medical care has changed enormously since this program was first conceived, and the program ought to be modernized to reflect the increases in medical technology and the utilization of a wide range of care options.

As I have noted many times, no plan can be as all-encompassing and immediately satisfying as we might prefer. However, this bill puts the framework in place for a system that can be adjusted and improved upon over time and will directly and immediately help the population most in need.

I applaud all Members of the Energy and Commerce Committee and the Members of the Ways and Means Committee for the joint work on this essential legislation. It is my hope that upon completion of our floor vote today, we will see this measure moved forward immediately to conference with the Senate.

Mr. KNOLLENBERG. Mr. Speaker, today we have an opportunity to provide our seniors with a new prescription drug benefit and improved access to health care. It is a long overdue step in updating and improving Medicare.

Today's legislation will provide help for those who need it most. Our 6.5 million low-income seniors will receive a fully covered premium and a cost sharing benefit when their drug benefit switches from Medicaid to Medicare, paying no more than $2 per generic prescription, and no more than $5 for name brand drugs. This will also save states about $6.8 billion a year in Medicaid costs.

It is imperative that Medicare advance with technology. Prescription drugs are an increasingly important part of modern medicine, helping to relieve pain, cure disease, and enhance the lives of millions of Americans. Adding a drug benefit and updating how existing benefits are provided will be a very significant accomplishment.

Mr. Speaker, I encourage my colleagues to vote for this legislation that helps our seniors by providing a prescription drug benefit that they deserve. .

Mr. MOORE. Mr. Speaker, I rise today to express my opposition to this legislation and my support for the Blue Dog substitute, offered by Rep. THOMPSON, which we have not been allowed to debate on the House floor today, despite support on both sides of the Capitol.

We in Congress have been talking for years now about the necessity of adding a prescription drug benefit to Medicare. We know, as seniors know, that this talk has been cheap and it is imperative that a compromise be reached this year. The Senate has been proceeding in a bipartisan way toward a compromise that adds a substantial, but not perfect, benefit to Medicare and protects the long-term integrity of this social insurance program.

Instead of following the Senate's lead and working toward a compromise that will improve Medicare, a wildly popular and successful program, the House Republican leadership has chosen instead to add provisions to this legislation that attack the foundation of the Medicare program. The bill does not include a federal fallback if private plans choose not to offer a benefit. The experience that my constituents have had with Medicare+Choice show that private health care plans are at best an unstable partner for Medicare, and financial analysts have consistently publicly questioned whether "drug only" plans will ever be offered. For these reasons, it is absolutely vital that Medicare provide a viable and guaranteed fallback for all Medicare beneficiaries.

Additionally, H.R. 1 would transform Medicare, beginning in 2010, from a defined-benefit program to a defined-contribution program. This provision would gradually shift enormous costs onto people when they are sick and most in need of care, and destroy the fabric of this program that has served seniors well for nearly 50 years.

The Senate has crafted legislation that has broad support among Senators across the ideological spectrum. This legislation has won the support of both President Bush and Senator TED KENNEDY. Together with Representative THOMPSON and the Blue Dog Caucus, I am supporting legislation that uses the framework of the Senate compromise and improves on it, making it a much stronger bill. The Thompson plan includes a provision phasing in employer contributions so they will count toward the out-of-pocket limit for catastrophic coverage, thus giving employers an incentive to keep offering retiree benefits. The substitute guarantees a Medicare fall-back plan for all areas that do not have two private plans available. It also gives relief to state Medicaid plans by making Medicare the primary payer for all individuals eligible for Medicare and Medicaid. Finally, the Blue Dog substitute includes language that will reduce the high cost of prescription drugs by allowing Americans to reimport drugs from Canada and speeding approval of generic drugs.

The House bill falls short on several other fronts as well. It ignores the needs of community and teaching hospitals, meaning that hospitals in my district stand to lose over $11 million in denied inflation updates. Kansas teaching hospitals, like KU Med, would additionally lose out to the tune of $3.9 million in 2003 and $21 million over five years due to the Federal Government's failure to help pay for the excess costs of medical education. The Thompson substitute provides an adequate inflation update for all hospitals. Finally, H.R. 1 would cut $16 billion over 10 years from oncology services. Cancer patients all over the country will have to pay for provisions in this bill that sharply cut funding for cancer-fighting drugs and allow Medicare to continue to underpay for costs associated with providing chemotherapy services.

I cannot support the Democratic substitute because I believe that it is simply too expensive. I voted against the most recent tax cut because I believe that it is irresponsible for Congress to run up bills for our children to pay, and the Democratic substitute, although a much more robust benefit for our seniors, is simply more than our country can afford at this time. The Senate bill and the Blue Dog substitute both hew to the budget agreed to by the House and Senate. Neither bill is perfect, but I believe that the Thompson substitute builds a strong foundation for a prescription drug benefit on which we can build in future years.

Mr. CAPUANO. Mr. Speaker, today we have the opportunity to provide our seniors with a real prescription drug benefit, but instead of giving seniors the plan they deserve, we are taking steps to dismantle a program that older Americans have known and trusted for 38 years.

The Republican plan before us today fails to offer the types of guarantees that our seniors need and deserve. There is no defined benefit and no standard premium. So when my seniors ask how much their premiums will be or how much their drugs will cost, I cannot answer them. This is unacceptable.

This bill allows private insurance companies to decide premiums, prescription drug coverage benefits and even where coverage will be offered. This proposal threatens to dismantle Medicare and replace it with private health insurance coverage for all seniors. This is precisely the problem many seniors face—they cannot afford private insurance, and depend on Medicare.

This bill also provides additional funding for rural hospitals, but not urban teaching hospitals. This is a serious oversight. Urban teaching hospitals are facing incredible budget shortfalls. They play a critical role in training tomorrow's physicians, and their needs must also be addressed. If the Federal Government is going to offer additional funding to some hospitals, it must offer additional funding to urban teaching hospitals.

The Federal Government has a responsibility to ensure that Americans who contribute to the Medicare program during their working years will have access to dependable, equitable, and affordable health coverage. The Democratic substitute does just that—it lowers drug prices, guarantees coverage and enables seniors to get their medicines at the pharmacy of their choice. The Rangel/Dingell substitute addresses my concerns more effectively and I will strongly support it.

Mr. LEACH. Mr. Speaker, seldom has there been a more important bill for the State of Iowa.

On the one hand, this legislation provides for greater equity in Medicare reimbursement which will bring millions of additional dollars to the State and help prevent an exodus of healthcare providers from rural counties.

In addition, the brunt of the bill is about providing voluntary prescription drug coverage to Medicare eligible individuals. There is a conservative critique that the program is far too expensive, and a liberal critique that it is not generous enough. Both philosophical perspectives have a degree of validity, but the big picture is that Congress is moving in a direction of providing health security for millions of citizens. Low income individuals will, for the most part, be provided full comprehensive prescription drug coverage. Higher income citizens on a sliding scale will be provided partial coverage and all citizens will be provided coverage for catastrophic expenses.

There will be a cost to society in providing these benefits but the benefits far outweigh the costs. There may be better approaches that can be envisioned now or developed later, but this is the only framework approach that has a chance of receiving majority support in both bodies without a Presidential veto. It may not be enough and it may be too deferred in implementation but it nevertheless marks an important first step to meeting the most challenging need of many senior citizens.

Ms. DEGETTE. Mr. Speaker, I want to highlight a piece of the Dingell/Rangel substitute that pertains to Disproportionate Share Hospitals.

This was an amendment I offered in the Energy & Commerce Committee and I understand that since our mark-up the DSH allocation has been increased and I want to commend this action. I know there is real bipartisan support on this issue and I want to just reiterate how important it is that we get funding to our DSH hospitals right away.

The provision in the substitute would give DSH hospitals a large portion of the funding that has been cut in the past year. It would expend a billion dollars in FY '03 and then adjust payments in future years to ensure that our vital DSH hospitals do not go bankrupt.

The reason it is so important that this money is available next year is that our DSH hospitals have already suffered a cut of a billion dollars in the past year and now are in such bad shape financially, if we help them in dribs and drabs then many of them won't be around ten years from now.

There are public hospitals who are currently planning to make cuts of 25 percent next year in order to try to stay afloat.

Mr. Speaker, our public hospitals cannot afford these cuts. We are in real danger of losing numerous DSH hospitals over the next few years if we do not assist them right now.

This provision also helps the low-DSH hospitals which are the most strapped of all. Eighteen states have low-DSH hospitals due to historical expenditures that were basically frozen in place at a certain point.

These low-DSH States have been struggling for years with their Medicaid payments and they are currently held to only 1 percent of their Medicaid expenditures. My amendment, which accomplishes the same thing that a bill Rep. HEATHER WILSON introduced, would raise this to 3 percent which would help these States considerably.

While low-DSH States have been dealing with this situation for years, recently it has gotten much worse. The pressure on these hospitals has increased due to numerous factors such as increasing numbers of the uninsured, increasing numbers of Medicaid patients, the extreme situation so many States are in in terms of budget crises.

The fact of the matter is that DSH hospitals need help and need help now. They can't wait and we need to rectify this situation while the DSH hospitals are still around to help our most vulnerable citizens.

Mr. DELAURO. Mr. Speaker, in my 13 years in Congress, this House has sometimes risen to the occasion on matters of great national importance. My very first vote on the first Gulf War followed days of debate in which Members stated their heartfelt views on the prospect of war. After September 11th, we came together—Democrats and Republicans—to bind the Nation's wounds and provide for the national security of the Nation's victims of that terrorist act.

I wish I could say that this is one of those occasions—I wish I could say that, as we consider the very future of Medicare, we could rise above partisan politics and ideological viewpoint and do the right thing by our senior citizens. Medicare is one of the most important and successful government programs ever enacted, a program that has provided quality health care and a measure of economic security to hundreds of millions of senior citizens over the past four decades. Together, Medicare and Social Security represent the twin pillars of a social safety net and constitute what is in effect a social contract between the generations—that if you work hard all your life you may look forward to a dignified retirement and economic security in your old age.

I understand that we bear the responsibility of meeting the newest challenges that face our seniors—of finding new ways to care for our aging population and that changes to Medicare need to be made. Central to that process is dealing with the cost of prescription drugs and helping seniors afford them.

Unfortunately, the legislation before the House this week fails on both counts. It does not deliver an acceptable or adequate prescription drug benefit and it will not hold down the cost of drugs.

What it does do is open the door to privatization of Medicare—in other words, a return to the way things were before, when 1 out of every 3 seniors lived in poverty, largely due to the cost of medical expenses. Today, thanks to Medicare, that rate is closer to 1 in 10.

This bill sets in motion the privatization of Medicare by converting the program into a voucher system—essentially turning it over to the HMOs, the very organizations that have dropped 52 percent of the Medicare enrollees in my State over the last four years.

And it does nothing to contain costs. It prohibits the Secretary of Health and Human Services from even engaging in negotiations with the drug companies to lower prices. As a result, many seniors will pay more than they do now and their premiums will rise as the cost of drugs rises.

But the most inexplicable aspect of this bill is the huge gap in coverage. Once a senior receives drug benefits totaling $2,000, he or she is cut off until her bills total $4,900, necessitating that they pay $2,900 out of her own pocket—at the same time that they pay premiums for this supposed drug benefit.

It makes no sense. Throughout my time in Congress, the single most common concern I have heard from seniors at the local Stop N' Shop every weekend is how expensive their prescription drug bills are. Seniors know they are being taken advantage of. They know they can get drugs cheaper in Canada and overseas.

And I assure you when they find out we are doing nothing to hold down the excessive profiteering of the pharmaceutical companies, they are going to be angry. When seniors find out that their coverage essentially stops during mid-summer while they still have to pay premiums, they are not only going to be confused, they are going to feel utterly betrayed.

Mr. Speaker, we must provide a meaningful drug plan with guaranteed, defined benefits—with no gaps and no doughnut holes. We should act to contain costs by giving the Secretary of HHS the authority to negotiate lower prices so that seniors will not have to pay more than seniors in other countries for the same drug.

And perhaps most importantly we should honor our social contract with America's seniors by not privatizing Medicare and subjecting seniors to the uncertainties of the private health care market. We should not be penalizing seniors who live in rural communities, where pharmacies and private plans are scarce at best. We should be giving them a plan fully contained within the Medicare system, where seniors will not be forced to shop around for a plan only to be unceremoniously dropped soon thereafter. Giving them a plan that seniors have come to rely on and feel safe with is what we should be doing. That is real economic security. Medicare—the same plan my 89-year-old mother relies on today.

This debate is as important and historic as any I have been a part of in this body. If we allow this bill to become law, we are essentially tearing that social contract up—a contract my friend from Michigan, Mr. DINGELL, fought to pass 38 years ago. And by doing so, we would be saying that guaranteed health care for our seniors is no longer an obligation or responsibility of this government.

I did not come to Congress to preside over the dismantling of Medicare. That contract must be honored. I urge my colleagues to support a plan that does that.

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act. I want to thank Congresswoman LYNN WOOLSEY for her hard work in bringing Democratic women together to speak against the Republicans' shameful Prescription Drug bill.

As a freshman Member of Congress, I came here with a tremendous sense of optimism. By nature, I am an eternal optimist. But I am no fool, and the American people shouldn't be fooled either. Unfortunately, that is exactly what the Republicans are trying to do with their sham prescription drug bill.

If you believe the Republican bill solves the prescription drug crisis facing our seniors . . . if you think that seniors will get the medications they need, at a price they can afford . . . if you believe private insurance companies—the same people who brought you HMOs—will provide better coverage for seniors than a reformed Medicare system . . . or if you think you can get all the drugs your doctor prescribed, including the most expensive, at your local pharmacy. . . . then you should be listening to that old country song by George Strait called "Ocean Front Property." It goes something like this:

> I've got some ocean front property in Arizona from my front porch you can see the sea.
>
> I've got some ocean front property in Arizona and if you'll buy that I'll throw the Golden Gate in free.

Republicans are just like scam artists trying to sell you an ocean front property in the desert. But now they are trying to sell you a phony prescription drug package. We must not fall for it, especially when this is not what seniors want.

I say to my Republican colleagues, it is time to stop this heinous scam on seniors! It is time to show the greatest generation in our country the respect they deserve. After all, they are the people who served us in times of war, got us through the Great Depression, raised their children and made countless contributions to this country.

Worst of all, the Republican bill ignores the reality of older women, the face of Medicare. Women constitute 58 percent of the Medicare population at 65 and 71 percent at the age of 85. Since women normally outlive their male counterparts and many women spend time out of the workforce, caring for their children and sometimes, their own parents, Medicare beneficiaries are disproportionately female.

We need to make sure that every prescription is covered without a gap. Seniors, particularly women, must retain their right to see their doctor of choice. We must empower seniors to make the right choices, not insurance companies. This is exactly what the Democratic plan does and exactly what seniors want. In fact, according to a survey conducted by AARP: 4 out of 5 seniors don't want the GOP proposal.

Today, Mr. Speaker, I urge my colleagues not to support H.R. 1. Let's tell the Republicans don't try to sell seniors something they don't want.

Mr. JANKLOW. Mr. Speaker, I would like to submit the following letter into the CONGRESSIONAL RECORD.

BUSINESS FOR AFFORDABLE MEDICINE,
Washington, DC, June 24, 2003.

Hon. DENNIS HASTERT,
Speaker, U.S. House of Representatives,
Washington, DC.

DEAR SPEAKER HASTERT: We urge you to pass legislation as part of Medicare reform that will improve the Drug Price Competition and Patent Term Restoration Act, and the patent listing requirements under the Federal Food Drug, and Cosmetic Act (FFDCA).

States spend billions of dollars annually and provide prescription medicine to residents, state employees, and retirees. Tax payers are forced to pay hundreds of millions of dollars in excess costs for the medicine because of loopholes in the Hatch-Waxman Act that restrict timely access to lower-cost generic pharmaceuticals. As a result, BAM members, including states, companies, and labor groups, support changes to the Hatch-Waxman Act that will provide greater pharmaceutical competition and more timely access to generic.

Bipartisan legislation passed by the Senate last week will provide all purchasers with greater access to generics, and will produce hundreds of millions of dollars in savings for federal and state programs. We urge the House to adopt similar legislation as part of the effort by Congress to add a prescription drug benefit to Medicare, and urge you to resist changes or amendments that would weaken the most important cost-savings provisions in the Senate bill.

Specifically, BAM supports the proposed limit of one 30-month stay against FDA approval of generic products, as well as provisions to prevent the use of "late-listed" patents—those filed after generic applications are submitted—to obtain additional stays. Litigation under the Hatch-Waxman Act is increasingly tied to patents that have been listed after the filing of generic applications, resulting in the need for legislation to restrict the use of 30-month stays to only those patents listed in the Orange Book prior to the filing of related generic applications. We also support changes to provisions in the law that allow drug manufacturers to intentionally delay litigation on certain drug patents until the end of any 30-month stay.

In addition we are concerned that consumers, taxpayers and institutional purchasers have no standing under current law to challenge abusive listing. As a result, all purchasers have been forced at times to pay millions of dollars more than necessary for products that should have faced more timely competition from generics. We support efforts to ensure generic manufacturers will be provided with the most effective avenues possible for relief from unlawful listings.

BAM is committed to working with all members of Congress to restore balance to the Hatch-Waxman Act and improve pharmaceutical competition. We look forward to assisting your efforts.

Sincerely,

GOVERNOR M.J. "MIKE" FOSTER, JR.,
Louisiana.
GOVERNOR BOB WISE,
West Virginia.
GOVERNOR BRAD HENRY,
Oklahoma.
GOVERNOR BOB HOLDEN,
Missouri.
GOVERNOR RONNIE MUSGROVE,
Mississippi.
GOVERNOR THOMAS VILSACK,
Iowa.

Mr. ROGERS of Alabama. Mr. Speaker, one of the promises I made when I came to Washington was to improve the lives of East Alabama seniors. Unlike retirees in our country's metropolitan areas, the seniors of the Third District face far greater challenges.

For starters, most Third District seniors lives in rural areas with few choices in health care providers. This undoubtedly means higher health costs and fewer costs when it comes to doctors, and higher out-of-pocket expenses for covering the same level of basic medical needs.

Part of the problem, Mr. Speaker, is Medicare does not fairly and adequately reimburse doctors for their services. This is not fair, especially when retirees just across the Georgia border have far better access to doctors who are reimbursed by Medicare at higher rates. Seniors should not be penalized just because they live in rural areas.

But assuming we fix the reimbursement problem, this still leaves Medicare as a program designed for the 1960s, yet providing care in 2003. That's why I'm pleased to be in the House today to offer my full support for adding a prescription drug benefit under Medicare.

Earlier this year, Speaker HASTERT appointed me to his Prescription Drug Action Team to help craft a prescription drug benefit for Medicare. I've taken this responsibility around the Third District to listen to seniors describe what they think this benefit should do, and how it should be designed.

First and foremost, we must reduce the costs of prescription drugs. Modern medicine relies on these life-saving drugs more than ever, and doctors shown no signs of slowing the expected growth in prescriptions. But with Alabama seniors now paying an average of $1,200 per year for prescriptions, these costs are getting out of hand.

Consider seniors on fixed incomes, Mr. Speaker. These Alabamians, already strapped with high monthly bills, now face the costs of prescriptions rising beyond their means. We've already seen prescription drugs double or even triple in cost over the years. What will these seniors do when these drugs are priced out of reach? Will they be faced with filling their medicine cabinet or their pantry?

Mr. Speaker, this simply cannot continue. The U.S. House of Representatives has drafted a bill, the Medicare Prescription Drug Modernization Act of 2003, which includes a prescription drug benefit for seniors in both the traditional fee-for-service and in the new integrated health plans. The bill is not limited to adding prescription drug coverage for our state's seniors, but also includes much-needed modernizations to Medicare and improvements for health care providers, such as an increase in Medicare payments to doctors to ensure that seniors continue to have access to physician services. Most importantly, the bill includes improvements and increased funding for rural hospitals in the Third District.

This is hardly a perfect bill, but it is a good bill. The legislation helps Alabama's seniors receive better health care under Medicare and provides immediate relief from high prescription drug costs. President Bush supports it, and is ready to sign this bill should the House and Senate pass it.

Mr. Speaker, I'm proud to be in this House today and have the chance to improve the lives of Alabama's seniors. I will continue to work with my colleagues on both sides of the aisle, as well as those in the Senate, to help pass this important legislation now, and send it to the White House for President Bush to sign into law.

Mr. TAUZIN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). All time for general debate has expired.

GENERAL LEAVE

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 1.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. RANGEL

Mr. RANGEL. Mr. Chairman, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. RANGEL:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Prescription Drug and Modernization Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106-554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT

Sec. 101. Voluntary medicare outpatient prescription medicine program.

"PART D—VOLUNTARY PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND DISABLED

"Sec. 1859. Medicare outpatient prescription medicine benefit.
"Sec. 1859A. Negotiating fair prices with pharmaceutical manufacturers.
"Sec. 1859B. Contract authority.
"Sec. 1859C. Eligibility; voluntary enrollment; coverage.
"Sec. 1859D. Provision of, and entitlement to, benefits.
"Sec. 1859E. Administration; quality assurance.
"Sec. 1859F. Federal Medicare Prescription Medicine Trust Fund.
"Sec. 1859G. Compensation for employers covering retiree medicine costs.
"Sec. 1859H. Medicare Prescription Medicine Advisory Committee.
Sec. 102. Provision of medicare outpatient prescription medicine coverage under the Medicare+Choice program.
Sec. 103. Medigap revisions.
Sec. 104. Transitional assistance for low income beneficiaries.
Sec. 105. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).
Sec. 106. State Pharmaceutical Assistance Transition Commission.

TITLE II—MEDICARE+CHOICE

Sec. 201. Medicare+Choice improvements.
Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.
Sec. 203. Specialized Medicare+Choice plans for special needs beneficiaries.
Sec. 204. Medicare MSAs.
Sec. 205. Extension of reasonable cost contracts.
Sec. 206. Extension of municipal health service demonstration projects.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

Sec. 301. Medicare secondary payor (MSP) provisions.
Sec. 302. Competitive acquisition of certain items and services.
Sec. 303. Reform of payment for drugs and biologicals under the medicare program.
Sec. 304. Demonstration project for use of recovery audit contractors.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

Sec. 401. Fairness in the medicare disproportionate share hospital (DSH) adjustment for rural hospitals.
Sec. 402. Immediate establishment of uniform standardized amount in rural and small urban areas.
Sec. 403. Establishment of essential rural hospital classification.
Sec. 404. More frequent update in weights used in hospital market basket.
Sec. 405. Improvements to critical access hospital program.
Sec. 406. Redistribution of unused resident positions.
Sec. 407. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under prospective payment system for hospital outpatient department services.
Sec. 408. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 409. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 410. Improvement in payments to retain emergency capacity for ambulance services in rural areas.
Sec. 411. Two-year increase for home health services furnished in a rural area.
Sec. 412. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 413. GAO study of geographic differences in payments for physicians' services.

Sec. 414. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 415. Extension of telemedicine demonstration project.
Sec. 416. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.
Sec. 417. Medicare incentive payment program improvements for physician scarcity.
Sec. 418. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 419. Treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital.
Sec. 420. Establishment of floor on geographic adjustments of payments for physicians' services.
Sec. 421. Ambulance payment rates.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 501. Adjustment for indirect costs of medical education (IME).
Sec. 502. Recognition of new medical technologies under inpatient hospital pps.
Sec. 503. Increase in Federal rate for hospitals in Puerto Rico.
Sec. 504. Wage index adjustment reclassification reform .
Sec. 505. Clarifications to certain exceptions to medicare limits on physician referrals.

Subtitle B—Other Provisions

Sec. 511. Payment for covered skilled nursing facility services.
Sec. 512. Coverage of hospice consultation services.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

Sec. 601. Revision of updates for physicians' services.
Sec. 602. Studies on access to physicians' services.
Sec. 603. MedPAC report on payment for physicians' services.

Subtitle B—Preventive Services

Sec. 611. Coverage of an initial preventive physical examination.
Sec. 612. Coverage of cholesterol and blood lipid screening.
Sec. 613. Waiver of deductible for colorectal cancer screening tests.
Sec. 614. Improved payment for certain mammography services.

Subtitle C—Other Services

Sec. 621. Hospital outpatient department (HOPD) payment reform.
Sec. 622. Payment for ambulance services.
Sec. 623. Renal dialysis services.
Sec. 624. One-year moratorium on therapy caps; provisions relating to reports.
Sec. 625. Adjustment to payments for services furnished in ambulatory surgical centers.
Sec. 626. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
Sec. 627. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 628. Extension of coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
Sec. 629. Medicare coverage of diabetes laboratory diagnostic tests.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 701. Update in home health services.
Sec. 702. MedPAC study on medicare margins of home health agencies.
Sec. 703. Demonstration project to clarify the definition of homebound.

Subtitle B—Chronic Care Improvement

Sec. 721. Voluntary chronic care improvement under traditional fee-for-service.
Sec. 722. Chronic care improvement under Medicare+Choice plans.
Sec. 723. Institute of Medicine report.
Sec. 724. MedPAC report.

Subtitle C—Other Provisions

Sec. 731. Modifications to Medicare Payment Advisory Commission (MedPAC).
Sec. 732. Demonstration project for medical adult day care services.
Sec. 733. Improvements in national and local coverage determination process to respond to changes in technology.
Sec. 734. Treatment of certain physician pathology services.
Sec. 735. Medicare pancreatic islet cell transplant demonstration project.

TITLE VIII—MEDICAID

Sec. 801. Continuation of medicaid DSH allotment adjustments under BIPA 2000.
Sec. 802. Increase in floor for treatment as an extremely low DSH State to 3 percent in fiscal year 2003.
Sec. 803. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

Sec. 901. Construction; definition of supplier.
Sec. 902. Issuance of regulations.
Sec. 903. Compliance with changes in regulations and policies.
Sec. 904. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

Sec. 911. Increased flexibility in medicare administration.
Sec. 912. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

Sec. 921. Provider education and technical assistance.
Sec. 922. Small provider technical assistance demonstration program.
Sec. 923. Medicare provider ombudsman; medicare beneficiary ombudsman.
Sec. 924. Beneficiary outreach demonstration program.
Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

Sec. 931. Transfer of responsibility for medicare appeals.
Sec. 932. Process for expedited access to review.
Sec. 933. Revisions to medicare appeals process.
Sec. 934. Prepayment review.
Sec. 935. Recovery of overpayments.
Sec. 936. Provider enrollment process; right of appeal.
Sec. 937. Process for correction of minor errors and omissions without pursuing appeals process.
Sec. 938. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle V—Miscellaneous Provisions

Sec. 941. Policy development regarding evaluation and management (E & M) documentation guidelines.
Sec. 942. Improvement in oversight of technology and coverage.
Sec. 943. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
Sec. 944. EMTALA improvements.
Sec. 945. Emergency medical treatment and active labor act (EMTALA) technical advisory group.
Sec. 946. Authorizing use of arrangements to provide core hospice services in certain circumstances.
Sec. 947. Application of OSHA bloodborne pathogens standard to certain hospitals.
Sec. 948. BIPA-related technical amendments and corrections.
Sec. 949. Conforming authority to waive a program exclusion.
Sec. 950. Treatment of certain dental claims.
Sec. 951. Furnishing hospitals with information to compute dsh formula.
Sec. 952. Revisions to reassignment provisions.
Sec. 953. Other provisions.

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

Sec. 1001. Importation of prescription drugs.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Sec. 1101. Short title.
Sec. 1102. 30-month stay-of-effectiveness period.
Sec. 1103. Forfeiture of 180-day exclusivity period.
Sec. 1104. Bioavailability and bioequivalence.
Sec. 1105. Remedies for infringement.
Sec. 1106. Conforming amendments.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT

SEC. 101. VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION MEDICINE PROGRAM.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating section 1859 and part D as section 1858 and part E, respectively; and

(2) by inserting after part C the following new part:

"PART D—VOLUNTARY PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND DISABLED

"MEDICARE OUTPATIENT PRESCRIPTION MEDICINE BENEFIT

"SEC. 1859. Subject to the succeeding provisions of this part, the voluntary prescription medicine benefit program under this part provides the following:

"(1) PREMIUM.—The monthly premium is $25.

"(2) DEDUCTIBLE.—The annual deductible is $100.

"(3) COINSURANCE.—The coinsurance is 20 percent.

"(4) OUT-OF-POCKET LIMIT.—The annual limit on out-of-pocket spending on covered medicines is $2,000.

"NEGOTIATING FAIR PRICES WITH PHARMACEUTICAL MANUFACTURERS

"SEC. 1859A. (a) AUTHORITY TO NEGOTIATE PRICES WITH MANUFACTURERS.—The Secretary shall, consistent with the requirements of this part and the goals of providing quality care and containing costs under this part, negotiate contracts with manufacturers of covered outpatient prescription medicines that provide for the maximum prices that may be charged to individuals enrolled under this part by participating pharmacies for dispensing such medicines to such individuals.

"(b) PROMOTION OF BREAKTHROUGH MEDICINES.—In conducting negotiations with manufacturers under this part, the Secretary shall take into account the goal of promoting the development of breakthrough medicines (as defined in section 1859H(b)).

"CONTRACT AUTHORITY

"SEC. 1859B. (a) CONTRACT AUTHORITY.—

"(1) IN GENERAL.—The Secretary is responsible for the administration of this part and shall enter into contracts with appropriate pharmacy contractors on a national or regional basis to administer the benefits under this part.

"(2) PROCEDURES.—The Secretary shall establish procedures under which the Secretary—

"(A) accepts bids submitted by entities to serve as pharmacy contractors under this part in a region or on a national basis;

"(B) awards contracts to such contractors to administer benefits under this part to eligible beneficiaries in the region or on a national basis; and

"(C) provides for the termination (and nonrenewal) of a contract in the case of a contractor's failure to meet the requirements of the contract and this part.

"(3) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

"(4) TERMS AND CONDITIONS.—Such contracts shall have such terms and conditions as the Secretary shall specify and shall be for such terms (of at least 2 years, but not to exceed 5 years) as the Secretary shall specify consistent with this part.

"(5) USE OF PHARMACY CONTRACTORS IN PRICE NEGOTIATIONS.—Such contracts shall require the contractor involved to negotiate contracts with manufacturers that provide for maximum prices for covered outpatient prescription medicines that are lower than the maximum prices negotiated under section 1859A(a), if applicable. The price reductions shall be passed on to eligible beneficiaries and the Secretary shall hold the contractor accountable for meeting performance requirements with respect to price reductions and limiting price increases.

"(6) AREA FOR CONTRACTS.—

"(A) REGIONAL BASIS.—

"(i) IN GENERAL.—Except as provided in clause (ii) and subject to subparagraph (B), the contract entered into between the Secretary and a pharmacy contractor shall require the contractor to administer the benefits under this part in a region determined by the Secretary under subparagraph (B) or on a national basis.

"(ii) PARTIAL REGIONAL BASIS.—

"(I) IN GENERAL.—If determined appropriate by the Secretary, the Secretary may permit the benefits to be administered in a partial region determined appropriate by the Secretary.

"(II) REQUIREMENTS.—If the Secretary permits administration pursuant to subclause (I), the Secretary shall ensure that the partial region in which administration is effected is no smaller than a State and is at least the size of the commercial service area of the contractor for that area.

"(B) DETERMINATION.—

"(i) IN GENERAL.—In determining regions for contracts under this part, the Secretary shall—

"(I) take into account the number of individuals enrolled under this part in an area in order to encourage participation by pharmacy contractors; and

"(II) ensure that there are at least 10 different regions in the United States.

"(ii) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of administrative areas under this paragraph shall not be subject to administrative or judicial review.

"(7) SUBMISSION OF BIDS.—

"(A) SUBMISSION.—

"(i) IN GENERAL.—Subject to subparagraph (B), each entity desiring to serve as a pharmacy contractor under this part in an area shall submit a bid with respect to such area to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

"(ii) BID THAT COVERS MULTIPLE AREAS.—The Secretary shall permit an entity to submit a single bid for multiple areas if the bid is applicable to all such areas.

"(B) REQUIRED INFORMATION.—The bids described in subparagraph (A) shall include—

"(i) a proposal for the estimated prices of covered outpatient prescription medicines and the projected annual increases in such prices, including the additional reduction in price negotiated below the Secretary's maximum price and differentials between preferred and nonpreferred prices, if applicable;

"(ii) a statement regarding the amount that the entity will charge the Secretary for administering the benefits under the contract;

"(iii) a statement regarding whether the entity will reduce the applicable coinsurance percentage pursuant to section 1859E(a)(1)(A)(ii) and if so, the amount of such reduction and how such reduction is tied to the performance requirements described in subsection (c)(4)(A)(ii);

"(iv) a detailed description of the performance requirements for which the administrative fee of the entity will be subject to risk pursuant to subsection (c)(4)(A)(ii);

"(v) a detailed description of access to pharmacy services provided by the entity, including information regarding whether the pharmacy contractor will use a preferred pharmacy network, and, if so, how the pharmacy contractor will ensure access to pharmacies that choose to be outside of that network, and whether there will be increased cost-sharing for beneficiaries if they obtain medicines at such pharmacies;

"(vi) a detailed description of the procedures and standards the entity will use for—

"(I) selecting preferred prescription medicines; and

"(II) determining when and how often the list of preferred prescription medicines should be modified;

"(vii) a detailed description of any ownership or shared financial interests with pharmaceutical manufacturers, pharmacies, and other entities involved in the administration or delivery of benefits under this part as proposed in the bid;

"(viii) a detailed description of the entity's estimated marketing and advertising expenditures related to enrolling and retaining eligible beneficiaries; and

"(ix) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.

The procedures under clause (vi) shall include the use of a pharmaceutical and therapeutics committee the members of which include practicing pharmacists.

"(8) AWARDING OF CONTRACTS.—

"(A) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goals of providing quality care and of containing costs under this part, award in a competitive manner at least 2 contracts to administer benefits under this part in each area specified under paragraph (6), unless only 1 pharmacy contractor submitting a bid meets the minimum standards specified under this part and by the Secretary.

"(B) DETERMINATION.—In determining which of the pharmacy contractors that submitted bids that meet the minimum standards specified under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of relevant factors, with respect to—

"(i) how well the contractor meets such minimum standards;

"(ii) the amount that the contractor will charge the Secretary for administering the benefits under the contract;

"(iii) the performance standards established under subsection (c)(2) and performance requirements for which the administrative fee of the entity will be subject to risk pursuant to subsection (c)(4)(A)(ii);

"(iv) the proposed negotiated prices of covered outpatient medicines and annual increases in such prices;

"(v) factors relating to benefits, quality and performance, beneficiary cost-sharing, and consumer satisfaction;

"(vi) past performance and prior experience of the contractor in administering a prescription medicine benefit program;

"(vii) effectiveness of the contractor in containing costs through pricing incentives and utilization management; and

"(viii) such other factors as the Secretary deems necessary to evaluate the merits of each bid.

"(C) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts with pharmacy contractors under this part, the Secretary may waive conflict of interest laws generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

"(i) is not inconsistent with the—

"(I) purposes of the programs under this part; or

"(II) best interests of beneficiaries enrolled under this part; and

"(ii) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the program under this part.

"(D) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of the Secretary to award or not award a contract to a pharmacy contractor under this part shall not be subject to administrative or judicial review.

"(9) ACCESS TO BENEFITS IN CERTAIN AREAS.—

"(A) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient prescription medicines under this part to each eligible beneficiary enrolled under this part that resides in an area that is not covered by any contract under this part.

"(B) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that each eligible beneficiary enrolled under this part that resides in different areas in a year is provided the benefits under this part throughout the entire year.

"(b) QUALITY, FINANCIAL, AND OTHER STANDARDS AND PROGRAMS.—In consultation with appropriate pharmacy contractors, pharmacists, and health care professionals with expertise in prescribing, dispensing, and the appropriate use of prescription medicines, the Secretary shall establish standards and programs for the administration of this part to ensure appropriate prescribing, dispensing, and utilization of outpatient medicines under this part, to avoid adverse medicine reactions, and to continually reduce errors in the delivery of medically appropriate covered benefits. The Secretary shall not award a contract to a pharmacy contractor under this part unless the Secretary finds that the contractor agrees to comply with such standards and programs and other terms and conditions as the Secretary shall specify. The standards and programs under this subsection shall be applied to any administrative agreements described in subsection (a) the Secretary enters into. Such standards and programs shall include the following:

"(1) ACCESS.—

"(A) IN GENERAL.—The pharmacy contractor shall ensure that covered outpatient prescription medicines are accessible and convenient to eligible beneficiaries enrolled under this part for whom benefits are administered by the pharmacy contractor, including by offering the services 24 hours a day and 7 days a week for emergencies.

"(B) ON-LINE REVIEW.—The pharmacy contractor shall provide for on-line prospective review available 24 hours a day and 7 days a week in order to evaluate each prescription for medicine therapy problems due to duplication, interaction, or incorrect dosage or duration of therapy.

"(C) GUARANTEED ACCESS TO MEDICINES IN RURAL AND HARD-TO-SERVE AREAS.—The Secretary shall ensure that all beneficiaries have guaranteed access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas, including through the use of incentives such as bonus payments to retail pharmacists in rural areas and extra payments to the pharmacy contractor for the cost of rapid delivery of pharmaceuticals and any other actions necessary.

"(D) PREFERRED PHARMACY NETWORKS.—

"(i) IN GENERAL.—If a pharmacy contractor uses a preferred pharmacy network to deliver benefits under this part, such network shall meet minimum access standards established by the Secretary.

"(ii) STANDARDS.—In establishing standards under clause (i), the Secretary shall take into account reasonable distances to pharmacy services in both urban and rural areas.

"(E) ADHERENCE TO NEGOTIATED PRICES.—The pharmacy contractor shall have in place procedures to assure compliance of pharmacies with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices).

"(F) CONTINUITY OF CARE.—

"(i) IN GENERAL.—The pharmacy contractor shall ensure that, in the case of an eligible beneficiary who loses coverage under this part with such entity under circumstances that would permit a special election period (as established by the Secretary under section 1859C(b)(3)), the contractor will continue to provide coverage under this part to such beneficiary until the beneficiary enrolls and receives such coverage with another pharmacy contractor under this part or, if eligible, with a Medicare+Choice organization.

"(ii) LIMITED PERIOD.—In no event shall a pharmacy contractor be required to provide the extended coverage required under clause (i) beyond the date which is 30 days after the coverage with such contractor would have terminated but for this subparagraph.

"(2) ENROLLEE GUIDELINES.—The pharmacy contractor shall, consistent with State law, apply guidelines for counseling enrollees regarding—

"(A) the proper use of covered outpatient prescription medicine; and

"(B) interactions and contra-indications.

"(3) EDUCATION.—The pharmacy contractor shall apply methods to identify and educate providers, pharmacists, and enrollees regarding—

"(A) instances or patterns concerning the unnecessary or inappropriate prescribing or dispensing of covered outpatient prescription medicines;

"(B) instances or patterns of substandard care;

"(C) potential adverse reactions to covered outpatient prescription medicines;

"(D) inappropriate use of antibiotics;

"(E) appropriate use of generic products; and

"(F) the importance of using covered outpatient prescription medicines in accordance with the instruction of prescribing providers.

"(4) COORDINATION.—The pharmacy contractor shall coordinate with State prescription medicine programs, other pharmacy contractors, pharmacies, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

"(5) COST DATA.—

"(A) The pharmacy contractor shall make data on prescription medicine negotiated prices (including data on discounts) available to the Secretary.

"(B) The Secretary shall require, either directly or through a pharmacy contractor, that participating pharmacists, physicians, and manufacturers—

"(i) maintain their prescription medicine cost data (including data on discounts) in a form and manner specified by the Secretary;

"(ii) make such prescription medicine cost data available for review and audit by the Secretary; and

"(iii) certify that the prescription medicine cost data are current, accurate, and complete, and reflect all discounts obtained by the pharmacist or physician in the purchasing of covered outpatient prescription medicines.

Discounts referred to in subparagraphs (A) and (B) shall include all volume discounts, manufacturer rebates, prompt payment discounts, free goods, in-kind services, or any other thing of financial value provided explicitly or implicitly in exchange for the purchase of a covered outpatient prescription medicine.

"(6) REPORTING.—The pharmacy contractor shall provide the Secretary with periodic reports on—

"(A) the contractor's costs of administering this part;

"(B) utilization of benefits under this part;

"(C) marketing and advertising expenditures related to enrolling and retaining individuals under this part; and

"(D) grievances and appeals.

"(7) RECORDS AND AUDITS.—The pharmacy contractor shall maintain adequate records related to the administration of benefits under this part and afford the Secretary access to such records for auditing purposes.

"(8) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The pharmacy contractor shall comply with requirements of section 1851(h) (relating to marketing material and application forms) with respect to this part in the same manner as such requirements apply under part C, except that the provisions of paragraph (4)(A) of such section shall not apply with respect to discounts or rebates provided in accordance with this part.

"(c) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—

"(1) IN GENERAL.—The Secretary shall include in a contract awarded under subsection (b) with a pharmacy contractor such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate. The contract may provide financial or other incentives to encourage greater savings to the program under this part.

"(2) PERFORMANCE STANDARDS.—The Secretary shall provide for performance standards (which may include monetary bonuses if the standards are met and penalties if the standards are not met), including standards relating to the time taken to answer member and pharmacy inquiries (written or by telephone), the accuracy of responses, claims processing accuracy, online system availability, appeal procedure turnaround time, system availability, the accuracy and timeliness of reports, and level of beneficiary satisfaction.

"(3) OTHER INCENTIVES.—Such incentives under this subsection may also include—

"(A) financial incentives under which savings derived from the substitution of generic and other preferred multi-source medicines in lieu of nongeneric and nonpreferred medicines are made available to pharmacy contractors, pharmacies, beneficiaries, and the Federal Medicare Prescription Medicine Trust Fund; and

"(B) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization or improving quality that does not reduce the access of beneficiaries to medically necessary covered outpatient medicines.

"(4) REQUIREMENTS FOR PROCEDURES.—

"(A) IN GENERAL.—The Secretary shall establish procedures for making payments to each pharmacy contractor with a contract under this part for the administration of the benefits under this part. The procedures shall provide for the following:

"(i) ADMINISTRATIVE PAYMENT.—Payment of administrative fees for such administration.

"(ii) RISK REQUIREMENT.—An adjustment of a percentage (determined under subparagraph (B)) of the administrative fee payments made to a pharmacy contractor to ensure that the contractor, in administering the benefits under this part, pursues performance requirements established by the Secretary, including the following:

"(I) QUALITY SERVICE.—The contractor provides eligible beneficiaries for whom it administers benefits with quality services, as measured by such factors as sustained pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and member service support access, and timely action with regard to appeals and current beneficiary service surveys.

"(II) QUALITY CLINICAL CARE.—The contractor provides such beneficiaries with quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse drug reactions and reduce medication errors and specific clinical suggestions to improve health and patient and prescriber education as appropriate.

"(III) CONTROL OF MEDICARE COSTS.—The contractor contains costs under this part to the Federal Medicare Prescription Medicine Trust Fund and enrollees, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of beneficiaries to medically necessary covered outpatient prescription medicines.

"(B) PERCENTAGE OF PAYMENT TIED TO RISK.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the percentage of the administrative payments to a pharmacy contractor that will be tied to the performance requirements described in subparagraph (A)(ii).

"(ii) LIMITATION ON RISK TO ENSURE PROGRAM STABILITY.—In order to provide for program stability, the Secretary may not establish a percentage to be adjusted under this paragraph at a level that jeopardizes the ability of a pharmacy contractor to administer the benefits under this part or administer such benefits in a quality manner.

"(C) RISK ADJUSTMENT OF PAYMENTS BASED ON ENROLLEES IN PLAN.—To the extent that a pharmacy contractor is at risk under this paragraph, the procedures established under this paragraph may include a methodology for risk adjusting the payments made to such contractor based on the differences in actuarial risk of different enrollees being served if the Secretary determines such adjustments to be necessary and appropriate.

"(d) AUTHORITY RELATING TO PHARMACY PARTICIPATION.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a pharmacy contractor may establish consistent with this part conditions for the participation of pharmacies, including conditions relating to quality (including reduction of medical errors) and technology.

"(2) AGREEMENTS WITH PHARMACIES.—Each pharmacy contractor shall enter into a participation agreement with any pharmacy that meets the requirements of this subsection and section 1859E to furnish covered outpatient prescription medicines to individuals enrolled under this part.

"(3) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and conditions:

"(A) APPLICABLE REQUIREMENTS.—The pharmacy shall meet (and throughout the contract period continue to meet) all applicable Federal requirements and State and local licensing requirements.

"(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Secretary (and such a pharmacy contractor) shall establish concerning the quality of, and enrolled individuals' access to, pharmacy services under this part. Such standards shall require the pharmacy—

"(i) not to refuse to dispense covered outpatient prescription medicines to any individual enrolled under this part;

"(ii) to keep patient records (including records on expenses) for all covered outpatient prescription medicines dispensed to such enrolled individuals;

"(iii) to submit information (in a manner specified by the Secretary to be necessary to administer this part) on all purchases of such medicines dispensed to such enrolled individuals; and

"(iv) to comply with periodic audits to assure compliance with the requirements of this part and the accuracy of information submitted.

"(C) ADHERENCE TO NEGOTIATED PRICES.—(i) The total charge for each medicine dispensed by the pharmacy to an enrolled individual under this part, without regard to whether the individual is financially responsible for any or all of such charge, shall not exceed the price negotiated under section 1859A(a) or, if lower, negotiated under subsection (a)(5) (or, if less, the retail price for the medicine involved) with respect to such medicine plus a reasonable dispensing fee determined contractually with the pharmacy contractor.

"(ii) The pharmacy does not charge (or collect from) an enrolled individual an amount that exceeds the individual's obligation (as determined in accordance with the provisions of this part) of the applicable price described in clause (i).

"(D) ADDITIONAL REQUIREMENTS.—The pharmacy shall meet such additional contract requirements as the applicable pharmacy contractor specifies under this section.

"(4) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to pharmacies participating in the program under this part.

"ELIGIBILITY; VOLUNTARY ENROLLMENT; COVERAGE

"SEC. 1859C. (a) ELIGIBILITY.—Each individual who is entitled to hospital insurance benefits under part A or is eligible to be enrolled in the medical insurance program under part B is eligible to enroll in accordance with this section for outpatient prescription medicine benefits under this part.

"(b) VOLUNTARY ENROLLMENT.—

"(1) IN GENERAL.—An individual may enroll under this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this subsection.

"(2) INITIAL ENROLLMENT PERIOD.—

"(A) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who satisfies subsection (a) as of November 1, 2005, the initial general enrollment period shall begin on August 1, 2005, and shall end on March 1, 2006.

"(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who first satisfies subsection (a) on or after November 1, 2005, the individual's initial enrollment period shall begin on the first day of the third month before the month in which such individual first satisfies such paragraph and shall end seven months later. The Secretary shall apply rules similar to the rule described in the second sentence of section 1837(d).

"(3) SPECIAL ENROLLMENT PERIODS (WITHOUT PREMIUM PENALTY).—

"(A) EMPLOYER COVERAGE AT TIME OF INITIAL GENERAL ENROLLMENT PERIOD.—In the case of an individual who—

"(i) at the time the individual first satisfies subsection (a) is enrolled in a group health plan (including continuation coverage) that provides outpatient prescription medicine coverage by reason of the individual's (or the individual's spouse's) current (or, in the case of continuation coverage, former) employment status, and

"(ii) has elected not to enroll (or to be deemed enrolled) under this subsection during the individual's initial enrollment period,

there shall be a special enrollment period of 6 months beginning with the first month that includes the date of the individual's (or individual's spouse's) retirement from or termination of current employment status with the employer that sponsors the plan, or, in the case of continuation coverage, that includes the date of termination of such coverage, or that includes the date the plan substantially terminates outpatient prescription medicine coverage.

"(B) DROPPING OF RETIREE PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who—

"(i) at the time the individual first satisfies subsection (a) is enrolled in a group health plan that provides outpatient prescription medicine coverage other than by reason of the individual's (or the individual's spouse's) current employment; and

"(ii) has elected not to enroll (or to be deemed enrolled) under this subsection during the individual's initial enrollment period,

there shall be a special enrollment period of 6 months beginning with the first month that includes the date that the plan substantially terminates outpatient prescription medicine coverage and ending 6 months later.

"(C) LOSS OF MEDICARE+CHOICE PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who is enrolled under part C in a Medicare+Choice plan that provides prescription medicine benefits, if such enrollment is terminated because of the termination or reduction in service area of the plan, there shall be a special enrollment period of 6 months beginning with the first month that includes the date that such plan is terminated or such reduction occurs and ending 6 months later.

"(D) LOSS OF MEDICAID PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who—

"(i) satisfies subsection (a);

"(ii) loses eligibility for benefits (that include benefits for prescription medicine) under a State plan after having been enrolled (or determined to be eligible) for such benefits under such plan; and

"(iii) is not otherwise enrolled under this subsection at the time of such loss of eligibility,

there shall be a special enrollment period specified by the Secretary of not less than 6 months beginning with the first month that includes the date that the individual loses such eligibility.

"(4) LATE ENROLLMENT WITH PREMIUM PENALTY.—The Secretary shall permit an individual who satisfies subsection (a) to enroll other than during the initial enrollment period under paragraph (2) or a special enrollment period under paragraph (3). But, in the case of such an enrollment, the amount of the monthly premium of the individual is subject to an increase under section 1859C(e)(1).

"(5) INFORMATION.—

"(A) IN GENERAL.—The Secretary shall broadly distribute information to individuals who satisfy subsection (a) on the benefits provided under this part. The Secretary shall periodically make available information on the cost differentials to enrollees for the use of generic medicines and other medicines.

“(B) TOLL-FREE HOTLINE.—The Secretary shall maintain a toll-free telephone hotline (which may be a hotline already used by the Secretary under this title) for purposes of providing assistance to beneficiaries in the program under this part, including responding to questions concerning coverage, enrollment, benefits, grievances and appeals procedures, and other aspects of such program.

“(6) ENROLLEE DEFINED.—For purposes of this part, the term ‘enrollee’ means an individual enrolled for benefits under this part.

“(c) COVERAGE PERIOD.—

“(1) IN GENERAL.—The period during which an individual is entitled to benefits under this part (in this subsection referred to as the individual's ‘coverage period’) shall begin on such a date as the Secretary shall establish consistent with the type of coverage rules described in subsections (a) and (e) of section 1838, except that in no case shall a coverage period begin before January 1, 2006. No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period.

“(2) TERMINATION.—The Secretary shall provide for the application of provisions under this subsection similar to the provisions in section 1838(b).

“(d) PROVISION OF BENEFITS TO MEDICARE+CHOICE ENROLLEES.—In the case of an individual who is enrolled under this part and is enrolled in a Medicare+Choice plan under part C, the individual shall be provided the benefits under this part through such plan and not through payment under this part.

“(e) LATE ENROLLMENT PENALTIES; PAYMENT OF PREMIUMS.—

“(1) LATE ENROLLMENT PENALTY.—

“(A) IN GENERAL.—In the case of a late enrollment described in subsection (b)(4), subject to the succeeding provisions of this paragraph, the Secretary shall establish procedures for increasing the amount of the monthly premium under this part applicable to such enrollee by an amount that the Secretary determines is actuarially sound for each such period.

“(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account months of lapsed coverage in a manner comparable to that applicable under the second sentence of section 1839(b).

“(C) PERIODS NOT TAKEN INTO ACCOUNT.—

“(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the enrollee can demonstrate that the enrollee was covered under a group health plan that provides coverage of the cost of prescription medicines whose actuarial value (as defined by the Secretary) to the enrollee equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription medicine benefit program under this part.

“(ii) APPLICATION.—This subparagraph shall only apply with respect to a coverage period the enrollment for which occurs before the end of the 60-day period that begins on the first day of the month which includes the date on which the plan terminates or reduces its service area (in a manner that results in termination of enrollment), ceases to provide, or reduces the value of the prescription medicine coverage under such plan to below the value of the coverage provided under the program under this part.

“(2) INCORPORATION OF PREMIUM PAYMENT AND GOVERNMENT CONTRIBUTIONS PROVISIONS.—The provisions of sections 1840 and 1844(a)(1) shall apply to enrollees under this part in the same manner as they apply to individuals 65 years of age or older enrolled under part B. For purposes of this subsection, any reference in a section referred to in a previous subsection to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Federal Medicare Prescription Medicine Trust Fund.

“(f) ELECTION OF PHARMACY CONTRACTOR TO ADMINISTER BENEFITS.—The Secretary shall establish a process whereby each individual enrolled under this part and residing in a region may elect the pharmacy contractor that will administer the benefits under this part with respect to the individual. Such process shall permit the individual to make an initial election and to change such an election on at least an annual basis and under such other circumstances as the Secretary shall specify.

“PROVISION OF, AND ENTITLEMENT TO, BENEFITS

“SEC. 1859D. (a) BENEFITS.—Subject to the succeeding provisions of this section, the benefits provided to an enrollee by the program under this part shall consist of the following:

“(1) COVERED OUTPATIENT PRESCRIPTION MEDICINE BENEFITS.—Entitlement to have payment made on the individual's behalf for covered outpatient prescription medicines.

“(2) LIMITATION ON COST-SHARING FOR PART B OUTPATIENT PRESCRIPTION MEDICINES.—

“(A) IN GENERAL.—Once an enrollee has incurred aggregate countable cost-sharing (as defined in subparagraph (B)) equal to the stop-loss limit specified in subsection (c)(4) for expenses in a year, entitlement to the elimination of cost-sharing otherwise applicable under part B for additional expenses incurred in the year for outpatient prescription medicines or biologicals for which payment is made under part B.

“(B) COUNTABLE COST-SHARING DEFINED.—For purposes of this part, the term ‘countable cost-sharing’ means—

“(i) out-of-pocket expenses for outpatient prescription medicines with respect to which benefits are payable under part B, and

“(ii) cost-sharing under subsections (c)(3)(B) and (c)(3)(C)(i).

“(b) COVERED OUTPATIENT PRESCRIPTION MEDICINE DEFINED.—

“(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of this part the term ‘covered outpatient prescription medicine’ means any of the following products:

“(A) A medicine which may be dispensed only upon prescription, and—

“(i) which is approved for safety and effectiveness as a prescription medicine under section 505 of the Federal Food, Drug, and Cosmetic Act;

“(ii)(I) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a medicine, and (II) which has not been the subject of a final determination by the Secretary that it is a ‘new drug’ (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

“(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a medicine, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such medicine under such section because the Secretary has determined that the medicine is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

“(B) A biological product which—

“(i) may only be dispensed upon prescription;

“(ii) is licensed under section 351 of the Public Health Service Act; and

“(iii) is produced at an establishment licensed under such section to produce such product.

“(C) Insulin approved under appropriate Federal law, and needles, syringes, and disposable pumps for the administration of such insulin.

“(D) A prescribed medicine or biological product that would meet the requirements of subparagraph (A) or (B) but that is available over-the-counter in addition to being available upon prescription, but only if the particular dosage form or strength prescribed and required for the individual is not available over-the-counter.

“(E) Smoking cessation agents (as specified by the Secretary).

“(2) EXCLUSION.—The term ‘covered outpatient prescription medicine’ does not include—

“(A) medicines or classes of medicines, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), as the Secretary may specify and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this part;

“(B) except as provided in paragraphs (1)(D) and (1)(E), any product which may be distributed to individuals without a prescription;

“(C) any product when furnished as part of, or as incident to, a diagnostic service or any other item or service for which payment may be made under this title; or

“(D) any product that is covered under part B of this title.

“(c) PAYMENT OF BENEFITS.—

“(1) COVERED OUTPATIENT PRESCRIPTION MEDICINES.—There shall be paid from the Federal Medicare Prescription Medicine Trust Fund, in the case of each enrollee who incurs expenses for medicines with respect to which benefits are payable under this part under subsection (a)(1), amounts equal to the sum of—

“(A) the price for which the medicine is made available under this part (consistent with sections 1859A and 1859B), reduced by any applicable cost-sharing under paragraphs (2) and (3); and

“(B) a reasonable dispensing fee.

The price under subparagraph (A) shall in no case exceed the retail price for the medicine involved.

“(2) DEDUCTIBLE.—The amount of payment under paragraph (1) for expenses incurred in a year, beginning with 2006, shall be reduced by an annual deductible equal to the amount specified in section 1859(2) (subject to adjustment under paragraph (8)). Only expenses for countable cost-sharing (as defined in subsection (a)(2)(B)) shall be taken into account in applying this paragraph.

"(3) COINSURANCE.—

"(A) IN GENERAL.—The amount of payment under paragraph (1) for expenses incurred in a year shall be further reduced (subject to the stop-loss limit under paragraph (4)) by coinsurance as provided under this paragraph.

"(B) PREFERRED MEDICINES.—The coinsurance under this paragraph in the case of a preferred medicine (including a medicine treated as a preferred medicine under paragraph (5)), is equal to 20 percent of the price applicable under paragraph (1)(A) (or such lower percentage as may be provided for under section 1859E(a)(1)(A)(ii)). In this part, the term 'preferred medicine' means, with respect to medicines classified within a therapeutic class, those medicines which have been designated as a preferred medicine by the Secretary or the pharmacy contractor involved with respect to that class and (in the case of a nongeneric medicine) with respect to which a contract has been negotiated under this part.

"(C) NONPREFERRED MEDICINES.—The coinsurance under this paragraph in the case of a nonpreferred medicine that is not treated as a preferred medicine under paragraph (5) is equal to the sum of—

"(i) 20 percent of the price for lowest price preferred medicine that is within the same therapeutic class; and

"(ii) the amount by which—

"(I) the price at which the nonpreferred medicine is made available to the enrollee; exceeds

"(II) the price of such lowest price preferred medicine.

"(4) NO COINSURANCE ONCE OUT-OF-POCKET EXPENDITURES EQUAL STOP-LOSS LIMIT.—Once an enrollee has incurred aggregate countable cost-sharing under paragraph (3) (including cost-sharing under part B attributable to outpatient prescription drugs or biologicals) equal to the amount specified in section 1859(4) (subject to adjustment under paragraph (8)) for expenses in a year—

"(A) there shall be no coinsurance under paragraph (3) for additional expenses incurred in the year involved; and

"(B) there shall be no coinsurance under part B for additional expenses incurred in the year involved for outpatient prescription drugs and biologicals.

"(5) APPEALS RIGHTS RELATING TO COVERAGE OF NONPREFERRED MEDICINES.—

"(A) PROCEDURES REGARDING THE DETERMINATION OF MEDICINES THAT ARE MEDICALLY NECESSARY.—Each pharmacy contractor shall have in place procedures on a case-by-case basis to treat a nonpreferred medicine as a preferred medicine under this part if the preferred medicine is determined to be not as effective for the enrollee or to have significant adverse effect on the enrollee. Such procedures shall require that such determinations are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

"(B) PROCEDURES REGARDING DENIALS OF CARE.—Such contractor shall have in place procedures to ensure—

"(i) a timely internal review for resolution of denials of coverage (in whole or in part and including those regarding the coverage of nonpreferred medicines) in accordance with the medical exigencies of the case and a timely resolution of complaints, by enrollees in the plan, or by providers, pharmacists, and other individuals acting on behalf of each such enrollee (with the enrollee's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C;

"(ii) that the entity complies in a timely manner with requirements established by the Secretary that (I) provide for an external review by an independent entity selected by the Secretary of denials of coverage described in clause (i) not resolved in the favor of the beneficiary (or other complainant) under the process described in such clause and (II) are comparable to the external review requirements established for Medicare+Choice organizations under part C; and

"(iii) that enrollees are provided with information regarding the appeals procedures under this part at the time of enrollment with a pharmacy contractor under this part and upon request thereafter.

"(6) TRANSFER OF FUNDS TO COVER COSTS OF PART B PRESCRIPTION MEDICINE CATASTROPHIC BENEFIT.—With respect to benefits described in subsection (a)(2), there shall transferred from the Federal Medicare Prescription Medicine Trust Fund to the Federal Supplementary Medical Insurance Trust Fund amounts equivalent to the elimination of cost-sharing described in such subsection.

"(7) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—For purposes of making payment under part B for medicines that would be covered outpatient prescription medicines but for the exclusion under subparagraph (B) or (C) of subsection (b)(2), the Secretary may elect to apply the payment basis used for payment of covered outpatient prescription medicines under this part instead of the payment basis otherwise used under such part, if it results in a lower cost to the program.

"(8) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—With respect to expenses incurred in a year after 2006—

"(i) the deductible under paragraph (2) is equal to the deductible determined under such paragraph (or this subparagraph) for the previous year increased by the percentage increase in per capita program expenditures (as estimated in advance for the year involved under subparagraph (B)); and

"(ii) the stop-loss limit under paragraph (3) is equal to the stop-loss limit determined under such paragraph (or this subparagraph) for the previous year increased by such percentage increase.

The Secretary shall adjust such percentage increase in subsequent years to take into account misestimations made of the per capita program expenditures under clauses (i) and (ii) in previous years. Any increase under this subparagraph that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(B) ESTIMATION OF INCREASE IN PER CAPITA PROGRAM EXPENDITURES.—The Secretary shall before the beginning of each year (beginning with 2007) estimate the percentage increase in average per capita aggregate expenditures from the Federal Medicare Prescription Medicine Trust Fund for the year involved compared to the previous year.

"(C) RECONCILIATION.—The Secretary shall also compute (beginning with 2008) the actual percentage increase in such aggregate expenditures in order to provide for reconciliation of deductibles, stop-loss limits, and premiums under the second sentence of subparagraph (A) and under section 1859D(d)(2).

"(d) AMOUNT OF PREMIUMS.—

"(1) MONTHLY PREMIUM RATE IN 2006.—The monthly premium rate in 2006 for prescription medicine benefits under this part is the amount specified in section 1859(1).

"(2) INFLATION ADJUSTMENT FOR SUBSEQUENT YEARS.—The monthly premium rate for a year after 2006 for prescription medicine benefits under this part is equal to the monthly premium rate for the previous year under this subsection increased by the percentage increase in per capita program expenditures (as estimated in advance for the year involved under subsection (c)(8)(B)). The Secretary shall adjust such percentage in subsequent years to take into account misestimations made of the per capita program expenditures under the previous sentence in previous years. Any increase under this paragraph that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"ADMINISTRATION; QUALITY ASSURANCE

"SEC. 1859E. (a) RULES RELATING TO PROVISION OF BENEFITS.—

"(1) PROVISION OF BENEFITS.—

"(A) IN GENERAL.—In providing benefits under this part, the Secretary (directly or through the contracts with pharmacy contractors) shall employ mechanisms to provide benefits appropriately and efficiently, and those mechanisms may include—

"(i) the use of—

"(I) price negotiations (consistent with subsection (b));

"(II) reduced coinsurance (below 20 percent) to encourage the utilization of appropriate preferred medicines; and

"(III) methods to reduce medication errors and encourage appropriate use of medications; and

"(ii) permitting pharmacy contractors, as approved by the Secretary, to make exceptions to section 1859D(c)(3)(C) (relating to cost-sharing for non-preferred medicines) to secure best prices for enrollees so long as the payment amount under section 1859D(c)(1) does not equal zero.

"(B) CONSTRUCTION.—Nothing in this subsection shall be construed to prevent the Secretary (directly or through the contracts with pharmacy contractors) from using incentives to encourage enrollees to select generic or other cost-effective medicines, so long as—

"(i) such incentives are designed not to result in any increase in the aggregate expenditures under the Federal Medicare Prescription Medicine Trust Fund; and

"(ii) a beneficiary's coinsurance shall be no greater than 20 percent in the case of a preferred medicine (including a nonpreferred medicine treated as a preferred medicine under section 1859D(c)(5)).

"(2) CONSTRUCTION.—Nothing in this part shall preclude the Secretary or a pharmacy contractor from—

"(A) educating prescribing providers, pharmacists, and enrollees about medical and cost benefits of preferred medicines;

"(B) requesting prescribing providers to consider a preferred medicine prior to dispensing of a nonpreferred medicine, as long as such request does not unduly delay the provision of the medicine;

"(C) using mechanisms to encourage enrollees under this part to select cost-effective medicines or less costly means of receiving or administering medicines, including the use of therapeutic interchange programs, disease management programs, and notification to the beneficiary that a more affordable generic medicine equivalent was not selected by the prescribing provider and a statement of the lost cost savings to the beneficiary;

“(D) using price negotiations to achieve reduced prices on covered outpatient prescription medicines, including new medicines, medicines for which there are few therapeutic alternatives, and medicines of particular clinical importance to individuals enrolled under this part; and

“(E) utilizing information on medicine prices of OECD countries and of other payors in the United States in the negotiation of prices under this part.

“(b) Price Negotiations Process.—

“(1) Requirements with respect to preferred medicines.—Negotiations of contracts with manufacturers with respect to covered outpatient prescription medicines under this part shall be conducted in a manner so that—

“(A) there is at least a contract for a medicine within each therapeutic class (as defined by the Secretary in consultation with such Medicare Prescription Medicine Advisory Committee);

“(B) if there is more than 1 medicine available in a therapeutic class, there are contracts for at least 2 medicines within such class unless determined clinically inappropriate in accordance with standards established by the Secretary; and

“(C) if there are more than 2 medicines available in a therapeutic class, there is a contract for at least 2 medicines within such class and a contract for generic medicine substitute if available unless determined clinically inappropriate in accordance with standards established by the Secretary.

“(2) Establishment of therapeutic classes.—The Secretary, in consultation with the Medicare Prescription Medicine Advisory Committee (established under section 1859H), shall establish for purposes of this part therapeutic classes and assign to such classes covered outpatient prescription medicines.

“(3) Disclosure concerning preferred medicines.—The Secretary shall provide, through pharmacy contractors or otherwise, for—

“(A) disclosure to current and prospective enrollees and to participating providers and pharmacies in each service area a list of the preferred medicines and differences in applicable cost-sharing between such medicines and nonpreferred medicines; and

“(B) advance disclosure to current enrollees and to participating providers and pharmacies in each service area of changes to any such list of preferred medicines and differences in applicable cost-sharing.

“(4) No review.—The Secretary's establishment of therapeutic classes and the assignment of medicines to such classes and the Secretary's determination of what is a breakthrough medicine are not subject to administrative or judicial review.

“(c) Confidentiality.—The Secretary shall ensure that the confidentiality of individually identifiable health information relating to the provision of benefits under this part is protected, consistent with the standards for the privacy of such information promulgated by the Secretary under the Health Insurance Portability and Accountability Act of 1996, or any subsequent comprehensive and more protective set of confidentiality standards enacted into law or promulgated by the Secretary. Nothing in this subsection shall be construed as preventing the coordination of data with a State prescription medicine program so long as such program has in place confidentiality standards that are equal to or exceed the standards used by the Secretary.

“(d) Fraud and Abuse Safeguards.—The Secretary, through the Office of the Inspector General, is authorized and directed to issue regulations establishing appropriate safeguards to prevent fraud and abuse under this part. Such safeguards, at a minimum, should include compliance programs, certification data, audits, and recordkeeping practices. In developing such regulations, the Secretary shall consult with the Attorney General and other law enforcement and regulatory agencies.

“FEDERAL MEDICARE PRESCRIPTION MEDICINE TRUST FUND

“Sec. 1859F. (a) Establishment.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ‘Federal Medicare Prescription Medicine Trust Fund’ (in this section referred to as the ‘Trust Fund’). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

“(b) Application of SMI Trust Fund Provisions.—The provisions of subsections (b) through (i) of section 1841 shall apply to this part and the Trust Fund in the same manner as they apply to part B and the Federal Supplementary Medical Insurance Trust Fund, respectively.

“COMPENSATION FOR EMPLOYERS COVERING RETIREE MEDICINE COSTS

“Sec. 1859G. (a) In General.—In the case of an individual who is eligible to be enrolled under this part and is a participant or beneficiary under a group health plan that provides outpatient prescription medicine coverage to retirees the actuarial value of which is not less than the actuarial value of the coverage provided under this part, the Secretary shall make payments to such plan subject to the provisions of this section. Such payments shall be treated as payments under this part for purposes of sections 1859F and 1859C(e)(2). In applying the previous sentence with respect to section 1859C(e)(2), the amount of the Government contribution referred to in section 1844(a)(1)(A) is deemed to be equal to the aggregate amount of the payments made under this section.

“(b) Requirements.—To receive payment under this section, a group health plan shall comply with the following requirements:

“(1) Compliance with requirements.—The group health plan shall comply with the requirements of this Act and other reasonable, necessary, and related requirements that are needed to administer this section, as determined by the Secretary.

“(2) Annual assurances and notice before termination.—The sponsor of the plan shall—

“(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered under the group health plan meets the requirements of this section and will continue to meet such requirements for the duration of the sponsor's participation in the program under this section; and

“(B) guarantee that it will give notice to the Secretary and covered enrollees—

“(i) at least 120 days before terminating its plan, and

“(ii) immediately upon determining that the actuarial value of the prescription medicine benefit under the plan falls below the actuarial value required under subsection (a).

“(3) Beneficiary information.—The sponsor of the plan shall report to the Secretary, for each calendar quarter for which it seeks a payment under this section, the names and social security numbers of all enrollees described in subsection (a) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

“(4) Audits.—The sponsor or plan seeking payment under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription medicine coverage, the accuracy of payments made, and such other matters as may be appropriate.

“(c) Payment.—

“(1) In general.—The sponsor of a group health plan that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made on a quarterly basis of the amount specified in paragraph (2) for each individual described in subsection (a) who during the quarter is covered under the plan and was not enrolled in the insurance program under this part.

“(2) Amount of payment.—

“(A) In general.—The amount of the payment for a quarter shall approximate, for each such covered individual, ⅔ of the sum of the monthly Government contribution amounts (computed under subparagraph (B)) for each of the 3 months in the quarter.

“(B) Computation of monthly government contribution amount.—For purposes of subparagraph (A), the monthly Government contribution amount for a month in a year is equal to the amount by which—

“(i) 1⁄12 of the average per capita aggregate expenditures, as estimated under section 1859D(c)(8) for the year involved; exceeds

“(ii) the monthly premium rate under section 1859D(d) for the month involved.

“MEDICARE PRESCRIPTION MEDICINE ADVISORY COMMITTEE

“Sec. 1859H. (a) Establishment of Committee.—There is established a Medicare Prescription Medicine Advisory Committee (in this section referred to as the ‘Committee’).

“(b) Functions of Committee.—The Committee shall advise the Secretary on policies related to—

“(1) the development of guidelines for the implementation and administration of the outpatient prescription medicine benefit program under this part; and

“(2) the development of—

“(A) standards required of pharmacy contractors under section 1859D(c)(5) for determining if a medicine is as effective for an enrollee or has a significant adverse effect on an enrollee under this part;

“(B) standards for—

“(i) defining therapeutic classes;

“(ii) adding new therapeutic classes;

“(iii) assigning to such classes covered outpatient prescription medicines; and

“(iv) identifying breakthrough medicines;

“(C) procedures to evaluate the bids submitted by pharmacy contractors under this part;

“(D) procedures for negotiations, and standards for entering into contracts, with manufacturers, including identifying medicines or classes of medicines where Secretarial negotiation is most likely to yield savings under this part significantly above those that which could be achieved by a pharmacy contractor; and

“(E) procedures to ensure that pharmacy contractors with a contract under this part are in compliance with the requirements under this part.

For purposes of this part, a medicine is a 'breakthrough medicine' if the Secretary, in consultation with the Committee, determines it is a new product that will make a significant and major improvement by reducing physical or mental illness, reducing mortality, or reducing disability, and that no other product is available to beneficiaries that achieves similar results for the same condition. The Committee may consider cost-effectiveness in establishing standards for defining therapeutic classes and assigning drugs to such classes under subparagraph (B).

"(c) Structure and Membership of the Committee.—

"(1) Structure.—The Committee shall be composed of 19 members who shall be appointed by the Secretary.

"(2) Membership.—

"(A) In general.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Committee.

"(B) Specific members.—Of the members appointed under paragraph (1)—

"(i) 5 shall be chosen to represent practicing physicians, 2 of whom shall be gerontologists;

"(ii) 2 shall be chosen to represent practicing nurse practitioners;

"(iii) 4 shall be chosen to represent practicing pharmacists;

"(iv) 1 shall be chosen to represent the Centers for Medicare & Medicaid Services;

"(v) 4 shall be chosen to represent actuaries, pharmacoeconomists, researchers, and other appropriate experts;

"(vi) 1 shall be chosen to represent emerging medicine technologies;

"(vii) 1 shall be chosen to represent the Food and Drug Administration; and

"(viii) 1 shall be chosen to represent individuals enrolled under this part.

"(d) Terms of Appointment.—Each member of the Committee shall serve for a term determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on January 1, 2005.

"(e) Chairperson.—The Secretary shall designate a member of the Committee as Chairperson. The term as Chairperson shall be for a 1-year period.

"(f) Committee Personnel Matters.—

"(1) Members.—

"(A) Compensation.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

"(B) Travel expenses.—The members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

"(2) Staff.—The Committee may appoint such personnel as the Committee considers appropriate.

"(g) Operation of the Committee.—

"(1) Meetings.—The Committee shall meet at the call of the Chairperson (after consultation with the other members of the Committee) not less often than quarterly to consider a specific agenda of issues, as determined by the Chairperson after such consultation.

"(2) Quorum.—Ten members of the Committee shall constitute a quorum for purposes of conducting business.

"(h) Federal Advisory Committee Act.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

"(i) Transfer of Personnel, Resources, and Assets.—For purposes of carrying out its duties, the Secretary and the Committee may provide for the transfer to the Committee of such civil service personnel in the employ of the Department of Health and Human Services (including the Centers for Medicare & Medicaid Services), and such resources and assets of the Department used in carrying out this title, as the Committee requires.

"(j) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.".

(b) Application of General Exclusions from Coverage.—

(1) Application to part D.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking "part A or part B" and inserting "part A, B, or D".

(2) Prescription medicines not excluded from coverage if appropriately prescribed.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (H), by striking "and" at the end;

(B) in subparagraph (I), by striking the semicolon at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(J) in the case of prescription medicines covered under part D, which are not prescribed in accordance with such part;".

(c) Conforming Amendments.—(1) Part C of title XVIII is amended—

(A) in section 1851(a)(2)(B) (42 U.S.C. 1395w-21(a)(2)(B)), by striking "1859(b)(3)" and inserting "1858(b)(3)";

(B) in section 1851(a)(2)(C) (42 U.S.C. 1395w-21(a)(2)(C)), by striking "1859(b)(2)" and inserting "1858(b)(2)";

(C) in section 1852(a)(1) (42 U.S.C. 1395w-22(a)(1)), by striking "1859(b)(3)" and inserting "1858(b)(3)";

(D) in section 1852(a)(3)(B)(ii) (42 U.S.C. 1395w-22(a)(3)(B)(ii)), by striking "1859(b)(2)(B)" and inserting "1858(b)(2)(B)";

(E) in section 1853(a)(1)(A) (42 U.S.C. 1395w-23(a)(1)(A)), by striking "1859(e)(4)" and inserting "1858(e)(4)"; and

(F) in section 1853(a)(3)(D) (42 U.S.C. 1395w-23(a)(3)(D)), by striking "1859(e)(4)" and inserting "1858(e)(4)".

(2) Section 1171(a)(5)(D) (42 U.S.C. 1320d(a)(5)(D)) is amended by striking "or (C)" and inserting "(C), or (D)".

SEC. 102. PROVISION OF MEDICARE OUTPATIENT PRESCRIPTION MEDICINE COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) Requiring Availability of an Actuarially Equivalent Prescription Medicine Benefit.—Section 1851 (42 U.S.C. 1395w-21) is amended by adding at the end the following new subsection:

"(j) Availability of Prescription Medicine Benefits.—

"(1) In general.—Notwithstanding any other provision of this part, each Medicare+Choice organization that makes available a Medicare+Choice plan described in section 1851(a)(2)(A) shall make available such a plan that offers coverage of covered outpatient prescription medicines that is at least actuarially equivalent to the benefits provided under part D. Information respecting such benefits shall be made available in the same manner as information on other benefits provided under this part is made available. Nothing in this paragraph shall be construed as requiring the offering of such coverage separate from coverage that includes benefits under parts A and B.

"(2) Treatment of prescription medicine enrollees.—In the case of a Medicare+Choice eligible individual who is enrolled under part D, the benefits described in paragraph (1) shall be treated in the same manner as benefits described in part B for purposes of coverage and payment and any reference in this part to the Federal Supplementary Medical Insurance Trust Fund shall be deemed, with respect to such benefits, to be a reference to the Federal Medicare Prescription Medicine Trust Fund.".

(b) Application of Quality Standards.—Section 1852(e)(2)(A) (42 U.S.C. 1395w-22(e)(2)(A)) is amended—

(1) by striking "and" at the end of clause (xi);

(2) by striking the period at the end of clause (xii) and inserting ", and"; and

(3) by adding at the end the following new clause:

"(xiii) comply with the standards, and apply the programs, under section 1859B(b) for covered outpatient prescription medicines under the plan.".

(c) Payment Separate From Payment for Part A and B Benefits.—Section 1853 (42 U.S.C. 1395w-23) is amended—

(1) in subsection (a)(1)(A), by striking "and (i)" and inserting "(i), and (j)"; and

(2) by adding at the end the following new subsection:

"(j) Payment for Prescription Medicine Coverage Option.—

"(1) In general.—In the case of a Medicare+Choice plan that provides prescription medicine benefits described in section 1851(j)(1), the amount of payment otherwise made to the Medicare+Choice organization offering the plan shall be increased by the amount described in paragraph (2). Such payments shall be made in the same manner and time as the amount otherwise paid, but such amount shall be payable from the Federal Medicare Prescription Medicine Trust Fund.

"(2) Amount.—The amount described in this paragraph is the monthly Government contribution amount computed under section 1859G(c)(2)(B), but subject to adjustment under paragraph (3). Such amount shall be uniform geographically and shall not vary based on the Medicare+Choice payment area involved.

"(3) Risk adjustment.—The Secretary shall establish a methodology for the adjustment of the payment amount under this subsection in a manner that takes into account the relative risks for use of outpatient prescription medicines by Medicare+Choice enrollees. Such methodology shall be designed in a manner so that the total payments under this title (including part D) are not changed as a result of the application of such methodology.".

(d) Separate Application of Adjusted Community Rate (ACR).—Section 1854 (42

U.S.C. 1395w–24) is amended by adding at the end the following:

"(i) Application to Prescription Medicine Coverage.—The Secretary shall apply the previous provisions of this section (including the computation of the adjusted community rate) separately with respect to prescription medicine benefits described in section 1851(j)(1).".

(f) Conforming Amendments.—

(1) Section 1851 (42 U.S.C. 1395w–21) is amended—

(A) in subsection (a)(1)(A), by striking "parts A and B" and inserting "parts A, B, and D"; and

(B) in subsection (i) by inserting "(and, if applicable, part D)" after "parts A and B".

(2) Section 1852(a)(1)(A) (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting "(and under part D to individuals also enrolled under such part)" after "parts A and B".

(3) Section 1852(d)(1) (42 U.S.C. 1395w–22(d)(1)) is amended—

(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(C) by adding at the end the following:

"(F) the plan for part D benefits guarantees coverage of any specifically named prescription medicine for an enrollee to the extent that it would be required to be covered under part D.

In carrying out subparagraph (F), a Medicare+Choice organization has the same authority to enter into contracts with respect to coverage of preferred medicines as the Secretary has under part D, but subject to an independent contractor appeal or other appeal process that would be applicable to determinations by such a pharmacy contractor consistent with section 1859D(c)(5).".

(e) Limitation on Cost-Sharing.—Section 1854(e) (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

"(5) Limitation on cost-sharing.—In no event may a Medicare+Choice organization include a requirement that an enrollee pay cost-sharing in excess of the cost-sharing otherwise permitted under part D.".

SEC. 103. MEDIGAP REVISIONS.

(a) Required Coverage of Covered Outpatient Prescription Medicines.—Section 1882(p)(2)(B) (42 U.S.C. 1395ss(p)(2)(B)) is amended by inserting before "and" at the end the following: "including a requirement that an appropriate number of policies provide coverage of medicines which complements but does not duplicate the medicine benefits that beneficiaries are otherwise eligible for benefits under part D of this title (with the Secretary and the National Association of Insurance Commissioners determining the appropriate level of medicine benefits that each benefit package must provide and ensuring that policies providing such coverage are affordable for beneficiaries;".

(b) Effective Date.—The amendment made by subsection (a) shall take effect on January 1, 2006.

(c) Transition Provisions.—

(1) In general.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the amendments made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC standards.—If, within 9 months after the date of enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the "NAIC") modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) Secretary standards.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) Date specified.—

(A) In general.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) Additional legislative action required.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section; but

(ii) having a legislature which is not scheduled to meet in 2004 in a legislative session in which such legislation may be considered;

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 2004. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 104. TRANSITIONAL ASSISTANCE FOR LOW INCOME BENEFICIARIES.

(a) QMB Coverage of Premiums and Cost-Sharing.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking "and" at the end of clause (i),

(B) by adding "and" at the end of clause (ii), and

(C) by adding at the end the following new clause:

"(iii) premiums under section 1859D(d).";

(2) in subparagraph (B), by inserting "and section 1859D(c)(3)(B) and 1859D(c)(3)(C)(i)" after "1813"; and

(3) in subparagraph (C), by striking "and section 1833(b)" and inserting ", section 1833(b), and section 1859D(c)(2)".

(b) Expanded SLMB Eligibility.—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) by striking "and" at the end of clause (iii);

(2) by adding "and" at the end of clause (iv); and

(3) by adding at the end the following new clause:

"(v)(I) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) and section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries) who are enrolled under part D of title XVIII and are described in section 1905(p)(1)(B) or would be so described but for the fact that their income exceeds 100 percent, but is less than 150 percent, of the official poverty line (referred to in such section) for a family of the size involved;

"(II) subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries and individuals described in subclause (I)) who are enrolled under part D of title XVIII and would be described in section 1905(p)(1)(B) but for the fact that their income exceeds 150 percent, but is less than 175 percent, of the official poverty line (referred to in such section) for a family of the size involved, for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) and section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, and the assistance for medicare cost-sharing described in section 1905(p)(3)(A)(iii) is reduced (on a sliding scale based on income) from 100 percent to 0 percent as the income increases from 150 percent to 175 percent of such poverty line;".

(c) Federal Financing.—The third sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting before the period at the end the following: "and with respect to amounts expended that are attributable to section 1902(a)(10)(E)(v) (other than for individuals described in section 1905(p)(1)(B))".

(d) Treatment of Territories.—

(1) In general.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(A) by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively; and

(B) by inserting after paragraph (4) the following new paragraph:

"(5)(A) In the case of a State, other than the 50 States and the District of Columbia—

"(i) the provisions of paragraph (3) insofar as they relate to section 1859D and the provisions of section 1902(a)(10)(E)(v) shall not apply to residents of such State; and

"(ii) if the State establishes a plan described in subparagraph (B) (for providing medical assistance with respect to the provision of prescription medicines to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in subparagraph (C).

"(B) The plan described in this subparagraph is a plan that—

"(i) provides medical assistance with respect to the provision of covered outpatient medicines (as defined in section 1859D(b)) to low-income medicare beneficiaries; and

"(ii) assures that additional amounts received by the State that are attributable to the operation of this paragraph are used only for such assistance.

"(C)(i) The amount specified in this subparagraph for a State for a year is equal to the product of—

"(I) the aggregate amount specified in clause (ii); and

"(II) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

"(ii) The aggregate amount specified in this clause for—

"(I) 2006, is equal to $25,000,000; or

"(II) a subsequent year, is equal to the aggregate amount specified in this clause for the previous year increased by annual percentage increase specified in section 1859D(c)(8)(B) for the year involved.

"(D) The Secretary shall submit to Congress a report on the application of this paragraph and may include in the report such recommendations as the Secretary deems appropriate.".

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1905(p)(5)(A)(ii)" after "Subject to subsection (g)".

(e) APPLICATION OF COST-SHARING.—Section 1902(n)(2) (42 U.S.C. 1396a(n)(2)) is amended by adding at the end the following: "The previous sentence shall not apply to medicare cost-sharing relating to benefits under part D of title XVIII.".

(f) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for premiums and cost-sharing incurred on or after January 1, 2006, with regard to whether regulations to implement such amendments are promulgated by such date.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking "17" and inserting "19"; and

(B) in paragraph (2)(B), by inserting "experts in the area of pharmacology and prescription medicine benefit programs," after "other health professionals,".

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2004.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

"(D) PRESCRIPTION MEDICINE BENEFIT PROGRAM.—Specifically, the Commission shall review, with respect to the prescription medicine benefit program under part D, the following:

"(i) The methodologies used for the management of costs and utilization of prescription medicines.

"(ii) The prices negotiated and paid, including trends in such prices and applicable discounts and comparisons with prices under section 1859E(a)(2)(E).

"(iii) The relationship of pharmacy acquisition costs to the prices so negotiated and paid.

"(iv) The methodologies used to ensure access to covered outpatient prescription medicines and to ensure quality in the appropriate dispensing and utilization of such medicines.

"(v) The impact of the program on promoting the development of breakthrough medicines.".

SEC. 106. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established, as of the first day of the third month beginning after the date of the enactment of this Act, a State Pharmaceutical Assistance Transition Commission (in this section referred to as the "Commission") to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the medicare prescription drug program under part D of title XVIII of the Social Security Act.

(2) DEFINITIONS.—For purposes of this section:

(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term "State pharmaceutical assistance program" means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act assistance to low-income medicare beneficiaries for the purchase of prescription drugs.

(B) PROGRAM PARTICIPANT.—The term "program participant" means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(b) COMPOSITION.—The Commission shall include the following:

(1) A representative of each governor of each State that the Secretary identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under part D of title XVIII of the Social Security Act.

(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

(4) Representatives of Medicare+Choice organizations and other private health insurance plans, as appointed by the Secretary.

(5) The Secretary (or the Secretary's designee) and such other members as the Secretary may specify.

The Secretary shall designate a member to serve as chair of the Commission and the Commission shall meet at the call of the chair.

(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

(2) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this title.

(3) Principles of medicare modernization provided under title II of this Act.

(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and the Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

TITLE II—MEDICARE+CHOICE

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERVICE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by adding at the end the following:

"(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

"(i) IN GENERAL.—For 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

"(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.".

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking "or (C)" and inserting "(C), or (D)".

(b) REVISION OF BLEND.—

(1) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting "who (with respect to determinations for 2004) are enrolled in a Medicare+Choice plan" after "the average number of medicare beneficiaries".

(2) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1)(A), by inserting "(for a year before 2004)" after "multiplied"; and

(B) in paragraph (5), by inserting "(before 2004)" after "for each year".

(c) INCREASING MINIMUM PERCENTAGE INCREASE TO NATIONAL GROWTH RATE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended—

(A) in subparagraph (B)(iv), by striking "and each succeeding year" and inserting ", 2003, and 2004";

(B) in subparagraph (C)(iv), by striking "and each succeeding year" and inserting "and 2003"; and

(C) by adding at the end of subparagraph (C) the following new clause:

"(v) For 2004 and each succeeding year, the greater of—

"(I) 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year; or

"(II) the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.".

(2) Conforming amendment.—Section 1853(c)(6)(C) (42 U.S.C. 1395w–23(c)(6)(C)) is amended by inserting before the period at the end the following: ", except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004".

(d) Inclusion of Costs of DOD and VA Military Facility Services to Medicare-eligible Beneficiaries in Calculation of Medicare+Choice Payment Rates.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)", and

(2) by adding at the end the following new subparagraph:

"(E) Inclusion of costs of DOD and VA military facility services to medicare-eligible beneficiaries.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(e) Extending Special Rule for Certain Inpatient Hospital Stays to Rehabilitation Hospitals.—

(1) In general.—Section 1853(g) (42 U.S.C. 1395w–23(g)) is amended—

(A) by inserting "or from a rehabilitation facility (as defined in section 1886(j)(1)(A))" after "1886(d)(1)(B))"; and

(B) in paragraph (2)(B), by inserting "or section 1886(j), as the case may be," after "1886(d)".

(2) Effective date.—The amendments made by paragraph (1) shall apply to contract years beginning on or after January 1, 2004.

(f) MedPAC Study of AAPCC.—

(1) Study.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) as applied under section 1853(c)(1)(A) of such Act (as amended by subsection (a)). Such study shall include an examination of—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment under the Medicare+Choice program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) Report.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

(g) Report on Impact of Increased Financial Assistance to Medicare+Choice Plans.—Not later than July 1, 2006, the Medicare Benefits Administrator shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and BIPA) on the availability of Medicare+Choice plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(h) Limitation on Application to 2004 and 2005.—Notwithstanding any other provision of law, the amendments made by this section shall only apply to payment rates for 2004 and 2005 and for subsequent years the payment shall be made on the basis of law as in effect before the date of the enactment of this Act.

SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE+CHOICE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD.

(a) Change in Reporting Deadline.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)), as amended by section 532(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking "2002, 2003, and 2004 (or July 1 of each other year)" and inserting "2002 and each subsequent year".

(b) Delay in Annual, Coordinated Election Period.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking "and after 2005"; and

(2) by striking ", 2004, and 2005" and inserting "and any subsequent year".

(c) Annual Announcement of Payment Rates.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking "and after 2005"; and

(2) by striking "and 2005" and inserting "and each subsequent year".

SEC. 203. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) Treatment as Coordinated Care Plan.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: "Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.".

(b) Specialized Medicare+Choice Plan for Special Needs Beneficiaries Defined.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraph:

"(4) Specialized medicare+choice plans for special needs beneficiaries.—

"(A) In general.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

"(B) Special needs beneficiary.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

"(i) is institutionalized (as defined by the Secretary);

"(ii) is entitled to medical assistance under a State plan under title XIX; or

"(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.".

(c) Restriction on Enrollment Permitted.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

"(f) Restriction on Enrollment for Specialized Medicare+Choice Plans for Special Needs Beneficiaries.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.".

(d) Report to Congress.—Not later than December 31, 2005, the Medicare Benefits Administrator shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) Effective Dates.—

(1) In general.—The amendments made by subsections (a), (b), and (c) shall take effect upon the date of the enactment of this Act.

(2) Deadline for issuance of requirements for special needs beneficiaries; transition.—No later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 204. MEDICARE MSAS.

Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting "or with an organization offering a MSA plan" after "section 1851(a)(2)(A)".

SEC. 205. EXTENSION OF REASONABLE COST CONTRACTS.

Subparagraph (C) of section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is amended to read as follows:

"(C)(i) Subject to clause (ii), may be extended or renewed under this subsection indefinitely.

"(ii) For any period beginning on or after January 1, 2008, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area, during the entire previous year, was within the service area of 2 or more plans which were coordinated care Medicare+Choice plans under part C or 2 or more enhanced fee-for-service plans under part E and each of which plan for that previous year for the area involved meets the following minimum enrollment requirements:

"(I) With respect to any portion of the area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area, 5,000 individuals.

"(II) With respect to any other portion of such area, 1,500 individuals.".

SEC. 206. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking "December 31, 2004, but only with respect to" and all that follows and inserting "December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.".

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

SEC. 301. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SEC. 302. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) In General.—Section 1847 (42 U.S.C. 1395w-3) is amended to read as follows:

"COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

"Sec. 1847. (a) Establishment of Competitive Acquisition Programs.—

"(1) Implementation of programs.—

"(A) In general.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

"(B) Phased-in implementation.—The programs shall be phased-in—

"(i) among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

"(I) at least ⅓ of such areas in 2009; and

"(II) at least ⅔ of such areas in 2010; and

"(ii) among items and services in a manner such that the programs apply to the highest cost and highest volume items and services first.

"(C) Waiver of certain provisions.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

"(2) Items and services described.—The items and services referred to in paragraph (1) are the following:

"(A) Durable medical equipment and medical supplies.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), including items used in infusion and drugs and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

"(B) Other equipment and supplies.—Items, equipment, and supplies (as described in section 1842(s)(2)(D) other than enteral nutrients).

"(C) Off-the-shelf orthotics.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

"(3) Exception authority.—In carrying out the programs under this section, the Secretary may exempt—

"(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

"(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

"(4) Special rule for certain rented items of durable medical equipment.—In the case of a covered item for which payment is made on a rental basis under section 1834(a), the Secretary shall establish a process by which rental agreements for the covered items entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1834(a).

"(5) Physician authorization.—The Secretary may establish a process under which a physician may prescribe a particular brand or mode of delivery of an item or service if the item or service involved is clinically more appropriate than other similar items or services.

"(6) Application.—For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1834(a).

"(b) Program Requirements.—

"(1) In general.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

"(2) Conditions for awarding contract.—

"(A) In general.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

"(i) The entity meets quality and financial standards specified by the Secretary or developed by the Program Advisory and Oversight Committee established under subsection (c).

"(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

"(iii) Beneficiary access to a choice of multiple suppliers in the area is maintained.

"(iv) Beneficiary liability is limited to 20 percent of the applicable contract award price, except in such cases where a supplier has furnished an upgraded item and has executed an advanced beneficiary notice.

"(B) Development of quality standards for DME products.—

"(i) In general.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. Not later than July 1, 2007, the Secretary shall establish new quality standards for products subject to competitive acquisition under this section. Such standards shall be applied prospectively and shall be published on the website of the Department of Health and Human Services.

"(ii) CONSULTATION WITH PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—The Secretary shall consult with the Program Advisory and Oversight Committee (established under subsection (c)) to review (and advise the Secretary concerning) the quality standards referred to in clause (i).

"(3) CONTENTS OF CONTRACT.—

"(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

"(B) TERM OF CONTRACTS.—The Secretary shall recompete contracts under this section not less often than once every 3 years.

"(4) LIMIT ON NUMBER OF CONTRACTORS.—

"(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

"(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

"(5) PAYMENT.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on the bids submitted and accepted under this section for such items and services.

"(6) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

"(A) the contractor has submitted a bid for such items and services under this section; and

"(B) the Secretary has awarded a contract to the contractor for such items and services under this section.

In this section, the term 'bid' means a request for a proposal for an item or service that includes the cost of the item or service, and where appropriate, any services that are attendant to the provision of the item or service.

"(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary shall consider the similarity of the clinical efficiency and value of specific codes and products, including products that may provide a therapeutic advantage to beneficiaries, before delineating the categories and products that will be subject to bidding.

"(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries and monitoring quality of services with respect to the program.

"(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

"(1) ESTABLISHMENT.—There is established a Program Advisory and Oversight Committee (hereinafter in this section referred to as the 'Committee').

"(2) MEMBERSHIP; TERMS.—The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

"(3) DUTIES.—

"(A) TECHNICAL ASSISTANCE.—The Committee shall provide advice and technical assistance to the Secretary with respect to the following functions:

"(i) The implementation of the program under this section.

"(ii) The establishment of requirements for collection of data.

"(iii) The development of proposals for efficient interaction among manufacturers and distributors of the items and services and providers and beneficiaries.

"(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

"(4) INAPPLICABILITY OF FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

"(d) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in beneficiary cost-sharing, access to and quality of items and services, and beneficiary satisfaction.

"(e) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

"(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

"(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

"(B) which are furnished by entities that did not have a face-to-face encounter with the individual.

"(2) TERMS AND CONDITIONS.—Such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2).

"(3) REPORT.—The Secretary shall submit to Congress—

"(A) an initial report on the project not later than December 31, 2008; and

"(B) such progress and final reports on the project after such date as the Secretary determines appropriate.".

(b) CONFORMING AMENDMENTS.—

(1) DURABLE MEDICAL EQUIPMENT; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(A) in paragraph (1)(B), by striking "The payment basis" and inserting "Subject to subparagraph (E)(i), the payment basis";

(B) in paragraph (1)(C), by striking "This subsection" and inserting "Subject to subparagraph (E)(ii), this subsection";

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(E) APPLICATION OF COMPETITIVE ACQUISITION; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of covered items and services that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

"(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

"(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied."; and

(D) in paragraph (10)(B), by inserting "in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(E)" after "under this subsection".

(2) OFF-THE-SHELF ORTHOTICS; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(h) (42 U.S.C. 1395m(h)) is amended—

(A) in paragraph (1)(B), by striking "and (E)" and inserting ", (E), and (H)(i)";

(B) in paragraph (1)(D), by striking "This subsection" and inserting "Subject to subparagraph (H)(ii), this subsection";

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(H) APPLICATION OF COMPETITIVE ACQUISITION TO ORTHOTICS; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of orthotics described in paragraph (2)(B) of section 1847(a) that are included in a competitive acquisition program in a competitive acquisition area under such section—

"(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

"(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.".

(c) REPORT ON ACTIVITIES OF SUPPLIERS.—The Secretary shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act, as amended by subsection (a), are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability.

SEC. 303. REFORM OF PAYMENT FOR DRUGS AND BIOLOGICALS UNDER THE MEDICARE PROGRAM.

(a) PAYMENT REFORM.—

(1) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended to read as follows:

"(o) PAYMENT FOR DRUGS AND BIOLOGICALS.—

"(1) GENERAL RULE.—If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological shall be based on the following:

"(A) MULTI-SOURCE (GENERIC) DRUGS.—In the case of a drug or biological that meets the requirements for a multi-source drug under subclauses (I) and (II) of section 1927(k)(7)(A)(i), 105 percent of the volume-weighted median average acquisition price for any drug or biological covered under the same medicare HCPCS code.

"(B) SINGLE SOURCE (BRAND) DRUGS AND BIOLOGICALS.—In the case of a drug or biological that meets the requirements for a single source drug under section 1927(k)(7)(A)(iv), 105 percent of the average acquisition price for the drug or biological.

"(C) ACCESS EXCEPTION.—The Secretary may modify the rate otherwise applicable in order to assure access to necessary drugs and biologicals in the case of sole community providers in rural and other areas where the providers are not reasonably able to obtain the drugs and biologicals at the payment rates otherwise applicable. Such modification shall not result in a change of more than 15 percent of the rate otherwise applicable.

"(D) DATA-RELATED EXCEPTION.—If the Secretary determines that there is insufficient data available with respect to compute an average acquisition price for a drug or biological for a quarter or that, because of a significant change in price from quarter-to-quarter, the available data on the average acquisition price does not accurately reflect the actual, current acquisition cost for the drug or biological, the Secretary may substitute for the quarters involved an appropriate payment for the drug or biological for such average acquisition price.

"(E) APPLICATION OF NDC CODES.—If the Secretary determines that it is appropriate to provide for payment under this subsection using national drug code (NDC) instead of HCPCS codes, in applying subparagraph (A) the reference to the same HCPCS code shall be deemed a reference to the appropriate national drug codes for those drugs or biologicals that are therapeutically and pharmaceutically equivalent and bioequivalent (as defined for purposes of section 1927(k)(7)(A)).

"(2) DEFINITION OF AVERAGE ACQUISITION PRICE.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'average acquisition price' means, with respect to a drug or biological and with respect to each dosage form and strength of the drug or biological product (without regard to any special packaging, labeling, or identifiers on the dosage form or product or package), the average of all final sales prices charged by the manufacturer of the drug or biological product in the United States, excluding sales exempt from inclusion in the calculation of best price under section 1927(c)(1)(C) (other than under clause (ii)(III) of such section) and excluding sales subject to a rebate under section 1927, as reported under paragraph (3).

"(B) NET PRICE.—Such average acquisition price shall be calculated net of all of the following (as estimated by the Secretary):

"(i) Volume discounts.

"(ii) Prompt pay discounts and cash discounts.

"(iii) Charge-backs.

"(iv) Short-dated product discounts (for spoilage and other factors).

"(v) Free goods and services.

"(vi) Rebates.

"(vii) All other price concessions provided by the drug manufacturer.

The Secretary may make subsequent adjustments in such average acquisition price to take into account updated information and differences between the price previously estimated and the actual average acquisition price.

"(C) WEIGHTING.—The average of all final sales prices described in subparagraph (A) shall be determined by dividing—

"(i) the sum of all final prices charged by the manufacturer (net of the adjustments made under subparagraph (B)) for sales in the period involved that are included in subparagraph (A) for the drug or biological, by

"(ii) the total number of units of such sales in the period.

"(D) DISTRIBUTION OF REPORTS.—The Secretary shall promptly distribute applicable payment rates under this subsection to carriers and fiscal intermediaries and other contractors that make payment for drugs and biologicals under this section in order to apply a uniform reimbursement rate under this section.

"(3) PRICE REPORTING REQUIREMENT.—

"(A) IN GENERAL.—As a condition for payment for any drug or biological of a manufacturer under this subsection, the manufacturer of the drug or biological shall—

"(i) report, on a quarterly basis, to the Secretary (or the Secretary's designee) the manufacturer's average acquisition price and the information required under subparagraph (C) for all drugs and biologicals of the manufacturer by national drug code (NDC);

"(ii) maintain such records (in written or electronic form) regarding such sales and prices for all such drugs and biologicals as may be necessary to audit the information so reported or required to be reported; and

"(iii) provide the Secretary with access to such records in order to permit the Secretary to audit information so reported or required to be reported.

"(B) PENALTIES.—The provisions of section 1927(b)(3)(C) shall apply with respect to the reporting of information under subparagraph (A) in the same manner as it applies to the reporting of information under section 1927(b)(3)(A), except that the reference in clause (i) of such section to $10,000 is deemed a reference to $100,000 and any reference to a suspension of an agreement is deemed a reference to a suspension of payment for the drug or biological involved under this part. The Secretary shall promptly refer to the Inspector General of the Department of Health and Human Services and, if appropriate, to appropriate officials in the Department of Justice cases in which the Secretary becomes aware of a false price representation made in the information submitted under this paragraph.

"(C) FORM OF REPORTING.—Information required to be reported under subparagraph (A)(i) shall be reported in a form and manner specified by the Secretary. The information required to be reported shall include the identification of the generic name of the drug or biological and its brand name (if any), the national drug code (NDC) and the HCPCS code assigned to the drug or biological, the dosage form, strength, volume, and package size involved. The information for a quarter shall be submitted not later than 30 days after the end of the quarter. The information shall be accompanied by a written and signed certification by an officer of the manufacturer attesting to the accuracy of the information reported. Such information shall include updated information on the net price realized (taking into account rebates and other amounts affecting net price), regardless of the period for which such a rebate or other adjustment in net price might have been earned.

"(D) AUDITING.—The Secretary shall audit on a periodic basis information reported or required to be reported under this paragraph. The Secretary may conduct such independent price gathering activities, such as surveys and review of published catalog information or other transactional information, as may be appropriate to verify the accuracy of the information reported.

"(4) DISPENSING FEE.—If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary shall pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy. Such a dispensing fee shall be subject to adjustment from year to year based upon changes in the consumer price index over time and may be adjusted as the Secretary determines to be appropriate to reflect differences in the costs of dispensing different drugs and biologicals.

"(5) PAYMENT REQUIRED ON AN ASSIGNMENT-RELATED BASIS.—

"(A) IN GENERAL.—Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment-related basis.

"(B) APPLICATION OF ENFORCEMENT PROVISIONS.—The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to services furnished by a practitioner described in subsection (b)(18)(C).".

(2) EFFECTIVE DATE.—Subject to subsection (i)(2), the amendment made by paragraph (1) shall apply to drugs and biologicals furnished on or after January 1, 2004.

(b) MEDICARE PAYMENT FOR DRUG ADMINISTRATION SERVICES.—

(1) IN GENERAL.—The Secretary shall revise the practice expense relative value units for drug administration services for years beginning with the year 2005 in accordance with this subsection. For purposes of this subsection, the term "drug administration services" includes chemotherapy administration services, therapeutic and diagnostic infusions and injections, and such other services as the Secretary specifies.

(2) DIRECT COSTS EQUAL TO 100 PERCENT OF CPEP ESTIMATES.—Using the information, including estimates of clinical staff time, developed in the clinical practice expert panel process, including refinements by American Medical Association committees, the Secretary shall estimate the costs of the nursing and other clinical staff, supplies, and procedure-specific equipment (exceeding a cost specified by the Secretary) used in furnishing each type of drug administration service. The Secretary shall utilize without revision the minutes of clinical staff time determined in such process. The Secretary shall convert the information from such process to estimated costs by applying the most current available data on staff salary, supply, and equipment costs, and such costs shall be updated to 2005 based on estimated changes in prices since the date of such data.

(3) TOTAL PRACTICE EXPENSES.—The Secretary shall estimate the total practice expenses of each drug administration service by assuming that the direct costs for the service determined under paragraph (3) are 33.2 percent of such total practice expenses.

(4) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under paragraph (3) to practice expense relative value units for each drug administration service by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(5) UPDATES.—For years after 2005, the relative values determined under paragraph (4) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this subsection.

(6) MULTIPLE PUSHES.—In establishing the payment amounts under this subsection, the Secretary shall establish the payment amount for intravenous chemotherapy administration by push technique based on the administration of a single drug. The Secretary shall make the same payment for

each additional drug administered by push technique during the same encounter, except to the extent that the Secretary finds that the cost of administering additional drugs is less than the cost of administering the first drug.

(c) Payments for Chemotherapy Support Services.—

(1) General.—Beginning in 2005, the Secretary shall recognize and make payments under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for chemotherapy support services furnished incident to physicians' services. For the purposes of this section, the term "chemotherapy support services" are services furnished by the staff of physicians to patients undergoing treatment for cancer that were not included in the computation of clinical staff costs under subsection b(2). Such services include social worker services, nutrition counseling, psychosocial services, and similar services.

(2) Direct costs.—The Secretary shall estimate the cost of the salary and benefits of staff furnishing chemotherapy support services as they are provided in oncology practices that furnish these services to cancer patients in a manner that is considered to be high quality care. The estimate shall be based on the weekly cost of such services per patient receiving chemotherapy.

(3) Total costs.—The Secretary shall estimate the total practice expenses of chemotherapy support services by assuming that the direct costs for the service determined under paragraph (2) are 33.2 percent of such total practice expenses.

(4) Conversion to relative value units.—The Secretary shall convert the total practice expenses determined under paragraph (3) to practice expense relative value units for chemotherapy support services by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for chemotherapy support services under such section 1848.

(5) Updates.—For years after 2005, the relative values determined under paragraph (4) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this subsection.

(d) Cancer Therapy Management Services.—Beginning in 2005, the Secretary shall recognize and establish a payment amount for the service of cancer therapy management to account for the greater pre-service and post-service work associated with visits and consultations conducted by physicians treating cancer patients compared to typical visits and consultations. The payment amount may vary by the level and type of the related visit or consultation.

(e) Other Services Without Physician Work Relative Value Units.—Beginning in 2005, the Secretary shall develop a revised methodology for determining the payment amounts for services that are paid under the fee schedule established by section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and that do not have physician work relative value units, including radiation oncology services. Such methodology shall result in payment amounts that fully cover the costs of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of any one specialty's services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

(f) Report to Congress.—Not later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that are projected to be adopted under subsections (b), (c), (d), and (e) of this section.

(g) Institute of Medicine Study.—

(1) General.—The Secretary shall request the Institute of Medicine to conduct the study described in this subsection.

(2) Baseline study.—The first phase of the study shall include the following objectives:

(A) An assessment of the extent to which the current medicare payment system, prior to implementation of the amendments made by this section, facilitates appropriate access to care by cancer patients in the various treatment settings.

(B) The identification of the comprehensive range of services furnished to cancer patients in the outpatient setting, including support services such as psychosocial services and counseling, and recommendations regarding the types of services that ought to be furnished to medicare patients with cancer.

(C) A discussion of the practice standards necessary to assure the safe provision of services to cancer patients.

(D) An analysis of the extent to which the current medicare payment system supports the role of nurses in the provision of oncology services and recommendations for any necessary improvements in the payment system in that respect.

(E) The development of a framework for assessing how the amendments made by this act affect the provision of care to medicare patients with cancer in the various treatment settings.

(3) Second phase of study.—After the implementation of the amendments made by this section, the study shall determine whether and how those amendments affected the provision of care to medicare patients with cancer.

(4) Consultation.—The Institute of Medicine shall consult with the National Cancer Policy Board and organizations representing cancer patients and survivors, oncologists, oncology nurses, social workers, cancer centers, and other healthcare professionals who treat cancer patients in planning and carrying out this study.

(5) Due dates.—

(A) The study required by paragraph (2) shall be submitted to the Congress and the Secretary of Health and Human Services no later than June 30, 2004.

(B) The study required by paragraph (3) shall be submitted to the Congress and the Secretary of Health and Human Services no later than December 31, 2006.

(i) Study of Payments for Blood Clotting Factors and Other Biologicals.—

(1) In general.—The Secretary of Health and Human Services shall provide for a study of the appropriateness of the medicare payment methodology for blood clotting factors and other biologicals under part B of title XVIII of the Social Security Act. Not later than 9 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on such study and shall include in such report recommendations regarding whether to apply the payment methodology provided under the amendment made by subsection (a)(1) and alternative recommendations for appropriate dispensing fees.

(2) Delay in effective date.—The amendment made by subsection (a)(1) shall not apply to blood clotting factors furnished before the first day of the first calendar year that begins at least 6 months after the date the report under paragraph (1) has been submitted to the Congress.

SEC. 304. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) In General.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A or part B of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) Scope and Duration.—

(1) Scope.—The project shall cover at least 2 States that are among the States with—

(A) the highest per capita utilization rates of medicare services, and

(B) at least 3 contractors.

(2) Duration.—The project shall last for not longer than 3 years.

(c) Waiver.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) Qualifications of Contractors.—

(1) In general.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) Ineligibility of certain contractors.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) Preference for entities with demonstrated proficiency with private insurers.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency in recovery audits with private insurers or under the medicaid program under title XIX of such Act.

(e) Construction Relating to Conduct of Investigation of Fraud.—A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) Report.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

SEC. 401. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting ", and, after October 1, 2004, for any other hospital described in clause (iv)," after "clause (iv)(I)" in the matter preceding subclause (I).

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting "and before October 1, 2004," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xiii)";

(ii) in subclause (III)—

(I) by inserting "and before October 1, 2004," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xii)";

(iii) in subclause (IV)—

(I) by inserting "and before October 1, 2004," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (x) or (xi)";

(iv) in subclause (V)—

(I) by inserting "and before October 1, 2004," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xi)"; and

(v) in subclause (VI)—

(I) by inserting "and before October 1, 2004," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (x)";

(B) in clause (viii), by striking "The formula" and inserting "For discharges occurring before October 1, 2004, the formula"; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "With respect to discharges occurring before October 1, 2004, for purposes".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2004.

SEC. 402. IMMEDIATE ESTABLISHMENT OF UNIFORM STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS.

(a) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

(1) in clause (iv), by inserting "and ending on or before September 30, 2003," after "October 1, 1995,"; and

(2) by redesignating clauses (v) and (vi) as clauses (vii) and (viii), respectively, and inserting after clause (iv) the following new clauses:

"(v) For discharges occurring in the fiscal year beginning on October 1, 2003, the average standardized amount for hospitals located in areas other than a large urban area shall be equal to the average standardized amount for hospitals located in a large urban area.".

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "IN DIFFERENT AREAS";

(B) in the matter preceding clause (i), by striking ", each of";

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking "and" after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking the period at the end and inserting "; and"; and

(E) by adding at the end the following new clause:

"(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

"(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.".

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting ", for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting ", for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region,".

SEC. 403. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

(a) CLASSIFICATION.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended—

(1) in the heading by adding "ESSENTIAL RURAL HOSPITALS" at the end; and

(2) by adding at the end the following new paragraphs:

"(4)(A) The term 'essential rural hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is located in a rural area (as defined for purposes of section 1886(d)), has more than 25 licensed acute care inpatient beds, has applied to the Secretary for classification as such a hospital, and with respect to which the Secretary has determined that the closure of the hospital would significantly diminish the ability of medicare beneficiaries to obtain essential health care services.

"(B) The determination under subparagraph (A) shall be based on the following criteria:

"(i) HIGH PROPORTION OF MEDICARE BENEFICIARIES RECEIVING CARE FROM HOSPITAL.—(I) A high percentage of such beneficiaries residing in the area of the hospital who are hospitalized (during the most recent year for which complete data are available) receive basic inpatient medical care at the hospital.

"(II) For a hospital with more than 200 licensed beds, a high percentage of such beneficiaries residing in such area who are hospitalized (during such recent year) receive specialized surgical inpatient care at the hospital.

"(III) Almost all physicians described in section 1861(r)(1) in such area have privileges at the hospital and provide their inpatient services primarily at the hospital.

"(ii) SIGNIFICANT ADVERSE IMPACT IN ABSENCE OF HOSPITAL.—If the hospital were to close—

"(I) there would be a significant amount of time needed for residents to reach emergency treatment, resulting in a potential significant harm to beneficiaries with critical illnesses or injuries;

"(II) there would be an inability in the community to stablize emergency cases for transfers to another acute care setting, resulting in a potential for significant harm to medicare beneficiaries; and

"(III) any other nearby hospital lacks the physical and clinical capacity to take over the hospital's typical admissions.

"(C) In making such determination, the Secretary may also consider the following:

"(i) Free-standing ambulatory surgery centers, office-based oncology care, and imaging center services are insufficient in the hospital's area to handle the outpatient care of the hospital.

"(ii) Beneficiaries in nearby areas would be adversely affected if the hospital were to close as the hospital provides specialized knowledge and services to a network of smaller hospitals and critical access hospitals.

"(iii) Medicare beneficiaries would have difficulty in accessing care if the hospital were to close as the hospital provides significant subsidies to support ambulatory care in local clinics, including mental health clinics and to support post acute care.

"(iv) The hospital has a committment to provide graduate medical education in a rural area.

"(C) QUALITY CARE.—The hospital inpatient score for quality of care is not less than the median hospital score for qualify of care for hospitals in the State, as established under standards of the utilization and quality control peer review organization under part B of title XI or other quality standards recognized by the Secretary.

A hospital classified as an essential rural hospital may not change such classification and a hospital so classified shall not be treated as a sole community hospital, medicare dependent hospital, or rural referral center for purposes of section 1886.".

(b) PAYMENT BASED ON 102 PERCENT OF ALLOWED COSTS.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

"(11) In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for inpatient hospital services for discharges occurring during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this paragraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under part A or as waiving any requirement for billing for such services.".

(2) HOSPITAL OUTPATIENT SERVICES.—Section 1833(t)(13) (42 U.S.C. 1395l(t)(13)) is amended by adding at the end the following new subparagraph:

"(B) SPECIAL RULE FOR ESSENTIAL RURAL HOSPITALS.—In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for covered OPD services during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this subparagraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under this part or as waiving any requirement for billing for such services.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2004.

SEC. 404. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) REPORT.—Not later than October 1, 2004, the Secretary shall submit a report to Congress on the frequency established under subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l); 1395m(g)(1); 42 U.S.C. 1395tt(a)(3)) are each amended by inserting "equal to 102 percent of" before "the reasonable costs".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after October 1, 2003.

(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting ";physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services" and inserting "services covered under this title".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to costs incurred for services provided on or after January 1, 2004.

(c) PERMITTING CAHs TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i-4(c)(2)(B)(iii)) is amended to read as follows:

"(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;".

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i-4(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2004.

(d) ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) ELIMINATION.—

(A) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A-482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2005.

(2) TECHNICAL CORRECTION.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A-486), as paragraph (9).

(e) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting ", in the cases described in subparagraphs (A) through (D)" after "1986"; and

(B) by striking "and" at the end of subparagraph (C);

(C) by adding "and" at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

(2) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

(3) REINSTATEMENT OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after January 1, 2004.

(f) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

"The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective as if included in the enactment of section 403(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A-371).

(g) ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR GRANT PROGRAM.—

(1) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i-4(g)) is amended by adding at the end the following new paragraph:

"(4) FUNDING.—

"(A) IN GENERAL.—Subject to subparagraph (B), payment for grants made under this subsection during fiscal years 2004 through 2008 shall be made from the Federal Hospital Insurance Trust Fund.

"(B) ANNUAL AGGREGATE LIMITATION.—In no case may the amount of payment provided for under subparagraph (A) for a fiscal year exceed $25,000,000.".

(2) CONFORMING AMENDMENT.—Section 1820 (42 U.S.C. 1395i-4) is amended by striking subsection (j).

SEC. 406. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting "subject to subparagraph (I)," after "October 1, 1997,";

(2) in subparagraph (H)(i), by inserting "subject to subparagraph (I)," after "subparagraphs (F) and (G),"; and

(3) by adding at the end the following new subparagraph:

"(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

"(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

"(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2004, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

"(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2002.

"(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

"(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2003.

"(V) AFFILIATION.—With respect to hospitals which are members of the same affiliated group (as defined by the Secretary under subparagraph (H)(ii)), the provisions of this section shall be applied with respect to such an affiliated group by deeming the affiliated group to be a single hospital.

"(ii) REDISTRIBUTION.—

"(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

"(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2004, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2005.

"(III) Considerations in redistribution.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

"(IV) Priority for rural and small urban areas.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

"(V) Application of locality adjusted national average per resident amount.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

"(VI) Construction.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

"(iii) Resident level and limit defined.—In this subparagraph:

"(I) Resident level.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

"(II) Otherwise applicable resident limit.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.".

(b) Conforming Amendment to IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: "The provisions of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentece of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection.".

(c) Report on Extension of Applications Under Redistribution Program.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

SEC. 407. TWO-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) Hold Harmless Provisions.—

(1) In general.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking "SMALL" and inserting "CERTAIN";

(B) by inserting "or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area" after "100 beds"; and

(C) by striking "2004" and inserting "2006".

(2) Effective date.—The amendment made by subsection (a)(2) shall apply with respect to payment for OPD services furnished on and after January 1, 2004.

(b) Study; Adjustment.—

(1) Study.—The Secretary shall conduct a study to determine if, under the prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), costs incurred by rural providers of services by ambulatory payment classification groups (APCs) exceed those costs incurred by urban providers of services.

(2) Adjustment.—Insofar as the Secretary determines under paragraph (1) that costs incurred by rural providers exceed those costs incurred by urban providers of services, the Secretary shall provide for an appropriate adjustment under such section 1833(t) to reflect those higher costs by January 1, 2005.

SEC. 408. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) In General.—Section 1888(e)(2)(A) (42 U.S.C. 1395yy(e)(2)(A)) is amended—

(1) in clause (i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

(2) by adding at the end the following new clause:

"(iv) Exclusion of certain rural health clinic and federally qualified health center services.—Services described in this clause are—

"(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

"(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were not furnished by an individual affiliated with a rural health clinic or a Federally qualified health center.".

(b) Effective Date.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2004.

SEC. 409. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) In General.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting "or nurse practitioner (as defined in subsection (aa)(5))" after "the physician (as defined in subsection (r)(1))".

(b) Prohibition on Nurse Practitioner Certifying Need for Hospice.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting "(which for purposes of this subparagraph does not include a nurse practitioner)" after "attending physician (as defined in section 1861(dd)(3)(B))".

SEC. 410. IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9); and

(2) by adding at the end the following new paragraph:

"(10) Assistance for rural providers furnishing services in low medicare population density areas.—

"(A) In general.—In the case of ground ambulance services furnished on or after January 1, 2004, for which the transportation originates in a qualified rural area (as defined in subparagraph (B)), the Secretary shall provide for an increase in the base rate of the fee schedule for mileage for a trip established under this subsection. In establishing such increase, the Secretary shall, based on the relationship of cost and volume, estimate the average increase in cost per trip for such services as compared with the cost per trip for the average ambulance service.

"(B) Qualified rural area defined.—For purposes of subparagraph (A), the term 'qualified rural area' is a rural area (as defined in section 1886(d)(2)(D)) with a population density of medicare beneficiaries residing in the area that is in the lowest three quartiles of all rural county populations.".

SEC. 411. TWO-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) In General.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) during 2004 and 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

(b) Waiving Budget Neutrality.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) In General.—Section 1128B(b)(3) (42 U.S.C. 1320a-7(b)(3)) is amended—

(1) in subparagraph (E), by striking "and" after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(G) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.".

(b) Rulemaking for Exception for Health Center Entity Arrangements.—

(1) Establishment.—

(A) In general.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(G) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) Factors to consider.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) INTERIM FINAL EFFECT.—No later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 413. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions; and

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 414. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

"(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 415. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking "4-year" and inserting "8-year"; and

(2) in subsection (d)(3), by striking "$30,000,000" and inserting "$60,000,000".

SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking "WAGE LEVELS.—The Secretary" and inserting "WAGE LEVELS.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary"; and

(2) by adding at the end the following new clause:

"(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2004.—

"(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2003, the Secretary shall substitute the '62 percent' for the proportion described in the first sentence of clause (i).

"(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.".

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: "The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Medicare Prescription Drug and Modernization Act of 2003 had not been enacted.".

SEC. 417. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) ADDITIONAL BONUS PAYMENT FOR CERTAIN PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 1395*l*) is amended by adding at the end the following new subsection:

"(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

"(1) IN GENERAL.—In the case of physicians' services furnished in a year—

"(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

"(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

"(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall periodically determine, for each county or equivalent area in the United States, the following:

"(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

"(i) primary care physicians; or

"(ii) physicians who are not primary care physicians.

"(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both.

"(C) DETERMINATION OF RATIOS.—

"(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the 'primary care ratio') of the number of primary care physicians (determined under subparagraph (A)(i)), to number of medicare beneficiaries determined under subparagraph (B).

"(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the 'specialist care ratio') of the number of other physicians (determined under subparagraph (A)(ii)), to number of medicare beneficiaries determined under subparagraph (B).

"(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

"(4) IDENTIFICATION OF COUNTIES.—The Secretary shall identify—

"(A) those counties and areas (in this paragraph referred to as 'primary care scarcity counties') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph; and

"(B) those counties and areas (in this subsection referred to as 'specialist care scarcity counties') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph.

There is no administrative or judicial review respecting the identification of a county or area or the assignment of a specialty of any physician under this paragraph.

"(5) RURAL CENSUS TRACKS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

"(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term 'physician' means a physician described in section 1861(r)(1) and the term 'primary care physician' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

"(7) PUBLICATION OF LIST OF COUNTIES.—In carrying out this subsection for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a primary care scarcity county or specialist care scarcity county under this subsection for the year involved.".

(2) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to physicians' services furnished on or after January 1, 2004.

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(A) by inserting "(1)" after "(m)"; and

(B) by adding at the end the following new paragraphs:

"(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).

"(3) In carrying out paragraph (1) for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a health professional shortage area under paragraph (1) for the year involved.".

(2) Effective date.—The amendments made by paragraph (1) shall apply to physicians' services furnished on or after January 1, 2004.

SEC. 418. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

"(12) Payment adjustment for low-volume hospitals.—

"(A) Payment adjustment.—

"(i) In general.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

"(ii) Applicable percentage increase.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

"(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

"(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph; and

"(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

"(iii) Low-volume hospital defined.—For purposes of this paragraph, the term 'low-volume hospital' means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

"(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

"(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

"(B) Prohibiting certain reductions.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).".

SEC. 419. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2004 or 2005 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) Payment based on reasonable costs.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) No beneficiary cost-sharing.—Notwithstanding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 420. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w-4(e)(1)) is amended—

(1) in subparagraph (A), by striking "subparagraphs (B) and (C)" and inserting "subparagraphs (B), (C), (E), and (F)"; and

(2) by adding at the end the following new subparagraphs:

"(E) Floor for work geographic indices.—

"(i) In general.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

"(ii) Work floor index.—For purposes of clause (i), the term 'applicable floor index' means—

"(I) 0.980 with respect to services furnished during 2004; and

"(II) 1.000 for services furnished during 2005, 2006, and 2007.

"(F) Floor for practice expense and malpractice geographic indices.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 421. AMBULANCE PAYMENT RATES.

(a) Payment Rates.—Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is amended to read as follows:

"(3) Payment rates.—

"(A) In general.—Subject to any adjustment under subparagraph (B) and paragraph (9) and the full payment of a national mileage rate pursuant to subparagraph (2)(E), in establishing such fee schedule, the following rules shall apply:

"(i) Payment rates in 2003.—

"(I) Ground ambulance services.—In the case of ground ambulance services furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services at a rate based on the average costs (as determined by the Secretary on the basis of the most recent and reliable information available) incurred by full cost ambulance suppliers in providing nonemergency basic life support ambulance services covered under this title, with adjustments to the rates for other ground ambulance service levels to be determined based on the rule established under paragraph (1). For the purposes of the preceding sentence, the term 'full cost ambulance supplier' means a supplier for which volunteers or other unpaid staff comprise less than 20 percent of the supplier's total staff and which receives less than 20 percent of space and other capital assets free of charge.

"(II) Other ambulance services.—In the case of ambulance services not described in subclause (I) that are furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services based on the rule established under paragraph (1).

"(ii) Payment rates in subsequent years for all ambulance services.—In the case of any ambulance service furnished under this part in 2004 or any subsequent year, the Secretary shall set the payment rates under the fee schedule for such service at amounts equal to the payment rate under the fee schedule for that service furnished during the previous year, increased by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year.

"(B) Adjustment in rural rates.—For years beginning with 2004, the Secretary, after taking into consideration the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall adjust the fee schedule payment rates that would otherwise apply under this subsection for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.".

(b) Conforming Amendment.—Section 221(c) of BIPA is repealed.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 501. ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME).

Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) by striking "and" at the end of subclause (VI);

(2) in subclause (VII)—

(A) by striking "on or after October 1, 2002," and inserting "during fiscal year 2003,"; and

(B) by striking the period at the end and inserting "; and"; and

(3) by inserting after subclause (VII) the following new subclauses:

"(VIII) during each of fiscal years 2004 and 2005, 'c' is equal to 1.47; and

"(IX) on or after October 1, 2005, 'c' is equal to 1.35.".

SEC. 502. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) Improving Timeliness of Data Collection.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

"(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.".

(b) ELIGIBILITY STANDARD FOR TECHNOLOGY OUTLIERS.—

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

(A) by inserting "(I)" after "(vi)"; and

(B) by adding at the end the following new subclause:

"(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD-9-CM (or a successor coding methodology) that enables the identification of specific discharges in which the service or technology has been used.".

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting "(applying a threshold specified by the Secretary that is 75 percent of one standard deviation for the diagnosis-related group involved)" after "is inadequate".

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following subclause:

"(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority review has been provided under section 515(d)(5) of such Act. Nothing in this subclause shall be construed as effecting the authority of the Secretary to determine whether items and services are medically necessary and appropriate under section 1862(a)(1).".

(4) PROCESS FOR PUBLIC INPUT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by paragraph (1), is amended—

(A) in clause (i), by adding at the end the following: "Such mechanism shall be modified to meet the requirements of clause (viii).": and

(B) by adding at the end the following new clause:

"(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

"(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

"(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

"(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.".

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further amended by adding at the end the following new clause:

"(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, the new technology would no longer meet the threshold of exceeding 75 percent of the standard deviation for the diagnosis-related group involved under clause (ii)(I). No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).".

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after "the estimated average cost of such service or technology" the following: "(based on the marginal rate applied to costs under subparagraph (A))".

(e) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL INPATIENT TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking "subject to paragraph (4)(C)(iii),".

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2005.

(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2003 THAT ARE DENIED.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 503. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and inserting "the applicable Puerto Rico percentage (specified in subparagraph (E))"; and

(B) in clause (ii), by striking "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

(2) by adding at the end the following new subparagraph:

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

"(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 41 percent and the applicable Federal percentage is 59 percent;

"(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 33 percent and the applicable Federal percentage is 67 percent; and

"(v) on or after October 1, 2005, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.".

SEC. 504. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM .

(a) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

"(11)(A) In order to recognize commuting patterns among Metropolitan Statistical Areas and between such Areas and rural areas, the Secretary shall establish a process, upon application of a subsection (d) hospital that establishes that it is a qualifying hospital described in subparagraph (B), for an increase of the wage index applied under paragraph (3)(E) for the hospital in the amount computed under subparagraph (D).

"(B) A qualifying hospital described in this subparagraph is a subsection (d) hospital—

"(i) the average wages of which exceed the average wages for the area in which the hospital is located; and

"(ii) which has at least 10 percent of its employees who reside in one or more higher wage index areas.

"(C) For purposes of this paragraph, the term 'higher wage index area' means, with respect to a hospital, an area with a wage index that exceeds that of the area in which the hospital is located.

"(D) The increase in the wage index under subparagraph (A) for a hospital shall be equal to the percentage of the employees of the hospital that resides in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

"(i) the difference between (I) the wage index for such area, and (II) the wage index of the area in which the hospital is located (before the application of this paragraph); and

"(ii) the number of employees of the hospital that reside in such higher wage index area divided by the total number of such employees that reside in all high wage index areas.

"(E) The process under this paragraph shall be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10) with respect to data submitted by hospitals to the Board on the location of residence of hospital employees and wages under the applicable schedule established for geographic reclassification.

"(F) A reclassification under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

"(G) A hospital that is reclassified under this paragraph for a period is not eligible for reclassification under paragraphs (8) or (10) during that period.

"(H) Any increase in a wage index under this paragraph for a hospital shall not be taken into account for purposes of—

"(i) computing the wage index for the area in which the hospital is located or any other area; or

"(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).".

(b) Effective Date.—The amendment made by subsection (a) shall first apply to the wage index for cost reporting period beginning on or after October 1, 2004.

SEC. 505. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) Ownership and Investment Interests in Whole Hospitals.—

(1) In general.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(A) by striking "and" at the end of subparagraph (A); and

(B) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

"(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and".

(2) Definition.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

"(7) Specialty hospital.—

"(A) In general.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

"(i) patients with a cardiac condition;

"(ii) patients with an orthopedic condition;

"(iii) patients receiving a surgical procedure; or

"(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

"(B) Exception.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

"(i) determined by the Secretary—

"(I) to be in operation before June 12, 2003; or

"(II) under development as of such date;

"(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

"(iii) that meets such other requirements as the Secretary may specify.".

(b) Effective Date.—Subject to subsection (c), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) Application of Exception for Hospitals Under Development.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(2), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

Subtitle B—Other Provisions

SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) Adjustment to RUGs for AIDS Residents.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

"(12) Adjustment for residents with AIDS.—

"(A) In general.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

"(B) Sunset.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.".

(b) Effective Date.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) Coverage of Hospice Consultation Services.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting "; and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

"(A) an evaluation of the individual's need for pain and symptom management;

"(B) counseling the individual with respect to end-of-life issues and care options; and

"(C) advising the individual regarding advanced care planning.".

(b) Payment.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.".

(c) Conforming Amendment.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: "and services described in section 1812(a)(5)".

(d) Effective Date.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 601. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) Update for 2004 and 2005.—

(1) In general.—Section 1848(d) (42 U.S.C. 1395w-4(d)) is amended by adding at the end the following new paragraph:

"(5) Update for 2004 and 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.".

(2) Conforming amendment.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting "and paragraph (5)" after "subparagraph (D)".

(3) Not treated as change in law and regulation in sustainable growth rate determination.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)).

(b) Use of 10-Year Rolling Average in Computing Gross Domestic Product.—

(1) In general.—Section 1848(f)(2)(C) (42 U.S.C. 1395w-4(f)(2)(C)) is amended—

(A) by striking "projected" and inserting "annual average"; and

(B) by striking "from the previous applicable period to the applicable period involved" and inserting "during the 10-year period ending with the applicable period involved".

(2) Effective date.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2003.

SEC. 602. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO Study on Beneficiary Access to Physicians' Services.—

(1) Study.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(B) an examination of changes in the use by beneficiaries of physicians' services over time;

(C) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(2) Report.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

(b) Study and Report on Supply of Physicians.—

(1) Study.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) Report to congress.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described

in paragraph (1), including any recommendations for legislation.

(c) GAO STUDY OF MEDICARE PAYMENT FOR INHALATION THERAPY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the medicare program.

(2) REPORT.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 603. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w-4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

(b) VOLUME OF PHYSICIAN SERVICES.—The Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1848(f) of the Social Security Act).

(2) An examination of the relative growth of volume in physician services between medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

(4) An examination of the impact on volume of demographic changes.

(5) An examination of shifts in the site of service of services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have affected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

Subtitle B—Preventive Services

SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) an initial preventive physical examination (as defined in subsection (ww));".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Initial Preventive Physical Examination

"(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services (excluding clinical laboratory tests), as determined by the Secretary, consistent with the recommendations of the United States Preventive Services Task Force.".

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking "and" before "(6)", and

(B) by inserting before the period at the end the following: ", and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))".

(2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in clause (N), by inserting "(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))" after "80 percent"; and

(B) in clause (O), by inserting "(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))" after "80 percent".

(d) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting "(2)(W)," after "(2)(S),".

(e) OTHER CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) by striking "and" at the end of subparagraph (H);

(B) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(J) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;"; and

(2) in paragraph (7), by striking "or (H)" and inserting "(H), or (J)".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only for individuals whose coverage period begins on or after such date.

SEC. 612. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 611(a), is amended—

(1) in subparagraph (V), by striking "and" at the end;

(2) in subparagraph (W), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(X) cholesterol and other blood lipid screening tests (as defined in subsection (XX));".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 611(b), is amended by adding at the end the following new subsection:

"Cholesterol and Other Blood Lipid Screening Test

"(xx)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

"(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 611(e), is amended—

(1) by striking "and" at the end of subparagraph (I);

(2) by striking the semicolon at the end of subparagraph (J) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1861(xx)(1)), which is performed more frequently than is covered under section 1861(xx)(2).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 613. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.

(a) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)), as amended by section 611(c)(1), is amended—

(1) by striking "and" before "(7)"; and

(2) by inserting before the period at the end the following: ", and (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))".

(b) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are each amended—

(1) by striking "DEDUCTIBLE AND" in the heading; and

(2) in subclause (I), by striking "deductible or" each place it appears.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services furnished on or after Janaury 1, 2004.

SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography".

(b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diagnostic mammography performed on or after January 1, 2004, for which payment is made under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4), the Secretary, based on the most recent cost data available, shall provide for an appropriate adjustment in the payment amount for the technical component of the diagnostic mammography.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

Subtitle C—Other Services

SEC. 621. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) PAYMENT FOR DRUGS.—

(1) MODIFICATION OF AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(A) by redesignating paragraph (13) as paragraph (14); and

(B) by inserting after paragraph (12) the following new paragraph:

“(13) DRUG APC PAYMENT RATES.—

“(A) IN GENERAL.—With respect to payment for covered OPD services that includes a specified covered outpatient drug (defined in subparagraph (B)), the amount provided for payment for such drug under the payment system under this subsection for services furnished in—

“(i) 2004, 2005, or 2006, shall in no case—

“(I) exceed 95 percent of the average wholesale price for the drug; or

“(II) be less than the transition percentage (under subparagraph (C)) of the average wholesale price for the drug; or

“(ii) a subsequent year, shall be equal to the average price for the drug for that area and year established under the competitive acquisition program under section 1847A as calculated and applied by the Secretary for purposes of this paragraph.

“(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

“(i) IN GENERAL.—In this paragraph, the term ‘specified covered outpatient drug’ means, subject to clause (ii), a covered outpatient drug (as defined in 1927(k)(2), that is—

“(I) a radiopharmaceutical; or

“(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

“(ii) EXCEPTION.—Such term does not include—

“(I) a drug for which payment is first made on or after January 1, 2003, under paragraph (6); or

“(II) a drug for a which a temporary HCPCS code has not been assigned.

“(C) TRANSITION TOWARDS HISTORICAL AVERAGE ACQUISITION COST.—The transition percentage under this subparagraph for drugs furnished in a year is determined in accordance with the following table:

For the year—	The transition percentage for—		
	Single source drugs are—	Innovator multiple source drugs are—	Generic drugs are—
2004	83%	81.5%	46%
2005	77%	75%	46%
2006	71%	68%	46%

“(D) PAYMENT FOR NEW DRUGS UNTIL TEMPORARY HCPCS CODE ASSIGNED.—With respect to payment for covered OPD services that includes a covered outpatient drug (as defined in 1927(k)) for a which a temporary HCPCS code has not been assigned, the amount provided for payment for such drug under the payment system under this subsection shall be equal to 95 percent of the average wholesale price for the drug.

“(E) CLASSES OF DRUGS.—For purposes of this paragraph, each of the following shall be treated as a separate class of drugs:

“(i) SOLE SOURCE DRUGS.—A sole source drug which for purposes of this paragraph means a drug or biological that is not a multiple source drug (as defined in subclauses (I) and (II) of section 1927(k)(7)(A)(i)) and is not a drug approved under an abbreviated new drug application under section 355(j) of the Federal Food, Drug, and Cosmetic Act.

“(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—Innovator multiple source drugs (as defined in section 1927(k)(7)(A)(ii)).

“(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—Noninnovator multiple source drugs (as defined in section 1927(k)(7)(A)(iii)).

“(F) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION FACTORS.—Additional expenditures resulting from this paragraph and paragraph (14)(C) in a year shall not be taken into account in establishing the conversion factor for that year.”.

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(14), as redesignated by paragraph (1)(A), is amended by adding at the end the following new subparagraph:

“(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory procedure classification groups (APCs) with respect to drugs to $50 per administration.”.

(3) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

“(E) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory procedure codes established separately for drugs.”.

(4) PAYMENT FOR PASS THROUGH DRUGS.—Clause (i) of section 1833(t)(6)(D) (42 U.S.C. 1395l(t)(6)(D)) is amended by inserting after “under section 1842(o)” the following: “(or if the drug is covered under a competitive acquisition contract under section 1847A for an area, an amount determined by the Secretary equal to the average price for the drug for that area and year established under such section as calculated and applied by the Secretary for purposes of this paragraph)”.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2004.

(b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

(1) IN GENERAL.—Section 1833(t)(14), as so redesignated and amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

“(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost.”.

(2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2) is amended—

(A) in subparagraph (F), by striking “and” at the end;

(B) in subparagraph (G), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(H) with respect to devices of brachytherapy, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.”.

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(13)(B) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

(c) APPLICATION OF FUNCTIONAL EQUIVALENCE TEST.—

(1) IN GENERAL.—Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

“(F) LIMITATION ON APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—The Secretary may not apply a ‘functional equivalence’ payment standard (including such standard promulgated on November 1, 2002) or any other similar standard in order to deem a particular drug or biological to be identical to or similar to another drug or biological with respect to its mechanism of action or clinical effect to deny pass-through status to new drugs or biologics or to remove such status of an existing eligible drug or biologic under this paragraph unless—

“(i) the Secretary develops by regulation (after providing notice and a period for public comment) criteria for the application of such standard; and

“(ii) such criteria provide for coordination with the Federal Food and Drug Administration and require scientific studies that show the clinical relationship between the drugs or biologicals treated as functionally equivalent.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of the enactment of this Act, unless such application was being made to such drug or biological prior to June 13, 2003.

(d) HOSPITAL ACQUISITION COST STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the costs incurred by hospitals in acquiring covered outpatient drugs for which payment is made under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(2) DRUGS COVERED.—The study in paragraph (1) shall not include those drugs for which the acquisition costs is less than $50 per administration.

(3) REPRESENTATIVE SAMPLE OF HOSPITALS.—In conducting the study under paragraph (1), the Secretary shall collect data from a statistically valid sample of hospitals with an urban/rural stratification.

(4) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations with respect to the following:

(A) Whether the study should be repeated, and if so, how frequently.

(B) Whether the study produced useful data on hospital acquisition cost.

(C) Whether data produced in the study is appropriate for use in making adjustments to payments for drugs and biologicals under section 1847A of the Social Security Act.

(D) Whether separate estimates can made of overhead costs, including handing and administering costs for drugs.

SEC. 622. PAYMENT FOR AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 410(a), is amended—

(1) in paragraph (2)(E), by inserting “consistent with paragraph (11)” after “in an efficient and fair manner”; and

(2) by adding at the end the following new paragraph:

"(11) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year, the portion of the payment amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

"(A) For 2004, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

"(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

"(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

"(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

"(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.".

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(12) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to such miles.".

(c) GAO REPORT ON COSTS AND ACCESS.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under section 1834(l) of the Social Security Act, as amended by this section). Not later than December 31, 2007, the Comptroller General shall submit to Congress a final report on such access and supply.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulance services furnished on or after January 1, 2004.

SEC. 623. RENAL DIALYSIS SERVICES.

(a) DEMONSTRATION OF ALTERNATIVE DELIVERY MODELS.—

(1) USE OF ADVISORY BOARD.—In carrying out the demonstration project relating to improving care for people with end-stage renal disease through alternative delivery models (as published in the Federal Register of June 4, 2003), the Secretary shall establish an advisory board comprised of representatives described in paragraph (2) to provide advice and recommendations with respect to the establishment and operation of such demonstration project.

(2) REPRESENTATIVES.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The medicare payment advisory commission, established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(D) The National Kidney Foundation.

(E) The National Institute of Diabetes and Digestive and Kidney Diseases of National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(I) Providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking "and (C)" and inserting ", (C), and (D)";

(B) in subparagraph (B), by striking "In the case" and inserting "Subject to subparagraph (D), in the case"; and

(C) by adding at the end the following new subparagraph:

"(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.".

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)), as amended by subsection (b), is further amended by striking "Until" and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and until".

(c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent.

SEC. 624. ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 1-YEAR MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking "and 2002" and inserting "2002, and 2004".

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2003, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) IDENTIFICATION OF CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps under section 1833(g)(4) of the Social Security Act (42 U.S.C. 1395l(g)(4)).

(2) REPORTS TO CONGRESS.—

(A) PRELIMINARY REPORT.—Not later than July 1, 2004, the Secretary shall submit to Congress a preliminary report on the conditions and diseases identified under paragraph (1).

(B) FINAL REPORT.—Not later than September 1, 2004, the Secretary shall submit to Congress a final report on such conditions and diseases.

(C) RECOMMENDATIONS.—Not later than October 1, 2004, the Secretary shall submit to Congress a recommendation of criteria, with respect to such conditions and disease, under which a waiver of the therapy caps would apply.

(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL THERAPIST SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access to physical therapist services in States authorizing such services without a physician referral and in States that require such a physician referral. The study shall—

(A) examine the use of and referral patterns for physical therapist services for patients age 50 and older in States that authorize such services without a physician referral and in States that require such a physician referral;

(B) examine the use of and referral patterns for physical therapist services for patients who are medicare beneficiaries;

(C) examine the potential effect of prohibiting a physician from referring patients to physical therapy services owned by the physician and provided in the physician's office;

(D) examine the delivery of physical therapists' services within the facilities of Department of Defense; and

(E) analyze the potential impact on medicare beneficiaries and on expenditures under the medicare program of eliminating the need for a physician referral and physician certification for physical therapist services under the medicare program.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

SEC. 625. ADJUSTMENT TO PAYMENTS FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended in the last sentence by inserting "and each of fiscal years 2004 through 2008" after "In each of the fiscal years 1998 through 2002".

SEC. 626. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE FOR ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—Section 1833(o) (42 U.S.C. 1395l(o)) is amended—

(1) in paragraph (1), by striking "no more than the limits established under paragraph (2)" and inserting "no more than the amount of payment applicable under paragraph (2)"; and

(2) in paragraph (2), to read as follows:

"(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

"(B) The Secretary or a carrier may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

"(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.".

(b) Conforming Amendments.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting "(and includes shoes described in section 1861(s)(12))" after "in section 1861(s)(9)".

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(c) Effective Date.—The amendments made by this section shall apply to items furnished on or after January 1, 2004.

SEC. 627. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) Waiver of Penalty.—

(1) In general.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2004. The Secretary of Health and Human Services shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) Medicare Part B Special Enrollment Period.—

(1) In general.—In the case of any individual who, as of the date of the enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

(2) Coverage period.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 628. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) In General.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611(a) and 612(a) is amended—

(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraph (W);

(B) by adding "and" at the end of subparagraph (X); and

(C) by adding at the end the following new subparagraph:

"(Y) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (yy));"; and

(2) by adding at the end the following new subsection:

"Intravenous Immune Globulin

"(yy) The term 'intravenous immune globulin' means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.".

(b) Payment as a Drug or Biological.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting "(including intravenous immune globulin (as defined in section 1861(yy)))" after "with respect to drugs and biologicals".

(c) Effective Date.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 629. MEDICARE COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.

(a) Coverage.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by sections 611 and 612, is amended—

(1) in subparagraph (W), by striking "and" at the end;

(2) in subparagraph (X), by adding "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(Y) diabetes screening tests and services (as defined in subsection (yy));".

(b) Services Described.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611 and 612, is further amended by adding at the end the following new subsection:

"Diabetes Screening Tests and Services

"(yy)(1) The term 'diabetes screening tests' means diagnostic testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

"(A) a fasting plasma glucose test; and

"(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

"(2) For purposes of paragraph (1), the term 'individual at risk for diabetes' means an individual who has any, a combination of, or all of the following risk factors for diabetes:

"(A) A family history of diabetes.

"(B) Overweight defined as a body mass index greater than or equal to 25 kg/m2.

"(C) Habitual physical inactivity.

"(D) Belonging to a high-risk ethnic or racial group.

"(E) Previous identification of an elevated impaired fasting glucose.

"(F) Identification of impaired glucose tolerance.

"(G) Hypertension.

"(H) Dyslipidemia.

"(I) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

"(J) Polycystic ovary syndrome.

"(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.".

(c) Frequency.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by sections 611 and 612, is amended—

(1) by striking "and" at the end of subparagraph (J);

(2) by striking the semicolon at the end of subparagraph (K) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(L) in the case of a diabetes screening tests or service (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3).".

(d) Effective Date.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 701. UPDATE IN HOME HEALTH SERVICES.

(a) Change to Calender Year Update.—

(1) In general.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking "each fiscal year (beginning with fiscal year 2002)" and inserting "fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)"; and

(ii) by inserting "or year" after "the fiscal year";

(B) in paragraph (3)(B)(ii)(II), by striking "any subsequent fiscal year" and inserting "2004 and any subsequent year";

(C) in paragraph (3)(B)(iii), by inserting "or year" after "fiscal year" each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting "or year" after "fiscal year" each place it appears; and

(ii) by inserting "or years" after "fiscal years"; and

(E) in paragraph (5), by inserting "or year" after "fiscal year".

(2) Transition rule.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2003, shall be such amount (or amounts) for the previous calendar quarter.

(b) Changes in Updates for 2004, 2005, and 2006.—Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B), is amended—

(1) by striking "or" at the end of subclause (I);

(2) by redesignating subclause (II) as subclause (III);

(3) in subclause (III), as so redesignated, by striking "2004" and inserting "2007"; and

(4) by inserting after subclause (I) the following new subclause:

"(II) each of 2004, 2005, and 2006 the home health market basket percentage increase minus 0.4 percentage points; or".

SEC. 702. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) Study.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

SEC. 703. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely affects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term "home health services" has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

Subtitle B—Chronic Care Improvement

SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

Title XVIII is amended by inserting after section 1806 the following new section:

"CHRONIC CARE IMPROVEMENT

"SEC. 1807. (a) IN GENERAL.—

"(1) IN GENERAL.—The Secretary shall establish a process for providing chronic care improvement programs in each CCIA region for medicare beneficiaries who are not enrolled under part C and who have certain chronic conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, prostate and colon cancer, hypertension, or other disease as identified by the Secretary as appropriate for chronic care improvement. Such a process shall begin to be implemented no later than 1 year after the date of the enactment of this section.

"(2) TERMINOLOGY.—For purposes of this section:

"(A) CCIA REGION.—The term 'CCIA region' means a chronic care improvement administrative region delineated under subsection (b)(2).

"(B) CHRONIC CARE IMPROVEMENT PROGRAM.—The terms 'chronic care improvement program' and 'program' means such a program provided by a contractor under this section.

"(C) CONTRACTOR.—The term 'contractor' means an entity with a contract to provide a chronic care improvement program in a CCIA region under this section.

"(D) INDIVIDUAL PLAN.—The term 'individual plan' means a chronic care improvement plan established under subsection (c)(5) for an individual.

"(3) CONSTRUCTION.—Nothing in this section shall be construed as expanding the amount, duration, or scope of benefits under this title.

"(b) COMPETITIVE BIDDING PROCESS.—

"(1) IN GENERAL.—Under this section the Secretary shall award contracts to qualified entities for chronic care improvement programs for each CCIA region under this section through a competitive bidding process.

"(2) PROCESS.—Under such process—

"(A) the Secretary shall delineate the United States into multiple chronic care improvement administrative regions; and

"(B) the Secretary shall select at least 2 winning bidders in each CCIA region on the basis of the ability of each bidder to carry out a chronic care improvement program in accordance with this section, in order to achieve improved health and financial outcomes.

"(3) ELIGIBLE CONTRACTOR.—A contractor may be a disease improvement organization, health insurer, provider organization, a group of physicians, or any other legal entity that the Secretary determines appropriate.

"(c) CHRONIC CARE IMPROVEMENT PROGRAMS.—

"(1) IN GENERAL.—Each contract under this section shall provide for the operation of a chronic care improvement program by a contractor in a CCIA region consistent with this subsection.

"(2) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS.—Each contractor shall have a method for identifying medicare beneficiaries in the region to whom it will offer services under its program. The contractor shall identify such beneficiaries through claims or other data and other means permitted consistent with applicable disclosure provisions.

"(3) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each beneficiary identified under paragraph (2) as a prospective participant in one or more programs concerning participation in a program. Such communication may be made by the Secretary (or on behalf of the Secretary) and shall include information on the following:

"(A) A description of the advantages to the beneficiary in participating in a program.

"(B) Notification that the contractor offering a program may contact the beneficiary directly concerning such participation.

"(C) Notification that participation in a program is voluntary.

"(D) A description of the method for the beneficiary to select the single program in which the beneficiary wishes to participate and for declining to participate and a method for obtaining additional information concerning such participation.

"(4) PARTICIPATION.—A medicare beneficiary may participate in only one program under this section and may terminate participation at any time in a manner specified by the Secretary.

"(5) INDIVIDUAL CHRONIC CARE IMPROVEMENT PLANS.—

"(A) IN GENERAL.—For each beneficiary participating in a program of a contractor under this section, the contractor shall develop with the beneficiary an individualized, goal-oriented chronic care improvement plan.

‘‘(B) ELEMENTS OF INDIVIDUAL PLAN.—Each individual plan developed under subparagraph (A) shall include a single point of contact to coordinate care and the following, as appropriate:

‘‘(i) Self-improvement education for the beneficiary (such as education for disease management through medical nutrition therapy) and support education for health care providers, primary caregivers, and family members.

‘‘(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

‘‘(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

‘‘(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

‘‘(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

‘‘(C) CONTRACTOR RESPONSIBILITIES.—In establishing and carrying out individual plans under a program, a contractor shall, directly or through subcontractors—

‘‘(i) guide participants in managing their health, including all their co-morbidities, and in performing activities as specified under the elements of the plan;

‘‘(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

‘‘(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

‘‘(6) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for programs and contractors under this section.

‘‘(7) ACCREDITATION.—The Secretary may provide that programs that are accredited by qualified organizations may be deemed to meet such requirements under this section as the Secretary may specify.

‘‘(c) CONTRACT TERMS.—

‘‘(1) IN GENERAL.—A contract under this section shall contain such terms and conditions as the Secretary may specify consistent with this section. The Secretary may not enter into a contract with an entity under this section unless the entity meets such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the population to be served.

‘‘(2) USE OF SUBCONTRACTORS PERMITTED.—A contractor may carry out a program directly or through contracts with subcontractors.

‘‘(3) BUDGET NEUTRAL PAYMENT CONDITION.—In entering into a contract with an entity under this subsection, the Secretary shall establish payment rates that assure that there will be no net aggregate increase in payments under this title over any period of 3 years or longer, as agreed to by the Secretary. Under this section, the Secretary shall assure that medicare program outlays plus administrative expenses (that would not have been paid under this title without implementation of this section), including contractor fees, shall not exceed the expenditures that would have been incurred under this title for a comparable population in the absence of the program under this section for the 3-year contract period.

‘‘(4) AT RISK RELATIONSHIP.—For purposes of section 1128B(b)(3)(F), a contract under this section shall be treated as a risk-sharing arrangement referred to in such section.

‘‘(5) PERFORMANCE STANDARDS.—Payment to contractors under this section shall be subject to the contractor's meeting of clinical and financial performance standards set by the Secretary.

‘‘(6) CONTRACTOR OUTCOMES REPORT.—Each contractor offering a program shall monitor and report to the Secretary, in a manner specified by the Secretary, the quality of care and efficacy of such program in terms of—

‘‘(A) process measures, such as reductions in errors of treatment and rehospitalization rates;

‘‘(B) beneficiary and provider satisfaction;

‘‘(C) health outcomes; and

‘‘(D) financial outcomes.

‘‘(7) PHASED IN IMPLEMENTATION.—Nothing in this section shall be construed as preventing the Secretary from phasing in the implementation of programs.

‘‘(d) BIANNUAL OUTCOMES REPORTS.—The Secretary shall submit to the Congress biannual reports on the implementation of this section. Each such report shall include information on—

‘‘(1) the scope of implementation (in terms of both regions and chronic conditions);

‘‘(2) program design; and

‘‘(3) improvements in health outcomes and financial efficiencies that result from such implementation.

‘‘(e) CLINICAL TRIALS.—The Secretary shall conduct randomized clinical trials, that compare program participants with medicare beneficiaries who are offered, but decline, to participate, in order to assess the potential of programs to—

‘‘(1) reduce costs under this title; and

‘‘(2) improve health outcomes under this title.

‘‘(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary, in appropriate part from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for contracts with chronic care improvement programs under this section.

‘‘(g) LIMITATION ON FUNDING.—In no case shall the funding under this section exceed $100,000,000 over a period of 3 years.’’.

SEC. 722. CHRONIC CARE IMPROVEMENT UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(1) by amending subsection (e) to read as follows:

‘‘(e) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS FOR BENEFICIARIES WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—

‘‘(1) IN GENERAL.—Each Medicare+Choice organization with respect to each Medicare+Choice plan it offers shall have in effect, for enrollees with multiple or sufficiently severe chronic conditions, a chronic care improvement program that is designed to manage the needs of such enrollees and that meets the requirements of this subsection.

‘‘(2) ENROLLEE WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—For purposes of this subsection, the term ‘enrollee with multiple or sufficiently severe chronic conditions’ means, with respect to an enrollee in a Medicare+Choice plan of a Medicare+Choice organization, an enrollee in the plan who has one or more chronic conditions, such as congestive heart failure, diabetes, COPD, stroke, prostate and colon cancer, hypertension, or other disease as identified by the organization as appropriate for chronic care improvement.

‘‘(3) GENERAL REQUIREMENTS.—

‘‘(A) IN GENERAL.—Each chronic care improvement program under this subsection shall be conducted consistent with this subsection.

‘‘(B) IDENTIFICATION OF ENROLLEES.—Each such program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet the organization's criteria for participation under the program.

‘‘(C) DEVELOPMENT OF PLANS.—For an enrollee identified under subparagraph (B) for participation in a program, the program shall develop, with the enrollee's consent, an individualized, goal-oriented chronic care improvement plan for chronic care improvement.

‘‘(D) ELEMENTS OF PLANS.—Each chronic care improvement plan developed under subparagraph (C) shall include a single point of contact to coordinate care and the following, as appropriate:

‘‘(i) Self-improvement education for the enrollee (such as education for disease management through medical nutrition therapy) and support education for health care providers, primary caregivers, and family members.

‘‘(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

‘‘(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

‘‘(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

‘‘(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

‘‘(E) ORGANIZATION RESPONSIBILITIES.—In establishing and carrying out chronic care improvement plans for participants under this paragraph, a Medicare+Choice organization shall, directly or through subcontractors—

‘‘(i) guide participants in managing their health, including all their co-morbidities, and in performing the activities as specified under the elements of the plan;

‘‘(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

‘‘(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

‘‘(3) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for chronic care improvement programs under this section.

‘‘(4) ACCREDITATION.—The Secretary may provide that chronic care improvement programs that are accredited by qualified organizations may be deemed to meet such requirements under this subsection as the Secretary may specify.

‘‘(5) OUTCOMES REPORT.—Each Medicare+Choice organization with respect to its chronic care improvement program under this subsection shall monitor and report to the Secretary information on the quality of care and efficacy of such program as the Secretary may require.’’; and

(2) by amending subparagraph (I) of subsection (c)(1) to read as follows:

‘‘(I) CHRONIC CARE IMPROVEMENT PROGRAM.—A description of the organization's chronic care improvement program under subsection (e).’’.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning on or after 1 year after the date of the enactment of this Act.

SEC. 723. INSTITUTE OF MEDICINE REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a study of the barriers to effective integrated care improvement for medicare beneficiaries with multiple or severe chronic conditions across settings and over time and to submit a report under subsection (b).

(2) SPECIFIC ITEMS.—The study shall examine the statutory and regulatory barriers to coordinating care across settings for medicare beneficiaries in transition from one setting to another (such as between hospital, nursing facility, home health, hospice, and home). The study shall specifically identify the following:

(A) Clinical, financial, or administrative requirements in the medicare program that present barriers to effective, seamless transitions across care settings.

(B) Policies that impede the establishment of administrative and clinical information systems to track health status, utilization, cost, and quality data across settings.

(C) State-level requirements that may present barriers to better care for medicare beneficiaries.

(3) CONSULTATION.—The study under this subsection shall be conducted in consultation with experts in the field of chronic care, consumers, and family caregivers, working to integrate care delivery and create more seamless transitions across settings and over time.

(b) REPORT.—The report under this subsection shall be submitted to the Secretary and Congress not later than 18 months after the date of the enactment of this Act.

SEC. 724. MEDPAC REPORT.

(a) EVALUATION.—shall conduct an evaluation that includes a description of the status of the implementation of chronic care improvement programs under section 1807 of the Social Security Act, the quality of health care services provided to individuals in such program, the health status of the participants of such program, and the cost savings attributed to implementation of such program.

(b) REPORT.—Not later than 2 years after the date of implementation of such chronic care improvement programs, the Commission shall submit a report on such evaluation.

Subtitle C—Other Provisions

SEC. 731. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b) (42 U.S.C. 1395b-6(b)) is amended by adding at the end the following new paragraph:

"(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.".

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b-6(b)(2)(B)(i)) is amended by inserting "the efficient provision of" after "expenditures for".

(c) APPLICATION OF DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—Section 1805(c)(2)(D) (42 U.S.C. 1395b-6(c)(2)(D)) is amended by adding at the end the following: "Members of the Commission shall be treated as employees of the Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

(d) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services. The Commission shall examine data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the "demonstration project") under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in not more than 5 States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day care services.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later 30 months after the commencement of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term "home health agency" has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) MEDICAL ADULT DAY CARE FACILITY.—The term "medical adult day care facility" means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) MEDICAL ADULT DAY CARE SERVICES.—The term "medical adult day care services" means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 733. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting "consistent with subsection (k)" after "the Secretary shall ensure"; and

(B) by adding at the end the following new subsection:

"(k) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

"(1) CRITERIA AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the criteria the Secretary uses in making national coverage determinations, including how evidence to demonstrate that a procedure or device is reasonable and necessary is considered.

"(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 12 months after the date of the request.

"(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period that begins on the date a request for a national coverage determination is made, the Secretary shall—

"(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

"(B) provide a 30-day period for public comment on such draft;

"(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

"(D) include in such final decision summaries of the public comments received and responses thereto;

"(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and.

"(F) in the case of a decision to grant the coverage determination, assign or temporary or permanent code during the 60-day period referred to in subparagraph (C).

"(4) CONSULTATION WITH OUTSIDE EXPERTS IN CERTAIN NATIONAL COVERAGE DETERMINATIONS.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

"(5) LOCAL COVERAGE DETERMINATION PROCESS.—With respect to local coverage determinations made on or after January 1, 2004—

"(A) PLAN TO PROMOTE CONSISTENCY OF COVERAGE DETERMINATIONS.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

"(B) CONSULTATION.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

"(C) DISSEMINATION OF INFORMATION.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

"(6) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the terms 'national coverage determination' and 'local coverage determination' have the meaning given such terms in paragraphs (1)(B) and (2)(B), respectively, of section 1869(f).".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to national and local coverage determinations as of January 1, 2004.

(b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.—

(1) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement paragraph (1)).

(3) EFFECTIVE DATE.—This subsection shall apply to clinical trials begun before, on, or after the date of the enactment of this Act and to items and services furnished on or after such date.

(c) ISSUANCE OF TEMPORARY NATIONAL CODES.—Not later than January 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act.

SEC. 734. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1848(i) (42 U.S.C. 1395w-4(i)) is amended by adding at the end the following new paragraph:

"(4) TREATMENT OF CERTAIN INPATIENT PHYSICIAN PATHOLOGY SERVICES.—

"(A) IN GENERAL.—With respect to services furnished on or after January 1, 2001, and before January 1, 2006, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary shall treat such component as a service for which payment shall be made to the laboratory under this section and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) or as a hospital outpatient service for which payment is made to the hospital under section 1833(t).

"(B) DEFINITIONS.—In this paragraph:

"(i) COVERED HOSPITAL.—

"(I) IN GENERAL.—The term 'covered hospital' means, with respect to an inpatient or outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a carrier with a contract under section 1842 and not to the hospital.

"(II) CHANGE IN OWNERSHIP DOES NOT AFFECT DETERMINATION.—A change in ownership with respect to a hospital on or after the date referred to in subclause (I) shall not affect the determination of whether such hospital is a covered hospital for purposes of such subclause.

"(ii) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who is entitled to benefits under part A, or enrolled under this part, or both, but is not enrolled in any of the following:

"(I) A Medicare+Choice plan under part C.

"(II) A plan offered by an eligible organization under section 1876.

"(III) A program of all-inclusive care for the elderly (PACE) under section 1894.

"(IV) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).".

(b) CONFORMING AMENDMENT.—Section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–550), as enacted into law by section 1(a)(6) of Public Law 106–554, is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section shall take effect as if included in the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

SEC. 735. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

(e) WAIVER AUTHORITY.—The Secretary may waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

TITLE VIII—MEDICAID

SEC. 801. CONTINUATION OF MEDICAID DSH ALLOTMENT ADJUSTMENTS UNDER BIPA 2000.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f))—

(1) in paragraph (2)—

(A) in the heading, by striking "THROUGH 2002" and inserting "THROUGH 2000";

(B) by striking "ending with fiscal year 2002" and inserting "ending with fiscal year 2000"; and

(C) in the table in such paragraph, by striking the columns labeled "FY 01" and "FY02";

(2) in paragraph (3)(A), by striking "paragraph (2)" and inserting "paragraph (4)"; and

(3) in paragraph (4), as added by section 701(a)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554)—

(A) by striking "FOR FISCAL YEARS 2001 AND 2002" in the heading;

(B) in subparagraph (A), by striking "Notwithstanding paragraph (2), the" and inserting "The";

(C) in subparagraph (C)—

(i) by striking "NO APPLICATION" and inserting "APPLICATION"; and

(ii) by striking "without regard to" and inserting "taking into account".

(b) INCREASE IN MEDICAID DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Effective for DSH allotments beginning with fiscal year 2003, the item in the table contained in section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r-4(f)(2)) for the District of Columbia for the DSH allotment for FY 00 (fiscal year 2000) is amended by striking "32" and inserting "49".

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the application of section 1923(f)(4) of the Social Security Act (as amended by subsection (a)) to the District of Columbia for fiscal year 2003 and subsequent fiscal years.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to DSH allotments for fiscal years beginning with fiscal year 2003.

SEC. 802. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE TO 3 PERCENT IN FISCAL YEAR 2003.

(a) INCREASE IN DSH FLOOR.—Section 1923(f)(5) of the Social Security Act (42 U.S.C. 1396r-4(f)(5)) is amended—

(1) by striking "fiscal year 1999" and inserting "fiscal year 2001";

(2) by striking "August 31, 2000" and inserting "August 31, 2002";

(3) by striking "1 percent" each place it appears and inserting "3 percent"; and

(4) by striking "fiscal year 2001" and inserting "fiscal year 2003".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect as if enacted on October 1, 2002, and apply to DSH allotments under title XIX of the Social Security Act for fiscal year 2003 and each fiscal year thereafter.

SEC. 803. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r-8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: "(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)".

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

SEC. 901. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) CONSTRUCTION.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

"Supplier

"(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.".

SEC. 902. ISSUANCE OF REGULATIONS.

(a) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

"(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

"(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

"(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 903. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(a), is amended by adding at the end the following new subsection:

"(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

"(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

"(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

"(2)(A) If—

"(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

"(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

"(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

"(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 904. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than one year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(a), is amended by adding at the end the following new subsection:

"(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

Subtitle B—Contracting Reform

SEC. 911. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function;

"(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

"(C) the entity has sufficient assets to financially support the performance of such function; and

"(D) the entity meets such other requirements as the Secretary may impose.

"(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

"(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

"(C) Transfer of functions.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

"(D) Incentives for quality.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

"(2) Compliance with requirements.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

"(3) Performance requirements.—

"(A) Development of specific performance requirements.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

"(B) Consultation.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

"(C) Inclusion in contracts.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

"(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

"(ii) shall be used for evaluating contractor performance under the contract; and

"(iii) shall be consistent with the written statement of work provided under the contract.

"(4) Information requirements.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) Surety bond.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(c) Terms and Conditions.—

"(1) In general.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

"(2) Prohibition on mandates for certain data collection.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

"(1) Certifying officer.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) Disbursing officer.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) Liability of medicare administrative contractor.—

"(A) In general.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

"(B) Relationship to false claims act.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the 'False Claims Act').

"(4) Indemnification by secretary.—

"(A) In general.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

"(B) Conditions.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

"(C) Scope of indemnification.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

"(D) Written approval for settlements.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

"(E) Construction.—Nothing in this paragraph shall be construed—

"(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

"(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.".

(2) Consideration of incorporation of current law standards.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) Conforming Amendments to Section 1816 (Relating to Fiscal Intermediaries).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) Conforming Amendments to Section 1842 (Relating to Carriers).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services," in the matter preceding clause (i); and

(II) by striking "carrier" and inserting "medicare administrative contractor" in clause (i);

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,"; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking "carrier" and inserting "medicare administrative contractor"; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2010.

(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of the enactment of this Act and before the date specified under subparagraph (A), the Secretary may enter into new agreements under section 1816 of the Social Security Act (42 U.S.C. 1395h) without regard to any of the provider nomination provisions of such section.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1), is amended by adding at the end the following new subsection:

"(e) REQUIREMENTS FOR INFORMATION SECURITY.—

"(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

"(2) INDEPENDENT AUDITS.—

"(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

"(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of

Health and Human Services may establish; and

“(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

“(B) Deadline for initial evaluation.—

“(i) New contractors.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

“(ii) Other contractors.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

“(C) Reports on evaluations.—

“(i) To the Department of Health and Human Services.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

“(ii) To congress.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

“(iii) Agency reporting.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.”.

(b) Application of Requirements to Fiscal Intermediaries and Carriers.—

(1) In general.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) Deadline for initial evaluation.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 921. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) Coordination of Education Funding.—

(1) In general.—Title XVIII is amended by inserting after section 1888 the following new section:

“PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

“Sec. 1889. (a) Coordination of Education Funding.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.”.

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) Report.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) Incentives To Improve Contractor Performance.—

(1) In general.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a), is amended by adding at the end the following new subsection:

“(f) Incentives To Improve Contractor Performance in Provider Education and Outreach.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.”.

(2) Application to fiscal intermediaries and carriers.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO report on adequacy of methodology.—Not later than October 1, 2004, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) Report on use of methodology in assessing contractor performance.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) Provision of Access to and Prompt Responses From Medicare Administrative Contractors.—

(1) In general.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a) and subsection (b), is further amended by adding at the end the following new subsection:

“(g) Communications with Beneficiaries, Providers of Services and Suppliers.—

“(1) Communication strategy.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

“(2) Response to written inquiries.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

“(3) Response to toll-free lines.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

“(4) Monitoring of contractor responses.—

“(A) In general.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

“(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

“(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

“(B) Development of standards.—

“(i) In general.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

“(ii) Evaluation.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

“(C) Direct monitoring.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.”.

(2) Effective date.—The amendment made by paragraph (1) shall take effect October 1, 2004.

(3) Application to fiscal intermediaries and carriers.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C.

1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

"(b) ENHANCED EDUCATION AND TRAINING.—

"(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2005 and 2006 and such sums as may be necessary for succeeding fiscal years.

"(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

"(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

"(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

"(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

"(A) a provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a supplier with fewer than 10 full-time-equivalent employees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

"(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

"(1) provides answers in an easily accessible format to frequently asked questions, and

"(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

"(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

"(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term "small providers of services or suppliers" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2005, $1,000,000, and

(2) for fiscal year 2006, $6,000,000.

SEC. 923. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; MEDICARE PROVIDER OMBUDSMAN";

(2) by inserting "PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)" after "(a)";

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

"(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

"(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.".

(b) Medicare Beneficiary Ombudsman.—Title XVIII, as previously amended, is amended by inserting after section 1809 the following new section:

"MEDICARE BENEFICIARY OMBUDSMAN

"Sec. 1810. (a) In General.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

"(b) Duties.—The Medicare Beneficiary Ombudsman shall—

"(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

"(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

"(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary;

"(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

"(C) assistance to such individuals in presenting information under section 1860D–2(b)(4)(D)(v); and

"(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

"(c) Working With Health Insurance Counseling Programs.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.".

(c) Deadline for Appointment.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(d) Funding.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(e) Use of Central, Toll-Free Number (1–800–MEDICARE).—

(1) Phone triage system; listing in medicare handbook instead of other toll-free numbers.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: "The Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.".

(2) Monitoring accuracy.—

(A) Study.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free number 1–800–MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) Report.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 924. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) In General.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) Locations.—

(1) In general.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) Assistance for rural beneficiaries.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) Duration.—The demonstration program shall be conducted over a 3-year period.

(d) Evaluation and Report.—

(1) Evaluation.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) Report.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 925. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) In General.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) Inclusion of Information in Certain Hospital Discharge Plans.—

(1) In general.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking "hospice services" and inserting "hospice care and post-hospital extended care services"; and

(B) by inserting before the period at the end the following: "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides".

(2) Effective date.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1), from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another other officer of the Department.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA (114 Stat. 2763A–543), is amended by striking "of the Social Security Administration".

SEC. 932. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision";

(2) in paragraph (1)(F)—

(A) by striking clause (ii);

(B) by striking "PROCEEDING" and all that follows through "DETERMINATION" and inserting "DETERMINATIONS AND RECONSIDERATIONS"; and

(C) by redesignating subclauses (I) and (II) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

(3) by adding at the end the following new paragraph:

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

"(C) ACCESS TO JUDICIAL REVIEW.—

"(i) IN GENERAL.—If the appropriate review panel—

"(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

"(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

"(D) REVIEW PANELS.—For purposes of this subsection, a 'review panel' is a panel consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection (c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.".

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

(d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases of termination.

(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year 2005 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

SEC. 933. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 932(a), is further amended by adding at the end the following new paragraph:

"(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by BIPA, is amended by adding at the end the following new paragraphs:

"(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

"(A) the written notice on the determination shall include—

"(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

"(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

"(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section; and

"(B) the person provided such notice may obtain, upon request, the specific provision of the policy, manual, or regulation used in making the determination.

"(5) REQUIREMENTS OF NOTICE OF REDETERMINATIONS.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

"'(A) the written notice on the redetermination shall include—

"(i) the specific reasons for the redetermination;

"(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

"(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

"(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

"(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

"(C) the person provided such notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.".

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting "be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)" after "in writing, "; and

(B) by inserting "and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section" after "such decision,".

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)), as amended by BIPA, is amended—

(A) in the heading, by inserting "; NOTICE" after "SECRETARY"; and

(B) by adding at the end the following new paragraph:

"(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

"(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

"(B) the procedures for obtaining additional information concerning the decision; and

"(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.".

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking "prepare" and inserting "submit" and by striking "with respect to" and all that follows through "and relevant policies".

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking "sufficient training and expertise in medical science and legal matters" and inserting "sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing"; and

(B) by adding at the end the following new subparagraph:

"(K) INDEPENDENCE REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

"(I) is not a related party (as defined in subsection (g)(5));

"(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party.

"(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.".

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

"(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals)."; and

(B) by adding at the end the following new subsection:

"(g) QUALIFICATIONS OF REVIEWERS.—

"(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

"(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

"(2) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party.

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(I) the individual is not involved in the provision of items or services in the case under review;

"(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

"(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

"(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

"(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

"(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

"(C) The health care professional that provides the items or services involved in the case.

"(D) The institution at which the items or services (or treatment) involved in the case are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

"(F) Any other party determined under any regulations to have a substantial interest in the case involved.".

(3) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking "not fewer than 12 qualified independent contractors under this subsection" and inserting "with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection".

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A-534).

(5) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 934. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by sections 912(b), 921(b)(1), and 921(c)(1), is further amended by adding at the end the following new subsection:

"(h) CONDUCT OF PREPAYMENT REVIEW.—

"(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

"(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

"(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

"(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

"(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

"(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

"(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

"(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 935. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

"(f) RECOVERY OF OVERPAYMENTS.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) HARDSHIP.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

"(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

"(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

"(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

"(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

"(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

"(ii) there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

"(2) LIMITATION ON RECOUPMENT.—

"(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

"(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

"(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

"(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

"(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

"(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

"(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) CONSENT SETTLEMENT REFORMS.—

"(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

"(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services or supplier—

"(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

"(II) the nature of the problems identified in such evaluation; and

"(III) the steps that the provider of services or supplier should take to address the problems; and

"(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

"(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

"(7) PAYMENT AUDITS.—

"(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

"(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

"(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

"(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

"(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.".

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: "; ENROLLMENT PROCESSES"; and

(2) by adding at the end the following new subsection:

"(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) ENROLLMENT PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

"(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

"(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

"(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.".

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 937. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) CLAIMS.—The Secretary shall develop, in consultation with appropriate Medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) PERMITTING USE OF CORRECTED AND SUPPLEMENTARY DATA.—

(1) IN GENERAL.—Section 1886(d)(10)(D)(vi) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

"Notwithstanding subclause (I), a hospital may submit, and the Secretary may accept upon verification, data that corrects or supplements the data described in such subclause without regard to whether the corrected or supplementary data relate to a cost report that has been settled.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to fiscal years beginning with fiscal year 2004.

(3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS PERMITTED FOR FISCAL YEAR 2004.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a hospital may submit (or resubmit) an application for a change described in section 1886(d)(10)(C)(i)(II) of the Social Security Act for fiscal year 2004 if the hospital demonstrates on a timely basis to the satisfaction of the Secretary that the use of corrected or supplementary data under the amendment made by paragraph (1) would materially affect the approval of such an application.

(B) APPLICATION OF BUDGET NEUTRALITY.—If one or more hospital's applications are approved as a result of paragraph (1) and subparagraph (A) for fiscal year 2004, the Secretary shall make a proportional adjustment in the standardized amounts determined under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) for fiscal year 2004 to assure that approval of such applications does not result in aggregate payments under section 1886(d) of such Act that are greater or less than those that would otherwise be made if paragraph (1) and subparagraph (A) did not apply.

SEC. 938. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 933(d)(2)(B), is further amended by adding at the end the following new subsection:

"(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

"(1) ESTABLISHMENT OF PROCESS.—

"(A) IN GENERAL.—With respect to a Medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

"(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

"(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

"(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

"(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

"(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

"(3) REQUEST FOR PRIOR DETERMINATION.—

"(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

"(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

"(4) RESPONSE TO REQUEST.—

"(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

"(i) the item or service is so covered;

"(ii) the item or service is not so covered; or

"(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

"(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

"(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

"(5) EFFECT OF DETERMINATIONS.—

"(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

"(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

"(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

"(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

"(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

"(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

"(6) LIMITATION ON FURTHER REVIEW.—

"(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

"(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

"(i) decides not to seek a prior determination under this subsection with respect to items or services; or

"(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

"(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.".

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with Medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term "advance beneficiary notice" means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

Subtitle V—Miscellaneous Provisions

SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for, or clinical examples of, evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) Study on Appropriate Coding of Certain Extended Office Visits.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) Definitions.—In this section—

(1) the term "rural area" has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act. 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term "teaching settings" are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 942. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) Council for Technology and Innovation.—Section 1868 (42 U.S.C. 1395ee), as amended by section 921(a), is amended by adding at the end the following new subsection:

"(c) Council for Technology and Innovation.—

"(1) Establishment.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) Composition.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) Duties.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) Executive coordinator for technology and innovation.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.".

(b) Methods for Determining Payment Basis for New Lab Tests.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

"(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

"(B) Determinations under subparagraph (A) shall be made only after the Secretary—

"(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

(c) GAO Study on Improvements in External Data Collection for Use in the Medicare Inpatient Payment System.—

(1) Study.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) Report.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) Process for Adoption of ICD Codes as Data Standard.—Section 1172(f) (42 U.S.C. 1320d–1(f)) is amended by inserting after the first sentence the following: "Notwithstanding the preceding sentence, if the National Committee on Vital and Health Statistics has not made a recommendation to the Secretary before the date of the enactment of this sentence, with respect to the adoption of the International Classification of Diseases, 10th Revision, Procedure Coding System ('ICD–10–PCS') and the International Classification of Diseases, 10th Revision, Clinical Modification ('ICD–10–CM') as a standard under this part for the reporting of diagnoses, the Secretary may implement ICD-10-PCS only with respect to inpatient services as such a standard.".

SEC. 943. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) In General.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) Reference Laboratory Services Described.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 944. EMTALA IMPROVEMENTS.

(a) Payment for EMTALA-Mandated Screening and Stabilization Services.—

(1) In general.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

"(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

"(4) Notice upon closing an investigation.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.".

(c) Prior Review by Peer Review Organizations in EMTALA Cases Involving Termination of Participation.—

(1) In General.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting "or in terminating a hospital's participation under this title" after "in imposing sanctions under paragraph (1)"; and

(B) by adding at the end the following new sentences: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.".

(2) Effective date.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 945. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) Establishment.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term "EMTALA" refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) Membership.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) General Responsibilities.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) Administrative Matters.—

(1) Chairperson.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) Meetings.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) Termination.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) Waiver of Administrative Limitation.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 946. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) In General.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

"(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.".

(b) Conforming Payment Provision.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(c) Effective Date.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 947. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) In General.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking "and" at the end;

(B) in subparagraph (S), by striking the period at the end and inserting ", and"; and

(C) by inserting after subparagraph (S) the following new subparagraph:

"(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated)."; and

(2) by adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

"(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

"(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.".

(b) Effective Date.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 948. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) Technical Amendments Relating to Advisory Committee under BIPA Section 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking "established under section 1114(f)"; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking "under subsection (f)"; and

(ii) by striking "section 1862(a)(1)" and inserting "subsection (a)(1)".

(b) Terminology Corrections.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking "policy" and inserting "determination"; and

(B) in subclause (IV), by striking "medical review policies" and inserting "coverage determinations".

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C)) is amended by striking "policy" and "POLICY" and inserting "determination" each place it appears and "DETERMINATION", respectively.

(c) Reference Corrections.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking "subclause (I), (II), or (III)" and inserting "clause (i), (ii), or (iii)";

(2) in subparagraph (B), by striking "clause (i)(IV)" and "clause (i)(III)" and inserting "subparagraph (A)(iv)" and "subparagraph (A)(iii)", respectively; and

(3) in subparagraph (C), by striking "clause (i)", "subclause (IV)" and "subparagraph (A)" and inserting "subparagraph (A)", "clause (iv)" and "paragraph (1)(A)", respectively each place it appears.

(d) Other Corrections.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c-3(e)) is amended by striking paragraph (5).

(e) Effective Date.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 949. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a-7(c)(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.".

SEC. 950. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) In General.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

"(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

"(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.".

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 951. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days described in subclause (II) of section 1886(d)(5)(F)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) used in computing the disproportionate patient percentage under such section for that hospital. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 952. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) In General.—Section 1842(b)(6)(A) (42 U.S.C. 1395u(b)(6)(A)) is amended by striking "or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service," and inserting "or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such other program integrity and other safeguards as the Secretary may determine to be appropriate,".

(b) Conforming Amendment.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "except to an employer or facility" and inserting "except to an employer, entity, or other person".

(c) Effective Date.—The amendments made by section shall apply to payments made on or after the date of the enactment of this Act.

SEC. 953. OTHER PROVISIONS.

(a) GAO Reports on the Physician Compensation.—

(1) Sustainable Growth Rate and Updates.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) Physician compensation generally.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) Annual Publication of List of National Coverage Determinations.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c) GAO Report on Flexibility in Applying Home Health Conditions of Participation to Patients Who Are Not Medicare Beneficiaries.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to such recipients.

(d) OIG Report on Notices Relating to Use of Hospital Lifetime Reserve Days.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 1001. IMPORTATION OF PRESCRIPTION DRUGS.

(a) In General.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

"SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

"(a) Definitions.—In this section:

"(1) Importer.—The term 'importer' means a pharmacist or wholesaler.

"(2) Pharmacist.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

"(3) Prescription drug.—The term 'prescription drug' means a drug subject to section 503(b), other than—

"(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

"(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

"(C) an infused drug (including a peritoneal dialysis solution);

"(D) an intravenously injected drug; or

"(E) a drug that is inhaled during surgery.

"(4) Qualifying laboratory.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

"(5) Wholesaler.—

"(A) In general.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

"(B) Exclusion.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

"(b) Regulations.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

"(c) Limitation.—The regulations under subsection (b) shall—

"(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

"(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

"(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

"(d) Information and Records.—

"(1) In general.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

"(A) The name and quantity of the active ingredient of the prescription drug.

"(B) A description of the dosage form of the prescription drug.

"(C) The date on which the prescription drug is shipped.

"(D) The quantity of the prescription drug that is shipped.

"(E) The point of origin and destination of the prescription drug.

"(F) The price paid by the importer for the prescription drug.

"(G) Documentation from the foreign seller specifying—

"(i) the original source of the prescription drug; and

"(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

"(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

"(I) The name, address, telephone number, and professional license number (if any) of the importer.

"(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

"(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

"(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

"(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

"(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

"(i) is approved for marketing in the United States; and

"(ii) meets all labeling requirements under this Act.

"(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

"(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

"(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

"(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

"(e) TESTING.—The regulations under subsection (b) shall require—

"(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

"(2) if the tests are conducted by the importer—

"(A) that information needed to—

"(i) authenticate the prescription drug being tested; and

"(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

"(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

"(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

"(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

"(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

"(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

"(i) PROHIBITION OF DISCRIMINATION.—

"(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

"(2) DISCRIMINATION.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

"(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

"(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

"(j) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

"(k) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—

"(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

"(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

"(B) exercise discretion to permit individuals to make such importations in circumstances in which—

"(i) the importation is clearly for personal use; and

"(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

"(2) WAIVER AUTHORITY.—

"(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

"(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

"(3) DRUGS IMPORTED FROM CANADA.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

"(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

"(B) is accompanied by a copy of a valid prescription;

"(C) is imported from Canada, from a seller registered with the Secretary;

"(D) is a prescription drug approved by the Secretary under chapter V;

"(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

"(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

"(l) STUDIES; REPORTS.—

"(1) BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES.—

"(A) STUDY.—

"(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

"(I) importations of prescription drugs made under the regulations under subsection (b); and

"(II) information and documentation submitted under subsection (d).

"(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—

"(I) evaluate the compliance of importers with the regulations under subsection (b);

"(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

"(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

"(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(2) BY THE COMPTROLLER GENERAL.—

"(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

"(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

"(n) EFFECTIVENESS OF SECTION.—

"(1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

"(2) PROCEDURE.—The Secretary shall not submit a certification under paragraph (1) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

"(A)(i) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

"(ii) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

"(iii) identifies specifically the causes of the increased risk; and

"(iv)(I) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

"(II) if the Secretary determines that any measures described in subclause (I) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

"(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

"(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

"(ii) determines that the benefits do not outweigh the detriment.

"(o) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

"(p) CONDITIONS.—This section shall become effective only if the Secretary certifies to the Congress that implementation of this section will—

"(1) pose no additional risk to the public's health and safety; and

"(2) result in a significant reduction in the cost of covered products to the American consumer.".

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking "covered product in violation of section 804" and inserting "prescription drug in violation of section 804"; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(a)" and inserting "prescription drug under section 804(b)".

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 1101. SHORT TITLE.

This title may be cited as the "Greater Access to Affordable Pharmaceuticals Act".

SEC. 1102. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

"(B) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

"(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

"(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

"(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

"(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(II) the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking "under the following" and inserting "by applying the following to each certification made under paragraph (2)(A)(vii)"; and

(ii) in clause (iii)—

(I) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted."; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

"(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(aa) the date on which the court enters judgment reflecting the decision; or

"(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(bb) by striking subclause (II) and inserting the following:

"(II) if before the expiration of such period the district court decides that the patent has been infringed—

"(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

"(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(cc) in subclause (III), by striking "on the date of such court decision." and inserting "as provided in subclause (I); or"; and

(dd) by inserting after subclause (III) the following:

"(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II).";

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

"(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

"(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under paragraph (2)(B) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

"(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

"(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).".

(b) APPLICATIONS GENERALLY.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b), by striking paragraph (3) and inserting the following:

"(3) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

"(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

"(B) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

"(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

"(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

"(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking "under the following" and inserting "by applying the following to each certification made under subsection (b)(2)(A)(iv)";

(B) in subparagraph (C)—

(i) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.";

(ii) in the second sentence—

(I) by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(II) by striking clause (i) and inserting the following:

"(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(I) the date on which the court enters judgment reflecting the decision; or

"(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(III) by striking clause (ii) and inserting the following:

"(ii) if before the expiration of such period the district court decides that the patent has been infringed—

"(I) if the judgment of the district court is appealed, the approval shall be made effective on—

"(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(II) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(IV) in clause (iii), by striking "on the date of such court decision." and inserting "as provided in clause (i); or"; and

(V) by inserting after clause (iii), the following:

"(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii)."; and

(iii) in the third sentence, by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

"(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

"(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

"(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

"(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).".

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

"(5) The filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought by the applicant under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.".

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 1103. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 1102) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

"(iv) 180-DAY EXCLUSIVITY PERIOD.—

"(I) DEFINITIONS.—In this paragraph:

"(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

"(bb) FIRST APPLICANT.—The term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

"(cc) SUBSTANTIALLY COMPLETE APPLICATION.—The term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

"(dd) TENTATIVE APPROVAL.—

"(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

"(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

"(II) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant."; and

(2) by inserting after subparagraph (C) the following:

"(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

"(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

"(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

"(aa) the earlier of the date that is—

"(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

"(BB) 30 months after the date of submission of the application of the first applicant; or

"(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

"(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

"(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

"(CC) The patent expires.

"(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

"(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

"(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

"(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

"(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

"(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

"(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

"(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

"(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

"(II) no applicant shall be eligible for a 180-day exclusivity period.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term "decision of a court" as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 1104. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

"(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

"(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action."; and

(2) by adding at the end the following:

"(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.".

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 1105. REMEDIES FOR INFRINGEMENT.

Section 287 of title 35, United States Code, is amended by adding at the end the following:

"(d) CONSIDERATION.—In making a determination with respect to remedy brought for infringement of a patent that claims a drug or a method or using a drug, the court shall consider whether information on the patent was filed as required under 21 U.S.C. 355 (b) or (c), and, if such information was required to be filed but was not, the court may refuse to award treble damages under section 284.".

SEC. 1106. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking "(j)(5)(D)(ii)" each place it appears and inserting "(j)(5)(F)(ii)";

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking "(j)(5)(D)" each place it appears and inserting "(j)(5)(F)"; and

(3) in subsections (e) and (l), by striking "505(j)(5)(D)" each place it appears and inserting "505(j)(5)(F)".

The SPEAKER pro tempore. Pursuant to House Resolution 299, the gentleman from New York (Mr. RANGEL) and the gentleman from Louisiana (Mr. TAUZIN) each will control 30 minutes.

Mr. TAUZIN. Mr. Speaker, I yield 15 minutes to the gentleman from California (Mr. THOMAS) or his designee, and ask unanimous consent that he may control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

Mr. RANGEL. Mr. Speaker, I yield 15 minutes to the gentleman from Michigan (Mr. DINGELL) and ask unanimous consent that he be permitted to further allocate that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) is recognized for 15 minutes.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I appreciate the statement made by the gentleman from Louisiana (Mr. TAUZIN) that we all are concerned about our older citizens and those that are to follow, and certainly we all have to appreciate the fact that we are all here because we stand on someone else's shoulders, someone else who made the sacrifice, and I am very proud to share the responsibility of this bill with the gentleman from Michigan (Mr. DINGELL), who has dedicated his entire life, and his dad before him, in making certain that he and those of us who support him and what he believes in improves the quality of life of not only the seniors today.

It took us a long time to get where we are where people feel some degree of comfort that the Federal Government will be there for them, whether it is Social Security, whether it is Medicaid, whether it is Medicare. It has been government, yes, this government, this wonderful government, this government who gave me the GI bill, this government which allowed older citizens to have some degree of pride in having Social Security to cushion themselves from poverty, and this government that provided health care for the very poor, and under Medicare we had hoped that we would have provided prescription drugs for them.

I do not know when this animosity came against government, why we felt we had to starve these programs which some of us have been so proud of. Somebody asked how do you pay for your bill? This is a strange thing to ask, especially when the chairman of the Committee on the Budget is on the floor. He has been able to do magic with numbers over there. He started out with a $5.6 trillion surplus, and with magic converted it to a $3.4 trillion deficit. He can take $9 trillion and find some way to spend it in tax cuts. Even tonight, some $173 billion, $100 billion just found last night, and we will get $400 billion from what they have allocated, but we think that it takes twice that much.

Is that asking to do, is that something that we have to go to the Committee on the Budget for and ask? Can you sprinkle your magic powder on us and make it possible for the older people not to have gaps in services? Is it asking too much to treat them, not that they are wealthy in dollars and cents, but they are wealthy in terms of the investment they made in this country to make it possible for the multinationals and the wealthy people to get the tax breaks that they are getting, and it seems to me since compassion is not there, that maybe we can look at it as a cost savings vehicle.

How many senior citizens will not have to go to the hospitals which are so expensive, how much of a part of our health expenses is a part of the institutions which our seniors are forced to go into? If you have to make a decision and you are in doubt, why not make the doubt in favor of the senior citizens? Everything that is missing in the Republican bill that is good, we put in our bill to make certain that it is better.

One thing that we are saying is this, do not hate the government until you do not have any need for it. And seniors when they read the difference of the bills, and you bet your life they can read, they may be old but they are not stupid. They can pick up the daily newspapers, and if they do not go to the pharmaceutical corporations but rather go to the local drugstore, they will find out in short order who is their best friend.

Do not knock the government. It is not as bad as some Members think. Give the people an opportunity so that we can say citizens, we appreciate all that you have done for us, and we in the Congress believe that the least we can do for you as you grow older is to ease your pain and, more important, the fear you have that once you go to the doctor that at least you will be able to get the drugs that are prescribed for your illness.

Mr. Speaker, we do not have to challenge each other's integrity, but I tell Members this, that there are Members on the other side of the aisle that hold Social Security in utter contempt. There are Members who talk about Medicare as though the communists created the package, and they resented it when it started, and they think it is worse than ever today.

What I am saying is let us do what they tell doctors to do, and do no harm. Let us leave here saying that at least on this day there was a substitute, they did not have to do it the way the majority would want.

Mr. Speaker, I yield the balance of my time to the gentleman from California (Mr. STARK), the ranking member of the Subcommittee on Health, and I ask unanimous consent that he may further allocate that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

(Mr. WILSON of South Carolina asked and was given permission to speak out of order and to revise and extend his remarks.)

SOUTH CAROLINA LOSES A LEGEND

Mr. WILSON of South Carolina. Mr. Speaker, it is with great sadness tonight that I announce that Senator Strom Thurmond passed away at 9:45. I was a former staff member of Senator Thurmond, my wife was a staff person for Senator Thurmond, and our three sons have been pages with his office.

With the death of Strom Thurmond, South Carolina has lost its greatest statesman of the 20th century, just as John Calhoun was the most revered South Carolinian of the 19th century. Strom Thurmond will never be replaced in the countless hearts of those who loved and respected him.

The entire Wilson family mourns this profound loss and we extend our sympathy to the Thurmond family.

Senator Strom Thurmond will endure as the leading example of a public servant due to his love and devotion to all the people of South Carolina regardless of status, race, politics or region.

He was our living legend. Strom's life was dedicated to achieving peace through strength, as shown by his military service in liberating Europe from Nazi fascists, his tireless work in fighting for a strong national defense in Congress which ultimately led to the defeat of Soviet communism.

□ 2300

He pioneered the development of the South Carolina Republican Party from effective nonexistence in the 1960s to majority status by the end of the century. He has been a role model of service to South Carolina's young people and our family has had three generations on his staff: my wife's two uncles were staff attorneys, my wife and I were interns, and our three oldest sons were pages. A distinguished highlight for our family was to host Senator THURMOND on the last Sunday before his last election in 1996 at the First Presbyterian Church in Columbia.

The legacy of Strom Thurmond will always be felt in South Carolina because of his steadfast integrity and the meaningful results of his thoughtful constituent service. He was my personal hero, and I will miss him dearly.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

Let me join in expressing the sorrow of the folks in Louisiana for your loss in South Carolina. We will pray for his soul.

Mr. Speaker, the Democratic substitute in this debate can be summed up rather easily. According to CBO, it will spend over a trillion dollars. It busts the budget. Therefore, it is on the floor with a budget waiver. It at the same time excludes and does not contain any of the reforms that the base bill includes, that are designed to save Medicare from failure, from insolvency. I am not predicting Medicare's failure or insolvency. CBO is. CRS is. Everyone who has estimated the strength of our Medicare system predicts very soon, in our lifetimes, it will go insolvent. None of the reforms that are designed to save Medicare from insolvency are here. In fact, the Democratic substitute piles on a trillion dollars' worth of expenses to the Medicare system with no reforms to make sure the system is saved.

When I mentioned earlier that you ought to test the credibility of arguments on this floor by what is said and what is fact and what is of record, let me take you back to the statements of the distinguished gentlewoman from California who criticized the base bill because CBO said it might mean that as much as 30 percent or so of employers might drop their retiree coverage under the base bill in favor of the plans we offer. CBO estimated the Democratic substitute, too, on that point.

How credible is an argument against the base bill that complains about a potential 30 percent loss of employer coverage when CBO estimates that 100 percent of employers will drop retiree coverage under the Democratic substitute? That all taxpayer dollars will be used to substitute private dollars? And the Medicare system, already crushed and about to go into insolvency, will have to assume all that responsibility, too? If you really believe in Medicare, why would you burden it so? Why would you eliminate private coverage in America, as CBO estimates would happen under the Democratic substitute?

This substitute busts our budget. It purports to provide more drug coverage than the base bill but no reforms, it does not save Medicare; and on top of that it virtually eliminates private retiree coverage in America. Why would we want to go that direction? We rejected that direction during the Clinton years when Mrs. CLINTON presented us with one-size-fits-all health care for all Americans. We recognized then that if you do not have the competitive choices in America in health care, just as we do with so many other services, that things go bad in this country and that sooner or later the crushing weight of benefits added upon benefits added upon benefits means the working people of America have to pay more and more and more taxes. In fact, it is estimated that within 70 years, if we do not begin today making decisions like we ask the House to make, entitlements in America will eat up every tax dollar paid into the Treasury by every citizen in America, and we will have no money for any other function in this country. That is where this substitute takes us, and that is why we need to reject it.

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

My dear friends and colleagues, I lay before you the Republican plan. I ask you to look at it with a straight face, because it is inexplicable, and I cannot explain it to you with a straight face. The amendment which was offered by my dear friend, the gentleman from New York (Mr. RANGEL), on behalf of him and me, does the following things: it gives and sets forth a very clear set of benefits. Senior citizens pay $25 a month; they get 80 percent of drug costs from government after a $100 deductible. This is what you get if you get the Republican plan. But that is not the worst you get. If you are a senior citizen, you fall into a doughnut hole. After you get $2,000 in drugs that you get under the plan, all of a sudden your payments by the government stop; you have to keep on paying premiums, but you get no benefit until you have got $5,100. They are going to privatize your Medicare in the year 2010. That is pretty bad.

But it is followed by other things: massive subsidies to the insurance companies which commence in 2 years, in 2006. But that is not all. No guarantee as to what it costs you in terms of what you have to pay in the way of premiums, no assurance that you will get any particular level of benefits. The only person who is going to cut a fat hog out of this deal are those good-hearted, flinty-hearted, cold-hearted folk in the insurance business who are going to all of a sudden get a key to the United States Treasury, the right to collect any amount of money they want and to sucker the Secretary of HHS any old way they are minded and to walk home and to pay the money perhaps to the senior citizens but possibly to their shareholders or in dividends or perhaps to pay it in salaries or in bonuses to their corporate officers. That is what you get under the Republican plan. And privatization of Social Security as you know it today.

The Republicans have said that they intend to do away with Social Security. Well, this is what is happening here. The Democratic plan compels the drug houses to negotiate with the Federal Government and the Secretary. The Republicans preclude him by absolutely prohibiting him from negotiating. We do not tolerate under the Democratic plan the Republican opportunity to privatize Medicare. And just wait till your senior citizens find out what you are doing to them with privatization and doing away with fee-for-service and substituting in lieu of this the kind of plan that you talk about where there is no assurance of protection for the senior citizens.

The Republicans say the bill costs too much. Well, it pays some $800 billion to 40 million senior citizens. Just last week, without a gasp of shame, my Republican friends set it up so that 200,000 families got the same amount of money. I think it is time we looked after the senior citizens and not the fat cats that my Republican colleagues and friends look after.

Vote for the Democratic plan. Vote down the Republican plan. Let us take care of the senior citizens. It is the right thing to do.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let us look at the facts behind the rhetoric here. What is going to be the impact of this Democratic substitute on seniors? My colleague from Louisiana just reminded us that 100 percent of employers are going to drop their plans. If there is one thing my senior citizens say to me when I go into senior centers it is, look, help those who need it, but do not destroy my employer-provided retiree plan. Do not touch it. This amendment destroys it, wipes it out. That is not in the interest of your seniors.

But let us look at what it will do to premiums. You were concerned that we did not sock a premium into law. Look what you do in your bill. You sock the premium into law and then you have it rise according to drug inflation. Drug inflation is double-digit. Do you not get it? Those premiums are going to rise steeply. Why would you do that to our seniors?

And let us look at the effect on prices. There is one thing seniors say to you over and over again, the prices are too high. Yet according to Dr. Holtz-Eakin's testimony of April 9, 2003, he says, "If you subsidize 90 percent of any insurance product versus 70 percent of the product, the larger subsidy will lead to a lower incentive to control costs and will lead to higher prices and higher spending." Yours is a giveaway to the pharmaceutical industry. It will drive prices up because there is no incentive for the PBM or the plan to negotiate prices down and they can just pass it on to the government, because we are going to pay it all. Yours is going to drive prices up, premiums up and employer plans out of the market. I do not know why you think you are doing the seniors a good service.

And look at the impact on their kids, because they care about their kids and their grandkids. We have heard testimony over and over again that if you have a 10-year-old child, in 20 years when that kid is 30 and trying to pay back college loans, trying to buy a house, trying to get established, having to buy a car, that child will live in a Nation in which three-quarters of all the Federal revenues will go to Social Security, Medicare and Medicaid.

What is that child to do about education for their children? What is that young person to do to make a living? You shoulder so much debt on the next generation that they will not have public education the way we know it today. They will not have the roads and bridges that a strong economy depends on. They will not be able to defend this Nation in a world that is going to be far more dangerous than the one we have known. This is utterly irresponsible. It is so irresponsible that when the other body proposed this plan in the Senate the last session of Congress, they could not write a budget resolution because they did not know how to handle the extraordinary debt that this creates in the decades ahead.

I urge my colleagues to think that something that looks pretty for your seniors, in fact, will be terrible for their health.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume. I know earlier I moved the distinguished gentleman from Louisiana, the chairman of the Committee on Energy and Commerce, to talk about his poverty and I wanted to join him in that. I too was raised poor. I was raised so poor that I never slept alone until I was married. I want to go on and suggest that I am not going to let you have that field all to yourself.

We have introduced a substitute. Unlike your bill, ours has specific benefits. Your bill, I would remind the gentlewoman from Connecticut, has no benefit in it. It is all estimates. It is all examples. There is no benefit in your bill, and indeed in our substitute there is. You have heard it. It is simple. It is $25 a month, 20 percent coinsurance, no gaps; and we pay out of pocket after $2,000.

Yes, you will say it costs a lot of money. The gentlewoman from Connecticut forgets about the $5.6 trillion surplus that Bush had when he came into office and which he squandered on tax cuts in the meantime. But we do have an income transfer as we have been accused of. It is very simple. You can look at it this way. You have given $800 billion to 10,000 of the richest families each year when you did away with the inheritance tax. No question about it. That is what it costs. Those are the beneficiaries. We would take that money as an alternative and give it to what will be in a short 10 years 100 million seniors. What you have given away to the richest seniors in this country would more than pay for a drug benefit of the magnitude that we offer, a standard Medicare drug benefit, and I suggest that that is a transfer worth making and that that defines the difference between us.

□ 2315

You give $800 billion to 10,000 families a year, the richest in America. We would give that $800 billion to 100 million seniors who needed a drug benefit that they can define, depend on and understand, and that is why the Members should support the Democratic substitute. It is defined. It is real. It solves the problem for seniors, and it is, I think, one of the highest priorities that this House has.

Mr. Speaker, I reserve the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), the chairman of the Oversight and Investigations Subcommittee of the Committee on Energy and Commerce.

Mr. GREENWOOD. Mr. Speaker, I thank the chairman of the committee for yielding me this time.

The gentleman from Michigan (Mr. DINGELL) and others have presented a chart earlier that purported to show that somehow our plan was too complicated. It is a complicated issue to provide prescription drug benefits to millions of Americans who have never had them.

Let me show another chart that describes our plan and it is not complicated at all. Today a senior citizen walks into a drugstore and wants to buy Lopressor, 100 milligrams. She has to pay, for 30 tabs, $45.99 right out of her pocket. Under our bill the price first comes down because of the group purchasing power to $36.79 and then what does she pay? She pays $7.36 and if she is low income she pays $5. That is a big difference from $46.

Let us look at Lipitor. An awful lot of Americans take Lipitor every day to keep their cholesterol down. I do. It costs $108.65 today because for 40 years the Democrats did not do anything about prescription drugs and for 8 years President Clinton did not do anything about prescription drugs, but under our plan Lipitor goes down to $86.92 because of our purchasing power, but the beneficiary pays, his/her share, $17.38. Pretty straightforward. Pretty simple. Nothing complicated about that.

Celebrex, an important antiinflammatory drug for arthritis that so many seniors suffer from, a very popular drug. $86.28 today to get 30 tablets of that for 1 month. We bring it down to $69.02 because of our power of purchasing, but the beneficiary pays $13.80 for a month's supply and if they are a poor senior citizen, $5. $5, down from $86.28.

Zoloft, 100 milligrams, 30 tabs for a month, it is an antidepressant. A lot of elderly suffer from depression, unfortunately, at their age in part because they do not have good health care. We bring the price down to $63.17. The beneficiary pays $12.63 a month and, if she is poor, $5 a month.

This chart is pretty straightforward and pretty simple. This demonstrates what happens when good-minded people do very hard work with very smart staff, employing very good ideas. We get the job done for the elderly, a job that I am sorry to the gentleman from California (Mr. STARK), I am sorry to the gentleman from Michigan (Mr. DINGELL). They have been here for a long time and they have done nothing. A lot of talk tonight. A lot of good talk, a lot of bogeyman talk, a lot of scare-the-seniors talk tonight, but we will get this done. It will be very simple. It will be very straightforward. The senior citizens will love it, and as a measure of that you are all going to be voting for it next month.

Mr. DINGELL. Mr. Speaker, I yield myself 15 seconds.

I hope my colleagues look at that chart because it has the same factual value as Alice in Wonderland. There is no requirement that any of those drugs be made available. There is no requirement that they be made available at any particular price or that they have to be made available under the plan at any particular cost because of cost sharing with the insurance.

Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, today the House should be considering a Medicare prescription drug benefit for all America's seniors and disabled citizens that would be a benefit that is certain, a benefit that is affordable, and a benefit that helps Medicare beneficiaries with all of their drugs. It should not have large gaps in coverage as the Republican bill does. It should not let private insurance companies charge whatever premium they want and cover whatever drugs they want as the Republican bill does. It should be available in every part of the country, not only in areas where private insurers decide they can make a profit, and it should not cost seniors more if they live in Iowa instead of Virginia or California instead of Rhode Island. Most importantly, it should be a part of the Medicare program, just as dependable as the rest of the Medicare is for seniors and disabled people today.

The Republican bill fails all of these tests. It makes promises on the one hand and then takes them away when we read the fine print. It claims to give special help to America's low-income seniors so that they can afford to pay for the prescription drug program, but then it makes seniors subject to a detailed and invasive assets test before they can get help.

If they have over $6,000 in the bank, they do not get any help. When we figure out what they have got if they count the value of their car and it is worth more than $4,500, and what car is not? They do not get any help. They count the value of the clothes and furniture and appliances if they are worth more than $2,000. They can even count the value of their burial plot if it exceeds $1,500. So instead of making sure people of very modest income who need help to get in, they get the fine print eliminating a lot of these people who should be helped, and it makes all of them go through a demeaning and complex process to prove they have few assets.

All this to get help with their drug expenses. This is just wrong. Instead of spending the public's money to get the best possible drug benefit, this Republican bill spends our dollars to bribe insurance companies to sell a drug plan. It pays for profits for the insurance companies instead of the bills for our seniors.

What we should be doing is using the purchasing power of America's seniors, 40 million of them, to get good prices on their drugs as they do in Canada and get good coverage. That is what the Democratic substitute does. I urge my colleagues to vote for the Democratic substitute and against the Republican bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSLE), a member of the Committee on Ways and Means and esteemed chairman of the Committee on the Budget.

Mr. NUSSLE. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I would like to know where the new Democrat budget hawks are tonight, those new birds who seem to have flown the coop, who have spent the last many months here on the floor talking about the debt tax, something that does not exist but they have sure gotten a lot of ink about it. All sorts of national debt charts have been coming across the floor. In fact, they even one day used the pages, these young high school students, to demonstrate the national debt. But where are they tonight? Where are they when we read the letter from the Congressional Budget Office that says that their so-called substitute would add $1 trillion to the deficit? Where are they? They have flown the coop. We are not hearing about the deficit all of a sudden. In fact, what we heard about is that tax cuts have caused all of the problems.

In fact, one gentleman even had the audacity to stand up and act as though Washington hands money out to people. Tax relief, my friends, is money left in the pockets of people that they earned. We do not hand money out. Money comes from them. And if you are going to waste it on a $1 trillion program, that not only does not fit within the budget that controls tonight but did not even fit within your substitute budget of just 4 months ago.

In fact, if we add the Democrat budget together with the budget that controls today, you bust not only the Republican budget, you bust the Democrat budget, but you bust both budgets combined. That takes a lot of work, to be able to bust both budgets and add $1 trillion to the deficit and have all of these new deficit Democrat hawks whom we cannot find tonight.

It is interesting. Boy, we heard a lot from them all year long, nickeling and diming and worrying about all of that. But when you come to the floor with $1 trillion that says in the same letter that all the employers are going to drop their coverage for retirees, 100 percent are going to drop their coverage, and you have the audacity to present that kind of substitute that busts both budgets, do not come here any more this year and talk about the deficit.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds.

I have the same letter, and it says nothing about employers dropping coverage.

Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT), a member of the Committee on Ways and Means, who understands that spending money to provide a decent drug benefit for seniors is not wasting money.

Mr. MCDERMOTT. Mr. Speaker, Members of the House and those listening to this, I think you ought to take a piece of paper right now and write this down. The premium is $25. The deductible is $100 a year. The coinsurance means you pay 20 percent, the government pays 80 percent for your drugs, and there is a cap on how much you can spend out of pocket, $2,000. That is written into our bill.

In contrast, we have this magic pill that has been given to us where the other side says trust us. Remember, these are the people who told us that there were weapons of mass destruction in Iraq. They were right there. They were going to be delivered in 45 minutes. And, in fact, the President of the United States stood right here and said, Mr. Speaker, that he believed that they had tried to buy uranium from Niger. It was known that that was a lie. It was known. So now they come out here with this drug bill and they say listen, we think it will be about $35 and maybe you will get this and maybe you will get that, but nothing is written down. I want the people to remember those four things.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair reminds the Member not to make personal remarks regarding the President of the United States.

Mr. TAUZIN. Mr. Speaker, it is almost like Minister of Information Baghdad Bob just arrived here.

Mr. Speaker, I yield myself 2 minutes.

PARLIAMENTARY INQUIRY

Mr. MCDERMOTT. Mr. Speaker, Parliamentary inquiry.

The SPEAKER pro tempore. The gentleman from Louisiana has the floor. Does the gentleman yield?

Mr. TAUZIN. Mr. Speaker, I do not yield.

Mr. MCDERMOTT. Point of personal privilege, Mr. Speaker. Were you making some reference about Baghdad whom? Is that appropriate for the Speaker of the House?

The SPEAKER pro tempore. The gentleman from Washington (Mr. MCDERMOTT) is not in order since the gentleman from Louisiana (Mr. TAUZIN) has the time and such a point may not challenge debate.

Mr. TAUZIN. Mr. Speaker, I want to illustrate one of the real inadequacies of the Democratic substitute. In the main bill we reformed something called average wholesale price. I hope everyone knows what that is. I am going to illustrate it for you tonight. Under average wholesale price systems built into Medicare by the Democratic Party all these years, this is what happens. A person goes in for cancer therapy, a senior citizen, and the doctor needs a drug that costs $10; so the doctor buys a chemotherapy drug for $10. The patient ought to have to pay $2 under that, 20 percent co-pay under law. But that is not what happens. Under the average wholesale price system devised by Democratic administrations in the past under Medicare, this is what happens. The government has a phony average wholesale price posted. It might be $200 for that drug that only costs the doctor $10, and the poor patient has to put up 20 percent, not of the $10 but 20 percent of the $200. The patient puts up $40 for a drug that only costs the doctor $10 when the patient should have put up $2. That is called the average wholesale price system. It is rotten. It stinks. Our bill gets rid of it. And we replace it by reimbursing oncologists in America for not one time what their practice expense really ought to be reimbursed under the law, but we double it.

□ 2330

We give them $430 million, twice what CMS estimates they ought to get.

So we get rid of this stinky system that is charging American seniors 20 percent of phony prices and costing the government Medicare system tens of times what the drugs are really costing the doctors, and we replace it with a rational, a rational reimbursement system.

Now, the Democrats try to settle that system too. Let me tell my colleagues what they do in their substitute. They substitute this average wholesale price system with a system of reimbursement that, according to CBO estimates, is going to cost $14 billion over 10 years; and it is going to cost seniors another $3 billion of copays. We ought to reject that solution.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, the only thing that stinks here is the Republican bill, and it stinks for a lot of reasons.

First of all, because it is not going to give the seniors any benefit. They are not going to have really any drug benefit whatsoever. It is going to force them into an HMO. They will not have any choice of doctors. And fundamentally, in the end what the Republican bill does is kill Medicare by setting up a voucher system so we do not even have traditional Medicare.

I am sick and tired of hearing my Republican colleagues on the other side criticize traditional Medicare. Medicare is not insolvent. Medicare is a good program. Do not tell me that Medicare is broke or Medicare needs to be fixed. And I say to the gentlewoman from Connecticut, do not insult me and say the Democrats are irresponsible, the Democrats are putting us in debt. The Republicans are the ones that are putting us in debt, because you are borrowing from the trust fund so there is no money left in it because you want to kill Medicare. That is what you are all about.

These gentlemen over here, these Democrats who have been here for a long time, they are here tonight because they want to save Medicare. They understand that Medicare can be helped by putting on a prescription drug benefit, so they look at the tried and true system, they look at what we do in part B for our doctor bills, and they say, yes, let us just add a benefit like part B. We will have a low premium. We will have a low deductible. We will pay 80 percent of the cost on the Federal Government. We will have a catastrophic at 2,000. Just add the tried and true program, like we have in part B, and add a drug benefit. We do not need HMOs. We do not need all of these other gimmicks that the Republicans come up with.

And then these gentlemen, my colleagues, the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL), they say, well, we can pay for this very easily by negotiating the price and giving the Secretary the power to lower the prices. That would cut the program in half. That is what our Democratic leader said. That would cut the cost of the program in half so we would not have to go into debt. We would not have to borrow from the trust fund and make it insolvent, which is what my Republican colleagues have been doing here and what they are proposing.

Mr. Speaker, do not sell out to the HMOs and the insurance companies. That is what you are doing. You are selling out by saying everybody has got to go into an HMO because you are in bed with the insurance companies. You are selling out to the pharmaceutical industry because you want no price reductions, because you are going to get some benefit from the pharmaceutical industry.

And then you come up with: this is complicated. The gentleman from Pennsylvania (Mr. GREENWOOD) said, oh this is complicated. There is nothing complicated here. It is simple. We have had the program for years. We just add the prescription drug benefit, and we have a negotiated price. It is very simple.

Do not give me this chart. I mean, look at this garbage. How could anyone possibly understand it? I cannot even understand it myself, and you expect my mother or somebody's grandmother to understand this thing? You are making it complicated. You are destroying Medicare. Do not insult us as Democrats. We have been out there protecting it for years.

Mrs. JOHNSON of Connecticut. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN), a member of the Committee on Ways and Means.

Mr. RYAN of Wisconsin. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I want to calm down a little bit. There has been a lot of shouting around here, a lot of heated rhetoric, a lot of hyperbole. Let us just look at a couple of facts.

It is a fact that the Medicare actuaries are telling us that Medicare is going insolvent in 13 years. The entire trust fund goes bankrupt in 2036. It is a fact that if we add more money on top of Medicare without doing any reforms, you are going to accelerate the insolvency of Medicare. We can try and speak those facts away, but the fact remains that those are facts.

Now, what this Democrat substitute does is it costs over $1 trillion. It accelerates the bankruptcy of Medicare. The basic assumption in this CBO estimate is that every employer providing private drug coverage for the retirees is going to drop it. And why would they not? Why would they not drop it if the Federal Government is going to pay for it all?

What the facts are is that this plan is going to accelerate the bankruptcy of Medicare.

Now, what are we trying to achieve with the Republican bill? Mr. Speaker, there are parts of this bill that none of us all like. I have my own criticisms. But what we are trying to achieve is not only modernizing this program so it works for today's seniors by giving them cheaper drugs and coverage of drugs, but we are also trying to modernize this program and save it for the baby boom generation.

We have 77 million retirees coming in this country starting in 15 years; and if we accelerate the bankruptcy of this program as the Democrats are proposing to do, it is not going to be there for them.

So what we are doing with these market-based reforms and giving seniors more choices? We are giving them the chance that this program will be solvent for the boomers when they retire. That is the responsible thing to do here. The responsible thing is to make it work for today's seniors, make it modern, make it comprehensive, work on prescription drug prices, work on prescription drug coverage, but give seniors more choices, use competition, use the things that have worked in the past so we can save this program for the baby boomers. That is what the Republican bill does.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds for a couple of housekeeping things.

In 13 years, the revenues start to decline, but it does not go insolvent for 24 years. And I say to the gentleman from Ohio (Mr. NUSSLE), if he has indeed the same letter that we are informed we have from CBO dated June 26, it says nothing in there about employers turning back Medicare, so he either misspoke or made it up, which, in my State, we call telling a lie. Unless he has a different letter, which I am assured by CBO he does not, then he made that up.

Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. MENENDEZ).

Mr. MENENDEZ. Mr. Speaker, I rise on behalf of my 84-year-old mother and millions like her across this country. She worked her entire life in the factories of New Jersey. Today she has Alzheimer's and spends over half of her social security check on prescription drugs. If it was not for my sister and me, she would not be able to live with the dignity she deserves.

Now, this Republican package is wrapped in a label that says, "I care," but when you open it up, it contains nothing more than an empty promise.

Under this Republican plan, which lacks the compassion promised by the President and expected from our doctors, millions of seniors who want to stay in traditional Medicare with their own doctor would essentially be forced into HMOs and left without the choices they deserve. This bill is the road towards privatizing Medicare.

Republicans just cannot help themselves. Once again, they have chosen corporate interests over human interests. America's seniors deserve our respect. They have worked too hard, sacrificed too much to be forced to choose between paying their rent, putting food on the table, and having access to life-enhancing drugs.

Support the Democratic substitute that has a real prescription drug provision under Medicare.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from California (Mr. CUNNINGHAM), our fighter pilot commander extraordinaire.

Mr. CUNNINGHAM. Mr. Speaker, I had pneumonia about 5 years ago, and I went to pick up the prescription drug and I looked at it. It was 120 bucks. As I picked it up, I sat there and I thought, how does a family with three or four children afford 120 bucks per bottle of Augmentin to help them with the flu or with other antibiotics? It is a real fact. It is hard.

But Mr. Speaker, I say to the gentleman from Michigan (Mr. DINGELL), does he know the cost of my prescription drug? It cost me $17. Because my wife worked with the Encinitas school district and she had insurance. That is what we want, is a private-public partnership for those people that cannot afford prescription drugs to help them. Over 1.4 million people in California will have no copay, no cost whatsoever. But it will help them in our bill.

I think that your bill, with its costs, is devastating in the long run. It will not help.

If Democrats can demonize pharmaceutical companies, then what is left? The government. If you can demonize insurance companies, what is left for health care? Government-controlled health care. We rejected that in 1993 when the then First Lady offered it. I oppose government-controlled health care, and maybe that is the difference in us, because it will drive this country in debt.

I talked to some people from Canada. Do my colleagues know where they go to get their health care? They come clear down to Buffalo, New York to get it, because it is so bad with their government-controlled health care.

Let us defeat the Democratic substitute and support the primary bill.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, the Republican prescription drug plan is bad for America and even worse for rural America.

Today I sent around a letter to Members explaining exactly why this GOP bill shortchanges rural areas like Northern Michigan, which I represent.

The Rangel-Dingell substitute ensures that rural areas are treated fairly. The Republican plan continues to put citizens in these areas at a huge disadvantage. The Rangel-Dingell bill goes far beyond the meager provisions for rural health care providers included in the GOP bill. Our bill, the Democratic bill, provides over $10 billion in additional relief for rural areas and removing the harmful Medicare privatization provisions that just have not worked in rural America.

Instead of helping seniors with their prescription drug plan, the Republican plan subsidizes private insurance companies. This plan tends to bribe private insurance companies to provide service in rural districts like mine. These insurance companies have come before our Committee on Energy and Commerce and have testified that they will not be providing the service, and the Republican plan just will not work.

If insurance companies do change their minds, there is nothing in this bill that will prevent them from shifting the added costs to our seniors. I had an amendment in the Committee on Energy and Commerce that would have prevented increases in the monthly premiums for seniors, no matter where they live. But unfortunately, it was voted down on a party line vote.

The GOP plan has a huge gap in coverage and does nothing to reduce the inflated prices big drug companies are charging for prescription drugs. In fact, the Republican plan has a noninterference clause that says the Health and Human Services Secretary will not, will not be allowed to negotiate lower prices for Americans.

The Rangel-Dingell bill will ensure that every senior, regardless of where they live, will be able to obtain the prescription drugs and the quality of health care they require to live a healthy life. This coverage will be provided through Medicare. Democrats are working to strengthen this program, not to do away with it, as the gentleman from California (Mr. THOMAS) called for when he said, and I quote him, "To those who say the GOP bill will end Medicare as we know it, our answer is: We certainly hope so." Thus, the real motive behind the GOP plan is to do away with Medicare. Democrats proudly stand behind Medicare. Support the Rangel-Dingell substitute.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. HAYWORTH), a member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, I thank my friend from Connecticut, and she has visited Arizona, and I know that the hour grows late and the debate grows heated and sometimes well-intentioned efforts from some are thrown in the confusion.

Mr. Speaker, I rise to urge this House to reject the Democratic substitute and to vote "yes" for H.R. 1, for reasonable, rational, clear-cut reform of Medicare that will bring Medicare into the 21st century with prescription drug coverage.

□ 2345

Mr. Speaker, we have read even tonight in Europe the development of a cardiac drug that is estimated to cut heart attacks by 80 percent. We have made great gains in pharmacology; but we do not continue those gains, Mr. Speaker, if we opt for a trillion dollar travesty. And make no mistake, that is what the minority substitute is offering to us this evening.

It was interesting, my friend from Iowa, who pointed out that the deficit hawks on the other sides had flown the coop. It is interesting, so many on the left who are so quick to indict folks higher on the economic scale tonight are strangely silent when we offer a plan where we give the priorities to those who need the help first.

The irony is, my friends on the left in the trillion dollars travesty section say, do not worry. Let us break the bank. Let the good times roll. Take command and control, put it together with a trillion bucks. No worries. But we know what would happen under that plan. It is a prescription for bankruptcy. And it is a prescription to mortgage the future of the working families that my friends purport to support.

People of good will can have different opinions, and we certainly have them here in the House tonight. The question often comes down to this, when is enough enough? With the left it is never enough.

Reject insanity. Vote for rationality, "yes" to H.R. 1; "no" to the Democratic substitute.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair would remind Members of the time remaining. The gentleman from Louisiana (Mr. TAUZIN) has 4½ minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 3½ minutes remaining and would be next in line to close. The gentlewoman from Connecticut (Mrs. JOHNSON) has 5½ minutes remaining and would be the second to close. The gentleman from Michigan (Mr. DINGELL) has 4¼ minutes remaining and would be the first to close.

The Chair recognizes the gentleman from California.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. KUCINICH).

Mr. KUCINICH. Mr. Speaker, everyone in America knows the price of drugs is too high. Seniors know it best. Proponents of H.R. 1 are not representing the seniors of America. They represent the biggest campaign contributors in America, the private health insurance industry led by drug makers.

The Rangel-Dingell substitute will bring down the cost of the drugs. It allows Medicare to buy drugs in bulk and negotiate for lower prices, which the VA already does. Skyrocketing drug costs are not only driving up health care expenses but are causing seniors to make cruel choices between prescriptions and food, prescriptions and clothing. Some seniors are even splitting pills to make prescriptions last.

Seniors are crying out for help, but their pleas are drowned out by the cash registers humming away at the majority party headquarters, while insurance and pharmaceutical company lobbyists rush to the great Medicare sellout event.

Yes, some of our friends are indeed trying to take care of people in their old age. Themselves.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I want to point out that despite what you may have heard on the floor tonight, our basic package contains $27.2 billion of assistance to rural health care. That is the largest package of rural health care we have ever voted on all the times we have voted on Medicare prescription drugs.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. UPTON), the chairman of the Subcommittee on Telecommunications and the Internet of the Committee on Energy and Commerce.

Mr. UPTON. Mr. Speaker, I have heard a lot of criticism tonight about this drug bill; and I want to remind all of us as we go back to our districts, as we have heard for so many years at our town meetings and so many events, America wants and needs a prescription drug program for our seniors. I remind all of our colleagues here tonight that this program is voluntary. You do not have to participate if you do not want to, but for many Americans they will want to participate. They are going to participate.

Mr. Speaker, I want to relate a little story that happened to me in my district last summer. I was at my son's little league game. A woman ran up to me as I was getting in my car and packing up the gear. She said, My mom just had a stroke. It will cost her $600 a month to survive. We never had that in our budget. We cannot afford it. Is the plan that you passed last week, this was last year, is that going to help my mom? I put my hands on her shoulders and I said, Yes, I believe that it will. She will be able to benefit from this plan. You will be able to use the assets that you have and to have her survive in a meaningful way.

Yet, the other body never came back. The other body never came back with a plan and, in fact, that woman and her family were very distraught.

This is a plan tonight that can pass with bipartisan support, not only in this Chamber but the other Chamber on the other side of the Capitol. The President will sign this bill. It is within the budget. No, it is not perfect. But we can take a step to help the woman that I had talked to last year as well as the thousands of people that have come to our town meetings over the course of the last number of years.

Mr. Speaker, I urge my colleagues to defeat the Democratic substitute and, yes, support this plan that we take up a little bit later this morning.

Mr. DINGELL. Mr. Speaker, I yield 2¼ minutes to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, once upon a time in 1989, a group of very angry seniors chased their Congressman, the powerful chairman of the House Committee on Ways and Means, into his car because they wanted him to know that they did not like the catastrophic health care bill.

This happens to be the picture that appeared on the front page of the Chicago Tribune in August of 1989. This was a bill that passed this body with overwhelming bipartisan support and all of the national senior citizens organizations supported the bill. There was only one problem. No one had checked in with rank-and-file seniors around the country who sat down with their calculators and they figured out what the benefit would be that they would get and how much it would cost them, and they did not like the answer.

Now, I show you this photo not to revive the debate on catastrophic because within a couple of months the bill was repealed, something very unusual and usually very difficult. I show you this photo as a friendly warning. If you pass H.R. 1 tonight, you better also go out and buy some running shoes because senior citizens are too smart to be fooled by Republican speeches or anybody else's speeches. They will figure out on their own what this bill does, which is, as the current chairman of the powerful House Committee on Ways and Means hopes, destroy Medicare as we know it.

Seniors will get out their calculators and figure it out.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Ohio (Mr. PORTMAN).

Mr. PORTMAN. Mr. Speaker, it has been a very interesting debate, too, as you listen to this debate tonight. We had 3 hours of good debate on the Republican legislation, the underlying bill which provides historic prescription drug coverage and does so within the budget. Now is the opportunity for the Democrats to talk about their substitute. So what is your idea? And you know what we are having? More discussion of the underlying legislation. Again, historic legislation to add prescription drug coverage that is within the budget.

The Democrats are not talking about their bill. It adds $1 trillion to the deficit. That busts our budget. It busts their budget. In fact, it busts both budgets combined.

The Democrat legislation does so by loading up the bill, not by helping those seniors who need it the most. The underlying legislation provides for about 30 percent of the seniors that need it most, those under 150 percent of poverty, no deduction, no deductible, no cost sharing, a simple copay when you go to the pharmacy, total subsidy for the prescription drug coverage. Instead, the Democrat plan by going to a trillion dollars would provide coverage for those who do not even need it. It sounds like what they accuse Republicans of.

I was really interested to see, when you look at page 12 of the Democrat bill, there is also something else interesting. They say we do not provide guaranteed access. We do provide guaranteed access. The government actually steps in when there are not plans available, negotiates down the risk which assures coverage.

If you look at page 12, what does the Democrat plan do? It says, "The Secretary shall develop procedures to ensure coverage."

That will give you some comfort. I can see why they are not talking about their legislation. I would not either. Vote for the underlying bill. Vote down this substitute that they will not talk about.

Mr. STARK. Mr. Speaker, I yield myself 1½ minutes.

Mr. Speaker, just to straighten out some of the figures, the Republicans do indeed add $26.7 billion for rural providers. We add $39.1 billion for rural providers. That is $2.5 billion more, and I would hope that the Republicans are not lying to the seniors.

You can lie to us because we are used to it. The White House has set the tone for that. But do not lie to the seniors. There is nothing in your bill. I say to the gentleman from Ohio (Mr. PORTMAN), there is nothing in your bill that guarantees anything, and to say that to the seniors is lying to them.

There is nothing in your bill that guarantees a thing to the seniors and you know it. And if you do not know it, read it again. Otherwise, you are lying to the seniors.

Our bill provides a Medicare benefit which is definable. Yours does not. You do not require any benefits if no insurance company steps up to the plate and there is nothing that requires it. There is not one line in your bill that requires an insurance company to provide anything. So it is all a fantasy. At least we are requiring the government to provide a benefit to the seniors in the same manner they are now familiar, under Medicare with a determined premium, a determined deductible, determined benefits, the same across the country. None of that is available through the Republican bill. To tell the seniors otherwise is lying. You have lied to us tonight and stop lying to the seniors. So support our substitute and vote down the great Republican lie.

Mr. DINGELL. Mr. Speaker, I have an inquiry as to time first before I yield the balance of my time. I believe the gentlewoman from Illinois (Ms. SCHAKOWSKY) did not get the full 2¼ minutes that I yielded to her. I would like to know how much time I have left and how much I can properly yield the gentlewoman from Illinois.

The SPEAKER pro tempore. The gentleman from Michigan has 3 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me time.

Again, this is just a warning, a friendly warning to you that if you pass H.R. 1 tonight, you better also go out and get your running shoes because the seniors are too smart to be fooled by your proposal. And you can trash Medicare all you want. You can call it an outdated program, antiquated; but I do not know who you are talking to.

I do believe that you love your mothers, but it is obvious to me that you do not call them enough. You do not go to senior centers enough. Not the ones I have gone to in my 5 years as director of the State Council of Senior Citizens. Seniors love their Medicare. The only thing they do not like is that it does not cover prescription drugs. And that is why if you are smart or out of shape and not able to be chased by seniors, you will vote for the Rangel-Dingell substitute.

The Democratic substitute is what seniors have been asking for and what every politician has been promising them, an understandable, defined, dependable Medicare prescription drug benefit. It has all the features of Medicare that our seniors know and love, a set premium, no copayments.

Vote for the substitute or start running.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Virginia (Mr. TOM DAVIS).

Mr. TOM DAVIS of Virginia. Mr. Speaker, I would like to engage in a colloquy with my colleague.

Can she confirm that the language in H.R. 1 includes plans under the Federal Employee Retirement Plan as an employment base plan?

☐ 0000

Mrs. JOHNSON of Connecticut. Mr. Speaker, will the gentleman yield?

Mr. TOM DAVIS of Virginia. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Speaker, yes, that is correct.

Mr. TOM DAVIS of Virginia. This will allow OPM to take advantage of the subsidies in the bill just as other employees and unions will?

Mrs. JOHNSON of Connecticut. That is correct.

Mr. TOM DAVIS of Virginia. Mr. Speaker, I appreciate the gentlewoman's and the chairman's willingness to work with us on this issue. I think that allowing the subsidies H.R. 1 provides for will result in lower premiums and improved benefits for all FEHBP enrollees.

Mrs. JOHNSON of Connecticut. I thank the gentleman, and I look forward to working with the gentleman on this issue as the bill moves to conference.

Mr. TOM DAVIS of Virginia. Mr. Speaker, as I said, I appreciate the willingness of the gentlewoman to clarify that.

I have another concern, that Federal employees are often treated differently from current Federal employees in ways that are not always equitable. Retirees are different from current Federal employees. For example, current employees are allowed to pay their health insurance premiums from pre-tax dollars. Federal retirees are not.

FEHBP currently does not provide different benefits for retirees and current employees. One is simply a member of FEHBP. I think it is important that this dynamic remain once a Medicare prescription drug benefit is put into place, whichever plan passes.

As chairman of the Committee on Government Reform, I look at this from an employer's perspective. We do not want private employers to drop the prescription drug coverage they provide for their retirees. H.R. 1 provides incentives so that they will not do so, but we as the Federal Government have to lead by example.

I have introduced legislation that simply states that Federal retirees will continue to be treated on par with current Federal employees when it comes to prescription benefits. I regret we were unable to include this language in H.R. 1, but I am grateful to have the commitment of the Speaker and the majority leader to bring this bill to the floor as soon as we return from recess.

Mr. TAUZIN. Mr. Speaker, may I inquire how many minutes are left for each one of the four who have allocated time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 2 minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 1 minute remaining and would be next to close. The gentlewoman from Connecticut (Mrs. JOHNSON) has 2½ minutes remaining, and the gentleman from Michigan (Mr. DINGELL) has 2 minutes remaining.

Mr. TAUZIN. Mr. Speaker, we reserve the balance of our time. If anyone wants to use some more time at this time would be a good time to do it.

Mr. DINGELL. Mr. Speaker, I reserve the balance of my time, and I want to yield it to our leader.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 30 seconds.

This is a historic evening. It is our opportunity tonight to provide prescription drugs to all seniors under Medicare as an entitlement and to do it in a way that is fair, simple and generous and sustainable. It is our opportunity tonight to modernize the benefit program under Medicare to deal with chronic care for our seniors, a big concern for them, and to structure Medicare in such a way that it will be sustainable, the dollars will be there and Medicare will be able to provide the health retirement security in the future that it has in the past.

I urge support of H.R. 1 and defeat of the substitute.

CALL OF THE HOUSE

Mr. TAUZIN. Mr. Speaker, I move a call of the House.

The SPEAKER pro tempore. A quorum is not present.

A call of the House was ordered.

The call was taken by electronic device, and the following Members responded to their names:

[Roll No. 329]

ANSWERED "PRESENT"—421

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert

Boehner
Bonilla
Bonner
Bono
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). There are 2 minutes remaining in this vote.

☐ 0022

The SPEAKER pro tempore. On this rollcall, 421 Members have recorded their presence by electronic device, a quorum.

Under the rule, further proceedings under the call are dispensed with.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) is recognized.

Mr. DINGELL. Mr. Speaker, I yield the balance of my time to the distinguished gentleman from Arkansas (Mr. BERRY).

The SPEAKER pro tempore. The gentleman from Arkansas is recognized for 2 minutes.

Mr. BERRY. Mr. Speaker, we are here this evening on a very serious matter. It can literally mean life or death for many of our elderly citizens. Our great Nation was founded, and has so far been successful, based on the self-evident truth in the Declaration of Independence that all men are created equal. They are endowed by their Creator with certain inalienable rights, and that among these are life, liberty, and the pursuit of happiness.

Mr. Speaker, these founding truths were followed by a firm commitment from our Founding Fathers, the last sentence in the Declaration of Independence. It says: In support of this declaration, with a firm reliance on the protection of Divine Providence, we mutually pledge to each other our lives, our fortunes, and our sacred honor.

Mr. Speaker, I think that those men would be heartbroken to see what happens here this evening. As I said earlier, the Republicans are in charge. We recognize that. You can do what you want to do. You do, and I give you credit, for publicly acknowledging that you want to destroy Medicare. You do, and I give you credit, for some of your leaders publicly acknowledging that you would put us into bankruptcy just so we can make the government smaller, so we can do away with certain social programs that you do not like. And I give you credit for that. In fact, I think some of you, and I have seen it, have publicly proclaimed you are proud of it.

My dilemma is, why would you want to do what you are trying to do tonight to the greatest generation, the men and women that went through the Depression, fought World War II, and then built this great Nation into what it is today and turned it over to my generation?

I had a cute little remark in there, but I am not going to use it because I think this is far too serious, this business we take up this evening. A government should not make poor people poorer, rich people richer. It should not create a situation where no one has to be responsible, and it should not make it possible for a person or group of persons to be able to take advantage of others because of an act of that government.

If you do what you are talking about doing, you will make that exact thing possible. You will make it possible for insurance companies and pharmaceutical companies to rob the senior citizens of this country.

The SPEAKER pro tempore. The gentlewoman from Connecticut (Mrs. JOHNSON) is recognized.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield the balance of my time to the gentleman from Texas (Mr. DELAY), the majority leader.

Mr. DELAY. Mr. Speaker, I want to commend all those that have worked so hard on probably the most important issue that most of us will vote on in our career. There is very few times that you are going to have a vote like this.

☐ 0030

Mr. Speaker, the gentleman from California (Mr. THOMAS), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Louisiana (Mr. TAUZIN), the members of the Committee on Ways and Means, members of the Committee on Energy and Commerce, Members know this is incredibly important. The future of our seniors, the future of our children are at stake.

Yogi Berra said when you reach a fork in the road, take it. That is sort of where we are tonight, at that fork in the road. Many of us want to take it because we know, we have witnessed Medicare being a system at the present time that is a disaster waiting to happen.

We are spending $267-plus billion a year on Medicare. Payroll taxes only pay 57 percent of that, general revenue and other taxes pay 30 percent, and premiums pay 10 percent. In less than 20 years, the payroll taxes will only cover 30 percent, the rest will come from our children and their incomes. That is on top of the fact that there is over $13 trillion in unfunded liability. In just 5 years, we will be spending over $400 billion per year on Medicare. Now some on my side of the aisle think $400 billion is a lot of money over 10 years, and giving this benefit is really expensive.

But at the same time what are we getting for this system that has been designed to bankrupt this country? What we are getting is doctors refusing to take seniors as patients. We have hospitals closing. We have costs escalating through the roof. Medicare is driving other health care costs through the roof. Seniors are having to make spending decisions based upon the cost of their health care or their drugs. This is the system they want to preserve. This is the system that they want to see continue. But many of us, both Democrats and Republicans, think that this is a time that we have an incredible opportunity.

I came here to make a difference; and, frankly, since this Republican House has been in the majority we have made an incredible difference. Some Members wanted to preserve the old welfare system. We reformed welfare. Some of our Members have commented over the last few days that entitlements are forever. No, they are not. Welfare was an entitlement, and we changed it. We stood up and led and took the responsibility to do so. Tax relief, tax reform, paying down the debt, not one time in 40 years did the other side of the aisle balance the budget, we did. They spent 40 years driving up the debt on our children, we paid over $550 billion on that debt.

So what are we faced with on this road that forks? What is the solution? The Democrats have offered their solution, and I say to Members, we get a glimpse of the future. I hope Members watched the debate on their substitute because that is a glimpse of the future if this bill does not pass.

Let me tell Members what people have said about their substitute. According to Tom Saving, who is a current Medicare trustee, the Democrat plan would lead to Medicare consuming not only all of the Medicare payroll taxes, but also more than 54 percent of all Federal income taxes by the year 2040 and over 90 percent of all Federal income taxes by the year 2075. They want to continue the plan. The Democrat plan would add between $18 trillion and $30 trillion in unfunded liabilities to the Federal Government's balance sheet. They want to preserve Medicare, and that is what it would be.

Now what is the Senate's solution? More of the same. The Senate is writing a bill over there that Senator KENNEDY is very proud of. Well, the Senate has got to do what it has got to do.

What is our solution? It has been talked about over and over again, but what we are desperately trying to do is bend that growth curve and get a handle on this and still bring good quality health care to our senior citizens by bringing market forces into play, by addressing the third party payment problem through copayments, deductibles and so forth, but give seniors the right to choose the type of health care that they think is best suited for their needs, not what some government program tells them is going to suit their needs.

We want to start us down that fork to make Medicare a viable, reliable program for generations to come. I just ask my colleagues and Democrats to vote no. What is the alternative if this bill does not pass tonight? What is the alternative? I do not know the answer to that question. I have asked that question for the 6 months that we have been working on this piece of legislation. I do not know what the alternative is, but I do know we have an opportunity.

Mr. Speaker, sometimes things are not the way you want them to be. Sometimes a bill does not have quite as many reforms as Members want. This bill does not have as many reforms as I would like to see, but it is starting us on a different path, a path of fiscal responsibility, a path that provides quality health care to our seniors, provides them choice.

A study was just done. They claim that all these private plans will not work. Our own plan, FEHBP, has been growing at a slower rate than the Medicare plan. That ought to tell Members something, when there is competitiveness in the process, costs are held down and quality is increased.

Let me tell Members, this is the beginning of something that we can be proud of. It may not be the end. We may have to change it down the line, but we need the opportunity to move this forward so we can provide a future for our children that brings sanity to this process. That is why we came here, to bring sanity to this process. I urge all Members on both sides of the aisle to join us because Medicare is too important for partisan politics.

Mr. Speaker, the American people have asked us for this. They sent us here to do this, and they deserve this approach. It is the right thing to do. It is the right time to do it, and if we fail to act now, we may never have another chance to make it right. The American people have given us this opportunity to lead; and in leadership, responsibility has to be there. We are ready to stand up and lead, and it is our job to seize that opportunity today. I just ask Members, I implore Members to vote yes for Medicare, vote yes for our seniors, vote yes for this bill.

Mr. STARK. Mr. Speaker, I yield the balance of my time to the gentlewoman from California (Ms. PELOSI), the minority leader.

Ms. PELOSI. Mr. Speaker, the distinguished majority leader who just spoke said something that I agree with. He said that this issue that we are voting on tonight is probably one of the most important issues we will vote on in our career. Mr. Leader, I quite agree.

Mr. Speaker, that is why it is hard to understand why we are taking up this debate in the dark of night when the Senate has taken up the bill for 2 weeks with the consideration of 30 amendments, to have a free and open exchange of ideas about this most important issue in our careers. And when the bill was sent to the floor in this House of Representatives for this most important issue, no amendments were allowed. Why were they not allowed, because of the fear that they might have passed and improved this Republican bill on the floor which dishonors the seniors that it pretends to support and dishonors the people who sent us to this House of Representatives by not allowing their amendments to be heard on this floor.

My leadership role afforded me the opportunity to speak at some length earlier about my concerns about the Republican bill and my preference for the Democratic bill. I had only intended to take one moment to close, but after hearing my colleagues talk about fiscal responsibility, I cannot resist the opportunity to state the facts because it is one of the mysteries of this floor, that Members can come to the floor and misrepresent the facts, and that is in order, but to call them on it is out of order. But I am going to take that risk.

The fact is that under the Clinton administration and the legislation passed in this House with 100 percent of the Democratic votes and not one Republican vote, coming out of the Clinton years we were on a path of $5.6 trillion in surplus, in surplus. In the 2½ years in the Bush administration, we are now on a path going to $3 trillion in deficit, a swing of over $8 trillion onto the national debt, and they call that fiscally sound, as they give away huge tax cuts to the 200,000 wealthiest families in America, and many of us in this room are part of that and would benefit, but not in the enlightened self-interest of this country. But for that same money, every senior citizen in America could have a real, guaranteed, defined prescription drug benefit.

Mr. Speaker, I want to make two more points. We have had some debate; unfortunately, none of our amendments were we allowed to bring to the floor. It is late, and we usually do these things in the dark of night so the American people cannot see and cannot have the bright light of day on the debate on this floor to see what is happening to them and to their futures.

□ 0045

But I want to make just two points about the bills. The Democratic bill is a defined guaranteed benefit under Medicare. The Republican bill is not. I heard the distinguished chairman of the Committee on the Budget speak about the cost of the Democratic bill. The Democratic bill cost would be in half if the Republicans would allow the Secretary of HHS to negotiate for best prices. That provision is in the Democratic bill. It makes sense, right? Forty million seniors, lots of purchasing power, lots of leverage. It makes sense. Not to the Republicans. Their bill has a prohibition on the Secretary negotiating for best prices. A prohibition.

I think there are many questions about the Republican bill. It is very complex. But as seniors look at it and they ask those questions, I think there is one question that every American should have: Why do the Republicans have a prohibition on the Secretary negotiating for the best possible price, reducing the cost of prescription drugs to seniors and to the American taxpayer? Why? I will tell you why. Because tonight we have a debate between the special interests and the public interest. The Democrats have come to this floor as servants of the people. The Republicans have come to this floor as handmaidens of the prescription drug industry.

I urge my colleagues to support this amendment and oppose the Republican bill.

Mr. TAUZIN. Mr. Speaker, in order to close this historic debate, I yield the balance of my time to the gentleman from Illinois (Mr. HASTERT), the distinguished Speaker of our whole House.

Mr. HASTERT. Mr. Speaker, the hour is late. We have had a lot of rhetoric. We have had a lot of flailing of arms and pointing fingers across the aisle. It is time for us to come to a reasoned decision. It is time for us to look at all the debate that we have had, to look at the facts. I guess I could be suckered into a debate about fiscal responsibility over the past years, votes we have had and votes we did not have. But the fact is we have a very important bill on the floor of this House tonight, a bill that probably will reach into every American household and give people decisions and benefits on how they are going to take care of their mothers and their fathers and the elderly people that they hold dear.

I want to salute those folks who worked hard on both sides of the aisle to carry on this debate. I thank the gentleman from California (Mr. THOMAS) and the gentleman from Louisiana (Mr. TAUZIN). I am grateful for their hard work. I have worked on health care issues in this Congress for more than a decade. When you compare me to the great gentleman from Michigan, that is probably not very much time. But Bob Michel put me on Mrs. CLINTON's health care task force back in 1993 and Newt Gingrich asked me to deal with the issue of health insurance portability in 1995 and we did that. In every Congress that I have presided as Speaker, this House has passed a prescription drug benefit as part of an effort to modernize Medicare. Today, we have a chance to take a most dramatic step in health care reform, the most dramatic step we have taken in 25 years.

Some of my friends on the other side of the aisle say that we do not spend enough. That is not surprising, because they think that $1 trillion over $400 billion is better over a 10-year period of time. Some of my friends on this side of the aisle believe we spend too much. That is not surprising, either, given their philosophical beliefs. But this bill spends what we can afford to spend. We cannot afford to ignore this issue this year. We on both sides of the aisle have held out a promise to America's seniors that we will give them an opportunity to have a prescription drug benefit and a new modern Medicare. Ladies and gentlemen, we hold out this promise. Tonight is the night that we have an opportunity to fulfill that promise.

In a sense, this is the best of times and the worst of times when it comes to health care in this country. We have the finest doctors. We have the best hospitals. We have people who are uninsured. But we also have the cutting-edge issues and lifesaving prescription drugs. We also have skyrocketing costs. And we have too many people who are uninsured. And we have drugs that for some folks are just too expensive. Last week, we passed legislation to deal with the uninsured when we passed association health plans. Today we deal with the cost issues of health care. Earlier today we passed a health savings account bill which puts the consumer in the driver's seat in driving down costs. And now, in this bill, we make Medicare work better for senior citizens. A Medicare program that does not include a prescription drug benefit is not serving America's seniors well.

When Medicare was first conceived in the 1960s, it was at its heart a program with the costs of going to hospitals and going to doctors. Back then, prescription drugs were not used to the extent they are today. You got an aspirin once in a while, but they just did not play the role they play today. Today because of advancements made over the last 30 years and the R&D we have done in this country, we have drugs that help us stay out of the hospital, we have drugs to help with cholesterol, we have drugs that help us with diabetes, with arthritis, with high blood pressure, on and on and on. And there are lifesaving drugs.

Seniors should have better access at a better price to these drugs through the Medicare system. This bill makes that happen. It will cut drug costs by an average of 37 percent for the average senior. It also includes catastrophic coverage so that no senior with high drug costs will be forced into bankruptcy. This is a compassionate program for senior citizens.

This bill also includes conservative reforms to make sure that Medicare stays solvent. We cannot allow the Medicare system to continue to grow so large that it actually bankrupts this country. We must introduce market-based reforms that lead to greater choices for seniors and greater competition among providers. I agree with the proposition that an 80-year-old grandmother should not be forced into a PPO simply because she gets a prescription drug benefit. But I also agree that a 50-year-old father who has health care choices throughout his whole working career will feel comfortable shopping around for the best health care plan for his individual needs when he qualifies for Medicare. Competition, choice, the marketplace, these are the concepts which will save Medicare for the coming decades.

Mr. Speaker, I urge my colleagues on both sides of the aisle to support this bill. This is a defining moment for this Congress. It is too late for obstruction. It is too late for nit-picking. It is too late for all the lame excuses that we often hear. Senior citizens will long remember if you voted for them today, but they will never forget if you voted against them.

Ladies and gentlemen, not many times in this great hall do we have a piece of legislation when all the forces come together and we have an opportunity to make real change. We have that opportunity tonight. I ask you to vote to provide senior citizens with a better Medicare system and a real prescription drug benefit.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). All time for debate has expired.

Pursuant to House Resolution 299, the previous question is ordered on the bill and on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL).

The question is on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL).

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. RANGEL. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 175, noes 255, answered "present" 1, not voting 4, as follows:

[Roll No. 330]

AYES—175

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Boswell
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Clay
Clyburn
Conyers
Cooper
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Doyle
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larson (CT)
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sánchez, Linda T.
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Solis
Spratt
Stark
Strickland
Stupak
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOES—255

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Case
Castle
Chabot
Chocola
Coble
Cole
Collins
Costello
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (FL)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Dooley (CA)
Doolittle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hobson
Hoekstra
Hooley (OR)
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Larsen (WA)
Latham
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (OK)
Manzullo
Marshall
Matheson
McCotter
McCrery
McHugh
McIntyre
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moore
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Sabo
Sanchez, Loretta
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Souder
Stearns
Stenholm
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Udall (CO)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

ANSWERED "PRESENT"—1

Baird

NOT VOTING—4

LaTourette
McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 0112

Messrs. BACHUS, COSTELLO, and LIPINSKI changed their vote from "aye" to "no."

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. THOMPSON OF CALIFORNIA

Mr. THOMPSON of California. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. THOMPSON of California. Yes, I am, Mr. Speaker, in its present form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

MOTION TO RECOMMIT WITH INSTRUCTIONS

Mr. THOMPSON of California moves to recommit the bill H.R. 1 jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with the following amendments:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Prescription Drug and Medicare Improvement Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

Sec. 101. Medicare voluntary prescription drug delivery program.

"PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

"Sec. 1860D. Definitions; treatment of references to provisions in MedicareAdvantage program.

"Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

"Sec. 1860D-1. Establishment of voluntary prescription drug delivery program.
"Sec. 1860D-2. Enrollment under program.
"Sec. 1860D-3. Election of a Medicare Prescription Drug plan.
"Sec. 1860D-4. Providing information to beneficiaries.
"Sec. 1860D-5. Beneficiary protections.
"Sec. 1860D-6. Prescription drug benefits.
"Sec. 1860D-7. Requirements for entities offering Medicare Prescription Drug plans; establishment of standards.

“Subpart 2—Prescription Drug Delivery System

“Sec. 1860D–10. Establishment of service areas.
“Sec. 1860D–11. Publication of risk adjusters.
“Sec. 1860D–12. Submission of bids for proposed Medicare Prescription Drug plans.
“Sec. 1860D–13. Approval of proposed Medicare Prescription Drug plans.
“Sec. 1860D–14. Computation of monthly standard prescription drug coverage premiums.
“Sec. 1860D–15. Computation of monthly national average premium.
“Sec. 1860D–16. Payments to eligible entities.
“Sec. 1860D–17. Computation of monthly beneficiary obligation.
“Sec. 1860D–18. Collection of monthly beneficiary obligation.
“Sec. 1860D–19. Premium and cost-sharing subsidies for low-income individuals.
“Sec. 1860D–20. Reinsurance payments for expenses incurred in providing prescription drug coverage above the annual out-of-pocket threshold.
“Sec. 1860D–21. Direct subsidy for sponsor of a qualified retiree prescription drug plan for plan enrollees eligible for, but not enrolled in, this part.

“Subpart 3—Miscellaneous Provisions

“Sec. 1860D–25. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.
“Sec. 1860D–26. Other related provisions.
Sec. 102. Study and report on permitting part B only individuals to enroll in medicare voluntary prescription drug delivery program.
Sec. 103. Rules relating to medigap policies that provide prescription drug coverage.
Sec. 104. Medicaid and other amendments related to low-income beneficiaries.
Sec. 105. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).
Sec. 106. Study regarding variations in spending and drug utilization.

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

Sec. 111. Medicare prescription drug discount card and transitional assistance for low-income beneficiaries.

Subtitle C—Standards for Electronic Prescribing

Sec. 121. Standards for electronic prescribing.

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

Sec. 201. Eligibility, election, and enrollment.
Sec. 202. Benefits and beneficiary protections.
Sec. 203. Payments to MedicareAdvantage organizations.
Sec. 204. Submission of bids; premiums.
Sec. 205. Special rules for prescription drug benefits.
Sec. 206. Facilitating employer participation.
Sec. 207. Administration by the Center for Medicare Choices.
Sec. 208. Conforming amendments.
Sec. 209. Effective date.

Subtitle B—Preferred Provider Organizations

Sec. 211. Establishment of MedicareAdvantage preferred provider program option.

Subtitle C—Other Managed Care Reforms

Sec. 221. Extension of reasonable cost contracts.
Sec. 222. Specialized Medicare+Choice plans for special needs beneficiaries.
Sec. 223. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.
Sec. 224. Institute of Medicine evaluation and report on health care performance measures.
Sec. 225. Expanding the work of medicare quality improvement organizations to include parts C and D.

TITLE III—CENTER FOR MEDICARE CHOICES

Sec. 301. Establishment of the Center for Medicare Choices.
Sec. 302. Miscellaneous administrative provisions.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

Sec. 401. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.
Sec. 402. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.
Sec. 403. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 404. Fairness in the medicare disproportionate share hospital (DSH) adjustment for rural hospitals.
Sec. 405. Critical access hospital (CAH) improvements.
Sec. 406. Authorizing use of arrangements to provide core hospice services in certain circumstances.
Sec. 407. Services provided to hospice patients by nurse practitioners, clinical nurse specialists, and physician assistants.
Sec. 408. Authority to include costs of training of psychologists in payments to hospitals under medicare.
Sec. 409. Revision of Federal rate for hospitals in Puerto Rico.
Sec. 410. Authority regarding geriatric fellowships.
Sec. 411. Clarification of congressional intent regarding the counting of residents in a nonprovider setting and a technical amendment regarding the 3-year rolling average and the IME ratio.
Sec. 412. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.
Sec. 413. GAO study and report on appropriateness of payments under the prospective payment system for inpatient hospital services.

Subtitle B—Provisions Relating to Part B

Sec. 421. Establishment of floor on geographic adjustments of payments for physicians' services.
Sec. 422. Medicare incentive payment program improvements.
Sec. 423. Increase in renal dialysis composite rate.
Sec. 424. Extension of hold harmless provisions for small rural hospitals and treatment of certain sole community hospitals to limit decline in payment under the OPD PPS.
Sec. 425. Increase in payments for certain services furnished by small rural and sole community hospitals under medicare prospective payment system for hospital outpatient department services.
Sec. 426. Increase for ground ambulance services furnished in a rural area.
Sec. 427. Ensuring appropriate coverage of air ambulance services under ambulance fee schedule.
Sec. 428. Treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital.
Sec. 429. Improvement in rural health clinic reimbursement.
Sec. 430. Elimination of consolidated billing for certain services under the medicare PPS for skilled nursing facility services.
Sec. 431. Freeze in payments for certain items of durable medical equipment and certain orthotics; establishment of quality standards and accreditation requirements for DME providers.
Sec. 432. Application of coinsurance and deductible for clinical diagnostic laboratory tests.
Sec. 433. Basing medicare payments for covered outpatient drugs on market prices.
Sec. 434. Indexing part B deductible to inflation.
Sec. 435. Revisions to reassignment provisions.
Sec. 436. Extension of treatment of certain physician pathology services under medicare.
Sec. 437. Adequate reimbursement for outpatient pharmacy therapy under the hospital outpatient PPS.
Sec. 438. Limitation of application of functional equivalence standard.
Sec. 439. Medicare coverage of routine costs associated with certain clinical trials.
Sec. 440. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 441. Demonstration of coverage of chiropractic services under medicare.
Sec. 442. Medicare health care quality demonstration programs.
Sec. 443. Medicare complex clinical care management payment demonstration.
Sec. 444. Medicare fee-for-service care coordination demonstration program.
Sec. 445. GAO study of geographic differences in payments for physicians' services.

Subtitle C—Provisions Relating to Parts A and B
Sec. 451. Increase for home health services furnished in a rural area.
Sec. 452. Limitation on reduction in area wage adjustment factors under the prospective payment system for home health services.
Sec. 453. Clarifications to certain exceptions to medicare limits on physician referrals.
Sec. 454. Demonstration program for substitute adult day services.
Sec. 455. Medicare secondary payor (MSP) provisions.
TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS
Subtitle A—Regulatory Reform
Sec. 501. Rules for the publication of a final regulation based on the previous publication of an interim final regulation.
Sec. 502. Compliance with changes in regulations and policies.
Sec. 503. Report on legal and regulatory inconsistencies.
Subtitle B—Appeals Process Reform
Sec. 511. Submission of plan for transfer of responsibility for medicare appeals.
Sec. 512. Expedited access to judicial review.
Sec. 513. Expedited review of certain provider agreement determinations.
Sec. 514. Revisions to medicare appeals process.
Sec. 515. Hearing rights related to decisions by the Secretary to deny or not renew a medicare enrollment agreement; consultation before changing provider enrollment forms.
Sec. 516. Appeals by providers when there is no other party available.
Sec. 517. Provider access to review of local coverage determinations.
Subtitle C—Contracting Reform
Sec. 521. Increased flexibility in medicare administration.
Subtitle D—Education and Outreach Improvements
Sec. 531. Provider education and technical assistance.
Sec. 532. Access to and prompt responses from medicare contractors.
Sec. 533. Reliance on guidance.
Sec. 534. Medicare provider ombudsman.
Sec. 535. Beneficiary outreach demonstration programs.
Subtitle E—Review, Recovery, and Enforcement Reform
Sec. 541. Prepayment review.
Sec. 542. Recovery of overpayments.
Sec. 543. Process for correction of minor errors and omissions on claims without pursuing appeals process.
Sec. 544. Authority to waive a program exclusion.
TITLE VI—OTHER PROVISIONS
Sec. 601. Increase in medicaid DSH allotments for fiscal years 2004 and 2005.
Sec. 602. Increase in floor for treatment as an extremely low DSH State under the medicaid program for fiscal years 2004 and 2005.
Sec. 603. Increased reporting requirements to ensure the appropriateness of payment adjustments to disproportionate share hospitals under the medicaid program.
Sec. 604. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.
Sec. 605. Assistance with coverage of legal immigrants under the medicaid program and SCHIP.
Sec. 606. Establishment of consumer ombudsman account.
Sec. 607. GAO study regarding impact of assets test for low-income beneficiaries.
Sec. 608. Health care infrastructure improvement.
Sec. 609. Capital infrastructure revolving loan program.
Sec. 610. Federal reimbursement of emergency health services furnished to undocumented aliens.
Sec. 611. Increase in appropriation to the health care fraud and abuse control account.
Sec. 612. Increase in civil penalties under the False Claims Act.
Sec. 613. Increase in civil monetary penalties under the Social Security Act.
Sec. 614. Extension of customs user fees.
TITLE VII—ACCESS TO AFFORDABLE PHARMACEUTICALS
Sec. 701. Short title.
Sec. 702. 30-month stay-of-effectiveness period.
Sec. 703. Forfeiture of 180-day exclusivity period.
Sec. 704. Bioavailability and bioequivalence.
Sec. 705. Remedies for infringement.
Sec. 706. Conforming amendments.
TITLE VIII—IMPORTATION OF PRESCRIPTION DRUGS
Sec. 801. Importation of prescription drugs.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

"PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

"DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICAREADVANTAGE PROGRAM

"SEC. 1860D. (a) DEFINITIONS.—In this part:

"(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Center for Medicare Choices as established under section 1808.

"(2) COVERED DRUG.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

"(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section; or

"(iii) insulin described in subparagraph (C) of such section;

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—

"(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B, but shall be so considered if such payment is not available under part A or B or because benefits under such parts have been exhausted.

"(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully resolved under subsection (d) or (e)(2) of section 1860D–5.

"(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A Medicare Prescription Drug plan or a MedicareAdvantage plan may exclude from qualified prescription drug coverage any covered drug—

"(i) for which payment would not be made if section 1862(a) applied to part D; or

"(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–5(e).

"(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A and enrolled under part B.

"(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Administrator determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Drug plan, including—

"(A) a pharmaceutical benefit management company;

"(B) a wholesale or retail pharmacist delivery system;

"(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

"(D) any other risk-bearing entity; or

"(E) any combination of the entities described in subparagraphs (A) through (D).

"(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 1860D–6(c)(3), or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

"(6) MEDICAREADVANTAGE ORGANIZATION; MEDICAREADVANTAGE PLAN.—The terms 'MedicareAdvantage organization' and 'MedicareAdvantage plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to MedicareAdvantage organizations).

"(7) MEDICARE PRESCRIPTION DRUG PLAN.—The term 'Medicare Prescription Drug plan' means prescription drug coverage that is offered under a policy, contract, or plan—

"(A) that has been approved under section 1860D–13; and

"(B) by an eligible entity pursuant to, and in accordance with, a contract between the Administrator and the entity under section 1860D–7(b).

"(8) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860D–25) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

“(9) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term ‘qualified prescription drug coverage’ means the coverage described in section 1860D–6(a)(1).

“(10) STANDARD PRESCRIPTION DRUG COVERAGE.—The term ‘standard prescription drug coverage’ means the coverage described in section 1860D–6(c).

“(b) APPLICATION OF MEDICAREADVANTAGE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a Medicare Prescription Drug plan and an eligible entity, unless otherwise provided in this part such provisions shall be applied as if—

“(1) any reference to a MedicareAdvantage plan included a reference to a Medicare Prescription Drug plan;

“(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

“(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

“(4) any reference to part C included a reference to this part.

“Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

“ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

“SEC. 1860D–1. (a) PROVISION OF BENEFIT.—

“(1) IN GENERAL.—The Administrator shall provide for and administer a voluntary prescription drug delivery program under which each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

“(A) MEDICAREADVANTAGE ENROLLEES RECEIVE COVERAGE THROUGH MEDICAREADVANTAGE PLAN.—

“(i) IN GENERAL.—Except as provided in clause (ii), an eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization shall receive coverage of benefits under this part through such plan.

“(ii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE MSA PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in an MSA plan under part C shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term ‘MSA plan’ has the meaning given such term in section 1859(b)(3).

“(iii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—An eligible beneficiary who is enrolled under this part, and enrolled in a private fee-for-service plan under part C shall—

“(i) receive benefits under this part through such plan if the plan provides qualified prescription drug coverage; and

“(ii) if the plan does not provide qualified prescription drug coverage, receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term ‘private fee-for-service plan’ has the meaning given such term in section 1859(b)(2).

“(B) FEE-FOR-SERVICE ENROLLEES RECEIVE COVERAGE THROUGH A MEDICARE PRESCRIPTION DRUG PLAN.—An eligible beneficiary who is enrolled under this part but is not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

“(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

“(3) SCOPE OF BENEFITS.—Pursuant to section 1860D–6(b)(3)(C), the program established under this part shall provide for coverage of all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes).

“(4) PROGRAM TO BEGIN IN 2006.—The Administrator shall establish the program under this part in a manner so that benefits are first provided beginning on January 1, 2006.

“(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(1)(F)), such beneficiary—

“(1) may continue to receive such coverage and not enroll under this part; and

“(2) pursuant to section 1860D–2(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

“(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

“ENROLLMENT UNDER PROGRAM

“SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

“(1) PROCESS SIMILAR TO PART B ENROLLMENT.—The Administrator shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

“(2) CONDITION OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive access to qualified prescription drug coverage.

“(b) SPECIAL ENROLLMENT PROCEDURES.—

“(1) LATE ENROLLMENT PENALTY.—

“(A) INCREASE IN MONTHLY BENEFICIARY OBLIGATION.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1860D–17 applicable to such beneficiary by an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

“(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

“(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

“(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

“(C) PERIODS NOT TAKEN INTO ACCOUNT.—

“(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

“(ii) BENEFICIARY MUST INVOLUNTARILY LOSE COVERAGE.—Clause (i) shall only apply with respect to coverage—

“(I) in the case of coverage described in clause (ii) of subparagraph (F), if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f));

“(II) in the case of coverage described in clause (i), (iii), or (iv) of subparagraph (F), if the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage; or

“(III) in the case of a beneficiary with coverage described in clause (v) of subparagraph (F), if the issuer of the policy terminates coverage under the policy.

“(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

“(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

“(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's ‘continuous period of eligibility’ is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

“(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate ‘continuous period of eligibility’ with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

“(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—Subject to subparagraph (G), for purposes of this part, the term ‘creditable prescription drug coverage’ means any of the following:

“(i) DRUG-ONLY COVERAGE UNDER MEDICAID.—Coverage of covered outpatient drugs (as defined in section 1927) under title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.

“(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)).

“(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

“(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

‘‘(v) Prescription drug coverage under medigap policies.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)).

‘‘(G) Requirement for creditable coverage.—Coverage described in clauses (i) through (v) of subparagraph (F) shall not be considered to be creditable coverage under this part unless the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

‘‘(H) Disclosure.—

‘‘(i) In general.—Each entity that offers coverage of the type described in clause (ii) (iii), (iv), or (v) of subparagraph (F) shall provide for disclosure, consistent with standards established by the Administrator, of whether the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

‘‘(ii) Waiver of limitations.—An individual may apply to the Administrator to waive the application of subparagraph (G) if the individual establishes that the individual was not adequately informed that the coverage the beneficiary was enrolled in did not provide the level of benefits required in order for the coverage to be considered creditable coverage under subparagraph (F).

‘‘(2) Initial election periods.—

‘‘(A) Open enrollment period for current beneficiaries in which late enrollment procedures do not apply.—In the case of an individual who is an eligible beneficiary as of November 1, 2005, there shall be an open enrollment period of 6 months beginning on that date under which such beneficiary may enroll under this part without the application of the late enrollment procedures established under paragraph (1)(A).

‘‘(B) Individual covered in future.—In the case of an individual who becomes an eligible beneficiary after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

‘‘(3) Special enrollment period for beneficiaries who involuntarily lose creditable prescription drug coverage.—

‘‘(A) Establishment.—The Administrator shall establish a special open enrollment period (as described in subparagraph (B)) for an eligible beneficiary that loses creditable prescription drug coverage.

‘‘(B) Special open enrollment period.—The special open enrollment period described in this subparagraph is the 63-day period that begins on—

‘‘(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the later of the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan or the date the beneficiary is provided with notice of such termination or reduction;

‘‘(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the later of the date on which the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage or the date the beneficiary is provided with notice of such loss of eligibility; or

‘‘(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the latter of the date on which the issuer of the policy terminates coverage under the policy or the date the beneficiary is provided with notice of such termination.

‘‘(c) Period of Coverage.—

‘‘(1) In general.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

‘‘(2) Open and special enrollment.—

‘‘(A) Open enrollment.—An eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2006.

‘‘(B) Special enrollment.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(3) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

‘‘(3) Limitation.—Coverage under this part shall not begin prior to January 1, 2006.

‘‘(d) Termination.—

‘‘(1) In general.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

‘‘(2) Coverage terminated by termination of coverage under part A or B.—

‘‘(A) In general.—In addition to the causes of termination specified in paragraph (1), the Administrator shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

‘‘(B) Effective date.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if earlier) under part B.

‘‘(3) Procedures regarding termination of a beneficiary under a plan.—The Administrator shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a Medicare Prescription Drug plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(1)).

‘‘ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

‘‘Sec. 1860D–3. (a) In General.—

‘‘(1) Process.—

‘‘(A) Election.—

‘‘(i) In general.—The Administrator shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization—

‘‘(I) shall make an election to enroll in any Medicare Prescription Drug plan that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and

‘‘(II) may make an annual election to change the election under this clause.

‘‘(ii) Clarification regarding enrollment.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in any Medicare Prescription Drug plan that has been designated by the Administrator in the area. The Administrator shall establish a process for designating a plan or plans in order to carry out the preceding sentence.

‘‘(B) Requirements for process.—In establishing the process under subparagraph (A), the Administrator shall—

‘‘(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a MedicareAdvantage plan under section 1851, including—

‘‘(I) the establishment of special election periods under subsection (e)(4) of such section; and

‘‘(II) the application of the guaranteed issue and renewal provisions of section 1851(g) (other than clause (i) and the second sentence of clause (ii) of paragraph (3)(C), relating to default enrollment); and

‘‘(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

‘‘(2) First enrollment period for plan enrollment.—The process developed under paragraph (1) shall ensure that eligible beneficiaries who enroll under this part during the open enrollment period under section 1860D–2(b)(2) are permitted to elect an eligible entity prior to January 1, 2006, in order to ensure that coverage under this part is effective as of such date.

‘‘(b) Enrollment in a MedicareAdvantage Plan.—

‘‘(1) In general.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization shall receive access to such coverage under this part through such plan.

‘‘(2) Rules.—Enrollment in a MedicareAdvantage plan is subject to the rules for enrollment in such plan under section 1851.

‘‘(c) Information to entities to facilitate enrollment.—Notwithstanding any other provision of law, the Administrator may provide to each eligible entity with a contract under this part such information about eligible beneficiaries as the Administrator determines to be necessary to facilitate efficient enrollment by such beneficiaries with such entities. The Administrator may provide such information only so long as and to the extent necessary to carry out such objective.

‘‘PROVIDING INFORMATION TO BENEFICIARIES

‘‘Sec. 1860D–4. (a) Activities.—

‘‘(1) In general.—The Administrator shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

‘‘(2) Special rule for first enrollment under the program.—The activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860D–3(a)(2).

‘‘(b) Requirements.—

‘‘(1) In general.—The activities described in subsection (a) shall—

"(A) be similar to the activities performed by the Administrator under section 1851(d);

"(B) be coordinated with the activities performed by—

"(i) the Administrator under such section; and

"(ii) the Secretary under section 1804; and

"(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

"(2) Comparative information.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

"(A) Benefits.—The benefits provided under the plan and the formularies and grievance and appeals processes under the plan.

"(B) Monthly beneficiary obligation.—The monthly beneficiary obligation under the plan.

"(C) Quality and performance.—The quality and performance of the eligible entity offering the plan.

"(D) Beneficiary cost-sharing.—The cost-sharing required of eligible beneficiaries under the plan.

"(E) Consumer satisfaction surveys.—The results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan (conducted pursuant to section 1860D–5(h).

"(F) Additional information.—Such additional information as the Administrator may prescribe.

"BENEFICIARY PROTECTIONS

"Sec. 1860D–5. (a) Dissemination of Information.—

"(1) General information.—An eligible entity offering a Medicare Prescription Drug plan shall disclose, in a clear, accurate, and standardized form to each enrollee at the time of enrollment, and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

"(A) Access to covered drugs, including access through pharmacy networks.

"(B) How any formulary used by the entity functions.

"(C) Copayments, coinsurance, and deductible requirements.

"(D) Grievance and appeals processes.

The information described in the preceding sentence shall also be made available on request to prospective enrollees during open enrollment periods.

"(2) Disclosure upon request of general coverage, utilization, and grievance information.—Upon request of an individual eligible to enroll in a Medicare Prescription Drug plan, the eligible entity offering such plan shall provide information similar (as determined by the Administrator) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

"(3) Response to beneficiary questions.—An eligible entity offering a Medicare Prescription Drug plan shall have a mechanism for providing on a timely basis specific information to enrollees upon request, including information on the coverage of specific drugs and changes in its formulary.

"(4) Claims information.—An eligible entity offering a Medicare Prescription Drug plan must furnish to enrolled individuals in a form easily understandable to such individuals—

"(A) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

"(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to the initial coverage limit and annual out-of-pocket limit for the current year (except that such notice need not be provided more often than monthly).

"(5) Approval of marketing material and application forms.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

"(b) Access to Covered Drugs.—

"(1) Access to negotiated prices for prescription drugs.—An eligible entity offering a Medicare Prescription Drug plan shall have in place procedures to ensure that beneficiaries are not charged more than the negotiated price of a covered drug. Such procedures shall include the issuance of a card (or other technology) that may be used by an enrolled beneficiary for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

"(2) Assuring pharmacy access.—

"(A) In general.—An eligible entity offering a Medicare Prescription Drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established by the Administrator under section 1860D–7(g) that ensure such convenient access. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

"(B) Use of point-of-service system.—An eligible entity offering a Medicare Prescription Drug plan shall establish an optional point-of-service method of operation under which—

"(i) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

"(ii) the plan may charge beneficiaries through adjustments in copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860D–6(c).

"(3) Requirements on development and application of formularies.—If an eligible entity offering a Medicare Prescription Drug plan uses a formulary, the following requirements must be met:

"(A) Pharmacy and therapeutic (P&T) committee.—

"(i) In general.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

"(ii) Composition.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

"(B) Formulary development.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate.

"(C) Inclusion of drugs in all therapeutic categories and classes.—

"(i) In general.—The formulary must include drugs within each therapeutic category and class of covered drugs (as defined by the Administrator), although not necessarily for all drugs within such categories and classes.

"(ii) Requirement.—In defining therapeutic categories and classes of covered drugs pursuant to clause (i), the Administrator shall use—

"(I) the compendia referred to section 1927(g)(1)(B)(i); and

"(II) other recognized sources of drug classifications and categorizations determined appropriate by the Administrator.

"(D) Provider education.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

"(E) Notice before removing drugs from formulary.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries, physicians, and pharmacists.

"(F) Appeals and exceptions to application.—The eligible entity must have, as part of the appeals process under subsection (e), a process for timely appeals for denials of coverage based on such application of the formulary.

"(c) Cost and Utilization Management; Quality Assurance; Medication Therapy Management Program.—

"(1) In general.—An eligible entity shall have in place the following with respect to covered drugs:

"(A) A cost-effective drug utilization management program, including incentives to reduce costs when appropriate.

"(B) Quality assurance measures to reduce medical errors and adverse drug interactions and to improve medication use, which—

"(i) shall include a medication therapy management program described in paragraph (2); and

"(ii) may include beneficiary education programs, counseling, medication refill reminders, and special packaging.

"(C) A program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

"(2) Medication therapy management program.—

"(A) In general.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure) or multiple prescriptions, that covered drugs under the Medicare Prescription Drug plan are appropriately used to optimize therapeutic outcomes through improved medication use and to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(B) Elements.—Such program may include—

"(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

"(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

‘‘(iii) detection of patterns of overuse and underuse of prescription drugs.

‘‘(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

‘‘(D) CONSIDERATIONS IN PHARMACY FEES.—The eligible entity offering a Medicare Prescription Drug plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

‘‘(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

‘‘(d) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

‘‘(1) IN GENERAL.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with Medicare Prescription Drug plans of the eligible entity under this part in accordance with section 1852(f).

‘‘(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply to an eligible entity with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

‘‘(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

‘‘(e) APPEALS.—

‘‘(1) IN GENERAL.—Subject to paragraph (2), the requirements of paragraphs (4) and (5) of section 1852(g) shall apply to an eligible entity with respect to drugs not included on any formulary in a manner that is similar (as determined by the Administrator) to the manner that such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

‘‘(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered drug that is not on a formulary of the entity under the terms applicable for a formulary drug if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

‘‘(f) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the Medicare Prescription Drug plan offered by the entity, the entity shall have in place procedures to—

‘‘(1) safeguard the privacy of any individually identifiable beneficiary information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996;

‘‘(2) maintain such records and information in a manner that is accurate and timely;

‘‘(3) ensure timely access by such beneficiaries to such records and information; and

‘‘(4) otherwise comply with applicable laws relating to patient privacy and confidentiality.

‘‘(g) UNIFORM MONTHLY PLAN PREMIUM.—An eligible entity shall ensure that the monthly plan premium for a Medicare Prescription Drug plan charged under this part is the same for all eligible beneficiaries enrolled in the plan.

‘‘(h) CONSUMER SATISFACTION SURVEYS.—An eligible entity shall conduct consumer satisfaction surveys with respect to the plan and the entity. The Administrator shall establish uniform requirements for such surveys.

‘‘PRESCRIPTION DRUG BENEFITS

‘‘SEC. 1860D–6. (a) REQUIREMENTS.—

‘‘(1) IN GENERAL.—For purposes of this part and part C, the term ‘qualified prescription drug coverage’ means either of the following:

‘‘(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (c)) and access to negotiated prices under subsection (e).

‘‘(B) ACTUARIALLY EQUIVALENT PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered drugs which meets the alternative coverage requirements of subsection (d) and access to negotiated prices under subsection (e), but only if it is approved by the Administrator as provided under subsection (d).

‘‘(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—

‘‘(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–13(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered drugs that exceeds the coverage required under paragraph (1).

‘‘(B) REQUIREMENT.—An eligible entity may not offer a Medicare Prescription Drug plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Drug plan in the area that only provides the coverage of prescription drugs that is required under paragraph (1).

‘‘(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan or the MedicareAdvantage plan may use a variety of cost control mechanisms, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

‘‘(b) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

‘‘(c) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term ‘standard prescription drug coverage’ means coverage of covered drugs that meets the following requirements:

‘‘(1) DEDUCTIBLE.—

‘‘(A) IN GENERAL.—The coverage has an annual deductible—

‘‘(i) for 2006, that is equal to $275; or

‘‘(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

‘‘(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

‘‘(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

‘‘(3) INITIAL COVERAGE LIMIT.—

‘‘(A) IN GENERAL.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

‘‘(i) for 2006, that is equal to $4,500; or

‘‘(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

‘‘(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

‘‘(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

‘‘(A) IN GENERAL.—The coverage provides benefits with cost-sharing that is equal to 20 percent after the individual has incurred costs (as described in subparagraph (C)) for covered drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

‘‘(B) ANNUAL OUT-OF-POCKET LIMIT.—

‘‘(i) IN GENERAL.—For purposes of this part, the ‘annual out-of-pocket limit’ specified in this subparagraph—

‘‘(I) for 2006, is equal to $3,700; or

‘‘(II) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

‘‘(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

‘‘(C) APPLICATION.—In applying subparagraph (A)—

‘‘(i) incurred costs shall only include costs incurred, with respect to covered drugs, for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3) (including costs incurred for covered drugs described in section 1860D(a)(2)(C)); and

‘‘(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs, except that only the applicable percent (specified in subparagraph (D)) of the amount of portion of such costs that are paid or reimbursed through insurance, a group health plan, or other third-party payment arrangement for such costs shall not be counted.

‘‘(D) APPLICABLE PERCENT DEFINED.—

‘‘(i) IN GENERAL.—For purposes of subparagraph (C)(ii), but subject to clause (ii), the applicable percent specified in this subparagraph is—

‘‘(I) for years before 2010, 20 percent;

‘‘(II) for 2011, 2012, 2013, 2014, and 2015, 40 percent; and

‘‘(III) for any year thereafter, 100 percent.

‘‘(ii) SECRETARIAL LIMITATION ON TOTAL EXPENDITURES.—The Secretary, in consultation with the Office of Management and Budget, shall estimate at the time of enactment of this part, the aggregate budget outlays that will result during the 10-fiscal-year period beginning with fiscal year 2004 from the enactment of the Prescription Drug and Medicare Improvement Act of 2003. If such estimate exceeds $393,000,000,000, the Secretary shall provide for such proportional reductions in the percentages specified in clause (i) as the Secretary determines to be necessary to assure that such aggregate budget outlays during such period do not exceed such amount.

‘‘(E) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the entities in which such individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may also periodically ask individuals enrolled in a plan offered by the entity whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D–2(d).

‘‘(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered drugs in the United States for beneficiaries under this title, as determined by the Administrator for the 12-month period ending in July of the previous year.

‘‘(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan or MedicareAdvantage plan may provide a different prescription drug benefit design from the standard prescription drug coverage described in subsection (c) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

‘‘(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT PRESCRIPTION DRUG COVERAGE.—

‘‘(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (f)) is at least equal to the actuarial value (as so determined) of standard prescription drug coverage.

‘‘(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1860D–17(c) and reinsurance payments under section 1860D–20 with respect to such coverage.

‘‘(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (f)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (c)(3), of an amount equal to at least the product of—

‘‘(i) such initial coverage limit minus the deductible under subsection (c)(1); and

‘‘(ii) the percentage specified in subsection (c)(2).

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

‘‘(2) DEDUCTIBLE AND LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES MAY NOT VARY.—The coverage may not vary the deductible under subsection (c)(1) for the year or the limitation on out-of-pocket expenditures by beneficiaries described in subsection (c)(4) for the year.

‘‘(e) ACCESS TO NEGOTIATED PRICES.—

‘‘(1) ACCESS.—

‘‘(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a MedicareAdvantage organization, the entity or organization shall provide beneficiaries with access to negotiated prices used for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the deductible, any cost-sharing, or an initial coverage limit (described in subsection (c)(3)). For purposes of this part, the term ‘negotiated prices’ includes all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations and shall reflect prices that are no higher than the prices negotiated by the Secretary under subparagraph (B).

‘‘(B) SECRETARIAL NEGOTIATED PRICE.—Notwithstanding any other provision of this part, the Secretary shall, consistent with the requirements of this part and the goals of providing quality care and containing costs under this part, negotiate contracts with manufacturers of covered outpatient prescription drugs that provide for the maximum prices that may be charged to individuals enrolled under this part by participating pharmacies for dispensing such drugs to such individuals.

‘‘(C) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a MedicareAdvantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

‘‘(2) CARDS OR OTHER TECHNOLOGY.—

‘‘(A) IN GENERAL.—In providing the access under paragraph (1), the eligible entity or MedicareAdvantage organization shall issue a card or use other technology pursuant to section 1860D–5(b)(1).

‘‘(B) NATIONAL STANDARDS.—

‘‘(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with parts C and D of title XI and may be based on standards developed by an appropriate standard setting organization.

‘‘(ii) CONSULTATION.—In developing the standards under clause (i), the Administrator shall consult with the National Council for Prescription Drug Programs and other standard-setting organizations determined appropriate by the Administrator.

‘‘(iii) IMPLEMENTATION.—The Administrator shall implement the standards developed under clause (i) by January 1, 2008.

‘‘(3) DISCLOSURE.—The eligible entity offering a Medicare Prescription Drug plan and the MedicareAdvantage organization offering a MedicareAdvantage plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made available to the entity or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

‘‘(4) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D–7(f)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a MedicareAdvantage organization offering a MedicareAdvantage plan.

‘‘(f) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

‘‘(1) PROCESSES.—For purposes of this section, the Administrator shall establish processes and methods—

‘‘(A) for determining the actuarial valuation of prescription drug coverage, including—

‘‘(i) an actuarial valuation of standard prescription drug coverage and of the reinsurance payments under section 1860D–20;

‘‘(ii) the use of generally accepted actuarial principles and methodologies; and

‘‘(iii) applying the same methodology for determinations of alternative coverage under subsection (d) as is used with respect to determinations of standard prescription drug coverage under subsection (c); and

‘‘(B) for determining annual percentage increases described in subsection (c)(5).

Such processes shall take into account any effect that providing actuarially equivalent prescription drug coverage rather than standard prescription drug coverage has on drug utilization.

“(2) Use of outside actuaries.—Under the processes under paragraph (1)(A), eligible entities and MedicareAdvantage organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

“REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

“Sec. 1860D-7. (a) General Requirements.—An eligible entity offering a Medicare Prescription Drug plan shall meet the following requirements:

“(1) Licensure.—Subject to subsection (c), the entity is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare Prescription Drug plan.

“(2) Assumption of financial risk.—

“(A) In general.—Subject to subparagraph (B) and subsections (d)(2) and (e) of section 1860D-13, to the extent that the entity is at risk pursuant to such section 1860D-16, the entity assumes financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Drug plan and that is not covered under section 1860D-20.

“(B) Reinsurance permitted.—To the extent that the entity is at risk pursuant to section 1860D-16, the entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

“(3) Solvency for unlicensed entities.—In the case of an eligible entity that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such entity shall meet solvency standards established by the Administrator under subsection (d).

“(b) Contract Requirements.—The Administrator shall not permit an eligible beneficiary to elect a Medicare Prescription Drug plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 1860D-16 or 1860D-20, unless the Administrator has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Drug plan. Such contract shall provide that the entity agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

“(c) Waiver of Certain Requirements in Order To Ensure Beneficiary Choice.—

“(1) In general.—In the case of an eligible entity that seeks to offer a Medicare Prescription Drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) have been met.

“(2) Grounds for approval.—The grounds for approval under this paragraph are the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

“(3) Application of waiver procedures.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

“(4) References to certain provisions.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this subsection to Medicare Prescription Drug plans and eligible entities—

“(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

“(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (d).

“(d) Solvency Standards for Non-Licensed Entities.—

“(1) Establishment and publication.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

“(2) Compliance with standards.—An eligible entity that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such eligible entities with respect to such solvency standards in the manner described in section 1855(c)(2).

“(e) Licensure Does Not Substitute for or Constitute Certification.—The fact that an entity is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the eligible entity to meet other requirements imposed under this part for an eligible entity.

“(f) Incorporation of Certain MedicareAdvantage Contract Requirements.—The following provisions of section 1857 shall apply, subject to subsection (c)(4), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

“(1) Protections against fraud and beneficiary protections.—Section 1857(d).

“(2) Intermediate sanctions.—Section 1857(g), except that in applying such section—

“(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

“(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

“(3) Procedures for termination.—Section 1857(h).

“(g) Other Standards.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Drug plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by January 1, 2005.

“(h) Periodic Review and Revision of Standards.—

“(1) In general.—Subject to paragraph (2), the Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards if the Administrator determines such revision to be appropriate.

“(2) Prohibition of midyear implementation of significant new regulatory requirements.—The Administrator may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on an eligible entity or a Medicare Prescription Drug plan.

“(i) Relation to State Laws.—

“(1) In general.—The standards established under this part shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Drug plans which are offered by eligible entities under this part—

“(A) to the extent such law or regulation is inconsistent with such standards; and

“(B) in the same manner as such laws and regulations are superseded under section 1856(b)(3).

“(2) Standards specifically superseded.—State standards relating to the following are superseded under this section:

“(A) Benefit requirements, including requirements relating to cost-sharing and the structure of formularies.

“(B) Premiums.

“(C) Requirements relating to inclusion or treatment of providers.

“(D) Coverage determinations (including related appeals and grievance processes).

“(E) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare Prescription Drug plan.

“(3) Prohibition of state imposition of premium taxes.—No State may impose a premium tax or similar tax with respect to—

“(A) monthly beneficiary obligations paid to the Administrator for Medicare Prescription Drug plans under this part; or

“(B) any payments made by the Administrator under this part to an eligible entity offering such a plan.

“Subpart 2—Prescription Drug Delivery System

“ESTABLISHMENT OF SERVICE AREAS

“Sec. 1860D-10. (a) Establishment.—

“(1) Initial establishment.—Not later than April 15, 2005, the Administrator shall establish and publish the service areas in which Medicare Prescription Drug plans may offer benefits under this part.

“(2) Periodic review and revision of service areas.—The Administrator shall periodically review the service areas applicable under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

“(b) Requirements for Establishment of Service Areas.—

“(1) In general.—The Administrator shall establish the service areas under subsection (a) in a manner that—

“(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

“(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

“(2) Additional requirements.—The Administrator shall establish the service areas under subsection (a) consistent with the following requirements:

“(A) There shall be at least 10 service areas.

“(B) Each service area must include at least 1 State.

“(C) The Administrator may not divide States so that portions of the State are in different service areas.

“(D) To the extent possible, the Administrator shall include multistate metropolitan statistical areas in a single service area. The Administrator may divide metropolitan statistical areas where it is necessary to establish service areas of such size and geography as to maximize the participation of Medicare Prescription Drug plans.

"(3) May conform to MedicareAdvantage preferred provider regions.—The Administrator may conform the service areas established under this section to the preferred provider regions established under section 1858(a)(3).

"PUBLICATION OF RISK ADJUSTERS

"Sec. 1860D–11. (a) Publication.—Not later than April 15 of each year (beginning in 2005), the Administrator shall publish the risk adjusters established under subsection (b) to be used in computing—

"(1) the amount of payment to Medicare Prescription Drug plans in the subsequent year under section 1860D–16(a), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage); and

"(2) the amount of payment to MedicareAdvantage plans in the subsequent year under section 1858A(c), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

"(b) Establishment of Risk Adjusters.—

"(1) In general.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to plans referred to in subsection (a) to take into account variation in costs based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments described in paragraphs (1) and (2) of subsection (a).

"(2) Considerations.—In establishing the methodology under paragraph (1), the Administrator may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MedicareAdvantage organizations.

"(3) Data collection.—In order to carry out this subsection, the Administrator shall require—

"(A) eligible entities to submit data regarding drug claims that can be linked at the beneficiary level to part A and part B data and such other information as the Administrator determines necessary; and

"(B) MedicareAdvantage organizations (except MSA plans or a private fee-for-service plan that does not provide qualified prescription drug coverage) to submit data regarding drug claims that can be linked to other data that such organizations are required to submit to the Administrator and such other information as the Administrator determines necessary.

"SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

"Sec. 1860D–12. (a) Submission.—

"(1) In general.—Each eligible entity that intends to offer a Medicare Prescription Drug plan in an area in a year (beginning with 2006) shall submit to the Administrator, at such time in the previous year and in such manner as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b).

"(2) Annual submission.—An eligible entity shall submit the information required under paragraph (1) with respect to a Medicare Prescription Drug plan that the entity intends to offer on an annual basis.

"(b) Information Described.—The information described in this subsection includes information on each of the following:

"(1) The benefits under the plan (as required under section 1860D–6).

"(2) The actuarial value of the qualified prescription drug coverage.

"(3) The amount of the monthly plan premium under the plan, including an actuarial certification of—

"(A) the actuarial basis for such monthly plan premium;

"(B) the portion of such monthly plan premium attributable to standard prescription drug coverage or actuarially equivalent prescription drug coverage and, if applicable, to benefits that are in addition to such coverage; and

"(C) the reduction in such monthly plan premium resulting from the payments provided under section 1860D–20.

"(4) The service area for the plan.

"(5) Whether the entity plans to use any funds in the plan stabilization reserve fund in the Prescription Drug Account that are available to the entity to stabilize or reduce the monthly plan premium submitted under paragraph (3), and if so, the amount in such reserve fund that is to be used.

"(6) Such other information as the Administrator may require to carry out this part.

"(c) Options Regarding Service Areas.—

"(1) In general.—The service area of a Medicare Prescription Drug plan shall be either—

"(A) the entire area of 1 of the service areas established by the Administrator under section 1860D–10; or

"(B) the entire area covered by the medicare program.

"(2) Rule of construction.—Nothing in this part shall be construed as prohibiting an eligible entity from submitting separate bids in multiple service areas as long as each bid is for a single service area.

"APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

"Sec. 1860D–13. (a) Approval.—

"(1) In general.—The Administrator shall review the information filed under section 1860D–12 and shall approve or disapprove the Medicare Prescription Drug plan.

"(2) Requirements for approval.—The Administrator may not approve a Medicare Prescription Drug plan unless the following requirements are met:

"(A) Compliance with requirements.—The plan and the entity offering the plan comply with the requirements under this part.

"(B) Application of FEHBP standard.—(i) The portion of the monthly plan premium submitted under section 1860D–12(b) that is attributable to standard prescription drug coverage reasonably and equitably reflects the actuarial value of the standard prescription drug coverage less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

"(ii) If the plan provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium reasonably and equitably reflects the actuarial value of the coverage provided less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

"(b) Negotiation.—In exercising the authority under subsection (a), the Administrator shall have the authority to—

"(1) negotiate the terms and conditions of the proposed monthly plan premiums submitted and other terms and conditions of a proposed plan; and

"(2) disapprove, or limit enrollment in, a proposed plan based on—

"(A) the costs to beneficiaries under the plan;

"(B) the quality of the coverage and benefits under the plan;

"(C) the adequacy of the network under the plan; or

"(D) other factors determined appropriate by the Administrator.

"(c) Special Rules for Approval.—The Administrator may approve a Medicare Prescription Drug plan submitted under section 1860D–12 only if the benefits under such plan—

"(1) include the required benefits under section 1860D–6(a)(1); and

"(2) are not designed in such a manner that the Administrator finds is likely to result in favorable selection of eligible beneficiaries.

"(d) Access to Competitive Coverage.—

"(1) Number of contracts.—The Administrator, consistent with the requirements of this part and the goal of containing costs under this title, shall, with respect to a year, approve at least 2 contracts to offer a Medicare Prescription Drug plan in each service area (established under section 1860D–10) for the year.

"(2) Authority to reduce risk to ensure access.—

"(A) In general.—Subject to subparagraph (B), if the Administrator determines, with respect to an area, that the access required under paragraph (1) is not going to be provided in the area during the subsequent year, the Administrator shall—

"(i) adjust the percents specified in paragraphs (2) and (4) of section 1860D–16(b) in an area in a year; or

"(ii) increase the percent specified in section 1860D–20(c)(1) in an area in a year.

The administrator shall exercise the authority under the preceding sentence only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

"(B) Requirements for use of authority.—In exercising authority under subparagraph (A), the Administrator—

"(i) shall not provide for the full underwriting of financial risk for any eligible entity;

"(ii) shall not provide for any underwriting of financial risk for a public eligible entity with respect to the offering of a nationwide Medicare Prescription Drug plan; and

"(iii) shall seek to maximize the assumption of financial risk by eligible entities to ensure fair competition among Medicare Prescription Drug plans.

"(C) Requirement to accept 2 full-risk qualified bids before exercising authority.—The Administrator may not exercise the authority under subparagraph (A) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year under paragraph (1) before the application of subparagraph (A).

"(D) Reports.—The Administrator, in each annual report to Congress under section 1808(c)(1)(D), shall include information on the exercise of authority under subparagraph (A). The Administrator also shall include such recommendations as may be appropriate to limit the exercise of such authority.

"(e) Guaranteed Access.—

"(1) Access.—In order to assure access to qualified prescription drug coverage in an area, the Administrator shall take the following steps:

"(A) Determination.—Not later than September 1 of each year (beginning in 2005) and for each area (established under section 1860D–10), the Administrator shall make a determination as to whether the access required under subsection (d)(1) is going to be provided in the area during the subsequent year. Such determination shall be made after the Administrator has exercised the authority under subsection (d)(2).

“(B) CONTRACT WITH AN ENTITY TO PROVIDE COVERAGE IN AN AREA.—Subject to paragraph (3), if the Administrator makes a determination under subparagraph (A) that the access required under subsection (d)(1) is not going to be provided in an area during the subsequent year, the Administrator shall enter into a contract with an entity to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage enrolled in a MedicareAdvantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) during the subsequent year. An entity may be awarded a contract for more than 1 of the areas for which the Administrator is required to enter into a contract under this paragraph but the Administrator may enter into only 1 such contract in each such area. An entity with a contract under this part shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

“(C) REQUIREMENT TO ACCEPT 2 REDUCED-RISK QUALIFIED BIDS BEFORE ENTERING INTO CONTRACT.—The Administrator may not enter into a contract under subparagraph (B) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year after the Administrator has exercised the authority under subsection (d)(2) in the area for the year.

“(D) ENTITY REQUIRED TO MEET BENEFICIARY PROTECTION AND OTHER REQUIREMENTS.—An entity with a contract under subparagraph (B) shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

“(E) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under subparagraph (B).

“(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

“(A) IN GENERAL.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(B), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D–17(c)) of the monthly national average premium (as computed under section 1860D–15) for the area for the year, as adjusted using the geographic adjuster under subparagraph (B).

“(B) ESTABLISHMENT OF GEOGRAPHIC ADJUSTER.—The Administrator shall establish an appropriate methodology for adjusting the monthly beneficiary obligation (as computed under subparagraph (A)) for the year in an area to take into account differences in drug prices among areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in an area and eligible beneficiaries in other areas and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Administrator had not applied such adjustment.

“(3) PAYMENTS UNDER THE CONTRACT.—

“(A) IN GENERAL.—A contract entered into under paragraph (1)(B) shall provide for—

“(i) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

“(ii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

“(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

“(i) The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and with the entity.

“(ii) The entity provides such beneficiaries with quality clinical care.

“(iii) The entity provides such beneficiaries with quality services.

“(C) ENTITY ONLY AT RISK TO THE EXTENT OF THE FEES TIED TO PERFORMANCE REQUIREMENTS.—An entity with a contract under paragraph (1)(B) shall only be at risk for the provision of benefits under the contract to the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

“(4) ELIGIBLE ENTITY THAT SUBMITTED A BID FOR THE AREA NOT ELIGIBLE TO BE AWARDED THE CONTRACT.—An eligible entity that submitted a bid to offer a Medicare Prescription Drug plan for an area for a year under section 1860D–12, including a bid submitted after the Administrator has exercised the authority under subsection (d)(2), may not be awarded a contract under paragraph (1)(B) for that area and year. The previous sentence shall apply to an entity that was awarded a contract under paragraph (1)(B) for the area in the previous year and submitted such a bid under section 1860D–12 for the year.

“(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

“(A) The contract shall be for a 2-year period.

“(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

“(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D-6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

“(6) ENTITY NOT PERMITTED TO MARKET OR BRAND THE CONTRACT.—An entity with a contract under paragraph (1)(B) may not engage in any marketing or branding of such contract.

“(7) RULES FOR AREAS WHERE ONLY 1 COMPETITIVELY BID PLAN WAS APPROVED.—In the case of an area where (before the application of this subsection) only 1 Medicare Prescription Drug plan was approved for a year—

“(A) the plan may (at the option of the plan) be offered in the area for the year (under rules applicable to such plans under this part and not under this subsection);

“(B) eligible beneficiaries described in paragraph (1)(B) may receive access to qualified prescription drug coverage through enrollment in the plan or with an entity with a contract under paragraph (1)(B); and

“(C) for purposes of applying section 1860D–3(a)(1)(A)(ii), such plan shall be the plan designated in the area under such section.

“(f) TWO-YEAR CONTRACTS.—Except for a contract entered into under subsection (e)(1)(B), a contract approved under this part (including a contract under) shall be for a 2-year period.

“COMPUTATION OF MONTHLY STANDARD PRESCRIPTION DRUG COVERAGE PREMIUMS

“SEC. 1860D–14. (a) IN GENERAL.—For each year (beginning with 2006), the Administrator shall compute a monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13 and for each MedicareAdvantage plan.

“(b) REQUIREMENTS.—The monthly standard prescription drug coverage premium for a plan for a year shall be equal to—

“(1) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides standard prescription drug coverage or an actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium approved for the plan under section 1860D–13 for the year; and

“(2) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2)—

“(A) an amount that reflects only the actuarial value of the standard prescription drug coverage offered under the plan; or

“(B) if determined appropriate by the Administrator, the monthly plan premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan (or, if applicable, the MedicareAdvantage plan) that, as required under section 1860D–6(a)(2)(B) for a Medicare Prescription Drug plans and a MedicareAdvantage plan—

“(i) is offered by such entity or organization in the same area as the plan; and

“(ii) does not provide additional prescription drug coverage pursuant to such section.

“COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

“SEC. 1860D–15. (a) COMPUTATION.—

“(1) IN GENERAL.—For each year (beginning with 2006) the Administrator shall compute a monthly national average premium equal to the average of the monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan and each MedicareAdvantage plan (as computed under section 1860D–14). Such premium may be adjusted pursuant to any methodology determined under subsection (b), as determined appropriate by the Administrator.

“(2) WEIGHTED AVERAGE.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

“(b) GEOGRAPHIC ADJUSTMENT.—The Administrator shall establish an appropriate methodology for adjusting the monthly national average premium (as computed under subsection (a)) for the year in an area to take into account differences in prices for covered drugs among different areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in that area and other eligible beneficiaries and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner as to not result in a change in aggregate payments made under this part than would have been made if the Administrator had not applied such adjustment.

“(c) Special Rule for 2006.—For purposes of applying this section for 2006, the Administrator shall establish procedures for determining the weighted average under subsection (a)(2) for 2005.

“PAYMENTS TO ELIGIBLE ENTITIES

“Sec. 1860D–16. (a) Payment of Monthly Plan Premiums.—For each year (beginning with 2006), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly plan premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

“(b) Portion of Total Payments of Monthly Plan Premiums Subject to Risk.—

“(1) Notification of spending under the plan.—

“(A) In general.—For each year (beginning in 2007), the eligible entity offering a Medicare Prescription Drug plan shall notify the Administrator of the following:

“(i) Total actual costs.—The total amount of costs that the entity incurred in providing standard prescription drug coverage (or prescription drug coverage that is actuarially equivalent pursuant to section 1860D–6(a)(1)(B)) for all enrollees under the plan in the previous year.

“(ii) Actual costs for specific drugs.—With respect to the total amount under clause (i) for the year, a breakdown of—

“(I) each covered drug that constitutes a portion of such amount;

“(II) the negotiated price for the eligible entity for each such drug;

“(III) the number of prescriptions; and

“(IV) the average beneficiary coinsurance rate for a each covered drug that constitutes a portion of such amount.

“(B) Certain expenses not included.—The amounts under clauses (i) and (ii)(II) of subparagraph (A) may not include—

“(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

“(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2); or

“(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20.

“(2) Adjustment of payment.—

“(A) No adjustment if allowable costs within risk corridor.—If the allowable costs (specified in paragraph (3)) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (4)(A)(i)) for the plan for the year, then no additional payments shall be made by the Administrator and no payments shall be made by (or collected from) the eligible entity offering the plan.

“(B) Increase in payment if allowable costs above upper limit of risk corridor.—

“(i) In general.—If the allowable costs for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Administrator shall increase the total of the monthly payments made to the entity offering the plan for the year under subsection (a) by an amount equal to the sum of—

“(I) the applicable percent (as defined in subparagraph (D)) of such allowable costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(iv)); and

“(II) 90 percent of such allowable costs which are more than such second threshold upper limit of the risk corridor.

“(ii) Special transitional corridor for 2006 and 2007.—If the Administrator determines with respect to 2006 or 2007 that at least 60 percent of Medicare Prescription Drug plans and MedicareAdvantage Plans (excluding MSA plans or private fee-for-service plans that do not provide qualified prescription drug coverage) have allowable costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year and that such plans represent at least 60 percent of eligible beneficiaries enrolled under this part, clause (i)(I) shall be applied by substituting ‘90 percent’ for ‘applicable percent’.

“(C) Plan payment if allowable costs below lower limit of risk corridor.—If the allowable costs for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the entity offering the plan shall a make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to—

“(i) the applicable percent (as so defined) of such allowable costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(ii)); and

“(ii) 90 percent of such allowable costs which are less than such second threshold lower limit of the risk corridor.

“(D) Applicable percent defined.—For purposes of this paragraph, the term ‘applicable percent’ means—

“(i) for 2006 and 2007, 75 percent; and

“(ii) for 2008 and subsequent years, 50 percent.

“(3) Establishment of allowable costs.—

“(A) In general.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year, adjusted under subparagraph (B)(ii).

“(B) Repricing of costs.—

“(i) Calculation of average plan cost.—Utilizing the information obtained under paragraph (1)(A)(ii) and section 1860D–20(b)(1)(B), for each year (beginning with 2006), the Administrator shall establish an average negotiated price with respect to all Medicare Prescription Drug plans for each covered drug.

“(ii) Adjustment if actual costs exceed average costs.—With respect to a Medicare Prescription Drug plan for a year, the Administrator shall reduce the amount described in paragraph (1)(A)(i) for the plan for the year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under paragraph (1)(A)(ii)) for which the negotiated prices are greater than the average negotiated price for the covered drug for the year (as determined under clause (i)).

“(4) Establishment of risk corridors.—

“(A) In general.—For each year (beginning with 2006), the Administrator shall establish a risk corridor for each Medicare Prescription Drug plan. The risk corridor for a plan for a year shall be equal to a range as follows:

“(i) First threshold lower limit.—The first threshold lower limit of such corridor shall be equal to—

“(I) the target amount described in subparagraph (B) for the plan; minus

“(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

“(ii) Second threshold lower limit.—The second threshold lower limit of such corridor shall be equal to—

“(I) the target amount described in subparagraph (B) for the plan; minus

“(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

“(iii) First threshold upper limit.—The first threshold upper limit of such corridor shall be equal to the sum of—

“(I) such target amount; and

“(II) the amount described in clause (i)(II).

“(iv) Second threshold upper limit.—The second threshold upper limit of such corridor shall be equal to the sum of—

“(I) such target amount; and

“(II) the amount described in clause (ii)(II).

“(B) Target amount described.—The target amount described in this paragraph is, with respect to a Medicare Prescription Drug plan offered by an eligible entity in a year—

“(i) in the case of a plan offered by an eligible entity that provides standard prescription drug coverage or actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a), reduced by the percentage specified in subparagraph (D); and

“(ii) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a) that are related to standard prescription drug coverage (determined using the rules under section 1860D–14(b)), reduced by the percentage specified in subparagraph (D).

“(C) First and second threshold risk percentage defined.—

“(i) First threshold risk percentage.—Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

“(I) for 2006 and 2007, and 2.5 percent;

“(II) for 2008 through 2011, 5 percent; and

“(III) for 2012 and subsequent years, a percentage established by the Administrator, but in no case less than 5-percent.

“(ii) Second threshold risk percentage.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

"(I) for 2006 and 2007, 5.0 percent;

"(II) for 2008 through 2011, 10 percent

"(III) for 2012 and subsequent years, a percentage established by the Administrator that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

"(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to paragraph (2) of section 1860D–13(d), the Administrator may reduce the applicable first or second threshold risk percentage in an area in a year in order to ensure the access to plans required under paragraph (1) of such section.

"(D) TARGET AMOUNT NOT TO INCLUDE ADMINISTRATIVE EXPENSES NEGOTIATED BETWEEN THE ADMINISTRATOR AND THE ENTITY OFFERING THE PLAN.—For each year (beginning in 2006), the Administrator and the entity offering a Medicare Prescription Drug plan shall negotiate, as part of the negotiation process described in section 1860D–13(b) during the previous year, the percentage of the payments to the entity under subsection (a) with respect to the plan that are attributable and reasonably incurred for administrative expenses for providing standard prescription drug coverage or actuarially equivalent prescription drug coverage in the year.

"(5) PLANS AT RISK FOR ENTIRE AMOUNT OF ADDITIONAL PRESCRIPTION DRUG COVERAGE.—An eligible entity that offers a Medicare Prescription Drug plan that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2) shall be at full financial risk for the provision of such additional coverage.

"(6) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

"(7) DISCLOSURE OF INFORMATION.—

"(A) IN GENERAL.—Each contract under this part shall provide that—

"(i) the entity offering a Medicare Prescription Drug plan shall provide the Administrator with such information as the Administrator determines is necessary to carry out this section; and

"(ii) the Administrator shall have the right to inspect and audit any books and records of the eligible entity that pertain to the information regarding costs provided to the Administrator under paragraph (1).

"(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

"(c) STABILIZATION RESERVE FUND.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—There is established, within the Prescription Drug Account, a stabilization reserve fund in which the Administrator shall deposit amounts on behalf of eligible entities in accordance with paragraph (2) and such amounts shall be made available by the Secretary for the use of eligible entities in contract year 2008 and subsequent contract years in accordance with paragraph (3).

"(B) REVERSION OF UNUSED AMOUNTS.—Any amount in the stabilization reserve fund established under subparagraph (A) that is not expended by an eligible entity in accordance with paragraph (3) or that was deposited for the use of an eligible entity that no longer has a contract under this part shall revert for the use of the Prescription Drug Account.

"(2) DEPOSIT OF AMOUNTS FOR 5 YEARS.—

"(A) IN GENERAL.—If the target amount for a Medicare Prescription Drug plan for 2006, 2007, 2008, 2009, or 2010 (as determined under subsection (b)(4)(B)) exceeds the applicable costs for the plan for the year by more than 3 percent, then—

"(i) the entity offering the plan shall make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to the portion of such excess that is in excess of 3 percent of the target amount; and

"(ii) the Administrator shall deposit an amount equal to the amount collected or otherwise recovered under clause (i) in the stabilization reserve fund on behalf of the eligible entity offering such plan.

"(B) APPLICABLE COSTS.—For purposes of subparagraph (A), the term 'applicable costs' means, with respect to a Medicare Prescription Drug plan and year, an amount equal the sum of—

"(i) the allowable costs for the plan and year (as determined under subsection (b)(3)(A); and

"(ii) the total amount by which monthly payments to the plan were reduced (or otherwise recovered from the plan) for the year under subsection (b)(2)(C).

"(3) USE OF RESERVE FUND TO STABILIZE OR REDUCE MONTHLY PLAN PREMIUMS.—

"(A) IN GENERAL.—For any contract year beginning after 2007, an eligible entity offering a Medicare Prescription Drug plan may use funds in the stabilization reserve fund in the Prescription Drug Account that were deposited in such fund on behalf of the entity to stabilize or reduce monthly plan premiums submitted under section 1860D–12(b)(3).

"(B) PROCEDURES.—The Administrator shall establish procedures for—

"(i) reducing monthly plan premiums submitted under section 1860D–12(b)(3) pursuant to subparagraph (A); and

"(ii) making payments from the plan stabilization reserve fund in the Prescription Drug Account to eligible entities that inform the Secretary under section 1860D–12(b)(5) of the entity's intent to use funds in such reserve fund to reduce such premiums.

"(d) PORTION OF PAYMENTS OF MONTHLY PLAN PREMIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES TIED TO PERFORMANCE REQUIREMENTS.—

"(1) IN GENERAL.—The Administrator shall establish procedures to adjust the portion of the payments made to an entity under subsection (a) that are attributable to administrative expenses (as determined pursuant to subsection (b)(4)(D)) to ensure that the entity meets the performance requirements described in clauses (ii) and (iii) of section 1860D–13(e)(4)(B).

"(2) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

"(e) PAYMENT TERMS.—

"(1) ADMINISTRATOR PAYMENTS.—Payments to an entity offering a Medicare Prescription Drug plan under this section shall be made in a manner determined by the Administrator and based upon the manner in which payments are made under section 1853(a) (relating to payments to MedicareAdvantage organizations).

"(2) PLAN PAYMENTS.—The Administrator shall establish a process for collecting (or other otherwise recovering) amounts that an entity offering a Medicare Prescription Drug plan is required to make to the Administrator under this section.

"(f) PAYMENTS TO MEDICAREADVANTAGE PLANS.—For provisions related to payments to MedicareAdvantage organizations offering MedicareAdvantage plans for qualified prescription drug coverage made available under the plan, see section 1858A(c).

"(g) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

"COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION

"SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan in a year shall be determined as follows:

"(1) MONTHLY PLAN PREMIUM EQUALS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the applicable percent (as determined in subsection (c)) of the amount of such monthly national average premium.

"(2) MONTHLY PLAN PREMIUM LESS THAN MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for the Medicare Prescription Drug plan for the year is less than the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to—

"(A) the applicable percent of the amount of such monthly national average premium; minus

"(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

"(3) MONTHLY PLAN PREMIUM EXCEEDS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the sum of—

"(A) the applicable percent of the amount of such monthly national average premium; plus

"(B) the amount by which the monthly plan premium approved by the Administrator for the plan exceeds the amount of such monthly national average premium.

"(b) BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—In the case of an eligible beneficiary that is enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), the Medicare monthly beneficiary obligation for qualified prescription drug coverage shall be determined pursuant to section 1858A(d).

"(c) APPLICABLE PERCENT.—For purposes of this section, except as provided in section 1860D–19 (relating to premium subsidies for low-income individuals), the applicable percent for any year is the percentage equal to a fraction—

“(1) the numerator of which is 27.5 percent; and

“(2) the denominator of which is 100 percent minus a percentage equal to—

“(A) the total reinsurance payments which the Administrator estimates will be made under section 1860D–20 to qualifying entities described in subsection (e)(3) of such section during the year; divided by

“(B) the sum of—

“(i) the amount estimated under subparagraph (A) for the year; and

“(ii) the total payments which the Administrator estimates will be made under sections 1860D–16 and 1858A(c) during the year that relate to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

“COLLECTION OF MONTHLY BENEFICIARY OBLIGATION

“SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—

“(1) IN GENERAL.—Subject to paragraph (2), the amount of the monthly beneficiary obligation (determined under section 1860D–17) applicable to an eligible beneficiary under this part (after application of any increase under section 1860D–2(b)(1)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

“(2) PROCEDURES FOR SPONSOR TO PAY OBLIGATION ON BEHALF OF RETIREE.—The Administrator shall establish procedures under which an eligible beneficiary enrolled in a Medicare Prescription Drug plan may elect to have the sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section) in which the beneficiary is enrolled pay the amount of the monthly beneficiary obligation applicable to the beneficiary under this part directly to the Administrator.

“(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

“(1) by the beginning of each year, the name, social security account number, monthly beneficiary obligation owed by each individual enrolled in a Medicare Prescription Drug plan for each month during the year, and other information determined appropriate by the Administrator; and

“(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

“(c) COLLECTION FOR BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—For provisions related to the collection of the monthly beneficiary obligation for qualified prescription drug coverage under a MedicareAdvantage plan, see section 1858A(e).

“PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

“SEC. 1860D–19. (a) AMOUNT OF SUBSIDIES.—

“(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.—In the case of a qualified medicare beneficiary (as defined in paragraph (4)(A))—

“(A) section 1860D–17 shall be applied—

“(i) in subsection (c), by substituting ‘0 percent’ for the applicable percent that would otherwise apply under such subsection; and

“(ii) in subsection (a)(3)(B), by substituting ‘the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides’ for ‘the amount of such monthly national average premium’, but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

“(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

“(C) section 1860D–6(c)(2) shall be applied by substituting ‘2.5 percent’ for ‘50 percent’ each place it appears;

“(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 5.0 percent; and

“(E) section 1860D–6(c)(4)(A) shall be applied by substituting ‘2.5 percent’ for ‘10 percent’.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

“(2) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SPECIFIED LOW INCOME MEDICARE BENEFICIARIES AND QUALIFYING INDIVIDUALS.—In the case of a specified low income medicare beneficiary (as defined in paragraph (4)(B)) or a qualifying individual (as defined in paragraph (4)(C))—

“(A) section 1860D–17 shall be applied—

“(i) in subsection (c), by substituting ‘0 percent’ for the applicable percent that would otherwise apply under such subsection; and

“(ii) in subsection (a)(3)(B), by substituting ‘the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides’ for ‘the amount of such monthly national average premium’, but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

“(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

“(C) section 1860D–6(c)(2) shall be applied by substituting ‘5.0 percent’ for ‘50 percent’ each place it appears;

“(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 10.0 percent; and

“(E) section 1860D–6(c)(4)(A) shall be applied by substituting ‘2.5 percent’ for ‘10 percent’.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

“(3) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—

“(A) IN GENERAL.—In the case of a subsidy-eligible individual (as defined in paragraph (4)(D))—

“(i) section 1860D–17 shall be applied—

“(I) in subsection (c), by substituting ‘subsidy percent’ for the applicable percentage that would otherwise apply under such subsection; and

“(II) in subparagraphs (A) and (B) of subsection (a)(3), by substituting ‘the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides’ for ‘the amount of such monthly national average premium’, but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year; and

“(ii) the annual deductible applicable under section 1860D–6(c)(1)—

“(I) for 2006, shall be reduced to $50; and

“(II) for a subsequent year, shall be reduced to the amount specified under this clause for the previous year increased by the percentage specified in section 1860D–6(c)(5) for the year involved;

“(iii) section 1860D–6(c)(2) shall be applied by substituting ‘10.0 percent’ for ‘50 percent’ each place it appears;

“(iv) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 20.0 percent; and

“(v) such individual shall be responsible for the cost-sharing described in section 1860D–6(c)(4)(A).

In no case may the application of clause (i) result in a monthly beneficiary obligation that is below 0.

“(B) SUBSIDY PERCENT DEFINED.—For purposes of subparagraph (A)(i), the term ‘subsidy percent’ means, with respect to a State, a percent determined on a linear sliding scale ranging from—

“(i) 0 percent with respect to a subsidy-eligible individual residing in the State whose income does not exceed 135 percent of the poverty line; to

“(ii) the highest percentage that would otherwise apply under section 1860D–17 in the service area in which the subsidy-eligible individual resides, in the case of a subsidy-eligible individual residing in the State whose income equals 160 percent of the poverty line.

“(4) DEFINITIONS.—In this part:

“(A) QUALIFIED MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term ‘qualified medicare beneficiary’ means an individual who—

“(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

“(ii) is described in section 1905(p)(1).

“(B) SPECIFIED LOW INCOME MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term ‘specified low income medicare beneficiary’ means an individual who—

“(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

“(ii) is described in section 1902(a)(10)(E)(iii).

“(C) QUALIFYING INDIVIDUAL.—Subject to subparagraph (H), the term ‘qualifying individual’ means an individual who—

“(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and “(ii) is described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX).

“(D) Subsidy-eligible individual.—Subject to subparagraph (H), the term ‘subsidy-eligible individual’ means an individual—

“(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

“(ii) whose income is less than 160 percent of the poverty line; and

“(iii) who is not—

“(I) a qualified medicare beneficiary;

“(II) a specified low-income medicare beneficiary; or

“(III) a qualifying individual.

“(E) Poverty line.—The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“(F) Eligibility determinations.—Beginning on November 1, 2005, the determination of whether an individual residing in a State is an individual described in subparagraph (A), (B), (C), or (D) and, for purposes of paragraph (3), the amount of an individual’s income, shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

“(G) Nonapplication to territorial residents.—In the case of an individual who is not a resident of the 50’States or the District of Columbia—

“(i) the subsidies provided under this section shall not apply; and

“(ii) such individuals may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with section 1935 under the State medicaid program under title XIX.

“(b) Rules in Applying Cost-Sharing Subsidies.—Nothing in this section shall be construed as preventing an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan from waiving or reducing the amount of the deductible or other cost-sharing otherwise applicable pursuant to section 1860D–6(a)(2).

“(c) Administration of Subsidy Program.—The Administrator shall establish a process whereby, in the case of an individual eligible for a cost-sharing subsidy under subsection (a) who is enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan—

“(1) the Administrator provides for a notification of the eligible entity or MedicareAdvantage organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

“(2) the entity or organization involved reduces the cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

“(3) the Administrator periodically and on a timely basis reimburses the entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

“(d) Relation to Medicaid Program.—For provisions providing for eligibility determinations and additional Federal payments for expenditures related to providing prescription drug coverage for territorial residents under the medicaid program, see section 1935.

“REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD

“Sec. 1860D–20. (a) Reinsurance Payments.—

“(1) In general.—Subject to section 1860D–21(b), the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

“(2) Budget authority.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

“(b) Notification of Spending Under the Plan for Costs Incurred in Providing Prescription Drug Coverage Above the Annual Out-of-Pocket Threshold.—

“(1) In general.—Each qualifying entity shall notify the Administrator of the following with respect to a qualifying covered individual for a coverage year:

“(A) Total actual costs.—The total amount (if any) of costs that the qualifying entity incurred in providing prescription drug coverage for the individual in the year after the individual had reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

“(B) Actual costs for specific drugs.—With respect to the total amount under subparagraph (A) for the year, a breakdown of—

“(i) each covered drug that constitutes a portion of such amount;

“(ii) the negotiated price for the qualifying entity for each such drug;

“(iii) the number of prescriptions; and

“(iv) the average beneficiary coinsurance rate for each covered drug that constitutes a portion of such amount.

“(2) Certain expenses not included.—The amounts under subparagraphs (A) and (B)(ii) of paragraph (1) may not include—

“(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A); or

“(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2).

“(3) Restriction on use of information.—The restriction specified in section 1860D–16(b)(7)(B) shall apply to information disclosed or obtained pursuant to the provisions of this section.

“(c) Reinsurance Payment Amount.—

“(1) In general.—The reinsurance payment amount under this subsection for a qualifying covered individual for a coverage year is an amount equal to 80 percent of the allowable costs (as specified in paragraph (2)) incurred by the qualifying entity with respect to the individual and year.

“(2) Allowable costs.—

“(A) In general.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year, adjusted under subparagraph (B).

“(B) Repricing of costs if actual costs exceed average costs.—The Administrator shall reduce the amount described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under subsection (b)(1)(B)) that are greater than the average cost for the covered drug for the year (as determined under section 1860D–16(b)(3)(A)).

“(d) Payment Methods.—

“(1) In general.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator’s best estimate of amounts that will be payable after obtaining all of the information.

“(2) Source of payments.—Payments under this section shall be made from the Prescription Drug Account.

“(e) Definitions.—In this section:

“(1) Coverage year.—The term ‘coverage year’ means a calendar year in which covered drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

“(2) Qualifying covered individual.—The term ‘qualifying covered individual’ means an individual who—

“(A) is enrolled in this part and in a Medicare Prescription Drug plan;

“(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage); or

“(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan.

“(3) Qualifying entity.—The term ‘qualifying entity’ means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

“(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

“(B) A MedicareAdvantage organization offering a MedicareAdvantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

“(C) The sponsor of a qualified retiree prescription drug plan.

“(4) Qualified retiree prescription drug plan.—

“(A) In general.—The term ‘qualified retiree prescription drug plan’ means employment-based retiree health coverage if, with respect to a qualifying covered individual who is covered under the plan, the following requirements are met:

“(i) Assurance.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

“(ii) Disclosure of information.—The sponsor complies with the requirements described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

"(B) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

"(5) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

"SEC. 1860D–21. (a) DIRECT SUBSIDY.—

"(1) IN GENERAL.—The Administrator shall provide for the payment to a sponsor of a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) for each qualifying covered individual (described in subparagraph (C) of section 1860D-20(e)(2)) enrolled in the plan for each month for which such individual is so enrolled.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the direct subsidy percent determined for the year of the monthly national average premium for the area for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D-11.

"(B) DIRECT SUBSIDY PERCENT.—For purposes of subparagraph (A), the term 'direct subsidy percent' means the percentage equal to—

"(i) 100 percent; minus

"(ii) the applicable percent for the year (as determined under section 1860D–17(c).

"(b) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

"(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

"Subpart 3—Miscellaneous Provisions

"PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

"SEC. 1860D–25. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

"(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the Account as provided in this part.

"(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

"(b) PAYMENTS FROM ACCOUNT.—

"(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

"(A) payments to eligible entities under section 1860D–16;

"(B) payments under 1860D–19 for low-income subsidy payments for cost-sharing;

"(C) reinsurance payments under section 1860D-20;

"(D) payments to sponsors of qualified retiree prescription drug plans under section 1860D–21;

"(E) payments to MedicareAdvantage organizations for the provision of qualified prescription drug coverage under section 1858A(c); and

"(F) payments with respect to administrative expenses under this part in accordance with section 201(g).

"(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

"(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments and transfers made from the Account in the year.

"OTHER RELATED PROVISIONS

"SEC. 1860D–26. (a) RESTRICTION ON ENROLLMENT IN A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY A SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—

"(1) IN GENERAL.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that is a sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section), notwithstanding any other provision of this part and in accordance with regulations of the Administrator, the entity offering the plan may restrict the enrollment of eligible beneficiaries enrolled under this part to eligible beneficiaries who are enrolled in such coverage.

"(2) LIMITATION.—The sponsor of the employment-based retiree health coverage described in paragraph (1) may not offer enrollment in the Medicare Prescription Drug plan described in such paragraph based on the health status of eligible beneficiaries enrolled for such coverage.

"(b) COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

"(1) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), may enter into an agreement with a State pharmaceutical assistance program described in paragraph (2) to coordinate the coverage provided under the plan with the assistance provided under the State pharmaceutical assistance program.

"(2) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DESCRIBED.—For purposes of paragraph (1), a State pharmaceutical assistance program described in this paragraph is a program that has been established pursuant to a waiver under section 1115 or otherwise.

"(c) REGULATIONS TO CARRY OUT THIS PART.—

"(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing this part in interim final form without prior opportunity for public comment.

"(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).".

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking "and" before "such amounts"; and

(B) by inserting before the period the following: ", and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D–25";

(2) in subsection (g), by inserting after "by this part," the following: "the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),";

(3) in subsection (h), by inserting after "1840(d)" the following: "and sections 1860D-18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)"; and

(4) in subsection (i), by inserting after "section 1840(b)(1)" the following: ", sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),".

(c) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(d) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) STUDY.—The Administrator of the Center for Medicare Choices (as established under section 1808 of the Social Security Act, as added by section 301(a)) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) REPORT.—Not later than January 1, 2005, the Administrator of the Center for Medicare Choices shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

"(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO PART D ENROLLEES.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

"(B) PENALTIES.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

"(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POLICYHOLDER OBTAINS PRESCRIPTION DRUG COVERAGE UNDER PART D.—

"(A) IN GENERAL.—The issuer of a medicare supplemental policy—

"(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F' (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)), or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

"(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

"(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the open enrollment period established under section 1860D-2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

"(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who—

"(i) enrolls in the medicare prescription drug delivery program under part D; and

"(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' (including the benefit package classified as 'J' with a high deductible feature, as described in section 1882(p)(11)) under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

"(C) ENFORCEMENT.—The provisions of subparagraph (A) shall be enforced as though they were included in subsection (s).

"(3) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG COVERAGE.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D-2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

"(A) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

"(B) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D.".

(b) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

SEC. 104. MEDICAID AND OTHER AMENDMENTS RELATED TO LOW-INCOME BENEFICIARIES.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (64);

(2) by striking the period at the end of paragraph (65) and inserting "; and"; and

(3) by inserting after paragraph (65) the following new paragraph:

"(66) provide for making eligibility determinations under section 1935(a).".

(b) NEW SECTION.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

"SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

"SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall satisfy the following:

"(1) DETERMINATION OF ELIGIBILITY FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—For purposes of section 1807A, submit to the Secretary an eligibility plan under which the State—

"(A) establishes eligibility standards consistent with the provisions of that section;

"(B) establishes procedures for providing presumptive eligibility for eligible low-income beneficiaries (as defined in section 1807A(i)(2)) under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

"(C) makes determinations of eligibility and income for purposes of identifying eligible low-income beneficiaries (as so defined) under that section; and

"(D) communicates to the Secretary determinations of eligibility or discontinuation of eligibility under that section for purposes of notifying prescription drug card sponsors under that section of the identity of eligible medicare low-income beneficiaries.

"(2) DETERMINATION OF ELIGIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER PART D OF TITLE XVIII FOR LOW-INCOME INDIVIDUALS.—Beginning November 1, 2005, for purposes of section 1860D-19—

"(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with such section;

"(B) establish procedures for providing presumptive eligibility for individuals eligible for subsidies under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

"(C) inform the Administrator of the Center for Medicare Choices of such determinations in cases in which such eligibility is established; and

"(D) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D-19).

"(3) AGREEMENT TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD OFFICES.—Enter into an agreement with the Commissioner of Social Security to use all Social Security field offices located in the State as information and enrollment sites for making the eligibility determinations required under paragraphs (1) and (2).

"(b) FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—

"(1) ENHANCED MATCH FOR ELIGIBILITY DETERMINATIONS.—Subject to paragraphs (2) and (4), with respect to calendar quarters beginning on or after January 1, 2004, the amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under section 1903(a)(7) except that, in applying such section with respect to such expenditures incurred for—

"(A) such calendar quarters occurring in fiscal year 2004 or 2005, '75 percent' shall be substituted for '50 per centum';

"(B) calendar quarters occurring in fiscal year 2006, '70 percent' shall be substituted for '50 per centum';

"(C) calendar quarters occurring in fiscal year 2007, '65 percent' shall be substituted for '50 per centum'; and

"(D) calendar quarters occurring in fiscal year 2008 or any fiscal year thereafter, '60 percent' shall be substituted for '50 per centum'.

"(2) 100 PERCENT MATCH FOR ELIGIBILITY DETERMINATIONS FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—In the case of amounts expended by a State on or after November 1, 2005, to determine whether an individual is a subsidy-eligible individual for purposes of section 1860D-19, such expenditures shall be reimbursed under section 1903(a)(7) by substituting '100 percent' for '50 per centum'.

"(3) ENHANCED MATCH FOR UPDATES OR IMPROVEMENTS TO ELIGIBILITY DETERMINATION SYSTEMS.—With respect to calendar quarters occurring in fiscal year 2004, 2005, or 2006, the Secretary, in addition to amounts otherwise paid under section 1903(a), shall pay to each State which has a plan approved under this title, for each such quarter an amount equal to 90 percent of so much of the sums expended during such quarter as are attributable to the design, development, acquisition, or installation of improved eligibility determination systems (including hardware and software for such systems) in order to carry out the requirements of subsection (a) and section 1807A(h)(1) and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c). No payment shall be made to a State under the preceding sentence unless the State's improved eligibility determination system—

"(A) satisfies such standards for improvement as the Secretary may establish; and

"(B) complies, and is compatible, with the standards established under part C of title XI and any regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).

"(4) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate expenditures described in paragraph (1), (2), or (3) that may otherwise be made for similar eligibility determinations or expenditures.

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

"(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f)) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

"(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

"(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) PHASE-OUT PROPORTION.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

"(i) 2006 is 100 percent;

"(ii) 2007 is 95 percent;

"(iii) 2008 or 2009, is 90 percent;

"(iv) 2010 is 85 percent; or

"(v) 2011, 2012, or 2013 is 80 percent.

"(d) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan.

"(e) TREATMENT OF TERRITORIES.—

"(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

"(A) the previous provisions of this section shall not apply to residents of such State; and

"(B) if the State establishes a plan described in paragraph (2), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be further increased by the amount specified in paragraph (3).

"(2) PLAN.—The plan described in this paragraph is a plan that—

"(A) provides medical assistance with respect to the provision of covered drugs (as defined in section 1860D(a)(2)) to individuals described in subparagraph (A), (B), (C), or (D) of section 1860D–19(a)(3); and

"(B) ensures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

"(3) INCREASED AMOUNT.—

"(A) IN GENERAL.—The amount specified in this paragraph for a State for a fiscal year is equal to the product of—

"(i) the aggregate amount specified in subparagraph (B); and

"(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

"(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

"(i) the last 3 quarters of fiscal year 2006, is equal to $22,500,000;

"(ii) fiscal year 2007, is equal to $30,000,000; and

"(iii) any subsequent fiscal year, is equal to the aggregate amount specified in this subparagraph for the previous fiscal year increased by the annual percentage increase specified in section 1860D–6(c)(5) for the calendar year beginning in such fiscal year.

"(4) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State described in paragraph (1) for purposes of providing medical assistance described in paragraph (2)(A).

"(5) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

"(f) DEFINITION.—For purposes of this section, the term 'subsidy-eligible individual' has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).".

(C) CONFORMING AMENDMENTS.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(c)(1) for the State and the quarter".

(2) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

(4) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)), as amended by section 111(b), is amended—

(A) by striking "and" at the end of subclause (IV);

(B) by striking the period at the end of subclause (V) and inserting "; and"; and

(C) by adding at the end the following new subclause:

"(VI) any prices charged which are negotiated under a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a MedicareAdvantage plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3).".

(c) EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH 2008.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as follows:

"(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2008) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;".

(2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(c) (42 U.S.C. 1396u–3(c)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking "and" at the end;

(ii) in subparagraph (E)—

(I) by striking "fiscal year 2002" and inserting "each of fiscal years 2002 through 2008"; and

(II) by striking the period and inserting "; and"; and

(iii) by adding at the end the following new subparagraph:

"(F) the first quarter of fiscal year 2009, $100,000,000."; and

(B) in paragraph (2)(A), by striking "the sum of" and all that follows through "1902(a)(10)(E)(iv)(II) in the State; to" and inserting "twice the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to".

(d) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b–14) is amended—

(1) in the section heading, by inserting "AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII" after "COST-SHARING";

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting "for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies under section 1860D–19" before the semicolon; and

(ii) in subparagraph (B), by inserting ", program, and subsidies" after "medical assistance"; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting ", the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19" after "assistance"; and

(ii) in subparagraph (A), by striking "such eligibility" and inserting "eligibility for medicare cost-sharing under the medicaid program"; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting ", for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies for low-income individuals under section 1860D–19" after "1933"; and

(B) in paragraph (2), by inserting ", program, and subsidies" after "medical assistance".

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking "17" and inserting "19"; and

(B) in paragraph (2)(B), by inserting "experts in the area of pharmacology and prescription drug benefit programs," after "other health professionals,".

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2005.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

"(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.".

SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING AND DRUG UTILIZATION.

(a) STUDY.—The Secretary shall study on an ongoing basis variations in spending and drug utilization under part D of title XVIII of the Social Security Act for covered drugs to determine the impact of such variations on premiums imposed by eligible entities offering Medicare Prescription Drug plans under that part. In conducting such study, the Secretary shall examine the impact of geographic adjustments of the monthly national average premium under section 1860D–15 of such Act on—

(1) maximization of competition under part D of title XVIII of such Act; and

(2) the ability of eligible entities offering Medicare Prescription Drug plans to contain costs for covered drugs.

(b) REPORT.—Beginning with 2007, the Secretary shall submit annual reports to Congress on the study required under subsection (a).

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

SEC. 111. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new sections:

"MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

"SEC. 1807. (a) ESTABLISHMENT.—There is established a medicare prescription drug discount card endorsement program under which the Secretary shall—

"(1) endorse prescription drug discount card programs offered by prescription drug card sponsors that meet the requirements of this section; and

"(2) make available to eligible beneficiaries information regarding such endorsed programs.

"(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

"(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish procedures—

"(i) for identifying eligible beneficiaries; and

"(ii) under which such beneficiaries may make an election to enroll in any prescription drug discount card program endorsed under this section and disenroll from such a program.

"(B) LIMITATION.—An eligible beneficiary may not be enrolled in more than 1 prescription drug discount card program at any time.

"(2) ENROLLMENT FEES.—

"(A) IN GENERAL.—A prescription drug card sponsor may charge an annual enrollment fee to each eligible beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

"(B) AMOUNT.—No enrollment fee charged under subparagraph (A) may exceed $25.

"(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is the same for all eligible medicare beneficiaries enrolled in the program.

"(D) COLLECTION.—Any enrollment fee shall be collected by the prescription drug card sponsor.

"(c) PROVIDING INFORMATION TO ELIGIBLE BENEFICIARIES.—

"(1) PROMOTION OF INFORMED CHOICE.—

"(A) BY THE SECRETARY.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs. Such dissemination shall be coordinated with the dissemination of educational information on other medicare options.

"(B) BY PRESCRIPTION DRUG CARD SPONSORS.—Each prescription drug card sponsor shall make available to each eligible beneficiary (through the Internet and otherwise) information—

"(i) that the Secretary identifies as being necessary to promote informed choice among endorsed prescription drug discount card programs by eligible beneficiaries, including information on enrollment fees, negotiated prices for prescription drugs charged to beneficiaries, and services relating to prescription drugs offered under the program;

"(ii) on how any formulary used by such sponsor functions.

"(2) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1–800–MEDICARE toll free telephone number for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established under this section and prescription drug discount card programs endorsed under such program.

"(d) BENEFICIARY PROTECTIONS.—

"(1) IN GENERAL.—Each prescription drug discount card program endorsed under this section shall meet such requirements as the Secretary identifies to protect and promote the interest of eligible beneficiaries, including requirements that—

"(A) relate to appeals by eligible beneficiaries and marketing practices; and

"(B) ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

"(2) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

"(3) QUALITY ASSURANCE.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall have in place adequate procedures for assuring that quality service is provided to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor.

"(4) CONFIDENTIALITY OF ENROLLEE RECORDS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(5) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under subsection (b)(2)(A).

"(6) PRICES.—

"(A) AVOIDANCE OF HIGH PRICED DRUGS.—A prescription drug card sponsor may not recommend switching an eligible beneficiary to a drug with a higher negotiated price absent a recommendation by a licensed health professional that there is a clinical indication with respect to the patient for such a switch.

"(B) PRICE STABILITY.—Negotiated prices charged for prescription drugs covered under a prescription drug discount card program endorsed under this section may not change more frequently than once every 60 days.

"(e) PRESCRIPTION DRUG BENEFITS.—

"(1) IN GENERAL.—Each prescription drug card sponsor may only provide benefits that relate to prescription drugs (as defined in subsection (i)(2)) under a prescription drug discount card program endorsed under this section.

"(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

"(A) IN GENERAL.—Subject to subparagraph (D), each prescription drug card sponsor shall provide eligible beneficiaries who enroll in a prescription drug discount card program offered by such sponsor that is endorsed under this section with access to negotiated prices used by the sponsor with respect to prescription drugs dispensed to eligible beneficiaries.

"(B) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The requirements of section 1927 relating to manufacturer best price shall not apply to the negotiated prices for prescription drugs made available under a prescription drug discount card program endorsed under this section.

"(C) GUARANTEED ACCESS TO NEGOTIATED PRICES.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures to ensure that eligible beneficiaries have access to the negotiated prices for prescription drugs provided under subparagraph (A).

"(D) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card program if the program excludes the drug under a formulary.

"(3) BENEFICIARY SERVICES.—Each prescription drug discount card program endorsed under this section shall provide pharmaceutical support services, such as education, counseling, and services to prevent adverse drug interactions.

"(4) DISCOUNT CARDS.—Each prescription drug card sponsor shall issue a card to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor that the beneficiary may use to obtain benefits under the program.

"(f) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT AND APPROVAL.—

"(1) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

"(2) APPROVAL.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to endorse the prescription drug discount card program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

"(g) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a prescription drug card sponsor offering a prescription drug discount card program uses a formulary, the following requirements must be met:

"(1) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

"(A) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

"(B) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

"(2) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

"(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

"(A) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (as defined by the Secretary), although not necessarily for all drugs within such categories and classes.

"(B) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutic categories and classes.

"(4) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

"(5) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and pharmacies.

"(h) FRAUD AND ABUSE PREVENTION.—

"(1) IN GENERAL.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

"(2) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions and may revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

"(3) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for any violation of this section. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(4) REPORTING TO SECRETARY.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall report information relating to program performance, use of prescription drugs by eligible beneficiaries enrolled in the program, financial information of the sponsor, and such other information as the Secretary may specify. The Secretary may not disclose any proprietary data reported under this paragraph.

"(5) DRUG UTILIZATION REVIEW.—The Secretary may use claims data from parts A and B for purposes of conducting a drug utilization review program.

"(i) DEFINITIONS.—In this section:

"(1) ELIGIBLE BENEFICIARY.—

"(A) IN GENERAL.—The term 'eligible beneficiary' means an individual who—

"(i) is entitled to, or enrolled for, benefits under part A and enrolled under part B; and

"(ii) is not a dual eligible individual (as defined in subparagraph (B)).

"(B) DUAL ELIGIBLE INDIVIDUAL.—

"(i) IN GENERAL.—The term 'dual eligible individual' means an individual who is—

"(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that includes but is limited solely to covered outpatient drugs (as such term is defined for purposes of section 1927); and

"(II) entitled to benefits under part A and enrolled under part B.

"(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

"(2) PRESCRIPTION DRUG.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'prescription drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

"(ii) a biological product or insulin described in subparagraph (B) or (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—The term 'prescription drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(3) NEGOTIATED PRICE.—The term 'negotiated price' includes all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations.

"(4) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' means any entity with demonstrated experience and expertise in operating a prescription drug discount card program, an insurance program that provides coverage for prescription drugs, or a similar program that the Secretary determines to be appropriate to provide eligible beneficiaries with the benefits under a prescription drug discount card program endorsed by the Secretary under this section, including—

"(A) a pharmaceutical benefit management company;

"(B) a wholesale or retail pharmacist delivery system;

"(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

"(D) any other entity; or

"(E) any combination of the entities described in subparagraphs (A) through (D).

"TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES

"SEC. 1807A. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is established a program under which the Secretary shall award contracts to prescription drug card sponsors offering a prescription drug discount card that has been endorsed by the Secretary under section 1807 under which such sponsors shall offer a prescription drug assistance card program to eligible low-income beneficiaries in accordance with the requirements of this section.

"(2) APPLICATION OF DISCOUNT CARD PROVISIONS.—Except as otherwise provided in this section, the provisions of section 1807 shall apply to the program established under this section.

"(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

"(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the enrollment procedures established under section 1807(b)(1)(A)(ii) shall apply for purposes of this section.

"(B) ENROLLMENT OF ANY ELIGIBLE LOW-INCOME BENEFICIARY.—Each prescription drug card sponsor offering a prescription drug assistance card program under this section shall permit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

"(C) SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—An eligible low-income beneficiary who enrolls in a prescription drug assistance card program offered by a prescription drug card sponsor under this section shall be simultaneously enrolled in a prescription drug discount card program offered by such sponsor.

"(2) WAIVER OF ENROLLMENT FEES.—

"(A) IN GENERAL.—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

"(B) PAYMENT BY SECRETARY.—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fee charged under section 1807(b)(2)(A) on behalf of each eligible low-income beneficiary enrolled in a prescription drug discount card program under paragraph (1)(C) offered by such sponsor.

"(c) ADDITIONAL BENEFICIARY PROTECTIONS.—

"(1) PROVIDING INFORMATION TO ELIGIBLE LOW-INCOME BENEFICIARIES.—In addition to the information provided to eligible beneficiaries under section 1807(c), the prescription drug card sponsor shall—

"(A) periodically notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the amount of coverage for prescription drugs remaining under subsection (d)(2)(A); and

“(B) notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the grievance and appeals processes under the program.

“(2) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—For purposes of determining whether convenient access has been provided under section 1807(d)(2) with respect to eligible low-income beneficiaries enrolled in a prescription drug assistance card program, the Secretary may only make a determination that such access has been provided if an appropriate arrangement is in place for eligible low-income beneficiaries who are in a long-term care facility (as defined by the Secretary) to receive prescription drug benefits under the program.

“(3) COORDINATION OF BENEFITS.—

“(A) IN GENERAL.—The Secretary shall establish procedures under which eligible low-income beneficiaries who are enrolled for coverage described in subparagraph (B) and enrolled in a prescription drug assistance card program have access to the prescription drug benefits available under such program.

“(B) COVERAGE DESCRIBED.—Coverage described in this subparagraph is as follows:

“(i) Coverage of prescription drugs under a State pharmaceutical assistance program.

“(ii) Enrollment in a Medicare+Choice plan under part C.

“(4) GRIEVANCE MECHANISM.—Each prescription drug card sponsor with a contract under this section shall provide in accordance with section 1852(f) meaningful procedures for hearing and resolving grievances between the prescription drug card sponsor (including any entity or individual through which the prescription drug card sponsor provides covered benefits) and enrollees in a prescription drug assistance card program offered by such sponsor.

“(5) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—

“(A) IN GENERAL.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply with respect to covered benefits under a prescription drug assistance card program under this section in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(B) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug assistance card program offered by a prescription drug card sponsor that provides for tiered pricing for drugs included within a formulary and provides lower prices for preferred drugs included within the formulary, an eligible low-income beneficiary who is enrolled in the program may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

“(C) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

“(6) APPEALS.—

“(A) IN GENERAL.—Subject to subparagraph (B), a prescription drug card sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in a similar manner (as determined by the Secretary) as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(B) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

“(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The prescription drug card sponsor must have, as part of the appeals process under this paragraph, a process for timely appeals for denials of coverage based on the application of the formulary.

“(d) PRESCRIPTION DRUG BENEFITS.—

“(1) IN GENERAL.—Subject to paragraph (5), all the benefits available under a prescription drug discount card program offered by a prescription drug card sponsor and endorsed under section 1807 shall be available to eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor.

“(2) ASSISTANCE FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—

“(A) $600 ANNUAL ASSISTANCE.—Subject to subparagraphs (B) and (C) and paragraph (5), each prescription drug card sponsor with a contract under this section shall provide coverage for the first $600 of expenses for prescription drugs incurred during each calendar year by an eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor.

“(B) COINSURANCE.—

“(i) IN GENERAL.—The prescription drug card sponsor shall determine an amount of coinsurance to collect from each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor for which coverage is available under subparagraph (A).

“(ii) AMOUNT.—The amount of coinsurance collected under clause (i) shall be at least 10 percent of the negotiated price of each prescription drug dispensed to an eligible low-income beneficiary.

“(iii) CONSTRUCTION.—Amounts collected under clause (i) shall not be counted against the total amount of coverage available under subparagraph (A).

“(C) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible low-income beneficiary is not enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor with a contract under this section, the amount of assistance available under subparagraph (A) shall be reduced by $50.

“(D) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—The dollar amount of coverage described in subparagraph (A) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

“(E) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Secretary may waive such requirements of this section and section 1807 as may be necessary to ensure that each eligible low-income beneficiaries has access to the assistance described in subparagraph (A).

“(3) ADDITIONAL DISCOUNTS.—A prescription drug card sponsor with a contract under this section shall provide each eligible low-income beneficiary enrolled in a prescription drug assistance program offered by the sponsor with access to negotiated prices that reflect a minimum average discount of at least 20 percent of the average wholesale price for prescription drugs covered under that program.

“(4) ASSISTANCE CARDS.—Each prescription drug card sponsor shall permit eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor to use the discount card issued under section 1807(e)(4) to obtain benefits under the program.

“(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible low-income beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug assistance card program if the program excludes the drug under a formulary and such exclusion is not successfully resolved under paragraph (4), (5), or (6) of subsection (c).

“(e) REQUIREMENTS FOR PRESCRIPTION DRUG CARD SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE CARD PROGRAMS.—

“(1) IN GENERAL.—Each prescription drug card sponsor shall—

“(A) process claims made by eligible low-income beneficiaries;

“(B) negotiate with brand name and generic prescription drug manufacturers and others for low prices on prescription drugs;

“(C) track individual beneficiary expenditures in a format and periodicity specified by the Secretary; and

“(D) perform such other functions as the Secretary may assign.

“(2) DATA EXCHANGES.—Each prescription drug card sponsor shall receive data exchanges in a format specified by the Secretary and shall maintain real-time beneficiary files.

“(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The prescription drug card sponsor offering the prescription drug assistance card program shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the eligible low-income beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest priced generic drug covered under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy or other dispenser.

“(f) SUBMISSION OF BIDS AND AWARDING OF CONTRACTS.—

“(1) SUBMISSION OF BIDS.—Each prescription drug card sponsor that seeks to offer a prescription drug assistance card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

“(2) AWARDING OF CONTRACTS.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to award a contract to the prescription drug card sponsor offering the program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

“(3) NUMBER OF CONTRACTS.—There shall be no limit on the number of prescription drug card sponsors that may be awarded contracts under paragraph (2).

"(4) Contract provisions.—

"(A) Duration.—A contract awarded under paragraph (2) shall be for the lifetime of the program under this section.

"(B) Withdrawal.—A prescription drug card sponsor that desires to terminate the contract awarded under paragraph (2) may terminate such contract without penalty if such sponsor gives notice—

"(i) to the Secretary 90 days prior to the termination of such contract; and

"(ii) to each eligible low-income beneficiary that is enrolled in a prescription drug assistance card program offered by such sponsor 60 days prior to such termination.

"(C) Service area.—The service area under the contract shall be the same as the area served by the prescription drug card sponsor under section 1807.

"(5) Simultaneous approval of discount card and assistance programs.—A prescription drug card sponsor may submit an application for endorsement under section 1807 as part of the bid submitted under paragraph (1) and the Secretary may approve such application at the same time as the Secretary awards a contract under this section.

"(g) Payments to Prescription Drug Card Sponsors.—

"(1) In general.—The Secretary shall pay to each prescription drug card sponsor offering a prescription drug assistance card program in which an eligible low-income beneficiary is enrolled an amount equal to the amount agreed to by the Secretary and the sponsor in the contract awarded under subsection (f)(2).

"(2) Payment from part B trust fund.—The costs of providing benefits under this section shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"(h) Eligibility Determinations Made by States; Presumptive Eligibility.—States shall perform the functions described in section 1935(a)(1).

"(i) Appropriations.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 such sums as may be necessary to carry out the program under this section.

"(j) Definitions.—In this section:

"(1) Eligible beneficiary; negotiated price; prescription drug.—The terms 'eligible beneficiary', 'negotiated price', and 'prescription drug' have the meanings given those terms in section 1807(i).

"(2) Eligible low-income beneficiary.—The term 'eligible low-income beneficiary' means an individual who—

"(A) is an eligible beneficiary (as defined in section 1807(i));

"(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and

"(C) is described in clause (iii) or (iv) of section 1902(a)(10)(E) or in section 1905(p)(1).

"(3) Prescription drug card sponsor.—The term 'prescription drug card sponsor' has the meaning given that term in section 1807(i), except that such sponsor shall also be an entity that the Secretary determines is—

"(A) is appropriate to provide eligible low-income beneficiaries with the benefits under a prescription drug assistance card program under this section; and

"(B) is able to manage the monetary assistance made available under subsection (d)(2);

"(C) agrees to submit to audits by the Secretary; and

"(D) provides such other assurances as the Secretary may require.

"(4) State.—The term 'State' has the meaning given such term for purposes of title XIX.".

(b) Exclusion of Prices From Determination of Best Price.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking "and" at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting "; and"; and

(3) by adding at the end the following new subclause:

"(V) any negotiated prices charged under the medicare prescription drug discount card endorsement program under section 1807 or under the transitional prescription drug assistance card program for eligible low-income beneficiaries under section 1807A.".

(c) Exclusion of Prescription Drug Assistance Card Costs From Determination of Part B Monthly Premium.—Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking "attributable to the application of section" and inserting "attributable to—

"(1) the application of section";

(2) by striking the period and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(2) the prescription drug assistance card program under section 1807A.".

(d) Regulations.—

(1) Authority for interim final regulations.—The Secretary may promulgate initial regulations implementing sections 1807 and 1807A of the Social Security Act (as added by this section) in interim final form without prior opportunity for public comment.

(2) Final regulations.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).

(3) Exemption from the Paperwork Reduction Act.—The promulgation of the regulations under this subsection and the administration the programs established by sections 1807 and 1807A of the Social Security Act (as added by this section) shall be made without regard to chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act").

(e) Implementation; Transition.—

(1) Implementation.—The Secretary shall implement the amendments made by this section in a manner that discounts are available to eligible beneficiaries under section 1807 of the Social Security Act and assistance is available to eligible low-income beneficiaries under section 1807A of such Act not later than January 1, 2004.

(2) Transition.—The Secretary shall provide for an appropriate transition and discontinuation of the programs under section 1807 and 1807A of the Social Security Act. Such transition and discontinuation shall ensure that such programs continue to operate until the date on which the first enrollment period under part D ends.

Subtitle C—Standards for Electronic Prescribing

SEC. 121. STANDARDS FOR ELECTRONIC PRESCRIBING.

Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

"Part D—Electronic Prescribing

"Standards for Electronic Prescribing

"Sec. 1180. (a) Standards.—

"(1) Development and Adoption.—

"(A) In general.—The Secretary shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as 'standards') to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information. .

"(B) Consultation.—In developing and adopting the standards under subparagraph (A), the Secretary shall consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiary information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

"(2) Objective.—Any standards developed or adopted under this part shall be consistent with the objectives of improving—

"(A) patient safety; and

"(B) the quality of care provided to patients.

"(3) Requirements.—Any standards developed or adopted under this part shall comply with the following:

"(A) Electronic transmittal of prescriptions.—

"(i) In general.—Except as provided in clause (ii), the standards require that prescriptions be written and transmitted electronically.

"(ii) Exceptions.—The standards shall not require a prescription to be written and transmitted electronically—

"(I) in emergency cases and other exceptional circumstances recognized by the Administrator; or

"(II) if the patient requests that the prescription not be transmitted electronically.

If a patient makes a request under subclause (II), no additional charges may be imposed on the patient for making such request.

"(B) Patient-specific medication history, eligibility, benefit, and other prescription information.—

"(i) In general.—The standards shall accommodate electronic transmittal of patient-specific medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care.

"(ii) Required information.—The information described in clause (i) shall include the following:

"(I) Information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medication history of the patient that may be relevant to the appropriate prescription for that patient.

"(II) Cost-effective alternatives (if any) to the drug prescribed.

"(III) Information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization.

"(IV) Information on potential interactions with drugs listed on the medication history, graded by severity of the potential interaction.

"(V) Other information to improve the quality of patient care and to reduce medical errors.

"(C) Undue burden.—The standards shall be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on the practice of medicine, pharmacy, or other health professions.

"(D) Compatibility with administrative simplification and privacy laws.—The standards shall be—

"(i) consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

"(ii) compatible with the standards adopted under part C.

"(4) TRANSFER OF INFORMATION.—The Secretary shall develop and adopt standards for transferring among prescribing and insurance entities and other necessary entities appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

"(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

"(1) IN GENERAL.—The Secretary shall adopt the standards under this part by January 1, 2006.

"(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—The Secretary shall, in consultation with appropriate representatives of interested parties, review the standards developed or adopted under this part and adopt modifications to the standards (including additions to the standards), as determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

"(c) COMPLIANCE WITH STANDARDS.—

"(1) REQUIREMENT FOR ALL INDIVIDUALS AND ENTITIES THAT TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—

"(A) IN GENERAL.—Individuals or entities that transmit or receive electronic medication history, eligibility, benefit and prescription information, shall comply with the standards adopted or modified under this part.

"(B) RELATION TO STATE LAWS.—The standards adopted or modified under this part shall supersede any State law or regulations pertaining to the electronic transmission of medication history, eligibility, benefit and prescription information.

"(2) TIMETABLE FOR COMPLIANCE.—

"(A) INITIAL COMPLIANCE.—

"(i) IN GENERAL.—Not later than 24 months after the date on which an initial standard is adopted under this part, each individual or entity to whom the standard applies shall comply with the standard.

"(ii) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, as defined by the Secretary for purposes of section 1175(b)(1)(B), clause (i) shall be applied by substituting '36 months' for '24 months'.

"(d) CONSULTATION WITH ATTORNEY GENERAL.—The Secretary shall consult with the Attorney General before developing, adopting, or modifying a standard under this part to ensure that the standard accommodates secure electronic transmission of prescriptions for controlled substances in a manner that minimizes the possibility of violations under the Comprehensive Drug Abuse Prevention and Control Act of 1970 and related Federal laws.

"GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION PROGRAMS

"SEC. 1180A. (a) IN GENERAL.—The Secretary is authorized to make grants to health care providers for the purpose of assisting such entities to implement electronic prescription programs that comply with the standards adopted or modified under this part.

"(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.".

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.

Section 1851 (42 U.S.C. 1395w–21) is amended to read as follows:

"ELIGIBILITY, ELECTION, AND ENROLLMENT

"SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREADVANTAGE PLANS.—

"(1) IN GENERAL.—Subject to the provisions of this section, each MedicareAdvantage eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

"(A) through—

"(i) the original Medicare fee-for-service program under parts A and B; and

"(ii) the voluntary prescription drug delivery program under part D; or

"(B) through enrollment in a MedicareAdvantage plan under this part.

"(2) TYPES OF MEDICAREADVANTAGE PLANS THAT MAY BE AVAILABLE.—A MedicareAdvantage plan may be any of the following types of plans of health insurance:

"(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans (with or without point of service options) and plans offered by provider-sponsored organizations (as defined in section 1855(d)).

"(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREADVANTAGE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a MedicareAdvantage medical savings account (MSA).

"(C) PRIVATE FEE-FOR-SERVICE PLANS.—A MedicareAdvantage private fee-for-service plan, as defined in section 1859(b)(2).

"(3) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this title, the term 'MedicareAdvantage eligible individual' means an individual who is entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

"(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice or a MedicareAdvantage plan may continue to be enrolled in that plan; and

"(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan or a MedicareAdvantage plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a 'MedicareAdvantage eligible individual' for purposes of electing to continue enrollment in another MedicareAdvantage plan.

"(b) SPECIAL RULES.—

"(1) RESIDENCE REQUIREMENT.—

"(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization only if the plan serves the geographic area in which the individual resides.

"(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1852(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost-sharing liability in obtaining such benefits.

"(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a MedicareAdvantage organization eliminates from its service area a MedicareAdvantage payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a MedicareAdvantage plan it offers so long as—

"(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

"(ii) there is no other MedicareAdvantage plan offered in the area in which the enrollee resides at the time of the organization's election.

"(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS.—

"(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

"(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

"(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

"(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

"(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

"(i) on or after January 1, 2004, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

"(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

"(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

"(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

"(c) PROCESS FOR EXERCISING CHOICE.—

"(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

"(2) COORDINATION THROUGH MEDICAREADVANTAGE ORGANIZATIONS.—

"(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization to make such election through the filing of an appropriate election form with the organization.

"(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicareAdvantage plan offered by a MedicareAdvantage organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

"(3) DEFAULT.—

"(A) INITIAL ELECTION.—

"(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

"(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a Medicare+Choice plan or another health plan (other than a MedicareAdvantage plan) offered by a MedicareAdvantage organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicareAdvantage plan offered by the organization (or, if the organization offers more than 1 such plan, such plan or plans as the Secretary identifies under such procedures).

"(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

"(i) the individual changes the election under this section; or

"(ii) the MedicareAdvantage plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

"(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

"(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

"(2) PROVISION OF NOTICE.—

"(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicareAdvantage eligible individual residing in an area the following:

"(i) GENERAL INFORMATION.—The general information described in paragraph (3).

"(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicareAdvantage plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

"(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

"(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial MedicareAdvantage enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

"(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

"(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicareAdvantage plans, the benefits under such plans, and the MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage for such plans.

"(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

"(A) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under parts A and B of the original medicare fee-for-service program, including—

"(i) covered items and services;

"(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

"(iii) any beneficiary liability for balance billing.

"(B) CATASTROPHIC COVERAGE AND COMBINED DEDUCTIBLE.—A description of the catastrophic coverage and unified deductible applicable under the plan.

"(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—The information required under section 1860D–4 with respect to coverage for prescription drugs under the plan.

"(D) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

"(E) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program (including such rights under part D) and the MedicareAdvantage program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

"(F) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

"(G) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicareAdvantage organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the MedicareAdvantage plan under this part.

"(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicareAdvantage plan for a year, shall include the following:

"(A) BENEFITS.—The benefits covered under the plan, including the following:

"(i) Covered items and services beyond those provided under the original medicare fee-for-service program option.

"(ii) Beneficiary cost-sharing for any items and services described in clause (i) and paragraph (3)(A)(i), including information on the unified deductible under section 1852(a)(1)(C).

"(iii) The maximum limitations on out-of-pocket expenses under section 1852(a)(1)(C).

"(iv) In the case of an MSA plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

"(v) In the case of a MedicareAdvantage private fee-for-service plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

"(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

"(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

"(viii) The organization's coverage of emergency and urgently needed care.

"(ix) The comparative information described in section 1860D–4(b)(2) relating to prescription drug coverage under the plan.

"(B) PREMIUMS.—

"(i) IN GENERAL.—The MedicareAdvantage monthly basic beneficiary premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, if any, for the plan or, in the case of an MSA plan, the MedicareAdvantage monthly MSA premium.

"(ii) REDUCTIONS.—The reduction in part B premiums, if any.

"(iii) NATURE OF THE PREMIUM FOR ENHANCED MEDICAL BENEFITS.—Whether the MedicareAdvantage monthly premium for enhanced benefits is optional or mandatory.

"(C) SERVICE AREA.—The service area of the plan.

"(D) QUALITY AND PERFORMANCE.—Plan quality and performance indicators for the benefits under the plan (and how such indicators compare to quality and performance indicators under the original medicare fee-for-service program under parts A and B and under the voluntary prescription drug delivery program under part D in the area involved), including—

"(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area);

“(ii) information on medicare enrollee satisfaction;

“(iii) information on health outcomes; and

“(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

“(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicareAdvantage options and the operation of this part in all areas in which MedicareAdvantage plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicareAdvantage plans.

“(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

“(7) PROVISION OF INFORMATION.—A MedicareAdvantage organization shall provide the Secretary with such information on the organization and each MedicareAdvantage plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

“(e) COVERAGE ELECTION PERIODS.—

“(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes eligible to elect to receive benefits under part B or D (whichever is later), there is 1 or more MedicareAdvantage plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a MedicareAdvantage plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

“(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), the following rules shall apply:

“(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

“(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

“(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a MedicareAdvantage eligible individual during 2006, during the first 6 months during 2006 in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF 1 CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

“(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

“(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 3 months of 2007 and each subsequent year, or, if the individual first becomes a MedicareAdvantage eligible individual during 2007 or any subsequent year, during the first 3 months of such year in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF 1 CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

“(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time during 2006 or any subsequent year, in the case of a MedicareAdvantage eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

“(i) to enroll in a MedicareAdvantage plan; or

“(ii) to change the MedicareAdvantage plan in which the individual is enrolled.

“(3) ANNUAL, COORDINATED ELECTION PERIOD.—

“(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

“(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term ‘annual, coordinated election period’ means, with respect to a year before 2003 and after 2006, the month of November before such year and with respect to 2003, 2004, 2005, and 2006, the period beginning on November 15 and ending on December 31 of the year before such year.

“(C) MEDICAREADVANTAGE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 2006), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicareAdvantage eligible individuals about MedicareAdvantage plans and the election process provided under this section.

“(D) SPECIAL INFORMATION CAMPAIGN IN 2005.—During the period beginning on November 15, 2005, and ending on December 31, 2005, the Secretary shall provide for an educational and publicity campaign to inform MedicareAdvantage eligible individuals about the availability of MedicareAdvantage plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section.

“(4) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual may discontinue an election of a MedicareAdvantage plan offered by a MedicareAdvantage organization other than during an annual, coordinated election period and make a new election under this section if—

“(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

“(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

“(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

“(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

“(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

“(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

“(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective on and after January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a MedicareAdvantage plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

“(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

“(A) may elect an MSA plan only during—

“(i) an initial open enrollment period described in paragraph (1);

“(ii) an annual, coordinated election period described in paragraph (3)(B); or

“(iii) the month of November 1998;

“(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

“(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

“(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a MedicareAdvantage organization—

“(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period beginning on November 15, 2005, and ending on December 31, 2005, and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

“(B) may accept other changes to elections at such other times as the organization provides.

“(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

“(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D, except as the Secretary may provide (consistent with sections 1838 and 1860D–2)) in order to prevent retroactive coverage.

“(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

“(3) Annual, coordinated election period.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

“(4) Other periods.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

“(g) Guaranteed Issue and Renewal.—

“(1) In general.—Except as provided in this subsection, a MedicareAdvantage organization shall provide that at any time during which elections are accepted under this section with respect to a MedicareAdvantage plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

“(2) Priority.—If the Secretary determines that a MedicareAdvantage organization, in relation to a MedicareAdvantage plan it offers, has a capacity limit and the number of MedicareAdvantage eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

“(A) first to such individuals as have elected the plan at the time of the determination; and

“(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

“(3) Limitation on termination of election.—

“(A) In general.—Subject to subparagraph (B), a MedicareAdvantage organization may not for any reason terminate the election of any individual under this section for a MedicareAdvantage plan it offers.

“(B) Basis for termination of election.—A MedicareAdvantage organization may terminate an individual's election under this section with respect to a MedicareAdvantage plan it offers if—

“(i) any MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary obligation for qualified prescription drug · coverage, or MedicareAdvantage monthly beneficiary premium for required or optional enhanced medical benefits required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums);

“(ii) the individual has engaged in disruptive behavior (as specified in such standards); or

“(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

“(C) Consequence of termination.—

“(i) Terminations for cause.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected to receive benefits under the original medicare fee-for-service program option.

“(ii) Termination based on plan termination or service area reduction.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicareAdvantage plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option.

“(D) Organization obligation with respect to election forms.—Pursuant to a contract under section 1857858., each MedicareAdvantage organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

“(h) Approval of Marketing Material and Application Forms.—

“(1) Submission.—No marketing material or application form may be distributed by a MedicareAdvantage organization to (or for the use of) MedicareAdvantage eligible individuals unless—

“(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review; and

“(B) the Secretary has not disapproved the distribution of such material or form.

“(2) Review.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

“(3) Deemed approval (1-stop shopping).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a MedicareAdvantage plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

“(4) Prohibition of certain marketing practices.—Each MedicareAdvantage organization shall conform to fair marketing standards, in relation to MedicareAdvantage plans offered under this part, included in the standards established under section 1856. Such standards—

“(A) shall not permit a MedicareAdvantage organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in section 1854(g)(1)(C)(i)); and

“(B) may include a prohibition against a MedicareAdvantage organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

“(5) Special treatment of marketing material following model marketing language.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

“(i) Effect of Election of MedicareAdvantage Plan Option.—

“(1) Payments to organizations.—Subject to sections 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a MedicareAdvantage organization under section 1853(a) with respect to an individual electing a MedicareAdvantage plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A, B, and D for items and services furnished to the individual.

“(2) Only organization entitled to payment.—Subject to sections 1853(f), 1853(h), 1853(i), 1857(f)(2), 1886(d)(11), and 1886(h)(3)(D), only the MedicareAdvantage organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.”.

SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.

Section 1852 (42 U.S.C. 1395w-22) is amended to read as follows:

“BENEFITS AND BENEFICIARY PROTECTIONS

“Sec. 1852. (a) Basic Benefits.—

“(1) In general.—Except as provided in section 1859(b)(3) for MSA plans, each MedicareAdvantage plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

“(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan;

“(B) except as provided in paragraph (2)(D), qualified prescription drug coverage under part D to individuals residing in the area served by the plan;

“(C) a maximum limitation on out-of-pocket expenses and a unified deductible; and

“(D) additional benefits required under section 1854(d)(1).,

“(2) Satisfaction of requirement.—

“(A) In general.—A MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

“(i) the sum of such payment amount and any cost-sharing provided for under the plan; is equal to at least

“(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

“(B) Reference to related provisions.—For provisions relating to—

“(i) limitations on balance billing against MedicareAdvantage organizations for noncontract providers, see sections 1852(k) and 1866(a)(1)(O); and

“(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(f).

“(C) Election of uniform coverage policy.—In the case of a MedicareAdvantage organization that offers a MedicareAdvantage plan in an area in which more than 1 local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to MedicareAdvantage enrollees (as identified by the Secretary) apply with respect to all MedicareAdvantage enrollees enrolled in the plan.

"(D) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—

"(i) IN GENERAL.—A private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

"(ii) AVAILABILITY OF DRUG COVERAGE FOR ENROLLEES.—If a beneficiary enrolls in a plan making the election described in clause (i), the beneficiary may enroll for drug coverage under part D with an eligible entity under such part.

"(3) ENHANCED MEDICAL BENEFITS.—

"(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each MedicareAdvantage organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), enhanced medical benefits that the Secretary may approve. The Secretary shall approve any such enhanced medical benefits unless the Secretary determines that including such enhanced medical benefits would substantially discourage enrollment by MedicareAdvantage eligible individuals with the organization.

"(B) AT ENROLLEES' OPTION.—A MedicareAdvantage organization may not provide, under an MSA plan, enhanced medical benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

"(C) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a MedicareAdvantage private fee-for-service plan from offering enhanced medical benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

"(D) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any enhanced medical benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

"(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicareAdvantage organization may (in the case of the provision of items and services to an individual under a MedicareAdvantage plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

"(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services; or

"(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

"(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicareAdvantage organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the benchmark amount announced under section 1853(b)(1)(A) at the beginning of such period, then, unless otherwise required by law—

"(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period; and

"(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Secretary of the actuarial costs associated with the coverage determination or legislative change in benefits.

"(6) AUTHORITY TO PROHIBIT RISK SELECTION.—The Secretary shall have the authority to disapprove any MedicareAdvantage plan that the Secretary determines is designed to attract a population that is healthier than the average population residing in the service area of the plan.

"(7) UNIFIED DEDUCTIBLE DEFINED.—In this part, the term 'unified deductible' means an annual deductible amount that is applied in lieu of the inpatient hospital deductible under section 1813(b)(1) and the deductible under section 1833(b). Nothing in this part shall be construed as preventing a MedicareAdvantage organization from requiring coinsurance or a copayment for inpatient hospital services after the unified deductible is satisfied, subject to the limitation on enrollee liability under section 1854(f).

"(b) ANTIDISCRIMINATION.—

"(1) BENEFICIARIES.—

"(A) IN GENERAL.—A MedicareAdvantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

"(B) CONSTRUCTION.—Except as provided under section 1851(a)(3)(B), subparagraph (A) shall not be construed as requiring a MedicareAdvantage organization to enroll individuals who are determined to have end-stage renal disease.

"(2) PROVIDERS.—A MedicareAdvantage organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

"(c) DISCLOSURE REQUIREMENTS.—

"(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicareAdvantage organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicareAdvantage plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

"(A) SERVICE AREA.—The plan's service area.

"(B) BENEFITS.—Benefits offered under the plan, including information described section 1852(a)(1) (relating to benefits under the original medicare fee-for-service program option, the maximum limitation in out-of-pocket expenses and the unified deductible, and qualified prescription drug coverage under part D, respectively) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicareAdvantage plans.

"(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits for such option).

"(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

"(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

"(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

"(ii) the process and procedures of the plan for obtaining emergency services; and

"(iii) the locations of—

"(I) emergency departments; and

"(II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

"(F) ENHANCED MEDICAL BENEFITS.—Enhanced medical benefits available from the organization offering the plan, including—

"(i) whether the enhanced medical benefits are optional;

"(ii) the enhanced medical benefits covered; and

"(iii) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits.

"(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

"(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

"(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

"(2) DISCLOSURE UPON REQUEST.—Upon request of a MedicareAdvantage eligible individual, a MedicareAdvantage organization must provide the following information to such individual:

"(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

"(B) Information on procedures used by the organization to control utilization of services and expenditures.

"(C) Information on the number of grievances, reconsiderations, and appeals and on the disposition in the aggregate of such matters.

"(D) An overall summary description as to the method of compensation of participating physicians.

"(E) The information described in subparagraphs (A) through (C) in relation to the qualified prescription drug coverage provided by the organization.

"(d) ACCESS TO SERVICES.—

“(1) IN GENERAL.—A MedicareAdvantage organization offering a MedicareAdvantage plan may select the providers from whom the benefits under the plan are provided so long as—

“(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

“(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

“(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

“(i) the services were not emergency services (as defined in paragraph (3)), but—

“(I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

“(II) it was not reasonable given the circumstances to obtain the services through the organization;

“(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area; or

“(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

“(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

“(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

“(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicareAdvantage plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

“(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

“(A) IN GENERAL.—The term ‘emergency services’ means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

“(i) are furnished by a provider that is qualified to furnish such services under this title; and

“(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

“(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

“(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

“(ii) serious impairment to bodily functions; or

“(iii) serious dysfunction of any bodily organ or part.

“(4) ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a MedicareAdvantage private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

“(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, B, or D for such services; or

“(B) the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan,

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

“(e) QUALITY ASSURANCE PROGRAM.—

“(1) IN GENERAL.—Each MedicareAdvantage organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicareAdvantage plans of the organization.

“(2) ELEMENTS OF PROGRAM.—

“(A) IN GENERAL.—The quality assurance program of an organization with respect to a MedicareAdvantage plan (other than a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan) it offers shall—

“(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicareAdvantage plans and organizations;

“(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

“(iii) provide access to disease management and chronic care services;

“(iv) provide access to preventive benefits and information for enrollees on such benefits;

“(v) evaluate the continuity and coordination of care that enrollees receive;

“(vi) be evaluated on an ongoing basis as to its effectiveness;

“(vii) include measures of consumer satisfaction;

“(viii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

“(ix) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

“(x) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

“(xi) have mechanisms to detect both underutilization and overutilization of services;

“(xii) after identifying areas for improvement, establish or alter practice parameters;

“(xiii) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

“(xiv) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

“(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS, AND NONNETWORK MSA PLANS.—The quality assurance program of an organization with respect to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan it offers shall—

“(i) meet the requirements of clauses (i) through (viii) of subparagraph (A);

“(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

“(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

“(C) DEFINITION OF NONNETWORK MSA PLAN.—In this subsection, the term ‘nonnetwork MSA plan’ means an MSA plan offered by a MedicareAdvantage organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

“(3) EXTERNAL REVIEW.—

“(A) IN GENERAL.—Each MedicareAdvantage organization shall, for each MedicareAdvantage plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (4)(B) and (14) of section 1154(a) with respect to services furnished by MedicareAdvantage plans for which payment is made under this title. The previous sentence shall not apply to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan that does not employ utilization review.

“(B) NONDUPLICATION OF ACCREDITATION.—Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

“(C) WAIVER AUTHORITY.—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

“(4) TREATMENT OF ACCREDITATION.—

“(A) IN GENERAL.—The Secretary shall provide that a MedicareAdvantage organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

“(B) Requirements described.—The provisions described in this subparagraph are the following:

“(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

“(ii) Subsection (b) (relating to antidiscrimination).

“(iii) Subsection (d) (relating to access to services).

“(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

“(v) Subsection (i) (relating to information on advance directives).

“(vi) Subsection (j) (relating to provider participation rules).

“(C) Timely action on applications.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

“(D) Construction.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with MedicareAdvantage organizations under subsection (c)(2) of such section.

“(5) Report to congress.—

“(A) In general.—The Secretary shall submit to Congress a biennial report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

“(B) Contents of report.—Each such report shall include the following:

“(i) A description of the means by which such programs focus on such racial and ethnic minorities.

“(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

“(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

“(f) Grievance Mechanism.—Each MedicareAdvantage organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with MedicareAdvantage plans of the organization under this part.

“(g) Coverage Determinations, Reconsiderations, and Appeals.—

“(1) Determinations by organization.—

“(A) In general.—A MedicareAdvantage organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

“(B) Explanation of determination.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

“(2) Reconsiderations.—

“(A) In general.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

“(B) Physician decision on certain reconsiderations.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

“(3) Expedited determinations and reconsiderations.—

“(A) Receipt of requests.—

“(i) Enrollee requests.—An enrollee in a MedicareAdvantage plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the MedicareAdvantage organization.

“(ii) Physician requests.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

“(B) Organization procedures.—

“(i) In general.—The MedicareAdvantage organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

“(ii) Expedition required for physician requests.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

“(iii) Timely response.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

“(4) Independent review of certain coverage denials.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

“(5) Appeals.—An enrollee with a MedicareAdvantage plan of a MedicareAdvantage organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

“(h) Confidentiality and Accuracy of Enrollee Records.—Insofar as a MedicareAdvantage organization maintains medical records or other health information regarding enrollees under this part, the MedicareAdvantage organization shall establish procedures—

“(1) to safeguard the privacy of any individually identifiable enrollee information;

“(2) to maintain such records and information in a manner that is accurate and timely; and

“(3) to assure timely access of enrollees to such records and information.

“(i) Information on Advance Directives.—Each MedicareAdvantage organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

“(j) Rules Regarding Provider Participation.—

“(1) Procedures.—Insofar as a MedicareAdvantage organization offers benefits under a MedicareAdvantage plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

“(A) providing notice of the rules regarding participation;

“(B) providing written notice of participation decisions that are adverse to physicians; and

“(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

“(2) Consultation in medical policies.—A MedicareAdvantage organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

“(3) Prohibiting interference with provider advice to enrollees.—

“(A) In general.—Subject to subparagraphs (B) and (C), a MedicareAdvantage organization (in relation to an individual enrolled under a MedicareAdvantage plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

“(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicareAdvantage plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicareAdvantage organization offering the plan—

“(i) objects to the provision of such service on moral or religious grounds; and

“(ii) in the manner and through the written instrumentalities such MedicareAdvantage organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

“(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

“(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicareAdvantage plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed pharmacist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

“(A) IN GENERAL.—No MedicareAdvantage organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

“(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

“(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

“(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group; and

“(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

“(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

“(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a MedicareAdvantage organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

“(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicareAdvantage organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicareAdvantage plan of the organization under this part by the organization's denial of medically necessary care.

“(6) SPECIAL RULES FOR MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a MedicareAdvantage organization (with respect to an individual enrolled in a MedicareAdvantage private fee-for-service plan it offers), if—

“(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

“(B) before providing such services, the provider, professional, or other entity —

“(i) has been informed of the individual's enrollment under the plan; and

“(ii) either—

“(I) has been informed of the terms and conditions of payment for such services under the plan; or

“(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the MedicareAdvantage organization.

“(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicareAdvantage organization described in section 1851(a)(2)(A) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicareAdvantage organization under this part) also applies with respect to an individual so enrolled.

“(2) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—

“(A) BALANCE BILLING LIMITS UNDER MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

“(i) IN GENERAL.—In the case of an individual enrolled in a MedicareAdvantage private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

“(ii) PROCEDURES TO ENFORCE LIMITS.—The MedicareAdvantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out clause (i).

“(iii) ASSURING ENFORCEMENT.—If the MedicareAdvantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

“(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provisions—

“(i) establishing a minimum payment rate in the case of noncontract providers under a MedicareAdvantage private fee-for-service plan, see section 1852(a)(2); or

“(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

“(C) INFORMATION ON BENEFICIARY LIABILITY.—

“(i) IN GENERAL.—Each MedicareAdvantage organization that offers a MedicareAdvantage private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A, B, and D, and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

“(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

“(I) notice of the fact that balance billing is permitted under such subparagraph for such services; and

“(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

“(l) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

“(1) ENSURING RETURN TO HOME SNF.—

“(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a MedicareAdvantage plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

“(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

"(ii) SNF AGREEMENT.—The facility has a contract with the MedicareAdvantage organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the MedicareAdvantage organization for the provision of such services and through which the enrollee would otherwise receive such services.

"(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

"(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the MedicareAdvantage plan.

"(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

"(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a MedicareAdvantage plan.

"(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

"(4) DEFINITIONS.—In this subsection:

"(A) HOME SKILLED NURSING FACILITY.—The term 'home skilled nursing facility' means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a MedicareAdvantage plan, any of the following skilled nursing facilities:

"(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

"(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

"(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

"(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means, with respect to an enrollee in a MedicareAdvantage plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.".

SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS.

Section 1853 (42 U.S.C. 1395w–23) is amended to read as follows:

"PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

"SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

"(1) MONTHLY PAYMENTS.—

"(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each MedicareAdvantage organization, with respect to coverage of an individual for a month under this part in a MedicareAdvantage payment area, separate monthly payments with respect to—

"(i) benefits under the original medicare fee-for-service program under parts A and B in accordance with subsection (d); and

"(ii) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicareAdvantage organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicareAdvantage plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicareAdvantage payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

"(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicareAdvantage organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

"(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

"(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the MedicareAdvantage organization for each individual enrolled with the organization shall equal the MedicareAdvantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

"(i) by multiplying the benchmark amount for that payment area by the ratio of—

"(I) the payment amount determined under subsection (d)(4); to

"(II) the weighted service area benchmark amount determined under subsection (d)(2); and

"(ii) using such risk adjustment factor as specified by the Secretary under subsection (b)(1)(B).

"(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

"(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of payments to plans under subsection (d)(4)(B).

"(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to MedicareAdvantage plans offered by MedicareAdvantage organizations in 2005, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

"(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

"(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicareAdvantage organizations to submit such data and other information as the Secretary deems necessary.

"(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.

"(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each MedicareAdvantage payment area for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the greater of the following amounts (adjusted as appropriate for the application of the risk adjustment methodology under paragraph (3)):

"(A) MINIMUM AMOUNT.—1/12 of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year.

"(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).

"(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'local fee-for-service rate' means the amount of payment for a month in a MedicareAdvantage payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive benefits under the original medicare fee-for-service program option and not enrolled in a MedicareAdvantage plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876.

"(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

"(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

"(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

"(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates are payable during the year—

"(aa) for the indirect costs of medical education under section 1886(d)(5)(B); and

"(bb) for direct graduate medical education costs under section 1886(h).

"(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

"(b) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

"(1) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

"(A) The benchmark amount for each MedicareAdvantage payment area (as calculated under subsection (a)(4)) for the year.

"(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each MedicareAdvantage payment area for the year.

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

"(A) provide for notice to MedicareAdvantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

"(B) provide such organizations with an opportunity to comment on such proposed changes.

"(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicareAdvantage organizations can compute each payment factor described in paragraph (1).

"(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

"(1) IN GENERAL.—For purposes of making payments under this part for years before 2006 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area before 2006 or a MedicareAdvantage payment area beginning with such year for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

"(A) BLENDED CAPITATION RATE.—The sum of—

"(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the MedicareAdvantage payment area, as determined under paragraph (3) for the year; and

"(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied by the budget neutrality adjustment factor determined under paragraph (5).

"(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

"(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

"(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

"(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

"(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

"(iv) For 2002 through 2013, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

"(v) For 2014 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

"(C) MINIMUM PERCENTAGE INCREASE.—

"(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

"(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

"(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

"(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent;

"(B) for 1999, the 'area-specific percentage' is 82 percent and the 'national percentage' is 18 percent;

"(C) for 2000, the 'area-specific percentage' is 74 percent and the 'national percentage' is 26 percent;

"(D) for 2001, the 'area-specific percentage' is 66 percent and the 'national percentage' is 34 percent;

"(E) for 2002, the 'area-specific percentage' is 58 percent and the 'national percentage' is 42 percent; and

"(F) for a year after 2002, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

"(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

"(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

"(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

"(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

"(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

"(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

"(I) 1998 is 20 percent;

"(II) 1999 is 40 percent;

"(III) 2000 is 60 percent;

"(IV) 2001 is 80 percent; and

"(V) a succeeding year is 100 percent.

"(C) PAYMENT ADJUSTMENT.—

"(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

"(I) for the indirect costs of medical education under section 1886(d)(5)(B); and

"(II) for direct graduate medical education costs under section 1886(h).

"(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

"(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

"(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

"(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year;

"(ii) the proportion of such rate for the year which is attributable to such type of services; and

"(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

"(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the 'national standardized annual Medicare+Choice capitation rate' for a year is equal to—

"(i) the sum (for all Medicare+Choice payment areas) of the product of—

"(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3); and

"(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

"(ii) the sum of the products described in clause (i)(II) for all areas for that year.

"(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

"(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

"(A) IN GENERAL.—In this part, the 'national per capita Medicare+Choice growth percentage' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

"(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

"(i) for 1998, 0.8 percentage points;

"(ii) for 1999, 0.5 percentage points;

"(iii) for 2000, 0.5 percentage points;

"(iv) for 2001, 0.5 percentage points;

"(v) for 2002, 0.3 percentage points; and

"(vi) for a year after 2002, 0 percentage points.

"(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

"(7) TRANSITION TO MEDICAREADVANTAGE COMPETITION.—

"(A) IN GENERAL.—For each year (beginning with 2006) payments to MedicareAdvantage plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

"(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2006) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1) for purposes of determining the benchmark amount under subsection (a)(4).

"(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT.—

"(1) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under section 1854(a) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part an are based on the assumptions described in section 1854(a)(2)(A)(iii).

"(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for the benefits under the original medicare fee-for-service program option for each plan equal to the weighted average of the benchmark amounts for benefits under such original medicare fee-for-service program option for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii).

"(3) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the weighted service area benchmark amount (as determined under paragraph (2)) for purposes of determining—

"(A) the payment amount under paragraph (4); and

"(B) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

"(4) DETERMINATION OF PAYMENT AMOUNT FOR ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the payment amount for MedicareAdvantage plans for the benefits under the original medicare fee-for-service program option as follows:

"(i) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount.

"(ii) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

"(B) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall adjust the amounts determined under subparagraph (A) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

"(6) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Secretary of the actuarial costs associated with the new benefits.

"(7) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—For purposes of this part, the term 'benefits under the original medicare fee-for-service program option' means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to, or enrolled for, benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.

"(e) MEDICAREADVANTAGE PAYMENT AREA DEFINED.—

"(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'MedicareAdvantage payment area' means a county, or equivalent area specified by the Secretary.

"(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicareAdvantage payment area shall be a State or such other payment area as the Secretary specifies.

"(3) GEOGRAPHIC ADJUSTMENT.—

"(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 2005) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a MedicareAdvantage payment area in the State otherwise determined under paragraph (1)—

"(i) to a single statewide MedicareAdvantage payment area;

"(ii) to the metropolitan based system described in subparagraph (C); or

"(iii) to consolidating into a single MedicareAdvantage payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

"(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for MedicareAdvantage payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicareAdvantage payment areas in the State in the absence of the adjustment under this paragraph.

"(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

"(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicareAdvantage payment area; and

"(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicareAdvantage payment area.

"(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

"(f) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

"(1) IN GENERAL.—If the amount of the MedicareAdvantage monthly MSA premium (as defined in section 1854(b)(2)(D)) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicareAdvantage MSA established (and, if applicable, designated) by the individual under paragraph (2).

"(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

"(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicareAdvantage MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986); and

"(B) if the individual has established more than 1 such MedicareAdvantage MSA, has designated 1 of such accounts as the individual's MedicareAdvantage MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

"(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicareAdvantage MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

"(g) PAYMENTS FROM TRUST FUNDS.—Except as provided in section 1858A(c) (relating to payments for qualified prescription drug coverage), the payment to a MedicareAdvantage organization under this section for individuals enrolled under this part with the organization and payments to a MedicareAdvantage MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

"(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

"(1) election under this part of a MedicareAdvantage plan offered by a MedicareAdvantage organization—

"(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicareAdvantage plan or the original medicare fee-for-service program option (as the case may be) elected before the election with such organization,

"(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge; and

"(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

"(2) termination of election with respect to a MedicareAdvantage organization under this part—

"(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge;

"(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicareAdvantage organization; and

"(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

"(i) SPECIAL RULE FOR HOSPICE CARE.—

"(1) INFORMATION.—A contract under this part shall require the MedicareAdvantage organization to inform each individual enrolled under this part with a MedicareAdvantage plan offered by the organization about the availability of hospice care if—

"(A) a hospice program participating under this title is located within the organization's service area; or

"(B) it is common practice to refer patients to hospice programs outside such service area.

"(2) PAYMENT.—If an individual who is enrolled with a MedicareAdvantage organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

"(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

"(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the MedicareAdvantage organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

"(C) the Secretary shall continue to make monthly payments to the MedicareAdvantage organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).".

SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

Section 1854 (42 U.S.C. 1395w–24) is amended to read as follows:

"SUBMISSION OF BIDS; PREMIUMS

"SEC. 1854. (a) SUBMISSION OF BIDS BY MEDICAREADVANTAGE ORGANIZATIONS.—

"(1) IN GENERAL.—Not later than the second Monday in September and except as provided in paragraph (3), each MedicareAdvantage organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each MedicareAdvantage plan that the organization intends to offer in a service area in the following year—

"(A) notice of such intent and information on the service area of the plan;

"(B) the plan type for each plan;

"(C) if the MedicareAdvantage plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

"(D) the enrollment capacity (if any) in relation to the plan and each payment area;

"(E) the expected mix, by health status, of enrolled individuals; and

"(F) such other information as the Secretary may specify.

"(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a MedicareAdvantage plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

"(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Information relating to the coverage of benefits under the original medicare fee-for-service program option as follows:

"(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under the original medicare fee-for-service program option to an individual enrolled in the plan that resides in the service area of the plan for a month.

"(ii) For the enhanced medical benefits package offered—

"(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

"(II) the portion of the actuarial value of such benefits package (if any) that will be applied toward satisfying the requirement for additional benefits under subsection (g);

"(III) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (as defined in subsection (b)(2)(C));

"(IV) a description of any cost-sharing;

"(V) a description of whether the amount of the unified deductible has been lowered or the maximum limitations on out-of-pocket expenses have been decreased (relative to the levels used in calculating the plan bid);

"(VI) such other information as the Secretary considers necessary.

"(iii) The assumptions that the MedicareAdvantage organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

"(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—The information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

‘‘(C) DETERMINING PLAN COSTS INCLUDED IN PLAN BID.—For purposes of submitting its plan bid under subparagraph (A)(i) a MedicareAdvantage plan offered by a MedicareAdvantage organization satisfies subparagraphs (A) and (C) of section 1852(a)(1) if the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled in such plan under this part with respect to benefits under the original medicare fee-for-service program option on which that bid is based (ignoring any reduction in cost-sharing offered by such plan as enhanced medical benefits under paragraph (2)(A)(ii) or required under clause (ii) or (iii) of subsection (g)(1)(C)) equals the amount specified in subsection (f)(1)(B).

‘‘(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted.

‘‘(4) REVIEW.—

‘‘(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the MedicareAdvantage organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

‘‘(B) MSA EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3).

‘‘(C) CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—Under the authority under subparagraph (A), the Secretary may disapprove the bid if the Secretary determines that the deductibles, coinsurance, or copayments applicable under the plan discourage access to covered services or are likely to result in favorable selection of MedicareAdvantage eligible individuals.

‘‘(5) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under paragraph (1) for a MedicareAdvantage plan must reasonably and equitably reflect the cost of benefits provided under that plan.

‘‘(b) MONTHLY PREMIUMS CHARGED.—

‘‘(1) IN GENERAL.—

‘‘(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization shall be equal to the sum of the following:

‘‘(i) The MedicareAdvantage monthly basic beneficiary premium (if any).

‘‘(ii) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (if any).

‘‘(iii) The MedicareAdvantage monthly obligation for qualified prescription drug coverage (if any).

‘‘(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

‘‘(2) PREMIUM TERMINOLOGY.—For purposes of this part:

‘‘(A) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term ‘MedicareAdvantage monthly basic beneficiary premium’ means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (d)(2) for the plan.

‘‘(B) MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term ‘MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage’ means, with respect to a MedicareAdvantage plan, the amount determined under section 1858A(d).

‘‘(C) MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The term ‘MedicareAdvantage monthly beneficiary premium for enhanced medical benefits’ means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

‘‘(D) MEDICAREADVANTAGE MONTHLY MSA PREMIUM.—The term ‘MedicareAdvantage monthly MSA premium’ means, with respect to a MedicareAdvantage plan, the amount of such premium filed under subsection (a)(3) for the plan.

‘‘(c) UNIFORM PREMIUM.—The MedicareAdvantage monthly basic beneficiary premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and the MedicareAdvantage monthly MSA premium charged under subsection (b) of a MedicareAdvantage organization under this part may not vary among individuals enrolled in the plan.

‘‘(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

‘‘(1) BIDS BELOW THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the weighted service area benchmark amount exceeds the plan bid, the Secretary shall require the plan to provide additional benefits in accordance with subsection (g).

‘‘(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be the MedicareAdvantage monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).

‘‘(e) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicareAdvantage organization shall permit the payment of any MedicareAdvantage monthly basic premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits on a monthly basis, may terminate election of individuals for a MedicareAdvantage plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in subsection (g)(1)(C)(i)).

‘‘(f) LIMITATION ON ENROLLEE LIABILITY.—

‘‘(1) FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—The sum of—

‘‘(A) the MedicareAdvantage monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (determined on the same basis as used in determining the plan's bid under paragraph (2)(C)) applicable on average to individuals enrolled under this part with a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A); must equal

‘‘(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive benefits under the original medicare fee-for-service program option if such individuals were not members of a MedicareAdvantage organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).

‘‘(2) FOR ENHANCED MEDICAL BENEFITS.—If the MedicareAdvantage organization provides to its members enrolled under this part in a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) with respect to enhanced medical benefits relating to benefits under the original medicare fee-for-service program option, the sum of the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year minus the actuarial value of any additional benefits pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C) that the plan specified under subsection (a)(2)(i)(II).

‘‘(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the same geographic area, the State, or in the United States, eligible to enroll in the MedicareAdvantage plan involved under this part or on the basis of other appropriate data.

‘‘(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a MedicareAdvantage private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

‘‘(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1852(a)(1); exceed

‘‘(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if they were not members of a MedicareAdvantage organization for the year.

‘‘(g) REQUIREMENT FOR ADDITIONAL BENEFITS.—

‘‘(1) REQUIREMENT.—

‘‘(A) IN GENERAL.—Each MedicareAdvantage organization (in relation to a MedicareAdvantage plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits described in subparagraph (C) as the organization may specify in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (D)).

"(B) EXCESS AMOUNT.—For purposes of this paragraph, the term 'excess amount' means, for an organization for a plan, is 100 percent of the amount (if any) by which the weighted service area benchmark amount (determined under section 1853(d)(2)) exceeds the plan bid (as adjusted under section 1853(d)(1)).

"(C) ADDITIONAL BENEFITS DESCRIBED.—The additional benefits described in this subparagraph are as follows:

"(i) Subject to subparagraph (F), a monthly part B premium reduction for individuals enrolled in the plan.

"(ii) Lowering the amount of the unified deductible and decreasing the maximum limitations on out-of-pocket expenses for individuals enrolled in the plan.

"(iii) A reduction in the actuarial value of plan cost-sharing for plan enrollees.

"(iv) Subject to subparagraph (E), such additional benefits as the organization may specify.

"(v) Contributing to the stabilization fund under paragraph (2).

"(vi) Any combination of the reductions and benefits described in clauses (i) through (v).

"(D) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the term 'adjusted excess amount' means, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

"(E) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

"(F) PREMIUM REDUCTIONS.—

"(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a MedicareAdvantage organization may elect a reduction in its payments under section 1853(a)(1)(A)(i) with respect to a MedicareAdvantage plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

"(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a MedicareAdvantage plan—

"(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

"(II) shall apply uniformly to each enrollee of the MedicareAdvantage plan to which such reduction applies.

"(G) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

"(H) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicareAdvantage organization from providing enhanced medical benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such enhanced medical benefits.

"(2) STABILIZATION FUND.—A MedicareAdvantage organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicareAdvantage plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such Trust Funds.

"(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term 'adjusted community rate' for a service or services means, at the election of a MedicareAdvantage organization, either—

"(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicareAdvantage plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)); or

"(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicareAdvantage coverage, or MedicareAdvantage eligible individuals in the area, in the State, or in the United States, eligible to elect MedicareAdvantage coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

"(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine the average amount of payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

"(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments to MedicareAdvantage organizations under section 1853.

"(i) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a MedicareAdvantage organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of 1 or more MedicareAdvantage payment areas.".

(b) STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Secretary, in consultation with beneficiaries, consumer groups, employers, and Medicare+Choice organizations, shall conduct a study to determine the extent to which the cost-sharing structures under Medicare+Choice plans under part C of title XVIII of the Social Security Act discourage access to covered services or discriminate based on the health status of Medicare+Choice eligible individuals (as defined in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3))).

(2) REPORT.—Not later than December 31, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS.

Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

"SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

"SEC. 1858A. (a) AVAILABILITY.—

"(1) PLANS REQUIRED TO PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE TO ENROLLEES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), on and after January 1, 2006, a MedicareAdvantage organization offering a MedicareAdvantage plan (except for an MSA plan) shall make available qualified prescription drug coverage that meets the requirements for such coverage under this part and part D to each enrollee of the plan.

"(B) PRIVATE FEE-FOR-SERVICE PLANS MAY, BUT ARE NOT REQUIRED TO, PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE.—Pursuant to section 1852(a)(2)(D), a private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

"(2) REFERENCE TO PROVISION PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—For the provisions of part D, made applicable to this part pursuant to paragraph (1), that permit a plan to make available qualified prescription drug coverage that includes coverage of covered drugs that exceeds the coverage required under paragraph (1) of section 1860D–6 in an area, but only if the MedicareAdvantage organization offering the plan also offers a MedicareAdvantage plan in the area that only provides the coverage that is required under such paragraph (1), see paragraph (2) of such section.

"(3) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Pursuant to sections 1854(g)(1)(F) and 1852(a)(3)(D), a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage may not make available coverage of any prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option) to an enrollee as an additional benefit or as an enhanced medical benefit.

"(b) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a MedicareAdvantage organization under a MedicareAdvantage plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, and such other requirements under part D that the Secretary determines appropriate in the same manner as such requirements apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or the plan under this part.

"(c) PAYMENTS FOR PRESCRIPTION DRUGS.—

"(1) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—For each year (beginning with 2006), the Secretary shall pay to each MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

"(B) APPLICATION OF PART D RISK CORRIDOR, STABILIZATION RESERVE FUND, AND ADMINISTRATIVE EXPENSES PROVISIONS.—The provisions of subsections (b), (c), and (d) of section 1860D–16 shall apply to a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage and payments made to such organization under subparagraph (A) in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan and payments made to such entity under subsection (a) of section 1860D–16.

"(2) PAYMENT FROM PRESCRIPTION DRUG ACCOUNT.—Payment made to MedicareAdvantage organizations under this subsection shall be made from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

"(d) COMPUTATION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a MedicareAdvantage eligible individual receiving qualified prescription drug coverage under a MedicareAdvantage plan during a year after 2005, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage of such individual in the year shall be determined in the same manner as the monthly beneficiary obligation is determined under section 1860D–17 for eligible beneficiaries enrolled in a Medicare Prescription Drug plan, except that, for purposes of this subparagraph, any reference to the monthly plan premium approved by the Secretary under section 1860D–13 shall be treated as a reference to the monthly premium for qualified prescription drug coverage submitted by the MedicareAdvantage organization offering the plan under section 1854(a)(2)(A) and approved by the Secretary.

"(e) COLLECTION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D–18, including subsection (b) of such section, shall apply to the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage (as determined under subsection (d)) required to be paid by a MedicareAdvantage eligible individual enrolled in a MedicareAdvantage plan in the same manner as such provisions apply to the amount of the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan under part D.

"(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND REINSURANCE PAYMENTS.—For provisions—

"(1) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–19; and

"(2) providing a MedicareAdvantage organization with reinsurance payments for certain expenses incurred in providing qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–20.".

(b) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking "section 1854(f)(1)(E)" and inserting "section 1854(d)(1)(A)(i)".

SEC. 206. FACILITATING EMPLOYER PARTICIPATION.

Section 1858(h) (as added by section 211) is amended by inserting "(including subsection (i) of such section)" after "section 1857".

SEC. 207. ADMINISTRATION BY THE CENTER FOR MEDICARE CHOICES.

On and after January 1, 2006, the MedicareAdvantage program under part C of title XVIII of the Social Security Act shall be administered by the Center for Medicare Choices established under section 1808 such title (as added by section 301), and each reference to the Secretary made in such part shall be deemed to be a reference to the Administrator of the Center for Medicare Choices.

SEC. 208. CONFORMING AMENDMENTS.

(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS.—Section 1855 (42 U.S.C. 1395w–25) is amended—

(1) in subsection (b), in the matter preceding paragraph (1), by inserting "subparagraphs (A), (B), and (D) of" before "section 1852(A)(1)"; and

(2) by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

(b) ESTABLISHMENT OF PSO STANDARDS.—Section 1856 (42 U.S.C. 1395w–26) is amended by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZATIONS.—Section 1857 (42 U.S.C. 1395w–27) is amended—

(1) in subsection (g)(1)—

(A) in subparagraph (B), by striking "amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums" and inserting "amounts of the MedicareAdvantage monthly basic premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits";

(B) in subparagraph (F), by striking "or" after the semicolon at the end;

(C) in subparagraph (G), by adding "or" after the semicolon at the end; and

(D) by inserting after subparagraph (G) the following new subparagraph:

"(H)(i) charges any individual an amount in excess of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage under section 1858A(d);

"(ii) provides coverage for prescription drugs that is not qualified prescription drug coverage;

"(iii) offers prescription drug coverage, but does not make standard prescription drug coverage available; or

"(iv) provides coverage for prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option described in section 1851(a)(1)(A)(i)) as an enhanced medical benefit under section 1852(a)(3)(D) or as an additional benefit under section 1854(g)(1)(F)."; and

(2) by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

(d) DEFINITIONS; MISCELLANEOUS PROVISIONS.—Section 1859 (42 U.S.C. 1395w–28) is amended—

(1) by striking subsection (c) and inserting the following new subsection:

"(c) OTHER REFERENCES TO OTHER TERMS.—

"(1) ENHANCED MEDICAL BENEFITS.—The term 'enhanced medical benefits' is defined in section 1852(a)(3)(E).

"(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—The term 'MedicareAdvantage eligible individual' is defined in section 1851(a)(3).

"(3) MEDICAREADVANTAGE PAYMENT AREA.—The term 'MedicareAdvantage payment area' is defined in section 1853(d).

"(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The 'national per capita Medicare+Choice growth percentage' is defined in section 1853(c)(6).

"(5) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The terms 'MedicareAdvantage monthly basic beneficiary premium', 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage', and 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' are defined in section 1854(b)(2).

"(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' has the meaning given such term in section 1860D(9).

"(7) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' has the meaning given such term in section 1860D(10)."; and

(2) by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

(e) CONFORMING AMENDMENTS EFFECTIVE BEFORE 2006.—

(1) EXTENSION OF MSAS.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended by striking "January 1, 2003" and inserting "January 1, 2004".

(2) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2)(A), by striking "THROUGH 2004" and "December 31,2004" and inserting "THROUGH 2005" and "December 31, 2005", respectively;

(B) in the heading of paragraph (2)(B), by striking "DURING 2005" and inserting "DURING 2006";

(C) in paragraphs (2)(B)(i) and (2)(C)(i), by striking "2005" and inserting "2006" each place it appears;

(D) in paragraph (2)(D), by striking "2004" and inserting "2005"; and

(E) in paragraph (4), by striking "2005" and inserting "2006" each place it appears.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of enactment of this Act.

(e) OTHER CONFORMING AMENDMENTS.—

(1) CONFORMING MEDICARE CROSS-REFERENCES.—

(A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking "section 1854(f)(1)(E)" and inserting "section 1854(g)(1)(C)(i)".

(B) Section 1840(i) (42 U.S.C. 1395s(i)) is amended by striking "section 1854(f)(1)(E)" and inserting "section 1854(g)(1)(C)(i)".

(C) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by striking "section 1854(f)(1)(E)" and inserting "section 1854(g)(1)(C)(i)".

(D) Section 1876(k)(3)(A) (42 U.S.C. 1395mm(k)(3)(A)) is amended by inserting "(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)" after section 1853(a).

(F) Section 1876(k)(4) (42 U.S.C. 1395mm(k)(4)(A)) is amended—

(i) in subparagraph (A), by striking "section 1853(a)(3)(B)" and inserting "section 1853(a)(3)(D)"; and

(ii) in subparagraph (B), by striking "section 1854(g)" and inserting "section 1854(h)".

(G) Section 1876(k)(4)(C) (42 U.S.C. 1395mm(k)(4)(C)) in amended by inserting "(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)" after "section 1851(e)(6)".

(H) Section 1894(d) (42 U.S.C. 1395eee(d)) is amended by adding at the end the following new paragraph:

"(3) Application of provisions.—For purposes of paragraphs (1) and (2), the references to section 1853 and subsection (a)(2) of such section in such paragraphs shall be deemed to be references to those provisions as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003.".

(2) Conforming medicare terminology.—Title XVIII (42 U.S.C. 1395 et seq.), except for part C of such title (42 U.S.C. 1395w–21 et seq.), and title XIX (42 U.S.C. 1396 et seq.) are each amended by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

SEC. 209. EFFECTIVE DATE.

(a) In General.—Except as provided in section 208(d)(3) and subsection (b), the amendments made by this title shall apply with respect to plan years beginning on and after January 1, 2006.

(b) MedicareAdvantage MSA Plans.—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if this title had not been enacted.

Subtitle B—Preferred Provider Organizations

SEC. 211. ESTABLISHMENT OF MEDICAREADVANTAGE PREFERRED PROVIDER PROGRAM OPTION.

(a) Establishment of Preferred Provider Program Option.—Section 1851(a)(2) is amended by adding at the end the following new subparagraph:

"(D) Preferred provider organization plans.—A MedicareAdvantage preferred provider organization plan under the program established under section 1858.".

(b) Program Specifications.—Part C of title XVIII (42 U.S.C. 1395w-21 et seq.) is amended by inserting after section 1857 the following new section:

"PREFERRED PROVIDER ORGANIZATIONS

"Sec. 1858. (a) Establishment of Program.—

"(1) In general.—Beginning on January 1, 2006, there is established a preferred provider program under which preferred provider organization plans offered by preferred provider organizations are offered to MedicareAdvantage eligible individuals in preferred provider regions.

"(2) Definitions.—

"(A) Preferred provider organization.—The term 'preferred provider organization' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to preferred provider organizations.

"(B) Preferred provider organization plan.—The term 'preferred provider organization plan' means a MedicareAdvantage plan that—

"(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

"(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

"(iii) is offered by a preferred provider organization.

"(C) Preferred provider region.—The term 'preferred provider region' means—

"(i) a region established under paragraph (3); and

"(ii) a region that consists of the entire United States.

"(3) Preferred provider regions.—For purposes of this part the Secretary shall establish preferred provider regions as follows:

"(A) There shall be at least 10 regions.

"(B) Each region must include at least 1 State.

"(C) The Secretary may not divide States so that portions of the State are in different regions.

"(D) To the extent possible, the Secretary shall include multistate metropolitan statistical areas in a single region. The Secretary may divide metropolitan statistical areas where it is necessary to establish regions of such size and geography as to maximize the participation of preferred provider organization plans.

"(E) The Secretary may conform the preferred provider regions to the service areas established under section 1860D–10.

"(b) Eligibility, Election, and Enrollment; Benefits and Beneficiary Protections.—

"(1) In general.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to preferred provider organization plans offered by a preferred provider organization.

"(2) Service area.—The service area of a preferred provider organization plan shall be a preferred provider region.

"(3) Availability.—Each preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

"(4) Authority to prohibit risk selection.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

"(5) Assuring access to services in preferred provider organization plans.—

"(A) In general.—In addition to any other requirements under this section, in the case of a preferred provider organization plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.

"(B) Determination of sufficient access.—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

"(C) Construction.—Subparagraph (B) shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

"(c) Payments to Preferred Provider Organizations.—

"(1) Payments to organizations.—

"(A) Monthly payments.—

"(i) In general.—Under a contract under section 1857 and subject to paragraph (5), subsection (e), and section 1859(e)(4), the Secretary shall make, to each preferred provider organization, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

"(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

"(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

"(ii) Special rule for end-stage renal disease.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a preferred provider organization plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

"(B) Adjustment to reflect number of enrollees.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

"(C) Comprehensive risk adjustment methodology.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

"(D) Adjustment for spending variations within a region.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

"(2) Annual calculation of benchmark amounts for preferred provider regions.—For each year (beginning in 2006), the Secretary shall calculate a benchmark amount for each preferred provider region for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the average of each benchmark amount calculated under section 1853(a)(4) for each MedicareAdvantage payment area for the year within such region, weighted by the number of MedicareAdvantage eligible individuals residing in each such payment area for the year.

"(3) Annual announcement of payment factors.—

"(A) Annual announcement.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

"(i) The benchmark amount for each preferred provider region (as calculated under paragraph (2)(A)) for the year.

"(ii) The factors to be used for adjusting payments described under—

"(I) the comprehensive risk adjustment methodology described in paragraph (1)(C) with respect to each preferred provider region for the year; and

“(II) the methodology used for adjustment for geographic variations within such region established under paragraph (1)(D).

“(B) Advance notice of methodological changes.—At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall—

“(i) provide for notice to preferred provider organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

“(ii) provide such organizations with an opportunity to comment on such proposed changes.

“(C) Explanation of assumptions.—In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that preferred provider organizations can compute each payment factor described in such subparagraph.

“(4) Secretary's determination of payment amount for benefits under the original medicare fee-for-service program.—The Secretary shall determine the payment amount for plans as follows:

“(A) Review of plan bids.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

“(B) Determination of preferred provider regional benchmark amounts.—The Secretary shall calculate a preferred provider regional benchmark amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

“(C) Comparison to benchmark.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

“(i) the payment amount under subparagraph (D); and

“(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

“(D) Determination of payment amount.—

“(i) In general.—Subject to clause (ii), the Secretary shall determine the payment amount to a preferred provider organization for a preferred provider organization plan as follows:

“(I) Bids that equal or exceed the benchmark.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

“(II) Bids below the benchmark.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

“(ii) Application of adjustment methodologies.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in paragraph (3)(A)(ii).

“(E) Factors used in adjusting bids and benchmarks for preferred provider organizations and in determining enrollee premiums.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

“(F) Adjustment for national coverage determinations and legislative changes in benefits.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to preferred provider organizations in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

“(5) Payments from trust fund.—The payment to a preferred provider organization under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

“(6) Special rule for certain inpatient hospital stays.—Rules similar to the rules applicable under section 1853(h) shall apply with respect preferred provider organizations.

“(7) Special rule for hospice care.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to preferred provider organizations.

“(d) Submission of Bids by PPOs; Premiums.—

“(1) Submission of bids by preferred provider organizations.—

“(A) In general.—For the requirements on submissions by MedicareAdvantage preferred provider organization plans, see section 1854(a)(1).

“(B) Uniform premiums.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

“(C) Application of FEHBP standard; prohibition on price gouging.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan must reasonably and equitably reflect the cost of benefits provided under that plan.

“(D) Review.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the preferred provider organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

“(E) Authority to limit number of plans in a region.—If there are bids for more than 3 preferred provider organization plans in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

“(2) Monthly premiums charged.—The amount of the monthly premium charged to an individual enrolled in a preferred provider organization plan offered by a preferred provider organization shall be equal to the sum of the following:

“(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

“(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

“(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

“(3) Determination of premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

“(4) Prohibition of segmenting preferred provider regions.—The Secretary may not permit a preferred provider organization to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

“(e) Portion of Total Payments to an Organization Subject to Risk for 2 Years.—

“(1) Notification of spending under the plan.—

“(A) In general.—For 2007 and 2008, the preferred provider organization offering a preferred provider organization plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

“(B) Certain expenses not included.—The total amount of costs specified in subparagraph (A) may not include—

“(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

“(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

“(C) Establishment of allowable administrative expenses.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a preferred provider organization plan may not exceed an amount determined appropriate by the Administrator.

“(2) Adjustment of payment.—

“(A) No adjustment if costs within risk corridor.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the preferred provider organization offering the plan.

“(B) Increase in payment if costs above upper limit of risk corridor.—

“(i) In general.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

"(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

"(II) 90 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

"(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

"(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

"(ii) 90 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

"(3) ESTABLISHMENT OF RISK CORRIDORS.—

"(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to a range as follows:

"(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 5 percent of such target amount.

"(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 10 percent of such target amount.

"(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (i)(II).

"(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (ii)(II).

"(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a preferred provider organization plan offered by a preferred provider organization in a year, an amount equal to the sum of—

"(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

"(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

"(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A preferred provider organization that offers a preferred provider organization plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

"(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

"(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a preferred provider organization and a preferred provider organization plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

"(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATIONS.—A preferred provider organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a preferred provider organization plan.

"(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to preferred provider organizations.

"(h) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—The provisions of section 1857 shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.".

(c) PREFERRED PROVIDER TERMINOLOGY DEFINED.—Section 1859(a) is amended by adding at the end the following new paragraph:

"(3) PREFERRED PROVIDER ORGANIZATION; PREFERRED PROVIDER ORGANIZATION PLAN; PREFERRED PROVIDER REGION.—The terms 'preferred provider organization', 'preferred provider organization plan', and 'preferred provider region' have the meaning given such terms in section 1858(a)(2).".

Subtitle C—Other Managed Care Reforms

SEC. 221. EXTENSION OF REASONABLE COST CONTRACTS.

(a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended by striking "2004" and inserting "2009".

(b) APPLICATION OF CERTAIN MEDICARE+CHOICE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Prescription Drug and Medicare Improvements Act of 2003 for plan years beginning on or after January 1, 2004, shall provide that the following provisions of the Medicare+Choice program under part C (and, on and after January 1, 2006, the provisions of the MedicareAdvantage program under such part) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare+Choice organizations and Medicare+Choice plans (or, on and after January 1, 2006, MedicareAdvantage organizations and MedicareAdvantage plans, respectively) under such part:

"(A) Paragraph (1) of section 1852(e) (relating to the requirement of having an ongoing quality assurance program) and paragraph (2)(B) of such section (relating to the required elements for such a program).

"(B) Section 1852(j)(4) (relating to limitations on physician incentive plans).

"(C) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

"(D) Section 1854(g), or, on and after January 1, 2006, section 1854(h) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

"(E) Section 1856(b) (regarding compliance with the standards established by regulation pursuant to such section, including the provisions of paragraph (3) of such section relating to relation to State laws).

"(F) Section 1852(a)(3)(A) (regarding the authority of organizations to include supplemental health care benefits and, on and after January 1, 2006, enhanced medical benefits under the plan subject to the approval of the Secretary).

"(G) The provisions of part C relating to timelines for benefit filings, contract renewal, and beneficiary notification.

"(H) Section 1854(e), or, on and after January 1, 2006, section 1854(f) (relating to proposed cost-sharing under the contract being subject to review by the Secretary).".

(c) PERMITTING DEDICATED GROUP PRACTICE HEALTH MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE MEDICARE COST CONTRACT PROGRAM.—Section 1876(h)(6) of the Social Security Act (42 U.S.C. 1395mm(h)(6)), as redesignated and amended by subsections (a) and (b), is amended—

(1) in subparagraph (A), by striking "After the date of the enactment" and inserting "Except as provided in subparagraph (C), after the date of the enactment";

(2) in subparagraph (B), by striking "subparagraph (C)" and inserting "subparagraph (D)";

(3) by redesignating subparagraph (C) as subparagraph (D); and

(4) by inserting after subparagraph (B), the following new subparagraph:

"(C) Subject to paragraph (5) and subparagraph (D), the Secretary shall approve an application to enter into a reasonable cost contract under this section if—

"(i) the application is submitted to the Secretary by a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act) that, as of January 1, 2004, and except as provided in section 1301(b)(3)(B) of such Act, provides at least 85 percent of the services of a physician which are provided as basic health services through a medical group (or groups), as defined in section 1302(4) of such Act; and

"(ii) the Secretary determines that the organization meets the requirements applicable to such organizations and contracts under this section.".

SEC. 222. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: "Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.".

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–28(b)) is amended by adding at the end the following new paragraph:

"(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

"(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

"(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

"(i) is institutionalized (as defined by the Secretary);

"(ii) is entitled to medical assistance under a State plan under title XIX; or

"(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.".

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

"(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2008, the plan may restrict the enrollment of individuals under the plan to individuals who are within 1 or more classes of special needs beneficiaries.".

(d) REPORT TO CONGRESS.—Not later than December 31, 2006, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 1 year after the date of enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 223. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking "part C or" and inserting "part C, with a PACE provider under section 1894 or 1934, or";

(B) by striking "(i)";

(C) by striking "and (ii)"; and

(D) by striking "members of the organization" and inserting "members of the organization or PACE program eligible individuals enrolled with the PACE provider,".

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

"(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

"(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

"(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).".

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (64), by striking "and" at the end;

(B) in paragraph (65), by striking the period at the end and inserting "; and"; and

(C) by inserting after paragraph (65) the following new paragraph:

"(66) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).".

(2) REFERENCE IN MEDICAID STATUTE.—Section 1934(b) (42 U.S.C. 1396u–4(b)) is amended by adding at the end the following new paragraphs:

"(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

"(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

"(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than the date that is 2 months after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the "Institute") shall conduct an evaluation of leading health care performance measures and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) catalogue, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance; and

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, health plans, purchasers, and consumers.

(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act, the Institute shall submit to the Secretary of Health and Human Services, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare+Choice program under part C of such title, and any other programs under such title XVIII.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for purposes of conducting the evaluation and preparing the report required by this section.

SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c–3(a)(1)) is amended by inserting ", Medicare+Choice organizations and MedicareAdvantage organizations under part C, and prescription drug card sponsors and eligible entities under part D" after "under section 1876".

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

"(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, prescription drug card sponsors and eligible entities under part D, and Medicare+Choice and MedicareAdvantage plans under part C quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

TITLE III—CENTER FOR MEDICARE CHOICES

SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 111, is amended by inserting after 1806 the following new section:

"ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES

"SEC. 1808. (a) ESTABLISHMENT.—By not later than March 1, 2004, the Secretary shall establish within the Department of Health and Human Services the Center for Medicare Choices, which shall be separate from the Centers for Medicare & Medicaid Services.

"(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

"(1) ADMINISTRATOR.—

"(A) IN GENERAL.—The Center for Medicare Choices shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall report directly to the Secretary.

"(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

"(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Choices, and shall have authority and control over all personnel and activities thereof.

"(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Center for Medicare Choices. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

"(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Center for Medicare Choices as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

"(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Center for Medicare Choices as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

"(2) DEPUTY ADMINISTRATOR.—

"(A) IN GENERAL.—There shall be a Deputy Administrator of the Center for Medicare Choices who shall be appointed by the Administrator.

"(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be the Acting Administrator of the Center for Medicare Choices during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

"(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

"(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

"(1) DUTIES.—

"(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

"(i) negotiating, entering into, and enforcing, contracts with plans for the offering of MedicareAdvantage plans under part C, including the offering of qualified prescription drug coverage under such plans; and

"(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the offering of Medicare Prescription Drug plans under part D.

"(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including duties relating to—

"(i) reasonable cost contracts with eligible organizations under section 1876(h); and

"(ii) demonstration projects carried out in part or in whole under such parts, including the demonstration project carried out through a MedicareAdvantage (formerly Medicare+Choice) project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(C) NONINTERFERENCE.—In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may not, to the extent possible, interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs.

"(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

"(2) MANAGEMENT STAFF.—

"(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ such management staff as determined appropriate. Any such manager shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in the following areas:

"(i) The review, negotiation, and administration of health care contracts.

"(ii) The design of health care benefit plans.

"(iii) Actuarial sciences.

"(iv) Compliance with health plan contracts.

"(v) Consumer education and decision making.

"(B) COMPENSATION.—

"(i) IN GENERAL.—Subject to clause (ii), the Administrator shall establish the rate of pay for an individual employed under subparagraph (A).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

"(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

"(A) IN GENERAL.—The Secretary, the Administrator of the Center for Medicare Choices, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator of the Center for Medicare Choices as is appropriate to carry out the purposes of this section.

"(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator requires to carry out the duties described in paragraph (1).

“(C) Construction.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

“(d) Office of Beneficiary Assistance.—

“(1) Establishment.—The Secretary shall establish within the Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Center for Medicare Choices.

“(2) Dissemination of information on benefits and appeals rights.—

“(A) Dissemination of benefits information.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Center for Medicare Choices, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

“(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

“(ii) Benefits, and limitations on payment under parts A, and B, including information on medicare supplemental policies under section 1882.

“(iii) Other areas determined to be appropriate by the Administrator.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, and D, and medicare supplemental policies with benefits under MedicareAdvantage plans under part C.

“(B) Dissemination of appeals rights information.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the MedicareAdvantage program under part C, and the voluntary prescription drug delivery program under part D.

“(3) Medicare ombudsman.—

“(A) In general.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

“(B) Duties.—The Medicare Ombudsman shall—

“(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

“(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

“(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MedicareAdvantage organization, an eligible entity under part D, or the Secretary; and

“(II) assistance to such beneficiaries with any problems arising from disenrollment from a MedicareAdvantage plan under part C or a prescription drug plan under part D; and

“(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

“(C) Coordination with state ombudsman programs and consumer organizations.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

“(i) provide information about the medicare program; and

“(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

“(e) Medicare Competitive Policy Advisory Board.—

“(1) Establishment.—There is established within the Center for Medicare Choices the Medicare Competitive Policy Advisory Board (in this section referred to as the ‘Board’). The Board shall advise, consult with, and make recommendations to the Administrator with respect to the administration of parts C and D, including the review of payment policies under such parts.

“(2) Reports.—

“(A) In general.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

“(B) Topics described.—Reports required under subparagraph (A) may include the following topics:

“(i) Fostering competition.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

“(ii) Education and enrollment.—Recommendations for the improvement of efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

“(iii) Quality.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

“(iv) Disease management programs.—Recommendations on the incorporation of disease management programs under parts C and D.

“(v) Rural access.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

“(C) Maintaining independence of board.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

“(3) Duty of administrator.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

“(4) Membership.—

“(A) Appointment.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

“(i) Three members shall be appointed by the President.

“(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

“(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Committee on Finance of the Senate.

“(B) Qualifications.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

“(C) Prohibition on inclusion of federal employees.—No officer or employee of the United States may serve as a member of the Board.

“(5) Compensation.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

“(6) Terms of office.—

“(A) In general.—The term of office of members of the Board shall be 3 years.

“(B) Terms of initial appointees.—As designated by the President at the time of appointment, of the members first appointed—

“(i) one shall be appointed for a term of 1 year;

“(ii) three shall be appointed for terms of 2 years; and

“(iii) three shall be appointed for terms of 3 years.

“(C) Reappointments.—Any person appointed as a member of the Board may not serve for more than 8 years.

“(D) Vacancy.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

“(7) Chair.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

“(8) Meetings.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

“(9) Director and staff.—

“(A) Appointment of director.—The Board shall have a Director who shall be appointed by the Chair.

“(B) In general.—With the approval of the Board, the Director may appoint such additional personnel as the Director considers appropriate.

“(C) Assistance from the administrator.—The Administrator shall make available to the Board such information and other assistance as it may require to carry out its functions.

“(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

“(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.”.

(b) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: “By not later than 1 year after the date of the enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.”.

SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER AND CO-SECRETARY OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—The fifth sentence of sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking “shall serve as the Secretary” and inserting “and the Administrator of the Center for Medicare Choices shall serve as the Co-Secretaries”.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

“Administrator of the Centers for Medicare & Medicaid Services.”.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking “Administrator of the Health Care Financing Administration.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2004.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking “(iv) For discharges” and inserting “(iv)(I) Subject to the succeeding provisions of this clause, for discharges”; and

(2) by adding at the end the following new subclauses:

“(II) For discharges occurring during fiscal year 2004, the operating standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the operating standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

“(III) For discharges occurring in a fiscal year beginning with fiscal year 2005, the Secretary shall compute an operating standardized amount for hospitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.”.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking “IN DIFFERENT AREAS”;

(B) in the matter preceding clause (i), by striking “each of which is”;

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2005,” before “for hospitals”; and

(ii) in subclause (II), by striking “and” after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2005,” before “for hospitals”; and

(ii) in subclause (II), by striking the period at the end and inserting “; and”; and

(E) by adding at the end the following new clause:

“(iii) for a fiscal year beginning after fiscal year 2004, for hospitals located in all areas, to the product of—

“(I) the applicable operating standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

“(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.”.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting “, for fiscal years before fiscal year 1997,” before “a regional adjusted DRG prospective payment rate”; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting “, for fiscal years before fiscal year 1997,” before “a regional DRG prospective payment rate for each region,”.

SEC. 402. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking “WAGE LEVELS.—The Secretary” and inserting “WAGE LEVELS.—

“(i) IN GENERAL.—Except as provided in clause (ii), the Secretary”; and

(2) by adding at the end the following new clause:

“(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2004.—

“(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2003, the Secretary shall substitute ‘62 percent’ for the proportion described in the first sentence of clause (i).

“(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.”.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: “The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.”.

SEC. 403. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

“(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

“(A) PAYMENT ADJUSTMENT.—

“(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

“(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

“(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

“(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph; and

“(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

“(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term ‘low-volume hospital’ means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

“(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

“(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

“(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).”.

SEC. 404. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) Equalizing DSH Payment Amounts.—

(1) In general.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting ", and, after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(I)" in the matter preceding subclause (I).

(2) Conforming amendments.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xiii)";

(ii) in subclause (III)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xii)";

(iii) in subclause (IV)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (x) or (xi)";

(iv) in subclause (V)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (xi)"; and

(v) in subclause (VI)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (x)";

(B) in clause (viii), by striking "The formula" and inserting "For discharges occurring before October 1, 2003, the formula"; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "With respect to discharges occurring before October 1, 2004, for purposes".

(b) Effective Date.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

(a) Permitting CAHs To Allocate Swing Beds and Acute Care Inpatient Beds Subject to a Total Limit of 25 Beds.—

(1) In general.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as follows:

"(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;".

(2) Conforming amendment.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(3) Effective date.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2003.

(b) Elimination of the Isolation Test for Cost-Based CAH Ambulance Services.—

(1) Elimination.—

(A) In general.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) Effective date.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2004.

(2) Technical correction.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9).

(c) Coverage of Costs for Certain Emergency Room On-Call Providers.—

(1) In general.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services" and inserting "services covered under this title".

(2) Effective date.—The amendments made by paragraph (1) shall apply to costs incurred for services provided on or after January 1, 2004.

(d) Authorization of Periodic Interim Payment (PIP).—

(1) In general.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in subparagraph (C), by striking "and" after the semicolon at the end;

(B) in subparagraph (D), by adding "and" after the semicolon at the end; and

(C) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

(2) Effective date.—The amendments made by paragraph (1) shall apply to payments for inpatient critical access facility services furnished on or after January 1, 2004.

(e) Exclusion of New CAHs From PPS Hospital Wage Index Calculation.—Section 1886(d)(3)(E)(i) (42 U.S.C. 1395ww(d)(3)(E)(i)), as amended by section 402, is amended by inserting after the first sentence the following new sentence: "In calculating the hospital wage levels under the preceding sentence applicable with respect to cost reporting periods beginning on or after January 1, 2003, the Secretary shall exclude the wage levels of any facility that became a critical access hospital prior to the cost reporting period for which such hospital wage levels are calculated.".

(f) Provisions Related to Certain Rural Grants.—

(1) Small rural hospital improvement program.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended—

(A) by redesignating paragraph (3)(F) as paragraph (5) and redesignating and indenting appropriately; and

(B) by inserting after paragraph (3) the following new paragraph:

"(4) Small rural hospital improvement program.—

"(A) Grants to hospitals.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible small rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

"(B) Application.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

"(C) Amount of grant.—A grant to a hospital under this paragraph may not exceed $50,000.

"(D) Use of funds.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.".

(2) Authorization for appropriations.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended to read as follows:

"(j) Authorization of Appropriations.—

"(1) HI trust fund.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under—

"(A) subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002; and

"(B) paragraphs (1) and (2) of subsection (g), $40,000,000 in each of the fiscal years 2004 through 2008.

"(2) General revenues.—There are authorized to be appropriated from amounts in the Treasury not otherwise appropriated for making grants to all States under subsection (g)(4), $25,000,000 in each of the fiscal years 2004 through 2008.".

(3) Requirement that states awarded grants consult with the state hospital association and rural hospitals on the most appropriate ways to use such grants.—

(A) In general.—Section 1820(g) (42 U.S.C. 1395i–4(g)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

"(6) Required consultation for states awarded grants.—A State awarded a grant under paragraph (1) or (2) shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.".

(B) Effective date and application.—The amendment made by subparagraph (A) shall take effect on the date of enactment of this Act and shall apply to grants awarded on or after such date and to grants awarded prior to such date to the extent that funds under such grants have not been obligated as of such date.

SEC. 406. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) In General.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

"(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.".

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after October 1, 2003.

SEC. 407. SERVICES PROVIDED TO HOSPICE PATIENTS BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS.

(a) IN GENERAL.—Section 1812(d)(2)(A) (42 U.S.C. 1395d(d)(2)(A) in the matter following clause (i)(II), is amended—

(1) by inserting "or services described in section 1861(s)(2)(K)" after "except that clause (i) shall not apply to physicians' services"; and

(2) by inserting ", or by a physician assistant, nurse practitioner, or clinical nurse specialist whom is not an employee of the hospice program, and who the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care," after the "(if not an employee of the hospice program)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to hospice care furnished on or after October 1, 2003.

SEC. 408. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS UNDER MEDICARE.

Effective for cost reporting periods beginning on or after October 1, 2004, for purposes of payments to hospitals under the medicare program under title XVIII of the Social Security Act for costs of approved educational activities (as defined in section 413.85 of title 42 of the Code of Federal Regulations), such approved educational activities shall include professional educational training programs, recognized by the Secretary, for psychologists.

SEC. 409. REVISION OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and inserting "the applicable Puerto Rico percentage (specified in subparagraph (E))"; and

(B) in clause (ii), by striking "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

(2) by adding at the end the following new subparagraph:

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before October 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

"(iii) on or after October 1, 2004, and before October 1, 2009, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent; and

"(iv) on or after October 1, 2009, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent.".

SEC. 410. AUTHORITY REGARDING GERIATRIC FELLOWSHIPS.

The Secretary shall have the authority to clarify that geriatric training programs are eligible for 2 years of fellowship support for purposes of making payments for direct graduate medical education under subsection (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) and indirect medical education under subsection (d)(5)(B) of such section on or after October 1, 2003.

SEC. 411. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING THE COUNTING OF RESIDENTS IN A NONPROVIDER SETTING AND A TECHNICAL AMENDMENT REGARDING THE 3-YEAR ROLLING AVERAGE AND THE IME RATIO.

(a) CLARIFICATION OF REQUIREMENTS FOR COUNTING RESIDENTS TRAINING IN NONPROVIDER SETTING.—

(1) D-GME.—Section 1886(h)(4)(E) (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.".

(2) IME.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.".

(b) LIMITING ONE-YEAR LAG IN THE INDIRECT MEDICAL EDUCATION (IME) RATIO AND THREE-YEAR ROLLING AVERAGE IN RESIDENT COUNT FOR IME AND FOR DIRECT GRADUATE MEDICAL EDUCATION (D-GME) TO MEDICAL RESIDENCY PROGRAMS.—

(1) IME RATIO AND IME ROLLING AVERAGE.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by adding at the end the following new sentence: "For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, subclauses (I) and (II) shall be applied only with respect to a hospital's approved medical residency training programs in the fields of allopathic and osteopathic medicine.".

(2) D-GME ROLLING AVERAGE.—Section 1886(h)(4)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(G)) is amended by adding at the end the following new clause:

"(iv) APPLICATION FOR FISCAL YEAR 2004 AND SUBSEQUENT YEARS.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, clauses (i) through (iii) shall be applied only with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine.".

SEC. 412. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking "and" at the end;

(2) in subparagraph (S), by striking the period and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(T) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care—

"(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

"(ii) under a program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4), .

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

SEC. 413. GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(1) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(2) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(b) REPORT.—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

Subtitle B—Provisions Relating to Part B

SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking "subparagraphs (B) and (C)" and inserting "subparagraphs (B), (C), (E), and (F)"; and

(2) by adding at the end the following new subparagraphs:

"(E) Floor for work geographic indices.—

"(i) In general.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

"(ii) Work floor index.—For purposes of clause (i), the term 'applicable floor index' means—

"(I) 0.980 with respect to services furnished during 2004; and

"(II) 1.000 for services furnished during 2005, 2006, and 2007.

"(F) Floor for practice expense and malpractice geographic indices.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 422. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) Procedures for Secretary, and Not Physicians, To Determine When Bonus Payments Under Medicare Incentive Payment Program Should Be Made.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting "(1)" after "(m)"; and

(2) by adding at the end the following new paragraph:

"(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).".

(b) Educational Program Regarding the Medicare Incentive Payment Program.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the medicare program on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)).

(c) Ongoing GAO Study and Annual Report on the Medicare Incentive Payment Program.—

(1) Ongoing study.—The Comptroller General of the United States shall conduct an ongoing study on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)). Such study shall focus on whether such program increases the access of medicare beneficiaries who reside in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) as a health professional shortage area to physicians' services under the medicare program.

(2) Annual reports.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Comptroller General considers appropriate.

SEC. 423. INCREASE IN RENAL DIALYSIS COMPOSITE RATE.

Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2005 and 2006, the composite rate for such services shall be increased by 1.6 percent under section 1881(b)(12) of such Act (42 U.S.C. 1395rr(b)(7)), as added by section 433(b)(5).

SEC. 424. EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND TREATMENT OF CERTAIN SOLE COMMUNITY HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPD PPS.

(a) Small Rural Hospitals.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by striking "2004" and inserting "2006".

(b) Sole community hospitals.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by adding at the end the following:

"(iii) Temporary treatment for sole community hospitals .—In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished in 2004, 2005, or 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.".

SEC. 425. INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) Increase.—

(1) In general.—In the case of an applicable covered OPD service (as defined in paragraph (2)) that is furnished by a hospital described in clause (i) or (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)), as amended by section 424, on or after January 1, 2004, and before January 1, 2008, the Secretary shall increase the medicare OPD fee schedule amount (as determined under paragraph (4)(A) of such section) that is applicable for such service in that year (determined without regard to any increase under this section in a previous year) by 5 percent.

(2) Applicable covered OPD services defined.—For purposes of this section, the term "applicable covered OPD service" means a covered clinic or emergency room visit that is classified within the groups of covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) established under paragraph (2)(B) of such section.

(b) No Effect on Copayment Amount.—The Secretary shall compute the copayment amount for applicable covered OPD services under section 1833(t)(8)(A) of the Social Security Act (42 U.S.C. 1395*l*(t)(8)(A)) as if this section had not been enacted.

(c) No Effect on Increase Under Hold Harmless or Outlier Provisions.—The Secretary shall apply the temporary hold harmless provision under clause (i) and (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)) and the outlier provision under paragraph (5) of such section as if this section had not been enacted.

(d) Waiving Budget Neutrality and No Revision or Adjustments.—The Secretary shall not make any revision or adjustment under subparagraph (A), (B), or (C) of section 1833(t)(9) of the Social Security Act (42 U.S.C. 1395*l*(t)(9)) because of the application of subsection (a)(1).

(e) No Effect on Payments After Increase Period Ends.—The Secretary shall not take into account any payment increase provided under subsection (a)(1) in determining payments for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) under such section that are furnished after January 1, 2008.

(f) Technical Amendment.—Section 1833(t)(2)(B) (42 U.S.C. 1395*l*(t)(2)(B)) is amended by inserting "(and periodically revise such groups pursuant to paragraph (9)(A))" after "establish groups".

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

"(10) Temporary increase for ground ambulance services furnished in a rural area.—

"(A) In general.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2008, for which the transportation originates in a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent.

"(B) Application of increased payments after 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.".

SEC. 427. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

(a) Coverage.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 426, is amended by adding at the end the following new paragraph:

"(11) Ensuring appropriate coverage of air ambulance services.—

"(A) In general.—The regulations described in section 1861(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the air ambulance rate if the air ambulance service—

"(i) is medically necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

"(ii) complies with equipment and crew requirements established by the Secretary.

"(B) Medically necessary.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if such service is requested—

"(i) by a physician or a hospital in accordance with the physician's or hospital's responsibilities under section 1867 (commonly known as the Emergency Medical Treatment and Active Labor Act);

"(ii) as a result of a protocol established by a State or regional emergency medical service (EMS) agency;

"(iii) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that the patient's condition is such that the time needed to transport the individual by land or the lack of an appropriate ground ambulance, significantly increases the medical risks for the individual; or

"(iv) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist attack.

"(C) Air ambulance services defined.—For purposes of this paragraph, the term 'air ambulance service' means fixed wing and rotary wing air ambulance services.".

(b) Conforming Amendment.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting ", subject to section 1834(l)(11)," after "but".

(c) Effective Date.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 428. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2004 or 2005 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) Payment based on reasonable costs.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) No beneficiary cost-sharing.—Notwithstanding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 429. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1833(f) (42 U.S.C. 1395*l*(f)) is amended—

(1) in paragraph (1), by striking ", and" at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking "in a subsequent year" and inserting "in 1989 through 2003"; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

"(3) in 2004, at $80 per visit; and

"(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.".

SEC. 430. ELIMINATION OF CONSOLIDATED BILLING FOR CERTAIN SERVICES UNDER THE MEDICARE PPS FOR SKILLED NURSING FACILITY SERVICES.

(a) Certain Rural Health Clinic and Federally Qualified Health Center Services.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (2)(A)(i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

(2) by adding at the end of paragraph (2)(A) the following new clause:

"(iv) Exclusion of certain rural health clinic and federally qualified health center services.—Services described in this clause are—

"(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

"(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by a physician or practitioner not affiliated with a rural health clinic or a Federally qualified health center.".

(b) Certain Services Furnished by an Entity Jointly Owned by Hospitals and Critical Access Hospitals.—For purposes of applying section 411.15(p)–(3)(iii) of title 42 of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned as a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) Technical Amendments.—Sections 1842(b)(6)(E) and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E); 1395cc(a)(1)(H)(ii)) are each amended by striking "section 1888(e)(2)(A)(ii)" and inserting "clauses (ii), (iii), and (iv) of section 1888(e)(2)(A)".

(d) Effective Date.—The amendments made by this section and the provision of subsection (b) shall apply to services furnished on or after January 1, 2004.

SEC. 431. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT AND CERTAIN ORTHOTICS; ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DME PROVIDERS.

(a) Freeze for DME.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (E), by striking "and" at the end;

(2) in subparagraph (F)—

(A) by striking "a subsequent year" and inserting "2003"; and

(B) by striking "the previous year." and inserting "2002;"; and

(3) by adding at the end the following new subparagraphs:

"(G) for each of the years 2004 through 2010—

"(i) in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

"(ii) in the case of covered items not described in clause (i), 0 percentage points; and

"(H) for a subsequent year, the percentage increase described in subparagraph (B) for the year involved.".

(b) Freeze for Off-the-Shelf Orthotics.—Section 1834(h)(4)(A) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)) is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "a subsequent year" and inserting "2003"; and

(3) by adding at the end the following new clauses:

"(ix) for each of the years 2004 through 2010—

"(I) in the case of orthotics that have not been custom-fabricated, 0 percent; and

"(II) in the case of prosthetics, prosthetic devices, and custom-fabricated orthotics, the percentage increase described in clause (viii) for the year involved; and

"(x) for 2011 and each subsequent year, the percentage increase described in clause (viii) for the year involved;".

(c) Establishment of Quality Standards and Accreditation Requirements for Durable Medical Equipment Providers.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(1) by redesignating paragraph (17), as added by section 4551(c)(1) of the Balanced Budget Act of 1997 (111 Stat. 458), as paragraph (19); and

(2) by adding at the end the following new paragraph:

"(20) Identification of quality standards.—

"(A) In general.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for providers of durable medical equipment throughout the United States that are developed by recognized independent accreditation organizations (as designated under subparagraph (B)(i)) and with which such providers shall be required to comply in order to—

"(i) participate in the program under this title;

"(ii) furnish any item or service described in subparagraph (D) for which payment is made under this part; and

"(iii) receive or retain a provider or supplier number used to submit claims for reimbursement for any item or service described in subparagraph (D) for which payment may be made under this title.

"(B) Designation of independent accreditation organizations.—

"(i) In general.—Not later that the date that is 6 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall designate independent accreditation organizations for purposes of subparagraph (A).

"(ii) Consultation.—In determining which independent accreditation organizations to designate under clause (i), the Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, suppliers, and manufacturers to review (and advise the Secretary concerning) selection of accrediting organizations and the quality standards of such organizations.

"(C) Quality standards.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

"(D) Items and services described.—The items and services described in this subparagraph are covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection, other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

"(E) Phased-in implementation.—The application of the quality standards described in subparagraph (A) shall be phased-in over a period that does not exceed 3 years.".

SEC. 432. APPLICATION OF COINSURANCE AND DEDUCTIBLE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) Coinsurance.—

(1) In general.—Section 1833(a) (42 U.S.C. 1395*l*(a)) is amended—

(A) in paragraph (1)(D)(i), by striking "(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis)"; and

(B) in paragraph (2)(D)(i), by striking "(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866)".

(2) Conforming amendment.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A) is amended by striking "and with respect to clinical diagnostic laboratory tests for which payment is made under part B".

(b) Deductible.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395*l*(b)) is amended—

(1) by striking paragraph (3); and

(2) by redesignating paragraphs (4), (5), and (6) as paragraphs (3), (4), and (5), respectively.

(c) Effective Date.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SEC. 433. BASING MEDICARE PAYMENTS FOR COVERED OUTPATIENT DRUGS ON MARKET PRICES.

(a) Medicare Market Based Payment Amount.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(1) in paragraph (1), by striking "equal to 95 percent of the average wholesale price." and inserting "equal to—

"(A) in the case of a drug or biological furnished prior to January 1, 2004, 95 percent of the average wholesale price; and

"(B) in the case of a drug or biological furnished on or after January 1, 2004, the payment amount specified in—

"(i) in the case of such a drug or biological that is first available for payment under this part on or before April 1, 2003, paragraph (4); and

"(ii) in the case of such a drug or biological that is first available for payment under this part after such date, paragraph (5)."; and

(2) by adding at the end the following new paragraphs:

"(4)(A) Subject to subparagraph (C), the payment amount specified in this paragraph for a year for a drug or biological is an amount equal to the lesser of—

"(i) the average wholesale price for the drug or biological; or

"(ii) the amount determined under subparagraph (B)

"(B)(i) Subject to clause (ii), the amount determined under this subparagraph is an amount equal to—

"(I) in the case of a drug or biological furnished in 2004, 85 percent of the average wholesale price for the drug or biological (determined as of April 1, 2003); and

"(II) in the case of a drug or biological furnished in 2005 or a subsequent year, the amount determined under this subparagraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

"(ii) In the case of a vaccine described in subparagraph (A) or (B) of section 1861(s)(10), the amount determined under this subparagraph is an amount equal to the average wholesale price for the drug or biological.

"(C)(i) The Secretary shall establish a process under which the Secretary determines, for such drugs or biologicals as the Secretary determines appropriate, whether the widely available market price to physicians or suppliers for the drug or biological furnished in a year is different from the payment amount established under subparagraph (B) for the year. Such determination shall be based on the information described in clause (ii) as the Secretary determines appropriate.

"(ii) The information described in this clause is the following information:

"(I) Any report on drug or biological market prices by the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States that is made available after December 31, 1999.

"(II) A review of drug or biological market prices by the Secretary, which may include information on such market prices from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physicians, suppliers, or any other source the Secretary determines appropriate.

"(III) Data and information submitted by the manufacturer of the drug or biological or by another entity.

"(IV) Other data and information as determined appropriate by the Secretary.

"(iii) If the Secretary makes a determination under clause (i) with respect to the widely available market price for a drug or biological for a year, the following provisions shall apply:

"(I) Subject to clause (iv), the amount determined under this subparagraph shall be substituted for the amount determined under subparagraph (B) for purposes of applying subparagraph (A)(ii)(I) for the year and all subsequent years.

"(II) The Secretary may make subsequent determinations under clause (i) with respect to the widely available market price for the drug or biological.

"(III) If the Secretary does not make a subsequent determination under clause (i) with respect to the widely available market price for the drug or biological for a year, the amount determined under this subparagraph shall be an amount equal to the amount determined under this subparagraph for the previous year increased by the percentage increase described in subparagraph (B)(i)(II) for the year involved.

"(iv) If the first determination made under clause (i) with respect to the widely available market price for a drug or biological would result in a payment amount in a year that is more than 15 percent less than the amount determined under subparagraph (B) for the drug or biological for the previous year (or, for 2004, the payment amount determined under paragraph (1)(A), determined as of April 1, 2003), the Secretary shall provide for a transition to the amount determined under clause (i) so that the payment amount is reduced in annual increments equal to 15 percent of the payment amount in such previous year until the payment amount is equal to the amount determined under clause (i), as increased each year by the percentage increase described in subparagraph (B)(i)(II) for the year. The preceding sentence shall not apply to a drug or biological where a generic version of the drug or biological first enters the market on or after January 1, 2004 (even if the generic version of the drug or biological is not marketed under the chemical name of such drug or biological).

"(5) In the case of a drug or biological that is first available for payment under this part after April 1, 2003, the following rules shall apply:

"(A) As a condition of obtaining a code to report such new drug or biological and to receive payment under this part, a manufacturer shall provide the Secretary (in a time, manner, and form approved by the Secretary) with data and information on prices at which the manufacturer estimates physicians and suppliers will be able to routinely obtain the drug or biological in the market during the first year that the drug or biological is available for payment under this part and such additional information that the manufacturer determines appropriate.

"(B) During the year that the drug or biological is first available for payment under this part, the manufacturer of the drug or biological shall provide the Secretary (in a time, manner, and form approved by the Secretary) with updated information on the actual market prices paid by such physicians or suppliers for the drug or biological in the year.

"(C) The amount specified in this paragraph for a drug or biological for the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (A) and other information that the Secretary determines appropriate.

"(D) The amount specified in this paragraph for a drug or biological for the year after the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (B) and other information that the Secretary determines appropriate.

"(E) The amount specified in this paragraph for a drug or biological for the year beginning after the year described in subparagraph (D) and each subsequent year is equal to the lesser of—

"(i) the average wholesale price for the drug or biological; or

"(ii) the amount determined—

"(I) by the Secretary under paragraph (4)(C)(i) with respect to the widely available market price for the drug or biological for the year, if such paragraph was applied by substituting 'the payment determined under paragraph (5)(E)(ii)(II) for the year' for 'established under subparagraph (B) for the year'; and

"(II) if no determination described in subclause (I) is made for the drug or biological for the year, under this subparagraph with respect to the drug or biological for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.".

(b) Adjustments to Payment Amounts for Administration of Drugs and Biologicals.—

(1) Adjustment in physician practice expense relative value units.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking "The adjustments" and inserting "Subject to clause (iv), the adjustments"; and

(ii) by adding at the end the following new clause:

"(iv) Exemption from budget neutrality in 2004.—Any additional expenditures under this part that are attributable to subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004."; and

(B) by adding at the end the following new subparagraph:

"(H) Adjustments in practice expense relative value units for drug administration services for 2004.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished in 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

"(i) covers practice expenses for oncology administration services; and

"(ii) meets criteria established by the Secretary for acceptance of such surveys.".

(2) Payment for multiple chemotherapy agents furnished on a single day through the push technique.—

(A) Review of policy.—The Secretary shall review the policy, as in effect on the date of enactment of this Act, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 anticancer chemotherapeutic agent to an individual on a single day through the push technique.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy if the Secretary determines such modification to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(3) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not disproportionately reduced relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments to such Act made by paragraph (1).

(4) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

"(6)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2004, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled 'Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost' (GAO–03–184), provide for a separate payment for the administration of such blood clotting factors in an amount that the Secretary determines to be appropriate.

"(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2004, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraphs (4) and (5) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

"(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2005 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.".

(5) INCREASE IN COMPOSITE RATE FOR END STAGE RENAL DISEASE FACILITIES.—Section 1881(b) (42 U.S.C. 1395rr(b)) is amended—

(A) in paragraph (7), by adding at the end the following new sentence: "In the case of dialysis services furnished in 2004 or a subsequent year, the composite rate for such services shall be determined under paragraph (12)."; and

(B) by adding at the end the following new paragraph:

"(12)(A) In the case of dialysis services furnished during 2004, the composite rate for such services shall be the composite rate that would otherwise apply under paragraph (7) for the year increased by an amount to ensure (as estimated by the Secretary) that—

"(i) the sum of the total amount of—

"(I) the composite rate payments for such services for the year, as increased under this paragraph; and

"(II) the payments for drugs and biologicals (other than erythropoetin) furnished in connection with the furnishing of renal dialysis services and separately billed by renal dialysis facilities under paragraphs (4) and (5) of section 1842(o) for the year; is equal to

"(ii) the sum of the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in clause (i)(II) that would have been made if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

"(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased pursuant to section 423 of the Prescription Drug and Medicare Improvement Act of 2003.

"(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent.

"(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 or a subsequent year, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year (determined as if such section 423 had not been enacted), increased by 0.05 percent.

"(E) If the Secretary implements a reduction in the payment amount under paragraph (4)(C) or (5) for a drug or biological described in subparagraph (A)(i)(II) for a year after 2004, the Secretary shall, as estimated by the Secretary—

"(i) increase the composite rate for dialysis services furnished in such year in the same manner that the composite rate for such services for 2004 was increased under subparagraph (A); and

"(ii) increase the percentage increase under subparagraph (C) or (D) (as applicable) for years after the year described in clause (i) to ensure that such increased percentage would result in expenditures equal to the sum of the total composite rate payments for such services for such years and the total payments for drugs and biologicals described in subparagraph (A)(i)(II) is equal to the sum of the total amount of the composite rate payments under this paragraph for such years and the payments for the drugs and biologicals described in subparagraph (A)(i)(II) that would have been made if the reduction in payment amount described in subparagraph had not been made.

"(F) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under this paragraph.".

(6) HOME INFUSION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraph (4), is amended by adding at the end the following new paragraph:

"(7)(A) Subject to subparagraph (B), in the case of infusion drugs and biologicals furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may make separate payments for furnishing such drugs and biologicals in an amount determined by the Secretary if the Secretary determines such separate payment to be appropriate.

"(B) In determining the amount of any separate payment under subparagraph (A) for a year, the Secretary shall ensure that the total amount of payments under this part for such infusion drugs and biologicals for the year and such separate payments for the year does not exceed the total amount of payments that would have been made under this part for the year for such infusion drugs and biologicals if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.".

(7) INHALATION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

"(8)(A) Subject to subparagraph (B), in the case of inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may increase payments for such equipment under section 1834(a) and may make separate payments for furnishing such drugs and biologicals if the Secretary determines such increased or separate payments are necessary to appropriately furnish such equipment and drugs and biologicals to beneficiaries.

"(B) The total amount of any increased payments and separate payments under subparagraph (A) for a year may not exceed an amount equal to 10 percent of the amount (as estimated by the Secretary) by which—

"(i) the total amount of payments that would have been made for such drugs and biologicals for the year if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted; exceeds

"(ii) the total amount of payments for such drugs and biologicals under paragraphs (4) and (5).".

(8) PHARMACY DISPENSING FEE FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1842(o)(2) (42 U.S.C. 1395u(o)(2)) is amended to read as follows:

"(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary—

"(A) in the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, shall pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy; and

"(B) in the case of a drug or biological not described in subparagraph (A), may pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy.".

(9) PAYMENT FOR CHEMOTHERAPY DRUGS PURCHASED BUT NOT ADMINISTERED BY PHYSICIANS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) and (7), is amended by adding at the end the following new paragraph:

"(9)(A) Subject to subparagraph (B), the Secretary may increase (in an amount determined appropriate) the amount of payments to physicians for anticancer chemotherapeutic drugs or biologicals that would otherwise be made under this part in order to compensate such physicians for anticancer chemotherapeutic drugs or biologicals that are purchased by physicians with a reasonable intent to administer to an individual enrolled under this part but which cannot be administered to such individual despite the reasonable efforts of the physician.

"(B) The total amount of increased payments made under subparagraph (A) in a year (as estimated by the Secretary) may not exceed an amount equal to 1 percent of the total amount of payments made under paragraphs (4) and (5) for such anticancer chemotherapeutic drugs or biologicals furnished by physicians in such year (as estimated by the Secretary).".

(c) Linkage of Revised Drug Payments and Increases for Drug Administration.—The Secretary shall not implement the revisions in payment amounts for a category of drug or biological as a result of the amendments made by subsection (a) unless the Secretary concurrently implements the adjustments to payment amounts for administration of such category of drug or biological for which the Secretary is required to make an adjustment, as specified in the amendments made by, and provisions of, subsection (b).

(d) Prohibition of Administrative and Judicial Review.—

(1) Drugs.—Section , 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6), (7), and (9) of subsection (b), is amended by adding at the end the following new paragraph:

"(10) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraph (2) or paragraphs (4) through (9).".

(2) Physician fee schedule.—Section 1848(i)(1) (42 U.S.C. 1395w-4(i)(1)) is amended—

(A) in subparagraph (D), by striking "and" at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(F) adjustments in practice expense relative value units under subsection (c)(2)(H).".

(3) Multiple chemotherapy agents and other services currently on the non-physician work pool.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(e) Studies and Reports.—

(1) GAO study and report on beneficiary access to drugs and biologicals.—

(A) Study.—The Comptroller General of the United States shall conduct a study that examines the impact the provisions of, and the amendments made by, this section have on access by medicare beneficiaries to drugs and biologicals covered under the medicare program.

(B) Report.—Not later than January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under subparagraph (A) together with such recommendations as the Comptroller General determines to be appropriate.

(2) Study and report by the HHS Inspector General on market prices of drugs and biologicals.—

(A) Study.—The Inspector General of the Department of Health and Human Services shall conduct 1 or more studies that—

(i) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers; and

(ii) compare such widely available market prices to the payment amount for such drugs and biologicals under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o).

(B) Requirement.—In conducting the study under subparagraph (A), the Inspector General shall focus on those drugs and biologicals that represent the largest portions of expenditures under the medicare program for drugs and biologicals.

(C) Report.—The Inspector General shall prepare a report on any study conducted under subparagraph (A).

SEC. 434. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended by striking "and $100 for 1991 and subsequent years" and inserting the following: ", $100 for 1991 through 2005, $125 for 2006, and for 2007 and thereafter, the amount in effect for the previous year, increase by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar".

SEC. 435. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) In General.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: "(ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if under such arrangement such entity submits the bill for such service and such arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,".

(b) Conforming Amendment.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "except to an employer or facility as described in clause (A)" and inserting "except to an employer or entity as described in subparagraph (A)".

(c) Effective Date.—The amendments made by this section shall apply to payments made on or after the date of enactment of this Act.

SEC. 436. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A-551) is amended by inserting ", and for services furnished during 2004 or 2005" before the period at the end.

SEC. 437. ADEQUATE REIMBURSEMENT FOR OUTPATIENT PHARMACY THERAPY UNDER THE HOSPITAL OUTPATIENT PPS.

(a) Special Rules for Drugs and Biologicals.—Section 1833(t) (42 U.S.C. 1395(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (14); and

(2) by inserting after paragraph (12) the following new paragraph:

"(13) Special rules for certain drugs and biologicals.—

"(A) Before 2007.—

"(i) In general.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2005, and before January 1, 2007, hospitals shall be reimbursed as follows:

"(I) Drugs and biologicals furnished as part of a current OPD service.—The amount of payment for a drug or biological described in subparagraph (D) provided as a part of a service that was a covered OPD service on May 1, 2003, shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under section 1842(o) on such date.

"(II) Drugs and biologicals furnished as part of other OPD services.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price that would have been determined under section 1842(o) on May 1, 2003, if payment for such a drug or biological could have been made under this part on that date.

"(ii) Update for 2006.—For 2006, the amounts determined under clauses (i) and (ii) shall be the amount established for 2005 increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

"(B) After 2007.—

"(i) Ongoing study and reports on adequate reimbursements.—

"(I) Study.—The Secretary shall contract with an eligible organization (as defined in subclause (IV)) to conduct a study to determine the hospital acquisition and handling costs for each individual drug or biological described in subparagraph (D).

"(II) Study requirements.—The study conducted under subclause (I) shall—

"(aa) be accurate to within 3 percent of true mean hospital acquisition and handling costs for each drug and biological at the 95 percent confidence level;

"(bb) begin not later than January 1, 2005; and

"(cc) be updated annually for changes in hospital costs and the addition of newly marketed products.

"(III) Reports.—Not later than January 1 of each year (beginning with 2006), the Secretary shall submit to Congress a report on the study conducted under clause (i) together with recommendations for such legislative or administrative action as the Secretary determines to be appropriate.

"(IV) Eligible organization defined.—In this clause, the term 'eligible organization' means a private, nonprofit organization within the meaning of section 501(c) of the Internal Revenue Code.

"(ii) Establishment of payment methodology.—Notwithstanding paragraph (6), the Secretary, in establishing a payment methodology on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, shall take into consideration the findings of the study conducted under clause (i)(I) in determining payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007.

"(C) Applicable percentage defined.—In this paragraph, the term 'applicable percentage' means—

"(i) with respect to a biological product (approved under a biologics license application under section 351 of the Public Health Service Act), a single source drug (as defined in section 1927(k)(7)(A)(iv)), or an orphan product designated under section 526 of the

Food, Drug, and Cosmetic Act to which the prospective payment system established under this subsection did not apply under the final rule for 2003 payments under such system, 94 percent;

"(ii) with respect to an innovator multiple source drug (as defined in section 1927(k)(7)(A)(ii)), 91 percent; and

"(iii) with respect to a noninnovator multiple source drug (as defined in as defined in section 1927(k)(7)(A)(iii)), 71 percent.

"(D) Drugs and biologicals described.—A drug or biological described in this paragraph is any drug or biological—

"(i) for which the amount of payment was determined under paragraph (6) prior to January 1, 2005;

"(ii) which is assigned to a drug specific ambulatory payment classification on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003; and

"(iii) that would have been reimbursed under paragraph (6) but for the application of this paragraph.".

(b) Exceptions to Budget Neutrality Requirement.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: "In determining the budget neutrality adjustment required by the preceding sentence for fiscal years 2005 and 2006, the Secretary shall not take into account any expenditures that would not have been made but for the application of paragraph (13).".

SEC. 438. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

"(F) Limitation of application of functional equivalence standard.—

"(i) In general.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

"(ii) Application.—Paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003 unless—

"(I) such application was being made to such drug or biological prior to such date of enactment; and

"(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

"(iii) Rule of construction.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

SEC. 439. MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.

(a) In General.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(b) Rule of Construction.—Nothing in this section shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement subsection (a)).

(c) Effective Date.—This section shall apply to clinical trials begun on or after January 1, 2005.

SEC. 440. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) Waiver of Penalty.—

(1) In general.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2002, 2003, 2004, or 2005 and who demonstrates to the Secretary before December 31, 2005, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2005. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2005 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) Medicare Part B Special Enrollment Period.—

(1) In general.—In the case of any individual who, as of the date of enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin 1 year after the date of the enactment of this Act and shall end on December 31, 2005.

(2) Coverage period.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 441. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) Definitions.—In this section:

(1) Chiropractic services.—The term "chiropractic services" has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) Demonstration project.—The term "demonstration project" means a demonstration project established by the Secretary under subsection (b)(1).

(3) Eligible beneficiary.—The term "eligible beneficiary" means an individual who is enrolled under part B of the medicare program.

(4) Medicare program.—The term "medicare program" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) Demonstration of Coverage of Chiropractic Services Under Medicare.—

(1) Establishment.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) No physician approval required.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a MedicareAdvantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) Consultation.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) Participation.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) Conduct of Demonstration Projects.—

(1) Demonstration sites.—

(A) Selection of demonstration sites.—The Secretary shall conduct demonstration projects at 6 demonstration sites.

(B) Geographic diversity.—Of the sites described in subparagraph (A)—

(i) 3 shall be in rural areas; and

(ii) 3 shall be in urban areas.

(C) Sites located in HPSAs.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) Implementation; duration.—

(A) Implementation.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) Duration.—The Secretary shall complete the demonstration projects by the date that is 3 years after the date on which the first demonstration project is implemented.

(d) Evaluation and Report.—

(1) Evaluation.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

SEC. 442. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

"HEALTH CARE QUALITY DEMONSTRATION PROGRAM

"SEC. 1866C. (a) DEFINITIONS.—In this section:

"(1) BENEFICIARY.—The term 'beneficiary' means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the MedicareAdvantage program) under part C.

"(2) HEALTH CARE GROUP.—

"(A) IN GENERAL.—The term 'health care group' means—

"(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

"(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

"(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

"(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

"(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

"(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

"(1) the provision of incentives to improve the safety of care provided to beneficiaries;

"(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

"(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

"(4) encourage shared decision making between providers and patients;

"(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

"(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

"(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

"(c) ADMINISTRATION BY CONTRACT.—

"(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

"(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

"(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

"(B) streamline documentation and reporting requirements otherwise required under this title.

"(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the traditional fee-for-service program under parts A and B or the package of benefits available through a staff model or a dedicated group model health maintenance organization under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

"(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

"(1) be a health care group;

"(2) meet quality standards established by the Secretary, including—

"(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

"(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

"(C) encouraging patient participation in preference-based decisions;

"(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

"(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

"(3) meet such other requirements as the Secretary may establish.

"(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

"(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

"(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

"(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

"(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

"(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

"(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

"(i) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.".

SEC. 443. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) Sites.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section, of which at least 3 shall be in an urban area and at least 1 shall be in a rural area. One of the sites shall be located in the State of Arkansas.

(3) Duration.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) Implementation.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) Participants.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) Principal Care Physician Responsibilities.—The Secretary shall enter into an agreement with each principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall—

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community services organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) Complex Clinical Care Management Fee.—

(1) Payment.—Under an agreement entered into under subsection (c), the Secretary shall pay to each principal care physician, on behalf of each eligible beneficiary under the care of that physician, the complex clinical care management fee developed by the Secretary under paragraph (2).

(2) Development of fee.—The Secretary shall develop a complex care management fee under this paragraph that is paid on a monthly basis and which shall be payment in full for all the functions performed by the principal care physician under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) Budget neutrality.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f). Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) Report.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) Definitions.—In this section:

(1) Activity of daily living.—The term "activity of daily living" means eating, toileting, transferring, bathing, dressing, and continence.

(2) Chronic condition.—The term "chronic condition" means a biological, physical, or mental condition that is likely to last a year or more, for which there is no known cure, for which there is a need for ongoing medical care, and which may affect an individual's ability to carry out activities of daily living or instrumental activities of daily living, or both.

(3) Eligible beneficiary.—The term "eligible beneficiary" means any individual who—

(A) is enrolled for benefits under part B of the medicare program;

(B) has at least 4 complex medical conditions (one of which may be cognitive impairment); and

(C) has—

(i) an inability to self-manage their care; or

(ii) a functional limitation defined as an impairment in 1 or more activity of daily living or instrumental activity of daily living.

(4) Instrumental activity of daily living.—The term "instrumental activity of daily living" means meal preparation, shopping, housekeeping, laundry, money management, telephone use, and transportation use.

(5) Medicare program.—The term "medicare program" means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) Principal care physician.—The term "principal care physician" means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 444. MEDICARE FEE-FOR-SERVICE CARE COORDINATION DEMONSTRATION PROGRAM.

(a) Establishment.—

(1) In general.—The Secretary shall establish a demonstration program to contract with qualified care management organizations to provide health risk assessment and care management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) Sites.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in rural areas.

(3) Duration.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) Implementation.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) Participants.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a care management organization who agrees to furnish care management services to the eligible beneficiary under the demonstration program.

(c) Contracts With CMOs.—

(1) In general.—The Secretary shall enter into a contract with care management organizations to provide care management services to eligible beneficiaries residing in the area served by the care management organization.

(2) Cancellation.—The Secretary may cancel a contract entered into under paragraph (1) if the care management organization does not meet negotiated savings or quality outcomes targets for the year.

(3) Number of cmos.—The Secretary may contract with more than 1 care management organization in a geographic area.

(d) Payment to CMOs.—

(1) Payment.—Under an contract entered into under subsection (c), the Secretary shall pay care management organizations a fee for which the care management organization is partially at risk based on bids submitted by care management organizations.

(2) Portion of payment at risk.—The Secretary shall establish a benchmark for quality and cost against which the results of the care management organization are to be measured. The Secretary may not pay a care management organization the portion of the fee described in paragraph (1) that is at risk unless the Secretary determines that the care management organization has met the agreed upon savings and outcomes targets for the year.

(e) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) Budget neutrality.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) Waiver Authority.—

(1) In general.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(2) Waiver of medigap preemptions.—The Secretary shall waive any provision of section 1882 of the Social Security Act that

would prevent an insurance carrier described in subsection (h)(3)(D) from participating in the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) CARE MANAGEMENT SERVICES.—The term "care management services" means services that are furnished to an eligible beneficiary (as defined in paragraph (2)) by a care management organization (as defined in paragraph (3)) in accordance with guidelines established by the Secretary that are consistent with guidelines established by the American Geriatrics Society.

(2) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) at high-risk (as defined by the Secretary, but including eligible beneficiaries with multiple sclerosis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).

(3) CARE MANAGEMENT ORGANIZATION.—The term "care management organization" means an organization that meets such qualifications as the Secretary may specify and includes any of the following:

(A) A physician group practice, hospital, home health agency, or hospice program.

(B) A disease management organization.

(C) A Medicare+Choice or MedicareAdvantage organization.

(D) Insurance carriers offering medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(E) Such other entity as the Secretary determines to be appropriate.

SEC. 445. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component;

(4) an evaluation of whether there is a sound economic basis for the implementation of the adjustment under subparagraphs (E) and (F) of section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)), as added by section 421, in those areas in which the adjustment applies;

(5) an evaluation of the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(A) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(B) the mobility of physicians, including specialists, over the last decade; and

(6) an evaluation of appropriateness of extending such adjustment or making such adjustment permanent.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

Subtitle C—Provisions Relating to Parts A and B

SEC. 451. INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after October 1, 2003, and before October 1, 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 452. LIMITATION ON REDUCTION IN AREA WAGE ADJUSTMENT FACTORS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

Section 1895(b)(4)(C) (42 U.S.C. 1395fff(b)(4)(C)) is amended—

(1) by striking "FACTORS.—The Secretary" and inserting "FACTORS.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary"; and

(2) by adding at the end the following new clause:

"(ii) LIMITATION ON REDUCTION IN FISCAL YEAR 2005 AND 2006.—For fiscal years 2004, 2005, and 2006, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more that 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.".

SEC. 453. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITS ON PHYSICIAN REFERRALS.—

(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(A) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(i) by striking "and" at the end of subparagraph (A); and

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

"(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and".

(B) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

"(7) SPECIALTY HOSPITAL.—

"(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

"(i) patients with a cardiac condition;

"(ii) patients with an orthopedic condition;

"(iii) patients receiving a surgical procedure; or

"(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

"(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

"(i) determined by the Secretary—

"(I) to be in operation before June 12, 2003; or

"(II) under development as of such date;

"(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

"(iii) that meets such other requirements as the Secretary may specify.".

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

"(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

"(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

"(B) the entity is not a specialty hospital (as defined in subsection (h)(7)); and

"(C) the Secretary determines, with respect to such entity, that such services would not be available in such area but for the ownership or investment interest.".

(b) EFFECTIVE DATE.—Subject to paragraph (2), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

SEC. 454. DEMONSTRATION PROGRAM FOR SUBSTITUTE ADULT DAY SERVICES.

(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which the Secretary provides eligible medicare beneficiaries with coverage under the medicare program of substitute adult day services furnished by an adult day services facility.

(b) PAYMENT RATE FOR SUBSTITUTE ADULT DAY SERVICES.—

(1) PAYMENT RATE.—For purposes of making payments to an adult day services facility for substitute adult day services under the demonstration program, the following rules shall apply:

(A) ESTIMATION OF PAYMENT AMOUNT.—The Secretary shall estimate the amount that would otherwise be payable to a home health agency under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for all home health services described in subsection (i)(4)(B)(i) under the plan of care.

(B) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the total amount payable for substitute adult day services under the plan of care is equal to 95 percent of the amount estimated to be payable under subparagraph (A).

(2) LIMITATION ON BALANCE BILLING.—Under the demonstration program, an adult day services facility shall accept as payment in full for substitute adult day services (including those services described in clauses (ii) through (iv) of subsection (i)(4)(B)) furnished by the facility to an eligible medicare beneficiary the amount of payment provided under the demonstration program for home health services consisting of substitute adult services.

(3) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration program and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration program and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration program had not been conducted, the Secretary shall adjust the rate of payment to adult day services facilities under paragraph (1)(B) in order to eliminate such excess.

(c) DEMONSTRATION PROGRAM SITES.—The demonstration program shall be conducted in not more than 3 sites selected by the Secretary.

(d) DURATION; IMPLEMENTATION.—

(1) DURATION.—The Secretary shall conduct the demonstration program for a period of 3 years.

(2) IMPLEMENTATION.—The Secretary may not implement the demonstration program before October 1, 2004.

(e) VOLUNTARY PARTICIPATION.—Participation of eligible medicare beneficiaries in the demonstration program shall be voluntary.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration program.

(2) MAY NOT WAIVE ELIGIBILITY REQUIREMENTS FOR HOME HEALTH SERVICES.—The Secretary may not waive the beneficiary eligibility requirements for home health services under title XVIII of the Social Security Act.

(g) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration program.

(2) REPORT.—Not later than 30 months after the commencement of the demonstration program, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the eligible medicare beneficiaries participating in the demonstration program as compared to such outcomes and costs to such beneficiaries receiving only home health services under title XVIII of the Social Security Act for the same health conditions.

(B) Such recommendations regarding the extension, expansion, or termination of the program as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) ADULT DAY SERVICES FACILITY.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the term "adult day services facility" means a public agency or private organization, or a subdivision of such an agency or organization, that—

(i) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(ii) provides the items and services described in paragraph (4)(B); and

(iii) meets the requirements of paragraphs (2) through (8) of subsection (o).

(B) INCLUSION.—Notwithstanding subparagraph (A), the term "adult day services facility" shall include a home health agency in which the items and services described in clauses (ii) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) WAIVER OF SURETY BOND.—The Secretary may waive the requirement of a surety bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(2) ELIGIBLE MEDICARE BENEFICIARY.—The term "eligible medicare beneficiary" means an individual eligible for home health services under title XVIII of the Social Security Act.

(3) HOME HEALTH AGENCY.—The term "home health agency" has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) SUBSTITUTE ADULT DAY SERVICES.—

(A) IN GENERAL.—The term "substitute adult day services" means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services:

(i) Items and services described in paragraphs (1) through (7) of such section 1861(m).

(ii) Meals.

(iii) A program of supervised activities designed to promote physical and mental health and furnished to the individual by the adult day services facility in a group setting for a period of not fewer than 4 and not greater than 12 hours per day.

(iv) A medication management program (as defined in subparagraph (C)).

(C) MEDICATION MANAGEMENT PROGRAM.—For purposes of subparagraph (B)(iv), the term "medication management program" means a program of services, including medicine screening and patient and health care provider education programs, that provides services to minimize—

(i) unnecessary or inappropriate use of prescription drugs; and

(ii) adverse events due to unintended prescription drug-to-drug interactions.

SEC. 455. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION OF AN INTERIM FINAL REGULATION.

(a) In General.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) With respect to the publication of a final regulation based on the previous publication of an interim final regulation—

"(i) subject to subparagraph (B), the Secretary shall publish the final regulation within the 12-month period that begins on the date of publication of the interim final regulation;

"(ii) if a final regulation is not published by the deadline established under this paragraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and

"(iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

"(B) If the Secretary determines before the deadline otherwise established in this paragraph that there is good cause, specified in a notice published before such deadline, for delaying the deadline otherwise applicable under this paragraph, the deadline otherwise established under this paragraph shall be extended for such period (not to exceed 12 months) as the Secretary specifies in such notice.".

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to interim final regulations published on or after such date.

(c) Status of Pending Interim Final Regulations.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) No Retroactive Application of Substantive Changes.—

(1) In general.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

"(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act.

(b) Timeline for Compliance With Substantive Changes After Notice.—

(1) In general.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

"(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

"(C)(i) Except as provided in clause (ii), a substantive change may not take effect before the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of enactment of this Act.

SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a)(1), is amended by adding at the end the following new subsection:

"(e)(1) Not later than 2 years after the date of enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of all communications and correspondence.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

Subtitle B—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) Submission of Transition Plan.—

(1) In general.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) Contents.—The plan shall include information on the following:

(A) Workload.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) Cost projections and financing.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) Transition timetable.—A timetable for the transition.

(D) Regulations.—The establishment of specific regulations to govern the appeals process.

(E) Case tracking.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) Feasibility of precedential authority.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) Access to administrative law judges.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) Independence of administrative law judges.—The steps that should be taken to ensure the independence of administrative law judges, including ensuring that such judges are in an office that is functionally and operationally separate from the Centers for Medicare & Medicaid Services and the Center for Medicare Choices.

(I) Geographic distribution.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to ensure timely access to such judges.

(J) Hiring.—The steps that should be taken to hire administrative law judges (and support staff).

(K) Performance standards.—The establishment of performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress, the Commissioner of Social Security, and the Secretary a report on such evaluation.

(c) SUBMISSION OF GAO REPORT REQUIRED BEFORE PLAN IMPLEMENTATION.—The Commissioner of Social Security and the Secretary may not implement the plan developed under subsection (a) before the date that is 6 months after the date the report required under subsection (b)(2) is submitted to the Commissioner and the Secretary.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision"; and

(2) by adding at the end the following new paragraph:

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

"(C) ACCESS TO JUDICIAL REVIEW.—

"(i) IN GENERAL.—If the appropriate review entity—

"(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than 1 applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

"(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

"(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, a 'review entity' is a panel of no more than 3 members from the Departmental Appeals Board, selected for the purpose of making determinations under this paragraph.".

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) GAO STUDY AND REPORT ON ACCESS TO JUDICIAL REVIEW.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the access of medicare beneficiaries and health care providers to judicial review of actions of the Secretary and the Department of Health and Human Services with respect to items and services under title XVIII of the Social Security Act subsequent to February 29, 2000, the date of the decision of Shalala, Secretary of Health and Human Services, et al. v. Illinois Council on Long Term Care, Inc. (529 U.S. 1 (2000)).

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations as the Comptroller General determines to be appropriate.

(d) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

"(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 514. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

"(3) TIMELY COMPLETION OF THE RECORD.—

"(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

"(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

"(C) Delay in decision deadlines until completion of record.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

"(D) Complete record described.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

"(i) written or testimonial evidence, or both, submitted by the person filing the request,

"(ii) written or oral argument, or both,

"(iii) the decision of, and the record for, the prior level of appeal, and

"(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.".

(b) Use of Patients' Medical Records.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

(c) Notice Requirements for Medicare Appeals.—

(1) Initial determinations and redeterminations.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

"(4) Requirements of notice of determinations and redeterminations.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

"(A) the reasons for the determination, including, as appropriate—

"(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

"(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

"(B) the procedures for obtaining additional information concerning the determination or redetermination; and

"(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.".

(2) Reconsiderations.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

"(E) Explanation of decision.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

"(i) to the extent appropriate, a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

"(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

"(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical or scientific rationale for the decision.".

(3) Appeals.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting "; Notice" after "Secretary"; and

(B) by adding at the end the following new paragraph:

"(4) Notice.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

"(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

"(B) the procedures for obtaining additional information concerning the decision; and

"(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.".

(4) Preparation of record for appeal.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking "such information as is required for an appeal" and inserting "the record for the appeal".

(d) Qualified Independent Contractors.—

(1) Eligibility requirements of qualified independent contractors.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting "(except in the case of a utilization and quality control peer review organization, as defined in section 1152)" after "means an entity or organization that"; and

(ii) by striking the period at the end and inserting the following: "and meets the following requirements:

"(A) General requirements.—

"(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

"(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

"(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

"(B) Independence requirements.—

"(i) In general.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

"(I) is not a related party (as defined in subsection (g)(5));

"(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

"(ii) Exception for compensation.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) Limitations on entity compensation.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional."; and

(B) in paragraph (3)(A), by striking ", and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection".

(2) Eligibility requirements for reviewers.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

"(D) Qualifications of reviewers.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals)."; and

(B) by adding at the end the following new subsection:

"(g) Qualifications of Reviewers.—

"(1) In general.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

"(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4).

"(2) Independence.—

"(A) In general.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

"(B) Exception.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(I) a nonaffiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

"(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

"(3) Limitations on reviewer compensation.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

"(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

"(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

"(C) The health care professional that provides the items or services involved in the case.

"(D) The institution at which the items or services (or treatment) involved in the case are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

"(F) Any other party determined under any regulations to have a substantial interest in the case involved.".

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking "12" and inserting "4".

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

"(d) EFFECTIVE DATE.—

"(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2004.

"(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003:

"(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

"(B) Subsection (c)(3)(C)(iii) of such section.

"(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

"(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.".

(2) CONFORMING AMENDMENTS.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 515. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

"(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

"(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

"(2) providers of services, physicians, practitioners, and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied are provided a mechanism to appeal such denial and a deadline for consideration of such appeals.".

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 502 and 503, is amended by adding at the end the following new subsection:

"(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.".

SEC. 516. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

"(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

"(5) AGGRIEVED PARTY DEFINED.—In this section, the term 'aggrieved party' means—

"(A) with respect to a national coverage determination, an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; and

"(B) with respect to a local coverage determination—

"(i) an individual who is entitled to benefits under part A, or enrolled under part B, or both, who is adversely affected by such a determination; or

"(ii) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.".

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting ", including, where appropriate, the specific requirements and clinical indications relating to the medical necessity of an item or service" before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 514(d)(2)(B), is amended by adding at the end the following new subsection:

"(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

"(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

"(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

"(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

"(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

"(B) each reversal described in subparagraph (A) involves substantially similar material facts;

"(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

"(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

"(4) APPROVAL OR REJECTION OF REQUEST.—

"(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

"(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.".

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after October 1, 2003;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function;

"(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

"(C) the entity has sufficient assets to financially support the performance of such function; and

"(D) the entity meets such other requirements as the Secretary may impose.

"(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and beneficiary services functions as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

"(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 6 years.

"(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

"(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

"(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

"(3) PERFORMANCE REQUIREMENTS.—

"(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

"(B) CONSIDERATIONS.—The Secretary shall include, as 1 of the standards, provider and beneficiary satisfaction levels.

"(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

"(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

"(ii) shall be used for evaluating contractor performance under the contract; and

"(iii) shall be consistent with the written statement of work provided under the contract.

"(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(6) RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.—A contract with a medicare administrative contractor under this section to perform the function of developing local coverage determinations (as defined in section 1869(f)(2)(B)) shall provide that the contractor shall—

"(A) designate at least 1 different individual to serve as medical director for each State for which such contract performs such function;

"(B) utilize such medical director in the performance of such function; and

"(C) appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in, the development of a local coverage determination in an advisory capacity.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

"(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

"(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the "False Claims Act").

"(5) INDEMNIFICATION BY SECRETARY.—

"(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

"(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

"(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

"(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

"(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

"(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.".

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services,"; and

(II) by striking "carrier" and inserting "medicare administrative contractor";

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,";

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), by striking "carrier" and inserting "medicare administrative contractor";

(E) in paragraph (5), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier" and "carrier responses" and inserting "contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor" and "contractor responses", respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the

funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) Incentives To Improve Contractor Performance.—

(1) In general.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

"(e) Incentives To Improve Contractor Performance in Provider Education and Outreach.—

"(1) Methodology to measure contractor error rates.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

"(2) GAO review of methodology.—The Comptroller General of the United States shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

"(3) Medicare contractor defined.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.".

(2) Report.—The Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of the Social Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses.

(c) Improved Provider Education and Training.—

(1) Increased funding for enhanced education and training through medicare integrity program.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)";

(B) in subparagraph (B), by striking "The amount appropriated" and inserting "Subject to subparagraph (C), the amount appropriated"; and

(C) by adding at the end the following new subparagraph:

"(C) Enhanced provider education and training.—

"(i) In general.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

"(ii) Use.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.".

(2) Tailoring education and training for small providers or suppliers.—

(A) In general.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

"(b) Tailoring Education and Training Activities for Small Providers or Suppliers.—

"(1) In general.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

"(2) Small provider of services or supplier.—In this subsection, the term 'small provider of services or supplier' means—

"(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.".

(B) Effective date.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) Additional Provider Education Provisions.—

(1) In general.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

"(c) Encouragement of Participation in Education Program Activities.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

"(d) Construction.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

"(1) of the screens used for identifying claims that will be subject to medical review; or

"(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(e) Definitions.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) In General.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

"(f) Communicating With Beneficiaries and Providers.—

"(1) Communication process.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

"(2) Response to written inquiries.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

"(3) Response to toll-free lines.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) Monitoring of contractor responses.—

"(A) In general.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) Development of standards.—

"(i) In general.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) Evaluation.—In conducting evaluations of individual medicare contractors, the Secretary shall consider the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) Direct monitoring.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(5) Medicare contractor defined.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).".

(b) Effective Date.—The amendment made by subsection (a) shall take effect October 1, 2004.

SEC. 533. RELIANCE ON GUIDANCE.

(a) In General.—Section 1871(d), as added by section 502(a), is amended by adding at the end the following new paragraph:

"(2) If—

"(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

"(i) by the Secretary; or

"(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

"(B) the Secretary determines that—

"(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

"(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

"(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.".

(b) Effective Date.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of enactment of this Act.

SEC. 534. MEDICARE PROVIDER OMBUDSMAN.

(a) Medicare Provider Ombudsman.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; MEDICARE PROVIDER OMBUDSMAN";

(2) by inserting "Practicing Physicians Advisory Council.—(1)" after "(a)";

(3) in paragraph (1),, as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) Medicare Provider Ombudsman.—

"(1) In general.—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

"(2) Duties.—The Medicare Provider Ombudsman shall—

"(A) provide assistance, on a confidential basis, to entities and individuals providing items and services, including covered drugs under part D, under this title with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(i) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

"(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

"(3) Staff.—The Secretary shall provide the Medicare Provider Ombudsman with appropriate staff.".

(b) Funding.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account)) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (42 U.S.C. 1395ee) (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAMS.

(a) Demonstration on the Provision of Advice and Assistance to Medicare Beneficiaries at Local Offices of the Social Security Administration.—

(1) Establishment.—The Secretary shall establish a demonstration program (in this subsection referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(2) Locations.—

(A) In general.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) Assistance for rural beneficiaries.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) Duration.—The demonstration program shall be conducted over a 3-year period.

(4) Evaluation and report.—

(A) Evaluation.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(B) Report.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(b) Demonstration on Providing Prior Determinations.—

(1) Establishment.—By not later than 1 year after the date of enactment of this Act, the Secretary shall establish a demonstration project to test the administrative feasibility of providing a process for medicare beneficiaries and entities and individuals furnishing such beneficiaries with items and services under title XVIII of the Social Security Act program to make a request for, and receive, a determination (after an advance beneficiary notice is issued with respect to the item or service involved but before such item or service is furnished to the beneficiary) as to whether the item or service is covered under such title consistent with the applicable requirements of section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A)) (relating to medical necessity).

(2) Evaluation and report.—

(A) Evaluation.—The Secretary shall provide for an evaluation of the demonstration program conducted under paragraph (1).

(B) Report.—By not later than January 1, 2006, the Secretary shall submit to Congress a report on such evaluation together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) In General.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

"(g) Conduct of Prepayment Review.—

"(1) Standardization of random prepayment review.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

"(2) Limitations on initiation of nonrandom prepayment review.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

"(3) Termination of nonrandom prepayment review.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

"(4) Construction.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) Random prepayment review defined.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.".

(b) Effective Date.—

(1) In general.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) Deadline for promulgation of certain regulations.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(3) Application of standard protocols for random prepayment review.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of enactment of this Act) as the

Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) In General.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

“(h) Recovery of Overpayments.—

“(1) Use of repayment plans.—

“(A) In general.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

“(B) Development of standards.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

“(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

“(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

“(C) Exceptions.—Subparagraph (A) shall not apply if—

“(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

“(ii) there is an indication of fraud or abuse committed against the program.

“(D) Immediate collection if violation of repayment plan.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

“(E) Relation to no fault provision.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

“(2) Limitation on recoupment.—

“(A) No recoupment until reconsideration exercised.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

“(B) Payment of interest.—

“(i) Return of recouped amount with interest in case of reversal.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

“(ii) Interest in case of affirmation.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

“(iii) Rate of interest.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

“(C) Medicare contractor defined.—For purposes of this subsection, the term ‘medicare contractor’ has the meaning given such term in section 1889(e).

“(3) Payment audits.—

“(A) Written notice for post-payment audits.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

“(B) Explanation of findings for all audits.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

“(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

“(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

“(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

“(C) Exception.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

“(4) Notice of over-utilization of codes.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

“(5) Standard methodology for probe sampling.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

“(6) Consent settlement reforms.—

“(A) In general.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

“(B) Opportunity to submit additional information before consent settlement offer.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

“(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

“(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

“(C) Consent settlement offer.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

“(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

“(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

“(I) the opportunity for a statistically valid random sample; or

“(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

“(D) Consent settlement defined.—For purposes of this paragraph, the term ‘consent settlement’ means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.”.

(b) Effective Dates and Deadlines.—

(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of overutilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) In General.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) Deadline.—Not later than 1 year after the date of enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a-7(c)(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.".

TITLE VI—OTHER PROVISIONS

SEC. 601. INCREASE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEARS 2004 AND 2005.

(a) In General.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)) is amended—

(1) in the paragraph heading, by striking "FISCAL YEARS 2001 AND 2002" and inserting "CERTAIN FISCAL YEARS";

(2) in subparagraph (A)—

(A) in clause (i)—

(i) by striking "paragraph (2)" and inserting "paragraphs (2) and (3)"; and

(ii) by striking "and" at the end;

(B) in clause (ii), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

"(iii) for fiscal year 2004, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

"(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003; and

"(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2004; and

"(iv) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

"(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002, 2003, and 2004; and

"(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2005."; and

(3) in subparagraph (C)—

(A) in the subparagraph heading, by striking "AFTER FISCAL YEAR 2002" and inserting "FOR OTHER FISCAL YEARS"; and

(B) by striking "2003 or" and inserting "2003, fiscal year 2006, or".

(b) DSH Allotment for the District of Columbia.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)), as amended by paragraph (1), is amended—

(1) in subparagraph (A), by inserting "and except as provided in subparagraph (C)" after "paragraph (2)";

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following:

"(C) DSH Allotment for the District of Columbia.—

"(i) In general.—Notwithstanding subparagraph (A), the DSH allotment for the District of Columbia for fiscal year 2004, shall be determined by substituting "49" for "32" in the item in the table contained in paragraph (2) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such allotment, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2000, 2001, 2002, and 2003.

"(ii) No application to allotments after fiscal year 2004.—The DSH allotment for the District of Columbia for fiscal year 2003, fiscal year 2005, or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotment determined under clause (i).".

(c) Conforming Amendment.—Section 1923(f)(3) of such Act (42 U.S.C. 1396r-4(f)(3)) is amended by inserting ", paragraph (4)," after "subparagraph (B)".

SEC. 602. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE UNDER THE MEDICAID PROGRAM FOR FISCAL YEARS 2004 AND 2005.

(a) In General.—Section 1923(f)(5) (42 U.S.C. 1396r-4(f)(5)) is amended—

(1) by striking "In the case of" and inserting the following:

"(A) In general.—In the case of"; and

(2) by adding at the end the following:

"(B) Increase in floor for fiscal years 2004 and 2005.—

"(i) Fiscal year 2004.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year.

"(ii) Fiscal year 2005.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2001, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2004, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2004.

"(iii) No application to allotments after fiscal year 2005.—The DSH allotment for any State for fiscal year 2006 or any succeeding fiscal year shall be determined under this subsection without regard to the DSH allotments determined under this subparagraph.".

(b) Allotment Adjustment.—

(1) In general.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following:

"(6) Allotment adjustment.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 that was implemented on January 1, 1994, is revoked or terminated before the end of either such fiscal year, the Secretary shall—

"(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

"(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that provides for the maximum amount (permitted consistent with paragraph (3)(B)(ii)) that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.".

(2) Treatment of institutions for mental diseases.—Section 1923(h)(1) of the Social Security Act (42 U.S.C. 1396r-4(h)(1)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting "(subject to paragraph (3))" after "the lesser of the following"; and

(B) by adding at the end the following new paragraph:

"(3) Special rule.—The limitation of paragraph (1) shall not apply in the case of a State to which subsection (f)(6) applies.".

SEC. 603. INCREASED REPORTING REQUIREMENTS TO ENSURE THE APPROPRIATENESS OF PAYMENT ADJUSTMENTS TO DISPROPORTIONATE SHARE HOSPITALS UNDER THE MEDICAID PROGRAM.

Section 1923 (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

"(j) ANNUAL REPORTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to submit an annual report that—

"(1) identifies each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year; and

"(2) includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.".

SEC. 604. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: "(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)".

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(C)) is amended by adding at the end the following:

"(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking "paragraph (2)" and inserting "paragraphs (2) and (4)"; and

(2) by adding at the end the following new paragraph:

"(4)(A) With respect to any or all of fiscal years 2005 through 2007, a State may elect (in a plan amendment under this title) to provide medical assistance under this title (including under a waiver authorized by the Secretary) for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

"(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

"(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

"(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

"(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).".

(b) SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) Section 1903(v)(4) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX and only with respect to any or all of fiscal years 2005 through 2007.".

SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(i) CONSUMER OMBUDSMAN ACCOUNT.—

"(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Consumer Ombudsman Account' (in this subsection referred to as the 'Account').

"(2) APPROPRIATED AMOUNTS TO ACCOUNT FOR HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.—

"(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year beginning with fiscal year 2005, the amount described in subparagraph (B) for such fiscal year for the purpose of making grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

"(B) AMOUNT DESCRIBED.—For purposes of subparagraph (A), the amount described in this subparagraph for a fiscal year is the amount equal to the product of—

"(i) $1; and

"(ii) the total number of individuals receiving benefits under this title for the calendar year ending on December 31 of the preceding fiscal year.".

(b) CONFORMING AMENDMENT.—Section 4360(g) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b-4(g)) is amended to read as follows:

"(g) FUNDING.—The Secretary shall use amounts appropriated to the Consumer Ombudsman Account in accordance with section 1817(i) of the Social Security Act for a fiscal year for making grants under this section for that fiscal year.".

SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR LOW-INCOME BENEFICIARIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered drugs for an individual described in subsection (b) differs from the drug utilization and access to covered drugs of an individual who qualifies for the transitional assistance prescription drug card program under section 1807A of the Social Security Act (as added by section 111) or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D-19 of the Social Security Act (as added by section 101).

(b) INDIVIDUAL DESCRIBED.—An individual is described in this subsection if the individual does not qualify for the transitional assistance prescription drug card program under section 1807A of the Social Security Act or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D-19 of the Social Security Act solely as a result of the application of an assets test to the individual.

(c) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(d) DEFINITIONS.—In this section:

(1) COVERED DRUGS.—The term "covered drugs" has the meaning given that term in section 1860D(a)(D) of the Social Security Act.

(2) QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARY; QUALIFYING INDIVIDUAL.—The terms "qualified medicare beneficiary", "specified low-income medicare beneficiary" and "qualifying individual" have the meaning given those terms under section 1860D-19 of the Social Security Act.

SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.

At the end of the Social Security Act, add the following new title:

"TITLE XXII—HEALTH CARE INFRASTRUCTURE IMPROVEMENT

"SEC. 2201. DEFINITIONS.

"In this title, the following definitions apply:

"(1) ELIGIBLE PROJECT COSTS.—The term 'eligible project costs' means amounts substantially all of which are paid by, or for the account of, an obligor in connection with a project, including the cost of—

"(A) development phase activities, including planning, feasibility analysis, revenue forecasting, environmental study and review, permitting, architectural engineering and design work, and other preconstruction activities;

"(B) construction, reconstruction, rehabilitation, replacement, and acquisition of facilities and real property (including land related to the project and improvements to land), environmental mitigation, construction contingencies, and acquisition of equipment;

"(C) capitalized interest necessary to meet market requirements, reasonably required reserve funds, capital issuance expenses, and other carrying costs during construction;

"(D) major medical equipment determined to be appropriate by the Secretary; and

"(E) refinancing projects or activities that are otherwise eligible for financial assistance under subparagraphs (A) through (D).

"(2) FEDERAL CREDIT INSTRUMENT.—The term 'Federal credit instrument' means a secured loan, loan guarantee, or line of credit authorized to be made available under this title with respect to a project.

"(3) INVESTMENT-GRADE RATING.—The term 'investment-grade rating' means a rating category of BBB minus, Baa3, or higher assigned by a rating agency to project obligations offered into the capital markets.

"(4) LENDER.—The term 'lender' means any non-Federal qualified institutional buyer (as defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known as Rule 144A(a) of the Securities and Exchange Commission and issued under the Securities Act of 1933 (15 U.S.C. 77a et seq.)), including—

"(A) a qualified retirement plan (as defined in section 4974(c) of the Internal Revenue Code of 1986) that is a qualified institutional buyer; and

"(B) a governmental plan (as defined in section 414(d) of the Internal Revenue Code of 1986) that is a qualified institutional buyer.

"(5) LINE OF CREDIT.—The term 'line of credit' means an agreement entered into by the Secretary with an obligor under section 2204 to provide a direct loan at a future date upon the occurrence of certain events.

"(6) LOAN GUARANTEE.—The term 'loan guarantee' means any guarantee or other pledge by the Secretary to pay all or part of the principal of and interest on a loan or other debt obligation issued by an obligor and funded by a lender.

"(7) LOCAL SERVICER.—The term 'local servicer' means a State or local government or any agency of a State or local government that is responsible for servicing a Federal credit instrument on behalf of the Secretary.

"(8) OBLIGOR.—The term 'obligor' means a party primarily liable for payment of the principal of or interest on a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

"(9) PROJECT.—The term 'project' means any project that is designed to improve the health care infrastructure, including the construction, renovation, or other capital improvement of any hospital, medical research facility, or other medical facility or the purchase of any equipment to be used in a hospital, research facility, or other medical research facility.

"(10) PROJECT OBLIGATION.—The term 'project obligation' means any note, bond, debenture, lease, installment sale agreement, or other debt obligation issued or entered into by an obligor in connection with the financing of a project, other than a Federal credit instrument.

"(11) RATING AGENCY.—The term 'rating agency' means a bond rating agency identified by the Securities and Exchange Commission as a Nationally Recognized Statistical Rating Organization.

"(12) SECURED LOAN.—The term 'secured loan' means a direct loan or other debt obligation issued by an obligor and funded by the Secretary in connection with the financing of a project under section 2203.

"(13) STATE.—The term 'State' has the meaning given the term in section 101 of title 23, United States Code.

"(14) SUBSIDY AMOUNT.—The term 'subsidy amount' means the amount of budget authority sufficient to cover the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a net present value basis, excluding administrative costs and any incidental effects on governmental receipts or outlays in accordance with the provisions of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.).

"(15) SUBSTANTIAL COMPLETION.—The term 'substantial completion' means the opening of a project to patients or for research purposes.

"SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT SELECTION.

"(a) ELIGIBILITY.—To be eligible to receive financial assistance under this title, a project shall meet the following criteria:

"(1) APPLICATION.—A State, a local servicer identified under section 2205(a), or the entity undertaking a project shall submit a project application to the Secretary.

"(2) ELIGIBLE PROJECT COSTS.—To be eligible for assistance under this title, a project shall have total eligible project costs that are reasonably anticipated to equal or exceed $40,000,000.

"(3) SOURCES OF REPAYMENTS.—Project financing shall be repayable, in whole or in part, from reliable revenue sources as described in the application submitted under paragraph (1).

"(4) PUBLIC SPONSORSHIP OF PRIVATE ENTITIES.—In the case of a project that is undertaken by an entity that is not a State or local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be publicly sponsored or sponsored by an entity that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code.

"(b) SELECTION AMONG ELIGIBLE PROJECTS.—

"(1) ESTABLISHMENT.—The Secretary shall establish criteria for selecting among projects that meet the eligibility criteria specified in subsection (a).

"(2) SELECTION CRITERIA.—

"(A) IN GENERAL.—The selection criteria shall include the following:

"(i) The extent to which the project is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

"(ii) The creditworthiness of the project, including a determination by the Secretary that any financing for the project has appropriate security features, such as a rate covenant, credit enhancement requirements, or debt services coverages, to ensure repayment.

"(iii) The extent to which assistance under this title would foster innovative public-private partnerships and attract private debt or equity investment.

"(iv) The likelihood that assistance under this title would enable the project to proceed at an earlier date than the project would otherwise be able to proceed.

"(v) The extent to which the project uses or results in new technologies.

"(vi) The amount of budget authority required to fund the Federal credit instrument made available under this title.

"(vii) The extent to which the project helps maintain or protect the environment.

"(B) SPECIFIC REQUIREMENTS.—The selection criteria shall require that a project applicant—

"(i) be engaged in research in the causes, prevention, and treatment of cancer;

"(ii) be designated as a cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State; and

"(iii) be located in a State that, on the date of enactment of this title, has a population of less than 3,000,000 individuals.

"(C) RATING LETTER.—For purposes of subparagraph (A)(ii), the Secretary shall require each project applicant to provide a rating letter from at least 1 rating agency indicating that the project's senior obligations have the potential to achieve an investment-grade rating with or without credit enhancement.

"SEC. 2203. SECURED LOANS.

"(a) IN GENERAL.—

"(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements with 1 or more obligors to make secured loans, the proceeds of which shall be used—

"(A) to finance eligible project costs;

"(B) to refinance interim construction financing of eligible project costs; or

"(C) to refinance existing debt or prior project obligations;

of any project selected under section 2202.

"(2) LIMITATION ON REFINANCING OF INTERIM CONSTRUCTION FINANCING.—A loan under paragraph (1) shall not refinance interim construction financing under paragraph (1)(B) later than 1 year after the date of substantial completion of the project.

"(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

"(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a secured loan under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

"(A) the Secretary may fund an amount of the secured loan not to exceed the capital reserve subsidy amount determined under paragraph (3) prior to the obligations receiving an investment-grade rating; and

"(B) the Secretary may fund the remaining portion of the secured loan only after the obligations have received an investment-grade rating by at least 1 rating agency.

"(b) TERMS AND LIMITATIONS.—

"(1) IN GENERAL.—A secured loan under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

"(2) MAXIMUM AMOUNT.—The amount of the secured loan shall not exceed 100 percent of the reasonably anticipated eligible project costs.

"(3) PAYMENT.—The secured loan—

"(A) shall—

"(i) be payable, in whole or in part, from reliable revenue sources; and

"(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

"(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

"(4) INTEREST RATE.—The interest rate on the secured loan shall be not less than the yield on marketable United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

"(5) MATURITY DATE.—The final maturity date of the secured loan shall be not later than 30 years after the date of substantial completion of the project.

"(6) NONSUBORDINATION.—The secured loan shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

"(7) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

"(c) REPAYMENT.—

"(1) SCHEDULE.—The Secretary shall establish a repayment schedule for each secured loan under this section based on the projected cash flow from project revenues and other repayment sources.

“(2) COMMENCEMENT.—Scheduled loan repayments of principal or interest on a secured loan under this section shall commence not later than 5 years after the date of substantial completion of the project.

“(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include any revenue generated by the project.

“(4) DEFERRED PAYMENTS.—

“(A) AUTHORIZATION.—If, at any time during the 10 years after the date of substantial completion of the project, the project is unable to generate sufficient revenues to pay the scheduled loan repayments of principal and interest on the secured loan, the Secretary may, subject to subparagraph (C), allow the obligor to add unpaid principal and interest to the outstanding balance of the secured loan.

“(B) INTEREST.—Any payment deferred under subparagraph (A) shall—

“(i) continue to accrue interest in accordance with subsection (b)(4) until fully repaid; and

“(ii) be scheduled to be amortized over the remaining term of the loan beginning not later than 10 years after the date of substantial completion of the project in accordance with paragraph (1).

“(C) CRITERIA.—

“(i) IN GENERAL.—Any payment deferral under subparagraph (A) shall be contingent on the project meeting criteria established by the Secretary.

“(ii) REPAYMENT STANDARDS.—The criteria established under clause (i) shall include standards for reasonable assurance of repayment.

“(5) PREPAYMENT.—

“(A) USE OF EXCESS REVENUES.—Any excess revenues that remain after satisfying scheduled debt service requirements on the project obligations and secured loan and all deposit requirements under the terms of any trust agreement, bond resolution, reimbursement agreement, credit agreement, loan agreement, or similar agreement securing project obligations may be applied annually to prepay the secured loan without penalty.

“(B) USE OF PROCEEDS OF REFINANCING.—The secured loan may be prepaid at any time without penalty, regardless of whether such repayment is from the proceeds of refinancing from non-Federal funding sources.

“(6) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan secured under this title under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the project of—

“(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

“(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

“(C)(i) unique research resources (such as population databases); or

“(ii) an affiliation with an entity that has unique research resources.

“(d) SALE OF SECURED LOANS.—

“(1) IN GENERAL.—Subject to paragraph (2), as soon as practicable after substantial completion of a project and after notifying the obligor, the Secretary may sell to another entity or reoffer into the capital markets a secured loan for the project if the Secretary determines that the sale or reoffering can be made on favorable terms.

“(2) CONSENT OF OBLIGOR.—In making a sale or reoffering under paragraph (1), the Secretary may not change the original terms and conditions of the secured loan without the written consent of the obligor.

“(e) LOAN GUARANTEES.—

“(1) IN GENERAL.—The Secretary may provide a loan guarantee to a lender in lieu of making a secured loan if the Secretary determines that the budgetary cost of the loan guarantee is substantially the same as that of a secured loan.

“(2) TERMS.—The terms of a guaranteed loan shall be consistent with the terms set forth in this section for a secured loan, except that the rate on the guaranteed loan and any prepayment features shall be negotiated between the obligor and the lender, with the consent of the Secretary.

“SEC. 2204. LINES OF CREDIT.

“(a) IN GENERAL.—

“(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements to make available lines of credit to 1 or more obligors in the form of direct loans to be made by the Secretary at future dates on the occurrence of certain events for any project selected under section 2202.

“(2) USE OF PROCEEDS.—The proceeds of a line of credit made available under this section shall be available to pay debt service on project obligations issued to finance eligible project costs, extraordinary repair and replacement costs, operation and maintenance expenses, and costs associated with unexpected Federal or State environmental restrictions.

“(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate subsidy amount for each secured loan, taking into account such letter.

“(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a line of credit under this section shall be contingent on the project's senior obligations receiving an investment-grade rating from at least 1 rating agency.

“(b) TERMS AND LIMITATIONS.—

“(1) IN GENERAL.—A line of credit under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

“(2) MAXIMUM AMOUNTS.—

“(A) TOTAL AMOUNT.—The total amount of the line of credit shall not exceed 33 percent of the reasonably anticipated eligible project costs.

“(B) 1-YEAR DRAWS.—The amount drawn in any 1 year shall not exceed 20 percent of the total amount of the line of credit.

“(3) DRAWS.—Any draw on the line of credit shall represent a direct loan and shall be made only if net revenues from the project (including capitalized interest, any debt service reserve fund, and any other available reserve) are insufficient to pay the costs specified in subsection (a)(2).

“(4) INTEREST RATE.—The interest rate on a direct loan resulting from a draw on the line of credit shall be not less than the yield on 30-year marketable United States Treasury securities as of the date on which the line of credit is obligated.

“(5) SECURITY.—The line of credit—

“(A) shall—

“(i) be payable, in whole or in part, from reliable revenue sources; and

“(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

“(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

“(6) PERIOD OF AVAILABILITY.—The line of credit shall be available during the period beginning on the date of substantial completion of the project and ending not later than 10 years after that date.

“(7) RIGHTS OF THIRD-PARTY CREDITORS.—

“(A) AGAINST FEDERAL GOVERNMENT.—A third-party creditor of the obligor shall not have any right against the Federal Government with respect to any draw on the line of credit.

“(B) ASSIGNMENT.—An obligor may assign the line of credit to 1 or more lenders or to a trustee on the lenders' behalf.

“(8) NONSUBORDINATION.—A direct loan under this section shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

“(9) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of providing a line of credit under this section.

“(10) RELATIONSHIP TO OTHER CREDIT INSTRUMENTS.—A project that receives a line of credit under this section also shall not receive a secured loan or loan guarantee under section 2203 of an amount that, combined with the amount of the line of credit, exceeds 100 percent of eligible project costs.

“(c) REPAYMENT.—

“(1) TERMS AND CONDITIONS.—The Secretary shall establish repayment terms and conditions for each direct loan under this section based on the projected cash flow from project revenues and other repayment sources.

“(2) TIMING.—All scheduled repayments of principal or interest on a direct loan under this section shall commence not later than 5 years after the end of the period of availability specified in subsection (b)(6) and be fully repaid, with interest, by the date that is 25 years after the end of the period of availability specified in subsection (b)(6).

“(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include reliable revenue sources.

“SEC. 2205. PROJECT SERVICING.

“(a) REQUIREMENT.—The State in which a project that receives financial assistance under this title is located may identify a local servicer to assist the Secretary in servicing the Federal credit instrument made available under this title.

“(b) AGENCY; FEES.—If a State identifies a local servicer under subsection (a), the local servicer—

“(1) shall act as the agent for the Secretary; and

“(2) may receive a servicing fee, subject to approval by the Secretary.

“(c) LIABILITY.—A local servicer identified under subsection (a) shall not be liable for the obligations of the obligor to the Secretary or any lender.

“(d) ASSISTANCE FROM EXPERT FIRMS.—The Secretary may retain the services of expert firms in the field of project finance to assist in the underwriting and servicing of Federal credit instruments.

“SEC. 2206. STATE AND LOCAL PERMITS.

“The provision of financial assistance under this title with respect to a project shall not—

"(1) relieve any recipient of the assistance of any obligation to obtain any required State or local permit or approval with respect to the project;

"(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

"(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

"SEC. 2207. REGULATIONS.

"The Secretary may issue such regulations as the Secretary determines appropriate to carry out this title.

"SEC. 2208. FUNDING.

"(a) FUNDING.—

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this title, $49,000,000 to remain available during the period beginning on July 1, 2004 and ending on September 30, 2008.

"(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this title, not more than $2,000,000 for each of fiscal years 2004 through 2008.

"(b) CONTRACT AUTHORITY.—Notwithstanding any other provision of law, approval by the Secretary of a Federal credit instrument that uses funds made available under this title shall be deemed to be acceptance by the United States of a contractual obligation to fund the Federal credit instrument.

"(c) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

"SEC. 2209. REPORT TO CONGRESS.

"Not later than 4 years after the date of enactment of this title, the Secretary shall submit to Congress a report summarizing the financial performance of the projects that are receiving, or have received, assistance under this title, including a recommendation as to whether the objectives of this title are best served—

"(1) by continuing the program under the authority of the Secretary;

"(2) by establishing a Government corporation or Government-sponsored enterprise to administer the program; or

"(3) by phasing out the program and relying on the capital markets to fund the types of infrastructure investments assisted by this title without Federal participation.".

SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

"CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

"SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

"(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

"(A) the acquisition of land necessary for the capital improvements;

"(B) the renovation or modernization of any building;

"(C) the acquisition or repair of fixed or major movable equipment; and

"(D) such other project expenses as the Secretary determines appropriate.

"(2) AUTHORITY TO GUARANTEE LOANS.—

"(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

"(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

"(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

"(c) FUNDING LIMITATIONS.—

"(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

"(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

"(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

"(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

"(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

"(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2008.".

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s-3) is amended by adding at the end the following new paragraph:

"(14)(A) The term 'rural entity' includes—

"(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

"(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

"(I) a county that is not part of a metropolitan statistical area; or

"(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

"(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

"(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

"(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).".

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q-2) is amended—

(1) in subsection (b)(2)(D), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)"; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking "section 1601(a)(2)(B)" and inserting "sections 1601(a)(2)(B) and 1603(a)(2)(B)"; and

(B) in paragraph (2)(A), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)".

SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $250,000,000 for each of fiscal years 2005 through 2008, for the purpose of making allotments under this section to States described in paragraph (1) or (2) of subsection (b). Funds appropriated under the preceding sentence shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State with respect to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall bear the same ratio to the total amount available for allotments under this paragraph for the fiscal year as the ratio of the number of undocumented alien apprehensions in the State in that fiscal year bears to the total of such numbers for all such States for such fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the 4 most recent quarterly apprehension rates for undocumented aliens in such States, as reported by the Immigration and Naturalization Service.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that is described in both of paragraphs (1) and (2) from receiving an allotment under both paragraphs for a fiscal year.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay directly to local governments, hospitals, or other providers located in the State (including providers of services received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization) that provide uncompensated emergency health services furnished to undocumented aliens during that fiscal year, and to the State, such amounts (subject to the total

amount available from such allotments) as the local governments, hospitals, providers, or State demonstrate were incurred for the provision of such services during that fiscal year.

(2) LIMITATION ON STATE USE OF FUNDS.—Funds paid to a State from allotments made under subsection (b) for a fiscal year may only be used for making payments to local governments, hospitals, or other providers for costs incurred in providing emergency health services to undocumented aliens or for State costs incurred with respect to the provision of emergency health services to such aliens.

(3) INCLUSION OF COSTS INCURRED WITH RESPECT TO CERTAIN ALIENS.—Uncompensated emergency health services furnished to aliens who have been allowed to enter the United States for the sole purpose of receiving emergency health services may be included in the determination of costs incurred by a State, local government, hospital, or other provider with respect to the provision of such services.

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which States, local governments, hospitals, or other providers located in the State may apply for payments from allotments made under subsection (b) for a fiscal year for uncompensated emergency health services furnished to undocumented aliens during that fiscal year.

(B) INCLUSION OF MEASURES TO COMBAT FRAUD.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that fraudulent payments are not made from the allotments determined under subsection (b).

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) shall allow for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term "hospital" has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

(2) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms "Indian tribe" and "tribal organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(3) PROVIDER.—The term "provider" includes a physician, any other health care professional licensed under State law, and any other entity that furnishes emergency health services, including ambulance services.

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(5) STATE.—The term "State" means the 50 States and the District of Columbia.

SEC. 611. INCREASE IN APPROPRIATION TO THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by striking "and" at the end; and

(B) by striking subclause (III), and inserting the following new subclauses:

"(III) for fiscal year 2004, the limit for fiscal year 2003 increased by $10,000,000;

"(IV) for fiscal year 2005, the limit for fiscal year 2003 increased by $15,000,000;

"(V) for fiscal year 2006, the limit for fiscal year 2003 increased by $25,000,000; and

"(VI) for each fiscal year after fiscal year 2006, the limit for fiscal year 2003."; and

(2) in clause (ii)—

(A) in subclause (VI), by striking "and" at the end;

(B) in subclause (VII)—

(i) by striking "each fiscal year after fiscal year 2002" and inserting "fiscal year 2003"; and

(ii) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

"(VIII) for fiscal year 2004, $170,000,000;

"(IX) for fiscal year 2005, $175,000,000;

"(X) for fiscal year 2006, $185,000,000; and

"(XI) for each fiscal year after fiscal year 2006, not less than $150,000,000 and not more than $160,000,000.".

SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE CLAIMS ACT.

(a) IN GENERAL.—Section 3729(a) of title 31, United States Code, is amended—

(1) by striking "$5,000" and inserting "$7,500"; and

(2) by striking "$10,000" and inserting "$15,000".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

SEC. 613. INCREASE IN CIVIL MONETARY PENALTIES UNDER THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)), in the matter following paragraph (7), is amended—

(1) by striking "$10,000" each place it appears and inserting "$12,500";

(2) by striking "$15,000" and inserting "$18,750"; and

(3) striking "$50,000" and inserting "$62,500".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

TITLE VII—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 701. SHORT TITLE.

This title may be cited as the "Greater Access to Affordable Pharmaceuticals Act".

SEC. 702. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

"(B) NOTICE OF OPINION THAT PATENT IS NOT VALID OR WILL NOT BE INFRINGED.—

"(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

"(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

"(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

"(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(II) the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is not valid or will not be infringed."; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking "under the following" and inserting "by applying the following to each certification made under paragraph (2)(A)(vii)"; and

(ii) in clause (iii)—

(I) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines is substantially complete, was submitted."; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

"(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(aa) the date on which the court enters judgment reflecting the decision; or

"(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(bb) by striking subclause (II) and inserting the following:

"(II) if before the expiration of such period the district court decides that the patent has been infringed—

"(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

"(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(cc) in subclause (III), by striking "on the date of such court decision." and inserting "as provided in subclause (I); or"; and

(dd) by inserting after subclause (III) the following:

"(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II).";

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

"(C) Civil action to obtain patent certainty.—

"(i) Declaratory judgment absent infringement action.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under paragraph (2)(B) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

"(ii) Counterclaim to infringement action.—

"(I) In general.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) No independent cause of action.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) No damages.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).".

(b) Applications Generally.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b), by striking paragraph (3) and inserting the following:

"(3) Notice of opinion that patent is not valid or will not be infringed.—

"(A) Agreement to give notice.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

"(B) Timing of notice.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

"(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(C) Recipients of notice.—An applicant required under this paragraph to give notice shall give notice to—

"(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) Contents of notice.—A notice required under this paragraph shall—

"(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is not valid or will not be infringed."; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking "under the following" and inserting "by applying the following to each certification made under subsection (b)(2)(A)(iv)";

(B) in subparagraph (C)—

(i) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.";

(ii) in the second sentence—

(I) by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(II) by striking clause (i) and inserting the following:

"(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(I) the date on which the court enters judgment reflecting the decision; or

"(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(III) by striking clause (ii) and inserting the following:

"(ii) if before the expiration of such period the district court decides that the patent has been infringed—

"(I) if the judgment of the district court is appealed, the approval shall be made effective on—

"(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(II) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(IV) in clause (iii), by striking "on the date of such court decision." and inserting "as provided in clause (i); or"; and

(V) by inserting after clause (iii), the following:

"(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii)."; and

(iii) in the third sentence, by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

"(D) Civil action to obtain patent certainty.—

"(i) Declaratory judgment absent infringement action.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

"(ii) Counterclaim to infringement action.—

"(I) In general.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).".

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

"(5) The filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought by the applicant under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.".

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 703. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 02) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

"(iv) 180-DAY EXCLUSIVITY PERIOD.—

"(I) DEFINITIONS.—In this paragraph:

"(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

"(bb) FIRST APPLICANT.—The term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

"(cc) SUBSTANTIALLY COMPLETE APPLICATION.—The term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

"(dd) TENTATIVE APPROVAL.—

"(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

"(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

"(II) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant."; and

(2) by inserting after subparagraph (C) the following:

"(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

"(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

"(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

"(aa) the earlier of the date that is—

"(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

"(BB) 30 months after the date of submission of the application of the first applicant; or

"(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

"(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

"(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

"(CC) The patent expires.

"(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

"(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

"(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

"(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

"(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

"(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

"(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

"(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

"(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

"(II) no applicant shall be eligible for a 180-day exclusivity period.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of

that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) Decision of a court when the 180-day exclusivity period has not been triggered.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term “decision of a court” as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 704. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) In General.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

“(A)(i) The term ‘bioavailability’ means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

“(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action.”; and

(2) by adding at the end the following:

“(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.”.

(b) Effect of Amendment.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 705. REMEDIES FOR INFRINGEMENT.

Section 287 of title 35, United States Code, is amended by adding at the end the following:

“(d) Consideration.—In making a determination with respect to remedy brought for infringement of a patent that claims a drug or a method or using a drug, the court shall consider whether information on the patent was filed as required under 21 U.S.C. 355 (b) or (c), and, if such information was required to be filed but was not, the court may refuse to award treble damages under section 284.”.

SEC. 706. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking “(j)(5)(D)(ii)” each place it appears and inserting “(j)(5)(F)(ii)”;

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking “(j)(5)(D)” each place it appears and inserting “(j)(5)(F)”; and

(3) in subsections (e) and (l), by striking “505(j)(5)(D)” each place it appears and inserting “505(j)(5)(F)”.

TITLE VIII—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 801. IMPORTATION OF PRESCRIPTION DRUGS.

(A) In General.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

“SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

“(a) Definitions.—In this section:

“(1) Importer.—The term ‘importer’ means a pharmacist or wholesaler.

“(2) Pharmacist.—The term ‘pharmacist’ means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

“(3) Prescription drug.—The term ‘prescription drug’ means a drug subject to section 503(b), other than—

“(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

“(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

“(C) an infused drug (including a peritoneal dialysis solution);

“(D) an intravenously injected drug; or

“(E) a drug that is inhaled during surgery.

“(4) Qualifying laboratory.—The term ‘qualifying laboratory’ means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

“(5) Wholesaler.—

“(A) In general.—The term ‘wholesaler’ means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

“(B) Exclusion.—The term ‘wholesaler’ does not include a person authorized to import drugs under section 801(d)(1).

“(b) Regulations.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

“(c) Limitation.—The regulations under subsection (b) shall—

“(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

“(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

“(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

“(d) Information and Records.—

“(1) In general.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

“(A) The name and quantity of the active ingredient of the prescription drug.

“(B) A description of the dosage form of the prescription drug.

“(C) The date on which the prescription drug is shipped.

“(D) The quantity of the prescription drug that is shipped

“(E) The point of origin and destination of the prescription drug.

“(F) The price paid by the importer for the prescription drug.

“(G) Documentation from the foreign seller specifying—

“(i) the original source of the prescription drug; and

“(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

“(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

“(I) The name, address, telephone number, and professional license number (if any) of the importer.

“(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

“(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

“(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

“(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

“(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

“(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

“(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

“(i) is approved for marketing in the United States; and

“(ii) meets all labeling requirements under this Act.

“(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

“(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

“(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

“(2) Maintenance by the secretary.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

“(e) Testing.—The regulations under subsection (b) shall require—

“(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

“(2) if the tests are conducted by the importer—

“(A) that information needed to—

“(i) authenticate the prescription drug being tested; and “(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

“(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

“(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

“(f) Registration of Foreign Sellers.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

“(g) Suspension of Importation.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

“(h) Approved Labeling.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

“(i) Prohibition of Discrimination.—

“(1) In general.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

“(2) Discrimination.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

“(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

“(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

“(j) Charitable Contributions.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

“(k) Waiver Authority for Importation by Individuals.—

“(1) Declarations.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

“(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

“(B) exercise discretion to permit individuals to make such importations in circumstances in which—

“(i) the importation is clearly for personal use; and

“(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

“(2) Waiver authority.—

“(A) In general.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

“(B) Guidance on case-by-case waivers.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

“(3) Drugs imported from Canada.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

“(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

“(B) is accompanied by a copy of a valid prescription;

“(C) is imported from Canada, from a seller registered with the Secretary;

“(D) is a prescription drug approved by the Secretary under chapter V;

“(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

“(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

“(l) Studies; Reports.—

“(1) By the Institute of Medicine of the National Academy of Sciences.—

“(A) Study.—

“(i) In general.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

“(I) importations of prescription drugs made under the regulations under subsection (b); and

“(II) information and documentation submitted under subsection (d).

“(ii) Requirements.—In conducting the study, the Institute of Medicine shall—

“(I) evaluate the compliance of importers with the regulations under subsection (b);

“(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

“(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

“(B) Report.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

“(2) By the comptroller general.—

“(A) Study..—he Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

“(B) Report.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

“(m) Construction.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

“(n) Effectiveness of Section.—

“(1) In general.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

“(2) Procedure.—The Secretary shall not submit a certification under paragraph (1) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

“(A)(i) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

“(ii) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

“(iii) identifies specifically the causes of the increased risk; and

“(iv)(I) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

“(II) if the Secretary determines that any measures described in subclause (I) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

“(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

“(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

“(ii) determines that the benefits do not outweigh the detriment.

“(o) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.”.

(b) Conforming amendments.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking “covered product in violation of section 804” and inserting “prescription drug in violation of section 804”; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(a)" and inserting "prescription drug under section 804(b)".

TITLE IX—OFFSET

SEC. 901. INCREASE IN MEDICAID BEST PRICE REBATE PERCENTAGE.

Section 1927(c)(1)(B)(i) (42 U.S.C. 1396r-8(c)(1)(B)(i)) is amended—

(1) in subclause (IV), by striking "and" at the end;

(2) in subclause (V)—

(A) by inserting "and before January 1, 2004," after "December 31, 1995,"; and

(B) by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subclause:

"(V) after December 31, 2003, is 20 percent.".

Make such changes in subsidy payments to employers under 1860D-21, as added by section 101, to ensure that the total cost of this Act does not exceed $393,000,000,000 during the 10-fiscal-year period that begins on October 1, 2003.

Mr. THOMPSON of California (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

The SPEAKER pro tempore. The gentleman from California (Mr. THOMPSON) is recognized for 5 minutes on his motion to recommit.

Mr. THOMPSON of California. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, during tonight's debate we have heard a number of times the Democrats do not have a feasible Medicare prescription drug proposal. This is just not true. The Blue Dogs have a motion to recommit that offers a real and an affordable prescription drug alternative, and it does so without calling for an end of Medicare. And we have included strong safeguard language that specifically instructs the Secretary to keep the costs of this measure within the $400 billion budget window. The Blue Dog motion to recommit provides Medicare fallback, unlike the Republican bill, protects traditional fee for service Medicare, unlike the Republican bill, and provides billions of dollars of relief for rural providers.

Unfortunately, for America's seniors, our proposal will only get 5 minutes of discussion tonight, 5 minutes to protect Medicare from privatization, 5 minutes to ensure rural seniors have a benefit if the PPOs do not come to their areas. And for all of the Members tonight who have said they are supporting the Republican bill in order to move the debate, the best way to do that is to support this recommit so we can promptly get a measure back here in the morning to vote on.

☐ 0115

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I rise in humble appreciation for the 45 seconds being allowed to me tonight to speak for what I am for in Medicare and to express my extreme disappointment in the leadership of this House for bringing to the floor a bill based on an ideological agenda that will undermine the traditional Medicare program and fail to offer reliable prescription drug coverage for seniors in rural areas, or seriously address the issue of prescription drug costs.

The motion to recommit promptly reported back to the floor will have a guaranteed fallback within Medicare for rural areas if private plans are not available, stronger provisions for rural providers, stays within the $400 billion allocation which safeguards to make sure that that happens, and it is based on the compromise in the other body that will give strong bipartisan support and become law.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentleman from Tennessee (Mr. TANNER).

Mr. TANNER. Mr. Speaker, I did not vote for the Democratic substitute because I thought it was too light on reform. The Republican bill is too light on substance.

Mr. Speaker, we have a middle ground here, if we were only allowed to offer it; and it is what the gentleman from Texas (Mr. STENHOLM) said. Basically, any meaningful reform in the Medicare or health care area, the crux of that matter is, one, a Federal backstop for rural America, which is not in the bill we are considering; and, two, some measure of cost containment. That is how we save the program. Neither one of these essential elements in my judgment is in the bill. If we could get this motion to recommit, we could fix it and we could come back here with strong bipartisan support.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT of Georgia. Mr. Speaker, I say to my colleagues, I plead with my colleagues to let us have this opportunity to recommit. We have had so much debate where we have talked about the cost of these plans, and I thought it was an unfair dig at my good friends, the gentleman from New York (Mr. RANGEL) and the gentleman from Michigan (Mr. DINGELL), and their bill being $1 trillion. That was not true, because there was no effort to put the cost containment in.

But we and the Blue Dogs have put together a budget; we put together a plan at $400 billion that falls right within the issue.

This is an important issue to all the people of this Nation. And here we are at 1:30 in the morning on my birthday. But I will tell my colleagues this: I could not find a better thing to do on my birthday than to be down here fighting for these seniors, that the Democratic Party has been fighting for ever since we have had a Democratic Party. I would hope that we would get this opportunity to recommit.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Vermont (Mr. SANDERS).

Mr. SANDERS. Mr. Speaker, I am not really a Blue Dog.

Mr. Speaker, the Republican proposal ignores the most important prescription drug issue facing our country: cost containment and the need to end the national disgrace by which our citizens are forced to pay, by far, the highest prices in the world for prescription drugs. If we do not pass this motion to recommit, the pharmaceutical industry will have succeeded in keeping prices high and their profits high.

This motion to recommit removes the poison pill in H.R. 1, the so-called Cochran amendment, and establishes a real prescription drug reimportation program with Canada. This provision alone, without costing the taxpayers one penny, will do more to help seniors and all Americans get affordable drugs than the $400 billion being spent by the Republicans.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Illinois (Mr. EMANUEL), who is not a Blue Dog, but knows a good deal when he sees one.

Mr. EMANUEL. Mr. Speaker, the speaker earlier talked about using competition and market forces. This bill allows competition between generics versus name brand, so we get the best price. It allows us to have competition whether we want to buy here in the United States, England, France, or Germany, and allows competition between those prices. It would save money. It uses market forces to reduce prices.

Third, it allows the Secretary of HHS to get the best available price, just like all of the Sam's Clubs all over America. It does that here. It allows competition and market forces to reduce prices.

These provisions have, in the past, received bipartisan support. They should receive bipartisan support today because they represent our common principles of reducing prices and making medications affordable to all Americans.

Mr. THOMPSON of California. Mr. Speaker, I urge this body to vote to send this motion back to committee and promptly report back a solid Medicare prescription drug benefit that we can pass tomorrow.

Mr. THOMAS. Mr. Speaker, I rise in opposition to the motion to recommit.

I do want to announce that today is the gentleman from Iowa's (Mr. NUSSLE) birthday as well.

As my colleagues know, I have a reputation for reading legislation. I apologize. As I began reading the motion to recommit, as I got to page 3, the comment of the gentleman from Vermont ringing in my ears, about how they are really concerned about cost containment.

It turns out subtitle D has been scratched from the bill, my colleagues might like to know. It contains section 131, additional requirements for annual financial report and oversight on the Medicare program. Section 132, trustee report on Medicare's unfunded obligations. That has been scratched from the bill.

And I continued to try to go through; but, actually, you only need the front page. My colleagues heard them say over and over again: "promptly." We know by now: "forthwith," "it works." "It comes back, we can vote on it."

I say: promptly, it does not mean a thing.

Vote "no" on the motion to recommit.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. THOMPSON of California. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 208, noes 223, not voting 4, as follows:

[Roll No. 331]

AYES—208

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Wamp
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOES—223

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

NOT VOTING—4

LaTourette
McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 0138

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. LEVIN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote will be followed by a 5-minute vote on H.R. 2417.

The vote was taken by electronic device, and there were—ayes 216, noes 215, answered "present" 1, not voting 3, as follows:

[Roll No. 332]

AYES—216

Aderholt
Akin
Alexander
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Houghton
Hulshof
Hunter
Hyde
Isakson
Israel
Issa

Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Matheson
McCotter
McCrery
McHugh
McKeon
Mica
Miller (MI)
Miller, Gary
Murphy
Myrick
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Saxton
Schrock
Sessions
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

NOES—215

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Burr
Burton (IN)
Buyer
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
DeMint
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Gutknecht
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hostettler
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lynch
Majette
Maloney
Markey
Marshall
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (FL)
Miller (NC)
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murtha
Musgrave
Nadler
Napolitano
Neal (MA)
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Pence
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Shadegg
Sherman
Skelton
Slaughter
Smith (MI)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tancredo
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

ANSWERED "PRESENT"—1

Istook

NOT VOTING—3

McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 0233

Live pair:

On this vote:

Mr. ISTOOK with Mr. YOUNG of Florida:

Mr. ISTOOK. Mr. Speaker, on my vote just recorded I voted "no." I have a pair with the gentleman from Florida, Mr. YOUNG, who is at a funeral, and desire to change my vote and be recorded as "present."

Mr. OTTER and Mrs. EMERSON changed their vote from "no" to "aye."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to section 3 of House Resolution 299, the text of H.R. 2596 will be appended to the engrossment of H.R. 1; and H.R. 2596 shall be laid on the table.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The pending business is the question of the passage of the bill, H.R. 2417, on which further proceedings were postponed earlier today.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the passage of the bill on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 410, nays 9, not voting 15, as follows:

[Roll No. 333]

YEAS—410

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Regula

Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)

NAYS—9

Capuano
Duncan
Fattah
Filner
Kucinich
Lewis (GA)
Owens
Paul
Waters

NOT VOTING—15

Baker
DeFazio
Dicks
Garrett (NJ)
Jones (NC)
Manzullo
McInnis
Musgrave
Myrick
Radanovich
Rangel
Smith (WA)
Stark
Tancredo
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. OSE) (during the vote). The Chair announces that one panel on the board is not operational and Members may confirm their votes at the voting stations.

□ 0242

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PROVIDING FOR AN ADJOURNMENT OR RECESS OF THE TWO HOUSES

Mr. DELAY. Mr. Speaker, pursuant to section 5 of House Resolution 299, I send to the desk a concurrent resolution (H. Con. Res. 231) and ask for its immediate consideration.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 231

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on the legislative day of Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Monday, July 7, 2003, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Monday, July 7, 2003, or at such other time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate whenever, in their opinion, the public interest shall warrant it.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

CONDITIONAL ADJOURNMENT OF THE HOUSE TO TUESDAY, JULY 1, 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its concurrence in House Concurrent Resolution 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY, JULY 9, 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday, July 9, 2003.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

□ 0245

APPOINTMENT OF HON. TOM DAVIS OF VIRGINIA TO ACT AS SPEAKER PRO TEMPORE TO SIGN ENROLLED BILLS AND JOINT RESOLUTIONS THROUGH JULY 7, 2003

The SPEAKER pro tempore laid before the House the following Communication from the Speaker:

WASHINGTON, DC,
June 26, 2003.

I hereby appoint the Honorable TOM DAVIS to act as Speaker pro tempore to sign enrolled bills and joint resolutions through July 7, 2003.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

The SPEAKER pro tempore (Mr. OSE). Without objection, the appointment is approved.

There was no objection.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 2407

Mr. MICHAUD. Mr. Speaker, I ask unanimous consent that my name be removed as cosponsor of H.R. 2407.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Maine?

There was no objection.

HONORING THE NORTHWESTERN BAND OF THE SHOSHONE NATION

(Mr. BISHOP of Utah asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BISHOP of Utah. Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout northern Utah and southern Idaho, and specifically to pay tribute to this tribe as it enters a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that consumes my district as well as the districts of my colleagues in Idaho and Nevada. Last month, the Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it is called, was the worst slaughter of Native Americans west of the Mississippi, with an estimate of double the number of deaths of those at Wounded Knee. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a solemn and very moving ceremony, the Northwestern Band of the Shoshone Nation was able to perform burial rites for the men, women and children who died on that site 140 years ago. Mr. Speaker, today I wish to honor those members of this tribe who gave their lives on that day in 1863.

I also want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this issue.

Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout Northern Utah and Southern Idaho, and to pay tribute to this tribe as it celebrates a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that makes up my district—and the districts of my colleagues from Idaho and Nevada. Last month, the Northwestern Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it is called, was the worst slaughter west of the Mississippi of Native Americans, with estimates of the dead nearly double those of Wounded Knee, South Dakota. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a solemn and moving ceremony, the Northwestern Band of the Shoshone Nation was able to perform burial rites for the men, women, and children who died on that site over 140 years ago. Mr. Speaker, today I wish to honor those members of the tribe who gave their lives on that day in 1863.

I want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this episode in our nation's history. Their goal is to obtain a total of 150 acres so that the Bear River Massacre site can be turned into a memorial. This story, along with the tribe's history and culture, will be preserved and shared with the public at the nearby American West Heritage Center in Wellsville, Utah, which is also located in my district.

Mr. Speaker, for the benefit of our colleagues, I am also submitting an article for the RECORD from a Salt Lake newspaper, which details the history of this site. I commend the past and current Shoshone leadership for their vision and efforts.

[From the Salt Lake Tribune, Feb. 4, 2003]

THIS HALLOWED GROUND

It never made any sense to call what happened at Idaho's Bear River 140 years ago a ``battle.'' When soldiers based in Salt Lake City went on a mad rampage and killed at least 250 men, women and children of the Northwestern Shoshone tribe on Jan. 29, 1863, it was a massacre.

And it still makes no sense that the site of that blot on our shared history is not officially designated as a national historic site.

Descendants of the Northwestern Shoshone see the historic significance of the place, and so does the National Park Service. But, while the site near Preston in southeastern Idaho drew a small crowd of devoted friends to mark Wednesday's anniversary of the horrible event, what happened there remains something that has been largely air-brushed, Stalin-like, from our official memory.

The stumbling block, apparently, is that Idaho Sen. Larry Craig has for eight years been bottling up a resolution to create a $14 million Bear River National Historic Site and Visitors Center. Craig says the park service has more immediate needs and, given the constant scuffle within all federal agencies for adequate funding, it is true that not every idea for a new national historic site can be fulfilled.

But the Bear River massacre is important enough that it needs to be burned into our collective memory. It was one of the earliest and one of the bloodiest encounters between Native Americans and European settlers in the Far West. Its memory has been kept alive by the tireless efforts of a few Shoshone, most notably Utah's Mae Timbimboo Parry, efforts that themselves deserve to be chronicled at an official historic site.

As the United States gears up to mark the 200th anniversary of Lewis and Clark's Corps of Discovery, with proper notice given to their Shoshone guide Sacagawea, now would be the proper time to note this terribly sad bit of fallout from that courageous expedition. The extra amount of attention that will be focused on Lewis and Clark should be used to earn support from historians, Congress, foundations and the general public to properly mark the site of the Bear River Massacre and formally mourn those who died there.

The place of the Bear River Massacre is a national historic site, whether we say so or not.

We should say so.

THE CRISIS IN LIBERIA

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in response to the troubling situation of unrest in our ally nation of Liberia. Because of the rich history of its birth in 1820 with the valiant acts of freed American slaves in founding the capital of Christopolis, now Monrovia, we certainly have a stake in the need for restoring peace.

Since the end of the seven-year civil war that claimed the lives of over 250,000 people, more than 1.3 million residents have had to flee the country for refuge in neighboring countries, many of which have already reached the end of their meager resources. The series of events in Liberia presents a harsh irony in light of yesterday's events: we celebrated a Constitutional victory in the Grutter v. Bollinger decision that came out of the highest court in the nation. Similarly ironic, on that same day, we saluted the Honorable Mayor Maynard Jackson, Jr., one of the most charismatic civic leaders of all time in his departure at age 65. This ironic juxtaposition of emotions reminds us that no matter how far we think we've gotten, there is always distance to be traveled in the work of making peace in the world.

The U.N. High Court indictment of Liberian President Charles Taylor on charges of crimes against humanity, largely stemming from his participaion in the civil war in Sierra Leone, has created a panic in Monrovia. A Liberian woman stated that "We are all tired of Charles Taylor, but we are afraid that his arrest in Ghana will create chaos." We in the United States now know the feeling of panic as we check the terror threat on a daily basis—today's threat level being Yellow, or "heightened." People shouldn't have to live in fear.

The economic effect of the renewed arms embargo, ban on dealing in rough diamonds, and airline restrictions on Liberia will be substantial for the citizens and business community. However, the human rights abuses such as summary executions, recruitment of child soldiers, sexual violence, looting of civilian property, and forced labor must end now. The mass evacuation aboard the French vessel *Orage* of the hundreds of foreigners, including Americans, holding dual U.S. and Liberian citizenship, Europeans, Lebanese, Ivorian and Indian nationals, Egyptians, and some Africans represents a departure from our goal of uniting our international community in peace. It is a moral imperative that we end the chaos caused by anarchy and criminal behavior. The Ceasefire Agreement between the Republic of Liberia, the Liberians United for Reconciliation and Democracy (LUR) groups, and the Movement for Democracy in Liberia (MODEL) is a start, but our help is imperative. We must make our voices heard and incite action from our colleagues in order to restore peace.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. WYNN (at the request of Ms. PELOSI) for today until 11:00 a.m. on account of personal business.

Mr. YOUNG of Florida (at the request of Mr. DELAY) for today from 6:00 p.m. and the balance of the week on account of attending a funeral.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Member (at the request of Ms. JACKSON-LEE of Texas) to revise and extend their remarks and include extraneous material:)

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 163. An act to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes; to the Committee on Education and the Work Force and the Committee on Resources.

S. 498. An act to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine, in recognition of his contributions to the Nation; to the Committee on Financial Services.

S. 867. An act to designate the facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, as the ``Ronald Reagan Post Office Building''; to the Committee on Government Reform.

ENROLLED BILLS SIGNED

Mr. Trandahl, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 825. An act to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the ``Michael J. Healy Post Office Building''.

H.R. 917. An act to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the ``Floyd Spence Post Office Building''.

H.R. 925. An act to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the ``Cesar Chavez Post Office''.

H.R. 981. An act to designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the "James R. Merry Post Office".

H.R. 985. An act to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the "Delbert L. Latta Post Office Building".

H.R. 1055. An act to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the "Dr. Roswell N. Beck Post Office Building".

H.R. 1368. An act to designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the "Norman D. Shumway Post Office Building".

H.R. 1465. An act to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the "General Charles Gabriel Post Office".

H.R. 1596. An act to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the "Timothy Michael Gaffney Post Office Building".

H.R. 1609. An act to designate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the "Admiral Donald Davis Post Office Building".

H.R. 1740. An act to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the "Dr. Caesar A.W. Clark, Sr. Post Office Building".

H.R. 2030. An act to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building".

SENATE ENROLLED BILL SIGNED

The Speaker announced his signature on an enrolled bill of the Senate of the following title:

S. 858. A act to extend the Abraham Lincoln Bicentennial Commission and for other purposes.

ADJOURNMENT

Mr. DELAY. Mr. Speaker, pursuant to House Concurrent Resolution 231, I move that the House do now adjourn.

The motion was agreed to.

The SPEAKER pro tempore. Pursuant to the previous order of the House of today, the House stands adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

Thereupon (at 2 o'clock and 47 minutes a.m. Friday, June 27, 2003, legislative day of June 26, 2003), pursuant to the previous order of the House of today, the House adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2886. A letter from the Deputy Secretary, Department of Defense, transmitting notification of munitions disposal, pursuant to 50 U.S.C. 1512(4); to the Committee on Armed Services.

2887. A letter from the Acting Under Secretary, Department of Defense, transmitting a report on the results of an evaluation of the programmatic impact of combining funding and administration for the Historically Black Colleges and Universities and Minority Institutions program, the Hispanic-Serving Institutions program, and the American Indian Tribal Colleges program; to the Committee on Armed Services.

2888. A letter from the Secretary, Department of Transportation, transmitting The Department's annual report as required by the Superfund Amendments and Reauthorization Act (SARA) of 1986, as amended, pursuant to 42 U.S.C. 9620; to the Committee on Energy and Commerce.

2889. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Natural Emission Standards for Hazardous Air Pollutants for Source Categories: General Provisions; and Requirements for Control Technology Determinations for Major Sources in Accordance with Clean Air Act Sections, Sections 112(g) and 112(j) [FRL-7498-8] (RIN: 2060-AK52) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2890. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of State Air Quality Plans for Designated Facilities and Pollutants; State of West Virginia; Control of Emissions from Existing Small Municipal Waste Combustion Units [WV06-6027a; FRL-7503-2] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2891. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of State Plans For Designated Facilities and Pollutants: Vermont; Negative Declaration [VT-1226a; FRL-7502-1] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2892. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval of the Clean Air Act, Section 112(I), Authority for Hazardous Air Pollutants: Management and Control of Asbestos Disposal Sites Not Operated After July 9, 1981: State of New Hampshire Department of Environmental Services [FRL-7490-6] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2893. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Revisions to Regional Haze Rule to Incorporate Sulfur Dioxide Milestones and Backstop Emissions Trading Program for Nine Western States and Eligible Indian Tribes Within that Geographic Area [FRL-7504-4] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2894. A letter from the Acting Prinicpal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Standards of Performance for Stationary Gas Turbines [OAR-2002-0053, FRL-7502-4] (RIN: 2060-AK35) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2895. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — National Emission Standards for Hazardous Air Pollutants for Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-Alone Semichemical Pulp Mills [OAR-2002-0045, FRL-7502-7] (RIN: 2060-AK53) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2896. A letter from the Director, Defense Security Cooperation Agency, transmitting the Department of Defense's proposed lease of defense articles to the Government of the Hashemite Kingdom of Jordan (Transmittal No. 02-03), pursuant to 22 U.S.C. 2796a(a); to the Committee on International Relations.

2897. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting notification that effective May 18, 2003 a 25% danger pay allowance has been designated for Saudi Arabia, pursuant to 5 U.S.C. 5928; to the Committee on International Relations.

2898. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting the FY 2002 Annual Report on U.S. Government Assistance to and Cooperative Activities with Eurasia; to the Committee on International Relations.

2899. A letter from the Assistant Attorney General, Department of Justice, transmitting the Department's proposed legislation relating to sexual abuse and contraband offenses relating to Federal prisoners; to the Committee on the Judiciary.

2900. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Airbus Model A319-131, -132, and -133; A320-232 and -233; and A321-231 Series Airplanes; Equipped with International Aero Engines (IAE) V25()()-A5 Engines [Docket No. 2003-NM-124-AD; Amendment 39-13159; AD 2003-10-14] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2901. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dassault Model Mystere-Falcon 50 Series Airplanes [Docket No. 2003-NM-118-AD; Amendment 39-13149; AD 2003-10-04] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2902. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 390 Airplanes [Docket No. 2003-CE-17-AD; Amendment 39-13150; AD 2003-10-05] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2903. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; CFM International (CFMI) CFM56-5C Series Turbofan Engines [Docket No. 95-ANE-64-AD; Amendment 39-

13094; AD 97-09-02R2] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2904. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dornier-Werke G.m.b.H. Model Do 27 Q-6 Airplanes [Docket No. 2002-CE-55-AD; Amendment 39-13096; AD 2003-06-08] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2905. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; SOCATA — Groupe AEROPATIALE Models MS 892A-150, MS 892E-150, MS 893A, MS 893E, MS 894E, Rallye 150T, and Rallye 150ST Airplanes [Docket No. 2002-CE-49-AD; Amendment 39-13095; AD 2003-06-07] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2906. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 440) Series Airplanes [Docket No. 2002-NM-100-AD; Amendment 39-13070; AD 2003-04-21] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2907. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dornier Model 328-100 and -300 Series Airplanes [Docket No. 2002-NM-218-AD; Amendment 39-13084; AD 2003-05-08] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2908. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HC-C2Y(K,R)-1BF/F8477- Propellers [Docket No. 2001-NE-47-AD; Amendment 39-13089; AD 2003-06-02] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2909. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Fokker Model F.28 Mark 0070 and 0100 Series Airplanes [Docket No. 2001-NM-289-AD; Amendment 39-13068; AD 2003-04-19] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2910. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-90-30 Airplanes [Docket No. 2001-NM-212-AD; Amendment 39-13067; AD 2003-04-18] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2911. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dowty Aerospace Propellers, Models R354, R375, R389, and R390 Propellers [Docket No. 2000-NE-18-AD; Amendment 39-13074; AD 2003-04-25] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2912. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HC-B3TN-5() Propellers [Docket No. 2001-NE-44-AD; Amendment 39-13072; AD 2003-04-23] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2913. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HD-E6C-3B/E13890K [Docket No. 2000-NE-60-AD; Amendment 39-13071; AD 2003-04-22] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2914. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2C10 Series Airplanes [Docket No. 2002-NM-93-AD; Amendment 39-13076; AD 2003-04-27] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2915. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 1900D Airplanes [Docket No. 2002-CE-32-AD; Amendment 39-13075; AD 2003-04-26] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2916. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada (Bell) Model 427 Helicopters [Docket No. 2002-SW-19-AD; Amendment 39-13063; AD 2003-04-14] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2917. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Fokker Model F.28 Mark 1000, 2000, 3000, and 4000 Series Airplanes [Docket No. 2001-NM-334-AD; Amendment 39-13057; AD 2003-04-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2918. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model SA341G and SA342J Helicopters [Docket No. 2002-SW-47-AD; Amendment 39-13062; AD 2003-04-13] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2919. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada Limited Model 427 Helicopters [Docket No. 2001-SW-43-AD; Amendment 39-13061; AD 2003-04-12] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2920. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Agusta S.p.A. Model A109E Helicopters [Docket No. 2002-SW-55-AD; Amendment 39-13060; AD 2002-25-51] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2921. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Sikorsky Aircraft Corporation Model S-76A, B, and C Helicopters [Docket No. 2003-SW-06-AD; Amendment 39-13064; AD 2003-04-15] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2922. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-90-30 Airplanes [Docket No. 2001-NM-389-AD; Amendment 39-13058; AD 2003-04-10] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2923. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 100 & 440) Airplanes [Docket No. 2002-NM-100-AD; Amendment 39-13070; AD 2003-04-21 R1] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2924. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model 717-200 Airplanes [Docket No. 2002-NM-353-AD; Amendment 39-13073; AD 2003-04-24] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2925. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Schweizer Aircraft Corporation Model 269D Helicopters [Docket No. 2002-SW-57-AD; Amendment 39-13134; AD 2003-09-05] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2926. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model DC-9-10, -20, -30, -40, and -50 Series Airplanes; and DC-9-81 (MD-81), DC-9-82 (MD-82), DC-9-83 (MD-83), DC-9-87 (MD-87), and MD-88 Airplanes [Docket No. 2001-NM-170-AD; Amendment 39-13136; AD 2003-09-07] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2927. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Cessna Aircraft Company Models 441 and F406 Airplanes [Docket No. 2002-CE-18-AD; Amendment 39-13138; AD 2003-09-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2928. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd & Co KG Models BR700-710A1-10 and

BR700-710A2-20 Turbofan Engines; Correction [Docket No. 2000-NE-48-AD; Amendment 39-13107; AD 2003-07-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2929. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd & Co KG Models BR700-710A1-10 and BR700-710A2-20 Turbofan Engines [Docket No. 2000-NE-48-AD; Amendment 39-13107; AD 2003-07-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2930. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Corporation (Formerly Allison Engine Company) 501-D Series Turboprop Engines [Docket No. 2001-NE-01-AD; Amendment 39-13098; AD 2003-07-02] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2931. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 747-200B and -200F Series Airplanes Powered by Pratt & Whitney JT9D-70 Series Engines [Docket No. 2002-NM-23-AD; Amendment 39-13059; AD 2003-04-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2932. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Model DH.125, HS.125, and BH.125 Series Airplanes; Model BAe.125 Series 800A, 800A (C-29A), 800A (U-125), 800B, 1000A, and 1000B Airplanes; and Model Hawker 800, 800 (including variant U-125A), 1000, and 800XP Airplanes [Docket No. 2002-NM-15-AD; Amendment 39-13069; AD 2003-04-20] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2933. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Beech Models 1900, 1900C, and 1900D Airplanes [Docket No. 2003-CE-07-AD; Amendment 39-13043; AD 2003-03-18] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2934. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a report entitled, "Suspension of Limitations Under the Jerusalem Embassy Act" (Presidential Determination No. 2003-26), pursuant to Public Law 104—45, section 6 (109 Stat. 400); jointly to the Committees on International Relations and Appropriations.

2935. A letter from the Associate Administrator, Office of Veterans Business Development, Small Business Administration, transmitting a letter regarding a report describing the activities of the Committee and any recommendations developed by the Committee for the promotion of small business concerns owned and controlled by veterans; jointly to the Committees on Small Business and Veterans' Affairs.

2936. A letter from the Railroad Retirement Board, transmitting a copy of the 22nd Actuarial Valuation of the Assets and Liabilities Under the Railroad Retirement Acts, pursuant to 45 U.S.C. 231f—1; jointly to the Committees on Ways and Means and Transportation and Infrastructure.

REPORTS OF COMMITTEE ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 438. A bill to increase the a mount of student loans that may be forgiven for teachers in mathematics, science, and special education; with an amendment (Rept. 108–182). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2211. A bill to reauthorize title II of the Higher Education Act of 1965; with an amendment (Rept. 108-183). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2210. A bill to reauthorize the Head Start Act to improve school readiness of disadvantaged children, and for other purposes; with an amendment (Rept. 108–184). Referred to the Committee of the Whole House on the State of the Union.

Mr. POMBO: Committee on Resources. H.R. 74. A bill to direct the Secretary of agriculture to convey certain land in the lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California (Rept. 108–185). Referred to the Committee of the Whole House and the State of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. CASE (for himself, Mr. Sanders, Ms. Bordallo, and Mr. Frost):

H.R. 2607. A bill to modify the contract consolidation requirements in the Small Business Act, and for other purposes; to the Committee on Small Business.

By Mr. SMITH of Michigan (for himself and Mr. Baird):

H.R. 2608. A bill to reauthorize the National Earthquake Hazards Reduction Program, and for other purposes; to the Committee on Science, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CONYERS:

H.R. 2609. A bill to amend title 11, United States Code, to provide for the avoidance of certain transfers, and the alternate prosecution of certain actions, relating to certain retirement benefits; to the Committee on the Judiciary.

By Mr. PETERSON of Minnesota (for himself, Mr. Latham, Mr. Cramer, Mr. Boehner, Mr. Hall, Mr. Simpson, Mr. Dooley of California, Mr. Gutknecht, Mr. Boswell, Mr. Janklow, Mr. Lucas of Kentucky, and Ms. Harris):

H.R. 2610. A bill to amend the Internal Revenue Code of 1986 to restore the estate tax and repeal the carryover basis rule, to increase the estate and gift tax unified credit to an exclusion equivalent of $5,000,000, and to reduce the rate of the estate and gifts taxes to the generally applicable capital gains income tax rate; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself, Mr. Brown of South Carolina, Mr. Evans, Mr. Filner, Mr. Gutierrez, Ms. Corrine Brown of Florida, Mr. Rodriguez, Mr. Ryan of Ohio, and Mr. Frost):

H.R. 2611. A bill to amend title II of the Social Security Act to exempt from the windfall elimination provision of such title individuals who are entitled to retired pay based on at least 20 years of service as a member of a uniformed service; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself and Mr. Evans):

H.R. 2612. A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide specially adapted housing assistance to veterans with permanent and total service-connected disabilities due to the loss, or loss of use of both upper extremities such as to preclude use of the arms at and below the elbows; to the Committee on Veterans' Affairs.

By Mr. SABO (for himself, Ms. Kaptur, and Mr. Frost):

H.R. 2613. A bill to amend title 17, United States Code, to exclude from copyright protection works resulting from scientific research substantially funded by the Federal Government; to the Committee on the Judiciary.

By Mr. McGOVERN (for himself, Mr. Shays, and Mr. Ferguson):

H.R. 2614. A bill to amend the Internal Revenue Code of 1986 to equalize the exclusion from gross income of parking and transportation fringe benefits and to provide for a common cost-of-living adjustment; to the Committee on Ways and Means.

By Mr. COSTELLO (for himself, Mr. Davis of Tennessee, Mr. Oberstar, Mr. Rahall, Mr. Filner, Mr. Menendez, Mr. Cummings, Mr. Lipinski, Mrs. Tauscher, Mr. Bishop of New York, Mr. Blumenauer, Mr. Emanuel, Mr. Nadler, Mr. Clay, Mr. Holden, Ms. Norton, Mr. Honda, Mr. Capuano, Mr. Baird, Ms. Eddie Bernice Johnson of Texas, Mr. Michaud, Mr. Larsen of Washington, Mr. Weiner, Mr. DeFazio, Ms. Millender-McDonald, Ms. Berkley, Mr. Pascrell, Mr. Boswell, Ms. Corrine Brown of Florida, Ms. Carson of Indiana, Mr. Thompson of California, Mr. Hoeffel, Mr. Lampson, Mr. Matheson, and Mr. Carson of Oklahoma):

H.R. 2615. A bill to provide funding for infrastructure investment to restore the United States economy and to enhance the security of transportation and environmental facilities throughout the United States; to the Committee on Transportation and Infrastructure, and in addition to the Committees on Ways and Means, Energy and Commerce, Financial Services, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FARR (for himself, Mr. Wolf, Mr. Hoeffel, Mr. Leach, and Mr. Wexler):

H.R. 2616. A bill to increase the capabilities of the United States to provide reconstruction assistance to countries or regions impacted by armed conflict, and for other purposes; to the Committee on International Relations.

By Mr. SHADEGG:

H.R. 2617. A bill to protect American consumers from identity theft and other forms of fraud; to the Committee on Financial Services, and in addition to the Committees on Ways and Means, and Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. OBEY:

H.R. 2618. A bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; to the Committee on Appropriations.

By Mr. CASE:

H.R. 2619. A bill to provide for the expansion of Kilauea Point National Wildlife Refuge; to the Committee on Resources.

By Mr. SMITH of New Jersey (for himself, Mr. Lantos, Mr. Pitts, Ms. Slaughter, and Ms. Eshoo):

H.R. 2620. A bill to authorize appropriations for fiscal years 2004 and 2005 for the Trafficking Victims Protection Act of 2000, and for other purposes; to the Committee on International Relations, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ALLEN (for himself, Mr. Simmons, Mr. Delahunt, Mrs. Capps, Mr. Capuano, Mr. Farr, Mr. Markey, Mr. George Miller of California, and Ms. Woolsey):

H.R. 2621. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fishing quota systems; to the Committee on Resources.

By Mr. BACHUS (for himself, Ms. Hooley of Oregon, Mrs. Biggert, Mr. Moore, Mr. LaTourette, Mr. Kanjorski, Mr. Castle, Mrs. Maloney, Mr. Shadegg, Mr. Ford, Mr. Tiberi, Mr. Hinojosa, Mr. Hensarling, Mr. Crowley, Mr. Sessions, Mr. Ross, Mr. Matheson, Mr. Davis of Alabama, Mr. Baker, Mr. King of New York, Mr. Lucas of Oklahoma, Mr. Lucas of Kentucky, Mr. Ney, Mrs. Kelly, Mr. Jones of North Carolina, Mr. Israel, Ms. Hart, Mr. Miller of North Carolina, Mrs. Capito, Mrs. McCarthy of New York, Mr. Barrett of South Carolina, Mr. Feeney, and Ms. Harris):

H.R. 2622. A bill to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes; to the Committee on Financial Services.

By Mr. BACHUS:

H.R. 2623. A bill to provide for the expansion of the Cahaba River National Wildlife Refuge in Bibb County, Alabama; to the Committee on Resources.

By Mr. BOSWELL:

H.R. 2624. A bill to amend title XVIII of the Social Security Act to improve the provision of items and services provided to Medicare beneficiaries residing in rural areas; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WAXMAN (for himself, Mr. Frost, Mr. Kind, Mr. Ackerman, Ms. Berkley, Mr. Carson of Oklahoma, Mr. Davis of Florida, Mr. Dooley of California, Mr. Engel, Mr. Etheridge, Mr. Ford, Mr. Hill, Mr. Israel, Mr. Lynch, Mrs. Maloney, Mr. Markey, Mr. Meehan, Mr. Pascrell, Ms. Schakowsky, Mr. Schiff, Mr. Sherman, Mrs. Tauscher, Mr. Weiner, and Mr. Wexler):

H.R. 2625. A bill to establish the Independent Commission on Intelligence about Iraq; to the Committee on Intelligence (Permanent Select).

By Mr. UPTON (for himself and Mr. Kind):

H.R. 2626. A bill to amend the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1966 to improve certain child nutrition programs, and for other purposes; to the Committee on Education and the Workforce.

By Mr. BURTON of Indiana (for himself, Mr. Pallone, and Mr. Paul):

H.R. 2627. A bill to amend the Internal Revenue Code of 1986 to provide that amounts paid for foods for special dietary use, dietary supplements, or medical foods shall be treated as medical expenses; to the Committee on Ways and Means.

By Mr. CAPUANO (for himself, Mr. Quinn, Mr. Abercrombie, Mr. Reyes, Ms. Lee, Mr. Grijalva, Mr. Lewis of Kentucky, Ms. Schakowsky, Mr. Rangel, Mr. Hinchey, Ms. Millender-McDonald, Mr. Owens, and Mr. Lantos):

H.R. 2628. A bill to provide affordable housing opportunities for families that are headed by grandparents and other relatives of children; to the Committee on Financial Services.

By Mr. CROWLEY (for himself, Mr. Sanders, Mr. Case, Mr. Hinchey, and Mrs. Maloney):

H.R. 2629. A bill to provide for the importation of drugs into the United States from Canada and Mexico,, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. JACKSON-LEE of Texas (for herself, Mr. Conyers, Mr. Gutierrez, Mr. Reyes, Mr. Rodriguez, Mr. Green of Texas, Mr. Gonzalez, Mr. Lampson, Mr. Frost, Mr. Grijalva, Ms. Solis, Mr. Sandlin, Mr. Becerra, Ms. Watson, Mr. Meek of Florida, Ms. Eddie Bernice Johnson of Texas, Ms. Lee, Mr. Hinchey, Mr. Meeks of New York, Mr. Menendez, Mr. Baca, Mr. Ortiz, Ms. Velázquez, Mrs. Napolitano, Mr. Honda, Mr. Serrano, Mr. Hinojosa, Mr. Farr, Mr. Berman, Ms. Loretta Sanchez of California, Ms. Linda T. Sánchez of California, Mr. Lewis of Georgia, Ms. Millender-McDonald, Mr. Meehan, and Ms. Lofgren):

H.R. 2630. A bill to prevent commercial alien smuggling, and for other purposes; to the Committee on the Judiciary.

By Mr. TOM DAVIS of Virginia (for himself, Mr. Wolf, Mrs. Jo Ann Davis of Virginia, and Mr. Moran of Virginia):

H.R. 2631. A bill to provide that the actuarial value of the prescription drug benefits offered to Medicare eligible enrollees by a plan under the Federal employees health benefits program shall be at least equal to the actuarial value of the prescription drug benefits offered by such plan to its enrollees generally; to the Committee on Government Reform.

By Mr. DUNCAN:

H.R. 2632. A bill to direct the Secretary of Transportation to issue a regulation requiring the installation of 2 combination cockpit voice recorder and digital flight data recorder systems in each commercial passenger aircraft, currently required to carry each of those recorders, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. EMANUEL (for himself, Mr. Ose, Mr. Frost, Mr. Sanders, Ms. Hooley of Oregon, Mr. Oberstar, Ms. DeLauro, Mr. Boucher, Mr. Davis of Alabama, Ms. Carson of Indiana, Mr. Davis of Illinois, Mr. Lantos, Mr. Cardoza, Mr. Tierney, Mr. Case, Mr. Grijalva, Mrs. McCarthy of New York, Ms. Linda T. Sánchez of California, and Mr. Serrano):

H.R. 2633. A bill to establish methods for preventing identity theft and to amend the Fair Credit Reporting Act to protect consumers' sensitive, private health-related information, and for other purposes; to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, the Judiciary, and Financial Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ENGLISH (for himself and Mr. Hayworth):

H.R. 2634. A bill to suspend temporarily the duty on certain steam generators and certain reactor vessel heads for use in nuclear reactors; to the Committee on Ways and Means.

By Mr. ENGLISH:

H.R. 2635. A bill to make permanent the reduction in capital gains rates for individuals made by the Jobs and Growth Tax Relief Reconciliation Act of 2003; to the Committee on Ways and Means.

By Mr. GREEN of Wisconsin (for himself, Mr. McInnis, and Mr. Ryan of Wisconsin):

H.R. 2636. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GUTIERREZ (for himself, Ms. DeLauro, Mr. Engel, Mr. Frost, Mr. Kucinich, Ms. Bordallo, Mr. Grijalva, Mr. McDermott, Ms. Eshoo, Ms. Lee, Mr. Owens, Mr. Lantos, Mr. Serrano, and Mr. Emanuel):

H.R. 2637. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions; to the Committee on Financial Services.

By Mr. HERGER:

H.R. 2638. A bill to amend the Internal Revenue Code of 1986 to make permanent the increase in expensing of certain depreciable business assets enacted by the Jobs and Growth Tax Relief Reconciliation Act 2003; to the Committee on Ways and Means.

By Ms. HOOLEY of Oregon:

H.R. 2639. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. KENNEDY of Rhode Island (for himself, Mr. Frost, and Ms. Norton):

H.R. 2640. A bill to provide greater access to affordable pharmaceuticals, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GEORGE MILLER of California (for himself and Mrs. Tauscher):

H.R. 2641. A bill to authorize the Secretary of the Interior to implement the Calfed Bay-Delta Program; to the Committee on Resources, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. MYRICK:

H.R. 2642. A bill to suspend temporarily the duty on Procion Yellow H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2643. A bill to suspend temporarily the duty on Procion Crimson H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2644. A bill to suspend temporarily the duty on Procion Navy H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2645. A bill to suspend temporarily the duty on Dianix Black XF; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2646. A bill to suspend temporarily the duty on Dianix Crimson SF; to the Committee on Ways and Means.

By Ms. NORTON:

H.R. 2647. A bill to provide for nuclear disarmament and economic conversion in accordance with District of Columbia Initiative Measure Number 37 of 1992; to the Committee on Armed Services, and in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. POMBO:

H.R. 2648. A bill to amend the Internal Revenue Code of 1986 to permit the use of proceeds of tax exempt private activity bonds for community and water facility loans guaranteed under the Consolidated Farm and Rural Development Act; to the Committee on Ways and Means.

By Mr. PORTER (for himself, Mr. Carter, and Mr. Cole):

H.R. 2649. A bill to prohibit the Secretary of Education from making any funds available to a State under any program administered by the Department of Education unless the Secretary determines that the State has in place a criminal information sharing system; to the Committee on Education and the Workforce.

By Mr. RAHALL (for himself, Ms. Pelosi, Mr. Udall of New Mexico, Mr. Rodriguez, and Mr. Hoyer):

H.R. 2650. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service; to the Committee on Resources.

By Ms. LINDA T. SÁNCHEZ of California (for herself, Mr. George Miller of California, Mr. Towns, Mr. Rush, Ms. Millender-McDonald, Mr. Frost, Mr. Grijalva, Mr. Pastor, Mr. Ortiz, Mr. Reyes, Mr. Hinojosa, Mr. Baca, Ms. Jackson-Lee of Texas, Mr. McGovern, Mr. Serrano, Mr. Etheridge, Mr. Engel, Mr. McDermott, Mr. Nadler, Mrs. Davis of California, and Ms. DeLauro):

H.R. 2651. A bill to direct the Secretary of Education to make grants to States to establish antibullying programs; to the Committee on Education and the Workforce.

By Mr. STUPAK:

H.R. 2652. A bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the sale of prescription drugs through the Internet; to the Committee on Energy and Commerce.

By Mr. UDALL of Colorado:

H.R. 2653. A bill to facilitate acquisition by the Secretary of the Interior of certain mineral rights, and for other purposes; to the Committee on Resources.

By Mr. VITTER:

H.R. 2654. A bill to amend the Outer Continental Shelf Lands Act to direct the Secretary of the Interior to issue regulations under which the Secretary may authorize use of a decommissioned offshore oil and gas platform for culture of marine organisms, an artificial reef, or scientific research, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WALSH (for himself, Mr. King of New York, Mr. Neal of Massachusetts, Mr. Crowley, Mr. Sweeney, Mr. McDermott, Mrs. McCarthy of New York, Mr. Doyle, Mr. Quinn, Mr. Mollohan, Mr. Holden, Mr. Smith of New Jersey, Mr. Ackerman, Mr. McNulty, Mr. Engel, Mr. Payne, Mr. Frost, and Mr. Duncan):

H.R. 2655. A bill to amend and extend the Irish Peace Process Cultural and Training Program Act of 1998; to the Committee on the Judiciary, and in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. WOOLSEY (for herself and Mr. Thompson of California):

H.R. 2656. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Resources.

By Mr. KING of New York (for himself, Mr. Walsh, Mr. Neal of Massachusetts, Mr. Crowley, Mr. Sweeney, Mr. Smith of New Jersey, Mr. Delahunt, Mr. Quinn, Mr. Capuano, Mr. Ackerman, Mr. Engel, Mr. Evans, Mr. Fossella, Mr. Holden, Mrs. Maloney, Mr. McNulty, Mr. Owens, Mr. Souder, and Mr. Weiner):

H.J. Res. 62. A joint resolution recognizing Commodore John Barry as the first flag officer of the United States Navy; to the Committee on Armed Services.

By Mr. DeLAY:

H. Con. Res. 231. Concurrent resolution providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate; considered and agreed to.

By Mr. ANDREWS (for himself, Mr. Sessions, Mr. Hefley, Mr. Souder, Mr. Pence, Mr. Burton of Indiana, and Mr. Wu):

H. Con. Res. 232. Concurrent resolution expressing the sense of Congress regarding security for Taiwan; to the Committee on International Relations.

By Mr. FOSSELLA (for himself and Mr. Towns):

H. Con. Res. 233. Concurrent resolution expressing the sense of Congress regarding the dire humanitarian situation in Liberia and efforts to introduce peace and justice to that country; to the Committee on International Relations.

By Ms. KILPATRICK (for herself, Mrs. Christensen, Mr. Serrano, Mr. Stark, Mr. Owens, Mr. Hoeffel, Mr. Davis of Illinois, Ms. Carson of Indiana, Mr. Waxman, Ms. Lee, Mrs. Jones of Ohio, Ms. Norton, and Mr. Kildee):

H. Con. Res. 234. Concurrent resolution recognizing the importance of preserving the survival of essential urban hospitals; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PASCRELL (for himself, Mr. Oxley, Mr. Brown of Ohio, Mr. Clay, Mr. Etheridge, Mr. Ferguson, Mr. Ford, Mr. Frost, Mr. Holt, Mr. Jefferson, Mr. Kucinich, Mr. Payne, Mr. Towns, Mr. Grijalva, Mr. McDermott, Mrs. Christensen, Mr. Pallone, Mr. Sabo, Mr. King of New York, Mr. Frank of Massachusetts, Ms. Kaptur, Mr. Acevedo-Vilá, Mr. Neal of Massachusetts, Mr. Doyle, Mr. Capuano, and Mr. Brady of Pennsylvania):

H. Con. Res. 235. Concurrent resolution celebrating the life and achievements of Lawrence Eugene "Larry" Doby; to the Committee on Government Reform.

By Mr. POMEROY:

H. Con. Res. 236. Concurrent resolution permitting the use of the rotunda of the Capitol for a ceremony to commemorate the unveiling of the statue of Sakajawea provided by the State of North Dakota for display in Statuary Hall; to the Committee on House Administration.

By Mr. RENZI (for himself, Mr. Franks of Arizona, and Mr. Grijalva):

H. Con. Res. 237. Concurrent resolution honoring the late Rick Lupe, lead forestry technician for the Bureau of Indian Affairs Fort Apache Agency, for his dedication and service to the United States and for his essential service in fighting wildfires and protecting the environment and communities of Arizona; to the Committee on Resources.

By Mr. ROHRABACHER:

H. Con. Res. 238. Concurrent resolution supporting efforts to advance regional and community based water and sanitation needs of Israelis, Palestinians, and Jordanians as an effective bridge for peace building in the Middle East; to the Committee on International Relations.

By Ms. WATSON (for herself, Mr. Lantos, and Mr. Payne):

H. Con. Res. 239. Concurrent resolution expressing the sense of the Congress that the global diamond industry, as represented by the World Diamond Council, should provide transition development assistance to communities in Sierra Leone, Angola, and the Democratic Republic of Congo, where the illicit trade in conflict diamonds for arms fueled civil war, and for other purposes; to the Committee on International Relations.

By Mr. HOEKSTRA:

H. Res. 300. A resolution recognizing the outstanding contributions of the faculty, staff, students, and alumni of Christian colleges and universities; to the Committee on Education and the Workforce.

By Mr. ABERCROMBIE:

H. Res. 301. A resolution expressing the sense of the House of Representatives that the Federal Government should actively pursue a unified approach to strengthen and promote the national policy on aquaculture; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FILNER (for himself, Mr. Towns, Mr. Cooper, Mrs. Tauscher, Mr. McGovern, Mr. Abercrombie, Mr. Pallone, Mr. Kirk, and Mr. Kucinich):

H. Res. 302. A resolution calling for the immediate and unconditional release from prison of certain Kurdish members of the Parliament of the Republic of Turkey; to the Committee on International Relations.

By Mr. LEWIS of Georgia (for himself, Mr. Scott of Georgia, Mr. Marshall, Mr. Bishop of Georgia, Ms. Majette, Mr. Isakson, Mr. Linder, Mr. Norwood, Mr. Kingston, Mr. Burns, Mr. Gingrey, Mr. Collins, Mr. Deal of Georgia, Mr. Ford, Ms. Lee, Mr. Davis of Illinois, Mr. Ballance, Mrs. Jones of Ohio, Mr. Watt, Ms. Corrine Brown of Florida, Mr. Rush, Mr. Scott of Virginia, Mr. Owens, Mr. Jefferson, Mr. Clay, Mr. Rangel, Mr. Meek of Florida, Mr. Cummings, Ms. Waters, Ms. Jackson-Lee of Texas, Mrs. Christensen, Mr. Payne, Ms. Millender-McDonald, and Mr. Thompson of Mississippi):

H. Res. 303. A resolution honoring Maynard Holbrook Jackson, Jr., former Mayor of the City of Atlanta, and extending the condolences of the House of Representatives on his death; to the Committee on Government Reform.

By Mrs. NORTHUP:

H. Res. 304. A resolution expressing the sense of the House of Representatives regarding United States citizens adopting children from the People's Republic of China; to the Committee on the Judiciary.

By Mr. ROTHMAN (for himself, Mr. Garrett of New Jersey, Mr. Andrews, Mr. LoBiondo, Mr. Pascrell, Mr. Ferguson, Mr. Pallone, Mr. Saxton, Mr. Payne, Mr. Frelinghuysen, Mr. Holt, Mr. Smith of New Jersey, and Mr. Menendez):

H. Res. 305. A resolution congratulating the New Jersey Devils for winning the 2003 Stanley Cup championship; to the Committee on Government Reform.

By Mr. SERRANO (for himself and Mr. Ney):

H. Res. 306. A resolution congratulating the New York Yankees on the occasion of their 100th anniversary; to the Committee on Government Reform.

By Mrs. TAUSCHER (for herself, Mr. Taylor of Mississippi, Mr. Waxman, Mr. Spratt, Mr. Allen, Mr. Cooper, Mr. Skelton, Mr. Frost, Mr. Schiff, and Mr. Dooley of California):

H. Res. 307. A resolution creating a select committee to investigate the effectiveness of the United States' intelligence structure to meet global threats; to the Committee on Rules.

MEMORIALS

Under clause 3 of rule XII,

134. The SPEAKER presented a memorial of the Senate of the State of Hawaii, relative to Senate Resolution No. 36 memorializing the United States Congress to appropriate adequate financial impact assistance for health, education, and other social services for Hawaii's Freely Associated States citizens; jointly to the Committees on Agriculture, Financial Services, Ways and Means, and Energy and Commerce.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 22: Mr. Wamp.

H.R. 91: Mr. Neugebauer.

H.R. 193: Mr. Boozman.

H.R. 218: Mr. Kildee and Mr. Hoekstra.

H.R. 236: Mr. Ross, Mr. Ruppersberger, and Mr. Scott of Georgia.

H.R. 276: Mr. Hastings of Washington.

H.R. 284: Mrs. Miller of Michigan, Mr. Young of Alaska, Mr. Dicks, Mr. Boozman, and Mr. Lewis of Georgia.

H.R. 290: Mr. Whitfield, Mr. Wynn, Mr. Owens, and Mr. Upton.

H.R. 339: Mr. Rogers of Michigan.

H.R. 384: Mr. Goode.

H.R. 401: Mr. Murphy.

H.R. 438: Mr. Bradley of New Hampshire and Ms. Eddie Bernice Johnson of Texas.

H.R. 465: Mr. Lewis of Kentucky and Mr. Manzullo.

H.R. 466: Mr. Janklow.

H.R. 505: Mrs. Wilson of New Mexico.

H.R. 528: Mr. Ramstad and Mr. Ferguson.

H.R. 577: Mr. Dingell and Mr. Ballance.

H.R. 594: Mr. Bishop of Utah, Mr. Peterson of Minnesota, and Mr. McDermott.

H.R. 643: Mr. Evans.

H.R. 648: Mr. Boozman.

H.R. 668: Ms. Watson.

H.R. 716: Mr. Sandlin.

H.R. 745: Mr. Gephardt.

H.R. 806: Mrs. Northup, Mr. Kingston, Ms. Lee, Mr. Rangel, Mr. Upton, and Mr. Olver.

H.R. 812: Mr. Sessions.

H.R. 817: Mr. Norwood.

H.R. 834: Ms. McCarthy of Missouri, Mr. Istook, Ms. Jackson-Lee of Texas, Mr. Lucas of Oklahoma, and Mr. Owens.

H.R. 839: Mr. Gerlach, Mr. Ryan of Ohio, Mr. Towns, Mr. Lampson, Mr. Pombo, Mr. Pascrell, Mr. Emanuel, Mrs. Maloney, Mr. Jefferson, Mr. Stupak, and Mr. Kanjorski.

H.R. 876: Mr. Kennedy of Minnesota.

H.R. 898: Ms. Millender-McDonald, Mr. Serrano, Mr. Waxman, Mr. Osborne, Mr. Conyers, Mrs. Kelly, Mr. Garrett of New Jersey, Mr. Clyburn, and Mr. Marshall.

H.R. 918: Mr. Oberstar, Mr. LaHood, Mr. Meehan, Mr. Rogers of Michigan, Mr. Stupak, Mr. Pascrell, Mr. Holt, Ms. McCollum, Ms. Baldwin, and Mr. Payne.

H.R. 919: Mr. Shaw.

H.R. 970: Mr. Spratt, Mr. Green of Wisconsin, Ms. DeLauro, and Mr. Rogers of Michigan.

H.R. 980: Mr. Hinchey, Mr. Filner, and Mr. Tierney.

H.R. 990: Mr. Bishop of Utah, Mr. Burgess, Mr. Bartlett of Maryland, Mrs. Cubin, Mr. Collins, Mr. DeMint, Mr. Sandlin, Mr. Carter, Mr. Rogers of Kentucky, Mr. Keller, and Mr. Foley.

H.R. 996: Mr. Portman and Mr. Tiahrt.

H.R. 997: Mr. Miller of Florida.

H.R. 1006: Mr. Kucinich and Ms. Linda T. Sánchez of California.

H.R. 1008: Mr. Latham and Mr. Beauprez.

H.R. 1046: Mr. McDermott.

H.R. 1049: Mr. Franks of Arizona.

H.R. 1059: Mr. McGovern.

H.R. 1066: Mr. Cannon.

H.R. 1068: Mr. Smith of New Jersey, Mr. Udall of New Mexico, Mr. Murphy, Mr. Schrock, Mr. Israel, and Mr. Toomey.

H.R. 1088: Ms. Ros-Lehtinen and Mr. Owens.

H.R. 1097: Mr. Larson of Connecticut and Mr. Owens.

H.R. 1102: Mr. Pomeroy.

H.R. 1117: Mr. Barton of Texas.

H.R. 1157: Mr. Oberstar, Mr. Cummings, and Mrs. Davis of California.

H.R. 1169: Mr. Janklow.

H.R. 1196: Mr. Wu.

H.R. 1207: Mr. Clyburn.

H.R. 1220: Mr. Issa.

H.R. 1231: Mr. Clyburn, Mr. Smith of Texas, Mrs. Musgrave, Mr. Meek of Florida, Mr. Lampson, Mr. Peterson of Minnesota, Mr. Goss, and Mr. Quinn.

H.R. 1244: Ms. Corrine Brown of Florida, Mr. McGovern, and Ms. Berkley.

H.R. 1260: Mr. Thornberry.

H.R. 1268: Mr. Clyburn and Mr. Deutsch.

H.R. 1279: Mr. Kildee.

H.R. 1288: Mrs. Musgrave and Mr. Emanuel.

H.R. 1301: Ms. Lofgren, Mr. Gerlach, Mr. Lynch, and Mr. Goode.

H.R. 1310: Mr. Sessions.

H.R. 1347: Mr. McGovern, Mr. Owens, and Mr. Frost.

H.R. 1372: Mr. Sam Johnson of Texas, Mr. Hensarling, Mr. Bell, Mr. Rohrabacher, and Mr. Meehan.

H.R. 1385: Mr. Oberstar, Mr. Matheson, Mr. English, and Ms. Velázquez.

H.R. 1400: Mr. Blumenauer.

H.R. 1414: Mr. DeFazio.

H.R. 1429: Mr. Evans.

H.R. 1461: Mr. Rothman.

H.R. 1466: Mr. Gordon.

H.R. 1477: Mr. Andrews.

H.R. 1482: Mr. Owens.

H.R. 1499: Mr. Owens.

H.R. 1501: Mrs. Napolitano.

H.R. 1532: Ms. Slaughter, Ms. Harman, Mr. Filner, Mr. Allen, and Mr. Dicks.

H.R. 1563: Mr. Wexler.

H.R. 1582: Mr. Janklow, Mr. Hensarling, Mr. Wu, Mr. Gonzalez, and Mr. King of Iowa.

H.R. 1592: Mrs. Davis of California.

H.R. 1611: Ms. DeLauro.

H.R. 1622: Mr. DeMint, Mr. Boozman, and Mr. Bonilla.

H.R. 1639: Mr. Moran of Virginia, Mr. Wexler, and Mr. Green of Texas.

H.R. 1641: Mr. Blumenauer.

H.R. 1675: Mr. Hastings of Washington.

H.R. 1684: Mr. Van Hollen, Ms. DeGette, Mr. Moore, Mr. Crowley, Mr. Farr, Mr. Moran of Virginia, Ms. Carson of Indiana, Mr. Engel, Mr. Tierney, Mr. Rangel, Mr. Meeks of New York, Ms. Eshoo, Mr. Schiff, Mr. McDermott, Mr. Bell, Ms. Norton, Mr. Wexler, Mr. Filner, Mr. Holt, Mr. Serrano, Mrs. Napolitano, Mr. Frank of Massachusetts, Mr. Price of North Carolina, and Mr. Blumenauer.

H.R. 1690: Mr. Filner.

H.R. 1707: Mr. Souder, Mr. Aderholt, Mr. Forbes, Mrs. Jo Ann Davis of Virginia, and Mr. Clyburn.

H.R. 1749: Mr. Putnam, Mr. Lewis of Kentucky, Mr. Frost, and Mrs. Christensen.

H.R. 1767: Mr. Hastings of Washington, Mr. Toomey, Mr. Bilirakis, Mr. Moran of Virginia, and Mr. Nethercutt.

H.R. 1769: Mr. Thompson of California and Ms. Linda T. Sánchez of California.

H.R. 1771: Mr. Calvert.

H.R. 1776: Mr. Emanuel.

H.R. 1792: Mr. Frost, Mr. Rodriguez, Ms. Bordallo, Mr. Sanders, Mr. Wilson of South Carolina, Mr. Souder, Mr. Towns, Mr. Grijalva, and Mr. Owens.

H.R. 1813: Ms. Eshoo.

H.R. 1819: Mr. Leach and Mr. Fletcher.

H.R. 1824: Mr. Dicks, Mr. Rothman, Mr. Brady of Pennsylvania, Mr. Baird, and Mr. Pascrell.

H.R. 1828: Ms. Norton, Mr. Becerra, Mr. Udall of New Mexico, Mr. Cooper, Mr. Menendez, Mr. Frelinghuysen, Mr. LoBiondo, Mr. Fletcher, Mrs. Capito, and Mr. Castle.

H.R. 1829: Mr. Platts and Mr. Meehan.

H.R. 1865: Mr. Leach.

H.R. 1867: Mr. Paul and Mr. Duncan.

H.R. 1874: Mr. Engel and Mr. Kucinich.

H.R. 1886: Ms. Velázquez and Mr. Davis of Tennessee.

H.R. 1918: Mr. Murphy.

H.R. 1919: Mr. McGovern, Mr. Grijalva, and Ms. Carson of Indiana.

H.R. 1920: Mr. McGovern, Mr. Owens, and Mrs. Christensen.

H.R. 1921: Mr. McGovern and Mr. Owens.

H.R. 1924: Mr. McGovern, Mr. Owens, Mr. Frost, and Mr. McIntyre.

H.R. 1997: Mr. Rahall and Mr. Lucas of Oklahoma.

H.R. 2008: Mrs. Christensen.

H.R. 2009: Mr. McGovern and Mr. Simmons.

H.R. 2011: Mr. Deutsch, Ms. Waters, Mr. Hayes, Mr. McHugh, Mr. Pastor, and Ms. McCollum.

H.R. 2042: Ms. Lee, Mr. Payne, Ms. McCarthy of Missouri, Mr. Inslee, Ms. Baldwin, Mrs. Napolitano, Ms. Slaughter, Mr. Case, Mrs. Tauscher, Ms. Carson of Indiana, Mr. Delahunt, and Mr. Israel.

H.R. 2047: Mr. Pomeroy.

H.R. 2053: Mr. Abercrombie and Mr. Grijalva.

H.R. 2075: Mr. Goss, Mr. Foley, Ms. Ros-Lehtinen, and Mr. Crenshaw.

H.R. 2090: Mr. Kucinich.

H.R. 2096: Mr. Green of Texas, Mr. Foley, Mr. Collins, Mr. Simmons, Mr. Skelton, Ms. Velázquez, Mr. Smith of New Jersey, and Mr. Moran of Virginia.

H.R. 2125: Mr. Stupak.

H.R. 2154: Mr. Lipinski.

H.R. 2172: Mr. Gillmor, Mr. McGovern, and Mr. Camp.

H.R. 2178: Mr. Ramstad.

H.R. 2180: Mrs. Biggert.

H.R. 2193: Mr. Ackerman and Mrs. McCarthy of New York.

H.R. 2203: Mr. Owens.

H.R. 2219: Mr. Frost.

H.R. 2220: Mr. Brady of Texas.

H.R. 2237: Mrs. Jones of Ohio and Mr. Ney.

H.R. 2249: Mr. Osborne.

H.R. 2309: Mr. McKeon, Mr. Dreier, Mr. Herger, Mr. Ose, Mr. Doolittle, Mr. Pombo, Mr. Radanovich, Mr. Nunes, Mr. Thomas, Mr. Gallegly, Mr. Royce, Mr. Lewis of California, Mr. Gary G. Miller of California, Mr. Calvert, Mrs. Bono, Mr. Rohrabacher, Mr. Cox, Mr. Issa, Mr. Cunningham, Mr. Hunter, Mr. Thompson of California, and Ms. Roybal-Allard.

H.R. 2314: Mr. Case, Mr. Kennedy of Rhode Island, Mr. McIntyre, and Mr. Brown of Ohio.

H.R. 2327: Mrs. Capito.

H.R. 2333: Mr. Rehberg.

H.R. 2340: Mr. Burr and Mr. Kolbe.

H.R. 2357: Mrs. Jo Ann Davis of Virginia.

H.R. 2379: Mr. Paul.

H.R. 2386: Mrs. Cubin, Mr. Rehberg, Mr. Bishop of Utah, and Mr. Hayworth.

H.R. 2393: Mr. Owens.

H.R. 2419: Mr. Blumenauer.

H.R. 2433: Mr. Gutierrez, Mr. Michaud, and Mr. Snyder.

H.R. 2435: Mr. Nadler, Mr. Thompson of California, and Mr. Davis of Florida.

H.R. 2441: Mrs. McCarthy of New York, Mrs. Napolitano, Mr. Shimkus, Ms. McCollum, Mr. Calvert, Mr. Platts, Mr. Larson of Connecticut, and Mr. Schiff.

H.R. 2455: Mr. Berman.

H.R. 2462: Mr. Clay and Mr. Obey.

H.R. 2470: Mr. Crowley, Mr. Payne, Mr. McNulty, Mr. Conyers, Mrs. Christensen, and Mr. Evans.

H.R. 2478: Mr. McDermott, Mr. Lantos, and Mr. Owens.

H.R. 2485: Mr. Kucinich.

H.R. 2505: Mr. Owens.

H.R. 2517: Mr. Coble.

H.R. 2519: Mr. Sabo, Mr. Simmons, Mr. Kleczka, and Mr. Gilchrest.

H.R. 2524: Mr. Waxman and Mr. Sanders.

H.R. 2533: Mr. Linder, Mr. Isakson, and Mr. Scott of Georgia.

H.R. 2537: Mr. Owens.

H.R. 2546: Ms. Lee.

H.R. 2553: Ms. Lofgren, Mr. Abercrombie, Mr. Rangel, and Mr. Ross.

H.R. 2556: Mr. Cox, Mr. Terry, and Mr. Souder.

H.R. 2564: Mr. McGovern.

H.R. 2568: Mr. Gordon and Ms. DeGette.

H.R. 2570: Mr. Wu and Mr. Clyburn.

H.R. 2595: Mr. Abercrombie, Mr. Case, and Ms. Bordallo.

H.J. Res. 9: Mr. Barrett of South Carolina.

H.J. Res. 36: Mr. Spratt.

H.J. Res. 59: Mr. LaHood.

H. Con. Res. 19: Mr. Dingell and Mr. Ballance.

H. Con. Res. 60: Mr. Beauprez, Mr. DeMint, and Mr. Rohrabacher.

H. Con. Res. 78: Ms. Eshoo.

H. Con. Res. 98: Ms. Bordallo, Mr. Scott of Georgia, and Mr. Akin.

H. Con. Res. 99: Ms. Eddie Bernice Johnson of Texas.

H. Con. Res. 111: Ms. Eddie Bernice Johnson of Texas and Mr. Issa.

H. Con. Res. 119: Mr. Shimkus, Mrs. Tauscher, and Mr. Berman.

H. Res. 49: Mr. Schiff.

H. Res. 103: Mr. Sanders.

H. Res. 142: Mr. Nadler and Mr. Gutierrez.

H. Res. 234: Mr. Carson of Oklahoma and Mr. Watt.

H. Res. 237: Ms. Majette.

H. Res. 259: Mr. McGovern and Mr. Ackerman.

H. Res. 285: Mr. McNulty, Mr. Waxman, and Mr. Burr.

H. Res. 290: Ms. Slaughter.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:

H.R. 2407: Mr. Michaud.

DISCHARGE PETITIONS

Under clause of rule XV, the following discharge petition was filed:

Petition 3, June 25, 2003 by Mr. TAYLOR on House Resolution 275, was signed by the following Members: Gene Taylor, Jane Harman, John S. Tanner, Charles W. Stenholm, Ed Case, and Leonard L. Boswell.

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:

Petition 2 by Mr. MARSHALL on House Resolution 251: Michael E. Capuano, Carolyn C. Kilpatrick, Luis V. Gutierrez, Norman D. Dicks, Martin Olav Sabo, William O. Lipinski, David R. Obey, Richard A. Gephardt, Richard E. Neal, and John M. Spratt, Jr.

SENATE—*Thursday, June 26, 2003*

The Senate met at 9:15 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, Rev. Richard A. Lapehn of Milton Presbyterian Church, Rittman, OH.

PRAYER

The guest Chaplain offered the following prayer:

Let us pray:

Triumphant and holy God, ruler of Heaven and Earth, You have given to us the privilege of living in these unprecedented times. We know that our hope is vain when it is placed in humankind. Scripture cries aloud, "As the heavens are higher than the earth, so are My ways higher than your ways, and My thoughts than your thoughts" declares the Lord (Isaiah 55:9). Blessed is the Nation whose God is the Lord.

May we listen for Your voice and learn, hear and obey You amid the competing pressures for our time. Our world will not thrive with pusillanimous leaders, bereft of the courage to speak and act for those things which are just and right in Your eyes. These uncommon days require leaders who will seek out Your vision, soak up Your wisdom, and rely upon Your strength for the rigorous task they face.

May debate be lively and leavened with hope, may conversations uplift and encourage, and may the words spoken in this Chamber bring persistent honor to Your Name. Bless each Senator with Your mercy. Your peace, and Your abiding Spirit. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, this morning the Senate will immediately resume consideration of S. 1, the prescription drug benefit/Medicare bill. Under the previous agreement, the Senate will begin two back-to-back rollcall votes shortly. We were in late last night, and we set those votes to occur the first thing this morning.

The voting schedule will be as follows: The first vote will be in relation to the Harkin amendment No. 991 dealing with demonstration programs. The second vote will be in relation to the Edwards amendment No. 1052 dealing with drug advertising. For the remainder of the day, we will continue to debate and vote on amendments to S. 1.

We have made very good progress over the last 2 weeks on this bill. The Democratic leader and I were just talking, and we still have 50 amendments pending. It is my hope a number of these amendments will be disposed of by voice vote. I know the managers are working along that line. Inevitably, though, we are going to have a very heavy voting schedule today and into this evening. Members should expect rollcall votes throughout the day and, if necessary, into the wee hours of the morning on Friday. We will know a little bit later today the pace of these amendments and how they can best be handled.

My intention was to finish this bill before the July 4 recess. I think everybody is working in good faith to do just that. With the cooperation of all Members, and if we are able to continue voting throughout the day and the debate-and-amendment process, we may be able to pass this legislation this evening.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I have indicated to the majority leader that I intend to work with him today to schedule as many of these votes and to work through the pending amendments.

As he noted, there are approximately 50 pending amendments. It is my hope that our managers might look carefully at many of them and perhaps accept them on voice votes, but those requiring rollcalls I hope can be scheduled earlier rather than later throughout the day.

We will work on our side to perhaps offer them en bloc, where we could have a sequence of rollcall votes throughout the day, but we certainly will work with the majority leader to see if we can accomplish as much as he has laid out for the schedule, with an expectation that perhaps by the end of this evening we will have completed our work on the bill.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

The PRESIDENT pro tempore. Under the previous order, the hour of 9:15 a.m. having arrived, the Senate will proceed to the consideration of S. 1, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the Medicare Program, to provide prescription drug coverage under the Medicare Program, and for other purposes.

Pending:

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare Program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare prescription drug plan, a Medicare Advantage organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid Program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the Medicare Advantage benchmark determinations.

Harkin modified amendment No. 991, to establish a demonstration project under the Medicaid Program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under Part D on January 1, 2004.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare Program.

Smith/Bingaman amendment No. 962, to provide reimbursement for federally qualified health centers participating in Medicare managed care.

Hutchison amendment No. 1004, to amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the Medicare Program at 6.5 percent.

Sessions amendment No. 1011, to express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under Medicaid and SCHIP as part of the reauthorization of the Temporary Assistance for Needy Families Program.

Conrad amendment No. 1019, to provide for coverage of self-injected biologicals under Part B of the Medicare Program until Medicare prescription drug plans are available.

Conrad amendment No. 1020, to permanently and fully equalize the standardized payment rate beginning in fiscal year 2004.

Conrad amendment No. 1021, to address Medicare payment inequities.

Clinton amendment No. 999, to provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level.

Clinton amendment No. 953, to provide training to long-term care ombudsman.

Clinton amendment No. 954, to require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information.

Reid (for Boxer) amendment No. 1036, to eliminate the coverage gap for individuals with cancer.

Reid (for Corzine) amendment No. 1037, to permit Medicare beneficiaries to use federally qualified health centers to fill their prescriptions.

Reid (for Jeffords) amendment No. 1038, to improve the critical access hospital program.

Reid (for Inouye) amendment No. 1039, to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a federally qualified health center or a Native Hawaiian health care system.

Thomas/Lincoln amendment No. 988, to provide for the coverage of marriage and family therapist services and mental health counselor services under Part B of the Medicare Program.

Edwards/Harkin amendment No. 1052, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Enzi/Lincoln amendment No. 1051, to ensure convenient access to pharmacies and prohibit the tying of contracts.

Enzi amendment No. 1030, to encourage the availability of Medicare Advantage benefits in medically underserved areas.

Hagel/Ensign amendment No. 1012, to provide Medicare beneficiaries with an additional choice of Medicare prescription drug plans under Part D that consists of a drug discount card and protection against high out-of-pocket drug costs.

Hagel amendment No. 1026, to provide Medicare beneficiaries with a discount card that ensures access to privately negotiated discounts on drugs and protection against high out-of-pocket drug costs.

Baucus (for Feinstein) amendment No. 1060, to provide for an income-related increase in the Part B premium for individuals with income in excess of $75,000 and married couples with income in excess of $150,000.

Baucus (for Akaka) amendment No. 1061, to provide for treatment of Hawaii as a low-DSH State for purposes of determining a Medicaid DSH allotment for the State for fiscal years 2004 and 2005.

Bingaman/Domenici amendment No. 1065, to update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies.

Bingaman amendment No. 1066, to permit the establishment of two new Medigap plans for Medicare beneficiaries enrolled for prescription drug coverage under Part D.

Graham (SC) modified amendment No. 948, to provide for the establishment of a National Bipartisan Commission on Medicare Reform.

Stabenow/Levin amendment No. 1075, to permanently extend a moratorium on the treatment of a certain facility as an institution for mental diseases.

Stabenow/Levin amendment No. 1076, to provide for the treatment of payments to certain comprehensive cancer centers.

Stabenow/Levin amendment No. 1077, to provide for the redistribution of unused resident positions.

Ensign/Lincoln amendment No. 1024, to amend title XVIII of the Social Security Act to repeal the Medicare outpatient rehabilitation therapy caps.

Smith/Feingold amendment No. 1073, to allow the Secretary to include in the definition of "specialized Medicare+Choice plans for special needs beneficiaries" plans that disproportionately serve such special needs beneficiaries or frail, elderly Medicare beneficiaries.

Grassley (for Craig) amendment No. 1087, to permit the offering of consumer-driven health plans under Medicare Advantage.

Baucus (for Mikulski) amendment No. 1088, to provide equitable treatment for children's hospitals.

Baucus (for Mikulski) amendment No. 1089, to provide equitable treatment for certain children's hospitals.

Baucus (for Mikulski) amendment No. 1090, to permit direct payment under the Medicare Program for clinical social worker services provided to residents of skilled nursing facilities.

Baucus (for Mikulski) amendment No. 1091, to extend certain municipal health service demonstration projects.

Grassley/Baucus amendment No. 1092, to evaluate alternative payment and delivery systems.

Kyl amendment No. 1093 (to amendment No. 1092) in the nature of a substitute.

AMENDMENT NO. 991

The PRESIDENT pro tempore. There will be 2 minutes equally divided on the amendment.

Who seeks recognition?

The Senator from Iowa.

Mr. HARKIN. The amendment before us is the one where the money follows the purse. It is $350 million a year for 5 years whereby States can use this money to get out of institutions, out of nursing homes, people with disabilities and get them into community, home-based living.

Thirteen years ago, this Congress and the President signed a bill called the Americans With Disabilities Act. One of the premises of that was we no longer wanted to segregate people with disabilities in our society. We wanted to integrate people with disabilities in education, work, travel, jobs, everything. However, under the Medicaid system, it is still segregation.

Seventy percent of our Medicaid money goes to institutional care, only 30 percent to community-based care. What this amendment says is that for the first year, the Federal Government will pick up the full share of the State so the State can take people out of institutions and put them into community-based living.

This was proposed by President Bush in his budget proposal for next year. It is exactly what the President proposed.

The PRESIDENT pro tempore. The Senator's time has expired.

Mr. HARKIN. I ask unanimous consent for an additional 30 seconds.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. HARKIN. The offset we use is also an offset supported by the administration. I have a letter Senators can look at—I put it in the RECORD last night—from the Department of Justice, supporting the offset we use to pay for this to ensure that we can get people in community-based settings and out of institutions.

I yield the floor.

Mr. SMITH. Mr. President, I would like to urge my colleagues to support the Harkin/Smith Money Follows the Person Amendment pending before the Senate.

This amendment would authorize the 2004 Money Follows the Person initiative in Medicaid, a part of the President's New Freedom Initiative to integrate people with disabilities into the communities where they live.

This amendment would create a 5-year program to help States move people with disabilities out of institutional settings and into their communities. For example, under this legislation, Oregon's effort to help an individual move out of an institutional care facility and into a community home would be 100-percent federally funded for 1 year.

After that first year, the Federal Government would pay its usual rate. Under the provisions of this amendment, states like Oregon can take advantage of $350 million dollars of Federal assistance for 5 years for a total of $1.75 billion.

This amendment is important to the disabled community for many reasons. First, by supporting States' efforts to help Americans who have been needlessly placed in institutional settings move into community settings, this amendment will help States increase access to home and community-based support for people with disabilities.

Second, by assisting the movement of people who are not best served by an institution into a community care facility, this amendment gives them the freedom to make choices. Too often, Americans with disabilities are unable to take advantage of opportunities others take for granted—to choose where they want to live, when to visit family and friends, and to be active members of their communities.

Third, this amendment helps honor those veterans whose disabilities resulted from noble and selfless service to this Nation. This morning, I heard from the head of the Oregon Chapter of the Paralyzed Veterans of America. He confirmed that this amendment would benefit countless disabled veterans in Oregon alone. I would ask unanimous consent that the letter that I received from the Paralyzed Veterans of America in support of this amendment be printed in the RECORD.

I likewise ask unanimous consent that a letter I received from United Cerebral Palsy and The Arc of the United States in support of this amendment be printed in the RECORD.

Finally, this amendment would help States comply with the Americans with Disabilities Act. As my colleagues in the Senate are well aware, we are nearing the 13th anniversary of the Americans with Disabilities Act and of the Olmstead Supreme Court decision.

That decision ruled that needless institutionalization of Americans with disabilities constitutes discrimination under the Americans with Disabilities Act. I urge my colleagues on both sides of the aisle to support this important amendment and to support the freedom of choice for Americans with disabilities.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE ARC AND UCP
PUBLIC POLICY COLLABORATION,
Washington, DC, June 25, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR SMITH: On behalf of United Cerebral Palsy and The Arc of the United States, we applaud your co-sponsorship of S. AMDT. 991 to the Prescription Drug and Medicare Improvement Act that would authorize the Money Follows the Person initiative in Medicaid proposed by President Bush in his FY 2004 budget as part of his New Freedom Initiative.

Senate Amendment 991 and the President's proposal would create a five-year program to provide 100 percent federal funding for one year on behalf of individuals who move from an institutional setting to the community with home and community services and supports. Money Follows the Person would assist states in meeting their obligations under the Olmstead Supreme Court decision to serve people with long term support needs in the least restrictive setting. The Arc and UCP believe that the Money Follows the Person initiative will help states increase access to home and community-based supports for people with disabilities and help states take greater steps to permanently re-balance their long-term supports delivery system. Changes in the institutional bias in the Medicaid program are long overdue. The Money Follows the Person initiative will assist states in making a transition for people who want to leave institutional settings.

UCP is a national organization that works with and for people with cerebral palsy and related disabilities and their families. It is committed to promoting and improving supports and services for people with disabilities so that they can live, work, go to school and otherwise be fully included in their communities. UCP also supports a broad range of research and education efforts on cerebral palsy and related disabilities.

The Arc is the national organization of and for people with mental retardation and related developmental disabilities and their families. It is devoted to promoting and improving supports and services for people with mental retardation and their families. The Arc also fosters research and education regarding the prevention of mental retardation in infants and young children.

We urge all Senators to join you and Senator Harkin to support inclusion of your amendment, S. AMDT. 991, in the Medicare Prescription Drug bill.

Sincerely,

LYNNE CLEVELAND,
Co-Chair.
LEON TRIEST,
Co-Chair.

OREGON PARALYZED VETERANS
OF AMERICA,
Salem, OR, June 25, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR SMITH: On behalf of the Oregon Chapter of the Paralyzed Veterans of America and other disabled citizens of the state of Oregon, we thank you for joining Senator Harkin in introducing Amendment 991 ("Money Follows the Person"), to the Prescription Drug and Medicare Improvement Act of 2003 (S. 1). This amendment would authorize an initiative contained in the President's proposed FY 2004 budget, a critical part of the administration's New Freedom Initiative to integrate people with disabilities into the community.

Amendment 991 includes fiscal offsets of $1.75 billion over five years to fund Medicaid demonstrations to assist states in developing and implementing cost-effective choices between institutional and community services. Financing Medicaid services for individuals who transition from institutions to the community is a major part of this effort.

When enacted, the Federal Government would fully reimburse states (100% Federal match) the cost of one year of Medicaid home and community-based services for people with disabilities who leave institutions. After the initial year, states would be responsible for matching payments at their usual Medicaid matching rate. $350 million would be available in FY 2004 and in each of the following four years to implement these changes.

PVA believes that this amendment is essential to enable Oregon and other states to comply with the Americans with Disabilities Act and the Supreme Court's Olmstead decision. People with disabilities must have a meaningful choice to receive long term services and supports in their home or community.

Again, thank you for introducing Amendment 991 during the prescription drug and Medicare debate.

Sincerely,

SAM LEAM,
President.
PATRICK E. ROGERS,
Government Relations Director.

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

● Mr. KERRY. Mr. President, I have been a long-standing supporter of the Olmstead decision to end the institutional bias in care for people with disabilities. Unfortunately, States have been slow to implement this landmark decision. To better help States in this effort, I am proud to say that I am an original cosponsor of Senator HARKIN's MiCASSA legislation, S. 971, the Medicaid Community-Based Attendant Services and Supports Act of 2003, a bill to ensure that "the money follows the people" and that true choice is granted for people with disabilities to decide whether they wish to live in their own communities instead of being institutionalized. The bill also provides major Federal resources to assist States with the costs of paying for community-based attendant and support services. Had I been present for the vote, I would have voted against the motion to table the Harkin amendment and would have voted in favor of its inclusion in the Medicare prescription drug bill.●

The PRESIDENT pro tempore. The Senator from Pennsylvania is recognized for 1½ minutes.

Mr. SANTORUM. Mr. President, I think what the Senator from Iowa has done is a very worthy thing. The President has focused on this. Part of the President's plan is what the Senator from Iowa has before us. The problem with this is that this is a Medicaid proposal that is under the jurisdiction of the Finance Committee. The Finance Committee would like the opportunity, in the context of looking at the Medicaid Program, to work this through the structure. A, to have this amendment come to the floor, not having gone through the normal process, I think is inappropriate; B, this is a Medicare bill, not a Medicaid bill.

I say to the Senator from Iowa, I know Senator GRASSLEY has said to me he is willing to work with his colleague from Iowa on moving this forward. The legislation the Senator from Iowa has put forward has merit and will probably receive bipartisan support, but it does not belong on this bill.

So I ask my colleagues—by the way, it is $1.75 billion. I understand there is an offset, but this is a Medicare bill and we should defeat this amendment.

I ask unanimous consent that the Senator from Colorado be recognized to lay down an amendment.

The PRESIDENT pro tempore. The Senator from Colorado.

Mr. ALLARD. Mr. President, I ask that the pending amendment be temporarily laid aside.

The PRESIDENT pro tempore. Without objection, it is so ordered.

AMENDMENT NO. 1017

Mr. ALLARD. I send amendment No. 1017 to the desk.

The PRESIDENT pro tempore. The clerk will report.

The bill clerk read as follows:

The Senator from Colorado (Mr. ALLARD), for himself, Mr. FEINGOLD, Mr. KOHL, and Mr. LEAHY, proposes an amendment numbered 1017.

Mr. ALLARD. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for temporary suspension of OASIS requirement for collection of data on non-medicare and non-medicaid patients)

At the end of title VI, insert the following:

SEC. . TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

Mr. ALLARD. Mr. President, Medicare home health providers are in a paperwork crisis. Current regulations of the Centers for Medicare and Medicaid Services, CMS, requires that caregivers administer voluminous paperwork to patients when they administer care.

These paperwork requirements are too excessive for both patients and caregivers. Caregivers must administer numerous forms including data collection, patient privacy information, a plan of care, advance directives, a visit schedule, a comprehensive assessment, and more.

One of these requirements, called OASIS, or the Outcome and Assessment Information Set, is 94 questions long and takes a few hours to fill out. Before a nurse or physical therapist administers care, she and the patient must sit down and answer questions and fill out this paperwork. Colorado providers have told me they spend more time filling out paperwork than they do caring for patients.

As a result of this excessive data collection and dissemination, home health caregivers are leaving the home health industry. Two weeks ago a home health administrator in Colorado Springs came to share with me the situation in her agency. On her plane trip here, three of her newly-home health physical therapists called to tell her they were leaving the agency because of excessive paperwork requirements. They said they were going to leave the home health industry and return to the hospital industry.

We cannot afford this. Home health care is a vital player in health care for seniors and all individuals. If this paperwork crisis continues, home health care will continue to lose caregivers and bloat its current caregiver shortage.

Currently CMS requires that home health caregivers administer OASIS to Medicare patients, to Medicaid patients, and to patients who have private health insurance. The problem with this regulation, however, is that the data collected for private health insurance patients is not even used. This data literally sits in the offices of home health agencies with no current purpose.

The fact is CMS requires that home health agencies encode the OASIS data for Medicare and Medicaid patients only and to transmit it to their States. Then the information is transmitted into the Federal OASIS Repository.

For all private insurance patients, the home health agencies do not have to encode or transmit the data. So these nurses, physical therapists, occupational therapists, and nurse practitioners are required to collect this data for no reason.

It is my understanding CMS intends to require the transmission of data for private health patients at some point. But it has been 4 years and they have not done it yet.

In the meantime there are still many problems with OASIS. Until CMS issues the improved regulation, caregivers should be allowed to stop collecting unused data that ends up in the filing cabinets of home health agencies.

The amendment I am offering with Senators FEINGOLD, COLLINS, KOHL, and LEAHY would suspend the CMS requirement of collecting OASIS data for private insurance patients, non-Medicare and non-Medicaid patients, until an outcome by CMS's two OASIS working groups is reached.

Specifically, OASIS would be suspended until the 2 months immediately after HHS issues its regulations about OASIS. The regulations will be based on the information collected from and the recommendations of CMS's two working groups that are determining over the course of 3 years ways to improve OASIS data collection and quality assurance.

Our amendment is supported by caregivers in home health who administer OASIS, including physical therapists, nurses, nurse practitioners, occupational therapists, and speech therapists. Congresswoman NANCY JOHNSON, chairwoman of the Oversight Subcommittee of the House Committee on Ways and Means, also strongly supports this amendment. In addition, our language was included in Medicare reform bills in the Senate in the last 2 consecutive years. Further, I commend Senator FEINGOLD for introducing legislation last Congress to reform OASIS and I commend Senator MURKOWSKI and Senator KERRY for their work on the MARCIA regulatory reform legislation, which included an OASIS suspension.

My colleagues and I believe OASIS data collection is helpful and should be applied. Even providers and patients, who must comply with the law, believe this. Yet the requirements to collect data should be achievable and inexcessive.

I am pleased to offer this amendment and urge my colleagues to support this effort for caregivers and patients.

Mr. ALLARD. Mr. President, I ask unanimous consent that the two additional cosponsors be added to the amendment, Senator KOHL and Senator LEAHY.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from Pennsylvania.

VOTE ON AMENDMENT NO. 991

Mr. SANTORUM. Mr. President, I move to table the Harkin amendment and ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would each vote "nay".

The PRESIDING OFFICER (Ms. MURKOWSKI). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 50, nays 48, as follows:

[Rollcall Vote No. 247 Leg.]

YEAS—50

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Kyl
Lott
Lugar
McCain
McConnell
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Snowe
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NAYS—48

Akaka
Bayh
Biden
Bingaman
Boxer
Byru
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Ensign
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Jeffords
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Miller
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Smith
Specter
Stabenow
Wyden

NOT VOTING—2

Kerry
Lieberman

The motion was agreed to.

Mr. SANTORUM. Madam President, I move to reconsider the vote.

Mr. GRASSLEY. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1052

Mr. BAUCUS. Madam President, will the Chair state the regular order?

The PRESIDING OFFICER. There will be 2 minutes evenly divided before the vote on the next amendment.

Mr. BAUCUS. I thank the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. The Senator from North Carolina.

Mr. EDWARDS. Madam President, yesterday we voted on the Edwards-Harkin amendment which had two provisions. The first provision dealt with the FDA approval process for "me too" drugs. There were concerns expressed by the Members of the Senate about that provision. Even though I disagreed with those concerns, I don't think it would have slowed down the FDA approval process. Because of those concerns, we have removed those provisions from this amendment.

The amendment we are about to vote on deals only with advertising. It in no way bans advertising. All this amendment does is require that the advertising engaged in by drug companies and pharmaceutical companies be evenhanded. The only thing this amendment requires is that the information be accurate and evenhanded. In other words, you can't have kids dancing in a field as the image on television and in small print at the bottom saying the drug can cause strokes or have other side effects.

We want to make sure the American people in these advertisements get accurate information and which is not misleading. This amendment does exactly that. We have eliminated the provision so many were concerned about yesterday.

I urge my colleagues to support this amendment. Let us make sure the American people get true and accurate information in the advertising they are seeing on drugs on television.

The PRESIDING OFFICER. Who yields time?

Mr. ENZI. Madam President, I rise in opposition to this amendment submitted by my colleague from North Carolina, Senator EDWARDS. Yesterday, the Senate defeated an amendment offered by my colleague that would have restricted direct-to-consumer advertising of prescription medicines.

This new amendment continues this effort by offering similar advertising provisions to those already defeated.

I have a list of 14 organizations which I ask unanimous consent be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JUNE 26, 2003.

To: Members of the United States Senate:

The undersigned organizations are writing in opposition to the amendment offered by Senator EDWARDS regarding changes to Direct to Consumer advertising of pharmaceutical products. This amendment would impose serious restrictions on information which is of considerable value to the millions of patients we represent.

Our organizations are advocates for millions of Americans who suffer from a broad range of illnesses. Early detection and treatment of these illnesses is an important factor in helping those individuals lead longer and healthier lives. Communication, public education and awareness are key components in the outcomes American patients can hope to achieve. Limiting access to credible information is bad healthcare policy and we urge you to oppose the Edwards amendment and any other efforts to deny Americans information.

Respectfully,

The National Alliance for the Mentally Ill.

The National Mental Health Association.

The American Association of Diabetes Educators.

The American Foundation for Urologic Disease.

The American Lung Foundation.

The National Health Council.

The Interamerican College of Physicians and Surgeons.

The Kidney Cancer Association.

The Society for Womens Health Research.

The National Headache Foundation.

The National Coalition for Women with Heart Disease.

The National Osteoporosis Foundation.

The American Liver Foundation.

The National Stroke Association.

Mr. ENZI. Madam President, these are organizations that are advocates for millions of Americans who suffer from a broad range of illnesses. Early detection and treatment of these illnesses is more communication. Public education and awareness are key components. Advertising is the key component of it.

This amendment would require the Secretary of Health and Human Services to promulgate new rules that would require advertisements to provide information about a drug's effectiveness in comparison to other drugs for "substantially the same condition." In other words, you have to advertise with your competitors as well. The unfortunate effect would be to make the advertisements even more complex, not less, for consumers. It would force ads to drop other information that would be beneficial to consumers.

I ask that you reject the amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

Mr. SANTORUM. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The bill clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "Yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 59, as follows:

[Rollcall Vote No. 248 Leg.]

YEAS—39

Akaka
Bayh
Bingaman
Boxer
Byrd
Cantwell
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Inouye
Johnson
Kennedy
Kohl
Landrieu
Leahy
Levin
Lincoln
Mikulski
Miller
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—59

Alexander
Allard
Allen
Baucus
Bennett
Biden
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hollings
Hutchison
Inhofe
Jeffords
Kyl
Lautenberg
Lott
Lugar
McCain
McConnell
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1052) was rejected.

Mr. GRASSLEY. Madam President, I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1092, AS MODIFIED

Mr. GRASSLEY. Madam President, I send to the desk a modification of the Grassley benchmark amendment filed last night. I ask that I have a right to modify my amendment.

The PRESIDING OFFICER. Without objection, the amendment is modified. It is not the pending amendment at this time.

The modification is as follows:

At the end of subtitle C of title II, add the following:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

“(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

“(1) ANNUAL DETERMINATION AND DESIGNATION.—

“(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D-11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

“(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

“(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

“(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

“(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

“(iii) Whether the Secretary expects that MedicareAdvantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

“(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

“(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

“(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

“(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

“(3) SUBMISSION OF BIDS.—

“(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

“(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

“(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

“(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

“(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

“(5) FUNDING LIMITATION.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period or year, as applicable, may not exceed the applicable amount (as defined in clause (ii)).

“(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term ‘applicable amount’ means—

“(I) for the period beginning on January 1, 2009, and ending on September 30, 2013, the total amount that would have been expended under this title during the period if this subsection had not been enacted plus $6,000,000,000; and

“(II) for fiscal year 2014 and any subsequent fiscal year, the total amount that would have been expended under this title during the year if this subsection had not been enacted.

“(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

“(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

“(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

“(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

“(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

“(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

“(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

“(A) a detailed description of—

“(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(iii) amounts remaining within the funding limitation specified in paragraph (5); and

“(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

“(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

“(8) Biennial GAO Reports.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

“(A) an evaluation of—

“(i) the quality of care provided to beneficiaries enrolled in a MedicareAdvantage preferred provider plan in a highly competitive region;

“(ii) the satisfaction of beneficiaries with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

“(9) Report on budget neutrality for fiscal years after 2013.—

“(A) In general.—If the Secretary intends to designate 1 or more regions as highly competitive regions with respect to calendar 2014 or any subsequent calendar year, the Secretary shall submit a report to Congress indicating such intent no later than April 1 of the calendar year prior to the calendar year in which the applicable designation year begins.

“(B) Requirements.—A report submitted under subparagraph (A) shall—

“(i) specify the steps (if any) that the Secretary will take pursuant to paragraph (5)(B) to ensure that the total amount expended as a result of the application of this subsection during the year will not exceed the applicable amount for the year (as defined in paragraph (5)(A)(ii)(II)); and

“(ii) contain a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that such steps will meet the requirements of paragraph (5)(A) based on an analysis using generally accepted actuarial principles and methodologies.”.

(b) Conforming Amendment.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

“(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.”.

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) Establishment.—

(1) Review and report on results of existing demonstrations.—

(A) Review.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) Report.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) Projects.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) Enhanced benefits or services.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) Project Sites and Duration.—

(1) In general.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that a region or regions are designated as such a highly competitive region.

(2) Rule of construction.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) Biennial GAO Reports.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) Funding.—

(1) In general.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) Limitation.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) Monitoring and reports.—

(A) Ongoing monitoring by the Secretary to ensure funding limitation is not violated.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) Reports.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(C) REPORT ON BUDGET NEUTRALITY FOR FISCAL YEARS AFTER 2013.—

(i) IN GENERAL.—If the Secretary intends to continue the projects under this section for fiscal year 2014 or any subsequent fiscal year, the Secretary shall submit a report to Congress indicating such intent no later than April 1 of the year prior to the year in which the fiscal year begins.

(ii) REQUIREMENTS.—A report submitted under clause (i) shall—

(I) specify the steps (if any) that the Secretary will take pursuant to paragraph (4) to ensure that the limitations described in paragraph (2)(B) will not be violated for the year; and

(II) contain a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that such steps will meet the requirements of paragraph (2) based on an analysis using generally accepted actuarial principles and methodologies.

(4) APPLICATION OF LIMITATION.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) AUTHORITY.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

Mr. BAUCUS. Mr. President, on behalf of Senator CONRAD, I ask unanimous consent that a letter from the Congressional Budget Office be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 26, 2003.

Hon. KENT CONRAD,
Ranking Member, Committee on the Budget,
U.S. Senate, Washington, DC.

DEAR SENATOR: The Congressional Budget Office has reviewed a proposed amendment (GOE03.597) by Senators Grassley and Baucus to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the Medicare program, to provide prescription drug coverage under the Medicare program, and for other purposes. That amendment would add subtitle D to title II, establishing an alternative payment system for preferred provider organizations in highly competitive regions and fee-for-service modernization projects.

CBO estimates that the amendment would add $12 billion in outlays to the cost of the bill over the 2009–2013 period—$6 billion for payments to preferred provider organizations and $6 billion for the fee-for-service modernization projects. The amendment would allow the programs to continue after 2013, but under the rules the amendment specifies for the Secretary of Health and Human Services, CBO estimates that those programs would incur no additional net costs after that time.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT A. SUNSHINE
(For Douglas Holtz-Eakin, Director.)

Mr. GRASSLEY. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BAUCUS. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1054

Mr. BAUCUS. Madam President, I ask unanimous consent that all pending amendments be set aside so that I might call up amendment No. 1054 on behalf of Senator FEINGOLD, with respect to Medicare beneficiaries.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. FEINGOLD, proposes an amendment numbered 1054.

Mr. BAUCUS. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To establish an Office of the Medicare Beneficiary Advocate)

At the end of subtitle D of title I, add the following:

SEC. 133. OFFICE OF THE MEDICARE BENEFICIARY ADVOCATE.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish within the Department of Health and Human Services, an Office of the Medicare Beneficiary Advocate (in this section referred to as the "Office").

(b) DUTIES.—The Office shall carry out the following activities:

(1) Establishing a toll-free telephone number for medicare beneficiaries to use to obtain information on the medicare program, and particularly with respect to the benefits provided under part D of title XVIII of the Social Security Act and the Medicare Prescription Drug plans and MedicareAdvantage plans offering such benefits. The Office shall ensure that the toll-free telephone number accommodates beneficiaries with disabilities and limited-English proficiency.

(2) Establishing an Internet website with easily accessible information regarding Medicare Prescription Drug plans and MedicareAdvantage plans and the benefits offered under such plans. The website shall—

(A) be updated regularly to reflect changes in services and benefits, including with respect to the plans offered in a region and the associated monthly premiums, benefits offered, formularies, and contact information for such plans, and to ensure that there are no broken links or errors;

(B) have printer-friendly, downloadable fact sheets on the medicare coverage options and benefits;

(C) be easy to navigate, with large print and easily recognizable links; and

(D) provide links to the websites of the eligible entities participating in part D of title XVIII.

(3) Providing regional publications to medicare beneficiaries that include regional contacts for information, and that inform the beneficiaries of the prescription drug benefit options under title XVIII of the Social Security Act, including with respect to—

(A) monthly premiums;

(B) formularies; and

(C) the scope of the benefits offered.

(4) Conducting outreach to medicare beneficiaries to inform the beneficiaries of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(5) Working with local benefits administrators, ombudsmen, local benefits specialists, and advocacy groups to ensure that medicare beneficiaries are aware of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(c) FUNDING.—

(1) ESTABLISHMENT.—Of the amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures, $2,000,000 may be used to establish the Office in accordance with this section.

(2) OPERATION.—With respect to each fiscal year occurring after the fiscal year in which the Office is established under this section, the Secretary may use, out of amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures for such fiscal year, such sums as may be necessary to operate the Office in that fiscal year. .

Mr. BAUCUS. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Madam President, I ask unanimous consent that the order to the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Madam President, I ask that the pending amendments be set aside and that the Senator from Washington be recognized for an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Washington.

AMENDMENT NO. 942

Ms. CANTWELL. Madam President, I ask unanimous consent that amendment No. 942 be the pending business.

The PRESIDING OFFICER. Without objection, it is so ordered. The amendment is the pending business.

AMENDMENT NO. 942, AS MODIFIED

Ms. CANTWELL. Madam President, I ask unanimous consent that the amendment be modified with the changes I send to the desk.

The PRESIDING OFFICER. The Senator has a right to modify her amendment. The amendment is so modified.

The amendment (No. 942), as modified, is as follows:

On page 204, after line 22, insert the following:

SEC. 133. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

(a) MEDICARE.—Subpart 3 of part D of title XVIII of the Social Security Act (as added by section 101) is amended by adding at the end the following new section:

"PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS

"SEC. 1860D-27. (a) PROHIBITION.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, an eligible entity offering a Medicare Prescription Drug plan under this part or a MedicareAdvantage organization offering a MedicareAdvantage plan under part C shall not enter into a contract with any pharmacy benefit manager (in this section referred to as a 'PBM') that is owned by a pharmaceutical manufacturing company.

"(2) PROVISION OF INFORMATION.—A PBM that manages prescription drug coverage under this part or part C shall provide the following information, on an annual basis, to the Assistant Attorney General for Antitrust of the Department of Justice and the Inspector General of the Health and Human Services Department:

"(A) The aggregate amount of any and all rebates, discounts, administrative fees, promotional allowances, and other payments received or recovered from each pharmaceutical manufacturer.

"(B) The amount of payments received or recovered from each pharmaceutical manufacturer for each of the top 50 drugs as measured by volume (as determined by the Secretary).

"(C) The percentage differential between the price the PBM pays pharmacies for a drug described in subparagraph (B) and the price the PBM charges a Medicare Prescription Drug Plan or a MedicareAdvantage organization for such drug.

"(b) FAILURE TO DISCLOSE.—

"(1) CIVIL PENALTY.—Any PBM that fails to comply with subsection (a) shall be liable for a civil penalty as determined appropriate through regulations promulgated by the Attorney General. Such penalty may be recovered in a civil action brought by the United States.

"(2) COMPLIANCE AND EQUITABLE RELIEF.—If any PBM fails to comply with subsection (a), the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General.

"(c) DISCLOSURE EXEMPTION.—Any information filed with the Assistant Attorney General under subsection (a)(2) shall be exempt from disclosure under section 552 of title 5, and no such information may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.".

Ms. CANTWELL. Madam President, I rise today to offer the Cantwell-Lincoln Prescription drug transparency amendment to S. 1, the medicare prescription drug bill. I thank my cosponsor, Senator LINCOLN, for working with me on this important amendment that will help protect consumers against high prescription drug prices.

This amendment does three things.

First, it requires any PBM contracting with Medicare to disclose to the Department of Justice how much of the rebates and discounts negotiated for Medicare are being passed back.

Second, the disclosure of these financial arrangements to the Department of Justice provides an incentive for PBMs to return as much of that savings as possible to Medicare, which will in turn, help reduce the high cost of prescription drugs.

Finally, it prohibits a pharmaceutical company from owning a pharmacy benefit manager, an inherent conflict of interest.

By requiring transparency, the Cantwell-Lincoln amendment works to prevent collusion on pricing and helps ensure seniors are not paying unnecessarily high prices for their medications.

PBMs have been the target of numerous lawsuits filed in recent years by health plans, employers and governments. The allegations in these lawsuits are always the same: overinflated drug prices, price collusion between PBMs and manufacturers, failure of PBMs to share discounts and rebates, and switching patients to more expensive drugs without the consent of the patient or the doctor.

The PBMs have denied wrongdoing and have settled in many cases.

Last year, Merck agreed to pay $42.5 million to settle lawsuits over allegations that Medco improperly promoted higher priced Merck drugs when less expensive options from other pharmaceutical companies were available.

In 1998, Merck signed a settlement agreement with the Federal Trade Commission stating that, "Medco has given favorable treatment to Merck drugs."

This admission is proof that pharmaceutical companies and PBMs have engaged in collusion on drug pricing in the past, extracting excessive profits from people who rely on these drug services. The Cantwell-Lincoln amendment is needed to help prevent price gouging in the future.

Other governments have struggled to keep a close watch on PBM practices.

In 2000, one of the big four PBMs, Advance PCS, was hired by the state of Arkansas to provide coverage for the state's 135,000 employees. A recent audit found that the PBM was over charging the state for numerous drugs. During one 4-month period, the PBM overcharged the state $479,000 on generic drugs alone.

PBM executives say that my amendment makes turning a profit impossible. It is true that PBMs are not charities but private companies with a duty to their shareholders to earn a profit.

Let's not forget, however, that these are also private companies charged with providing a Government-funded benefit in the best interests of 40 million senior citizens. These private companies also are duty bound to get the most for the Government's $400 billion investment.

Traveling in my home State of Washington, I hear regularly from senior citizens about the high cost of prescription drugs. While seniors in my State, like elsewhere in the country, want a Medicare prescription drug benefit, they also desperately want some relief from high prescription drug prices. They say, "Stop the price gouging. Do something to make sure that prescription drugs are reasonably affordable for everyone."

PBMs have come to dominate the prescription drug benefit market. Nearly 210 million Americans are served by one of the four largest PBMs.

According to the Centers for Medicaid and Medicare Services, national prescription drug spending increased by 15.7 percent in 2001. Despite promises from pharmacy benefit managers to lower costs, prescription drugs continue to be the fastest growing sector of health care spending in this country.

Soaring in tandem with prescription drugs prices are PBM profits. St. Louis-based Express Scripts—one of the four largest PBMs—provides coverage to 40 million people. The company reported that its net income grew 63 percent last year to $202.8 million.

Another one of the big four, Advance PCS, which covers 75 million people, was ranked by Fortune Magazine as the ninth fastest growing company in the nation based on its profits over the past 5 years.

Unfortunately, it has been near impossible to find out whether PBMs are fairly sharing rebates and other savings with patients or simply using it to boost the bottom line.

Even the General Accounting Office has been unable to find out how rebates are being divided between PBMs and the Federal Employees Health Benefits Plan. A GAO requested by Senator DORGAN last year failed to discover if the PBMs were passing along the savings because none of the PBMs financial documents were available for review.

Several private companies and employee groups that contract with PBMs have resorted to lawsuits to get access to this information.

The Cantwell-Lincoln amendment requires the PBM to disclose to the Department of Justice the financial arrangements that dictate what percentage of rebates and other savings are being passed back to the client.

This disclosure creates a major incentive for PBMs to return as much as possible of the rebates and spread back to the Medicare program. This incentive also will help reduce prescription drug prices.

The PBMs have argued that reporting this financial information would kill their ability to continue to negotiate low drug prices. I am a businesswoman, and I understand the need to keep financial agreements confidential. That is why my amendment mandates the information be handed over to the Department of Justice, where it remains confidential.

Department of Justice oversight also allows for regular review of these financial arrangements to weed out any potential collusion on pricing. This added protection also will help lower drug costs for seniors.

The Cantwell-Lincoln amendment also prohibits PBMs from being owned by pharmaceutical manufacturers. This cross-ownership is problematic because it could allow for pharmaceutical companies to collude with PBMs to favor the manufacturers more expensive drugs over less expensive alternatives.

A report on PBMs by the National Health Policy Forum points out the concerns raised by close relationships between PBMs and drug manufacturers. Close ties between the two could lead to a lack of drug choice for consumers, with one manufacturer's drugs getting preferential treatment by the PBM.

Actions taken this week by the U.S. attorney in Philadelphia reinforce the need for greater PBM oversight as outlined in the Cantwell-Lincoln amendment.

Madam President, I ask unanimous consent that articles from the Washington Post and Wall Street Journal be printed in the Record.

There being no objection, the material was ordered to be printed in the Record, as follows:

[From the Wall Street Journal, June 24, 2003]

U.S. Is Joining Lawsuit That Says Medco Put Profits Before Patients

(By Barbara Martinez)

The Justice Department is joining a lawsuit that alleges Merck & Co.'s Medco pharmacy-benefits subsidiary adopted an "aggressive profits-before-patients policy." Medco's approach resulted in a potentially dangerous lack of oversight in filling prescriptions and increased pharmaceutical costs for the federal government, the suit says.

The department's involvement in the suit, brought by two former Medco pharmacists, doesn't necessarily mean that it believes all the allegations. But it signals that the government investigated the accusations and found at least some of them worth pursuing in court. The government, which also joined a second lawsuit against Medco Monday that made similar allegations, intends to file its own complaint within 90 days. Justice Department investigators have been examining Medco and other pharmacy-benefit managers, or PBMs, for several years, but this is the first time they have indicated that any suit would be filed. PBMs handle prescription-drug-card benefits for millions of employees.

The complaint alleges that after Merck—one of the world's largest drug companies—purchased Medco in 1993, the PBM began to make systemic changes in its mail-order prescription-filling system—disregarding safety and instead promoting higher profits per prescription.

In a statement, Medco said, "We are confident that when all the facts are presented they will show that our business has one focus, providing the highest quality of prescription health care to our clients and members." It added: We are prepared to present a nigorous defense and believe that we will prevail. We will prove that the allegations" in the complaint "are absolutely untrue or reflect years-old isolated issues that were identified and corrected and in no way and at no time compromise the quality of patient care."

The airing of previously sealed allegations in the suit comes at a difficult time for both Merck and PBMs. Merck plans to spin off Medco as a publicly traded company this year, while PBMs have been angling to get a piece of a Medicare drug benefit currently being debated in Congress. Medco provides drug benefits to more than 60 million Americans, including millions of federal and state employees. Medco's annual revenue totals about $30 billion.

The case could have repercussions on Capitol Hill, too, where PBMs are locked in a fierce lobbying battle, especially with the retail-pharmacy industry, over details of Medicare legislation. The measure would create a drug benefit that PBMs would have a prominent role in providing. Already Monday, the National Community Pharmacists Association, which represents about 25,000 owners of independent drugstores, stepped up its lobbying efforts. The group is pushing for stricter disclosure requirements for PBMs.

In the newly unsealed complaint, which was filed in U.S. District Court in Philadelphia, the two former Medco pharmacists make detailed charges that enormous pressure was placed on employees to falsify orders to meet goals and to disregard complaints by patients and doctors about drug switching or pill shortages.

Daily internal publication of prescription-error rates to help pharmacists measure their own safety standards were eliminated, the suit asserts. Instead, daily loudspeaker messages announced prescription-filling costs, as well as the stock price of parent company Merck, the suit says. Many Medco employees are compensated in part with Merck stock options.

To save money, the suit alleges, Medco reduced licensed pharmacists' role in the filling and supervising of prescription drugs at its mail-order facilities. In addition, the job of calling a physician to discuss a potential drug interaction—once the job of only pharmacists—ultimately fell to employees who "seldom have college degrees, and have no prior training in pharmacy services other than limited on-the-job training." And as a result of being pressured to meet quotas on how many doctors to call, employees regularly lied on physician call records to indicate they alerted doctors about problems when they really had not, according to the lawsuit.

The lawsuit was filed under the Federal False Claims Act. In such lawsuits, the plaintiff, often a former employee of a company that does business with the government, alleges that the company has defrauded the government. If the government considers the allegations valid, if joins the complaint, litigates the case and shares any recovery or damages with the person who filed the suit.

Medco has a significant amount of legal government business, providing mail-order prescriptions to millions of federal employees through the Federal Employee's Health Benefit Program.

Many of the allegations in this complaint relate to Medco's mail-order business, where patients mail in a prescription and Medco fills it and sends it back. PBMs such as Medco have been pushing hard to promote their mail-order facilities as a cost-effective alternative to retail stores.

According to the suit, Medco "boasts to its clients nationwide that licensed pharmacists check each mail-order prescription before it is sent out, with as many as three or four quality checks." The suit says such scrutiny only happened prior to Merck's 1993 acquisition of Medco.

After the acquisition, Medco automated more of its prescription-filling capabilities and "significant changes" were instituted that "marked a shift from prudent pharmacy practices" to a "focus on profit maximization," the complaint said.

One of Medco's largest and most technologically advanced mail-order facilities is in Las Vegas, where the two former Medco pharmacists who filed the complaint worked. According to the suit, after Medco upgraded its Las Vegas facility in the mid-1990s, "pharmacists were no longer reading and verifying mailed prescriptions prior to entry into a computer." Instead, upon arrival, the prescriptions were entered by "data-entry clerks with no formal pharmacy training" and who were supervised by nonpharmacist managers.

The suit also alleges that under a special program, touted by Medco as promoting the most cost-effective drugs, Medco called doctors to get them to change their prescriptions because of undisclosed payments to Medco from drug manufacturers. The suit said patient and physician complaints about switching prescriptions were "common" but that "Medco routinely ignores these complaints, including the health risks associated with inappropriate drug switches."

In addition, Medco, like other PBMs, provides "drug utilization reviews" of prescriptions and patients. The process aims to prevent adverse drug interactions, verifies appropriate drug strength, catches drug allergies or duplicate medications.

Until 1995, such calls to physicians to alert them to possible problems were made by pharmacists who could fully explain the situation and suggest alternatives. Subsequently, the suit says, these calls were being made only by "cheaper, non-pharmacists employees." The pharmacist was only brought in at the end of a call, to verify information.

But with workers having quotas of 20 to 25 calls an hour, the pharmacist was handling as many as 100 calls within 60 minutes. As a result of pressures to meet the quotas, the complaint said, employees regularly fabricated records documenting that they called doctors to alert them to potential safety issues, among other matters, when they really hadn't. Sometimes, the suit says, the employees would change prescriptions without the pharmacist's intervention.

In other areas of the mail-order facility, the complaint says, employees "permanently delete, cancel or otherwise falsify prescriptions orders" to reduce back-order size. As a result, the complaint says, many patients didn't get the medications they needed.

[From the Washington Post, June 24, 2003]

U.S. Joining Suit Against Medco

(By Charles Duhigg)

The U.S. attorney in Philadelphia announced yesterday that he is joining a complaint against Medco Health Solutions Inc.

that alleges the nation's second-largest pharmacy-benefit manager improperly canceled prescriptions, switched medications without physician approval and sent patients partially filled orders.

The U.S. attorney's office has been investigating whistle-blower allegations against the company since 1999 and intends to file its own complaint in September, said Associate U.S. Attorney James G. Sheehan.

The government has decided to intervene in two lawsuits brought by three whistleblowers. Those suits allege that Medco changed prescriptions without a physician's approval to favor more expensive drugs produced by Merck & Co. and induced physicians with false information to switch to higher cost Merck drugs. Medco also destroyed mail order prescriptions without filling them and in other cases mailed patients less than the number of pills ordered but charged for the full amount, the lawsuits allege.

Medco is a subsidiary of Merck.

"We know from industry studies that almost half of mail order participants will run out of medicine within two days if they fail to receive their new prescriptions," said Patrick L. Meehan, the U.S. attorney for the eastern district of Pennsylvania.

Medco officials contend that the allegations are untrue or "reflect years-old isolated issues that were identified and corrected," said Ann Smith, director of public affairs at Medco. At no time was the quality of patient care compromised, Smith said.

Most Americans know pharmacy benefit managers, or PBMs, from the plastic cards they hand over at local pharmacies when filling a prescription. Major employers and health plans hire these companies to negotiate with drug companies to control drug costs for plan enrollees, and to oversee the complex paperwork associated with filling prescriptions.

The Senate is considering plans to provide prescription drug coverage to the elderly that may enhance the clout of pharmacy-benefit managers, industry analysts say. The companies are expected to administer government drug spending under some plans, according to congressional testimony offered by the National Association of Chain Drug Stores, and to receive a larger share of government reimbursements for prescription drugs.

More than 62 million Americans get prescriptions processed through Medco, according to the company. Medco handles pharmacy benefits totaling nearly $30 billion per year, including $1.2 billion from Blue Cross/Blue Shield as part of the Federal Employees Health Benefits Program.

George Bradford Hund and Walter W. Gauger, who both worked as pharmacists in Medco's Las Vegas processing facility, and Joseph Piacentile, a physician, allege in their complaints that on busy days Medco would cancel or destroy prescriptions to avoid penalties for delays in filling orders. Customers would be told that the prescriptions had never been received, Sheehan said.

The company is also accused of fabricating records and, when the handwriting on prescriptions was unclear or difficult to read, simply guessing at what they said, according to Sheehan. The government's suit against Medco could ask for damages in the millions of dollars and new oversight systems.

Merck acquired Medco in 1993 at a time when other drugmakers were purchasing pharmacy-benefit managers. By the end of the 1990s, all pharmaceutical manufacturers but Merck had sold their units amid concerns that the drug companies would use the benefit managers to push their own drugs, rather than doing what was best for clients.

I 1998 Merck signed a settlement agreement with the Federal Trade Commission stating that "Medco has given favorable treatment to Merck drugs." Last December, Medco agreed to pay $42.5 million to settle a class-action lawsuit alleging that the company improperly promoted higher priced Merck drugs rather than seeking the best price from alternative pharmaceutical companies. Merck announced it intended to spin off Medco last year, but delayed the initial public offering of shares because of the depressed stock market.

Yesterday's announcement marks the first significant legal action by a federal agency against a pharmacy-benefit manager. Previously, attorneys general of at least 25 states have opened inquires into Medco to determine whether it has violated state laws, and New York State Attorney General Eliot L. Spitzer said last Friday that his office was investigating another company, Express Scripts Inc., for allegedly overbilling state health plans.

Shares of Merck closed yesterday at $62.11, down 78 cents, or 1.24 percent.

[From the Washington Post, June 24, 2003]

MEDCO ACCUSED OF FAVORING MERCK DRUGS

(BY DAVID B. CARUSO)

Federal prosecutors on Monday said a company that was supposed to help health plans find low-cost prescription drugs instead pressured doctors to switch patients to medications made by its owner, pharmaceutical giant Merck & Co.

U.S. Attorney Patrick Meehan said his office has joined a pair of civil "whistleblower" lawsuits against Medco Health Solutions, accusing the Merck subsidiary of providing misleading information to the government in connection with its contract to manage drug benefits for federal employees.

More than 1,000 companies have hired Medco to coordinate prescription drug coverage for employee health plans, making it the nation's largest manager of pharmacy benefits, and the company is supposed to use its bulk-purchasing power to lower drug costs.

But the suits say Medco routinely induce physicians to switch patients to Merck drugs, even if a patient had been doing well on another medication that cost less.

The government also says the company failed to call doctors to explain prescriptions that were unclear, and fabricated records to make it appear as if calls from pharmacists to physicians had been made.

The three whistleblowers—a New Jersey doctor and two Nevada pharmacists who once worked for Medco—claim the firm also misled clients about its practice of accepting cash rebates from pharmaceutical companies in exchange for promoting their products. The suits claim the payments amount to kickbacks.

Medco spokesman Jeffrey Simek said the charges are "either absolutely untrue, or they reflect years-old isolated issues that were identified and corrected."

He denied the firm gives preferential treatment to Merck, or any other drug company.

"Our policy is that we will never make a drug interchange that will not result in a benefit for either our clients, or the members of their health plans," he said. "If we improperly favored any drug by any single company, we could never succeed."

Several health plans have previously sued Medco, claiming that it improperly accepted $3.56 billion in payments from drug companies in the late 1990s to promote their products, but Monday's filing by the U.S. Attorney in Philadelphia is the first such action by a federal prosecutor.

Medco, like other pharmacy benefit companies, acknowledges participating in rebate programs. Simek said the company took in $2.5 billion in rebates in 2001. But he said the payments work like coupons and ultimately lower medication costs for clients.

The suits also accuse Medco, of Franklin Lakes, N.J., of shortchanging patients by mailing them fewer than the number of pills they paid for. They say the company tried to avoid penalties for delays in filling mail orders by destroying prescriptions on days when the order volume was heavy.

Simek said the company investigated the allegations and determined they were isolated incidents that didn't affect patient care. Two employees were fired, he said.

Court filings identified the whistleblowers as Dr. Joseph Piacentile, of New Jersey, and George Bradford Hunt and Walter W. Gauger, two pharmacists who previously worked for Medco in Las Vegas.

Attorneys general in several states have said they are also investigating whether the company, and other pharmacy benefit firms, broke the law.

Merck has been trying to spin off its Medco business. It canceled an initial public offering for the company in July after revealing that it had misstated its revenues by $12 billion in recent years by counting prescription copyaments made to pharmacies as Medco revenue. Merck said in May that the firm would be spun off instead to Merck shareholders.

Ms. CANTWELL. Madam President, it was reported this week that U.S. Attorney Patrick Meehan plans to join a pair of lawsuits filed by three former Medco Health employees. The employees—two pharmacists and a doctor—allege that Medco provided misleading information to the Government related to a contract to provide drug coverage for Federal employees. The lawsuits accuse Medco of switching patients to more expensive drugs and fabricating records to make it look as if the prescription changes were made by doctors and not by Medco.

These are serious allegations resulting from an investigation that began in 1999. This is the first such action taken by a U.S. attorney against a PBM and is a strong signal that all is not right with this industry.

U.S. Attorney Patrick Meehan told the Newark Star Ledger:

> The kind of conduct alleged in the complaints threatens not only the integrity of the system as a whole, but also the well being of the very patients it is designed to benefit. These allegations suggest that, somewhere along the line, the focus became the profit instead of the patient.

The possibility of profitability trumping patient care has promoted a number of consumer groups to favor the accountability system outlined in my amendment. Consumers Union, Public Citizen, Families USA, AFSCME, the National Community Pharmacy Association and the Washington State Pharmacy Association all support my amendment.

Mr. President, I ask unanimous consent that letters of support be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONSUMERS UNION,
Washington, DC, June 25, 2003.

DEAR SENATOR: As the Senate continues to debate S. 1, the "Prescription Drug and Medicare Improvement Act of 2003," Consumers Union urges you to redouble your efforts to improve the legislation so that it better meets the needs of seniors and people with disabilities, many of whom are in dire need of meaningful protection from the devastating impact of spiraling prescription drug costs.

Some of Consumers Union's most serious concerns about S. 1 are:

The amount set aside in the Congressional budget resolution for a Medicare prescription drug bill, $400 billion over 10 years, is inadequate for the task and limits coverage to 22 percent of the projected prescription drug expenditures over this time period;

Prescription drug coverage provided by S. 1 is skimpy, leaving many beneficiaries who lack coverage in 2003 actually paying more out of their own pockets for prescription drugs in 2007, when they have coverage. (For more information, please see our report, Skimpy Benefits and Unchecked Expenditures: Medicare Prescription Drug Bills Fail to Offer Adequate Protection for Seniors and People with Disabilities, at www.consumersunion.org);

The bill lacks a standard, uniform benefit, does not guarantee the availability of a prescription drug benefit through the Medicare program, and leaves all beneficiaries uncertain about what coverage will be available to them (and uncertain about the premium they will be charged);

While the Senate has approved helpful amendments that would accelerate the introduction of generics and possibly provide beneficiaries access to lower-priced drugs from Canada, the bill's reliance on hundreds of private insurance companies and HMOs precludes the possibility of the federal government using its purchasing power to negotiate deep discounts for consumers. It does too little, therefore, to rein in spiraling prescription drug expenditures;

The bill creates confusion for Medicare beneficiaries, forcing them to sort out the options in the drug-only marketplace and options in the HMO/PPO marketplace, and it further complicates the "comparison shopping" task by allowing the prescription drug benefits to vary from the basic parameters (e.g., deductible, cost-sharing, doughnut, catastrophic coverage). Simply-put, the confusing options that will face Medicare beneficiaries flunks the "kitchen table" test;

S. 1 will leave many Medicare beneficiaries worse off since employers will cut back their retiree coverage because any coverage is not counted toward retirees' out-of-pocket costs; and

While the bill provides for a relatively generous subsidy for low-income consumers, it requires them to get their prescription drug benefit through Medicare instead of the currently universal Medicare program, even though they qualify for Medicare coverage by virtue of their age or disability.

We are deeply troubled by discussions that are underway that would undermine the traditional fee-for-service Medicare program—the very program that assures beneficiaries that they have the freedom to go to the doctor of their choice—by providing extra subsidization to private PPOs and HMOs. By enriching the benefits available in the private marketplace, PPOs and HMOs will attract relatively healthy people; the traditional fee-for-service Medicare option will erode over time, because of the design of the subsidies and desire to cut costs. The sickest and most vulnerable will be severely disadvantaged.

There are several amendments that would help address some of the problems with S. 1. We urge you to support amendments that would:

Expand the prescription drug benefits so that they are comparable to prescription drug coverage in employer-based health insurance plans;

Rein in prescription drug expenditures through the use of the federal government's buying power to negotiate deep discounts;

Provide for scientific study of the comparative effectiveness of alternative prescription drugs;

Guarantee that beneficiaries would have access to a prescription drug benefit through the Medicare program at a set premium;

Count the contributions made by employers toward beneficiaries' out-of-pocket costs;

Maintain a level-playing field so that benefits in PPOs and HMOs are not more generous than benefits available in traditional fee-for-service Medicare;

Instruct the National Association of Insurance Commissioners to adjust medigap benefit packages to allow beneficiaries to buy additional coverage;

Increase the transparency of transactions by pharmaceutical benefit managers;

Cut the time before the prescription drug benefits begin.

The current debate about a Medicare prescription drug benefit has led seniors and persons with disabilities to believe that relief is in sight. In its present form, S. 1 will be a big disappointment to beneficiaries when it is implemented in 2006. We urge you to amend S. 1 so that it is more effective in providing meaningful relief to Medicare beneficiaries while addressing the pressing need to curb prescription drug expenditures.

Sincerely,

GAIL E. SHEARER,
Director, Health Policy Analysis,
Washington Office.

SOCIETY OF PROFESSIONAL ENGINEERING EMPLOYEES IN AEROSPACE,
Seattle, WA, June 5, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: As you know, union members and retirees in Washington are very concerned about the current activities involving prescription drug benefits for Medicare seniors. We thought you should know that we are part of a national delegation of unions that met with Secretary Tommy Thompson to express our opposition to any PBM-based alternative to our local pharmacies.

PBMs own much of the mail order drug service in this country. For the past 2 years, we have been warning congressional members that a PBM-based benefit would potentially harm many local pharmacies that serve our communities. Still however, lawmakers almost passed a PBM-based benefit in the 107th Congress.

Since last year, the reputation of PBMs has grown worse. Now they are being sued by a California based union, AFSCME. Allegedly, four of the largest PBMs have been pocketing money that is meant for the consumer.

SPEEA urges you and your fellow Senators to look into this lawsuit before passing any PBM-based legislation. In this day and age, transparency must be part of any program set up by the United States government.

Sincerely,

CHARLES BOFFERDING,
Executive Director.

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL–CIO,
Washington, DC, June 24, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: On behalf of AFSCME's 1.4 million members, I am writing to express my strong support for your amendment to S. 1, the Medicare prescription drug bill, that would make certain that costs savings generated by Pharmacy Benefit Managers (PBM) on behalf of the Medicare program are returned to the program. We believe that this is a critical means of controlling costs for this new benefit.

PBMs create most of their cost savings and their profits by negotiating with drug manufacturers to receive favorable rates on a pharmaceutical company's drugs in exchange for including the drugs on the PBM's formulary of preferred medicines. This bill would require that all contracts with PBMs to provide the Medicare benefit with a private insurer or the government itself include language that would ensure that all savings negotiated with a pharmacy be passed back to the government or the private insurer administering the benefit on behalf of the government.

We believe it is crucial that PBMs be required to disclose the percentage of rebate they have negotiated with the pharmaceutical companies that are passed onto their clients. Your amendment would do precisely that—giving some assurance to consumers and the government that the savings achieved by the PBMs are being shared.

I believe that your amendment goes a long way toward ensuring that Medicare beneficiaries will receive their fair share of the cost savings produced by contracts with PBMs, and AFSCME strongly supports its adoption.

Sincerely,

CHARLES M. LOVELESS,
Director of Legislation.

JUNE 18, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: Families USA, the national consumer health advocacy organization, strongly endorses your amendment to ensure that the conflicts of interest, which can occur in the delivery of a Medicare prescription drug benefit, are minimized or avoided.

Everyone agrees that whether Medicare directly administers the benefit or whether it is administered through private plans, Pharmacy Benefit Managers (PBM) will be used. They have the expertise and knowledge necessary to help administer this program. But in the recent past, there have been examples of abuse in this sector, particularly troubling has been the steering of patients to a particular prescription drug product because it was more profitable for the administering company and not because it was better for the patient! In a very real sense, that is malpractice. It is inexcusable. It must be stopped. At least one major PBM has announced a code of ethics to prevent such abuses. But these important consumer protections should not depend on company-by-company internal codes of ethics. Your amendment is needed.

Your amendment requires the confidential disclosure of the type of information that will enable the Department of Health and Human Services to protect against rebates and kickbacks that would cause a company to steer people toward profitable medicine rather than needed medicine. Your amendment helps ensure that those who will surely be called on to help administer the new benefit provide good health care to the beneficiaries and not just profitable health care to their owners.

Sincerely,

RONALD F. POLLACK,
Executive Director.

WASHINGTON STATE
PHARMACY ASSOCIATION,
Renton, WA, June 23, 2003.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: The Washington State Pharmacy Association, representing pharmacy practitioners from all practice arenas in the State of Washington, strongly endorses your amendment to ensure that the conflicts of interest, which can occur in the delivery of a Medicare prescription drug benefit through a PBM, are minimized or avoided.

Pharmacy Benefit Managers (PBM) are an integral part of the health care delivery system. Efficient plan administration and timely claims processing are mandatory components of a successful health care benefit which are important to patients, payers and providers. However, in recent years the PBM industry has expanded their role to include benefit design that has created significant conflicts of interest and ethical questions of appropriate health care delivery versus profitable health care delivery.

Your amendment, as proposed, provides the necessary transparency that will provide patients, payers, and regulators the necessary information to appropriately monitor PBM business practices. Your amendment is a significant step toward insuring that the health care provided to the citizens of this country is focused on improving the patient's health and wellbeing and not the fiscal wellbeing of the pharmacy benefit managers.

Sincerely,

ROD SHAFER, R.Ph.,
CEO.

Ms. CANTWELL. Madam President, these groups and others have been trying to call attention to problematic PBM practices. These groups rightly point out that strong consumer protections are needed in any Medicare drug benefit.

The American Association of State, County and Municipal Employees agrees that these protections provide "a critical means of controlling costs."

A national coalition of workers representing more than 20 states also are supportive of efforts to monitor PBMs. Many in this coalition currently use PBMs to provide benefits and many of them are wondering why drug costs continue to rise.

There is a balance to be had here, and the Cantwell-Lincoln amendment makes sure the scale is not tipped too far one way. It is a good amendment that will lower prescription drug prices, provide much needed consumer protections and ensure strong government oversight. I urge my colleagues to support it.

Mr. GRASSLEY. Is the amendment before us now?

The PRESIDING OFFICER. The amendment is before us.

Mr. GRASSLEY. We have looked at the amendment on this side. It has been modified, and I urge we accept it on a voice vote.

Mr. BAUCUS. We have looked at this amendment. I agree with Senator GRASSLEY. We accept the amendment.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 942, as modified.

The amendment (No. 942), as modified, was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BYRD. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BYRD. Madam President, I ask unanimous consent that I may speak out of order.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BYRD. I thank the Chair.

(The remarks of Mr. BYRD are printed in today's RECORD under "Morning Business.")

AMENDMENT NO. 1095

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, I ask unanimous consent the pending amendments be temporarily set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. On behalf of the Senator from South Dakota, Senator JOHNSON, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. JOHNSON, for himself and Mr. COCHRAN, proposes an amendment numbered 1095.

Mr. REID. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for a 1-year medication therapy management assessment program)

At the end of subtitle A of title I, add the following:

SEC. . MEDICATION THERAPY MANAGEMENT ASSESSMENT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 geographic areas, each containing not less than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(3) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the program not later than January 1, 2005, but may not implement the assessment program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as an assessment site under subsection (a)(2) may participate in the assessment program under this section if such beneficiary identifies a qualified pharmacist who agrees to furnish medication therapy management services to the eligible beneficiary under the assessment program.

(c) CONTRACTS WITH QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF QUALIFIED PHARMACISTS.—The Secretary may contract with more than 1 qualified pharmacist at each site.

(d) PAYMENT TO QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—Under an contract entered into under subsection (c), the Secretary shall pay qualified pharmacists a fee for providing medication therapy management services.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The Secretary shall, in consultation with national pharmacist and pharmacy associations, design the fee paid under paragraph (1) to test various payment methodologies applicable with respect to medication therapy management services, including a payment methodology that applies a relative value scale and fee-schedule with respect to such services that take into account the differences in—

(A) the time required to perform the different types of medication therapy management services;

(B) the level of risk associated with the use of particular outpatient prescription drugs or groups of drugs; and

(C) the health status of individuals to whom such services are provided.

(e) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the assessment program under this section.

(2) BUDGET NEUTRALITY.—In conducting the assessment program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would

have paid if the assessment program under this section was not implemented.

(f) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the assessment program under this section.

(g) Availability of Data.—During the period in which the assessment program is conducted, the Secretary annually shall make available data regarding—

(1) the geographic areas and sites designated under subsection (a)(2);

(2) the number of eligible beneficiaries participating in the program under subsection (b) and the level and types medication therapy management services used by such beneficiaries;

(3) the number of qualified pharmacists with contracts under subsection (c), the location of such pharmacists, and the number of eligible beneficiaries served by such pharmacists; and

(4) the types of payment methodologies being tested under subsection (d)(2).

(h) Report.—

(1) In general.—Not later than 6 months after the completion of the assessment program under this section, the Secretary shall submit to Congress a final report summarizing the final outcome of the program and evaluating the results of the program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) Assessment of payment methodologies.—The final report submitted under paragraph (1) shall include an assessment of the feasibility and appropriateness of the various payment methodologies tested under subsection (d)(2).

(i) Definitions.—In this section:

(1) Medication therapy management services.—The term "medication therapy management services" means services or programs furnished by a qualified pharmacist to an eligible beneficiary, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual's understanding of the appropriate use of medications;

(C) to increase the individual's compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications; and

(E) to reduce the need for other costly medical services through better management of medication therapy.

(2) Eligible beneficiary.—The term "eligible beneficiary" means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) receiving, in accordance with State law or regulation, medication for—

(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or

(ii) such other chronic diseases as the Secretary may specify.

(3) Qualified pharmacist.—The term "qualified pharmacist" means an individual who is a licensed pharmacist in good standing with the State Board of Pharmacy.

Mr. McCONNELL. Mr. President, I ask unanimous consent that immediately following Senator KENNEDY's comments I be recognized to offer an amendment regarding cancer. I further ask unanimous consent that this morning the Senate proceed to a vote in relation to the McConnell amendment, to be followed immediately by a vote in relation to the Boxer amendment numbered 1036, to be followed immediately by a vote in relation to the Bingaman amendment numbered 1065, with no second degrees in order to the three above amendments prior to the vote, with 2 minutes equally divided prior to the vote, and with 10 minutes equally divided before the first vote.

Mr. REID. Mr. President, it is my understanding that as soon as Senator KENNEDY finishes his speech Senators McCONNELL and BOXER will be recognized for 10 minutes with the time equally divided, and then we go into the series of votes. Is that right?

Mr. McCONNELL. That is my understanding.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Massachusetts is recognized.

AMENDMENT NO. 1092

Mr. KENNEDY. Mr. President, we will have a chance to have greater discussion and debate on one of the important amendments that is before the Senate. But I wanted to bring to the attention of our Members as we go through the course of the day the Grassley-Baucus amendment, which has two different parts to it. I would like to address the part of the amendment which I find enormously compelling and which deserves the broad support of all the Members of this body.

This amendment provides equal funding for Medicare and the private plan demonstration plans. That is effectively what will be in the Grassley-Baucus amendment. The Republicans say the private sector can do a better job providing health care for seniors and we say Medicare can do a better job. This amendment tests both. This amendment improves the coordination of care for seniors with multiple chronic conditions who remain in Medicare. Republicans have said we need to move seniors into private plans if we want to provide chronic care coordination, disease management, or enhanced preventive services.

I am confident this demonstration program will show Medicare can do an even better job than private plans in providing preventive health services and ensuring care coordination. Care for patients with chronic conditions is especially critical. These patients account for 95 percent of Medicare spending, according to "Care Coordination for People with Chronic Conditions", an analysis published this year by Johns Hopkins University.

Currently, 60 million Americans have multiple chronic conditions, and that number is expected to grow to 157 million by the year 2020.

Sixty-two percent of seniors have multiple chronic conditions, but their care is often fragmented. A senior citizen may get treatment for her diabetes from one doctor, care for her arthritis from a second doctor and attention for her high blood pressure from a third.

Study after study shows that improving the coordination of care for those with multiple chronic conditions can improve outcomes and reduce costs.

For example, in Laconia, NH, the Home and Community Based Care program improved disease management for seniors with multiple conditions. This program saved an average of $8,100 in health care costs for each senior served and decreased admission to nursing homes.

In Georgia, the Service Options Using Resources in a Community Environment—SOURCE—program improved disease management for 1,600 beneficiaries in 80 counties. The costs of caring for those seniors in the SOURCE program over two years was over $4,000 lower than for those who were not in the program.

My own state of Massachusetts is part of the New England States Consortium, a multi-state effort funded by the Robert Wood Johnson Foundation to study the improvements that can be made in health care through better care coordination.

Expert groups in health care have said that care coordination should be one of the highest priorities for our health care system. For example, in its recent report, Priority Areas for National Action: Transforming Health Care Quality, the Institute of Medicine identified 20 "priority areas" for improving health care.

The Institute of Medicine has carefully examined the issue of care quality. The Institute's recent report, "Priority Areas for National Action" has a series of recommendations on improving the quality of health care in America. We have included in our amendment 13 of the 20 priority items that have been identified by the Institute of Medicine that will make a significant difference in quality. The amendment will have an important impact in reducing costs by improving care coordination and providing needed preventive services.

A recent study funded by the Robert Wood Johnson Foundation reaches the same conclusion. The study examined the effect of care coordination on outcomes for patients with diabetes. Care coordination and simple preventive services dramatically improved the outcome for patients with diabetes in terms of their blood glucose levels. Elevated blood glucose is a major concern for patients with diabetes, and preventive services are effective in keeping blood glucose levels down. As we know, diabetes is one of the principal health concerns for our country, and is of particular concern for our seniors.

A decrease of even one percentage point in the blood glucose level of a patient with diabetes can have a profound effect on health. That seemingly small decrease results in a 21 percent drop in mortality from the disease, a 12 percent decrease in strokes, a 24 percent decrease in renal failure, and a remarkable 43 percent drop in the amputations that so many patients face as a result of this cruel disease. More effective management of blood glucose levels is also effective in keeping patients out of hospitals or nursing homes and thus reducing costs. A reduction in blood glucose levels of just one percent reduces health care costs by $800 per patient.

These kinds of extraordinary improvements in health care quality are what this amendment is all about. We are going to provide some $6 billion nationwide over a 5-year period to give life to these kinds of quality improvement efforts, and we are going to challenge the private sector to do it as well.

. We believe that the kinds of quality improvement initiatives included in this amendment will be a major factor for the support for this legislation. Health care quality and its impact on health care costs is an aspect of the health care debate that has not received sufficient attention.

This amendment will give us an opportunity to take dramatic steps forward in Medicare which will strengthen and improve the quality of health care for our seniors. The amendment will also have a very positive impact in terms of cost reductions.

This amendment also addresses the whole question of prevention which is equally critical to keeping people healthy. Immunizations, managing high blood pressure, cancer screening, and patient education can all have an enormous impact on keeping people healthy and reducing costs. Too often Medicare pays huge amounts to care for people who are sick but fails to invest adequately in keeping them healthy.

Failure to invest adequately in preventive services is a tragic consequence of the repayment system we now have under the Medicare system. When the original Medicare system was established, we did not have the knowledge, awareness, and understanding of the importance of prevention nearly to extent we have it today. Preventive care was not reimbursed the way it should be.

Under this amendment, we will have the opportunity to provide the kinds of real, effective support for prevention programs they deserve. Increased support for preventive services will mean lower costs and better quality of care for our seniors under Medicare.

As I mentioned, too often we pay huge amounts to care for people who are sick, but fail to invest in keeping people healthy. This amendment gives Medicare the tools to invest in keeping people healthy. Too often the care for people with the highest cost, the most serious illnesses, such as cancer and stroke, is not optimal.

This demonstration will help Medicare assure the highest quality care for the sickest patients. Medicare is a fine program. It has kept our senior citizens secure for 40 years. Today let us make Medicare even better with this amendment.

I will include the selective parts of the studies I referred to previously in the RECORD. I ask unanimous consent that the selective parts be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. KENNEDY. Mr. President, as I mentioned, the New England Journal of Medicine—in a major study published just today—focuses on the issue of · quality. The study demonstrates that the problem most likely to occur in our health care system is not overutilization of services, but underutilization. This point bears repeating. Patients all over America are not receiving the services they need to keep them healthy. 46 percent of patients did not receive the recommended care, while only 11 percent received care that was not recommended and was potentially harmful. That means that four times as many patients did not receive the care they needed as received care they did not need. The problem in our health care system is not overutilization of services, but underutilization.

The problem of not receiving needed care is particularly acute for some of the most serious disorders that affect seniors. The New England Journal article states that less than a quarter of patients with diabetes received recommended blood tests. Fewer than two-thirds of patients with high blood pressure received the recommended care. These two diseases alone take an extraordinary toll on the lives of our citizens. Nearly 600,000 seniors die each year from heart disease, and complications of diabetes kill over 50,000 seniors. We could dramatically reduce the serious toll of these diseases—and many others—by improving access to preventive services and enhancing the quality of care.

Modern medicine—and a strong Medicare program—have been effective in allowing seniors to live with chronic conditions that once were fatal. Millions of seniors are alive today because of advances in the treatment of heart disease, high cholesterol, cancer and other serious illnesses. As a result of this success, however, millions of seniors have multiple chronic conditions which put them at higher risk for illness and hospitalization. The Institute of Medicine reports that only 0.7 percent of seniors with just one chronic condition require hospitalization in any given year. 6.2 percent of seniors with 4 chronic conditions are hospitalized, and over 25 percent of those with 10 or more chronic conditions require a hospital stay. Currently, 60 million Americans have multiple chronic conditions, and that number is expected to grow to 157 million over the next two decades.

Improving the coordination of care for those with multiple chronic conditions can markedly improve outcomes. Yet the average Medicare beneficiary sees more than six different doctors in a year. Clearly, we need to do more to see that seniors receive the most appropriate care for all their conditions—not just the one that any particular doctor among these six is treating individually. Study after study cited by the Institute of Medicine indicates that care is inadequately coordinated for patients with some of the most serious diseases.

Our health care system also fails to provide adequate preventive services. Survival rates for many forms of cancer increase dramatically if the disease is detected early—yet far too few patients receive the type of early screening that can literally mean the difference between life and death. For example, early diagnosis of colon cancer results in a survival rate of 90 percent, but that survival rate drops precipitously if the cancer spreads or grows before it is detected. Early detection not only saves lives—it reduces costs too. Proper screening can save up to $25,000 for every patient who avoids painful and lengthy treatment through early detection of cancer. Despite this compelling evidence of the value of preventive services, only a third of patients receive the recommended form of colon cancer screening.

The story is the same with adult immunization. Pneumonia and influenza are the seventh leading cause of death in the United States, and the fifth leading cause of death among seniors. Over a third of seniors with invasive pneumonia will die of the disease. Many cases of these diseases are preventable with a simple immunization—yet one-third to one-half of all seniors do not receive needed immunizations. Coverage rates for high-risk seniors are particularly poor. Tragically, only about a quarter of seniors with chronic disease receive a flu shot.

This very important amendment will address these challenges which the Institute of Medicine, the Robert Wood Johnson Foundation, and the New England Journal of Medicine have all commented on as being critical if we are going to strengthen quality and begin to get a greater handle on costs.

I will refer to the part of the amendment that addresses these questions.

Page 13 of the amendment describes the enhanced benefits that will now be available to beneficiaries in terms of care coordination, disease management and preventive services not otherwise covered under section 18 of the Social Security Administration. I ask unanimous consent to include the section of the bill containing this provision in the RECORD.

The amendment provides chronic care coordination services, disease management services and other benefits that the Secretary will determine to improve preventive health care for Medicare beneficiaries. These services will improve chronic disease management and management of complex life-threatening or high-cost conditions. The amendment will make a real difference in improving the health of millions of seniors.

This is really a historic opportunity. I can say, having been here for some period of time, the idea that you would get $6 billion over 5 years to be able to support prevention and the coordination of care for our seniors—I didn't believe it would ever be realized. We have that chance with this amendment.

I think one of the most important aspects of this legislation is its emphasis on the area of prevention, which is so important, as I have just described. Increased support for preventive health care services will improve and strengthen the quality of health care and also result in savings for the Medicare system. We have seen how these services help the intensely ill and sick and fragile elderly. And we will increase the coordination of services as well. All of this makes a great deal of sense. And we have the evidence—ample evidence—to show that action in this area can make a very important difference to the elderly.

I will let others describe the other part of the amendment dealing with private plans. But we challenge them, after the 5 years in which the resources will be spent—with a GAO study that will report back how the money has been spent—we challenge them to see which will make the greatest difference in terms of quality of care for our senior population and will make a difference in terms of the savings in the Medicare system. There is no question in my mind—no question in my mind—what that GAO report will demonstrate. We have clear documentation and scientific information that talks about the various studies that have been done to date, and also the conclusions that have been reached by the thoughtful, nonpartisan groups in this very area.

We welcome the opportunity to show to the American people which system is really going to work effectively. At the end of that period of time, we will have the chance to enhance and improve on that, to make sure the future generations' health care will be strengthened.

So I hope this amendment, which will be before us very soon, will receive overwhelming support because I think it will have a real chance to evaluate the different approaches and see what is going to be most effective in terms of quality and cost.

BLOOD GLUCOSE—REDUCTIONS PAY OFF

Longitudinal studies demonstrate that a one percentage point reduction in Hemoglobin A1C (blood glucose) results in: 14% decrease in total mortality; 21% decrease in diabetes-related deaths; 14% decrease in myocardial infarction; 12% decrease in strokes; 43% decrease in amputations; 24% decrease in renal failure; and $800 reduction in health care costs.

PROBLEMS WITH QUALITY OF CARE

The problem with quality that is most likely to occur, is underuse: 46.3 percent of participants did not receive recommended care. With overuse, 11.3 percent of participants received care that was not recommended and was potentially harmful.

VARIATIONS IN QUALITY

There is substantial variability in the quality-of-care patients receive for the 25 conditions for which at least 100 persons were eligible for analysis. Persons with senile cataracts received 78.7 percent of the recommended care; persons with alcohol dependence received 10.5 percent of the recommended care. The aggregate scores for individual conditions were generally not sensitive to the presence or absence of any single indicator of quality.

DISCUSSION

Overall, participants received about half of the recommended processes involved in care. These deficits in care have important implications for the health of the American public. For example, only 24 percent of participants in our study who had diabetes received three or more glycosylated hemoglobin tests over a two-year period. This routine monitoring is essential to the assessment of the effectiveness of treatment, to ensuring appropriate responses to poor glycemic control, and to the identification of complications of the disease at an early stage so that serious consequences may be prevented.

In our study, persons with hypertension received 64.7 percent of the recommended care. We have previously demonstrated a link between blood-pressure control and adherence to process-related measures of quality of care for hypertension. Persons whose blood pressure is persistently above normal are at increased risk for heart disease, stroke, and death. Poor blood-pressure control contributes to more than 68,000 preventable deaths annually.

FINAL LIST OF PRIORITY AREAS

The committee's selection process yielded a final set of 20 priority areas for improvement in health care quality. Improving the delivery of care in any of these areas would enable stakeholders at the national, state, and local levels to begin setting a course for quality health care while addressing unacceptable disparities in care for all Americans. The committee made no attempt to rank order the priority areas selected. The first 2 listed—care coordination and self-management/health literacy—are cross-cutting areas in which improvements would benefit a broad array of patients. The 17 that follow represent the continuum of care across the life span and are relevant to preventive care, inpatient/surgical care, chronic conditions, end-of-life care, and behavioral health, as well as to care for children and adolescents (see boxes ES-1 to ES-6). Finally, obesity is included as an "emerging area" that does not at this point satisfy the selection criteria as fully as the other 19 priority areas.

Recommendation 3: The committee recommends that DHHS, along with other public and private entities, focus on the following priority areas for transforming health care:

Care coordination (cross-cutting);

Self-management/health literacy (cross-cutting);

Asthma—appropriate treatment for persons with mild/moderate persistent asthma;

Cancer screening that is evidence-based—focus on colorectal and cervical cancer;

Children with special health care needs;

Diabetes—focus on appropriate management of early disease;

End of life with advanced organ system failure—focus on congestive heart failure and chronic obstructive pulmonary disease;

Frailty associated with old age—preventing falls and pressure ulcers, maximizing function, and developing advanced care plans;

Hypertension—focus on appropriate management of early disease;

Immunization—children and adults;

Ischemic heart disease—prevention, reduction of recurring events, and optimization of functional capacity;

Major depression—screening and treatment;

Medication management—preventing medication errors and overuse of antibiotics;

Nosocomial infections—prevention and surveillance;

Pain control in advanced cancer;

Pregnancy and childbirth—appropriate prenatal and intrapartum care;

Severe and persistent mental illness—focus on treatment in the public sector;

Stroke—early intervention and rehabilitation;

Tobacco dependence treatment in adults; and

Obesity (emerging area).

CARE COORDINATION—RATIONALE FOR SELECTION

Impact

Nearly half of the population—125 million Americans—lives with some type of chronic condition. About 60 million live with multiple such conditions. And more than 3 million—2.5 million women and 750,000 men—live with five such conditions (Partnership for Solutions, 2001). For those afflicted by one or more chronic conditions, coordination of care over time and across multiple health care providers and settings is crucial. Yet in a survey of over 1,200 physicians conducted in 2001, two-thirds of respondents reported that their training was not adequate to coordinate care or education for patients with chronic conditions (Partnership for Solutions, 2001).

More than 50 percent of patients with hypertension (Joint National Committee on Prevention, 1997), diabetes (Clark et al., 2000), tobacco addition (Perez-Stable and Fuentes-Afflick, 1998), hyperlipidemia (McBride et al., 1998), congestive heart failure (Ni et al., 1998), chronic atrial fibrillation (Samsa et al., 2000), asthma (Legorreta et al., 2000), and depression (Young et al., 2001) are currently managed inadequately. Among the Medicare-eligible population, the average beneficiary sees 6.4 different physicians in a year, 4.6 of those being in the outpatient setting (Anderson, 2002a).

CANCER SCREENING THAT IS EVIDENCE-BASED—RATIONALE FOR SELECTION

Impact

Colorectal cancer is the third most common cancer among men and women in the United States, with an estimated incidence of 148,300 cases annually. In 2002, 56,600 Americans died from colorectal cancer, making it the nation's second leading cause of cancer-related death. Lifetime risk for developing colorectal cancer is approximately 6 percent with over 90 percent of cases occurring after age 50 (American Cancer Society, 2002). The estimated long-term cost of treating stage II colon cancer is approximately $60,000 (Brown et al., 2002).

Cervical cancer is the ninth most common cancer among women in the United States, with an estimated incidence of 13,000 cases annually. Cervical cancer ranks thirteenth among all causes of cancer death, with about 4,100 women dying of the disease each year (American Cancer Society, 2002). The incidence of cervical cancer has steadily declined, dropping 46 percent between 1975 and 1999 from a rate of 14.8 per 100,000 women to 8.0 per 100,000 women (Ries et al., 2002). Despite these gains, cervical cancer continues to be a significant public health issue. It has been estimated that 60 percent of cases of cervical cancer are due to a lack of or deficiencies in screening (Sawaya and Grimes, 1999).

PREVENTION—CANCER SCREENING

Improvability

Early diagnosis of colorectal cancer while it is still at a localized state results in a 90 percent survival rate at 5 years (Ries et al., 2002). The American Cancer Society's (ACS) guidelines recommend screening for colorectal cancer beginning at age 50 for adults at average risk using one of the following five screening regimens: fecal occult blood test (FOBT) annually; flexible sigmoidoscopy every 5 years; annual FOBT plus flexible sigmoidoscopy every 5 years; double contrast barium enema every 5 years; or colonoscopy every 10 years (American Cancer Society, 2001). The United States Preventive Services Task Force strongly recommends screening for men and women 50 years of age and or older for colorectal cancer. Screening has been found to be cost-effective in saving lives, with estimates ranging from $10,000 and $25,000 life-year saved.

IMMUNIZATION (ADULT)—RATIONALE FOR SELECTION

Impact

Pneumonia and influenza are the seventh leading cause of death in the United States (The Commonwealth Fund, 2002). Pneumococcal disease causes 10,000 to 14,000 deaths annually; influenza causes an average of 110,000 hospitalizations and 20,000 deaths annually (United States Department of Health and Human Services, 2000). Approximately 30–43 percent of elderly people who have invasive pneumonia will die from the disease (United States Preventive Services Task Force, 1996). The elderly are also at increased risk for complications associated with influenza, and approximately 90 percent of the deaths attributed to the disease are among those aged 65 and older (Vishnu-Priya et al., 2000).

To decrease the burden of these diseases, including incapacitating malaise, doctor visits, hospitalizations, and premature deaths, experts recommend vaccination. Yet one-third to one-half of older adults (aged 65 and over) do not receive these vaccinations (The Commonwealth Fund, 2002). Coverage rates for high-risk adults who suffer from chronic disease are especially poor, with only 26 percent receiving an influenza vaccination and 13 percent a pneumococcal vaccination (Institute of Medicine, 2000).

Mr. KENNEDY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. McCONNELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1097

Mr. McCONNELL. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Kentucky [Mr. McCONNELL] proposes an amendment numbered 1097.

Mr. McCONNELL. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To protect seniors with cancer)

At the end of subtitle A of title I, add the following:

SEC. . PROTECTING SENIORS WITH CANCER.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cancer shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicaré Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with cancer, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with cancer, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cancer, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

(5) CONSTRUCTION.—Notwithstanding the preceding provisions of this section, nothing in this section shall be construed in a manner that would provide an individual who is diagnosed with cancer with benefits under part D of title XVIII of the Social Security Act (as added by section 101) that are different from the benefits that the individual would have been eligible for if such individual was not diagnosed with cancer.

Mr. McCONNELL. Mr. President, the amendment I just sent to the desk ensures protection of seniors diagnosed with cancer from the high prescription drug costs associated with that illness.

My amendment states specifically that any senior in Medicare and diagnosed with cancer shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 2.5-percent copayment for any drug spending up to $4,500 a year, no more than a 5-percent copayment for drug spending between $4,500 and $5,800 a year, and no more than a 2.5-percent copayment for any drug spending over $5,800 if their income is below the poverty level.

My amendment states that any senior in Medicare who is also diagnosed with cancer, with an income between 100 percent and 135 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 5-percent copayment for drug spending up to $4,500, no more than a 10-percent copayment for drug spending between $4,500 and $5,800, and no more than a 2.5-percent copayment for any drug spending over $5,800.

My amendment provides that any senior in Medicare diagnosed with cancer, with an income between 135 percent and 160 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no more than a $50 deductible, an average monthly premium not greater than $35, no more than a 10-percent copayment for drug spending up to $4,500, no more than a 20-percent copayment for drug spending between $4,500 and $5,800, and no more than a 10-percent copayment for any drug spending over $5,800.

My amendment also provides that any senior in Medicare and diagnosed with cancer, with an income above 160 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no more than a $275 deductible, an average monthly premium not greater than $35, no more than a 50-percent copayment for drug spending up to $4,500, and no more than a 10-percent copayment for drug spending over $5,800.

With this amendment, which conforms to the provisions within the bill, all seniors with cancer get help with prescription drug costs, especially the poor and moderate-income seniors.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. Two minutes.

Mr. McCONNELL. Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada.

Mr. REID. Mr. President, the Boxer amendment is very simple. It says if a person is receiving cancer drugs and they come to a period of time—as this bill is written—where they run out of the ability to get help from the Medicare Program, that they, in effect, are covered.

We want a cancer patient to have no donut hole, no gap in coverage. That is what the Boxer amendment is all about.

Mr. KENNEDY. Mr. President, do we have any time?

Mr. REID. We have at least 4 minutes.

Mr. KENNEDY. Will the Senator yield me a minute?

Mr. REID. Of course.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. REID. Mr. President, I yield 2 minutes to the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, the Boxer amendment provides the additional resources for the treatment of cancer. I think all of us understand the importance of the continuity of care in the treatment of disease generally. That is why I am going to continue to vigorously fight for additional resources to fill in this gap in the future for all diseases. But it is particularly important to fill this gap for people who are afflicted with the disease of cancer. They are waiting for Congress to fill in this gap.

It does seem to me, because of the compelling reasons for the continuity of care in terms of diseases generally we ought to be able to find the additional resources to fill this gap.

The Boxer amendment does not replace the fundamental structure of this legislation. It finds the additional resources to be able to make sure there will be continuity of care for what is, for many families, their Number 1 health concern. So that is a very compelling reason. I hope the amendment will be favorably considered.

I suggest the absence of a quorum.

Mr. REID. Mr. President, I ask the Senator to withhold the suggestion of a quorum.

Mr. KENNEDY. I withhold.

The PRESIDING OFFICER. Who yields time?

If no one yields time, time will be charged equally to both sides.

Who yields time?

The minority leader.

Mr. DASCHLE. Mr. President, I ask unanimous consent that all time be yielded back.

The PRESIDING OFFICER. Without objection, it is so ordered.

The question is on agreeing to the McConnell amendment No. 1097.

Mr. McCONNELL. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY), would vote "yea."

The PRESIDING OFFICER (Mr. BURNS). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 97, nays 1, as follows:

[Rollcall Vote No. 249 Leg.]

YEAS—97

Akaka
Alexander
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Boxer
Breaux
Brownback
Bunning
Burns
Byrd
Campbell
Cantwell
Carper
Chafee
Chambliss
Clinton
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Crapo
Daschle
Dayton
DeWine
Dodd
Dole
Domenici
Dorgan
Durbin
Edwards
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham (FL)
Graham (SC)
Grassley
Gregg
Hagel
Harkin
Hatch
Hollings
Hutchison
Inhofe
Inouye
Jeffords
Johnson
Kennedy
Kohl
Kyl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Lott
Lugar
McCain
McConnell
Mikulski
Miller
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Nickles
Pryor
Reed
Reid
Roberts
Rockefeller
Santorum
Sarbanes
Schumer
Sessions
Shelby
Smith
Snowe
Specter
Stabenow
Stevens
Sununu
Talent
Thomas
Voinovich
Warner
Wyden

NAYS—1

Ensign

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1097) was agreed to.

AMENDMENT NO. 1036

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). By previous order, there are 2 minutes evenly divided prior to the vote on the Boxer amendment.

The Senator from California is recognized.

Mrs. BOXER. The Senator from Kentucky and I agreed to an extra 30 seconds each, so I ask unanimous consent for that.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. Mr. President, I want to speak to the hearts and the minds of each and every one of my colleagues and friends, so I will speak straight from the shoulder.

The amendment we just voted for did nothing, not one thing, for cancer patients, except reiterate what is already in the underlying bill.

What my amendment does, and why I hope we will rise to the occasion and support it, is to send a strong message to anyone diagnosed with cancer, and to their families, friends, and loved ones, that if and when they are diagnosed with cancer, they will not face the benefit shutdown that is now in this bill.

I will show my colleagues on this chart that at $4,500 of drug costs, the benefit shuts down. I want my colleagues to think about someone they know with cancer, someone who is battling cancer. Do we want to put this burden on them? They must take their drugs. They cannot cut their pills in half in order to survive.

The Cancer Society tells us that 6 million to 7 million Medicare beneficiaries are battling some form of cancer, and 380,000 of them will die of cancer. Please, let us relieve this burden of them having to pay 100 percent of their drug costs during this benefit shutdown. I beg my colleagues to take a stand. I beg my colleagues to be compassionate. I beg my colleagues to be independent for once on an amendment and support the cancer patients who are counting on us today to at least relieve them of this terrible financial burden that will hit them just when they are the sickest.

I urge an aye vote.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Before I use my time, I have a unanimous consent request. That unanimous consent request is that the time lapse between the next two votes be 10 minutes instead of 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, first, from a parliamentary point of view, this amendment, if adopted, would subject the entire bill to a budget point of order. We have enough people in this body who maybe do not want a prescription drug bill that could take down the whole bill.

The other reason is, all the concerns the Senator has mentioned we have taken into account within the $400 billion capability of our legislation. We have before us this $400 billion to provide prescription drug benefits to our seniors. We have used that $400 billion to help low-income seniors with prescription drug costs if they have cancer, diabetes, or anything else for which they need drugs.

We have used the $400 billion to limit the catastrophic costs of prescription drugs to all seniors. We do not create two drug classes for the sick and the ill, and that is why we should move forward with this amendment so it does not bring down the whole bill on a potential budget point of order.

I move to table the amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. All time has expired. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The bill clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 54, nays 44, as follows:

[Rollcall Vote No. 250 Leg.]

YEAS—54

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Kyl
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NAYS—44

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Jeffords
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NOT VOTING—2

Kerry
Lieberman

The motion was agreed to.

AMENDMENT NO. 1065

The PRESIDING OFFICER. There are now 2 minutes equally divided prior to the vote on the amendment offered by the Senator from New Mexico.

The Senate will please be in order. The Senator from New Mexico will suspend until the Senate is in order.

The Senator from New Mexico.

Mr. BINGAMAN. I ask unanimous consent that the RECORD reflect we are updating the asset test to a limit of $10,000 per individual and $20,000 per couple.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Reserving the right to object, have we seen this? We do not seem to know about this.

The PRESIDING OFFICER. The Senate will be in order.

Mr. GRASSLEY. Reserving the right to object, we do not know about the modification—or do we? We do not seem to.

Mr. BINGAMAN. Mr. President, this is what the bill was intended to say. It is exactly what we have shared with your staff. It is just that there was a typo in it.

Mr. GRASSLEY. I withdraw the reservation.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico.

Mr. BINGAMAN. I ask unanimous consent that the Senator from Florida, Mr. GRAHAM, be added as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BINGAMAN. I also ask unanimous consent that we be allowed 2 minutes to advocate for the amendment and the opposition get 2 minutes as well.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BINGAMAN. Mr. President, I will take one of those 2 minutes and Senator DOMENICI the other.

This is a Bingaman-Domenici amendment. The purpose of it is not to eliminate the asset test. That was an earlier amendment I offered and then withdrew. Instead, it is to update the asset test, where you would still be required to demonstrate that your income was below poverty or in that range, but instead of having to demonstrate that your total combined assets were only $4,000, you would be able to show that they were less than $10,000.

This also eliminates the paperwork burden that currently is imposed in most States on people who are required to itemize their assets and essentially provide a full financial statement to get the full low-income benefit.

We think this is a needed update on the asset test. It will allow a lot more people to get the full benefit.

I yield the remaining time to Senator DOMENICI.

Mr. DOMENICI. Mr. President, this is a very simple amendment. I believe it is absolutely fair and nothing more than simple equity. We have had an asset test under Medicaid, which applies here, since 1988. It is $4,000. That means there is an income test and an asset test of $4,000. I believe the time has come to change that $4,000 to something more reasonable—not gigantic, just $10,000. It says the income test still applies, but you can own assets up to $10,000.

It also says you do not have to fill out all kinds of forms. You can sign an affidavit under penalty of felony, as to what your assets are, and that suffices. If there is anything this bill needs it is simplicity. So this adds simplicity to this form. But most of all, for the poor people, it permits them to own a car today. You know, hardly any cars are worth less than $4,000. I think you can be poverty stricken and still own an automobile.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. DOMENICI. I believe the amendment should be adopted.

The PRESIDING OFFICER. The Senate will come to order.

The Senator from Maine.

Ms. SNOWE. Mr. President, I urge my colleagues to vote against the amendment offered by Senator BINGAMAN. We are not here to alter the guidelines for the Medicaid Program because it certainly would have an impact on the underlying Medicaid Program.

Let me be clear. We did not create a new asset test for this benefit. We followed the asset test that exists in current law and that governs existing low-income assistance programs under Medicaid and Medicare.

Actually, we learned our lesson from the last debate last fall on the tripartisan bill. We realized in constructing that approach that we excluded 40 percent of low-income Medicare beneficiaries. So this time we built on the existing Medicaid and Medicare Programs. We created a new program for those under 160 percent of the poverty level that has no asset test. By doing so, we capture 8.5 million more Medicare beneficiaries for a total of 17.5 million Medicare beneficiaries or 43 percent of the overall program.

We target our assistance, the most assistance to those most in need. So it is important for our colleagues to understand, we are using asset tests that already exist in current law to maximize the most assistance to those most in need of this benefit.

Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 69, nays 29, as follows:

[Rollcall Vote No. 251 Leg.]

YEAS—69

Akaka
Alexander
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Boxer
Breaux
Brownback
Byrd
Campbell
Cantwell
Carper
Chafee
Chambliss
Clinton
Coleman
Collins
Conrad
Corzine
Daschle
Dayton
DeWine
Dodd
Domenici
Dorgan
Durbin
Edwards
Ensign
Feingold
Feinstein
Graham (FL)
Graham (SC)
Hagel
Harkin
Hollings
Hutchison
Inouye
Jeffords
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Lugar
McCain
Mikulski
Miller
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Roberts
Rockefeller
Sarbanes
Schumer
Smith
Specter
Stabenow
Stevens
Warner
Wyden

NAYS—29

Allard
Bond
Bunning
Burns
Cochran
Cornyn
Craig
Crapo
Dole
Enzi
Fitzgerald
Frist
Grassley
Gregg
Hatch
Inhofe
Kyl
Lott
McConnell
Murkowski
Nickles
Santorum
Sessions
Shelby
Snowe
Sununu
Talent
Thomas
Voinovich

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1065) was agreed to.

Mr. BINGAMAN. Mr. President, I move to reconsider the vote.

I move to lay that motion on the table.

The motion to lay on the table was agreed to.

CHANGE OF VOTE

Ms. LANDRIEU. Mr. President, on rollcall vote No. 251, I voted nay. I intended to vote yea. It does not change the outcome of the vote. I ask unanimous consent that the RECORD reflect as I have stated.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The foregoing tally has been changed to reflect the above order.)

Mr. FRIST. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. BUNNING). Without objection, it is so ordered.

Mr. FRIST. Mr. President, I ask unanimous consent that at 2:30 the Senate proceed to a vote in relation to a McConnell or designee amendment regarding Alzheimer's, to be followed immediately by a vote in relation to the Durbin amendment on the same subject, again, with no second degrees in order to either amendment prior to the votes; provided further that the Senate then proceed to a vote in relation to the Dorgan second-degree amendment on premiums to the Grassley-Baucus amendment No. 1092. Finally, I ask unanimous consent that following disposition of the Dorgan amendment, the Senate then proceed to a vote in relation to the underlying Grassley-Baucus amendment, with no other amendments in order to amendment No. 1092 other than the mentioned Kyl and Dorgan amendments. I also ask unanimous consent that there be 2 minutes equally divided for debate between each of the votes in this series as well.

Mr. REID. Reserving the right to object, everyone here is working in the best of faith to try to work through this situation. We don't have the actual document of the Durbin amendment. I have been told what is in that. I related that to the majority and to the two managers of the bill. It is very similar to the Boxer amendment. If it is anything different than that, I will make sure that we vitiate this agreement.

Mr. MCCONNELL. So if the Durbin amendment is other than we anticipate, I will obviously reserve the right to modify mine as well.

Mr. REID. Absolutely.

Mr. DORGAN. Mr. President, reserving the right to object, I ask the majority leader if in the period between now and when the first vote occurs, there will be provided 30 minutes for the offering and discussion of my amendment. I had previously talked with the Senator from Nevada. Senator PRYOR and I wish to be recognized for 30 minutes to offer our amendment. I simply ask if that timeframe allows that opportunity so that we have 30 minutes of debate.

Mr. MCCONNELL. Mr. President, I would like to make sure I am protected to lay down my amendment now.

The PRESIDING OFFICER. The Senator from Nevada has the floor.

Mr. REID. Mr. President, we have approximately an hour and a half. I would ask, as Senator DORGAN asked earlier, that he and Senator PRYOR be given 30 minutes of that hour and a half, and Senator DURBIN be given a half hour.

The PRESIDING OFFICER. The majority leader has the floor.

Mr. FRIST. Mr. President, I yield to the Senator from Kentucky.

Mr. MCCONNELL. Mr. President, we are talking about how to divide up an hour and a half. How about a consent that we divide the time equally?

Mr. REID. That will be fine. I ask unanimous consent that the agreement give each side an extra 5 minutes, so the vote would occur at 2:40, rather than 2:30, and the time be divided equally.

The PRESIDING OFFICER. Is there objection?

Mr. DORGAN. Reserving the right to object, I don't care what the vote is. Senator PRYOR and I wish to speak for 30 minutes. If that is not provided for in the unanimous consent, I will object.

Mr. REID. That is fine on this side.

Mr. FRIST. Mr. President, we have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

The PRESIDING OFFICER. The Senator from Kentucky is recognized.

AMENDMENT NO. 1102

Mr. MCCONNELL. Mr. President, pursuant to the consent agreement just entered into, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 1102.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To protect seniors with Alzheimer's disease)

At the end of subtitle A of title I, add the following:

SEC. . PROTECTING SENIORS WITH ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

Mr. MCCONNELL. Mr. President, very briefly, the amendment I just sent to the desk ensures protection of seniors diagnosed with Alzheimer's from the high prescription drug costs associated with that illness.

My amendment states specifically that any senior on Medicare diagnosed with Alzheimer's shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 2.5-percent copayment for drug spending up to $4,500, no more than a 5-percent copayment for drug spending between $4,500 and $5,800, and no more than a 2.5-percent copayment for any drug spending over $5,800 if their income is below the poverty level.

My amendment states that any senior on Medicare diagnosed with Alzheimer's with an income between 100 and 135 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, and no more than a 5-percent copayment for drug spending up to $4,500, no more than a 10-percent copayment for drug spending between $4,500 and $5,800, and no more than a 2.5-percent copayment for any drug spending over $5,800.

My amendment provides that any senior in Medicare diagnosed with Alzheimer's with an income between 135 percent and 160 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no more than a $50 deductible, an average monthly premium not greater than $35, no more than a 10-percent copayment for drug spending up to $4,500, no more than a 20-percent copayment for drug spending between $4,500 and $5,800, and no more than a 10-percent copayment for any drug spending above $5,800.

My amendment also provides that any senior on Medicare diagnosed with Alzheimer's with an income above 160 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no more than a $275 deductible, an average monthly premium not greater than $35, no more than a 50-percent copayment for drug spending up to $4,500, and no more than a 10-percent copayment for drug spending over $5,800.

With this amendment, which conforms to the provisions within the bill, all seniors with Alzheimer's get help with drug costs, especially the poor and moderate-income seniors.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Iowa.

AMENDMENT NO. 1093 WITHDRAWN

Mr. GRASSLEY. Mr. President, I ask unanimous consent, on behalf of Senator KYL, to withdraw the Kyl amendment to the Grassley amendment.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that the Dorgan amendment be offered now and the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection? Without objection.

The Senator from North Dakota.

AMENDMENT NO. 1103 TO AMENDMENT NO. 1092

Mr. DORGAN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from North Dakota [Mr. DORGAN] for himself and Mr. PRYOR, proposes an amendment numbered 1103.

Mr. DORGAN. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To reduce aggregate beneficiary obligations by $2,400,000,000 per year beginning in 2009)

In lieu of the matter proposed to be inserted, insert the following:

SEC. . AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:

"(d) AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall for each year (beginning with 2009) determine a percentage which—

"(1) shall apply in lieu of the applicable percent otherwise determined under subsection (c) for that year, and

"(2) will result in a decrease of $2,400,000,000 for that year in the aggregate monthly beneficiary obligations otherwise required of all eligible beneficiaries enrolled in a Medicare Prescription Drug Plan or a Medicare Advantage plan that provides qualified prescription drug coverage.

This subsection shall not apply in determining the applicable percent under subsection (c) for purposes of section 1860D–21.".

Mr. DORGAN. Mr. President, this is an amendment that deals with the question of what to do about the $12 billion of remaining available out of the $400 billion Congress set aside for a prescription drug benefit plan in the Medicare Program. According to CBO, the underlying bill is $12 billion of that $400 billion, so what do we do with that $12 billion? If the bill on the floor of the Senate to add prescription drugs to the Medicare Program costs $388 billion, and we have allocated $400 billion, the question is, what do you do with the other $12 billion? So we had a group of people—I am not quite sure who they were—negotiate over a period of time, and they have now developed a plan for what to do with the $12 billion.

By far, the simplest, most direct, and most appropriate use of the $12 billion would be to improve the prescription drug benefit for Medicare recipients. After all, that is why we are here. That is the purpose of this discussion and debate. That is the purpose of writing this legislation—to provide a prescription drug benefit to the Medicare Program that serves the interests of our senior citizens.

Regrettably, the Grassley amendment before us, to which I have just offered a second-degree amendment, does not accomplish those goals. So I offer an amendment that is very simple. It says let's try to improve this prescription drug benefit plan for senior citizens with the $12 billion that is available.

Let me just mention a word generally about Medicare. We have people on the floor of the Senate who don't like Medicare. They don't say it, I know. One of their colleagues said it yesterday in New York City. It is the only flash of candid comment that I have seen recently. Congressman THOMAS, in the New York Times, dated 6/26, says:

> Some of our friends on the other side of the aisle are saying that if this bill becomes law

> [meaning the Medicare prescription drug bill] it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so.

Let me read it again so we understand what he is saying: "Some of our friends [Democrats, he means] . . . are saying if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so."

When I was a young boy in a town of 400 people, my dad asked me to drive an old fellow to the hospital in Dickinson, ND. He was a man with a very serious health problem, and he had no relatives, had no vehicle, had no resources. So I was a teenager just about out of high school. I got him in my car and drove him to St. Joseph's Hospital in Dickinson, ND, and dropped him off there to be treated. He had a serious health problem but no insurance, no money, nothing.

The fact is, that was at a period of time in the late 1950s and early 1960s when a good many senior citizens had no capability to get health care. They had no insurance coverage. It wasn't the case that insurance companies were running after old folks to ask them: Can we please sell you a health insurance policy? They want to insure 22-year-olds—healthy, vibrant, young 22-year-olds.

That is where they make money. They don't make money by chasing 75-year-old people and selling them health insurance policies. Back in the early 1960s, one-half of America's elderly had no health insurance—none. None at all.

Then along came Medicare. The Congress had a real debate about that. I wasn't here then, but you know there were naysayers who say no to everything for the first time. They said no, no, no; you cannot create Medicare. Well, we did create Medicare, and now 99 percent of the senior citizens in this country don't have to go to bed at night worrying about whether they can get medical care because they have health care coverage under Medicare. God bless them for that. They needed it, they deserved it, and this country provided it through the Medicare Program.

Some say: We have incredible problems financing this program. Yes, we have some financial problems, no question about that. Do you know how we solve those problems? Go back to the old life expectancy. Go back 100 years and, on average, you were expected to live to 48 years of age in this country. Now people live to 76 to 77 years of age.

Life expectancy has increased dramatically in this country. That is good news. Our financing problems with Medicare are born of good news. People are living longer. Good for them. Good for us. Good for our country.

Is it a problem to have good news? I do not think so. We will solve these issues. But even as we have done that, even as people are living longer and better lives, these new miracle medicines that have been created since Medicare was created are very expensive but very necessary for people to continue their lifestyle. And we have no prescription drug coverage in the Medicare Program.

Clearly, if we wrote Medicare starting from scratch today, we would have prescription drug coverage. That is clear to everyone. But prescription drugs were not a key medical expense when Medicare was created, so now we have to put that coverage in the Medicare Program.

Because some people do not like the Medicare Program—to wit my colleague, Congressman THOMAS who said, "certainly we hope this will be the end of Medicare as we know it,"—they want to privatize Medicare. Now, keep in mind that the private sector is the sector that would not insure old people in the first place, which is the reason why Congress had to develop the Medicare Program.

That brings us back to this question of what to do with the $12 billion. We are struggling to put together a benefit that means something to the people who need it. This is not theory. It is not a debate in the abstract. It is about some 85-year-old widow who, today, is going to the pharmacy in the back of a grocery store and trying to figure out how much her prescription drugs are going to cost so she can figure out how much money she has left for groceries. That is happening in a real sense today all across this country.

We have $12 billion. We also have a bill that says to senior citizens: You pay $35 a month on an optional basis if you want this program of ours, and after $35 a month, you pay the first $275 in prescription drugs. Between $275 and $4,500, the Federal Government will help you by paying 50 percent of your prescription drug costs. And then between $4,500 and $5,800, there is what is famously called the donut hole, which means you receive no coverage.

So you are not covered until you spend $275, then you are partially covered, then you are not covered again, and then you get catastrophic coverage. This is the most byzantine, complicated system we could possibly put together. It clearly is done by committee. We could not have done this so badly if it were done without a committee.

Having said all of that, the question is, What do we do with the $12 billion? We are told today, with the Grassley amendment, that we will provide $6 billion of the $12 billion to test a new alternative bidding system for paying PPOs—and if this is not complicated enough, just stay with me—that would reimburse these PPOs based on the median amount of the three lowest bids. There is nothing here that protects American taxpayers by ensuring we are not paying private health plans substantially more than traditional Medicare costs.

Here is what it means in English. It means we are going to have an experiment with private sector delivery, but we are going to incentivize insurance companies. We are going to provide them some of this money so that they will actually want to offer this plan, so we can say at the end of it that somehow the plan is a good plan.

We already know that does not work. My colleague, Senator HOLLINGS, says there is no education in the second kick of a mule. We know this does not work. We know what happens. We know the Medicare Payment Advisory Committee, MedPAC, which is a nonpartisan committee that advises Congress on Medicare payment policies, says private plans cost 15 percent more than traditional Medicare. We know that. We do not have to spend $6 billion giving money to private insurers to do an experiment. We know what does not work. We know the cost advantage of Medicare, and yet our colleagues continue to resist and continue to insist that we move Medicare beneficiaries into the private sector. And now with half of the $12 billion, they say let's do this little experiment.

Will it enhance the health of senior citizens? No. Will it improve health care? No, not at all. Will it actually improve the underlying bill, improve the benefits, reduce the costs? No, not at all. This is just like a puppy dog following the master home. It is putting more and more money down this chute to pursue this dream of trying to demonstrate something we already know does not work.

Mr. DURBIN. Will the Senator yield?

Mr. DORGAN. I will be happy to yield.

Mr. DURBIN. Do I understand that senior citizens, given the choice between traditional Medicare and Medicare HMOs, have already voted and that 88 or 89 percent of them want traditional Medicare; that they do not want to put their medical fate in the hands of these HMO private insurers who are unreliable, who may or may not cover the procedures they need? Haven't the seniors of this country, with their experience, already voted on this issue we are considering?

Mr. DORGAN. Seniors have already made that judgment. They have already decided that. So we want to take $6 billion and give it to private health insurers at a time when Senators have been coming to the Chamber and saying we cannot improve this plan because we do not have any money. I have quotes of all the Senators, and I shall not name them all. I could read lots of quotes from the last 2 weeks of Senators. Why can't we improve it? Because we are limited by money. So now we have $12 billion more? That is what happens when you go into a room, shut the door, make a little deal, and say this is how we want to use this money: We are going to take $6 billion and try an experiment that we failed at previously. It makes no sense to me. It is a byzantine failure, in my judgment, to do it this way.

What I am proposing in my amendment is use the money to actually improve the program for senior citizens. We can drive down the cost of the prescription drug policies and improve the coverage.

Mr. DURBIN. I ask the Senator, if he will yield further, is the Senator aware of a recent survey of seniors—over 600 across the United States—where they were told what this plan, S. 1, is all about? They said the fact that the $35 premium is not mandated in this law but is simply a suggestion; it may go higher; the fact private insurance companies that provide the prescription drug benefit may decide to change the benefit or go out of business every 2 years; the fact there is a $275 deductible and a huge gap in coverage for the sickness of the senior citizens—when they looked at all those items, is the Senator aware of the fact that most of the seniors, when asked, said they did not believe that S. 1 really answered the need in America that seniors are looking for?

Mr. DORGAN. I know that is the case. I have seen the same survey to which the Senator referred. I think there are some provisions in this bill that have some merit. I prefer we do something rather than do nothing, but when we do something, let's do something right and something that benefits senior citizens. This is the case when you cite the polls, when you cite what our previous experience has been. It is a case, especially with respect to the use of this $6 billion, of the old joke from the movies: What are you going to believe, me or your own eyes?

The fact is, we have already had these experiments. We understand how much additional costs are involved in the private sector delivery of this benefit, and we also know what Medicare does and how Medicare works. We know the private insurers have about a 14-percent overhead in administrative costs and delivering their service. We know that. We also know Medicare has about a 4-percent cost, a dramatic advantage.

For that reason alone, you would want to provide this benefit through the traditional Medicare delivery system. Against all odds, we have people in this Chamber who, I guess, although they do not say it, believe along with Congressman THOMAS that this bill ought to be the end of Medicare as we know it. Congressman THOMAS said: Our answer to that is, we certainly hope so.

Mr. DURBIN. I ask the Senator, is it possible Halliburton is going to pay some of these services with the six—I will withdraw that question. I ask the Senator, if one believes in privatization and competition, why does the private sector need a $6 billion subsidy to compete with Medicare? If they are good, if they are efficient, if they are customer friendly, why do they need this Federal subsidy of $6 billion to offer an attractive health care package to seniors?

Mr. DORGAN. First, they do not need it, and no subsidy is warranted. The point of my amendment is to say if you have $12 billion, and they say let's take $6 billion and use it for an experiment that we know does not work, let's instead use that money to help seniors. Then the underlying amendment says let's take another $6 billion and test whether focusing on wellness will work, which we know it does work. We do not exactly have to have an experiment on that. Do things that promote wellness and the fact is you save money on the acute care side by not having people go into the hospital because they are taking care of themselves and have the kind of preventive care that is necessary to take care of themselves.

I have another amendment pending. It has been pending for nearly a week. I hope it will be approved by the end of this process. It is a very inexpensive amendment that deals with that very kind of wellness approach.

If senior citizens have heart disease, Medicare covers cholesterol screening. It makes sense, does it not? But Medicare does not cover cholesterol screening if one does not know they have heart disease. It does not make sense.

Heart disease is our biggest killer in this country. We ought to cover cholesterol screening across the board. That is the way one can discover who is at risk for heart disease at a point when steps can be taken to prevent it. Yet Medicare does not cover that screening unless a person already has evidence of heart disease.

There are many things we should do to improve Medicare's preventive coverage. My hope is that perhaps we will have that amendment approved before the end of this process.

My colleague from Illinois talked about HMOs a moment ago. We are not in the trenches of the HMO debate as it was first envisioned by the White House, which said to senior citizens, here is a Faustian bargain: we will give you a prescription drug benefit but only if you enroll in an HMO. Talk about a goofy proposal; that is it.

I have been talking about HMOs. There were some HMOs that did some good things, held down some prices. I understand that. But we have all also heard the stories of HMOs not taking good care of people. I guess we do not need to review the HMO stories about what happens to patients when profits were at stake. For instance, a woman falls off a cliff in the Shenandoah Mountains, sustains very serious head injuries and body injuries. She is hauled into an emergency room on a gurney in a coma. After a long convalescence, she finally gets out of the hospital only to be told by her HMO that they will not cover her emergency room treatment because she did not have prior approval to use the emergency room. This is a woman who is hauled in on a gurney in a coma.

I will not revisit all of those HMO stories because it will take too much time, but I will say this: With Medicare, we know what works. Some of my colleagues make the case that it costs too much. Do my colleagues really know what costs too much in Medicare? It costs too much because people are living too long. What a wonderful set of victories we have in this country. With great health care, people are living longer.

I probably should not talk about my uncle again, but I have an 81-year-old uncle who runs the 400 meter and 800 meter in the Senior Olympics. He is probably out running today. He runs 3 miles a day at 81 years old. Forty years ago, one reached 81 years old and they had to be in a chair someplace, but not any longer. People live longer, doing things no one ever expected them to do. And that includes my uncle. Good for them. Good for him. But because people live longer, Medicare costs more. That is not a sign of failure; it is a sign of success.

Now we are trying to add to Medicare that which should have been added some long while ago: The miracle drugs that do provide miracles but only if one can afford them. We are talking about covering the drugs that keep seniors out of the hospital and they do not have to go into an acute care hospital bed. That is what we are dealing with.

With this amendment, we are dealing with $12 billion. Instead of bifurcating it into two different experiments, one of which failed and one of which we do not need because we know the answer, what I propose we do is use that $12 billion to reduce from $43 to $38 the premium our senior citizens will have to pay for this prescription drug benefit, starting in 2009.

There are people who live on $350 or $450 a month, their total income from their miserable little Social Security payment, who are living alone in a small town, are struggling to buy food, struggling to buy the necessities of life. There are people who have been told by their doctor: Oh, by the way, you have heart disease and diabetes, and here are the prescription drugs you need; and they sit at home knowing they do not have a penny to pay for those prescription medicines. Talk to those seniors and understand how important this coverage is. The coverage ought to be good and extensive coverage, and it ought to provide what we know we should provide for senior citizens.

Second, it ought to be done in an affordable way. Unfortunately, another weakness of this plan is that there is no defined benefit, which means the premiums can vary. The monthly premiums will increase year after year because we have not done enough to put downward pressure on prescription drug prices—and as prescription drug prices increase, the monthly premium will increase. The expectation is that the monthly premium starts at $35 and goes to $60 in a 10-year period. My amendment proposes about a $6 reduction in the monthly premium for senior citizens. That is a more effective way to use this $12 billion. Either that, or I would propose we extend the coverage through the $1,300 gap that exists in coverage, which I think would also represent a meritorious way of using this amount of money.

My colleague, Senator PRYOR from Arkansas, is in the Chamber and he may wish to address this issue as well. I have offered this amendment on behalf of myself and my colleague Senator PRYOR, so I yield the floor in the hope that Senator PRYOR will wish to make some comments as well.

Mr. GRASSLEY. Mr. President, it is unfair for Members of the other side of the aisle to give us statistics that say 89 percent of the seniors are in for fee-for-service Medicare and only 11 percent are in Medicare+Choice and that is a nationwide average. It is an accurate statistic, but it does not speak to the seniors of America who like Medicare+Choice and I have figures from four cities—Miami, New York, San Francisco, and Chicago.

In Miami, 45 percent of the senior citizens have chosen managed care, the Medicare+Choice option, as opposed to fee-for-service; New York, 22 percent; San Francisco, 29 percent. In Chicago, it was only 6 percent. That may be one reason why Senator DURBIN keeps bringing this up quite regularly. This data is from the Congressional Research Service, and it is as recent as March 2003.

When people, wherever they are in the Senate, want to denigrate Medicare+Choice by saying only 11 percent of the people in this country join in and that is such a small percentage and that these figures are evidence it is not liked, go to Miami and ask 45 percent of the citizens who belong to Medicare+Choice why they like it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. PRYOR. Mr. President, last night was a difficult night for me because I was lying in bed worrying about the insurance companies and how we were not getting them enough money during this Congress. Of course, I am being facetious because I think we have a very clear choice.

I commend Senator DORGAN, Senator DURBIN, and a number of others who have shown national leadership on this effort to try to make this bill better. I think there is a broad consensus that we want to add a prescription drug benefit to Medicare. We want to help seniors all over this country, but at the same time we have to make sure it is set up the right way. It has to make sense.

Quite frankly, one of the things that to me does not make sense, and probably to most people around the country does not make sense, is that we might give a pretty healthy sum of money to the insurance industry.

All over the country—and I know it is certainly true in my State—insurance companies are raising premiums. It may be health care premiums—everybody knows those are going up. It may be property and casualty; it may be homeowners policies, auto policies, medical malpractice, legal malpractice. You name it, across the board, as far as I know, the price of every single kind of insurance in this country is going up.

Nonetheless, there are some in this Congress who want to actually give them a sizable chunk of money that could go to people who really need the help.

I take my hat off to Senator DORGAN for his leadership. One thing he has figured out is a way to make the monthly premium less for people. Now, saving $6 a month to someone at my income level, and all of our income levels, that is not a lot of money, but for those senior citizens all over this country who live below the poverty level—the only money they get every month is Social Security, maybe a little help from the family—$6 is a lot of money. Six dollars may make this program affordable for them. It is real money. It is money that at the end of the year, if you add it up, is only $72 a year, but that is real money to so many Americans all over this country.

The purpose of the bill, not just this amendment but the whole bill, is to help Americans afford their prescription drugs. I know that Senator DURBIN, who is in the Chamber, and Senator DORGAN and a number of others in this Chamber have tried to make prescription drugs more affordable in this legislation. There have been different efforts tried in different ways. One of the things I tried was to strengthen reimportation from Canada to try to make prescription drugs more affordable, but certainly making the premiums more affordable makes the program more accessible to more Americans. That is a win/win/win for everybody.

So I thank the Senator from North Dakota for yielding me some of his time. I know he is frantically talking to colleagues to try to have them adopt this amendment when we vote on it this afternoon.

Let's run through the numbers very quickly one more time so we understand clearly what we are talking about. This amendment expends $2.4 billion per year to make premiums cheaper. It will reduce the typical premium—this is average—by $6 a month.

I take my hat off to the folks in this Chamber who worked out compromise after compromise after compromise trying to come up with solutions to make this bill something that will become law, something that the majority of Members can vote for, not just in this Chamber but the House, something the President can sign.

I believe strongly people in this country deserve to have access to these wonderful prescription medications that are in many ways miracle drugs. It is a shame for this country to have these drugs available on the marketplace but so expensive that people cannot afford them. That is what we are trying to accomplish.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I thank my colleague from Arkansas as well as my colleague from North Dakota. They have come to the floor and said to the Members of the Senate, look, we found $12 billion. Imagine $12 billion over a period of time. We are in the middle of debating a prescription drug bill. What would the Senate do with new found money, $12 billion worth?

We took a look at the underlying bill, the prescription drug bill. There are a lot of problems with it. There is no guaranteed monthly premium. It has a deductible. It has a period of time when there is no coverage. You are paying prescription drug bills and you have no protection, no coverage. There are a lot of uncertainties in this bill.

You would think the first thing you would do with the $12 billion is make this a stronger bill, try to take care of some of the weaknesses, the deficiencies.

Wrong. Given $12 billion, an agreement has been reached not to give the money to the seniors to help them pay for prescription drugs but to give $6 billion to HMOs and private insurance companies, a $6 billion Federal subsidy so they can experiment with alternatives to Medicare.

I am like my colleague from Arkansas; I could not get a moment's rest last night for fear that we just were not going to give enough money to the insurance companies when this was all over with. I lost all my sleep the night before worried about the fact that maybe pharmaceutical companies would not get all the money that we could possibly throw their way. Then along comes this amendment. We can rest easy tonight because we will give $6 billion to HMOs. This industry which manufactures the milk of human kindness for seniors and families across the America by denying basic health care coverage so they can run up profits is going to need a Federal subsidy.

What a delicious irony that we cannot help poor seniors trying to pay for prescription drugs because, Senator, we just do not have enough money. And we cannot help our schools, we cannot pay for President Bush's No Child Left Behind, this unfunded mandate on everybody's local schools because, Senator, we just do not have enough money. But the $6 billion we just found we are going to give to the HMO insurance industry.

When they write the history of this debate, this amendment will stand out. This amendment is a tribute to selfishness, a tribute to shortsightedness. Why in the world aren't we helping the people who need it the most? Why are we giving the money to the HMOs so they can experiment with an effort to end Medicare?

I just ran into BILL THOMAS in the hallway, chairman of the House Ways and Means Committee, most powerful man when it comes to Medicare in the House of Representatives. He said in today's New York Times:

> Some of our friends on the other side of the aisle are saying if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so.

Well, thank you, Congressman THOMAS, for your candor. And your candor is the reason why so many Senators have now come to the Senate and said the only way to end Medicare is to subsidize HMOs with even more money so they can be more profitable and try to force Medicare out of business. That is what it is all about.

My colleagues will have two choices. They can join me in voting with Senator DORGAN, Senator PRYOR, and others and say if you have $12 billion, for goodness' sake, put it into this bill. Make this bill a little better for seniors. Reduce the cost for seniors. Give them some assurance of what they will pay. Provide more prescription drug coverage. That is one option. I will support it.

If it does not succeed, I will offer a second option. It reaches a point under the bill we are debating, during the course of a year, when there is a gap in coverage where the Federal Government will not help pay one penny on your prescription drugs, and about $3,700 into the year out-of-pocket expenses for prescription drugs, this plan cuts off. The underlying plan says you are on your own until you get in the range of $5,500. Then we will start paying you again. So there is a gap in coverage where that senior citizen, that widow living by herself, has to pay all of the prescription drug bills until she reaches the catastrophic coverage level.

This would not be a problem if you did not have over $3,700 in prescription drugs a year. But a lot of seniors do. I have run into them, met them in Illinois, heard their testimony on Capitol Hill from across the country.

I will offer an alternative to my colleagues in the Senate that says simply this: We want to make sure people who suffer from some of the most expensive diseases that afflict senior citizens can pay for their medication. So we will take the $12 billion and we will put it into the basic bill and cover heart disease, cancer, Alzheimer's, diabetes and its complications.

We are not going to leave you high and dry. At the end of $3,700 of subsidy from the Government, we are going to take the $12 billion and put them back in there to try to keep helping you if you are afflicted with one of these diseases.

I will readily concede to my colleagues that I can think of a half a dozen other diseases where people have horrendous prescription drug bills and need help but I will try to appeal to my colleagues. Here is your choice. You have a parent or a grandparent, suffering from cancer, who has to buy expensive drugs to stay alive. The Government program that we are proposing stops paying for those drugs halfway through the year because they have reached a point where they spent $3,700 and now they have to wait and spend another $1,500 to $1,800 of their own money before they have coverage. You can help them pay for those cancer therapies or you can send $6 billion in Federal subsidies to HMO insurance companies.

That is the choice. It is a fairly straightforward choice.

According to a July 2002 study, heart disease and hypertension are the most expensive conditions to treat. Millions of Medicare beneficiaries are suffering from them and struggling to pay for their medications. That is one of the conditions we would help pay for with the $12 billion, $6 billion of which is headed for these private insurance companies' subsidy.

The majority of America's cancer patients are on Medicare. They are your parents and grandparents. They are struggling with all forms of cancer. Nearly 60 percent of new cancer diagnoses and 50 percent of all cancer-related deaths occur in people 65 years and older.

I am not identifying a problem that does not exist. It exists. Ask any family about cancer, my family included. We all have stories to tell. And you know how expensive it is now to keep that loved one alive to try to give them a chance to survive. This bill cuts them off and leaves them high and dry. My amendment gives them a chance.

More than 2 million of all Medicare beneficiaries will have cancer in 2003. Let me give an example of a couple who wrote to my office. They wrote a couple years ago from a downstate community, a small community. It is one of the letters that Senators get every day, one that we saved. It was sent to us in September of 2002.

> Dear Senator DURBIN:
>
> My wife has multiple myeloma, which is a cancer of the bone marrow. This disease, while controllable, is not curable. As a result, she has to take a great deal of drugs for physical as well as mental anxiety.
>
> Last year our combined prescription drug bill [and this is the year 2000] was $4,500. This year our regular prescription drug bills will be more.
>
> Now my wife Marion has been put on Thalidomide. A great many multiple myeloma patients are now on Thalidomide. Said drug is very expensive. With a low dose [and this is in the year 2000] it is $455.99 a month.

Incidentally, we checked. That same low dose now costs $645 a month. So in 3 years it has gone up over 40 percent. It costs them $5,500 a year just for that drug. This is an elderly couple in their retirement on a fixed income, fighting cancer, putting every dollar in their savings into keeping one of them alive. Think about $644 a month. Think about seniors trying to survive on $1,100 a month on Social Security. And think about this bill which says to this family from Illinois and others just like them: I am sorry, but at some point we are going to stop paying.

Doesn't it make more sense for us to take the $6 billion and not give it in a subsidy to these private insurance companies but instead give it to these seniors to help them pay these bills? I think it does.

I don't have to tell you the story of Alzheimer's. Is there a family in America that does not have a loved one or a friend who is struggling with some form of Alzheimer's? God bless us; we are living longer, but as we do life gets more complicated. Let me give an example of a gentleman in Maplewood, MN. His annual out-of-pocket drug costs for Alzheimer's are $7,000—annual cost. This man is 78 years old. He pays as much out of pocket for prescription drugs as he does for all of his other household expenses combined. He is a World War II vet, father of three. He is a full-time caregiver for his wife. He hasn't had a vacation in 5 years. He has given up what he loves to do because he just can't afford them.

"I am managing the cost, but I'm pretty nervous about it," he says. Medicare can do something to help. Yes, it can. That is our choice. Are we going to do something to help these seniors facing the most expensive medical conditions or are we going to give $6 billion to private HMOs in a Federal subsidy?

The last one I include is diabetes and its complications. I am sad to report to you, those who are following this debate, diabetes is reaching epidemic proportions in America. Over 6 percent of the American population suffers from some form of diabetes. In the late stages of diabetes, the complications become horrible: Amputations, blindness, severe problems.

Faced with this in your senior retirement years, depending on a prescription drug plan, do you really want to say to these people and these families battling diabetes and its complications: We are going to cut you off. We would love to give you more but frankly we have to help the HMO insurance companies. Those are the ones who really need a helping hand.

You couldn't take that argument to any town in America. You couldn't take it to any public meeting. You couldn't take it to any senior citizens. You couldn't take it to any family with a loved one struggling with one of these diseases.

So my friends on the floor of the Senate are going to have a choice: $6 billion in Federal subsidies for HMOs or $6 billion to help seniors struggling with these terrible, life-threatening, expensive conditions, to pay their prescription drug bills. I think that choice is easy. I hope the majority of the Senate agrees.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time? The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume to address the issue of the amendment by the Senator from North Dakota and his attempt to take money from the $12 billion that is the bipartisan compromise that is a major compromise on this amendment between Republicans and Democrats. The $12 billion is being divided: $6 billion to make the marketplace provider organizations more competitive, to save money, and to get people into organizations that will manage particularly chronic disease; and the other $6 billion to go for Medicare demonstration projects to do the same, have about the same result, to have chronic disease management.

The reason for this compromise is both approaches deal with the issue that 5 percent of the sick people under Medicare are responsible for about 50 percent or 55 percent of the cost of Medicare. It is a small segment of people. If we were in business and we found 5 percent of our employees, or a certain problem we had with our business that was just 5 percent of it, but it was 50 percent of the cost of our business, we would hone in on that problem with the particular business.

The Federal Government is in the business of providing health care for our seniors. If we have 5 percent of our senior population who, for various reasons, are the cause of 50 percent of the costs of Medicare, then quite obviously we ought to concentrate on that 5 percent. We have plans to do that. This is how we use this $12 billion, and we do it in a bipartisan way.

Honestly, the Senator from North Dakota is very open about it; he has a better idea how to use that money. He would take it to lower the monthly premium paid by beneficiaries in the new Part D prescription drug program.

I have at least two problems with that. First of all, the Congressional Budget Office's rule of thumb is that it costs around $5 billion to lower the estimated $35-a-month premium by just $1. You spend $5 billion and reduce the monthly premium from $35 down to $34. So if you take the $12 billion that is available in the Grassley-Baucus amendment and use that to lower the premium for the people he wants to lower the premium for, instead of paying $35 a month they will be paying $32.50 a month.

My colleagues have to weigh that against the use of this money where we want to focus in on fee for service as well as the new Medicare Program, zeroing in on trying to save Medicare money by managing the chronic disease situations of the 5 percent of the most sick people under Medicare.

So the underlying Grassley-Baucus amendment, I remind my colleagues, authorizes the Secretary to establish a number of projects in fee-for-service Medicare Programs that would provide these enhanced services and benefits for beneficiaries. These enhanced services or benefits include preventive services, chronic care coordination, and disease management services. These are very worthwhile projects and have the potential to help many beneficiaries get better care and considerably reduce the cost in the Medicare Program.

I don't know how many Members on the other side of the aisle have worked with this issue we are trying to put $6 billion toward, chronic disease management. A lot of people who have the same political philosophy as the Senator from North Dakota are very concerned about doing that. We are concerned on this side about doing it as well. That is why it is a bipartisan piece of legislation.

I don't know how, in good conscience, the Senator from North Dakota can take money that would reduce a monthly premium by $2.50, still costing $32.50, away from chronic disease management and a lot of other things that people on his side of the aisle are very concerned about.

It would not be possible to do these projects that we have in the underlying amendment. It seems to me that the Grassley-Baucus amendment with this bipartisan compromise of $6 billion enhanced membership in PPOs as well as $6 billion for chronic disease management in the older fee-for-service Medicare Program is preferable to the second-degree amendment offered by the Senator from North Dakota.

I urge my colleagues to not support the amendment by the Senator from North Dakota.

This is the second or third time I have heard that seniors have voted on whether they like fee for service or Medicare+Choice, the argument being 89 percent of the people in this country are in fee for service. Eleven are in managed care, Medicare+Choice, HMO, whatever you want to call it. That is true for the Nation as a whole.

But remember that in the vast geographical part of America HMOs are not available. In the State of Iowa, only 1 county out of 99 has an HMO for our seniors to join. We have 4,000 Iowans in Medicare+Choice. No place else in Iowa can my citizens get it. The Des Moines Register is always editorializing why more of Iowa cannot have Medicare+Choice so the seniors of our country have that opportunity.

But what is unfair about the 89 percent versus the 11 percent, and Senators making statements that it is so overwhelming that seniors do not like Medicare+Choice, is the fact that if more had that choice more would take it.

I use, as a basis for my statement, that in the larger cities of America a much higher percentage of seniors have decided to join Medicare+Choice. They do it voluntarily. They can go in one year and get out the next, if they don't like it. They have voted by a much higher percentage in favor of Medicare+Choice. They like it because they get more for their money. First, they do not have to pay Medigap insurance. Second, they might get things such as eye glasses and a better deal on prescription drugs than people who are in traditional Medicare fee for service. Where they have had a chance to have that option, a much higher percentage of seniors than 11 percent will join. All you have to do is talk to people in my State who go to Arizona, California, and Florida for maybe the winter and find out about what people in those States have when they join Medicare+Choice. They ask, Why can't we have that in more places in the country?

A couple of speakers on the other side of the aisle have talked about wasting money with Medicare+Choice. I think you ought to ask the seniors who join and who like it. That is a much higher percentage than 11 percent in a lot of the cities. It is not a fair comparison to imply that since only 11 percent of the people in the country have it and because such a high percentage can't get it that Medicare+Choice is not desired by seniors of America.

Our underlying legislation, the Grassley-Baucus bill, is going to make that opportunity more available for people down the road as we bring in new options. What we want to do in the underlying bill is give our seniors the right to choose. Not enough of them have a right to choose. They have a right to choose prescription drugs. They don't want to join for prescription drugs if they don't have to. They have a right to choose between traditional Medicare. If seniors say they are satisfied with what they have, I can say to those seniors that they can keep what they have. It is their choice. But it you want to go over here and join something that has more options, you will have that right to choose. You should have that right to choose.

One of the complaints people made about the President's program was that if you were going to get prescription drugs you had to go over to a new type of Medicare. In traditional Medicare, you could not get prescription drugs—or at least not much of a program; at least not equal to what you could get over here in the new program.

That is where Senator BAUCUS and I disagree with the President of the United States. We believe in equal benefits. If you want prescription drugs, if you want to join it voluntarily, and if you want to stay in traditional Medicare fee for service, you can have prescription drugs. If you want to go over here and choose a new form and have prescription drugs with it, that is your choice.

The right to choose and fairness and equality and no pressure is the basis for this bipartisan Grassley-Baucus legislation. That is the basis for the compromise amendment that is before us which the Senator from North Dakota wants to detract from and use the money someplace else.

I think we need to keep this balanced approach. We need to keep the fairness, the equality, and no pressure and the right to choose. Seniors should have options just as other people have.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

AMENDMENT NO. 1108

Mr. DURBIN. Mr. President, I call up my amendment, which I send to the desk pursuant to the unanimous consent request.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Illinois [Mr. DURBIN] proposes an amendment numbered 1108.

Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide additional assistance for certain eligible beneficiaries under part D)

At the appropriate place insert the following:

SEC. . ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES UNDER PART D.

Section 1860D-26, as added by section 101, is amended by adding at the end the following:

"(d) ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES.—

"(1) PROGRAM.—Subject to paragraph (2), the Administrator shall implement a program (for the period beginning on January 1, 2009, and ending on September 30, 2013) to provide additional assistance to applicable eligible beneficiaries who have reached the initial coverage limit described in section 1860D–6(c)(3) for the year but have not reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)) for the year in order to reduce the cost-sharing requirement during this coverage gap.

"(2) FUNDING LIMITATION.—The Administrator shall implement the program described in paragraph (1) in such a manner that will result in a decrease of $12,000,000,000 in cost-sharing for covered drugs under part D by applicable eligible beneficiaries during the period described in such paragraph. The Administrator shall take appropriate steps to ensure that the costs of the program during such period do not exceed $12,000,000,000.

"(3) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'applicable eligible beneficiary' means an eligible beneficiary with cardiovascular disease, diabetes and its complications, cancer, or Alzheimer's disease who is enrolled under part D.".

Mr. DURBIN. Mr. President, I will speak briefly because I have to go to another meeting and return for the vote.

I have great respect for the Senators from Iowa and Montana, but I struggle to understand why we are giving a $6 billion subsidy to the HMOs in America. If they are so good, if they are so efficient, if the free market is truly better than the Government-run Medicare system, why in the world do they need $6 billion worth of the taxpayers' money? You know that of that $6 billion hundreds of millions of dollars are going to go to them in profits. We are literally subsidizing the profits of these companies. We are creating this artificial environment that suggests these companies can do just as good a job or better than Medicare with the $6 billion Federal subsidy to make it work.

I can't understand why my colleagues on the conservative side who are hidebound apostles of the free market system don't even wince when it comes to sending $6 billion to the HMOs and the private insurance industry in order to let them play on the field for health care for seniors in America. I don't get it. I certainly don't understand why you wouldn't take that same money to protect the most vulnerable people in America—our senior citizens who are struggling with heart disease, cancer, Alzheimer's, and diabetes and its complications. Why is the money for the boardrooms of the HMOs a good expenditure of tax dollars and the money for the family rooms of senior citizens struggling with these deadly diseases not a good investment with taxpayer dollars?

The underlying bill is the biggest breakthrough for the American pharmaceutical industry since the establishment of patents in the Constitution. This amendment with $6 billion in flatout tax subsidies to HMOs is the answer to the prayers of the insurance companies in America.

Is that what the Senate is all about? Are we supposed to come here to make certain that the wealthiest corporations in America get wealthier? I don't think so. They are doing quite well. The rate of return for pharmaceutical companies across America is 18 percent. The average for the S&P companies is 3 percent. These companies are immensely wealthy and profitable. We help them even more with this bill. We know how well the insurance companies are doing. We know the bonuses they give their executives and we are going to plow in $6 billion to make it even wealthier.

There is something else wrong. We know that a lot of average citizens in America—particularly senior citizens—are struggling. Pick up the morning papers. Whether it is the Washington Post or the New York Times, they go to speak to seniors in their real-life environment and talk to them about how they survive. Some of them are well off. Some are lucky. They have saved a lot of money or they have a good and generous retirement but a lot of them do not. A lot of them are literally struggling month to month, some even week to week, just to get by.

This morning in the Washington Post there was a story about a widow lady who said: At the end of the month, I'm lucky if I have a dollar left over. At the end of the article she said: I wonder how many Senators have ever thought about trying to live on $1,100 a month.

I don't know how she does it. I don't know how a lot of people do it in my State. Why wouldn't we want to help these people? Why is it the pharmaceutical companies and the HMOs are more important than the most vulnerable people in society? I don't get it.

Frankly, I think a lot of our colleagues, as I said earlier, ought to take these arguments, which sound so good on the floor of the Senate, back to the real world of the State they represent, take them into the town of their choice, the public meeting of their choice, and explain to people why HMOs need a subsidy but seniors do not need a helping hand. It just does not work.

So I will be offering an amendment that says we will take this $12 billion and focus it on the elderly people who suffer from some of the worst and most demanding diseases.

I reserve the remainder of my time.

The PRESIDING OFFICER (Mr. ALEXANDER). Who yields time?

The Senator from Montana.

Mr. BAUCUS. Mr. President, I listened quite closely to the Senator from Illinois, as well as to the Senator from North Dakota. They are each offering a separate amendment, but they are both similar in an attempt, generally, to accomplish the same result.

I say to my good friend from Illinois, as well as my good friend from North Dakota, who is presently not in the

Chamber, I am very sympathetic. If I had my way, we would be spending this newly found $12 billion very much in the way the Senator suggested. In fact, there are a lot of good ways. It is not only helping those with Alzheimer's, but it is also lowering the premium. There are a lot of ways we could be spending dollars to help get more drug benefits to more seniors. There is no doubt about that. But, unfortunately, we are 100 Senators.

The Senator from Illinois, the Senator from North Dakota, and I have a view of how some of these dollars should be spent in a perfect world, but the world is not perfect. This is a democracy. It is messy. As Winston Churchill once said—I will paraphrase very poorly, but the Senator knows this quote—basically, Winston Churchill said: A democracy, for all its fits and starts and delays and inefficiencies and herky-jerky jolting, and all that, is the world's worst form of government, except for all the others.

Here we are, in a democratic process, trying to figure out how to get prescription drug benefits to seniors. We have 100 Senators. I don't know of very many timid Senators. We don't have many Senators who don't speak their views. I don't know very many Senators who don't have strong views about subjects. I don't know of many Senators who are not thoughtful, articulate, and fighting hard for their constituents. And we have, as it turns out, Senators from two political parties: 51 Republicans, 48 Democrats, and 1 Independent; and at this time we are attempting to finally get prescription drug benefits to seniors.

This issue has been debated for 4 years, at least. It has been a politicized issue for 4 years. There has been a lot of talk for 4 years, a lot of rhetoric on both sides of the aisle for 4 years, and during all the talking there has not been any action; it has been all words, no deeds.

Well, here we are, at a time—after 4 years of just political posturing, to a large degree—where we are on the brink of getting prescription drug benefits passed for our seniors in our country.

Is it the best bill in the world? No. Could it be better? Yes. Do all Senators wish it could be better? Yes. But is it a good start? Is it a beginning? Is it a platform on which we can begin to build? Absolutely.

If we go back and look at the history of health care and assistance by the Government in providing health care to the needy and to Americans generally, it is a history of building, of starting somewhere, building on it, and making it better and better all the time.

Back in the 1930s it was the Wagner-Murray-Dingell legislation that was introduced to provide national health insurance for Americans. That was the idea: We need national health insurance for Americans.

Well, it was debated and debated. Not a lot more really happened. Then suddenly things changed in the 1960s. The idea of Medicare came along: Why not help at least our seniors? If we can't get national health insurance, the very least we can do is help our senior citizens get a break with respect to their health care bills. That is a good place to at least begin—by helping a good, solid segment of the population. And we did, back in 1965, by providing Medicare. And look what has happened since then. We have kept building on Medicare to make it better.

When Medicare was first enacted, 50 percent of a Part B premium was paid by the senior and the Government paid the other 50 percent of the premium for Part B. That is for doctor services. Now it is 25 percent. It has been improved over time. We also have added more benefits, some screening provisions. End-stage renal treatment has been added. There is a list of new additions to help our senior citizens.

Here we are now, on the brink of adding another major benefit: prescription drugs. After all these years, all the years of talking and talking and politicking and giving statements and speeches, we are finally on the brink of getting prescription drug benefits passed.

It has not been easy. Why has it not been easy? It has not been easy because there are two competing philosophies on the floor of the Senate on how to get prescription drug benefits to seniors. Even though the two competing philosophies are very different from each other, Senators on both sides of the aisle—most Senators, maybe even all Senators, but certainly most Senators—still want to work as hard as they can to try to fit these competing philosophies together in order to pass legislation this year to begin finally getting prescription drug benefits to seniors.

Also, these two competing philosophies are very different. One is competition. The argument is: Let private companies, themselves, with assistance from the Government, design how they give prescription drug benefits to our senior citizens, make them available at a big discount for senior citizens. The other philosophy is: Medicare should be the agency that should be the way—traditional Medicare, basically—to provide discounts for senior citizens to get drugs.

Essentially, the competing philosophies are 50–50. You have 51 Republicans, 48 Democrats, and 1 Independent. What are we going to do? Well, all we can do, if we want to get this done, is to just try our best to put these two together in a fair, balanced way—and the private competition model gets a break, gets a fair chance to see the degree to which it might work—so that senior citizens really do get the benefits and are not taken advantage of during our efforts to pass legislation.

It is a balance. It is trying to find the right way to accomplish that balance. It has been extremely difficult. I do not have to tell the Presiding Officer just how hard this has been. But we are right on the brink.

We are limited to $400 billion in providing the drug benefits for seniors over the next 10 years. Why are we limited to $400 billion? Well, this body passed a budget resolution not too long ago—both the House and the Senate—saying we are going to set aside $400 billion for prescription drug benefits for seniors. We never set aside anything like that in the past. So we have an opportunity now to use it. I don't think Senators want to miss this opportunity. I think they want to use the dollars that are there to get prescription drug benefits for seniors.

Well, as it turned out, when the Senate Finance Committee wrote this bill, trying its hardest to be balanced—and it is balanced; the best evidence of that is it passed by a large majority from both parties in the Finance Committee—we found it actually cost only about $388 billion. There was $12 billion remaining.

So the question before us is how we can spend that $12 billion. That is the question. In an attempt to maintain a balance and to work on two competing models and in an attempt to get the legislation passed so we can provide a prescription drug benefit to seniors, we have decided to split it, 6 and 6; $6 billion to the PPOs, have it available potentially for PPOs, if that is needed for the bidding process, beginning in the year 2009. I don't know how many Senators are going to be here in 2009, but at least beginning then. The other $6 billion, beginning in 2009, will then go, under Medicare fee for services, for disease management, chronic care, to help particularly seniors who really need that disease management and chronic care. It is really needed because there is very little disease management today under traditional Medicare. That is one of its shortcomings. That is what we have done.

Again it is a balance, a start, a beginning. I have a lot of sympathy with my friends on this side of the aisle. If I had my druthers and I were the only one writing this bill, I would take that $12 billion and spend it along the lines they are suggesting. But I am not the only Senator here. I am one of 100. It is my job and that of the chairman of the committee, Senator GRASSLEY, to try to find a balance—not for the sake of balance but for the sake of getting legislation passed so we can finally get prescription drugs to seniors.

If the amendments offered by the Senators from North Dakota or Illinois were to pass, guess what would happen.

First of all, those are killer amendments. If those amendments were to pass, that would mean this bill is in jeopardy of passage. That would mean senior citizens may not get the prescription drug benefits we are all trying to get; albeit just a first step, or it could also mean, on the other hand—and this is perhaps even more likely—if that amendment were to pass, I will bet you dollars to donuts—which is not a good phrase to use because we are trying to put dollars in the donut hole—the conservative part of this body, the Republican side of the aisle, would say: We are going to take that $12 billion and spend it our way. And they have the votes. They have the White House. So this amendment puts in jeopardy a very delicate, very balanced kind of deal between competing philosophies, fairly and evenly, so that we can get prescription drug legislation passed, so that we are just not talking about it anymore and finally doing something about it.

If it were to pass or looked like it would pass, the other side, which has more votes than this side has, would say: We will spend it our way.

Then colleagues on my side of the aisle would be quite distressed. They would be forced to ask themselves if they would support on final passage a bill way off to the right for competition instead of the bill which currently exists, particularly with the underlying amendment. I wish we could do more but at least it is a first step. If the history of Medicare is any guide, in future years we will continue to make it better. We will work on that donut hole. We will fill in the gaps. We will make sure premiums are not too high. We will try to help with Alzheimer's and all the other measures we desperately need to pay attention to as the days and years go by.

I implore my colleagues to think a little bit. Resist the siren song of doing something that sounds good but which very well could put the bill in real jeopardy. This is fair. It has $6 billion which may or may not be used for PPOs, depending upon what the bids are. This bill cuts off after a 5-year period; no more $6 billion can be spent. And $6 billion for disease management under traditional Medicare which will be spent. That is the question. Do you want balance or do you want to try to get something else passed right now that you like in the short term but could very well jeopardize the whole bill, which means another year, year 5, Congress is talking about this issue, Congress is not doing anything about it. Rather, we want year 1, we have finally got it done.

We are very close to getting it done. It is not perfect, but we will keep working on it over the years.

The PRESIDING OFFICER. Who yields time?

AMENDMENT NO. 1037, AS MODIFIED

Mr. BAUCUS. Mr. President, on behalf of the Senator from New Jersey, Mr. CORZINE, I ask unanimous consent that amendment No. 1037 be modified with the text that I send to the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment, as modified, is as follows:

At the end of subtitle A of title I, add the following:

SEC. . CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

EXCLUSION FROM PER VISIT LIMIT.—Section 1833(a)(3)) (42 U.S.C. 13951(a)(3)) is amended by inserting "(which regulations shall exclude any cost incurred for the provision of services pursuant to a contract with an eligible entity (defined in section 1860D(a)(4)) operating a plan under Part D, for which payment is made by such entity)" after "including those authorized under section 1861(v)(1)(A)".

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1110

Mr. BAUCUS. Mr. President, on behalf of the Senator from Michigan, Mr. LEVIN, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. LEVIN, proposes an amendment numbered 1110.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To ensure that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan)

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan or entering private insurance under this act.

AMENDMENT NO. 1111

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside so that I may send to the desk on behalf of Senator LEVIN an amendment to ensure that current retirees who have prescription drug coverage, who will loose their coverage as a result of enactment of this legislation, would have the option of drug coverage under Medicare fallback.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. LEVIN, proposes an amendment numbered 1111.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To ensure that current retirees who have prescription drug coverage who will lose their prescription drug coverage as a result of the enactment of this legislation have the option of drug coverage under the Medicare fallback)

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that the 37% of current retirees who have prescription drug coverage, estimated by the Congressional Budget Office who will lose their current employer retiree coverage as a result of the enactment of this legislation will have the option to enter either a Medicare backup plan or private insurance under this act.

Mr. BAUCUS. Mr. President, I ask unanimous consent that time under the quorum call be charged equally against both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENTS NOS. 1027 AND 1041, EN BLOC

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside and amendments numbered 1027 and 1041 be immediately considered.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] proposes amendments numbered 1027 and 1041, en bloc.

Mr. BAUCUS. Mr. President, I ask unanimous consent that further reading of the amendments be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT NO. 1027

(Purpose: To express the sense of the Senate regarding the implementation of the Prescription Drug and Medicare Improvement Act of 2003)

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE REGARDING IMPLEMENTATION OF THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003.

(a) IN GENERAL.—It is the sense of the Senate that the Committee on Finance of the Senate should hold not less than 4 hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of

2003 (hereinafter in this section referred to as the "Act") during which the Secretary or his designee should testify before the Committee.

(b) INITIAL HEARING.—It is the sense of the Senate that the first hearing described in subsection (a) should be held not later than 60 days after the date of the enactment the Act. At the hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) The progress toward implementation of the prescription drug discount card under section 111 of the Act.

(2) Development of the blueprint that will direct the implementation of the provisions of the Act, including the implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(3) Any problems that will impede the timely implementation of the Act.

(4) The overall progress toward implementation of the Act.

(c) SUBSEQUENT HEARINGS.—It is the sense of the Senate that the additional hearings described in subsection (a) should be held in each of May 2004, October 2004, and May 2005. At each hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) Progress on implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(2) Any problems that will impede timely implementation of the Act.

AMENDMENT NO. 1041

(Purpose: To require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project)

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas of Alaska are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

AMENDMENTS NOS. 936, 938, 988, 1027 AND 1041 EN BLOC

Mr. BAUCUS. Mr. President, on behalf of the chairman of the committee, Senator GRASSLEY, I ask unanimous consent that the pending amendments be set aside and that the following amendments be agreed to en bloc, and that the motions to reconsider be laid on the table en bloc: Amendments Nos. 936, 938, 988, 1027, and 1041.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments were agreed to en bloc.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the time I used be charged equally to both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I ask unanimous consent to proceed as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDING TITLE XXI OF THE SOCIAL SECURITY ACT

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 166, S. 312.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 312) to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

There being no objection, the Senate proceeded to consider the bill.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the managers' amendment be agreed to; that the bill, as amended, be read a third time and passed; that the motion to reconsider be laid upon the table; and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 1113) was agreed to, as follows:

(Purpose: To make a technical correction)

At the end, add the following:

SEC. 2. TECHNICAL CORRECTION.

(a) TEMPORARY INCREASE OF THE MEDICAID FMAP.—Section 401(a)(6)(A) of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027) is amended by inserting "after September 2, 2003," after "(42 U.S.C. 1315))".

(b) RETROACTIVE EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 401 of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027).

The bill (S. 312), as amended, was read the third time and passed, as follows:

S. 312

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001.

(a) EXTENDING AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001.—

(1) RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEARS 1998 AND 1999.—Paragraphs (2)(A)(i) and (2)(A)(ii) of section 2104(g) of the Social Security Act (42 U.S.C. 1397dd(g)) are each amended by striking "fiscal year 2002" and inserting "fiscal year 2004".

(2) EXTENSION AND REVISION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2000.—

(A) PERMITTING AND EXTENDING RETENTION OF PORTION OF FISCAL YEAR 2000 ALLOTMENT.—Paragraph (2) of such section 2104(g) is amended—

(i) in the heading, by striking "AND 1999" and inserting "THROUGH 2000"; and

(ii) by adding at the end of subparagraph (A) the following:

"(iii) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004.".

(B) REDISTRIBUTED ALLOTMENTS.—Paragraph (1) of such section 2104(g) is amended—

(i) in subparagraph (A), by inserting "or for fiscal year 2000 by the end of fiscal year 2002," after "fiscal year 2001,";

(ii) in subparagraph (A), by striking "1998 or 1999" and inserting "1998, 1999, or 2000";

(iii) in subparagraph (A)(i)—

(I) by striking "or" at the end of subclause (I),

(II) by striking the period at the end of subclause (II) and inserting "; or"; and

(III) by adding at the end the following new subclause:

"(III) the fiscal year 2000 allotment, the amount specified in subparagraph (C)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (C)(ii) for the State to the amount specified in subparagraph (C)(iii).";

(iv) in subparagraph (A)(ii), by striking "or 1999" and inserting ", 1999, or 2000";

(v) in subparagraph (B), by striking "with respect to fiscal year 1998 or 1999";

(vi) in subparagraph (B)(ii)—

(I) by inserting "with respect to fiscal year 1998, 1999, or 2000," after "subsection (e),"; and

(II) by striking "2002" and inserting "2004"; and

(vii) by adding at the end the following new subparagraph:

"(C) AMOUNTS USED IN COMPUTING REDISTRIBUTIONS FOR FISCAL YEAR 2000.—For purposes of subparagraph (A)(i)(III)—

"(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2000, less the total amount remaining available pursuant to paragraph (2)(A)(iii);

"(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years

2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b); and

"(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2000, of the amounts specified in clause (ii).".

(C) CONFORMING AMENDMENTS.—Such section 2104(g) is further amended—

(i) in its heading, by striking "AND 1999" and inserting ", 1999, AND 2000"; and

(ii) in paragraph (3)—

(I) by striking "or fiscal year 1999" and inserting ", fiscal year 1999, or fiscal year 2000"; and

(II) by striking "or November 30, 2001" and inserting "November 30, 2001, or November 30, 2002", respectively.

(3) EXTENSION AND REVISION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2001.—

(A) PERMITTING AND EXTENDING RETENTION OF PORTION OF FISCAL YEAR 2001 ALLOTMENT.—Paragraph (2) of such section 2104(g), as amended in paragraph (2)(A)(ii), is further amended—

(i) in the heading, by striking "2000" and inserting "2001"; and

(ii) by adding at the end of subparagraph (A) the following:

"(iv) FISCAL YEAR 2001 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2005.".

(B) REDISTRIBUTED ALLOTMENTS.—Paragraph (1) of such section 2104(g), as amended in paragraph (2)(B), is further amended—

(i) in subparagraph (A), by inserting "or for fiscal year 2001 by the end of fiscal year 2003," after "fiscal year 2002,";

(ii) in subparagraph (A), by striking "1999, or 2000" and inserting "1999, 2000, or 2001";

(iii) in subparagraph (A)(i)—

(I) by striking "or" at the end of subclause (II),

(II) by striking the period at the end of subclause (III) and inserting "; or"; and

(III) by adding at the end the following new subclause:

"(IV) the fiscal year 2001 allotment, the amount specified in subparagraph (D)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (D)(ii) for the State to the amount specified in subparagraph (D)(iii).";

(iv) in subparagraph (A)(ii), by striking "or 2000" and inserting "2000, or 2001";

(v) in subparagraph (B)—

(I) by striking "and" at the end of clause (ii);

(II) by redesignating clause (iii) as clause (iv); and

(III) by inserting after clause (ii) the following new clause:

"(iii) notwithstanding subsection (e), with respect to fiscal year 2001, shall remain available for expenditure by the State through the end of fiscal year 2005; and"; and

(vi) by adding at the end the following new subparagraph:

"(D) AMOUNTS USED IN COMPUTING REDISTRIBUTIONS FOR FISCAL YEAR 2001.—For purposes of subparagraph (A)(i)(IV)—

"(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2001, less the total amount remaining available pursuant to paragraph (2)(A)(iv);

"(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); and

"(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2001, of the amounts specified in clause (ii).".

(C) CONFORMING AMENDMENTS.—Such section 2104(g) is further amended—

(i) in its heading, by striking "AND 2000" and inserting "2000, AND 2001"; and

(ii) in paragraph (3)—

(I) by striking "or fiscal year 2000" and inserting "fiscal year 2000, or fiscal year 2001"; and

(II) by striking "or November 30, 2002," and inserting "November 30, 2002, or November 30, 2003,", respectively.

(4) EFFECTIVE DATE.—This subsection, and the amendments made by this subsection, shall be effective as if this subsection had been enacted on September 30, 2002, and amounts under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) from allotments for fiscal years 1998 through 2000 are available for expenditure on and after October 1, 2002, under the amendments made by this subsection as if this subsection had been enacted on September 30, 2002.

(b) AUTHORITY FOR QUALIFYING STATES TO USE PORTION OF SCHIP FUNDS FOR MEDICAID EXPENDITURES.—Section 2105 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following:

"(g) AUTHORITY FOR QUALIFYING STATES TO USE CERTAIN FUNDS FOR MEDICAID EXPENDITURES.—

"(1) STATE OPTION.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, with respect to allotments for fiscal years 1998, 1999, 2000, 2001, for fiscal years in which such allotments are available under subsections (e) and (g) of section 2104, a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of such allotments (instead of for expenditures under this title) for payments for such fiscal year under title XIX in accordance with subparagraph (B).

"(B) PAYMENTS TO STATES.—

"(i) IN GENERAL.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the total amount of funds described with respect to the State in subparagraph (A), the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under title XIX for expenditures of the State for the fiscal year described in clause (ii) if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)) of such expenditures.

"(ii) EXPENDITURES DESCRIBED.—For purposes of clause (i), the expenditures described in this clause are expenditures for such fiscal years for providing medical assistance under title XIX to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.

"(iii) NO IMPACT ON DETERMINATION OF BUDGET NEUTRALITY FOR WAIVERS.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.

"(2) QUALIFYING STATE.—In this subsection, the term 'qualifying State' means a State that—

"(A) as of April 15, 1997, has an income eligibility standard with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1902(a)(10)(A) or under a waiver under section 1115 implemented on January 1, 1994, that is up to 185 percent of the poverty line or above; and

"(B) satisfies the requirements described in paragraph (3).

"(3) REQUIREMENTS.—The requirements described in this paragraph are the following:

"(A) SCHIP INCOME ELIGIBILITY.—The State has a State child health plan that (whether implemented under title XIX or this title)—

"(i) as of January 1, 2001, has an income eligibility standard that is at least 200 percent of the poverty line or has an income eligibility standard that exceeds 200 percent of the poverty line under a waiver under section 1115 that is based on a child's lack of health insurance;

"(ii) subject to subparagraph (B), does not limit the acceptance of applications for children; and

"(iii) provides benefits to all children in the State who apply for and meet eligibility standards on a statewide basis.

"(B) NO WAITING LIST IMPOSED.—With respect to children whose family income is at or below 200 percent of the poverty line, the State does not impose any numerical limitation, waiting list, or similar limitation on the eligibility of such children for child health assistance under such State plan.

"(C) ADDITIONAL REQUIREMENTS.—The State has implemented at least 3 of the following policies and procedures (relating to coverage of children under title XIX and this title):

"(i) UNIFORM, SIMPLIFIED APPLICATION FORM.—With respect to children who are eligible for medical assistance under section 1902(a)(10)(A), the State uses the same uniform, simplified application form (including, if applicable, permitting application other than in person) for purposes of establishing eligibility for benefits under title XIX and this title.

"(ii) ELIMINATION OF ASSET TEST.—The State does not apply any asset test for eligibility under section 1902(l) or this title with respect to children.

"(iii) ADOPTION OF 12-MONTH CONTINUOUS ENROLLMENT.—The State provides that eligibility shall not be regularly redetermined more often than once every year under this title or for children described in section 1902(a)(10)(A).

"(iv) SAME VERIFICATION AND REDETERMINATION POLICIES; AUTOMATIC REASSESSMENT OF ELIGIBILITY.—With respect to children who are eligible for medical assistance under section 1902(a)(10)(A), the State provides for initial eligibility determinations and redeterminations of eligibility using the same verification policies (including with respect to face-to-face interviews), forms, and frequency as the State uses for such purposes under this title, and, as part of such redeterminations, provides for the automatic reassessment of the eligibility of such children for assistance under title XIX and this title.

"(v) OUTSTATIONING ENROLLMENT STAFF.—The State provides for the receipt and initial processing of applications for benefits under this title and for children under title XIX at facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(l)(2)(B) consistent with section 1902(a)(55).".

SEC. 2. TECHNICAL CORRECTION.

(a) TEMPORARY INCREASE OF THE MEDICAID FMAP.—Section 401(a)(6)(A) of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027) is amended by inserting "after September 2, 2003," after "(42 U.S.C. 1315))".

(b) RETROACTIVE EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 401 of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027).

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. I thank the Chair. Mr. President, I would like to make a couple comments before we begin voting.

This legislation is historic. It is incredibly important. It is the first reform in a major way to the Medicare Program since we wrote it over 35 years ago in 1965.

To get this legislation adopted by the Congress and signed into law by the President, there obviously has to be a great deal of work, a great deal of legitimate compromise among the various parties that have put this package together. That is what this bill does.

There are some Members of Congress who argue the Federal Government should do nothing with regard to Medicare—that the private sector should do everything and that the Federal Government should do nothing. There are others, on the other hand, who take the position that with regard to Medicare the Federal Government should do everything and the private sector should do nothing.

What we have been able to put together, under the leadership of the chairman and ranking member and many others who have worked so hard, is a compromise that says let's combine the best of what the Government can do with the best of what the private sector can do and put that package together. That is why we have gotten to the point we are today.

We saw a bill come out of the Senate Finance Committee in a bipartisan fashion with 16 votes in favor; only five votes against it. I predict when the final vote comes on this bill, we will see the same type of bipartisan representation with a significant number, maybe over three-fourths of the Senate saying, yes, this has sufficient improvement and reform in it for me to support it.

It has enough Government involvement to make sure it is paid for, enough Government involvement to make sure it is run properly but not micromanaged, and it has enough private sector involvement to deliver, for the very first time, through a competitive private delivery system, prescription drugs for all seniors regardless of where they are or in what program they happen to be.

It also says the private sector will offer, for the first time on a voluntary basis, to seniors who want to move into a new system a private delivery system that will cover drugs, will cover hospitals, and will also cover physician charges under the program. This is a historic opportunity to combine the best of what Government can do with the best of what the private sector can do.

There is going to be a very important amendment offered by Chairman GRASSLEY and the ranking member, Senator BAUCUS. Because we were able to get a score that said there is $12 billion extra money available, the question then became, How do we divide it? I never thought we would have such a difficult time spending money. We normally get into fights when we do not have enough money. Lo and behold, we found there was $12 billion in extra funds.

The question then for the Senate is how are we going to allocate that money? Senator BAUCUS and Senator GRASSLEY, working with Senator KENNEDY and others, came up with a plan that is fair.

It says to the Republican Members: Take half of it, and they want to utilize it for a demonstration program to determine whether PPOs or the provider networks in the private sector will work. We are not certain. We think they will. But let's do a test. And if it costs more, there will be $6 billion available to pay for it starting in the year 2009. That is what many Republicans thought was the right way to use half of the money.

On the other hand, Members on my side said, We need to do more for traditional fee-for-service. If they are going to experiment with the preferred providers in the private sector, we want to also know what will happen if we are able to put in more money for preventive health care and for people who want to stay in the old program.

What Senator BAUCUS and Senator GRASSLEY did, working with Senator KENNEDY, was to say to people who are inclined to the Democratic perspective, we are going to let you use $6 billion for people who want to stay in the old program. Here is what you can do with it: You can use the money to provide enhanced benefits for people who stay in traditional Medicare. What we mean by that is to give them additional care for chronic care coordination, for the chronically ill, to coordinate better how they are getting their health care.

We have more money for disease management, which is incredibly important. When we are talking about saving money and giving people a better quality of life; disease management is important. Also, they can use the money for other benefits and services that the Secretary determines will improve preventive health care for the beneficiaries.

What we have crafted is an effort to take the extra money and allow for a legitimate experiment, a legitimate test of whether the preferred provider system will cost less money—I think it will; they can provide services that I think are better and at a better price, but we do not know that for sure, so let's do some testing on it in certain regions of the country. If it saves money, hallelujah for everybody. But if it costs money, they will have $6 billion to help pay for those extra charges.

The Democrats, on the other hand, have the provisions to have $6 billion over the period in order to provide disease management and preventive health care services in the traditional Medicare Program. That is as fair as it can be in a divided Senate. If one side had their way, they would do it all with the preferred providers. If our side perhaps had their will, it would provide all the money to be put back in traditional Medicare, but we all know in a divided Senate that is not possible.

So the best possible compromise has been crafted by the chairman, Senator GRASSLEY; by the ranking member, Senator BAUCUS; and by Senator KENNEDY's involvement and many others who have worked on this issue.

This is a good amendment. It is an important amendment. We are on the edge of an historic day in being able to enact real Medicare reform with prescription drugs for all of our Nation's seniors. We cannot let that goal be lost while we fight over how to divide extra funds. I think this division is as fair as it possibly can be, and I urge all of our Members to vote for it. In fact, I think the vote should be approximately like it came out in the Finance Committee. We lost a few what I would say were on the left, we lost a few what I would say were on the right, of the political spectrum. But in the end the vast majority supported this legislation in the committee and will do so on the Senate floor.

I certainly ask them to support the Grassley-Baucus amendment when it is voted on as well.

I yield the floor.

The PRESIDING OFFICER. All time has expired.

VOTE ON AMENDMENT NO. 1102

The PRESIDING OFFICER. The question is on agreeing to the McConnell amendment No. 1102.

Mr. HATCH. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 252 Leg.]

YEAS—98

Akaka
Alexander
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Boxer
Breaux
Brownback
Bunning
Burns
Byrd
Campbell
Cantwell
Carper
Chafee
Chambliss
Clinton
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Crapo
Daschle
Dayton
DeWine
Dodd
Dole
Domenici
Dorgan
Durbin
Edwards
Ensign
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham (FL)
Graham (SC)
Grassley
Gregg
Hagel
Harkin
Hatch
Hollings
Hutchison
Inhofe
Inouye
Jeffords
Johnson
Kennedy
Kohl
Kyl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Lott
Lugar
McCain
McConnell
Mikulski
Miller
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Nickles
Pryor
Reed
Reid
Roberts
Rockefeller
Santorum
Sarbanes
Schumer
Sessions
Shelby
Smith
Snowe
Specter
Stabenow
Stevens
Sununu
Talent
Thomas
Voinovich
Warner
Wyden

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1102) was agreed to.

Mr. HATCH. Mr. President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1102, AS MODIFIED

Mr. HATCH. Mr. President, I ask unanimous consent that amendment 1102, which was just agreed to, be modified with the changes that are the desk.

The PRESIDING OFFICER (Mr. CRAPO). Without objection, it is so ordered.

The amendment (No. 1102), as modified, is as follows:

(Purpose: To protect seniors with cardiovascular disease, cancer, diabetes, or Alzheimer's disease)

At the end of subtitle A of title I, add the following:

SEC. . PROTECTING SENIORS WITH CARDIOVASCULAR DISEASE, CANCER, OR ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cardiovascular disease, cancer, diabetes or Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D-19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D-19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D-19(4)(C) of such Act) who is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D-17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D-19(a)(4)(D) of such Act) who is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D-19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D-19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D-6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D-6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

Mr. HATCH. Mr. President, I ask unanimous consent that the next three votes be 10 minutes in length each.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1108

Under the previous order, there will be 2 minutes equally divided on the Durbin amendment No. 1108.

Mr. DURBIN. Mr. President, with all due respect to my colleagues, the amendment we just agreed to did nothing. It did not add one penny or one new benefit to any senior suffering from Alzheimer's. This amendment I offer, along with Senator HARKIN, will put $12 billion into providing prescription drug coverage for the seniors we represent who suffer from heart disease, cancer, Alzheimer's, diabetes and its complications. Take your pick—a $6 billion tax subsidy for HMO and private insurance companies or $12 billion for your seniors struggling to pay impossible prescription drug bills who will be cut off under this bill. It is an easy choice for me. If you take it home to your State, you will find it is an easy choice, too.

I hope you will vote for this amendment.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I rise in opposition. I want to stress my opposition is not because I do not understand or am not sympathetic to the difficult situation beneficiaries who are afflicted with cardiovascular disease, cancer, or Alzheimer's disease experience.

But I also recognize there are millions and millions of other seniors who suffer from diseases just as debilitating and life-threatening as the ones my colleague has identified here. Under this proposal they would be treated as second-class citizens because they do not suffer from the right disease.

The most basic, and really the most important, tenet of the Medicare program is to provide a universal benefit to all seniors. We have done that under S. 1.

We crafted a prescription drug benefit that helps every senior and also targets the most help to those who are less able to afford the appropriate care.

While I am sympathetic to my colleagues' desire to enhance the benefit, I can't support a proposal that pits one group of seniors against the other based solely on this disease.

I urge my colleagues to vote against this amendment so we can remain faithful to the most basic tenet of the Medicare program, a universal benefit, and to ensure that the Senate does not discriminate against seniors based on their disease.

I move to table the amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 57, nays 41, as follows:

[Rollcall Vote No. 253 Leg.]

YEAS—57

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kennedy
Kyl
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NAYS—41

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Johnson
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NOT VOTING—2

Kerry
Lieberman

The motion was agreed to.

Mr. REID. Mr. President, I move to reconsider the vote and to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1103 TO AMENDMENT NO. 1092

The PRESIDING OFFICER. Under the previous order, there are 2 minutes equally divided on the Dorgan second-degree amendment.

Who yields time?

Mr. DORGAN. Mr. President, the importance of this amendment is answering the question, what to do with $12 billion. I propose we use that $12 billion to reduce the premium that senior citizens will be required to pay for this prescription drug benefit, roughly $7 a month, from $35 to $28.

The rebuttal to my amendment has been: This really doesn't mean very much. Only in this Chamber would $12 billion not mean very much. Frankly, this means a great deal to senior citizens. The underlying amendment represents the worst of all worlds. It says, let's give $6 billion to insurance companies. And I guarantee, you dye that money purple, you will have purple pockets in the insurance industry. That is where it is going. Let's have $6 billion go to the insurance industry to conduct an experiment that we already know has failed.

I don't understand why that is the way we want to use billions of dollars. Why not use it to help senior citizens close the coverage gap or, as I suggest, to reduce monthly premiums which start at $35 a month in this bill and then ratchet up and up and up as prescription drug prices increase. Pass my amendment and help senior citizens reduce these premiums.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Yes, $12 billion is a lot of money; $6 billion of that $12 billion he wants to take away from this provision, this bipartisan provision, that would be used for things he stands for. He has been talking about chronic disease management. He has been talking about managing to a better extent people with chronic diseases. We have put $6 billion into demonstration projects like that to save the taxpayers' money. Why? Because 5 percent of the seniors cause 50 percent of the costs to Medicare. That is why those demonstration projects are very important. That is why I hope you will vote against this amendment.

Mr. SANTORUM. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the amendment. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 59, as follows:

[Rollcall Vote No. 254 Leg.]

YEAS—39

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Johnson
Kohl
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—59

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kennedy
Kyl
Landrieu
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1103) was rejected.

AMENDMENT NO. 1092

The PRESIDING OFFICER. Under the previous order, there are now 2 minutes equally divided on the Grassley amendment.

The Senator from Montana.

Mr. BAUCUS. Mr. President, I say to my colleagues, this is the key amendment that will provide for the passage of this legislation and, therefore, prescription drug benefits for seniors. It is the key amendment.

Why do I say key amendment? Very simply because we have $12 billion, and we have to find a way, in an even-handed, balanced way, to spend that $12 billion. We have to marry two competing philosophies: private competition and Medicare.

We have, therefore, designed the solution that the $12 billion will be evenly divided to keep the balance so that we can get this legislation passed and, more importantly, so seniors get a prescription drug benefit as quickly as possible.

If this amendment is not adopted, we are going to be in the soup. There are going to be Senators from one side of the aisle who are going to want to spend all of it their way; there are going to be Senators on the other side of the aisle who want it all spent their way; and we are going to be nowhere. We are going to be back where we have been the last 4 years, talking about prescription drugs benefits but not doing something about it, not providing the benefits to our seniors.

This is a key amendment. This is the amendment which will allow benefits to go to seniors.

The PRESIDING OFFICER (Mr. SMITH). The Senator's time has expired.

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, to pick up on what Senator BAUCUS said, let me tell you what this does. There will be $6 billion spent on our side of the aisle to do the things about which we are concerned. What? Allow the competitive model to work, allow the new blueprint for Medicare to be successful, starting in 2009, because that is when the money is available, but what JON KYL and so many others on this side of the aisle have been concerned about is in this amendment. If my colleagues want to give competition a chance, this is the amendment they vote for.

On that side of the aisle, what is $6 billion? For chronic care and disease management. Senator KENNEDY has worked on this tirelessly. Five percent of Medicare recipients consume 50 percent of the Medicare benefits. What we need in the fee-for-service plan is programs for disease management and chronic illness management. As the Senator from Massachusetts said to me just a few minutes ago, nowhere else will we be able to find $6 billion to do this very important, cost-saving, quality improvement to the basic Medicare system. It is what both sides want.

We have come together and we hope we will get strong support for this amendment.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. DORGAN. Mr. President, parliamentary inquiry. Who is recognized to speak in opposition to the amendment?

The PRESIDING OFFICER. The majority leader was recognized.

Mr. FRIST. Mr. President, very briefly, this amendment is the culmination of several days of debate where both Democrats and Republicans have come together, again bringing different issues to the table, but together it is a positive, strong amendment for the American people and for seniors.

On the one hand, it invests $6 billion, that is not in the underlying bill, in preventive medicine, which almost does not exist in traditional Medicare, and in chronic disease management. All of us know 5 percent of the beneficiaries are responsible for 50 percent of the cost and we know we need to manage those people better. So we have $6 billion for preventive medicine and chronic disease management.

In addition, there is $6 billion to support the concept of private enterprise, competition, the private entities, which we believe is not the only salvation but critical if we are going to address the long-term, 75-year unfunded liabilities that are incurred when we add a new prescription drug benefit.

For that reason, I urge our colleagues on both sides of the aisle to recognize that we worked together, Democrats and Republicans, to come to this carefully negotiated agreement that will be to the benefit of seniors and individuals with disabilities.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, parliamentary inquiry. My understanding was prior to a vote there was to be time divided between opponents and supporters. We have just heard from three supporters.

The PRESIDING OFFICER. The agreement was the time was to be evenly divided.

Mr. DORGAN. Evenly divided between whom?

The PRESIDING OFFICER. The managers.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senator from North Dakota be given 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota.

Mr. DORGAN. Mr. President, there does need to be opposition, it seems to me, for those of us who believe this is not the right way to use $12 billion. The $12 billion was made available. Twelve billion is what we discovered. The CBO estimate was below the $400 billion available for this program. So the question was: How shall the $12 billion be used?

We have spent all of our lives in this Chamber making choices. Too often we make the wrong choices in circumstances such as this. We come back with a plan that says let's use the $12 billion for two purposes, and both of them are for experiments. In both cases, we know the answer to the experiments. One, $6 billion to the insurance companies so we can incentivize—subsidize—the insurance companies to see if they can provide the prescription drug benefit at equivalent or less cost than Medicare does. We know the answer to that. That experiment has been done.

Ask senior citizens all across this country what would you rather have, better benefits or lower costs or would you like to have $12 billion in demonstration projects? That is the choice. The choice has been presented to us at this point in this amendment to say let's bifurcate this into two $6 billion pots, both of which will be demonstration projects, the answer to which we know in both cases. First, the circumstance with subsidizing the insurance companies, we know the answer to that. They are going to provide this benefit at higher costs. We know that. Second, does wellness and chronic care help? Yes, we know that. Why do we not take the $12 billion and use it to provide better benefits or lower costs for senior citizens? After all, that is why we started this process, to provide a prescription drug benefit that works for senior citizens.

We come to the end of this process, and we have a group of people who go into a closed room and come out with a deal that says we have decided how the $12 billion should be used.

Ask senior citizens how they would like it used and I guarantee there is only one answer from every corner of this country: Use it to provide us benefits that were promised, deliver that which was promised to us.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SANTORUM. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to amendment No. 1092, as modified.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Ohio (Mr. VOINOVICH) is necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 71, nays 26, as follows:

[Rollcall Vote No. 255 Leg.]

YEAS—71

Alexander
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Feinstein
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Inouye
Jeffords
Kennedy
Kyl
Landrieu
Lautenberg
Lincoln
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Pryor
Reid
Roberts
Santorum
Schumer
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Warner
Wyden

NAYS—26

Akaka
Boxer
Byrd
Cantwell
Clinton
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Graham (FL)
Harkin
Hollings
Johnson
Kohl
Leahy
Levin
Mikulski
Murray
Nelson (FL)
Reed
Rockefeller
Sarbanes
Stabenow

NOT VOTING—3

Kerry
Lieberman
Voinovich

The amendment (No. 1092) was agreed to.

Mr. REID. Mr. President, I move to reconsider the vote.

Mr. ENSIGN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senate will be in order.

The Senator from Montana.

Mr. BAUCUS. Mr. President, on behalf of myself and the chairman of the committee, Senator GRASSLEY, I ask unanimous consent that at 5 p.m. today the Senate proceed to a vote in relation to the Sessions amendment, No. 1011, to be followed by a vote in relation to the Rockefeller amendment numbered 975, as modified; to be followed by a vote in relation to the Bingaman amendment numbered 1066; provided further that there be no amendment in order to the amendments prior to the votes, and there be 2 minutes equally divided for debate.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that the time between now and 5 o'clock be equally divided.

The PRESIDING OFFICER. Without objection, it is so ordered.

Who yields time?

Mr. REID. Mr. President, I suggest the absence of a quorum, and I ask unanimous consent that the time be equally divided.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I yield 5 minutes to the Senator from West Virginia.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, I thank the distinguished ranking member of the Finance Committee.

AMENDMENT NO. 975, AS MODIFIED

Mr. President, in accordance with the agreement just entered into, I send a modification of my amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The amendment is so modified.

The amendment (No. 975), as modified, is as follows:

On page 10, lines 12 and 13, strike "(other than a dual eligible individual, as defined in section 1860D–19(a)(4)(E))".

On page 21, strike lines 22 through 25, and insert "title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.

On page 107, line 3, strike "30 percent" and insert "27.5 percent".

On page 116, line 10, insert "and" after the semi-colon.

On page 116, line 12, strike "; and" and insert a period.

On page 116, strike lines 13 through 17.

On page 116, line 24, insert "and" after the semi-colon.

On page 117, line 2, strike "; and" and insert a period.

On page 117, strike lines 3 through 7.

On page 117, line 13, insert "and" after the semicolon.

On page 117, line 17, strike "; and" and insert a period.

On page 117, strike lines 18 through 23.

On page 118, line 6, insert "and" after the semicolon.

On page 118, in line 13, insert "or" after the semi-colon.

On page 118, line 14, strike "; or" and insert a period.

On page 118, strike line 15.

Beginning on page 118, strike line 16 and all that follows through page 119, line 9.

On page 119, line 10, strike "(F)" and insert "(E)".

On page 119, line 15, strike "(G)" and insert "(F)".

On page 119, line 19, strike "(C), (D), or (E)" and insert "(C), or (D)".

On page 120, line 3, strike "(H)" and insert "(G)".

On page 120, lines 5 and 6, strike "who is a dual eligible individual or an individual".

Beginning on page 121, line 24, strike "dual eligible" and all that follows through "and" on page 122, line 1.

On page 146, line 6, insert before the period "and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c)".

Beginning on page 146, strike line 23 and all that follows through page 149, line 21, and insert the following:

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

"(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f)) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

"(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

"(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) PHASE-OUT PROPORTION.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

"(i) 2006 is 100 percent;

"(ii) 2007 is 95 percent;

"(iii) 2008 or 2009, is 90 percent;

"(iv) 2010 is 86 percent; or

"(v) 2011, 2012, or 2013 is 80 percent.

"(d) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan."

Beginning on page 152, strike line 3 and all that follows through page 153, line 15, and insert the following:

"(f) DEFINITION.—For purposes of this section, the term 'subsidy-eligible individual' has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).".

(C) CONFORMING AMENDMENTS.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(c)(1) for the State and the quarter".

(2) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

Beginning on page 157, strike line 21 and all that follows through page 158, line 4.

On page 173, beginning on line 15, strike "that is not" and all that follows through "includes" on line 18 on that page, and insert "that includes but is limited solely to".

On page 190, in line 18, strike "and".

On page 190, between lines 18 and 19, insert the following:

"(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and".

On page 190, line 19, strike "(B)" and insert "(C)".

On page 529, between lines 8 and 9, insert the following:

SEC. 455. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

Mr. ROCKEFELLER. Mr. President, this amendment ensures that the Medicare prescription drug benefit we are debating is, in fact, truly universal. It is a principle we have all espoused over the years.

The underlying bill, which we are debating, precludes Medicare beneficiaries who are eligible for Medicaid from enrolling in the Medicare drug benefit. That would be the first time ever that Medicare beneficiaries would be, in fact, precluded from being Medicare beneficiaries.

The group, which is referred to as dual eligibles, consists of those who are the poorest seniors. They are those who have incomes below 74 percent of poverty. If my colleagues are interested, that income level is $6,645. That is their total gross income. The majority of them are single. The majority of them are women who are in poor health and more likely to be over the age of 85.

Precluding these people is wrong, and my amendment would fix it. I am happy to say the amendment is budget neutral. I will explain that in a minute.

Prescription drugs are optional as a benefit under Medicaid. We all know that. States can limit the number of prescriptions they make available. Some allow two or three prescriptions per year. They can cap the benefits. They can charge any copayments they want. They can end it altogether.

So you have States, predictably, already in a situation with very different Medicaid levels. Because of our financial situation nationally, and in our States, Medicaid is always going to be the very first benefit which will be cut. It has already happened, and will happen substantially more over the coming years.

I remind, again, my colleagues these are the poorest of the poor, the oldest of the old, and the sickest of the sick we are talking about.

I strongly urge my colleagues to provide all of the seniors in their States with the benefit of a real Medicare drug benefit by supporting this amendment.

If a State gets to the position where it is simply unable to continue with prescription drugs under the Medicaid program, and they virtually eliminate it, that poor person, below 74 percent of poverty—which is just a little bit over $6,000 a year—has nowhere else to go. Always—including presently—that person can return to Medicare. This underlying bill would preclude that from happening. My amendment would fix that in a budget-neutral fashion.

I hope my colleagues will support this amendment which I consider one of the most moral and humane of amendments that has come before this body on this issue.

I thank the Presiding Officer.

Mr. GRASSLEY. Mr. President, I rise in opposition to this amendment. In S. 1, beneficiaries who are enrolled in both Medicaid and Medicare will continue to receive the generous drug coverage that they currently know through the Medicaid program.

Some of my colleagues have argued that by having dual eligibles remain in the Medicaid program, Congress is treating these vulnerable seniors as second-class citizens and subjecting them to a lower quality benefit.

This is not the case. In fact, this letter from the Long Term Care Pharmacy Alliance applauds S. 1 for keeping the duals in Medicaid.

Specifically, the letter states, "This approach will preserve the time-tested safeguards designed to prevent medication errors and ensure quality care for the majority of these beneficiaries in the institutional setting."

The policy decision to cover the drug cost for dual eligibles in Medicaid was not made in vacuum. These vulnerable citizens deserve the best benefit available, which is the benefit provided through Medicaid. I also remind my colleagues that the intent of this legislation is to expand prescription drug coverage to our senior citizens who do not have access to prescription drugs or who are faced with paying a large share of their income for their drug coverage.

This does not describe the current coverage experienced by those who are dually eligible.

These seniors currently have a drug benefit through the Medicaid program. In fact, many advocates and beneficiaries describe and know this benefit to be very generous.

Medicaid was created to assist individuals who do not have the means to pay for their share of health care costs. That is a responsibility shared between the Federal Government and the States. Medicaid pays for many benefits that Medicare does not.

We all know that the purpose of S. 1 is to provide prescription drugs to seniors that do not currently have access to drugs or are paying extremely high drug costs.

However, recognizing the costs associated with covering the cost of providing prescription drug coverage to the dual eligible population, S. 1 does provide nearly 18 billion in new Federal dollars to compensate States for some of these costs.

This is because S. 1 provides minimum standards that ensure that every aspect of the benefit provided through Medicaid is the same high quality that is provided through part D of the Medicare program.

I remind my colleagues that adoption of this amendment will not expand coverage at all; it will simply shift the cost to the Federal Government and in time to the other Medicare beneficiaries.

In closing, I remind my colleagues that S. 1 helps to deliver care that is consistent with current law and is familiar to vulnerable beneficiaries.

I urge my colleagues to defeat this amendment.

I ask unanimous consent to print the letter to which I referred in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

LONG TERM CARE PHARMACY ALLIANCE,
Washington, DC, June 21, 2003.

Hon. CHARLES E. GRASSLEY,
Chairman, Committee on Finance, U.S. Senate, Dirksen Building, Washington, DC.

DEAR CHAIRMAN GRASSLEY: On behalf of the Long Term Care Pharmacy Alliance, I appreciate this opportunity to express our support for provisions of Medicare legislation you have advanced to protect the nation's frail elderly beneficiaries residing in nursing facilities. In particular, we are pleased that your legislation would allow dual eligible beneficiaries to retain their prescription drug coverage under Medicaid.

While most Medicare beneficiaries are able to walk into pharmacies to pick up their prescriptions or to receive vials of pills through the mail, a sizable percentage of beneficiaries cannot do so and need special services that retail and mail order pharmacies do not provide. Nursing home residents have specific diseases and multiple co-morbidities that require specialized pharmacy care.

To meet these needs, long-term pharmacies provide specialized packaging, 24-hour delivery, infusion therapy services, geriatric-specific formularies, clinical consultation and other services that are indispensable in the long-term care environment. Without such treatment, we cannot expect positive therapeutic outcomes for these patients. Failure to take into consideration the special pharmacy needs of the frail and institutionalized elderly will lead to a marked increase in medication errors and other adverse events.

In recognition of these concerns, your proposed legislation would retain the current system of Medicaid coverage to provide specialized pharmacy services to dual-eligible beneficiaries residing in nursing facilities. This approach will preserve the time-tested safeguards designed to prevent medication errors and ensure quality care for the majority of these beneficiaries in the institutional setting. Medicaid today provides generous benefits to dual eligible beneficiaries and has experience in addressing the special needs of nursing home patients. The proposed new Medicare Part D benefit does not contemplate the impact on nursing home residents which must be considered to protect these patients.

We are encouraged that Section 104 of the Senate bill requires the Secretary to provide recommendations to cover dual eligible beneficiaries by the new Medicare Part D benefit before statutorily mandating such action. Nevertheless, we strongly recommend additional language to address the special pharmacy needs of beneficiaries residing in nursing facilities who are not dually-eligible for Medicare and Medicaid. Such language would require the Secretary of Health and Human Services to review the current standards of practice for pharmacy services provided to patients in nursing facilities and to report to the Congress its findings prior to implementation of the new prescription drug benefit. This report would include a detailed description of the Department's plans to implement the provisions of this Act in a manner consistent with applicable state and federal laws designed to protect the safety and quality of care of nursing facility patients. Such provisions were included in legislation approved by the House Ways and Means and Energy and Commerce Committees, and we would respectfully request that you adopt similar language.

We appreciate your leadership in carefully considering the multitude of complex issues related to the creation of a new Medicare prescription drug benefit. We are grateful for the chance to work constructively with you to protect patient safety and to ensure the continued provision of quality pharmacy services to the most vulnerable seniors.

If you have any questions or would like additional information, please feel free to contact me. Again, thank you for your efforts to ensure patient safety and promote quality care for Medicare beneficiaries residing in nursing facilities.

Sincerely,

PAUL BALDWIN,
Executive Director.

Mr. KENNEDY. One of the great strengths of Medicare is that it is for everyone. Rich and poor alike contribute to the system. Rich and poor alike benefit from it.

At bottom, Medicare is a commitment to every senior citizen and every disabled American that we will not have two-class medicine in America. When a senior citizen enters a hospital, Medicare pays the same amount for their care whether they are a pauper or a millionaire. When a senior citizen goes to a doctor, she has the peace of mind of knowing that Medicare has the same obligation to pay for her treatment no matter what her financial circumstances—and the doctor has no financial interest in rationing her care according to the contents of her bank account.

Through the Medicaid Program, we do try to provide extra help for those who are poor. But the fact that Medicaid provides extra assistance for the poor does not reduce Medicare's obligation to provide equal treatment for all. Medicare always has primary payment responsibilities for the service it covers. Medicaid is always supplementary.

Medicaid provides critical help to the poor and elderly, but it does not provide the same reliable guarantees of equal treatment that Medicare does. Under Medicaid, States have limited the number of days of hospital care they would provide or the number of doctor visits they will support. States have placed arbitrary limits on the number of prescriptions.

This legislation sets an undesirable precedent for treatment of poor senior citizens who are eligible for both Medicare and Medicaid. For every other benefit, these senior citizens enroll in Medicare, and Medicaid supplements Medicare's coverage. But for this benefit, the bill says that the poor are excluded from Medicare. The only benefits they get are from the Medicaid Program. Medicare is for all senior citizens who paid into the program during their working years—not just some senior citizens. And it should stay that way.

This amendment rights this wrong. It says we will not take away the Medicare that the poor have earned by a lifetime of hard work.

The PRESIDING OFFICER. Who yields time?

Mr. BINGAMAN addressed the Chair.

The PRESIDING OFFICER. Who yields time to the Senator from New Mexico?

Mr. BINGAMAN. Mr. President, I request that the manager allot me 5 minutes.

Mr. BAUCUS. Mr. President, I yield 5 minutes to the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. I thank the Senator from Montana.

AMENDMENT NO. 1066

Mr. President, I would like to take this opportunity to explain amendment No. 1066, which is scheduled to be one of the amendments considered in this next block of amendments.

Mr. President, I am concerned that the prescription drug coverage included in S. 1 is not sufficient to fully meet the needs of our seniors and that those seniors who elect to participate in Part D and get this prescription drug benefit will be restricted from purchasing supplemental coverage.

The Kaiser Family Foundation estimates that in 2006—which is the year this legislation really takes effect, this benefit occurs—the average Medicare beneficiary will spend $3,160 per year on prescription drugs. Under the current plan, those individuals will have $1,700 that same year in out-of-pocket expenses in addition to the $420 they pay in Part D premiums. Therefore, the average Medicare beneficiary who elects Part D will have approximately $2,100 per year in out-of-pocket expenses. This translates, of course, into $175 a month. That is a significant expenditure for a lot of individuals and couples on a fixed income.

It would seem reasonable to allow these individuals who want to protect themselves against unpredictable and increasing prescription drug expenses to purchase supplemental insurance coverage that would allow additional prescription drugs to be purchased.

Medigap was designed to fill the gaps in Medicare. A sizable gap exists in the prescription drug benefit we are offering in this bill. Yet the current bill specifically prohibits seniors from filling that gap with a Medigap policy.

Section 103 of S. 1, which is the bill we are considering, explicitly prohibits people who elect Part D prescription drug coverage from purchasing additional prescription drug coverage as part of any Medigap plan.

Let me give you the quotation out of the bill. It says:

> No Medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under Part D.

So you essentially have a choice: Am I going to enroll in this new Part D and get this benefit and therefore forego any Medigap policy or am I going to stay out?

We are telling seniors whose cost burden, on average, will be $2,100 a year, and 10 percent of whom are likely to have out-of-pocket expenses of $4,000 or more per year, they will not be allowed to seek additional prescription drug relief.

The amendment I am offering would give seniors the option of purchasing more prescription coverage as part of a comprehensive Medigap plan. The amendment calls on the National Association of Insurance Commissioners to devise two new Medigap plans that would each offer prescription drug coverage to beneficiaries who elect Part D.

There are currently 10 standard Medigap plans. They are designated A through J, and they offer insurance to seniors. Of those, plans H, I, and J offer prescription drug coverage in addition to Part A and Part B wraparounds. Of these, H and J are the most commonly elected plans.

Under S. 1, the way it now stands, seniors who elect Part D would no longer qualify for H, I, or J. However, if the amendment is adopted, the two new policies designed by the National Association of Insurance Commissioners would be similar to the current Medigap policies of H and J, but their prescription drug coverage would be tailored to wrap around the Part D coverage. So seniors who are currently H or J subscribers would have the option of electing Part D and still maintaining a Medigap plan similar to what they have now.

The amendment would give the National Association of Insurance Commissioners 18 months to develop and report back on these two new plans. In my view, it would be a substantial improvement to the current bill.

As I said, my amendment will give the National Association of Insurance Commissioners 18 months to develop and report back on two new plans. The NAIC is the appropriate body to develop these plans because they have a system already in place for doing so with appropriate representation from all interested and affected parties. The NAIC can best determine how the benefits proposed in this amendment can be designed in order to avoid over-utilization and to coordinate with the existing medigap benefit packages. They were the body employed to develop the current Medigap plans A through J and they are the body best equipped to develop these two new plans.

This amendment is similar to language already included in the House version of the bill and thus already has a great deal of support in the House of Representatives.

This amendment also provides a provision to stabilize the Medigap market during this time of transition. The current bill states that seniors who are enrolled in H, I, or J at the time when they elect Part D will be displaced from their current Medigap plans and given open enrollment into any other Medigap plan A-G offered in their State. Our amendment will still guarantee them the option of enrolling in substitute coverage without the risk of discrimination based on age, health status, utilization, etc. However, our amendment will reduce the chaos of this transition time by keeping the majority of Medigap subscribers with their current carriers.

Let me explain. Beneficiaries displaced from H, I, or J will have the option of choosing any other Medigap plan—A-G—that their carrier offers or one of the two new plans. If their current carrier does not choose to offer one of the new plans then they will have the option of switching carriers in order to obtain a medigap policy that includes prescription coverage. Thus, the majority of seniors will be staying with their current carriers and thus, those carriers will be better able to predict the affect of this shift and better able to ease the transition for their subscribers.

This is a simple amendment that should elicit very little controversy. People may raise concerns because it will be difficult to construct a standardized wrap around benefit to compliment Part D when Part D is not standardized. But this is not a reason to deny people access to supplemental coverage. Rather, we are giving the NAIC 18 months to put together such a plan.

Consumer groups such as the Consumer Union and Medicare Advocacy support our amendment because it provides much needed additional coverage options for our Nation's seniors. Likewise, insurance carriers like it because it allows them to continue to provide a service that they have been providing up until this point and yet it does not force them to offer these new plans if they do not see them as viable. The cost of the amendment should be negligible as it is not adding any additional Government expenditure nor expediting a beneficiary's trip to the catastrophic threshold. This amendment simply gives seniors an opportunity to continue to seek the insurance industry an opportunity to meet the needs of our seniors not met by Medicare Part D.

Mr. President, I ask my colleagues to review this amendment before they vote. I think it is an excellent amendment.

I ask them to join me in supporting it.

The PRESIDING OFFICER. Who yields time?

AMENDMENT NO. 1011

Mr. GRAHAM of Florida. Mr. President, I rise to speak on an issue that will come before the Senate shortly. That is an amendment to strike the language from this legislation which is found in section 605, the legal immigrant child health provision. Let me give the background on section 605.

What this legislation would do would be to allow States on a State option basis to elect to provide health care for pregnant women for the period of their pregnancy, plus 60 days thereafter, and immigrant children. In both categories we are talking about legal immigrants, not people who have arrived outside the system and undocumented. These are individuals who have come to the United States under all of the procedures that allow for legal immigration, with the most prominent category being for family reunification.

The restoration of this has already been considered by the Senate Finance Committee, first in 2001, then in June of 2002, and most recently in the consideration of this legislation. This provision was sustained in the chairman's mark, as it had been placed by Senator GRASSLEY and Senator BAUCUS, by a vote of 13 to 8. There has been both consideration and approval of this provision by the Finance Committee.

It has been alleged that the provision of these services to legal immigrants will encourage illegal immigration. We are talking exclusively about pregnant women and children who have entered the United States on a legal basis.

Prior to 1996, there was no restriction on health care benefits for legal immigrants. We are now carving out from the current exclusion for health care two categories, which are both humane and very much in the public interest, that pregnant women have adequate access to health care and that children grow up with adequate health care.

It has been alleged that there are a number of benefits which have also been made available to legal immigrants, including emergency medical services, Head Start programs, foster care, school lunches, and food stamps. Those can be debated on their own merits but they are no substitute for providing to legal immigrants, children, and pregnant women a place to get appropriate health care.

It has also been stated that this should be a responsibility of the sponsor.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. GRAHAM of Florida. May I have 30 seconds to close?

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senator have 30 additional seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRAHAM of Florida. The Immigration and Naturalization Service under the current law has limited the kinds of public benefits that are relevant to the so-called public charge finding. INS officers place no weight on the receipt of noncash public benefits when determining whether an immigrant will be a public charge on society. This provision, section 605, is consistent with current national immigration policy. Therefore, I urge the defeat of this amendment.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. I believe our side has 2 minutes remaining. I ask unanimous consent for 4 minutes and yield the Senator from Alabama 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, included in the Medicare prescription drug reform bill in section 605 is a Medicaid reform of welfare benefits for noncitizens, reversing a policy adopted by this Senate in 1996 by a vote of 74 to 24. Section 605 is a very substantial change in our current policy. It will cost, according to CBO estimates, $500 million over just 3 years. It is not to be taken lightly. Frankly, we haven't had debate on it.

I have offered an amendment that would strike the existing language in section 605, along with a sense of the Senate that this matter go back to the Finance Committee for hearings this fall, the time when the Finance Committee plans to be addressing Medicaid welfare reform. That is what this is. This is Medicaid welfare reform, not Medicare senior citizens reform.

This is clearly unconnected to the purpose of the bill. It was slipped in as some sort of compromise. We ought not to allow that to happen, to erode a very important part of the 1996 Welfare Reform Act. The administration, which is very favorable to matters that would help immigrants in this country, opposes this change. They say it should be done, if at all, as part of the welfare reform of this fall.

That is why our sense of the Senate calls on the Finance Committee to reevaluate it as part of their requirement this fall on reform welfare. Millions of people come to this country legally. They come here with sponsors. Those sponsors say they will pay for the medical welfare needs of those people they sponsor. That is by affidavit and it should be honored, not undercut.

Mr. NICKLES. Mr. President, I wish to compliment Senator SESSIONS for his leadership. I urge my colleagues to vote in favor of the Sessions amendment to strike out this provision that does not belong in a Medicare bill.

This is a Medicaid provision. This is a welfare provision. We are going to reauthorize welfare later this summer. It should be considered at that time. This is part of the reforms that were made in 1996 when we passed the welfare reform act, one of the most successful bills we ever passed. If we are going to undermine that, do it with a little consideration. The administration opposes this because it doesn't belong here, and it is bad policy. This turns immigration policy on its head.

Let me read the current law on immigration policy. For a legal immigrant who comes into this country, it is required that the sponsor of that immigrant sign an affidavit of support to the U.S. Department of Justice which states:

> By signing this form, you, the sponsor, agree to support the intending immigrant and any spouse or children immigrating with him or her, and to reimburse any Government agency or private entity that provides these sponsored immigrants with Federal, State, or local means-tested public benefits.

This provision in the underlying bill would turn this law on its head and would basically take hundreds of millions of dollars away from Medicare recipients and give them to immigrants. So this is changing immigration law and Medicaid law. It needs to be dealt with in the Medicaid bill and welfare reform bill. It doesn't belong in this bill.

I urge my colleagues to vote in favor of the Sessions amendment.

Mrs. CLINTON. I rise to urge my colleagues to defeat this amendment.

In proposing this amendment, Senator SESSIONS argues that the restoration of health benefits to legal immigrants has not been fully reviewed or discussed. he also argues that SCHIP and Medicaid provisions are welfare reform measures and therefore not germane to the prescription drug bill. The amendment also states that Congress deliberately limited benefits available to legal immigrants when it removed these benefits in 1996.

I respectfully disagree with all of these three assertions.

First of all, the Senate Finance Committee has already extensively reviewed this issue. In 2001, the Finance Committee held a series of hearings on health coverage for the uninsured, including legal immigrants. During the TANF reauthorization mark-up in June 2002, there was a full debate on the restoration of health benefits to legal immigrants, and the Immigrant Children's Health Improvement Act passed as an amendment by a vote of 12 to 9. This year, during Finance Committee mark-up of the prescription drug bill, there was once again full debate on the restoration of health benefits to legal immigrants. Senator NICKLES offered an amendment to strike the immigrant children's health provision from the chairman's mark and that amendment failed by a vote of 8 to 13.

Second, I disagree with Senator SESSIONS' argument that Section 605 of the bill is not germane to Medicare prescription drug legislation. Every time this sort of provision comes to a vote, my colleagues on the other side of the aisle question the vehicle. When the immigrant child health provisions came up in committee last year, as part of the TANF reauthorization mark-up, Senator HATCH remarked that, "If we start playing with health care policy, this bill isn't going to go through." This year, Senator SESSIONS is saying that TANF reauthorization is the appropriate vehicle. I ask my colleagues on the other side of the aisle then—which one is the appropriate vehicle?

In fact, the restoration of health benefits to legal immigrants is also a major component of the effort to add a prescription drug benefit under Medicare. Senators GRASSLEY and BAUCUS realized this when they included this provision in the prescription drug mark as part of a compromise agreement that included both Senator KYL's undocumented aliens provision to reimburse hospitals for the cost of treating undocumented aliens and Senator GRAHAM's legal immigrants provision.

Finally, benefits to legal immigrants were cut in 1996 as a cost-saving measure, not as a matter of welfare reform. Section 605 of the underlying bill is also consistent with other policies approved by President Bush. Last year, the President signed legislation restoring food stamp benefits for legal immigrant children. The immigrant child health provisions would make these same children eligible for Medicaid and SCHIP. In an interview with the Associated Press in May 2002, Tommy Thompson, Secretary of the Department of Health and Human Services, stated that he had no "philosophical objection" to lifting the ban on providing health care benefits to legal immigrants.

Senator SESSIONS' amendment also has significant dire consequences for women and children, and could add costs to the Medicaid program, which I am certain that Senator SESSIONS did not intend. Current restrictions prevent thousands of legal immigrant children and pregnant women from getting the same access to preventive health care services that they would have if they were U.S. citizens. As a result of the restrictions, immigrant children have fewer opportunities to see a pediatrician and receive treatment before minor illnesses become serious and life-threatening. Families who are unable to get basic preventive care for their children have little choice but to turn to emergency rooms—the least cost-effective place to provide care—when their children become sick. Similarly, without prenatal care, a woman may give birth to a baby with low-birth weight, placing the baby at risk and resulting in hundreds of thousands of dollars in neonatal intensive care costs.

Frankly, I am saddened that we must fight over a bipartisan, thoughtful and extensively reviewed provision that will protect the health of children who legally came to our country and had no control over the length of time they were legal immigrants. We must ensure that it is defeated.

Mr. DASCHLE. Mr. President, with all deference to my colleague from Alabama, I strongly oppose this amendment to strike the provisions that would allow States to cover legal immigrants under Medicaid and SCHIP. As health care measures, these provisions are an appropriate addition to this legislation, and I am grateful that the chairman of the Senate Finance Committee included them in his bill.

Legal immigrants were banned from receiving Federal benefits under a number of programs, including Medicaid, for 5 years. The argument was made that people shouldn't come to this country if they are going to be a public charge.

But the reality is that legal immigrants don't come here for our benefits. They come because they want to work so they can make better lives for themselves and for their children. They work hard and they make a vital contribution to our economy. Many are forced to take low-paying jobs. And many of these jobs do not provide health insurance.

Immigrant families need access to health insurance just as much as citizen families. They are also just as deserving of this coverage as citizen families. Immigrants work hard. They pay taxes. They contribute to their communities. Immigrant children are also required to register for the Selective Service when they turn 18. According to the American Immigrant Law Foundation, 60,000 legal immigrants are on active duty in the U.S. Armed Forces.

Now, when an immigrant woman becomes pregnant, or her child gets sick, she has few places to turn except to emergency care, which is the most expensive means of providing health care. Many States have realized that this is not an acceptable way to address the health care needs of these families. Some 20 States now provide health care services to legal immigrants using their own funds. So the burden of caring for these families has been transferred to States and hospitals.

To respond to this situation, Senator GRAHAM introduced S. 845, the Immigrant Children's Health Improvement Act, or ICHIA, which simply allows States to use Federal Medicaid and SCHIP funding to provide coverage for pregnant women and children who are legal immigrants. The chairman of the Finance Committee included this provision to give States this option for fiscal years 2005, 2006, and 2007. This proposal has strong bipartisan support in both the Senate and in the House. It was adopted on a bipartisan basis last year in the Finance Committee, and a bipartisan group of Finance Committee members voted against stripping this provision from this bill this year.

The administration has suggested that this proposal would somehow create a new burden on the States. In fact, the proposal only gives States the option to provide this coverage, and allows them to use Federal resources to do so, thus giving them significant fiscal relief. No new burden would be imposed on the States. The National Governors Association and the National Conference of State Legislatures both support restoring these benefits. Even Governor Bush of Florida has indicated he supports this proposal.

More than 5 million children live in poor or "near-poor" noncitizen families. That is more than one-quarter of the total population of poor or "near-poor" children. Almost half of all low-income immigrant children are uninsured and they are more than twice as likely to be uninsured as low-income citizen children with native-born parents.

Many of these children will eventually become American citizens. By denying all but emergency health care, we increase the risk that these children will suffer long-term health consequences, which could reduce their ability to learn and develop, and become productive, contributing citizens.

It is also worth noting that the Medicaid/SCHIP ban also affects citizen children living in immigrant families. As many as 85 percent of immigrant families have at least one child who is a citizen. Although many of these children are eligible for Medicaid and SCHIP, receipt among eligible citizen children of noncitizen parents is significantly below that for other poor children. Parents may be confused about their children's eligibility, or concerned that somehow claiming these benefits will affect the status of other family members.

Making sure that pregnant immigrant women, and their children, have access to health care, including preventive care, is an investment in the future workforce of this Nation. I believe providing health care for all of our citizens, including pregnant women and children who are immigrants, is vital for our future economic strength. It is also the right thing to do. For that reason, I urge my colleagues to oppose this amendment.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I know we have an agreement that the vote will start at about 5 o'clock. I ask unanimous consent to speak for 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 975, AS MODIFIED

Mr. BAUCUS. Mr. President, I will divide my 2 minutes between two issues. First is the dual-eligible issue, concerning the amendment offered by the Senator from West Virginia, Mr. ROCKEFELLER. I have a lot of sympathy for what he is trying to do. In fact, my preference would be that low-income senior citizens get benefits under Medicare, not Medicaid.

Regrettably, we tried to strike a balance at this time so that the money spent on the bill, the $400 billion, was spent more on seniors, other beneficiaries, so they get better benefits, rather than spending the money in States to, in effect, bail out the States for their responsibilities under Medicaid. When we go to conference, I plan to do what I can, along with the chairman, to work this issue out. I think the Senator from West Virginia made a very good point.

AMENDMENT NO. 1011

On the other issue, the Sessions amendment, this provision is a health care provision, not a welfare provision. It is whether legal immigrants should get Medicaid benefits. That is all it comes down to.

My view is that it is the right policy. It is not neat and tidy, or perhaps not on the right bill, but it is something that should be done. It is the right thing to do. I urge Senators to not vote in favor of the Sessions amendment.

I yield the remainder of my time.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that we delay the vote so I can do some amendments that have been agreed to—a bipartisan list of amendments—to get them out of the way at this time.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1033, AS MODIFIED

Mr. GRASSLEY. Mr. President, I send a modification of Senator MIKULSKI's amendment to the desk on municipal health services and ask unanimous consent that it be modified.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment (No. 1033), as modified, is as follows:

At the end of title VI, add the following:

SEC. . EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking "December 31, 2004", and inserting "December 31, 2006".

AMENDMENT NO. 1067, AS MODIFIED

Mr. GRASSLEY. Mr. President, I send a modification to Senator LINCOLN's amendment No. 1067 on kidney disease to the desk and ask unanimous consent that it be modified.

The PRESIDING OFFICER. Is there objection?

Without objection, the amendment is so modified.

The amendment (No. 1067), as modified, is as follows:

On page 510, after line 18, add the following:

SEC. . MEDICARE COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C.1395x) is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (U), by striking "and" at the end;

(ii) in subparagraph (V)(iii), by adding "and" at the end; and

(iii) by adding at the end the following new subparagraph:

"(W) kidney disease education services (as defined in subsection (ww));"; and

(B) by adding at the end the following new subsection:

"Kidney Disease Education Services

"(ww)(1) The term 'kidney disease education services' means educational services that are—

"(A) furnished to an individual with kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

"(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

"(C) designed—

"(i) to provide comprehensive information regarding—

"(I) the management of comorbidities;

"(II) the prevention of uremic complications; and

"(III) each option for renal replacement therapy (including peritoneal dialysis, hemodialysis (including vascular access options), and transplantation); and

"(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy.

"(2) The term 'qualified person' means—

"(A) a physician (as described in subsection (r)(1));

"(B) an individual who—

"(i) is—

"(I) a registered nurse;

"(II) a registered dietitian or nutrition professional (as defined in subsection (vv)(2));

"(III) a clinical social worker (as defined in subsection (hh)(1));

"(IV) a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)); or

"(V) a transplant coordinator; and

"(ii) meets such requirements related to experience and other qualifications that the Secretary finds necessary and appropriate for furnishing the services described in paragraph (1); or

"(C) a renal dialysis facility subject to the requirements of section 1881(b)(1) with personnel who—

"(i) provide the services described in paragraph (1); and

"(ii) meet the requirements of subparagraph (A) or (B).

"(3) The Secretary shall develop the requirements under paragraph (2)(B)(ii) after consulting with physicians, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons.

"(4) In promulgating regulations to carry out this subsection, the Secretary shall ensure that such regulations ensure that each beneficiary who is entitled to kidney disease education services under this title receives such services in a timely manner that ensures that the beneficiary receives the maximum benefit of those services.

"(5) The Secretary shall monitor the implementation of this subsection to ensure that beneficiaries who are eligible for kidney disease education services receive such services in the manner described in paragraph (4).".

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting ", (2)(W)", after "(2)(S)".

(3) PAYMENT TO RENAL DIALYSIS FACILITIES.—Section 1881(b) of such Act (42 U.S.C. 1395rr(b)), as amended by section 433(b)(5), is further amended by adding at the end the following new paragraph:

"(13) For purposes of paragraph (7), the single composite weighted formulas determined under such paragraph shall not take into account the amount of payment for kidney disease education services (as defined in section 1861(ww)). Instead, payment for such services shall be made to the renal dialysis facility on an assignment-related basis under section 1848.".

(4) ANNUAL REPORT TO CONGRESS.—Not later than April 1, 2004, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the number of medicare beneficiaries who are entitled to kidney disease education services (as defined in section 1861(ww) of the Social Security Act, as added by paragraph (1)) under title XVIII of such Act and who receive such services, together with such recommendations for legislative and administrative action as the Secretary determines to be appropriate to fulfill the legislative intent that resulted in the enactment of that subsection.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

AMENDMENTS NOS. 1014, 1015, 1059, 1106, 1086, 1067, 1033, 935, 959, 1038, 1095, EN BLOC

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside and that the following amendments be called up en bloc: No. 1014, by Senator BOND, study of pharmacy services; No. 1015, by Senator DODD, study of blind and disabled; No. 1059, by Senator HATCH, HHS review; No. 1106, by Senator HATCH, citizens councils; No. 1086, by Senator MURKOWSKI, pharmacy access; No. 1067, by Senator LINCOLN, kidney disease; No. 1033, by Senator MIKULSKI, municipal health services; No. 935, by Senator LINCOLN, geriatric GME; No. 959, by Senator LINCOLN, physical therapy demo; No. 1038, by Senator JEFFORDS, critical access hospital; No. 1095, by Senator JOHNSON, therapy management.

I further ask unanimous consent that these amendments be agreed to en bloc and the motion to reconsider be laid upon the table en bloc.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendments were agreed to.

VOTE ON AMENDMENT NO. 1011

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to the Sessions amendment No. 1011.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the following two votes be 10-minute votes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER (Mr. CORNYN). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 33, nays 65, as follows:

[Rollcall Vote No. 256 Leg.]

YEAS—33

Allard
Allen
Bennett
Bunning
Burns
Byrd
Campbell
Chambliss
Cornyn
Craig
Crapo
Dole
Ensign
Enzi
Frist
Graham (SC)
Gregg
Hagel
Hatch
Hutchison
Inhofe
Kyl
Lott
McConnell
Murkowski
Nickles
Santorum
Sessions
Shelby
Stevens
Sununu
Talent
Thomas

NAYS—65

Akaka
Alexander
Baucus
Bayh
Biden
Bingaman
Bond
Boxer
Breaux
Brownback
Cantwell
Carper
Chafee
Clinton
Cochran
Coleman
Collins
Conrad
Corzine
Daschle
Dayton
DeWine
Dodd
Domenici
Dorgan
Durbin
Edwards
Feingold
Feinstein
Fitzgerald
Graham (FL)
Grassley
Harkin
Hollings
Inouye
Jeffords
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Lugar
McCain
Mikulski
Miller
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Roberts
Rockefeller
Sarbanes
Schumer
Smith
Snowe
Specter
Stabenow
Voinovich
Warner
Wyden

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1011) was rejected.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. GRAHAM of Florida. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT 975, AS MODIFIED

The PRESIDING OFFICER. There are now 2 minutes evenly divided prior to the next vote.

Mr. ROCKEFELLER. Mr. President, this next amendment has to do with dual eligibility. Never in the history of Medicare have we precluded Medicare beneficiaries from being Medicare beneficiaries. In the underlying bill, for the very first time, we do.

The people I refer to are called dual eligibles. Their average income is $6,500 a year. They tend to be over 85, single women, and very sick. They are on Medicaid. Medicaid, however, is optional according to the States. We know the States to be broke. The fastest growing expense they face is Medicaid. So they are cutting the benefits. They are cutting Medicaid. They will continue to do that. The States have no choice but to cut Medicaid. Some will do it because they wish to, all will do it because they have to.

When that possibility is gone, there is no place for these poorest of the poor to go. They are then, under the underlying bill, precluded from being Medicare beneficiaries. That is wrong. In my budget-neutral amendment I attempt to fix it. I hope my colleagues will support the amendment.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Two things for my colleagues to consider during the consideration of how to vote on this amendment: No. 1 is the money that is available to pay for his amendment, an offset, is the very same amount of money we, Senator BAUCUS and I, are using to offset the cost of a lot of demonstration projects that colleagues have asked us to do, a lot of minor amendments they have asked us to do. If that money is not there, there cannot be consideration given. That is not a threat; it is just a practical aspect of how the budget law works.

Secondly, remember, these dual eligibles are being taken care of very well in our underlying legislation. The point being, they will not be taken care of better. It is just it is going to cost the Federal Government more.

I hope you will take those things into consideration and vote down this amendment.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to amendment No. 975, as modified. The clerk will call the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 47, nays 51, as follows:

[Rollcall Vote No. 257 Leg.]

YEAS—47

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Collins
Conrad
Corzine
Daschle
Dayton
DeWine
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Snowe
Specter
Stabenow
Voinovich
Wyden

NAYS—51

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chafee
Chambliss
Cochran
Coleman
Cornyn
Craig
Crapo
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Stevens
Sununu
Talent
Thomas
Warner

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 975), as modified, was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. CRAIG. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1066

The PRESIDING OFFICER. There are now 2 minutes equally divided on the Bingaman amendment.

Mr. BINGAMAN. Mr. President, the bill before us has, in my view, a significant flaw in it. We are holding out this prescription drug benefit. But the bill we are considering here says if you want to take advantage of the benefit, you are thereby prohibited from buying any supplemental insurance to cover prescription drugs. Today, people are able to buy Medigap policies that cover prescription drugs. In the future they will not be able to, if this bill becomes law as it is.

My amendment would merely give people the option of buying a prescription drug supplemental policy if they chose to do so. It directs that two policies be developed that would accomplish that.

It is supported by the insurance industry. It is supported by the Consumers Union. Seniors would like to have this opportunity to reduce their risk of substantial out-of-pocket costs.

We ought to provide this benefit.

Mr. GRASSLEY. Mr. President, first of all, let me make very clear that we know that Medigap is very important as part of Medicare. We leave that untouched as it relates to 1965 model Medicare. In fact, many of my Iowa constituents want to keep that. But we as a policy matter have made it a very conscious choice to prevent the sale of wraparound Medigap plans for the new Part D drug benefit. This policy makes sense considering drug plans could be different everywhere else in the United States.

It is impossible to standardize Medigap policies like we did about 15 years ago so that seniors don't get ripped off. But the Congressional Budget Office tells us this new Medigap plan that is before us now will increase the cost of our bill. The cost of this amendment is $1.5 billion over 10 years, according to the Congressional Budget Office. That is because of the increased utilization that comes from having additional insurance.

I share the Senator's concern with gaps in coverage. I wish we didn't have any.

But we believe participating drug plans—especially drug plans delivered by PPOs—will offer benefits in a comprehensive fashion, lessening the need for expensive supplemental policies.

I urge my colleagues to reject this amendment.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER (Mr. CHAMBLISS). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 43, nays 55, as follows:

[Rollcall Vote No. 258 Leg.]

YEAS—43

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Clinton
Collins
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—55

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chafee
Chambliss
Cochran
Coleman
Cornyn
Craig
Crapo
DeWine
Dole
Domenici
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Inhofe
Jeffords
Kyl
Lincoln
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1066) was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, very briefly, it is almost 6:25, and we have just completed our 12th rollcall vote. We still have a fair amount of work to do. But in discussion with the managers of the bill and the Democratic leader, it is our intent to finish this bill tonight. I optimistically think we can finish in 2 or 3 hours, or this bill can go until midnight, or 1, or 2, or 3 in the morning.

Part of the problem we are having now is that people are still coming up and submitting amendments, and because we have been working in good faith over the last 2 weeks in the amendment process, we have not set strict filing deadlines.

Now that we are in the last several hours of consideration, I want to make the case and, in fact, plead with my colleagues that any amendments that need to be considered—let us hear about them. Let the managers hear about them in the next 15 minutes. That is the only way we can get a list to deal with them, and we will have rollcall votes on those that are necessary.

There will be a certain number of those amendments looked at by the managers. The ones I encourage you to bring to them for consideration to be accepted need to be budget neutral and have bipartisan support, and they need to be scored by the CBO. People keep bringing amendments forward now. I will ask—and then I want the Democratic leader to comment—that people, in the next 15 minutes or so, make sure the managers have the amendments. That way we can move ahead. We will finish tonight.

The PRESIDING OFFICER. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I hope we can do as the majority leader has suggested. We have had a good debate. I think this has been an excellent debate. The managers deserve credit for the way they have managed the legislation. We have had 12 rollcall votes today already. It is likely that we will have 16 or 17 by the end of the day, if not more; we had 9 yesterday. More than 50 amendments have now been considered.

I think it is time that we bring the debate to a close. There will be many more opportunities to talk about prescription drugs and health care with the array of legislative challenges that we face relating to health. I think we have been able to do a good deal, and I hope we can get cooperation now on both sides of the aisle. I hope the majority leader will hold to the commitment that we finish tonight. That would accommodate people's travel schedules tomorrow.

If we are going to do that—it is now 6:30—over the course of the next 4 or 5 hours, we have a lot of work to do even with what we know we have to vote on. I hope everybody will cooperate so we can minimize the time required to consider amendments. I hope those who may have remarks to make will perhaps hold off until after final passage and make those remarks after final passage. That would accommodate our time as well.

We will work with the majority leader to see if we can accomplish the schedule he has laid out. I hope we can do so well before the bewitching hour.

I yield the floor.

Mr. FRIST. Mr. President, when we finish this bill tonight, my expectation would be that we would not have votes tomorrow. That is assuming we are going to finish. I encourage anyone who has an amendment that needs to be considered to get it to the managers within the next 15 minutes. If we can do that, we can finish tonight and we will be able to consider each of those amendments, as the Democratic leader said.

I know some people want to talk for an hour but I ask Senators to keep their comments to a few minutes and we can vote throughout the night. We will have the opportunity after final passage tonight, or through tomorrow, to make statements—for those who wish to continue the debate.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, I rise to address this bill. I had hoped to do it earlier in the day but, unfortunately, the managers of the bill were unable to work the time in. I certainly regret taking time out of the schedule, which is obviously crowded. I do think it is important to speak up on the issue of this piece of legislation.

This is the most significant piece of spending legislation, and maybe even public policy legislation, outside of an international issue, that I expect I will vote on in my tenure in the Senate. Ironically, when I ran for this job, after serving as Governor of New Hampshire, one of the reasons I sought the job and one of the reasons I wanted to pursue a term in the Senate was that I was concerned about entitlement spending. In fact, during my first few years, I aggressively pursued setting up an entitlement commission to address entitlement spending, which I sponsored with Senator Kempthorne, who came in with me that year, and Senator Coverdell and Senator BENNETT, all of whom came in the year I was elected, in a bill to end unfunded mandates, many of which were entitlement oriented.

I tried to lead an effort in passing legislation to address reform of the Social Security system. I consider that to be a huge entitlement that we confront. My basic reason for seeking entitlement reform and responsibility was that I was concerned that it not only is what is driving the deficits of our country—which they continue to do—but, more importantly, as the demographics shifted in the Nation and we saw the baby boom generation, which represents a huge population, moving toward retirement, we, as a nation, were going to be placing on our children and our children's children an inordinate burden in the area of taxes in order to support the older generation—my generation—which would be retiring. It is because all the major programs, whether they are Social Security or Medicare, are built on the theory that there is a pyramid out there, that there will always be more people working and a lot more people working than those people who are taking their retirement benefits out of the system. That, of course, is the way it began.

Back in 1950, there were 12.5 people working for every person who retired under Social Security. Today, we are down to 3.5 people working for every 1 person retired on Social Security and under Medicare, and that is stressing the system.

Unfortunately, when we hit the retirement situation for the baby boom generation, the largest generation in the history of our Nation, the generation born between 1946 and 1955, we go down to two people working for every one person retired. We go from a pyramid to basically a rectangle, and the result is that we will end up putting an inordinate amount of stress on those people who are working to support those folks who are retired. So we need to address thoughtfully any entitlement expansion, to say nothing of the entitlements that are already on the books.

That is what brings me to the Chamber today to address this legislation because I believe very strongly that needy senior citizens should have a drug benefit. Clearly, prescription drugs have become the new way to treat disease and maintain public health in our Nation. We have been able to move from a system where you had to have invasive activity in the health care system, where you had to go through surgery, to a system where people can, as result of the keen use of our scientific community, take a pharmaceutical and actually have a better life than if they were to go under the knife, have surgery.

This is a revolution, and it is a revolution that is exploding and growing. Biotech activity, the nanotech activity, is only going to lead to more and more and better and better pharmaceuticals coming on the market to help people with their health.

It is absolutely unfair, in my opinion, that people who are in a low-income situation, especially retired people who are on a fixed low income, have to choose between their food and their housing and maybe their pharmaceuticals. That is not right in our society, and we can certainly afford to have that addressed.

It was my hope as we brought forward a pharmaceutical drug benefit for senior citizens that we would do it in a way that would address low-income seniors. Equally important, it is important that a middle-income senior should not have to spend all their assets for health care as a result of pharmaceutical costs. After a certain amount of spending, there should be catastrophic coverage that kicks in, relieving that person of the full responsibility or a large portion of their responsibility for the pharmaceutical cost. That is the type of structure at which we should be looking.

Putting in place this brand new drug benefit, we also have to look at the underlying Medicare system which we all know is fundamentally broken as we look out into the future. When the baby boom generation hits, it simply is not going to work. It is not going to support that generation. That is because it is a 1959 design, an automobile built in the fifties driving on the highways of the year 2000 which, when it gets to 2015, is going to be too old to function effectively. It needs to have put in place forces which are going to cause it to be more efficient, to be more effective in addressing a person's approach to their health care. Those forces have to be basically marketplace oriented. They cannot be price-control oriented.

My hope, my goal, my belief was that we would create a drug benefit that would help low-income seniors and, at the same time, give catastrophic coverage, and that would, fundamentally, reform the Medicare system so that we would end up with a more market-oriented system, something that was going to contain costs as we moved into the outyears.

What did we get? What is before us today? Essentially, what we have before us today is a drug benefit that will plant a fiscal disease that will afflict our children and our children's children. It is a drug benefit that is going to put in place a fiscal disease that will afflict our children for the next 75 years. By afflict them, I mean that our children and our children's children, under the benefit in this bill, are going to have to pay $6 trillion. That is the estimate. That may be the high end. It is somewhere between $4.6 trillion and $6 trillion. When you get into those numbers, it is pretty hard to get very definitive.

That is the burden this drug benefit in this bill puts on our children and our children's children to support my generation which is going to retire and take advantage of it.

That is a huge problem because what we are essentially saying to the person who is working in a restaurant or working in a garage or working on a computer line or working as a sales person, who is young and trying to raise a family, is that they are going to have to pay an inordinate amount of tax burden to support people who are retired with this drug benefit.

That would not be so bad if the drug benefit was not an income transfer from that person working in that garage, working in that restaurant, or working on that computer line to somebody who is a great deal wealthier than they are potentially. That would not be so bad if it was a transfer from that person to people who are low income or whose assets are about to be wiped out because of a drug expenditure.

That is not the way this bill works. The way this bill works is essentially to nationalize the entire drug delivery service for senior citizens to take all the present programs which presently benefit senior citizens for drug benefits—and there are a lot of them; there are a lot of seniors in this country today who already have a drug benefit; something like 76 percent is the estimate—to take a large percentage of those people and move them from their private programs to the public programs.

If you retired from a major corporation or even a smaller corporation in this country, it is very likely that in your retirement package, depending on how aggressive your union was or how successful your company was, you received a drug benefit during your retirement. But when this bill passes, the incentive is going to be to take that drug benefit which presently exists in the private sector under some sort of contractual agreement which you had when you retired and move it out of the private sector and throw it on the taxpayers of America.

Who are those taxpayers going to be? They are going to be our children and our children's children, people who are working for a living, trying to buy their kids a better education, a better home, better food, or even just a nice car or a night out at the movies. Their ability to do that is going to be undermined if this bill goes forward in its present form because so much will have to flow back to benefit people who already have the benefit in the private sector and are now going to be migrated over to the public sector.

Mr. President, $4.5 trillion to $6 trillion is a huge amount of money, a huge burden to put on our children. It is hard to put it in terms that are realistic and are visible when we are talking those type of dollars, but every American child born tonight—and there are a lot of kids being born tonight in America—starts out with a $44,000 debt they have to pay for Medicare for my retirement, for the retirement of everybody in this room, for the retirement of most of the people who are watching who are over the age of 45. They start out with a $44,000 debt.

When this bill passes, they will have another $12,000 to $15,000 added to that debt. So before they get through the first night of their life, as a result of this legislation they are going to owe $60,000. It is not fair. It is not right. We are not doing it the correct way.

There are ways to do this where the system is not nationalized, where all the people who already have a drug benefit are told there is no incentive for them to keep it.

We do not say in the private sector to the people who bought Medigap, to the people who have reached contractual agreements in retirement, to the people who have retained retirement coverage through the private sector, that there is no advantage to them keeping their program or, alternatively, the people who are giving them that program saying they are not going to give it to them anymore, and move those folks onto the public dole, onto the public system. It makes no sense.

Then there is the issue of the underlying question of Medicare. Not only is the drug benefit in this bill fundamentally flawed because it migrates huge numbers of people off the private sector and into the public sector, but the underlying purpose of the Medicare effort in this bill is flawed. If we are going to put in place this huge new benefit for seniors, and especially if it is going to be as grand and as pervasive, where we are basically saying to all seniors that they get a benefit here, no matter what their income is—if that is going to be put in place, that ought to at least be coupled with some sort of reform of the underlying Medicare system to try to bring under control those costs which are driving the outyear liability, which will be the tax burden for our children and their children.

The estimated outyear cost of Medicare that is unfunded is $13.3 trillion. When the baby-boom generation starts to hit the system in 2008, that is when it really starts to crank up, by the year 2020, 2025, when there will be large retirement populations as a result of this demographic shift, $13.3 trillion of unfunded liability.

Unfunded means it is just there. We have to pay it, but nobody has an idea of how they are going to do it. There is no trust fund for it. There is no money out there to do it. So the only way it is going to be done is to raise taxes or to cut the benefit, which is politically probably impossible, so to raise taxes on the young people who are working.

There is a third way, however, to do it, and that is to make Medicare a more cost-sensitive, more thoughtful, more efficient system for delivery of health care. Regrettably, under this bill that does not happen. There is a representation that that might happen, something called a PPO, which is supposedly going to create an opportunity for the private sector to come in and compete with the traditional Medicare system. The price control system will have a chance to compete with a marketplace system. That is the thematic statement of the bill. Unfortunately, it is illusory. It will not happen under the bill. CBO says maybe 2 percent of the people will migrate, will move over, to a PPO system. The administration says it is 48 percent. Logic tells us it is not going to fly, because the bill has been structured to defeat the probability a PPO, a marketplace system, will be allowed to work. All the little gimmicks in this bill are aimed at essentially undermining that.

Classic was the amendment that we passed earlier, which had been so gerrymandered, which was an effort by Senator KYL. So what are we told? Well, even though the bill has these fundamental flaws of having a drug benefit that migrates a large number of people out of the private sector into the public sector and essentially causes low-income working Americans who are young to have to support middle-income Americans who are retired and who had a private sector benefit, and even though the bill has this illusory marketplace representation, basically no real reform of Medicare, we are told we should vote for it because it is going to be improved in conference. At least that is what we are being told on our side of the aisle. I do not know what is being said on the other side of the aisle. Maybe they are not getting that same message. We are being told that by the administration.

The problem is, we are betting on the come. I mean, this is $6 trillion of unfunded liability we are talking about passing on to our kids. It is massive. If this bill were to pass in its present form, or anything near to its present form, it would fundamentally extinguish the torch which the Republican Party has allegedly—and I thought pretty effectively—carried for years which was the torch of spending responsibility.

That is why I came here, as I said when I began my statement. I came to try to do something about controlling the rate of growth of spending in the Federal Government, especially in the area of entitlements. I was told by one of the finest legislators I have ever met in my experience in 20 years in Government—a man named Barber Conable—one time on the floor of the House when I was mumbling about the fact that some bill was coming through that was a little expensive, you have to understand, JUDD, all Government moves to the left, and it is just a question of how many engines are on that train—think of it as a train—as it moves to the left, and our job as fiscal conservatives is to limit the number of engines that go on that train.

This bill, if it passes in its present form, is going to be all engine, and it is going to undermine our capacity to assure our children they have the opportunity to have the type of lifestyle which we have, because it is going to put a huge and unfair tax burden on them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. Mr. President, this morning one of the very able legislative assistants who has worked on this legislation for almost 7 years, going back to the time on the Medicare Commission when we first started doing Medicare reform, was on the floor working with me on amendments in this legislation. She had to temporarily leave because at 5:47 this afternoon she had a little baby girl. That is a very good excuse to not be on the Senate floor. But my legislative director, Sarah Walter, is doing fine. It is a baby girl. The name is yet to be determined, but I wanted to bring that to the attention of my colleagues and all of her colleagues on the professional staff.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho.

AMENDMENT NO. 1087 WITHDRAWN

Mr. CRAIG. Mr. President, this afternoon I will speak to amendment 1087. That amendment was pulled up last night by the manager of the bill, Senator GRASSLEY. I believe that amendment is at the desk.

The PRESIDING OFFICER. The Senator is correct. The amendment has been called up and is pending.

Mr. CRAIG. Mr. President, it is my intent within a few moments to withdraw this amendment, but I thought I should speak to it tonight because I am disappointed at this time that we could not get the scoring from CBO we felt would produce a revenue-neutral bill, or a cost-neutral bill, going into the final hours of this debate.

This is an amendment that produces in this legislation, and hopefully to take up in conference, a consumer-driven health care plan under the new MedicareAdvantage program all of us are talking about at this moment. The Senator from New Hampshire gave a very impassioned speech from the depths of his heart, frustrated that this bill does not balance out and provide enough of the incentives in the market that will offset and create the kind of competitive forces being designed for Medicare with the extension of prescription drugs in it offers.

For a few moments tonight, I did want to speak about that and explain it. As we get into conference with the House, the House has a consumer-driven health care concept within their legislation that is critical. It is something we ought to address.

First, the amendment before the Senate is designed to dovetail with and not disturb the overall MedicareAdvantage competitive dynamic. As a complement to MedicareAdvantage, consumer-driven health care plans would be subject to the same competitive rules as preferred provider organizations.

Second, I emphasize this amendment is carefully crafted. We thought it would ensure budget neutrality. But CBO says tonight, no, and I am not going to be too critical of them; we pushed them very hard in the last good number of days to quickly analyze and bring forth estimates. I think they are simply swamped. We will continue to work with them. We believe what we are offering is budget neutral.

Additionally, the Finance Committee chairman, the majority leader, and the White House have expressed the kind of support for these concepts in amendments. I appreciate it. As everyone begins to examine this structure, they become increasingly enthusiastic that this could become a component of the MedicareAdvantage Program.

For the benefit of my colleagues, let me describe for a moment the key features of this amendment. The amendment establishes a new category of competition within Medicare Advantage designed to encourage participation by consumer-driven health plans. These plans would be subject to the same requirements of PPOs in MedicareAdvantage, including prescription drug benefits and risk adjustment parameters.

Consumer-driven health care is one of the fastest growing innovations emerging in the employer health insurance market. Already 1.5 million Americans are estimated to be in consumer-driven health care in the summer of 2002, and that number is now growing very rapidly.

What is the consumer-driven health care? It harnesses market forces in ways similar to medical savings accounts. However, there are some differences between medical savings accounts and consumer-driven health care plans. For example, enrollees in consumer-driven health care do not have to make contributions to the account. In the private sector, the employer or in my amendment if it were to pass, Medicare makes the contribution to the personal care account. There would be no tax consequence for the senior under this amendment. In other words, it would not be viewed as income. Some in Congress might be familiar with the account because the American Postal Workers Union of the AFL–CIO consumer-driven health care plan is now available. It is in that bundle of choices that Federal employees have today to choose from. More and more employees are signing up for this concept.

This is what the union Web site states: We believe that people who have more control over how their health care dollars are spent are more satisfied consumers and the APWU health plan consumer-driven option is designed to give that kind of control.

It is the very thing the Senator from New Hampshire was talking about. It is what we ought to be striving for to balance off the differences and to create the competitive forces within the MedicareAdvantage program.

Benefits make sense in consumer-driven health care plans. I draw your attention to my chart. My amendment is designed to encourage market flexibility. The information on this chart is one example of what consumer-driven health care plans can provide. Web site education and decision support is one example. In other words, you can go to the Web site, look at it, make choices and decisions based on the best available information. 100-percent preventive care coverage—the very kind of thing we want in modern medicine today. Preventive benefits keep healthy people healthy instead of making the repairs after the human body breaks down.

There are no more barriers to necessary care, including annual physicals, mammograms, and preventive services. All are within this kind of health care plan. All are available today offered by the postal workers.

Patient control of personal care accounts for routine health care services are also included. Unused funds in these accounts then roll over into the next year.

High deductibles, that is true insurance, to protect against financial ruin in an acute health care crisis, in other words, catastrophic coverage.

A limit on annual out-of-pocket spending is an especially important feature. Traditional Medicare does not have an out-of-pocket limit and drives many seniors into bankruptcy. In other words, it limits financial risk when it kicks in at a certain point.

It includes care coordination, disease management, and provider network discounts. Consumer-driven health care gives control of health care back to patients. That is why more and more are enrolling in it. We know today, many who work in the health care area with our seniors know they look at the details of their spending; they look at the billing; they know more about their health care and what is being charged than most people realize. Patients and their physicians, ultimately, with this kind of insurance, join in partnerships to seek the finest care at the most reasonable costs.

Consumer-driven care is especially suited for patients who like to be personally involved in their health care decisions. More and more Americans who can use the necessary information want that kind of personal involvement.

Consumer-driven care eliminates wasteful Medicare spending, it increases patient awareness of health care costs, and encourages prudent purchasing of health care services. Any unspent funds in the personal care account would be returned to the Medicare trust fund upon the death or the disenrollment. That is a key factor. Federal dollars go into the trust fund and, if there are dollars remaining, they flow back into the trust fund of Medicare upon disenrollment or the death of the individual.

This amendment would be an important addition to the bill. I wish we could get it into the bill tonight. But it would be unfair to the manager of the bill at this time because it cannot get scored. I would not want to drive the cost up of the already-fixed segment of the MedicareAdvantage side. Already, it is less competitive than we would like it to be. I don't want to add to that disadvantage.

We believe ultimately that this will be a budget-neutral program. At that time, it will be the right thing to offer as part of the dynamics that we want to see in a modern health care delivery system and in an improved Medicare with a prescription drug program.

I thank my colleagues for listening. We will return with this when it is a final product. It may well make it into the conference between the House and the Senate. We will be working with our colleagues in the House because they have already provided that kind of a provision within the legislation which they are currently debating and voting upon.

With that, I ask unanimous consent to withdraw amendment No. 1086.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 1086) was withdrawn.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Since Medicare was established in 1965, people are living longer and living better. Today Medicare covers more than 40 million Americans, including 35 million over the age of 65 and nearly 6 million younger adults with permanent disabilities.

Congress now has the opportunity to modernize this important Federal entity to create a 21st century Medicare Program that offers comprehensive coverage for pharmaceutical drugs and improves the Medicare delivery system.

The proposal before the Senate would make available a voluntary Medicare prescription drug plan for all seniors. If enacted, Medicare beneficiaries have access to a discount card for prescription drug purchases starting in 2004. Projected savings from cards for consumers would range between 10 to 25 percent. A $600 subsidy would be applied to the card, offering additional assistance for low-income beneficiaries defined as 160 percent or below the Federal poverty level. Effective January 1, 2006, a new optional Medicare prescription drug benefit would be established under Medicare Part D.

This bill has the potential to make a dramatic difference for millions of Americans living with lower incomes and chronic health care needs. Low-income Medicare beneficiaries, who make up 44 percent of all Medicare beneficiaries, would be provided with prescription drug coverage with minimal out-of-pocket costs. For these seniors, copayments would not exceed 20 percent of the cost of the drugs.

For medical services, Medicare beneficiaries will have the freedom to remain in traditional fee-for-service Medicare for drug coverage, or to enroll in Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), also called MedicareAdvantage, which offers beneficiaries a wide choice of health care providers, while also coordinating health care effectively, especially for those with multiple chronic conditions. MedicareAdvantage health plans would be required to offer at least the standard drug benefit, available through traditional fee-for-service Medicare.

The legislation which is pending has been worked on, now, for many years. I congratulate the chairman of the committee, Senator GRASSLEY, and the ranking member, Senator BAUCUS, for the outstanding work which they have done. This is an extraordinarily complex subject, and it is a very complex bill.

We already know that there are many criticisms directed to this bill at various levels. Many would like to see the prescription drug program cover all of the costs without deductibles and without copays. There has been allocated in our budget plan $400 billion for prescription drug coverage. That is, obviously, a very substantial sum of money. There are a variety of formulas which could be worked out to utilize this funding. The current plan, depending upon levels of income, provides a deductible, then a copay, then what is called a donut hole where the recipient pays the entire costs of their drug coverage, and when it gets to a certain high level, it is catastrophic and there is coverage that pays almost all of it.

As I have reviewed these projections and these analyses, it is hard to say where the line ought to be drawn. It is a value judgment as to what deductibles ought to be, and for whom, and what the copays ought to be and for whom. I am seriously troubled by the so-called donut hole. But it is calculated to encourage people to take the medical care they really need, and at lower levels of income to have certain copays, which it is projected will be affordable. Then, when the costs move into the so-called catastrophic range, to have the plan pay for nearly all of the medical costs.

I think passage by the Senate would be a significant step forward. The House of Representatives, as usual, has a different plan—as is customary, with our bicameral legislative approach. Then the bill can be improved in conference.

The legislative process has the committee turning out a bill, and then many amendments, which generally are not known to Members in advance of brief debate and then votes. It is in the conference, after the bill is analyzed, that another fresh look is taken at the bill to produce the best legislative product in the public interest.

AMENDMENT NO. 983

I have already offered an amendment relating to end of life directives, number 983, which was adopted by unanimous consent.

Commenting on it very briefly, we find statistically that nearly 30 percent of Medicare expenditures occur during a person's last year of life. We find, beyond the last year of life, a tremendous percentage of medical costs occur in the last month, in the last few weeks, in the last week, or in the last few days.

Nobody should decide for anybody else what that person should have by way of end-of-life medical care. What care ought to be available is a very personal decision.

The living wills would give an individual an opportunity to make that judgment, to make a decision as to how much care he or she wanted near the end of his or her life and that is, to repeat, a matter highly personalized for the individual.

But if that decision was made to eliminate some of the very high costs at the very end of life, there would obviously be substantial savings to our medical system. As long as that comports with the will of the individual, that is something which ought to be considered.

The amendment directs the Secretary of Health and Human Services to include in its annual "Medicare And You" handbook, to be provided to each beneficiary, a section that specifies information on advanced directives and details on living wills, durable powers of attorney for health care, and directs the Secretary of HHS, in the introductory letter to the "Medicare And You" handbook, to reference the inclusion of advanced directives.

AMENDMENT NO. 1085

I have also submitted an amendment which is pending at the desk, amendment No. 1085, which has not yet been acted upon but which I will call up at an appropriate time.

This is an amendment which would update the Medicare physician fee formula. It is a sense-of-the-Senate resolution. The projections from the Medicare payment formula called for a 4.4-percent reduction on March 1, which would have been very problematic. The fact is, the Center for Medicare and Medicaid Services, CMS, now projects a Medicare conversion factor figure of 4.2 percent will be projected for the year 2004. This reduction threatens to destabilize an important element of the Medicare Program; namely, physician participation and willingness to accept Medicare payments. This instability is a result of the sustainable growth rate, a system of annual spending which targets physicians' services under Medicare.

This sense-of-the-Senate amendment would provide that the conferees on Medicare reform and prescription drug legislation should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years, and should consider adding provisions which would mitigate the swings in payment, such as establishing multiyear adjustments to recoup the variance and creating tolerance corridors for variations around the updated target trend.

AMENDMENT NO. 1118

I have also submitted an amendment designated as amendment No. 1118, which provides for a lifestyle modification program demonstration. This is projected on the factor that heart disease kills some 500,000 Americans each year. The costs of coronary disease currently relate to an expenditure of some $58 billion annually. There has been a test program of the Medicare lifestyle modification program operating in some 12 States which has been demonstrated to reduce the need for coronary procedures by 88 percent. This program could reduce cardiovascular expenditures by as much as $36 billion annually.

Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater. This program has also been applied to men with prostate cancer, who have shown significant improvements in prostate cancer markers using a similar approach in lifestyle modifications. My amendment expresses the sense of the Senate that the Secretary of Health and Human Services should carry out the lifestyle modification program demonstration at the national level and then provide it on a permanent basis, and include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis.

I have submitted one additional amendment, which is No. 1128 and which relates to State pharmaceutical assistance programs for the elderly and disabled. Currently, 18 States have comprehensive pharmacy assistance programs which provide prescription drug coverage for more than 1.1 million older and disabled Americans.

In my own State, Pennsylvania's Pharmaceutical Assistance Contract for the Elderly, known as PACE, established in 1984 provides prescription drug coverage to 230,000 Medicare beneficiaries, the vast majority of whom have incomes below 160 percent of the Federal poverty level. This enrollment is comprised largely of 70- and 80-year-old widows who have multiple diseases and limited educational background who have been enrolled in the PACE program for more than a decade.

There is a serious concern that if there is not a coordinated program, people will not be informed as to how to move from PACE to another program. This affects not only Pennsylvania but, as I stated, 17 other States.

The pending bill does not provide for coordination of benefits between State pharmaceutical programs and private insurers. Without a coordination of benefits for State plans to facilitate enrollment in private plans, many of these State program beneficiaries will be unable to assess the new Medicare drug benefit.

This amendment provides for coordination of benefits between States and private insurance companies and facilitates the enrollment of State pharmacy assistance beneficiaries in the private plans. Without this amendment, the majority of seniors enrolled in their State pharmacy programs will not be able to effectively access private plans.

I note the presence of other Senators who are seeking recognition. I attempted to be brief in my general statement about the bill and also in my descriptions of these four amendments, one of which has already been adopted.

I ask unanimous consent that at the conclusion of my remarks, there be printed in the RECORD a summary of the end-of-life directive amendment, a summary of the updating of the Medicare physician fee formula, a summary of the lifestyle modification program, and a summary of the State pharmaceutical assistance programs for the elderly and disabled, and also printed in the RECORD at this point the amendments themselves.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SUMMARY ON THE END OF LIFE DIRECTIVE AMENDMENT

The purpose of this amendment is to make it easier for individuals to make their own choices regarding their treatment when nearing the end of their life.

A health care advance directive is a document where a beneficiary gives instructions about their health care if, in the future, that beneficiary cannot speak for him or herself. The beneficiary can give someone they name ("agent" or "proxy") the power to make health care decisions on their behalf. They may also give instructions about the kind of health care they do or do not want.

In a traditional Living Will, a beneficiary would state their wishes about life-sustaining medical treatments if he or she is terminally ill. In a Health Care Power of Attorney, one appoints someone else to make medical treatment decisions for the beneficiary if they cannot make them on their own.

Unlike most Living Wills, a Health Care Advance Directive is not limited to cases of terminal illness. If the beneficiary cannot make or communicate decisions because of a temporary or permanent illness or injury, a Health Care Advance Directive helps them keep control over important health care decisions.

Observers have long noted that individuals incur the majority of health care costs in the last few months of life. Nearly 30 percent of Medicare expenditures occur during a person's last year of life.

Your amendment directs the Secretary of HHS to include in its annual "Medicare and You" handbook, which is provided to each beneficiary, a section that provides information on advanced directives and details on living wills and durable power of attorney for health care; and directs the Secretary of HHS, in the introductory letter to the "Medicare and You" handbook, to reference the inclusion of advanced directives information.

SUMMARY ON THE AMENDMENT TO UPDATE THE MEDICARE PHYSICIAN FEE FORMULA

Earlier this year, Congress passed legislation as part of the Fiscal Year 2003 Omnibus Appropriations bill (H.J. Res. 2) that avoided an impending 4.4 percent cut in the Medicare conversion factor. Although this change resulted in a welcomed 1.6 percent increase in the Medicare conversion factor for 2003, the Centers for Medicare and Medicaid Services' (CMS) preliminary Medicare conversion factor figure predicts a 4.2 percent reduction for 2004.

It is clear that this scheduled 4.2 percent reduction in the physician reimbursement formula threatens to destabilize an important element of the Medicare program, namely physician participation and willingness to accept Medicare patients.

The primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare.

The sustainable growth rate (SGR) system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for the immediate recoupment of the difference.

Both administrative and legislative action are needed to return stability to the Medicare physician payment system.

In its March 2003 report, the Medicare Payment Advisory Commission (MedPAC) stated that if "Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary in 2004."

With 17 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania's physicians have already suffered a $128.6 million loss, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $553 million or $17,396 per physician for the period 2003–2005.

Your amendment expresses the sense of the Senate that the conferees on Medicare reform and prescription drug legislation should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating "tolerance" corridors for variations around the update target trend.

SUMMARY OF THE AMENDMENT ON THE LIFESTYLE MODIFICATION PROGRAM

Heart disease kills more than 500,000 Americans per year. The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58 billion annually.

The Medicare Lifestyle Modification Program (also known as the Dean Ornish Program for Reversing Heart Disease) has been operating throughout 12 states and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36 billion annually.

Lifestyle choices such as diet and exercise effect heart disease and heart disease outcomes by 50 percent or greater.

Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dieticians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

The National Institutes of Health estimates that 17 million Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

Lifestyle modification programs are superior to medication therapy for treating diabetes. Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification. These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

Your amendment expresses the sense of the Senate that the Secretary of Health and Human Services should carry out the Lifestyle Modification Program Demonstration at the national level on a permanent basis and include as many medicare beneficiaries as would like to participate in the project on a voluntary basis.

SUMMARY OF THE AMENDMENT ON STATE PHARMACEUTICAL ASSISTANCE PROGRAMS FOR THE ELDERLY AND DISABLED

Currently, 18 states have comprehensive pharmacy assistance programs that provide prescription drug coverage to more than 1.1 million older and disabled residents.

The majority of these beneficiaries receive life saving medications to treat high blood pressure, heart disease, arthritis, diabetes, and eye disease.

Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE), established in 1984, provides prescription drug coverage to 230,000 Medicare beneficiaries, the vast majority of whom have incomes below 160% of the federal poverty level. This enrollment is comprised largely of 70 and 80–year-old widows who have multiple disease states, and less than a tenth grade education, and have been enrolled in PACE for more than a decade.

Currently, the pending bill the Senate does not provide for 'coordination of benefits', between state pharmaceutical programs and private insurers. Without a coordination of benefit mandate and a role for the state plans to facilitate enrollment in private plans, many of these state program beneficiaries will not be able to access the new Medicare drug benefit.

This amendment provides for the coordination of benefits between states and private insurance companies, and facilitates the enrollment of state pharmacy assistance beneficiaries into private plans, without this amendment the majority of the seniors enrolled in their state pharmacy programs will not be able to effectively access private plans.

AMENDMENT NO. 983

(Purpose: To provide medicare beneficiaries with information on advance directives)

On page 676, after line 22, insert the following:

SEC. . PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b-2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking "The notice" and inserting "(1) The notice"; and

(3) by adding at the end the following:

"(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

"(B) In this section:

"(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

"(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.".

AMENDMENT NO. ——

(Purpose: To permit existing State pharmaceutical assistance programs to wrap around the coverage provided by Medicare Prescription Drug plans and to facilitate the enrollment of eligible beneficiaries for prescription drug coverage)

On page 133, after line 25, insert the following:

"(3) COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

"(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

"(B) ELECTION.—Under the process established under section 1860D–3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or MedicareAdvantage plan through the existing State pharmaceutical assistance program.

"(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—In this paragraph, the term 'existing State pharmaceutical assistance program' means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004."

AMENDMENT NO. 1085

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS)

estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating "tolerance" corridors for variations around the update target trend.

AMENDMENT NO. ——

(Purpose: To express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries)

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

Mr. SPECTER. I thank the Chair. I yield the floor.

Mr. REID. Mr. President, I ask unanimous consent that the distinguished Senator from West Virginia be recognized to speak on the bill for up to 20 minutes and that following his statement, the Senator from Florida, Mr. GRAHAM, be recognized for 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from West Virginia.

Mr. BYRD. Mr. President, I thank the distinguished Democratic whip for his thoughtfulness and courtesies.

Mr. President, just last month we celebrated Older Americans Month, a time of reflection on the contribution of older Americans to our society—to their families, their communities, and their Nation. For many seniors, these "golden years" are the most valuable time in their lives, a time when they may no longer have the day-to-day aggravations of work, and can concentrate their time and efforts on something else—grandchildren, lifelong passions, learning new skills, acquiring knowledge, or participating in creative endeavors.

But that is not the case for many seniors. In too many instances, seniors who have worked and saved a lifetime find that today's cost of living far exceeds the level they can afford. Despite planning and frugality, today's costs simply have exceeded the means of many older Americans, and they find that the visions of the secure life they had expected post-retirement are now more a nightmare than a dream.

A big part of the problem is the value that our society places on the elderly—it is much too low.

Age discrimination is all too prevalent in the workplace. Long-held stereotypes—that seniors are slow, forgetful, less competent than their younger counterparts—limit opportunities for older workers and prevent businesses from benefiting from well-honed talents. Those stereotypical images are just plain wrong.

To be 65 today is not like it was to be 65 when I was a young man. The idea of pushing senior citizens out of the door to make room for younger workers is, itself, antiquated.

I grew up during the Great Depression when one had to work hard just to get a job and then work even harder to keep it. People of my generation, the generation Tom Brokaw has referred to as "The Greatest Generation"—I kind of like that term, "The Greatest Generation," although I don't quite agree with it.

Seniors in the workforce can be a positive and inspiring force.

The reason I don't agree with it is that I think the greatest generation was that generation that produced the Constitution of the United States and produced this constitutional system of government that we have today. We will talk more about that on a later day.

I grew up during the Great Depression when one had to work hard, as I say, just to get a job and then work harder to keep it. People of my generation, coming from that experience, developed a work ethic which can inspire young people today. Seniors in the workforce can be a positive, inspiring force. Moreover, better health care and healthier lifestyles have extended lifespans and led to a senior population with vigor and vitality.

But when the health of seniors does decline, this Nation does an embarrassingly poor job of dealing with their needs. Child care has become a booming business in this Nation. Millions are spent on bigger, brighter, better child care centers—lively places, filled with happy activities and stimulation. That is as it should be. But when the elderly need daily care, too often they are relegated to dim, overcrowded centers, places that serve as little more than warehouses that provide busy work for the hands, and little to fill the heart and soul.

Inestimable numbers of scam artists focus on the elderly. The offices of Attorney Generals across the nation are besieged with complaints from seniors who were prey for some con artists and ended up losing their life savings. Newspapers carry stories about CEOs of big, once-profitable companies who are awarded big bonuses, while the pensions of loyal retirees are squeezed. When this is how we treat our seniors, something is wrong with America.

Older citizens should rejoice in their long lives, in their collected experiences, and in their accomplishments. But in America today, magazines showcase images of young, vibrant models. Movies and television shows feature youthful actors and actresses. No one wants to be "old" anymore. It has become a tarnished word.

Older citizens today are generally not appreciated as either experienced "elders" or possessors of special wisdom. Older people are respected only to the extent that they remain capable of working, exercising, and taking care of themselves. In American culture, increasing age seems to portend decreasing value as a human being. It should be just the opposite.

How did the American culture develop such blatant disregard and disrespect for the elderly? Well, however we got to such a point, we are definitely here.

Senior citizens need to rise up and make their voices heard or else they will be forgotten, especially when it comes to policy formation that directly affects them, such as Medicare legislation before us today. The Senate is in the midst of an important debate on a major restructuring of Medicare—a debate that will shape the health care choices of millions of our Nation's senior citizen for years to come.

The Medicare program is in desperate need of renovation to meet the needs of today's older citizens living in a new era with dramatic advancements in the delivery of health care. Medicare was designed to provide health care benefits to the most vulnerable segments of the population, the elderly and the disabled.

When I voted, way back in 1965, to establish the Medicare program, pharmaceutical treatments, then more of a footnote in health care, were not nearly as commonly available as they are now. Today, they are a primary form of medical care and often substitute for more costly treatments like hospitalization and surgery.

Today, 40 million Americans rely on Medicare to help provide for their medical needs. With more than one-third of all Medicare beneficiaries lacking insurance coverage for the cost of needed medications, finding affordable prescription drug coverage is a critical issue for our Nation's seniors. Prescription drugs are an essential tool for treating and preventing many acute and chronic conditions, but Medicare fails to cover them on an outpatient basis. Too many seniors and disabled persons in this country, especially those living on fixed incomes, are forced to choose each month between paying for food and paying for shelter, or buying the essential medicines that their doctors have prescribed.

Our Nation's senior citizens are losing their patience. They are losing their dignity. And they are fed up with fast-rising drug costs that they cannot afford. Older citizens should not have to travel in bus loads to Canada and Mexico just to obtain the medications their doctors prescribe. What does it say about this country and its values when we fail to take care of our elderly citizens whose lifetime of work and sacrifice and dedication and industry helped to endow this country with the greatness it now enjoys?

Mr. President, I fear that the legislation before us today is a glaring example of how this Nation shortchanges our senior citizens. We are not taking care of our elderly citizens as they wrestle with the most serious issue in their lives. We are offering a partial fix to assuage senior anger. This bill fails to go far enough to meet the needs of our Nation's senior citizens. I am concerned that this measure would force Medicare beneficiaries to rely on a private, untried, untested, drug-only insurance market for their prescription drug coverage, rather than the traditional Medicare program that they know and trust. We split drug benefit off from Medicare?

I am concerned that this administration and some Members of Congress plan to phase out the traditional Medicare program as an option for new beneficiaries in the future. Some people have asserted that this legislation is merely a Trojan horse designed to get rid of Medicare. I sincerely hope that this is not the case, but there is something very suspicious about this particular horse.

I am worried that we may be endorsing the slow suicide of one of the most popular and effective Government programs in history. I have been down this tortured road before during my 50-year tenure in Congress. My constituents and others around the Nation are reeling from public programs that have been turned over to the so-called free market. Utility rates, cable rates, airline rates, you name it, the free market has ensured exorbitant prices with diminished service, especially for rural areas such as West Virginia. Pensions and retirement security have taken a similar beating.

The Medicare program, for which I voted in 1965, was originally created because the private sector did not offer affordable and reliable health insurance to the elderly and the disabled. Health care has certainly changed in the past 38 years, but what has not changed is the fact that the private market does not want to insure people who are old or disabled or likely to need care. Mr. President, what is the rationale for inventing some new hocus-pocus type of plan that exposes senior citizens to the whims of private insurance companies which may be more interested in profits than in providing comprehensive drug benefits?

Mr. President, this legislation, as currently designed, does not even provide sufficient prescription drug coverage. It would cover less than a quarter of Medicare beneficiaries' estimated drug costs over the next 10 years, and the complicated coverage formula has a large donut hole providing zero coverage just when seniors might need it most.

This legislation also includes copayments, premiums, and deductibles that may be unaffordable for man low- and middle-income seniors. The $35-per-month premium, the 50-percent copay, the $275 annual deductible, and the $5,800 stop-loss amount that we have heard so much about are only suggested amounts and certainly not a guarantee. A closer look at the fine print of this legislation reveals that private insurers could choose to charge senior citizens double or even triple these amounts.

Let's fact it, the kind of prescription drug benefit that we have repeatedly promised our Nation's elderly citizens, and that they now rightly expect, would cost at least $800 billion over the next decade. Yet the administration and congressional Republicans have only allocated $400 billion for the next 10 years for a Medicare prescription drug benefit. And during this same period, drug costs for senior citizens alone, according to the Congressional Budget Office, are expected to total almost $2 trillion.

One of the primary reasons this legislation contains such glaring deficiencies in the drug benefits being offered to seniors is not difficult to understand—this administration and Congress have chosen to make tax cuts a higher priority than prescription drugs for senior citizens. Since the Federal Treasury has already been raided, there is not enough money to adequately cover prescription drugs. Senior citizens ought to be outraged—outraged. Senior citizens ought to be outraged. I am a senior citizen, and I represent a State with a lot of senior citizens, and I am outraged! I am outraged!

What is the rationale for waiting until 2006—conveniently right after the next election cycle—to implement this legislation? Why wait? What are we so afraid of? We had Medicare up and running less than 12 months after creating it from scratch in 1965. So why can't we do it now? Mr. President, it seems that this Congress is trying to pull the wool over the eyes of our Nation's senior citizens—hoping to claim victory and keep senior citizens in the dark until they become painfully aware of the fine print—the fine print—of this legislation upon a visit to their local pharmacist in 2006.

Mr. President, this legislation, as it stands, does not provide the real, guaranteed, defined benefit that our senior citizens desperately need and does little to address the high cost of prescription drugs. I had hoped we could improve this legislation through the amendment process, but that does not appear to be the will of this Senate in the mad dash—the mad dash—to reach final passage before the recess. We should do better for our older citizens. We owe them so much.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM of Florida. Mr. President, this is a sad evening for me. I rise to oppose the prescription drug bill that we will be voting on shortly. No issue that we have debated over recent years has held so much promise, the promise that we could fundamentally reform Medicare from a program which today requires you to be sick enough to go to the doctor or the hospital in order to get services to one that would have its focus on wellness, including the opportunity to participate in a voluntary, comprehensive, universal, and affordable plan of prescription drugs.

Prescription drugs are, in today's health care system, a fundamental part of maintaining good health. I have spent the better part of the last 5 years, as have so many of my colleagues—and in the case of Senator BYRD, many more than 5 years—attempting to deliver a meaningful drug benefit for our Nation's seniors. I have learned some things during this period. Unfortunately, what I have learned convinces me that the bill before us tonight is not worthy of America's seniors. Because what we are about to deliver is a hollow promise and little else.

Why do I believe this? Why have I come to the conclusion that this proposal is not worthy of using all of the years of enthusiasm and commitment of America's seniors and many of those such as myself who represent a substantial number of those seniors? Why do we feel that this path is not acceptable?

First, there are gaps in the benefit which are too large to overcome. I could not go home to Florida or to any other place in America and tell people that this legislation is a good deal. This is especially the case for those with large out-of-pocket expenses. How do we tell a senior who halfway through the first year in which this will be available, 2006, their drug costs will double but they will continue to pay the monthly premiums?

That would be analogous to car insurance which says: You will be covered in case you have an accident from January to August but if you have one from September to December it is out of your pocket. Who would buy that automobile coverage?

The worst thing is that millions of seniors will never realize they have bought in to such an inadequate policy until it is too late.

Second, this bill does not provide a universal drug benefit. Under this plan, for instance, if you are a Medicare beneficiary but you are also poor, you will not get the prescription drug benefits for Medicare. That is right. Seniors at 74 percent or below the poverty level would be excluded from the Medicare benefit. They would get their prescription drugs through Medicaid. This is a clear effort for the Federal Government to unload a substantial part of its prescription drug expenses on the States, States which are already struggling with serious financial problems.

It is for that reason that the National Governors Association has opposed this design saying:

> It is not good health policy. It is not good precedent.

The argument is made that this is all we can do. We cannot do better because we do not have the resources to do better. This is analogous to the child who just has shot his mother and his father and now throws himself on the mercy of the court claiming to be an orphan. We have made the decision to be in the financial status that we are, and the consequence of that decision, as we debated a few weeks ago when we adopted the Senate's budget for the year, is that we are going to have to have an unnecessarily and unacceptably low level of financial support for a meaningful prescription drug benefit.

Third, this plan will cost many seniors more than they can afford. From repeated surveys, seniors have stated that they need a plan with no deductible so that coverage starts from the first prescription. And they need a premium of no more than $25 a month. Yet the sponsors of this bill suggest a $275 deductible and an average premium of $35 per month, an average premium which could actually be higher because the private insurance companies will determine the level of the premium. You can look through the over 600 pages of this bill and not find the number $35. That is a hope number but the actual number will be determined by the private insurance carriers.

Fourth, this bill would subject millions of America's seniors to a giant experiment, a giant experiment in delivering prescription drugs through an untested delivery system, a system which is unheard of in the private markets. It is stated that this system will be justified because it will be efficient and will use the power of competition to suppress cost. If this was such a good system, why don't we provide it for all Federal employees so they can get, we as Federal employees can get, the benefit of this greater efficiency and cost savings? The reason is because insuring drugs only is not an actuarially sustainable risk. It has been analogized to buying a fire insurance policy just to cover the kitchen. No insurance company is going to sell you a policy for the most vulnerable area of your house to actually experience a fire.

That is why no private insurance plan is available today which will provide you a prescription-only coverage. That is the equivalent of the kitchen in terms of its intensity and potential for explosion of cost within health care. Yet we are about to say that some 40 million of the most vulnerable and frail Americans are going to be the experiment for this ideology.

I have said it before and I will say it again: There is simply no reason to subject our Nation's seniors to this grand experiment, particularly when we already know what works. There is no reason to pump extra dollars into private insurance plans.

A few hours ago we adopted an amendment which will pump in $6 billion for additional benefits to HMOs. Those $6 billion could have been used to reduce the monthly premium, to close part of the gap of coverage. But what did we decide to do? We are going to give it to the HMOs so the Federal Government will be assuming more of the risk of coverage as opposed to these plans whose reason for being is to assume the risk and, therefore, have the incentive to provide the most efficient plans.

We are begging these HMOs to participate in the Medicare Program for the sake of a private sector veneer, for the sake of an ideology untested. We actually tried a version of this before. Guess what. It didn't work. I speak from experience. Medicare HMOs have dumped hundreds of thousands of Floridians from their rolls as they have in virtually every other State, and more are being dumped each day. But this Congress, rather than look to the reality of past experience, has determined to embark on this collision course at the expense of seniors and at the expense of common sense.

Fifth, I fear that we will have difficulty in convincing healthier seniors to sign up for this prescription drug benefit. As it is with virtually all insurance plans, it is critical that there be a mixture of those who have the greater likelihood of experiencing the risk with those who have the lesser likelihood in order to create an actuarially sound balance.

One-third of our seniors would not break even under this legislation. That is, one-third of seniors with drug spending of less than $1,135 per year would get no benefit should they voluntarily sign up for this plan. Therefore, how do we induce them to do so? One of the ways that we had induced them in the past was to have a meaningful catastrophic care provision, so that seniors who, today, are relatively healthy are insuring themselves against the risk that they might have a disease or an accident that would put them into much higher prescription drug costs.

Last year we determined that the level necessary to induce a large enough number of healthy seniors to participate was $4,000 in an annual drug expenditure, and if their previous employer made a contribution, that would be counted toward that $4,000. This bill increases the level at which a person would be eligible for catastrophic care to $5,800, and employer contributions would be excluded. This new level is significantly less of an inducement for healthy seniors to participate, and the effect is likely to be disappointing levels of participation.

Mr. President, I ask unanimous consent that a copy of today's front page article "For Struggling Seniors, Medicare Drug Plan's Proof Is in the Purse" from the Washington Post be printed in the Record following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. GRAHAM of Florida. The reporter interviewed active, healthy seniors at centers in Cleveland, OH, and they were skeptical of the cost of the benefits that would be offered under this bill.

Sixth, the fact that this bill doesn't take effect until 2006 is another brutal hoax on seniors, truly an abusive, shameful, misleading ploy.

The fact is, many of those who most need prescription drug coverage today simply will not live long enough to get any benefits under this plan. As much as I have wanted to vote for a drug bill, for those reasons, I simply cannot vote for the one before us this evening.

We have lost our focus. The focus should be on the Medicare Program in reform and how to help our 40 million seniors and disabled persons. Instead, the focus is everywhere else—insurance companies, drug companies, and hiding the flaws which ought to be exposed.

This focus is often presented as the issue of choice. Choice has different meanings. For the idealog, choice means a choice among delivery systems. But for seniors, choice means doctors, hospitals, and, hopefully, prescription drugs. Yes, this gives seniors a choice among delivery systems. For instance, if you are one of the 89 percent of seniors in a fee-for-service Medicare Program, you will get a choice of between two or more prescription drug plans. If that fails, you will then drop back into traditional Medicare.

The Stabenow amendment, which was defeated earlier in the debate, would have given seniors at least real choice between a prescription drug delivery system and fee-for-service Medicare as the delivery system.

The tragedy is that we know what we ought to be doing. What we ought to be doing is building on the strengths of our current Medicare system—one of the most popular health care programs in this Nation's history. We also ought to be seeing that we have a plan that is affordable and comprehensive.

I think the dye is cast and this bill is likely to pass the Senate. I will be hopeful that in conference it will improve but I think there is every likelihood to suspect that it will get worse. It will be my intention to introduce legislation that will correct the flaws of this legislation which, among other things, will provide for a patients' bill of rights, so that as we herd more seniors into HMOs, at least they will know the standards by which they will be asked to operate within that.

We are beginning to hear the first rumblings of dissent. Today's Miami Herald looked at the legislation before the two Houses and this is what they had to say:

> House and Senate bills attempting to offer prescription drug cost relief to Medicare seniors can be summed up with the movie title, Dumb and Dumber.
>
> Both bills promise dubious benefits without providing the security that seniors want and have, with traditional Medicare health coverage.

I ask unanimous consent that a copy of that editorial be printed in the Record after my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. GRAHAM of Florida. Medicare has served our seniors superbly. And where it has not, as in the area of prescription drugs, it has been because Congress has not allowed it to do so.

I hope when this bill comes back from conference, it will be better but I doubt that will be the case.

The PRESIDING OFFICER. The Senator has consumed 15 minutes.

Mr. GRAHAM of Florida. Mr. President, I will vote no today in the hopes that soon we will have an opportunity to pass a prescription drug bill that will fully meet the needs and expectations of older Americans.

EXHIBIT 1

[From the Washington Post, June 26, 2003]

FOR STRUGGLING SENIORS, MEDICARE DRUG PLAN'S PROOF IS IN THE PURSE

(By Ceci Connolly)

CLEVELAND.—As the Medicare drug package moving through Congress takes on an air of inevitability, Washington politicians are already jostling for credit. But in this working-class city 370 miles from Capitol Hill, prospects for the plan's eventual success may lie deep inside the handbags of women such as Marie A. Urban.

Stashed in there are her monthly Social Security statement, a half-dozen prescription discount cards and insurance letters rejecting several recent medical claims. The scraps of paper—creased and scribbled on—document a life near the financial edge.

After working 24 years as the secretary at St. Paul's Shrine, Urban, 72 collects $843.70 a month in Social Security. After housing and Medicare payments, she has $459 for utilities, food, car insurance, taxes and medication. "Some months I have 87 cents to live on," she said. With her drug bills this year already exceeding $1,500, she said she probably will try to cobble together the money to buy the prescription coverage that lawmakers plan to offer Medicare recipients.

"I don't know," she said. "My finances right now are very tight. I guess I'd have to go with it."

In interviews at two senior centers here, Urban and other retirees expressed deeply mixed feelings about the voluntary prescription drug benefit scheduled for votes in Congress as early as today. They exhibited a visceral distrust of Washington, voicing skepticism that elected officials would deliver a package that fits their health needs and budgetary constraints—in time for them to use it. They were disappointed that in most cases, benefits would not begin until a person spent nearly $1,000 a year on prescription drugs. And they were annoyed—but not totally surprised—that the program would not begin until 2006.

"They've been kicking this ball around for a while," said Carrie Adams, 66. "If they wanted to solve this, they would. The people with the ball are not relating to the people out here."

Ruby Bogus, 83, was a bit more sanguine. "We just have to live longer, girls," she said.

Both the House and Senate plans would require seniors to pay about $35 in monthly premiums and an annual deductible of $250 to $275 before receiving any subsidy. The Senate plan would cover half of a person's annual drug expenditures between $276 and $4,500. The recipient would pay the next $1,300 in prescription costs. If the person's total drug costs rose above $5,800 in a year, subsidies would resume.

The House bill would offer retirees an 80 percent subsidy on drug bills between $251 and $2,000 and no coverage for the next $1,500 worth of medications. The "catastrophic coverage" would begin when costs reached $3,501.

Asked whether either plan was attractive, Emily Eckert pulled a tiny notebook from her purse. It listed her daily medications: two pills to control sugar, one for high blood pressure, another to regulate potassium. Using her People's Drug Mart discount card—also tucked in her pocketbook—Eckert spends about $100 a month on prescriptions, plus $22 for diabetes test strips.

At 79, she has outlived two husbands, but at a high cost. Caring for her first husband, who had cancer, and the second, who had diabetes, wiped out $7,000 in savings and two life insurance policies valued at $3,000. Eckert has been in bankruptcy and worries about helping her three children, 10 grandchildren and 10 great-grandchildren.

"If it wasn't for this center, I'd be starving," she said, referring to the Senior Citizens Resources facility in the Old Brooklyn neighborhood. She wants to buy the drug coverage proposed for Medicare but isn't certain she will be able to pay the premiums.

The situations of Marie Urban and Emily Eckert may sound dire, but in many respects they are typical for the millions of senior citizens and disabled people who rely on Medicare for their health care. Not poor enough to qualify for Medicaid, yet not fortunate enough to have substantial savings or a lucrative retirement package, such people have clamored for years for help with the rising cost of medication.

Assuming the House and Senate pass their spending bills and then resolve their differences, Congress hopes to answer those demands by spending nearly $400 billion on drug coverage over 10 years. The legislation would mark the largest Medicare expansion in the program's 38-year history and could provide a political boost to President Bush and fellow Republicans who campaigned on the promise of alleviating drug costs.

However, as the conversations in Cleveland illustrated, many older Americans are watching with guarded optimism and could revolt if the final package fails to meet expectations. That would dash Republicans' hopes of taking away an issue that has been mostly associated with Democrats for decades.

Their elderly residents' fundamental question is whether they would save money under the new plans. The answer isn't easy.

Urban is torn. Most years she spends about $800 on medicine, so a benefit that does not begin paying off until after $1,000 in out-of-pocket spending looks like a money loser for her. But this year, a mysterious infection and several hospitalizations pushed her drug bills to $1,500, and the federally subsidized insurance would have saved her money. Urban drives 30 minutes to several pharmacies in the Cleveland suburbs to shop for the best deals. She gets agitated thinking about the complex math of the new proposal.

Howard Bram, 77, also complained about the complexity of a program that will involve choosing a plan, tracking out-of-pocket expenses and knowing when the coverage kicks in, lapses and then resumes in severe cases, all according to a sliding scale of benefits.

"It's just gonna blow their minds," he said. Bram is trying to figure out whether the drug plan would put a significant dent in the cost of the eight medications he takes.

Carrie Adams and Jean Nagorski are precisely the sort of customer-patients that Medicare will need—comparatively young, healthy and with some retirement income. Yet both women doubt they would buy the Medicare drug coverage because they believe they get a better bargain with the current supplemental insurance plans. Without clients such as Adams and Nagorski, policymakers worry, the new Medicare package will draw the oldest, sickest and poorest patients, leading to skyrocketing costs.

Despite the plan's limits, Adams predicted many friends will sign up for any program that might lower their drug bills. "They're gonna jump on this like white on rice," she said.

Zev Harel, 73, agreed.

"There are always those who hope for a revolution, but what has worked in the United States is evolution," said Harel, a professor at Cleveland State University and board member of the Western Reserve Area Agency on Aging. Many of his friends will be disappointed with the limits of the drug coverage, he said, but he considers it "a major improvement over the current situation."

If analyzed in the context of other types of insurance, the Medicare drug plan is a reasonable approach, Harel said. "This follows on the principle of purchasing protection."

But many others said the fundamental promise of Medicare—a system they supported through payroll taxes throughout their careers—has always been health care for all, and in today's world, that should include prescriptions.

"The politicians seem to say it's better than nothing, and we should be grateful," Urban grumbled.

To some retirees here, who clip coupons and follow the news, Washington's Medicare is just the latest example of the doings of out-of-touch elitists.

Nagorski reached into her purse and retrieved a recent newspaper clipping detailing the personal riches of the United States' elected leaders. The article identified several millionaires, including Sens. Bill Frist (R-Tenn.), Edward M. Kennedy (D-Mass.) and Ohio's senators, Mike DeWine and George V. Voinovich, both Republicans.

"Do you really think they care about the average person with what they earn?" Nagorski asked. "I don't think any of them are ever going to have to live on $1,100 a month."

[From the Miami Herald, June 26, 2003]

THE WRONG PRESCRIPTION—CONGRESS CONSIDERS INADEQUATE BILLS

U.S. House and Senate bills attempting to offer prescription-drug cost relief to Medicare seniors can be summed up with a movie title: Dumb and Dumber. Both bills promise dubious benefits without providing the security that seniors want, and have, with traditional Medicare health coverage.

With election-year politicking started already, the bad news is that a bad bill may actually be enacted after years of waiting. The politicians may easily be miscalculating. Most seniors, who faithfully turn out to vote, want prescription-drug coverage through Medicare—not the private insurers that the GOP-controlled Congress and White House are pushing.

Further, an increasing number of Americans—32 percent today versus 16 percent in 1999—says that neither the Republican Party nor the Democratic Party is doing a good job on the issue of prescription-drug benefits for the elderly, according to a recent poll by the Kaiser Family Foundation and Harvard School of Public Health. The proposed congressional legislation can only deepen that sense.

Each bill would cost about $400 billion over 10 years and suffer from complexity and coverage gaps. Under the Senate bill, for instance, a senior would pay the first $275 in drug costs (the deductible), then half of the costs—up to $4,500. They would then get no benefit until the bills total $5,800 (an out-of-pocket expense of $3,700), after which 90 percent of the cost would be covered. Have you got that?

It gets worse. Beyond the deductible and co-payments, seniors would pay a monthly premium—even while getting no benefits when they are in the coverage gap. Although the premium is "estimated" at $35 a month, it's actually subject to a drug-cost inflator that, at the moment, is four times higher than inflation. It's also subject to interpretation by private insurers, who presumably would contract with the government to administer this plan—an uncertain assumption.

The Senate bill also provides for a "fallback": if a region doesn't attract two competing private insurers, the government may contract with pharmacy-benefit managers, firms that actually manage the prescription-drug programs of most large health-insurance plans. So why contract with the private insurers in the first place when these pharmacy-benefit managers have the expertise to drive down drug costs by leveraging Medicare's enormous volume-buying power?

That the pharmaceutical companies are trying to strip this fallback provision does indicate who wants the benefits here—and we're not talking about Medicare seniors.

The House GOP measure, indeed, has no fallback provision—which could leave large areas of the country without access to the Medicare drug benefit. It has the same premium problem and a bigger coverage gap. But it would provide more generous benefits: A $250 deductible and 80 percent cost coverage up to $2,000.

Neither bill offers the drug-price relief, simplicity and security that seniors need. But what do you expect from a Congress and White House that already have spent $1.7 trillion on tax cuts since 2001? Seniors, and critical Medicare and Social Security concerns, apparently only matter as talking points for an election year.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, I know the Senator from Arizona is here to speak. He will speak for 10 or 15 minutes, is my understanding.

We are at a point where we have very few amendments left. We have a couple that may take a little debate but I think most of them will be disposed of with minimal debate. I hope everyone understands we are moving this along as quickly as possible. The managers have worked for 2 weeks on this matter.

After the Senator from Arizona finishes his statement, we should be in a position to have a number of votes lined up for later this evening.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, the passage of the Medicare prescription drug benefits legislation is a difficult vote for me. It is unacceptable that in a country as wealthy as ours seniors across the country are struggling to afford the high cost of prescription drugs. I have supported adding a prescription drug benefit to Medicare because I believe no beneficiary should have to choose between life-sustaining prescription medications and other vital necessities. Far too many American seniors face those choices every day. Many ration their supplies of medication, skip dosages, or cut pills in half.

In Arizona, busloads of seniors depart from Phoenix and Tucson every week, heading south to Mexico to purchase lower cost prescription drugs. The story is similar across the northern border, where seniors make daily trips to Canadian pharmacies. Throughout the country, an increasing number of seniors are looking to online pharmacies, selling reduced-priced prescriptions imported from other countries, oftentimes with questionable safety.

That said, I also recognize, as does every other Member of Congress, that

Medicare is on a fast track toward bankruptcy. The most recent Trustee's Report adjusted down the year Medicare will reach financial insolvency by 4 years, to 2026. Clearly, it is incumbent upon us to include comprehensive reform of the system in any Medicare prescription drug package in order to ensure that Medicare is financially sound for current beneficiaries as well as future generations.

Medicine has changed substantially since the creation of the Medicare system in 1965. Advances in medical technology and pharmaceuticals have led to more prescription-based treatments. The simple fact is, Americans now consume more prescriptions than ever before. In 1968, soon after the enactment of Medicare, American seniors spent about $65 a year on a handful of prescription medications. Today, seniors fill an average of 22 prescriptions a year, spending an estimated $999.

The bill before us represents one of the largest enhancements to Medicare since its creation, setting up an entirely new bureaucracy and establishing a sizable new entitlement program. I believe this bill addresses a real problem, the need to help struggling middle and low-income seniors. However, we must have no illusions. There are dangerous complexities and potential unintended consequences associated with this bill.

First, we must be realistic about the cost of this new entitlement program. For anyone who believes this bill will cost a maximum of $400 billion over the next 10 years, I have some oceanfront property in Gila Bend, AZ, to sell you.

Medicare and Social Security, together, represent an enormous unfunded liability for our Nation. In a few short years, millions of baby boomers will hit retirement age and the system will quickly become insolvent.

The numbers speak for themselves. Medicare currently has an unfunded liability of $13.3 trillion. Some have estimated the unfunded liability of the package before us in the $6 to $7 trillion range. A scholar at the American Enterprise Institute Scholar estimated that if passed, the Senate's prescription drug benefit legislation will result in a $12 trillion unfunded liability. Social Security and Medicare, with a prescription drug benefit, will together consume an estimated 21 percent of income taxes by the year 2020.

Long after the Members of this Congress and administration have left office, our children and our grandchildren, and a future Congress and administration, will be struck with the burden of cleaning up the mess we have created.

In the past 2 years, we have passed two large tax cuts. Government spending, however, has continued to increase well above the inflation use. Much of that spending is unnecessary, and represents a lack of fiscal discipline more common in times of federal budget surpluses. Yet our current budget deficit and national debt have risen dramatically. Security concerns in the post 9/11 era necessitate substantial increases in spending on defense and homeland security. We cannot sustain this level of fiscal profligacy indefinitely.

This extraordinary large new entitlement we are debating will impose an equally extraordinary burden on taxpayers. The money has to come from somewhere, and none of the "somewheres" are desirable. The reality is, this new benefit will be funded by raiding other entitlement trust funds, or by increasing our national debt, or by substantially increasing taxes.

Despite the enormous cost of this bill, this new entitlement will not provide the prescription drug coverage many seniors expect to receive. Nor does it enact significant reform measures needed to ensure the long-term solvency of the Medicare system.

Those seniors who think this bill will solve their financial problems will soon learn that there are substantial limitations to the benefit. When it does pass, the new prescription benefit will not be available immediately. In fact, it will take several years just to establish the new bureaucracy which will administer the prescription benefits.

Low-income seniors will benefit from this package, and I am pleased that they will. Many other seniors, however, will not receive a generous benefit, and might not even get out of the system what they will pay in deductible sand premiums. The Congressional Budget Office estimates that 37 percent of employers currently providing coverage to Medicare eligible seniors, will drop coverage if this bill passes. Last week, the Wall Street Journal quoted one analyst who called this bill the "automaker enrichment act," because companies such as the automakers who currently provide their retired employees with a prescription drug benefit are unlikely to continue doing so if the Federal Government assumes part of the burden for them.

I am concerned that we are about to repeat—I emphasize repeat—an enormous mistake. I have been around here long enough to remember another large Medicare prescription drug entitlement program we enacted in 1988, Medicare Catastrophic. The image of seniors outraged by the high cost and ineffectiveness of that package should be a cautionary tale to all of us.

Moreover, I am not confident that the Medicare Advantage portion of this new scheme, which establishes regional PPO options for seniors, will succeed. Many in the insurance industry have expressed skepticism and concern that such plans will not be profitable. In the end, the Federal Government, which acts as a fallback if no private plans are available, might end up covering the majority of the country. Not exactly the reform we all had hoped for.

The American people should be aware that this new benefit has substantial cost to seniors, and to current and future generations of taxpayers, who will bear the majority of a crushing financial burden. There will be unintended consequences of our actions. We can be sure of that. Moreover, we should be honest about the cost of this measure—$400 billion is merely a down payment for what we are creating. Given the fiscal realities we face, realities that will become more dire with every passing year, Congress and the administration should have committed to addressing the acute need for a drug benefit to alleviate the impossible choices confronting lower income seniors. And, most importantly, begun to seek consensus among responsible Members of both parties for the reforms we all know are necessary to save Medicare.

I recently heard a good assessment of this package: it is "an effort to do too much with too little, and thus doing nothing very well at all."

There are several good amendments that have been adopted during this debate. I am encouraged that a bill Senator SCHUMER and I worked on for the last 4 years, might finally be enacted into law as part of this package. Our amendment will increase competition in the pharmaceutical industry and ensure that all Americans have access to lower cost generic drugs. That amendments, which would not have been possible without the leadership of Senator GREGG and the support of Senator KENNEDY, will reduce the cost to the government of any Medicare prescription drug benefit.

I was happy to cosponsor an important amendment with Senators FEINSTEIN, NICKLES, CHAFEE, and GRAHAM, which I believe will add some fiscal discipline to the bill and the Medicare program. The amendment will add means testing to Medicare Part B—increasing co-payments for wealthier seniors.

I am also pleased that several measures which I have supported and cosponsored as separate bills, have been adopted as part of this package, including the Immigrant Children's Health Improvement Act, the Blind Empowerment Act, and funds to reimburse hospitals for the uncompensated cost of caring for undocumented immigrants. Additionally, there have been several good amendments that I think will improve overall health care in our country. In particular, I believe Senator GRASSLEY'S amendment which requires agreements between brand and generic pharmaceutical companies to be reported to the Federal Trade Commission and the Justice Department will shine some much needed light on potential collusive agreements.

Despite these welcome improvements, and recognizing that this legislation will address the crisis faced by lower income seniors, the costs of this entitlement remain, simply put, beyond the means of this country absent real reform of Medicare. Therefore, after much thought, I regret that I cannot vote for this legislation. I have reached this conclusion, not because I believe our seniors and disabled do not need or deserve prescription drug coverage, but because I do not believe our country can sustain the cost of this benefit, which will not, despite it's staggering expense, provide the assistance many beneficiaries will expect.

As I noted, Congress and the administration should have addressed the acute need for assistance of lower income seniors. And before we consider extending that assistance to other seniors, we should save Medicare first by instituting the reforms we all know are necessary, but which we apparently prefer to defer until we have retired from public service. I know that those reforms pose a very difficult political challenge to us, and that the bipartisanship we have commended in the drafting and consideration of the legislation before us today would be put to a far more severe test should we genuinely attempt to save the Medicare system from insolvency. However, should we simply add another huge, new unfunded liability to an already fiscally unsound entitlement, imposing a breathtakingly heavy tax burden on our children and their children, with devastating consequences for their prosperity and the national economy, we will have done the one thing no public servant should want to be remembered for, we will have left the country worse off than we found it.

I yield the floor.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. ALEXANDER). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, the Senator from Michigan, Mr. LEVIN, has been extremely patient. He has been waiting for us to get a unanimous consent for his amendment. We are very shortly going to get that, but prior to that being announced, the Senator from Michigan is going to offer amendment No. 1111. He is going to speak for 10 minutes. Senator STABENOW will speak for 5 minutes, and Senator GRASSLEY and Senator BAUCUS will speak for up to 10 minutes in opposition, if they need to. The leaders will arrange a vote at some time that they have agreed upon.

I ask unanimous consent that that be the case.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Michigan.

AMENDMENT NO. 1111

Mr. LEVIN. Mr. President, the amendment which I will be offering is designed to ensure that the CBO estimate of 37 percent of current retirees who now get their prescription drug coverage from their former employer and who will lose that coverage as a result of this bill will at least have the option of a prescription drug coverage under the Medicare fallback.

There are a number of problems which have been identified with this bill. Some of them are significant problems which cause many of us, who very much favor having a prescription drug benefit available to our seniors, great pause before we support this bill. For instance, there is a so-called yo-yo effect in this legislation. Some have called it the revolving door effect. The problem there is that seniors who are offered two private plans in their service area must pick one of those private plans. They cannot use the Medicare fallback. There will not be a Medicare fallback with a guaranteed premium because if two or more private companies offer a prescription drug program, with whatever premium they decide upon, then the seniors in that service area must pick one of those two private plans.

What happens then if the senior says, okay, I am going to pick that private plan A, and then a couple of years later the private sector decides to pull out of that service area? At that point, the senior will be offered the Medicare fallback.

Then what happens if the private insurance folks decide to come back into that service area? Could the senior keep the Medicare fallback plan? No. They are kicked out of that plan even if they want it. They have to go into one of the private plans again. Then that can be repeated over and over again. Each time private insurance companies decide to pull out of an area, the seniors then can get into a Medicare fallback, but when private companies come into the service area again, they are removed from the Medicare Program and have to go back to one of the plans. It is confusing, uncertain, unfair. It is the yo-yo effect, what others call the revolving door. It is a real problem with this plan. We ought to give much more certainty to that.

Another problem identified is the so-called donut hole problem. We have heard quite a bit about that problem where once a senior is told her drug spending reaches $4,500 for a year, she will have to pay 100 percent of the costs of the prescriptions until the total drug spending reaches $5,800. Now, premiums will continue to be paid during that period, but the gap in coverage will be there, so from $4,500 to $5,800. There is not a 50/50 deal between the plan and the senior; it is 100 percent burden of the senior during that period. That is a real gap in coverage. That is a gaping hole in coverage. I don't know of any other insurance program that is so unfairly structured. That is another problem which has been identified. There have been efforts made to correct that, without success.

Another problem identified is that the private insurance plans that may come into a service area do not have a cap on the premium; it is an unlimited premium. That is a problem which has been identified. The effort to put a cap on the premiums has failed.

But of all the flaws that have been identified, the weaknesses in this program, the one that troubles me most and that troubled seniors most is the fact that it has been estimated by the CBO and by the Health and Human Services folks who operate Medicare that 37 percent of current retirees who have a prescription drug program through their former employer are going to lose their prescription drug benefit following the enactment of the plan before the Senate; that is, a situation where we are actually going to see 37 percent of our seniors—that is the estimate—who currently have a benefit being worse off as a result of what we do.

There is a debate here as to whether the plan before the Senate is going to be good for seniors because of the donut hole or because of the fact there is no cap on premiums or because of this yo-yo effect, this revolving door effect. Is it a good plan? Is it not a good plan? Will seniors who don't have health insurance, a prescription drug program now, actually want to opt into this program? That people can debate. But, at a minimum, we should do no harm. At a minimum, we should not have millions of seniors who will lose an existing prescription drug program as a result of our enacting a plan. That is the time bomb in the bill before the Senate. We should not leave people worse off than they otherwise would be.

During the markup of this bill, we had some experts who testified. One was Tom Scully, Administrator of the Centers for Medicare and Medicaid Services at HHS:

> Among employees who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped.

A little later on, page 6 of the transcript of the markup of the Finance Committee:

> TOM SCULLY: Thirty-seven percent of those retirees who have employer-sponsored coverage . . . [will lose their coverage].

Then, a little later on in the markup of the Finance Committee, Senator CONRAD was going to ask a question of Mr. Holtz-Eakin, our CBO Director, about this issue, and the majority leader posed a question.

Senator FRIST: Senator CONRAD, could I—on that last—I'm over here—on this employers dropping it, can I just ask a follow-up question just real quick.

Senator CONRAD: Yeah. Absolutely.

Senator FRIST: You said—is it 37 percent of employers are going to drop——

TOM SCULLY: Yes.

Colleagues, Senator FRIST said something which I hope will reverberate in this Chamber.

Senator FRIST: This has huge implications.

Then the Director of the CBO said the following:

Mr. HOLTZ-EAKIN: Thirty-seven percent of employees—of retirees with such employee insurance.

Then there was a voice, unidentified by the reporter:

MALE VOICE: As I understand it, this 37 percent is the effect of our legislation.

Mr. HOLTZ-EAKIN: Correct.

Colleagues, Senator FRIST is correct. This has huge implications. And we ought to address it. The least we can do is to direct Health and Human Services to make available to designate a Medicare backup plan for the 37 percent of our current seniors who have a prescription drug program through their previous employer to make available to them the Medicare backup program so they at least know there will be a Medicare backup for them if they lose their current prescription drug program, as is projected by the Congressional Budget Office and by Health and Human Services. It seems to me that is the least we can do.

It still will be harmful because it is very unlikely for most of the people that the Medicare backup will be as good as their current prescription drug program. It is unlikely. But at least we can say, for those people, there will be a Medicare backup plan designated by HHS which will have the criteria established by HHS and the premium established by HHS. That is the least we can do for those who are going to lose their prescription drug benefit that they currently have following the enactment of this legislation.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator has 1 minute 15 seconds.

Mr. LEVIN. I reserve the remainder of my time.

I ask unanimous consent to call up amendment No. 1111.

The PRESIDING OFFICER. The amendment is pending.

Mr. LEVIN. I ask unanimous consent that my colleague from Michigan, Senator STABENOW, be listed as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEVIN. I ask unanimous consent that the excerpts from the quoted testimony be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Senator ROCKEFELLER. Okay. Actual dollars in the plan that are spent on, number one, the drug benefit itself, provider add backs and that's all I can see. I don't need the third one I've written down.

TOM SCULLY. These are figures that were in the table. We issued it to the Committee. Since this table was put together, there were some modest modifications to the drug benefit. In particular, putting the cap at $4,500.00 instead of $4,725.00. That changes the estimate on the drug benefit from $408 billion to $402 billion over ten years.

Senator ROCKEFELLER. Four hundred two?

TOM SCULLY. Four hundred two. Six billion dollars lower. And, the provider add backs are listed on pages 2 and 3—or, pages 1 and 2——

Senator ROCKEFELLER. Could you give them to me?

TOM SCULLY. There's a long list of them, and simply adding them up is not that—they interact in many ways.

Senator ROCKEFELLER. [Unintelligible].

TOM SCULLY. [Unintelligible].

Senator ROCKEFELLER. Next one is, percent of employers who drop retiree coverage. And, the number and percent of beneficiaries who will lose retiree coverage under this plan so far.

TOM SCULLY. We don't have an estimate of the number of employers. But, among employees who have employer-sponsored insurance, our estimate is consistent with 37% having their coverage dropped. Of that 37% of those who have such coverage, about 11% of beneficiaries overall.

MALE VOICE. Could you repeat that? I didn't get the—you might pull the microphone up a little closer to you.

TOM SCULLY. Thirty seven percent of those employees who have employer-sponsored coverage, it's 11% of beneficiaries overall.

Senator ROCKEFELLER. And, what percent would drop it?

TOM SCULLY. We don't know the number of employers who would drop coverage. We know the number of employees who are effected.

MALE VOICE. I thought you gave an estimate—excuse me—this is Senator Rockefeller's time, and I just want to make sure I——

TOM SCULLY. Let me repeat so it's——

MALE VOICE. Just repeat what you said.

TOM SCULLY. Underlying our estimate are that 37% of employees who have beneficiaries who have employed-sponsored insurance, retirees who have such employer-sponsored coverage, 37% will lose their coverage. And, that is 11% of total beneficiaries.

MALE VOICE. Could I also add into this, Senator Rockefeller? What we also need to know is, what percentage of the figure you said might drop—or, case would be dropped even—

Or, they could drop it entirely.

In those latter two cases, they can use the additional resources to provide other kinds of employee compensation.

What we've done is examine the literature to the extent that we can find it on employer responses to the shape of compensation packages in shaping our estimate of the number that would drop.

Senator CONRAD. Okay. Let me go to something that I have found difficult to follow. And, I'd like, if I could, to have the attention of the Chairman.

Senator FRIST. Senator Conrad, could I—on that last—I'm over here—on this employers dropping it, can I just ask a follow up question just real quick.

Senator CONRAD. Yeah. Absolutely.

Senator FRIST. You said—is it 37% of employers are going to drop——

TOM SCULLY. Yes.

Senator FRIST. This has huge implications.

Mr. HOLTZ-EAKIN. Thirty seven percent of employees—of retirees with such employee insurance.

Senator FRIST. Okay.

Mr. HOLTZ-EAKIN. And, that's 11% of overall Medicare beneficiaries.

MALE VOICE. Okay. If we did nothing, how many would be dropped over the next ten years? If you look at these curves, the employees—yours are getting out of the business, anyway—not out of the business, but the curve is going down.

What would it be ten years from now?

Mr. HOLTZ-EAKIN. We don't have an estimate of that. We isolated our estimate on the impact of the bill above the baseline. That's a question about the baseline estimate, and I don't have that.

MALE VOICE. Okay.

MALE VOICE. It's 37%, just so we're clear with each other. As I understand it, this 37% is the effect of our legislation.

Mr. HOLTZ-EAKIN. Correct.

MALE VOICE. I think the question Senator Frist has is, in your baseline you have an assumption that there will be changes, though, correct? Or, don't you?

Mr. HOLTZ-EAKIN. No, we do not.

MALE VOICE. And, would you suggest that that's an inaccurate baseline?

Mr. HOLTZ-EAKIN. In reality——

MALE VOICE. Its reality is not that. And, I can have a few of my retirees in Pennsylvania give you a call if you have any questions on that subject.

I mean, I think that's an unfair—I mean, baselines are supposed to be real, but not supposed to be artificial. That's artificial.

Mr. HOLTZ-EAKIN. The baseline issue that we—that is most important, that we capture is new retirees not having such coverage.

This is a provision that would induce existing retirees who have such coverage to have their coverage dropped or modified by their employer.

MALE VOICE. I understand what this provision does. I just want you—I just want an understanding of what would happen without this being calculated into the baseline.

MALE VOICE. Senator Santorum, we've looked at the literature and the surveys of the employee benefits consultants of retiree offerings.

What we understand is mainly happening is that, for current workers who are newly hired, they are—employers are no longer putting as part of their compensation package a guarantee of retiree healthcare.

As far as we can tell, the base of people who are near retirement or retired are not having their healthcare—there's not that much erosion going on.

MALE VOICE. I'll have the people from Bethlehem Steel and about seven other steel companies in Pennsylvania that I can just think of off the top of my head give you a call, and let you know that their retiree health benefits have been eliminated. I mean, it's happening all over the place.

Senator Rockefeller, would you like to join into this? I mean—so, I just—I think you need to look at your baseline, please.

And, then give us an understanding of maybe looking back over the last few years and projecting forward given the trends what—how the baseline would be affected. And, I think that would much—be a much fairer score as to what the impact of this bill would be.

Senator CONRAD. Mr. Chairman?

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Let me just say that I agree entirely with Senator Santorum. We know that people are dropping—employers are dropping their plans.

And, I understand your answer to this question is the effect of this bill.

I think one of the things we've got to do—Senator Frist said it well—this has got major implications; 37% having their healthcare plans dropped. That means it's going from being on the company's nickel to being on our nickel; that dramatically increases the cost.

So, if we can find ways to hold that number down, that's in our interest and we should pursue it.

Let me go——

Mr. HOLTZ-EAKIN. If we could, before we——

Senator CONRAD. Yes, sir.

Mr. HOLTZ-EAKIN. I understand the policy interest, and * * *.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I am very proud to be joining with my colleague on this very critical amendment. Can you imagine, you are someone who has worked hard all of your life, you have been fortunate enough to have a good-paying job with benefits, you are now retired and you are fortunate to have good health benefits and you find yourself in a situation that, as a result of an action taken here—and certainly there is an effort to move forward and provide people with prescription drug coverage—but if those who already have coverage find, as a result of an action we take, there is an incentive for their employer to drop their coverage, how would you feel about that?

I know how I would feel about that. This amendment is about making sure those who have worked hard all of their lives, who have retired and have had the confidence and the security to know that those health care benefits, retirement benefits they have worked so hard to have in their retirement, would be secure—to make sure if someone is covered right now for prescription drugs that he or she not lose the ability to continue, at least to know that if their employer changes their benefit, they would have immediately the security of the backup Medicare prescription drug plan.

This is very critical in a State such as Michigan where we have 37 percent of our retirees who have insurance, who right now are fortunate enough to have health care insurance and prescription drug coverage.

While there are positives in this bill so there are those who will receive help as a result of being low-income seniors, or those with very high prescription drug costs who will receive help under this bill, one of the glaring omissions and great concerns that I have relates to what Senator LEVIN was just speaking about, the unfairness of saying to a group of people who have been fortunate enough to have insurance and prescription drug coverage that, as a result of something done by the Congress, they would potentially lose that coverage. That makes absolutely no sense.

What our amendment is saying is if, in fact, their employer would have the incentive to change or drop their coverage, they should be guaranteed that something else is right there, that Medicare as a backup should be there.

My preference would be that we change the formulas so there is not the incentive to drop anyone. That was one of the reasons I strongly supported Senator ROCKEFELLER's amendment and other amendments that have been on the floor. Because my first choice is we take away any incentive for anyone to lose their prescription drug coverage. But unfortunately those amendments were not successful. We did not have the support to do that here.

Given that, we are now coming in and saying if, in fact, an employer, because of the incentives, makes a determination to drop coverage, that at a minimum, out of a sense of decency and fairness, at a minimum that retiree needs to know that Medicare prescription drug coverage, through Medicare, is available without wading through tons of insurance forms or picking through plans or going through all the ups and downs that have been described so many times in this Chamber. They need to know, after having coverage, having it available, having it dependable, that another plan is right there for them. That is the least we can do.

I hope we will join together in a bipartisan way this evening to agree to this very important amendment, and let us send a message to those fortunate enough to have health care insurance and prescription drug coverage that we remember them, we care about them, and we are going to make sure no harm is done to them in the process of putting together this prescription drug plan.

I yield the floor.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, this is the greatest and most prosperous Nation in history. Nobody has worked harder to make this country great than our senior citizens. And few things weigh more heavily on their minds than the soaring cost of prescription drugs.

You would think such a great, prosperous Nation would honor its elders, by making sure they get the medicines they need. That is why a comprehensive, meaningful and voluntary drug benefit for our senior citizens has been among my highest priorities.

Over the last several weeks, this Senate has worked hard to achieve that. In the process, many of us who shared that goal have disagreed about how to react it. In the end, we wound up with a bill that is not how I would have created a prescription drug benefit. But it is a start.

I am voting for this bill, because I believe some benefit is better than none. I am voting for it because of people like Shirley Rosamond of Sparks, NV. Shirley, who is 78 years old, raised eight children in the Sierra Nevada. She currently spends $400 a month on medicine, and has less than $400 left over to live on. This bill would reduce her monthly costs to less than $20 in medicine. And it would provide a similar level of assistance for tens of thousands of Nevada seniors.

I am voting for this bill in the hope it will be like the camel's nose under the tent—a foot in the door for our senior citizens.

I'm hoping we will pass this bill today, and then improve it in the future. And, yes, there is plenty of room for improvement.

For example,this bill will do little to help seniors whose income is $15,000 a year or more. Even if they spend more than $100 a month on prescription drugs. That is why I voted to make the program more generous.

This bill doesn't take effect soon enough. That is why I voted for and cosponsored the Lautenberg amendment to move the start date up to 2004, instead of 2006.

There are gaps in the coverage this bill provides. That is why I voted for Senator BOXERS' amendment to close the coverage gap, and Senator GRAHAM's amendment to cancel premiums while coverage is suspended.

There were other amendments that were very good but were not agreed to. Finally, this plan is just plain confusing—which means it won't give our senior citizens the peace of mind they deserve.

I voted to address all of these issues. I wish we had succeeded, and that this bill would provide the kind of coverage our senior citizens need. We didn't and it doesn't.

We have to be honest with our senior citizens, and with the American people. This isn't the best we can do for our senior citizens, but it is the best we can do tonight.

I will vote for this bill today, because it provides a start toward fulfilling our promise to senior citizens. It a start, and I won't stop fighting until we finish the job.

The PRESIDING OFFICER. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I know we are waiting for some completion on negotiations on an amendment. As I understand it, no one is seeking recognition to continue work on other amendments. So I will speak for a couple of minutes until somebody is prepared to come to the floor to continue our work. I don't want to delay the business of the Senate but I want to express myself, as the distinguished Democratic whip has been doing with regard to the legislation.

I, too, intend to support this bill. I am thinking of the old joke about a camel being a horse designed by a committee. Oftentimes, I think of that as we work our will on legislation. In many respects, this is the legislative version of a committee horse, a camel.

It is not the kind of bill I would write. It is not the kind of bill I would cosponsor. It is not the kind of bill I would enthusiastically endorse.

I look at some of the concerns we have about this legislation—concerns about an unlimited volatility in the premium, uncertainty about the benefit package, uncertainty with regard to the deductible, uncertainty with regard to the backup, uncertainty with regard to the way the provisions can be provided in rural areas. There are many issues. Mostly I think there is far greater confusion than there is understanding with regard to the benefits themselves as seniors attempt to determine whether they will be assisted by this bill.

The confusion and the uncertainty will be issues that we have to address at some later date. But having said that, I must say that the rural provisions—the effort made by our two distinguished managers to address the rural needs to overcome the inequities that exist today—alone merit consideration and I would suggest support for this legislation. The help for low-income seniors—tens of thousands of South Dakotans will get help they are not getting today in part because of this bill. The possibility that seniors could access generic drugs with far more regularly and successfully, and the possibility that we could reimport drugs at a lower price from Canada, all are reasons why I think this bill merits our support.

As I look to the balance and look to all of those things I wish were better, my response is that we are going to make them better. It may take months, if not years, but we are going to continue to work to make this a better bill and a better program.

There are so many ways that I hope we as Senators—Republican and Democrat—can work together to make this a better bill in future years.

There is a warning and a hope as we complete our debate tonight. The warning is that if this legislation comes back from conference in a significantly different form we will not be in the same position we are tonight. This bill will enjoy broad bipartisan support tonight. But if we fail, if we endorse a bill with some of the provisions of the House, then I daresay this legislation may still be in trouble.

My hope is that we can do what I have just suggested—that over the course of the next several years we can take a very close look at ways to make this legislation better and that we can address what I would consider to be serious shortfalls, especially the benefits shutdown that exists after a person pays $4,500. We are talking about a sickness penalty that, frankly, cannot be sustained. We have to find a way to address that serious shortcoming in this legislation. I hope it is done sooner rather than later.

I come to the floor with my gratitude for the work that has been done. This is the fifth year we have made an effort to pass meaningful prescription drug legislation. We can wait no longer. We simply can't allow the perfect to be the enemy of the good. We have to take what we can do and move to build upon something that we will do in future years to make it more meaningful, make it a better piece of legislation, and make it a law that we can be enthusiastic about someday.

I vote tonight with that expectation and that hope. I am hopeful that there will be many on both sides of the aisle who will share that perspective and that expectation.

I yield the floor.

Mr. FRIST. Mr. President, I ask unanimous consent that at 9:15 tonight the Senate proceed to a vote in relation to the Levin amendment, No. 1111, to be followed by a vote in relation to the Hagel-Ensign amendment, No. 1026, with no second degrees in order to the amendments prior to the votes and with 2 minutes of debate equally divided prior to each vote.

I further ask unanimous consent that prior to the vote Senator ENSIGN be recognized for up to 15 minutes and Senator HAGEL, for up to 10 minutes, and the two managers be given up to 5 minutes each; further, that it be in order for the Hagel-Ensign amendment to be modified up to the beginning of the stacked votes.

The PRESIDING OFFICER. Is there objection?

Mr. DASCHLE. Mr. President, reserving the right to object, I suggest that we make them perhaps 10-minute votes as well to expedite our votes.

Mr. FRIST. Mr. President, let us make it 10-minute votes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Nevada.

AMENDMENT NO. 1026

Mr. ENSIGN. Mr. President, I rise to speak on behalf of the amendment on which Senator HAGEL and I have been working actually for the last several years. This amendment received bipartisan support in the last Congress as a stand-alone bill. We actually made some improvements to it. We think if this amendment is adopted, it will dramatically improve what the committee has attempted to do to add a prescription drug benefit to Medicare. The only portion of the bill we are modifying in substantial form is the prescription drug part of it.

Let me talk about what our amendment exactly does. It would say to a person who is below 200 percent of poverty, they would pay the first $1,500 out of pocket. After that, the Government is going to pay for the rest of their drug costs, other than a 10-percent copay the person would pay.

However, if a person is up to 160 percent of poverty, we will give them, in a pharmaceutical benefit account, $500 per year, which they can use to go to a local pharmacy to buy their prescription drugs or they can use that money and negotiate the price of their prescription drugs through a pharmaceutical benefit manager and mass buy them with their drug discount card. If they want to use their local pharmacist, they can do that. And this $500, if they did not spend it that year, would be rolled over to the next year where it would cover the first part of their deductible. So if you are below 160 percent of poverty, the most you are going to pay out of pocket is less than $100 per month.

There are several benefits to our plan. First of all, with the committee mark, you pay a monthly premium of $35. You also have a deductible of $275. With our bill, you have no monthly premiums, you have a one-time annual fee of $25, and for low-income people, we waive that.

Our plan is completely voluntary. It also gives the most help to lower income seniors and gives progressively less help the more money you make.

So between 200 percent and 400 percent of poverty, $3,500 is your out-of-pocket expenses. Above that amount, the Government pays 90 percent. And from 400 percent to 600 percent of poverty, $5,500 is your out-of-pocket expenses. Above that amount, 20 percent is your deductible before catastrophic coverage kicks in.

For all of these people, though, who want to sign up for the plan, they get a drug discount card where they will save between 25 to 40 percent on their prescription drug costs. It is a completely voluntary program. And in this program, we have several benefits that we think are better than the committee's underlying bill.

One is, under our bill, States that have already enacted programs will be encouraged to keep their programs. Under the committee mark, every State that has a program for low-income seniors is going to drop those. There is no debate about that. As a matter of fact, the Secretary of HHS was before us. The person who oversees

Medicare was before us. Both of them said there is nothing in this bill that will say to the States: Don't drop your plans. And they agreed they will probably drop their plans.

Our bill works with the States that have those programs, States such as my State of Nevada, and encourages those programs to be kept.

A couple of other advantages that our bill has: I want to illustrate those with a couple of examples. These are real-life cases. This is a fictitious name, of course, to protect this woman's identity, but this is a real person. We call her Doris Jones. She is 75 years old. She has an income of about $17,000 a year. She is being treated for diabetes, hypertension, and high cholesterol. She is taking medications that are very typical of what this type of a disease management would require. Her out-of-pocket expenses right now are $3,648.

Let's compare how our amendment, the Hagel-Ensign approach, would affect her out-of-pocket expenses versus the bill on the floor if our amendment is not accepted.

Under our bill, she would have $1,700 out-of-pocket expenses a year. Under the committee bill that is before us today, she would have $2,383 a year. So it is a savings of almost $700 under our approach.

Another person: James is 68 years old. He has an income of about $16,000 a year. He is being treated for diabetes, a pretty severe case of diabetes, and he has all these different medications—very common medications today for a diabetic. His total out-of-pocket expenses today are $5,700.

How does he compare under the two provisions?

Under the Hagel-Ensign approach, about $1,900 would be his out-of-pocket expenses for the year; under the bill that is before us today, a little over $4,000 in out-of-pocket expenses a year. So the difference is almost $2,200 to this senior who is sick. And we certainly would not call him a rich person. I would call this person certainly a low- to moderate-income senior.

Now, Betty is another example. These are real-life examples taking real medicine, prescribed by real doctors. She is 66 years old. She has an income of $15,500. She is being treated for breast cancer and she is taking commonly prescribed medications for that. She is on low-dose radiation. She pays about $8,000 for her prescription drugs a year.

What would happen to her under the two different scenarios?

Under our scenario, she would pay about $2,100 out of pocket. Under the bill that is before us today, she would pay $4,300.

What we have done with our amendment is we have said: Let's help the seniors who need it the most. And we put the dollars to them. Under our amendment, people who are sick, with low and moderate income, they really get help. For people above that, they are treated about the same between our amendment and the bill. The out-of-pocket expenses for people between 200 and 400 percent of poverty are about the same.

When you start getting to the wealthier seniors, there is no question, the committee bill is more generous. For very low income seniors, the committee bill is slightly more generous. But for those who are really sick, our amendment is much better.

Also, there are a couple of other advantages.

In the future, to control costs, our amendment says: The person receiving the medication has something at stake. They are paying out of their own pocket for the first dollars, so they are going to shop. They are going to go around and see: Do I need generics? First of all, do I need the drug? Could I take a generic, which may be less expensive? Are there perhaps other alternatives for treatment that may be cheaper and just as effective? They will have that conversation with their doctor because they have something at stake.

I would argue that what the committee is doing—and I applaud what they are doing, trying in a bipartisan fashion—I believe our amendment would strengthen the committee's bill dramatically because it would target the dollars, those precious taxpayers' dollars, to the people who need it the most. It will also, though, in the future, control costs and, therefore, be more responsible to the next generation.

The committee mark, especially for very low income people, pays 97.5 percent of their drug costs, maybe a $1 to $2 copay. Well, there is going to be a tremendous amount of overutilization in that group.

Our amendment gives that group help by putting $500 of their first costs into an account. They will use that to go shop because if they do not use it, it gets rolled over to the next year where it covers more of their deductible. So they have something to benefit by if they do not use it.

So I implore our colleagues to look and compare. If you look and compare, you will see there truly is a difference.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I commend Senator HAGEL and Senator ENSIGN because they have been working very carefully over the last few years to help move this process along. They have had a different approach than I have had. I have had what I call a comprehensive, universal, voluntary approach. They have had one that is more targeted toward low-income people and toward catastrophic. We deal with that in our legislation, but we are very comprehensive. We are very universal. I don't attack their attempt, but it is just not as good as what is before the Senate. S. 1 already reflects the influence of their plan by providing a drug discount card which will give seniors access to discounted drug prices.

I would like to point out a few things. The Hagel-Ensign plan has two laudable objectives: to protect seniors against catastrophic costs and to ensure that low-income seniors are fully protected.

I am happy to report that S. 1 already meets these goals. S. 1 provides a generous protection for low-income beneficiaries, very generous. It also covers fully 90 percent of beneficiaries' out-of-pocket costs beyond $3,700. Most seniors don't have catastrophic drug costs and thus would not see any benefit from the coverage in the Hagel-Ensign plan. S. 1, on the other hand, would provide a significant basic benefit to most seniors each year. Passing a drug bill that most seniors would see no benefit from is a prescription for disaster. I am afraid of that.

So S. 1 already meets the main goals of the Hagel-Ensign plan, but it provides additional value to a much broader group of beneficiaries as well, the underlying bill, the one that they amend, the one they would decimate.

Another thing S. 1 does very well is use competition to maximize value to the taxpayers. There has been some concern that S. 1 doesn't have as much competitive reform as many of us would have preferred. But the Hagel-Ensign plan has far less reform and is much more government run.

I would like to explain: First, this amendment would rule out any true competition in the delivery of Medicare drug benefits. S. 1 would let private drug plans assume a modest amount of financial risk, giving them an incentive to drive hard bargains and keep taxpayers' costs down. It seems to me that is very significant—the difference between the underlying bill and their bill. We are going to drive drug prices down more through competition.

The Hagel-Ensign plan, it is pretty obvious from my point of view, allows for no such exemption, specifically mandating that the Government—in this case we are talking about the taxpayers—bears all the financial risk for delivering the benefit, much as Senator BOB GRAHAM's did the last year when we debated this very issue.

Under this amendment, the benefit would be delivered just like other Medicare benefits are today—by contractors that merely pay the claims that come in without any effort whatsoever, no effort to contain costs.

Second, the Hagel amendment doesn't include any of the improvements to the Medicare Program that President Bush has proposed and our bill includes. It does not include the role for private preferred provider organization plans to deliver an improved Medicare benefit package. It doesn't make modern innovations such as disease management services or rational cost sharing available to beneficiaries who choose them. It simply dumps a catastrophic drug benefit on to the 1965 vintage Medicare system.

What the people of this country need is improvement in Medicare, strengthening of Medicare, voluntary, universal, comprehensive. The Ensign plan wouldn't improve S. 1, but it would make it substantially worse.

I urge my colleagues to defeat the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I want to clear up something. We don't touch any of the other Medicare reforms in your bill. The whole thing with the PPOs, we touch the prescription drug part of the underlying bill.

You mentioned competition. I practiced veterinary medicine, built, owned, and operated two different animal hospitals. Why do I bring that up? It is because in veterinary medicine people pay out of their own pocket. Veterinarians are in an incredibly competitive field because we know that if somebody brings a case to you, they are going to shop about half the time based on price. So veterinarians have to be very competitive and price sensitive to that, so they work to become more efficient, to keep their costs down, because individuals shop.

In our health care system today, individuals do not shop because we have low deductible policies, and a lot of times the doctors waive those deductibles. Senator FRIST will be able to tell you about that. The hospitals waive the deductibles. So the person receiving the care is not accountable for the care, and so they don't shop. The doctor tells them, go get this service or this drug, and they don't think about it. They have modest, low copays, and they don't think about it.

The cost control, the competition, is established by 40 million people on Medicare, 40 million people receiving drugs. If they are paying out of their own pocket or low-income people have the $500 in a pharmaceutical benefit account, they have something at stake, so they go shop.

They ask the questions: Do I need the drug in the first place? Maybe I can get a generic. So they do the shopping. Also, we have pharmaceutical benefit managers in the bill. That is what the whole drug discount card is about. So those pharmaceutical benefit managers help lower the costs as well.

We have several reforms in this bill that are true reforms, that introduce competition to keep the costs down. That is why our bill actually scored lower.

Because of that, we were able to add a couple other things. When Senator HAGEL arrives, he will modify the amendment. For instance, we will allow Medicaid, the dual eligibles that people have been talking about today, to give States help in handling those dual eligibles through Medicare because our prescription drug cost to the taxpayer was less. It is because we have more reform on the prescription drug part of it than the underlying bill. It just a difference of philosophy of how you do it.

I come to this based on my experience in the private sector and how health care can be delivered by individuals shopping.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time be equally charged.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HAGEL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HAGEL. Mr. President, in the last 2 weeks the Senate has engaged in an historic effort to reform and strengthen Medicare. When we opened this debate 2 weeks ago, I said that what we would do here debating this bill would affect every American and future generations.

Health care is a defining issue for our Nation and future generations. Just a reminder: When Medicare was enacted in 1965, the Federal Government's lead actuary at that time projected that the hospital program, Medicare Part A, would grow to $9 billion by 1990. In fact, the program, in 1990, had then cost the taxpayers $66 billion. So we have some sense of how these programs can get out of hand if not defined clearly at the front end.

In addition to the internal problems of the changing realities of health care, Medicare is facing a looming external problem. The largest generation in American history, the baby boomers, are aging. These Americans—over 75 million of them—will be added to the Medicare rolls over the next few years. The baby boom generation has changed and shaped every market it has ever entered. Medicare will be no exception. We have a responsibility to address this demographic pressure now or risk the system collapsing under its own weight in the future.

Senator ENSIGN and I have come to the floor to offer an amendment to substitute only title I of the Finance Committee's bill, providing a prescription drug benefit for seniors. We believe any Medicare drug benefit must be sustainable for future generations. The benefit must deal with the realities that people are living longer and better and have higher health care expectations than ever before. We believe we can do better with our amendment.

Our amendment is a simple amendment. Seniors will be able to understand it clearly. Unlike the underlying bill, our amendment contains no premiums, no deductibles, and no gaps in coverage. Our modified amendment addresses three of the major issues we have tried to deal with in constructing this plan. First, it helps low-income seniors, those who need it the most. Two, it protects seniors from high out-of-pocket expenses, and it eases the burden prescription drug costs have placed on the States.

Our modified amendment would replace the prescription drug benefit in the Finance Committee plan with, No. 1, a prescription drug discount card for all seniors on Medicare with $30 billion in added funds for low-income seniors; No. 2, catastrophic coverage for all seniors; No. 3, $35 billion in cost-sharing for catastrophic drug costs with the States for the lowest income seniors eligible for both Medicare and Medicaid.

We give the Secretary of Health and Human Services the discretion to divide $65 billion for seniors and for help with drug costs at the State level. With our amendment, the Secretary will provide low-income seniors with money on a drug discount card to help defray their drug expenses.

States would also benefit under our amendment, and $35 billion is available to help States cover the catastrophic drug expenses for the dual eligibles. These are the very poorest of seniors.

These modifications to the amendment make it stronger by targeting aid to those who need it the most. This bill has been scored. We fall within the $400 billion budget number that is required.

This is a commonsense plan that is workable and responsible, and it addresses prescription drug concerns in the right way.

AMENDMENT NO. 1026, AS MODIFIED

Mr. HAGEL. Mr. President, I have a modification at the desk to amendment No. 1026. I ask unanimous consent that the amendment be modified.

The PRESIDING OFFICER. The amendment is so modified.

The amendment (No. 1026), as modified, is as follows:

TITLE I—MEDICARE PRESCRIPTION DRUG DISCOUNT

SEC. 101. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

"PART D—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

"DEFINITIONS

"SEC. 1860. In this part:

"(1) COVERED DRUG.—

"(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

"(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—

"(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D(a)(4)(B).

"(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered drug—

"(i) for which payment would not be made if section 1862(a) applied to part D; or

"(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D(a)(4).

"(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

"(A) eligible for benefits under part A or enrolled under part B; and

"(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

"(A) pharmaceutical benefit management company;

"(B) wholesale pharmacy delivery system;

"(C) retail pharmacy delivery system;

"(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

"(E) Medicare+Choice organization;

"(F) State (in conjunction with a pharmaceutical benefit management company);

"(G) employer-sponsored plan;

"(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

"(I) combination of the entities described in subparagraphs (A) through (H).

"(4) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

"ESTABLISHMENT OF PROGRAM

"SEC. 1860A. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

"(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

"(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

"(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

"(c) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

"(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"ENROLLMENT

"SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

"(1) ESTABLISHMENT OF PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

"(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

"(2) ENROLLMENT PERIODS.—

"(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

"(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

"(C) OPEN ENROLLMENT PERIOD IN 2005 FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

"(i) enroll under this part; or

"(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

"(3) PERIOD OF COVERAGE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

"(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

"(4) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

"(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual's coverage under this part if the individual is—

"(i) no longer enrolled in part A or B; or

"(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

"(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

"(i) the termination of coverage under part A or (if later) under part B; or

"(ii) the coverage under title XIX.

"(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

"(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

"(2) ELECTION PERIODS.—

"(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

"(i) annual coordinated election periods; and

"(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

"(B) INITIAL ELECTION PERIODS.—

"(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part

B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

"(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

"(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

"(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

"(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

"(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

"(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

"(3) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

"(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

"(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICARE+CHOICE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a Medicare+Choice plan.

"(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

"(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

"(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

"(F) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part. For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

"(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

"PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

"SEC. 1860C. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

"(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860B(c).

"ENROLLEE PROTECTIONS

"SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

"(1) GUARANTEED ISSUANCE AND NONDISCRIMINATION.—

"(A) GUARANTEED ISSUANCE.—

"(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

"(ii) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

"(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

"(2) DISCLOSURE OF INFORMATION.—

"(A) INFORMATION.—

"(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

"(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

"(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

"(II) How any formulary used by the eligible entity functions.

"(III) Information on grievance and appeals procedures.

"(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

"(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

"(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

"(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

"(3) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

"(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

"(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

"(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(4) APPEALS.—

"(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

"(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

"(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

"(1) ACCESS TO COVERED BENEFITS.—

"(A) ASSURING PHARMACY ACCESS.—

"(i) IN GENERAL.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(a)(3) that ensure such convenient access.

"(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

"(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

"(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860F(b).

"(B) USE OF STANDARDIZED TECHNOLOGY.—

"(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860F(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

"(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

"(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

"(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

"(ii) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

"(iii) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

"(iv) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

"(v) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

"(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860D(a).

"(2) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

"(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

"(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

"(iii) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

"(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(ii) ELEMENTS.—Such program may include—

"(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

"(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

"(III) detection of patterns of overuse and underuse of prescription drugs.

"(iii) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

"(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

"(C) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

"(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

"(ii) Subsection (c)(1) (relating to access to covered benefits).

"(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

"(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug covered under the plan that is therapeutically equivalent and bioequivalent.

"ANNUAL ENROLLMENT FEE

"SEC. 1860E. (a) AMOUNT.—

"(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

"(2) ANNUAL PERCENTAGE INCREASE.—

"(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

"(i) such dollar amount; multiplied by

"(ii) the inflation adjustment.

"(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

"(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

"(ii) such aggregate expenditures for the 12-month period ending with July 2005.

"(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

“(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

“(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

“(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

“(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

“BENEFITS UNDER THE PROGRAM

“SEC. 1860F. (a) ACCESS TO NEGOTIATED PRICES.—

“(1) NEGOTIATED PRICES.—

“(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term ‘prescription drugs’ is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

“(B) LIMITATIONS.—

“(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

“(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

“(2) DISCOUNT CARD.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

“(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

“(b) CATASTROPHIC BENEFIT.—

“(1) TEN PERCENT COST-SHARING.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

“(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

“(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as determined under section 1860I) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

“(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to $3,500.

“(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to $5,500.

“(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary's income for that year (rounded to the nearest multiple of $1).

“(3) APPLICATION.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

“(4) ANNUAL PERCENTAGE INCREASE.—

“(A) IN GENERAL.—In the case of any calendar year after 2006, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

“(i) such dollar amount; multiplied by

“(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

“(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

“(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

“(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

“(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

“(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

“REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

“SEC. 1860G. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

“(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

“(c) ADMINISTRATIVE FEE BID.—

“(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

“(2) BID SUBMISSION REQUIREMENTS.—

“(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

“(i) Enrollment, including income eligibility determination.

“(ii) Claims processing.

“(iii) Quality assurance, including drug utilization review.

“(iv) Beneficiary and pharmacy customer service.

“(v) Coordination of benefits.

“(vi) Fraud and abuse prevention.

“(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

“(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

“(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

“(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

“(d) AWARDING OF CONTRACTS.—

“(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

“(2) TERMS AND CONDITIONS.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

“(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

“(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

“(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

“(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

“(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

“(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

“(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

“(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

“(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

“(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

“(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

“(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

“PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

“SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

“(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860F(b); and

“(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

“(b) PAYMENT FOR COVERED DRUGS.—

“(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860F(b).

“(2) LIMITATIONS.—

“(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(B).

“(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a) or the price negotiated for insurance coverage under the Medicare+Choice program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

“(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

“(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

“(c) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

“DETERMINATION OF INCOME LEVELS

“SEC. 1860I. (a) DETERMINATION OF INCOME LEVELS.—

“(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E(c) and 1860F(b).

“(2) PROCEDURES:—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

“(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

“(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E(c) and 1860F(b); and

“(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

“(c) QUALITY CONTROL SYSTEM.—

“(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

“(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

“APPROPRIATIONS

“SEC. 1860J. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E.

“MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

“SEC. 1860K. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the ‘Board’).

“(b) ADVICE ON POLICIES; REPORTS.—

“(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

“(2) REPORTS.—

“(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

“(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

“(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

“(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

“(A) PRESIDENTIAL APPOINTMENTS.—

“(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

``(ii) Limitation.—Not more than 2 such members may be from the same political party.

``(B) Senatorial appointments.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

``(C) Congressional appointments.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

``(2) Qualifications.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

``(3) Composition.—Of the members appointed under paragraph (1)—

``(A) at least 1 shall represent the pharmaceutical industry;

``(B) at least 1 shall represent physicians;

``(C) at least 1 shall represent medicare beneficiaries;

``(D) at least 1 shall represent practicing pharmacists; and

``(E) at least 1 shall represent eligible entities.

``(d) Terms of Appointment.—

``(1) In general.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

``(2) Continuance in office and staggered terms.—

``(A) Continuance in office.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

``(B) Staggered terms.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

``(i) Presidential appointments.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

``(I) 2 years;

``(II) 4 years; and

``(III) 6 years.

``(ii) Senatorial appointments.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

``(I) 3 years; and

``(II) 6 years.

``(iii) Congressional appointments.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

``(I) 4 years; and

``(II) 5 years.

``(C) Reappointments.—Any person appointed as a member of the Board may not serve for more than 8 years.

``(D) Vacancies.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

``(e) Chairperson.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

``(f) Expenses and Per Diem.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

``(g) Meetings.—

``(1) In general.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

``(2) Quorum.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

``(h) Federal Advisory Committee Act.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

``(i) Personnel.—

``(1) Staff director.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

``(2) Staff.—

``(A) In general.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

``(B) Flexibility with respect to civil service laws.—

``(i) In general.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

``(ii) Maximum rate.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

``(j) Authorization of Appropriations.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.''.

(b) Conforming References to Previous Part D.—

(1) In general.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) Secretarial submission of legislative proposal.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) Effective Date.—

(1) In general.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) Implementation.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) Establishment of Center for Medicare Prescription Drugs.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) Duties.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 101).

(c) Director.—

(1) Appointment.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) Responsibilities.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) Personnel.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ``attributable to the application of section'' and inserting ``attributable to—

``(1) the application of section'';

(2) by striking the period and inserting ``; and''; and

(3) by adding at the end the following new paragraph:

``(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part D.''.

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

"(1) PROMULGATION OF MODEL REGULATION.—

"(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

"(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

"(ii) a uniform format is used in the policy with respect to such revised benefits; and

"(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2006 NAIC Model Regulation').

"(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2006 Federal Regulation').

"(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

"(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

"(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

"(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

"(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

"(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

"(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

"(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.".

SEC. . PARTIAL FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR CATASTROPHIC COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1): is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(d)(1) for the State and the quarter".

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

"(d) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

"(A) MEDICARE BENEFITS FOR MEDICAID ELIGIBLES.—The total amount of payments made in the quarter because of the operation of section 1845 that are attributable to individuals who are residents of the State and are eligible for medical assistance with respect to prescription drugs under this title.

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

"(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

"(A) 2005 is 90 percent;

"(B) a subsequent year before 2014, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

"(C) a year after 2013 is 0 percent.".

(3) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

"(e) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to benefits under part B of title XVIII and is eligible for medical assistance with respect to prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under such part B, without regard to section 1902(n)(2).".

(4) LIMITATION AND CAPS.—The Secretary will implement the above section to the extent possible within a total federal authorization of $35,000,000,000.

SEC. . ADDITION OF DOLLAR AMOUNT TO PRESCRIPTION DRUG DISCOUNT CARDS; EFFECTIVE DATE.

(a) ADDITION OF DOLLAR AMOUNTS TO PRESCRIPTION DRUG DISCOUNT CARDS.—Section 1860F (as added by section 101) is amended by adding at the end the following:

"(c) PROVISION OF DOLLAR AMOUNTS ON CARDS.—

"(1) AMOUNT OF ANNUAL ASSISTANCE.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, each eligible entity with a contract under this section shall provide coverage for the applicable amount of expenses for prescription drugs incurred during each calendar year by an eligible beneficiary enrolled in a prescription drug discount card plan offered by such entity.

"(B) APPLICABLE AMOUNT DEFINED.—For purposes of subparagraph (A), the term 'applicable amount' means the total amount that the Secretary determines will not cause expenditures under this part to exceed the total amount that would have been expended under this title if this part had not been enacted by more than $30,000,000,000 during the period beginning on January 1, 2005, and ending on September 30, 2010.

"(2) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible beneficiary is not enrolled in a prescription drug discount card plan offered by an eligible entity with a contract under this part, the amount of assistance available under paragraph (1) shall be reduced by $50.

"(3) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—

"(A) IN GENERAL.—The dollar amount of coverage described in paragraph (1) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

"(B) REFUND OF EXCESS AMOUNTS.—The Administrator shall refund to the eligible beneficiary the amount (if any) by which the dollar amount of coverage described in subparagraph (A) exceeds the catastrophic limit described in subsection (b).

"(4) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Administrator may waive such requirements of this part as may be necessary to ensure that each eligible beneficiary has access to the assistance described in subparagraph (A).

"(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card plan if the program excludes the drug under a formulary and such exclusion is not successfully resolved under the grievance or appeals processes provided for under this part.

"(6) PAYMENTS TO PLANS.—The Administrator shall reimburse each eligible entity for any costs incurred under this subsection.".

(b) EFFECTIVE DATE.—Part D is amended by adding at the end the following new section:

"EFFECTIVE DATE

"Sec. 1860L. Nothwithstanding any other provision of this part, the Voluntary Medicare Prescription Drug Discount and Security Program under this part shall apply only during the period beginning on January 1, 2005 and ending on December 31, 2010.".

Mr. HAGEL. Mr. President, I now ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. HAGEL. I thank the Chair and yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, the prescription drug bill, Medicare reform bill combination that we have before us today, as we all know, is a freight train coming through this place and there is no stopping it.

What is very unfortunate is that we have a very legitimate amendment on the floor today that is getting 20, 30 minutes' worth of debate. I put up some examples on the chart here of how this amendment we are offering is superior. I have tried to be objective, to say that above 200 percent of poverty, between 200 and 400 percent of poverty they are pretty equal plans. For the very low income, our amendment is slightly less generous, but it keeps the low-income people with something at stake so they will shop. We have heard nothing about that from the other side. There has been no debate, in other words. It is because there is an agreement to defeat any substantive amendment. It is unfortunate.

This is probably the most important vote, as far as an entitlement program, that any of us in our careers will ever take, and this bill is being rushed through so that we can get a "bill" to conference, where all of the improvements are going to be made.

We have an amendment before us that I believe should be debated. If you disagree, fine, but let's debate it and vote on it up or down. But I don't think this kind of a process is healthy for the Senate.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Mr. BREAUX. Mr. President, I yield myself whatever time we have in opposition to the amendment.

The PRESIDING OFFICER. Of whose time?

Mr. BREAUX. Off of the chairman, Senator GRASSLEY's time.

The PRESIDING OFFICER. The Senator is recognized.

Mr. BREAUX. Mr. President, I start off by commending the authors of the amendment for a real serious effort to try to improve the bill. But I rise in opposition because there is not any segment of the senior population that you could not isolate and target and say we can make, for this particular group, a better deal than they have in this bill. That is not the purpose of this legislation.

The purpose of Medicare is that it is universal. It is not a welfare bill. It is not just for low-income individuals. It is for every American citizen who has reached the age of 65, or older, and qualifies for the program. That is one of the greatest features of the Medicare Program—that everyone is essentially treated equal.

So it is easy, if you want to isolate a low-income group and say we are going to give them a better deal. But when you are looking at the entire population of almost 40 million Americans with whom we have to deal, that, indeed, is the real challenge, and that is why the content of this bill is far superior than to narrowly isolate only low-income people and say we can do a better deal for them. Of course, but you are not going to be able to do that in keeping with the general theme of what Medicare is all about and taking care of all Medicare seniors with the best possible deal.

I think that is what the goal of this Congress should be, and that is why what we have in the provisions here to give them prescription drugs, which would be within the Medicare Program, that people can voluntarily continue to accept the traditional Medicare or, if they would like, move into an expanded Medicare Advantage and get all of the benefits through a private, competitively delivered system.

What we have is the beginning of a program that can be improved upon and will be. But we have essentially an insurance-type program, similar to what we have as Federal employees, which can be improved upon. But it is for everybody. We, too, give special attention to lower income individuals, and maybe they can do it better, but it is going to have to come from somewhere else, and the somewhere else is the vast number of other seniors who would have some of their benefits diluted and reduced in order to make this a little better than what is in this bill.

The goal is to try to create a universal program across the board, and one that is fair to everyone. I think that is what is in the bill as it now stands.

Mr. GREGG. Will the Senator yield for a question?

Mr. BREAUX. Yes, I am happy to yield.

Mr. GREGG. Would the Senator agree that there wasn't, in the original program set up as an insurance program, which you would pay into during your working life under the Part A part of the insurance program, with the concept that when you retired, you would have paid for your health insurance. That is why everyone is covered under it. But is it not also true that under this drug benefit as proposed, nobody will have paid into the Medicare insurance plan for the purposes of this drug program? This drug program will be a new entitlement, and therefore it is reasonable that since it is going to be borne not by the people who worked for it but by the people who are working—it is going to be borne by them rather than the recipients—then it should be set up in a different structure along the lines that are proposed, which is you benefit the low income and you benefit people who have a catastrophic event rather than have a program that puts the benefit out to everyone and forces 37 percent of the population off private insurance plans and onto a public plan.

Mr. BREAUX. I am not sure whose time this is on. I will respond to the Senator's question. We have a health delivery system supervised by the Federal Government, and the beneficiaries are going to contribute to it. Those benefiting from it are going to have an average premium of $35 a month, a $275 deductible, and 50 percent copayment.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. BREAUX. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Parliamentary inquiry: Will the Chair inform the Senate as to the time allowable on this amendment?

The PRESIDING OFFICER. The Senator from Nebraska has 4 minutes 30 seconds remaining. No time remains in opposition.

Mr. BAUCUS. I wonder if I can get consent to speak for 1 minute on this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, two points: One, this amendment is totally new. We have not seen the language. We have been asking for the language for days. It has been filed in various forms. This is new language. The Senate has no idea what is in this amendment. We saw it for the first time maybe 15, 20, 30 minutes ago. It is impossible to know what this amendment does.

Point No. 2, essentially what we can tell by a cursory glance at the amendment is the amendment enters a whole new concept in Medicare that has not been done before, and that is means testing. It means tests those at the catastrophic levels.

I do not think we want to begin to go down that road tonight. It makes more sense to stay with the underlying bill which essentially gives a 44-percent rate to those beneficiaries with lower income.

The problem is it does not help, as our bill does, up to catastrophic, and then catastrophic is means tested. That is not the right thing to do, certainly at this hour after looking at it 30 minutes ago.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Nevada.

Mr. ENSIGN. Mr. President, I ask unanimous consent for whatever time I consume from Senator HAGEL's time to respond.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HAGEL. Mr. President, I understand I have 4 minutes 20 seconds.

The PRESIDING OFFICER. That is correct.

Mr. HAGEL. I yield to my colleague whatever time he requires from my time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENSIGN. Mr. President, means testing and universal have been mentioned. The Senator from New Hampshire mentioned that this is a brand new benefit, and that is why we are only talking about the prescription drug part—a brand new benefit for which young people in America are going to be paying for years and years. It seems to make sense that we try to control those costs.

Yes, our bill means tests. So does the underlying bill. To sit up here and say their bill does not means test is completely disingenuous. They have several levels in the low-income areas they means test. They are just means testing in a different area. If you means test one, why is calling our bill means testing when their bill means tests as well? How can they say our bill means tests and theirs does not? That is disingenuous.

It is critical that we have this debate. There was a complaint that they just saw this amendment tonight. Part of the reason is that we are trying to rush this bill through what is supposed to be the most deliberative body in the world, and we have this false deadline that we must get this bill passed before the July break. I submit, this deserves more debate. The debate cannot happen when it goes to conference because most of the Senate is cut out then and there is no debate when it comes back here.

With all due respect, I think we have a superior portion of the prescription drug plan, and I hope our colleagues vote for this plan.

I reserve the remainder of our time.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Mr. President, how much time is remaining?

The PRESIDING OFFICER. Two and a half minutes.

Mr. HAGEL. Mr. President, in addition to what my colleague from Nevada has said in response to the distinguished Senator from Montana, there is nothing new about this bill except two features.

This bill, the Hagel-Ensign bill, last year received more bipartisan votes on the floor of this Senate than any other bill. There is nothing new in this bill except two features. One is the $30 billion for low-income seniors' additional coverage, and the other is the $35 billion in cost sharing for catastrophic drug costs with Medicare and Medicaid to dual eligibles. That is what is new in the bill.

To say this is new and we have just sprung this on the Senate is a bit disingenuous. This bill has been around for almost 4 years in its current form.

I yield the floor.

The PRESIDING OFFICER. Does the Senator yield back his time?

Mr. HAGEL. Mr. President, I yield back all of my time.

AMENDMENT NO. 1111

The PRESIDING OFFICER. There are 2 minutes evenly divided on the Levin amendment No. 1111. Who yields time on the Levin amendment No. 1111?

Mr. BAUCUS. It is my understanding the sponsor, Senator LEVIN, is in the Chamber.

Mr. LEVIN. I have already spoken on the amendment.

The PRESIDING OFFICER (Mr. ENSIGN). All time is yielded back.

The question is on agreeing to amendment No. 1111.

Mr. BAUCUS. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Oklahoma (Mr. INHOFE) are necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER (Mr. GREGG). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 42, nays 54, as follows:

[Rollcall Vote No. 259 Leg.]

YEAS—42

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Clinton
Conrad
Corzine
Daschle
Dayton
Dodd
Dorgan
Durbin
Edwards
Feingold
Feinstein
Graham (FL)
Harkin
Hollings
Inouye
Johnson
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Stabenow
Wyden

NAYS—54

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Cornyn
Craig
Crapo
DeWine
Dole
Ensign
Enzi
Fitzgerald
Frist
Graham (SC)
Grassley
Gregg
Hagel
Hatch
Hutchison
Jeffords
Kyl
Lott
Lugar
McCain
McConnell
Miller
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Snowe
Specter
Stevens
Sununu
Talent
Thomas
Voinovich
Warner

NOT VOTING—4

Domenici
Inhofe
Kerry
Lieberman

The amendment (No. 1111) was rejected.

Mr. LOTT. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1026, AS MODIFIED

The PRESIDING OFFICER. Before we can go to the next amendment, we will have to have order in the Senate.

There are 2 minutes equally divided. Who seeks recognition? The Senator from Nevada.

Mr. ENSIGN. Mr. President, I will use 30 seconds and Senator HAGEL will use 30 seconds on this side.

The Hagel-Ensign amendment corrects several problems in the bill. Let me go over those real briefly.

We have no monthly premiums. We do not make middle-class taxpayers pay for prescription drugs for wealthy seniors. We preserve the State and the private plans that are already out there, which the underlying bill does not do. We give most of our help to low- and moderate-income seniors but we still control costs in our bill.

I encourage a "yes" vote on this amendment.

Mr. HAGEL. Mr. President, to summarize our amendment is simple: It helps those who need it most. It helps the States provide a discount drug card. It is affordable, with no monthly premiums, no deductibles, catastrophic coverage, and accountable market-based tools. It is a complete, affordable, discount drug plan that the next generation of this country can support. We can be proud of what we are doing for our seniors.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the major fatal problem with this amendment is it dispenses with the underlying principle of the underlying bill. That is universality. We are, in the legislation before us, providing for universal benefits.

This amendment violates that principle by saying no, not across the board for Americans but, rather, it introduces a whole new means testing provision for catastrophic. I just think it fatally violates the spirit of the legislation we are about to pass.

The PRESIDING OFFICER. All time has expired. The question is on agreeing the amendment No. 1026, as modified. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Oklahoma (Mr. INHOFE) are necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 21, nays 75, as follows:

[Rollcall Vote No. 260 Leg.]

YEAS—21

Allard
Brownback
Burns
Chambliss
Crapo
Dole
Ensign
Graham (SC)
Gregg
Hagel
Hutchison
Lott
Lugar
McCain
McConnell
Reid
Roberts
Santorum
Sessions
Sununu
Talent

NAYS—75

Akaka
Alexander
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Boxer
Breaux
Bunning
Byrd
Campbell
Cantwell
Carper
Chafee
Clinton
Cochran
Coleman
Collins
Conrad
Cornyn
Corzine
Craig
Daschle
Dayton
DeWine
Dodd
Dorgan
Durbin
Edwards
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham (FL)
Grassley
Harkin
Hatch
Hollings
Inouye
Jeffords
Johnson
Kennedy
Kohl
Kyl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Miller
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Nickles
Pryor
Reed
Rockefeller
Sarbanes
Schumer
Shelby
Smith
Snowe
Specter
Stabenow
Stevens
Thomas
Voinovich
Warner
Wyden

NOT VOTING—4

Domenici
Inhofe
Kerry
Lieberman

The amendment (No. 1026), as modified, was rejected.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, for the information of Senators, we have made tremendous progress today, and we are on the final leg. In conversations with the managers, it appears we will have one more series of stacked votes tonight and that will include final passage. That series will be it. The bill will be done.

We need somewhere between 45 minutes and an hour—hopefully 45 minutes, and hopefully people can yield back their time—before we can begin those votes. I think that is all we can say at this juncture, working in good faith. There are a lot of details. We are waiting for some of the final wording to come through in terms of the managers' package. Once we have that, we will be able to proceed with the voting.

I don't know how many amendments it will be. It could be two amendments; it could be four amendments; it could be one amendment or passage. But it is going to be probably two or four amendments beginning in about 45 minutes to an hour.

Mr. BYRD. Will the leader yield?

Mr. FRIST. Yes.

Mr. BYRD. On the preceding rollcall vote, 28 minutes were required. On this rollcall vote, 22 or 23 minutes were required. So we have over 50 minutes on two rollcall votes. Now, time is worth a little something around here to many of us who don't have much time left. I wonder if we can't do better than that.

I think the Senate ought to treat itself better than that. Senators owe to it other Senators to not just lag and cause rollcall votes to last so long. Twenty-eight minutes on a rollcall vote? Why can't we go over to tomorrow? We are going to be here anyhow. Why can't we go over? Here it is 15 minutes after 10. Do I have the floor, Mr. President?

The PRESIDING OFFICER. The majority leader has the floor.

Mr. BYRD. Very well.

Mr. FRIST. Mr. President, we can do better, and I think we ought to do our best to try to do maybe 10 minutes on the last series. It is late at night. We have all been working about 12, 13 hours nonstop. It is an important bill. We set out this morning to finish tonight. People are here. They are ready to finish it. It is late. After talking to the managers and the leadership on both sides, there is a general consensus that we ought to push ahead, get this bill done for the American people.

We can do it. Things have gone very well. We have had adequate time for debate and amendment. The distinguished Senator from West Virginia told me from day one: My advice to you as the majority leader is to make sure you give time for debate and amendment. He did forget to tell me that it is sometimes hard dealing back and forth as you are waiting for language to come, as you are trying to get the order for amendments in these last hours on a very complex bill, a bill that is as big as any bill we have passed this year and as complex, and it has taken a little bit more time.

I would have liked to have finished at 9 o'clock tonight. I think at this juncture, if we proceed over the next 45 minutes—let's do those rollcall votes in 10 minutes—we will be out of here. People will be able to leave tomorrow or stay and come to the floor and talk. I think that is the general sense of where we should go.

Mr. BYRD. Mr. President, will the Senator yield?

Mr. FRIST. The Senator is happy to yield to the Senator from West Virginia.

Mr. BYRD. Mr. President, we are falling into this way of doing things. Three-day work weeks. I will tell you, Mr. Leader, one night I am going to get the floor and Senators will be planning on finishing and going home the next day. They won't get to do that. I have seen this happening over and over and over more recently. Three-day work weeks, and we don't come in on Friday and work and vote.

If the Senator will continue to yield, just briefly?

Mr. FRIST. If the Senator will yield for a couple more minutes because we do have people who want to get on to the business. I certainly do yield for a few more minutes.

Mr. BYRD. Mr. President, I don't want to overtax the leader at this point or overtax other Senators. Just suffice it to say, we had better get out of this habit of just having 3-day workweeks, staying here until 10, 11, 12 on Thursday night so that people can go out on Friday. I started this thing of having a week at home every 4 weeks, but we worked the 5 days. We worked 5 days in each of the 3 weeks in between, and we started voting early on Mondays and we voted a full day on Friday. I know things have changed. I am not majority leader. I don't mean to be a problem to the majority leader. But this is getting to be a problem with some of us.

Mr. FRIST. Mr. President, let me just reply and say: Last Friday, you and I were on the floor at 3 in the afternoon. Just because we are not voting doesn't mean we are not working. Some of us do have constituents we go back to and spend time with. Some of us are working on bills and reading. Just because we are not voting does not mean we are not working.

Mr. BYRD. I understand that.

Mr. FRIST. Again, I suggest that we go back so we can work and debate and get these two or four amendments finished. I would be happy to talk to the Senator. I understand he wants us to be efficient and work 5 days a week. I would like to work 6 days a week.

Mr. BYRD. I have a wife at home and she needs me there. I ought to be there. I have stopped early on two occasions lately just to go be with her and let the Senate run its course. There is going to come a time when this Senator is going to keep the Senate in session a while. He can still do it.

I say this in the very best of spirit to the leader—and he is doing the best he can—there comes a time when some of us have duties elsewhere and we would like to keep our rollcall records clean. Soon I will have cast 17,000 rollcall votes. So I have been here for my share of the votes. I am getting a little bit fed up staying around here. This last rollcall vote was 23 minutes and the one before that was 28 minutes. There is a lot of hooping and hollering. What do the American people think of us? It is time we went home if we don't work.

I hope, Mr. Leader, that those of you who are so good at working out these things can get people to have voice votes or maybe cut down the time on their amendments.

Mr. FRIST. Mr. President, I suggest that, since we have our colleagues here and ready to work, we go back to work now. I think the Senator made his point. I am listening and I will heed that advice and counsel. I suggest we go back to work so we can get home tonight to our families as well.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition? The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I believe we are in the process of trying to wrap up debate on a few amendments. I believe momentarily Senator FEINSTEIN and Senator CHAFEE and I will be discussing our amendment. I will make my comments very brief. I know Senator FEINSTEIN wishes to speak on it. I hope we can conclude debate. I think there will only be two more amendments. I urge colleagues to make their comments brief and let's vote and finish action on this bill. I will defer my comments on the amendment because I believe the Senator from California is ready to speak.

The PRESIDING OFFICER. The Senator from California is recognized.

AMENDMENT NO. 1060, AS MODIFIED

Mrs. FEINSTEIN. Mr. President, I call up amendment No. 1060, as modified.

The PRESIDING OFFICER. Without objection, the amendment, as modified, is now the pending business.

The amendment (No. 1060), as modified, is as follows:

At the end of title IV, insert:

Subtitle D—Part B Premium

SEC. . INCOME-RELATED INCREASE IN MEDICARE PART B PREMIUM.

(a) In General.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

"(h) Increase in Premium for High-Income Beneficiaries.—

"(1) Amount of increase.—

"(A) In general.—Except as provided in paragraph (4), if the modified adjusted gross income of an individual for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) exceeds the threshold amount, the amount of the premium under subsection (a) for the individual for the calendar year shall, in lieu of the amount otherwise determined under subsection (a), be equal to the applicable percentage of an amount equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for the calendar year.

"(B) Applicable percentage.—The term 'applicable percentage' means the percentage determined in accordance with the following tables:

"(i) Individuals not filing joint returns.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $50,000	50 percent
More than $50,000 but not more than $100,000	75 percent
More than $100,000	100 percent.

"(ii) Individuals filing joint returns.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $100,000	50 percent
More than $100,000 but not more than $200,000	75 percent
More than $200,000	100 percent.

"(C) Definition of threshold amount.—For purposes of this subsection, the term 'threshold amount' means—

"(i) except as provided in clause (ii), $100,000; and

"(ii) $200,000 in the case of a taxpayer filing a joint return.

"(D) Inflation adjustment for threshold amount.—

"(i) In general.—In the case of any calendar year beginning after 2006, the dollar amount in clause (i) of subparagraph (C) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding calendar year exceeds such average for the 12-month period ending with June 2005.

"(ii) Joint returns.—The dollar amount described in clause (ii) of subparagraph (C) for any calendar year after 2006 shall be increased to an amount equal to twice the amount in effect under clause (i) of subparagraph (C) (after application of this subparagraph).

"(iii) Rounding.—If any dollar amount after being increased under clause (i) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

"(E) Definition of modified adjusted gross income.—For purposes of this subsection, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

"(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

"(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

"(F) Joint return.—For purposes of this subsection, the term 'joint return' has the meaning given such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

"(2) Determination of modified adjusted gross income.—The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

"(A) Notice.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year. In providing such notice, the Secretary shall use the most recent poverty line available as of the date the notice is sent.

"(B) Calculation based on information provided by beneficiary.—If, during the 60-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with appropriate information (as determined by the Secretary) on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

"(C) Calculation based on notice amount if no information is provided by the beneficiary or if the secretary determines that the provided information in not appropriate.—The amount initially determined by the Secretary under this paragraph with respect to an individual shall be the amount included in the notice provided to the individual under subparagraph (A) if—

"(i) the individual does not provide the Secretary with information under subparagraph (B); or

"(ii) the Secretary determines that the information provided by the individual to the Secretary under such subparagraph in not appropriate.

"(3) Adjustments.—

"(A) In general.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (2), the Secretary shall increase or decrease the amount of the individual's monthly premium under this part (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

"(i) the total amount of all monthly premiums paid by the individual under this part during the previous calendar year; and

"(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (2) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

"(B) Interest.—

"(i) Increase.—In the case of an individual for whom the amount initially determined by the Secretary under paragraph (2) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (2), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by an amount of interest equal to the sum of the amounts determined under clause (ii) for each of the months described in such clause.

"(ii) Computation.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (2) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (2) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

"(iii) EXCEPTION.—Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (2) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

"(C) STEPS TO RECOVER AMOUNTS DUE FROM PREVIOUSLY ENROLLED BENEFICIARIES.—In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this part for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium under this part for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

"(D) DECEASED BENEFICIARY.—In the case of a deceased individual for whom the amount of the monthly premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

"(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

"(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

"(4) WAIVER BY SECRETARY.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

"(5) TRANSFER TO PART B TRUST FUND.—

"(A) IN GENERAL.—The Secretary shall transfer amounts received pursuant to this subsection to the Federal Supplementary Medical Insurance Trust Fund.

"(B) DISREGARD.—In applying section 1844(a), amounts attributable to subparagraph (A) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B) thereof."

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting "or section subsection (h)" after "subsections (b) and (e)";

(B) in subsection (a)(3) of section 1839(a), by inserting "or subsection (h)" after "subsection (e)";

(C) in subsection (b), inserting "(and as increased under subsection (h))" after "subsection (a) or (e)"; and

(D) in subsection (f), by striking "if an individual" and inserting the following: "if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))".

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting "or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted," before "he may".

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

"(19) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

"(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Centers for Medicare & Medicaid Services return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the adjusted gross income of such taxpayer,

"(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

"(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

"(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

"(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act."

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3)(A) of section 6103(p) of such Code is amended by striking "or (18)" each place it appears and inserting "(18), or (19)".

(B) Paragraph (4) of section 6103(p) of such Code is amended by striking "or (16)" and inserting "(16), or (19)".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 2006.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(19) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 2002.

Mrs. FEINSTEIN. Mr. President, this amendment is presented on behalf of myself, Senators NICKLES, CHAFEE, LINDSEY GRAHAM, ALEXANDER, and MCCAIN.

This amendment provides that Medicare beneficiaries with an annual adjusted gross income of over $200,000, or above, pay the full cost of the Medicare Part B premium. The amendment uses a sliding scale to ramp up the beneficiary's share of the Part B premium.

The amendment we are offering would hold Medicare beneficiaries with annual adjusted gross incomes between $100,000 and $150,000 a year responsible for 50 percent of the cost of the premium. In 2003, this amounts to $116.40 a month, or $1,396 annually, rather than $58.20 monthly, or $698 annually, which is what the beneficiary pays today for the benefit.

Medicare beneficiaries with incomes between $150,000 a year and $200,000 a year—that is $300,000 to $400,000 for a couple—would be responsible for 75 percent of the total cost of the Part B premium. In 2003, this amounts to $174 or $2,095 annually.

Medicare beneficiaries with annual incomes above $200,000—that is $400,000 for couples—would be responsible for 100 percent of the total cost of the premium. In 2003, this amounts to $232.80 a month, or $2,793 annually. Now, for a beneficiary with an annual income of $200,000, this amounts to less than 1.4 percent of their annual income. For the vast majority of Medicare beneficiaries, some 37 million of the 38 million beneficiaries, Part B premiums would remain the same as they are today.

According to the Census Bureau, about 98 percent of all Medicare beneficiaries have annual incomes below $100,000. So the amendment we are proposing will affect about 2 percent of the most affluent and well off Medicare beneficiaries.

Let me be clear. This amendment does not deprive any Medicare beneficiary of any benefit. What this amendment says is that if you can afford to pay the price for the Medicare Part B premium, you should. Those Medicare beneficiaries who have annual incomes below $100,000 a year will still be able to receive a 75-percent Government subsidy for their premium.

Now, I strongly believe the time has come to begin to income-relate some of these benefits. The Federal Government should not be subsidizing the Part B premiums of those beneficiaries who can afford to pay for the cost of the premiums themselves.

Much has changed since the creation of Medicare in 1965. People are living longer, due in large part to improved diagnostic tools and treatment. There is no way Congress could have predicted the number of people who would come to rely on Medicare or the rate at which medical expenses would grow. When Medicare was established in 1965, the Part B premium was set at a level to cover about 50 percent of program costs. With medical inflation, the dollar amount of the premium has declined to cover only 25 percent of program costs.

The Omnibus Budget Reconciliation Act of 1993 established the Medicare

Part B premium to equal 25 percent of the program cost from 1996 to 1998. The Balanced Budget Act of 1997 permanently established the Part B premium at 25 percent. The bill to balance the budget in 1997 that passed out of the Senate Finance Committee included a provision to income relate the Medicare Part B premium. So this is nothing new.

The provision included in 1997 would have had beneficiaries with incomes over $50,000 for an individual and $75,000 for a couple paying a greater share of the premium. This provision was stripped out during conference.

Well, we were in a different financial situation when Congress made the decision to set the beneficiary's share of the Part B premium at 25 percent in 1997. At that time, we had only a $22 billion deficit. The next year the budget was in surplus to the tune of $69 billion.

With a Federal budget deficit of over $400 billion in the year 2003 and an increase in the Federal debt of $5.3 trillion, for a total of $12 trillion in debt expected by 2013, I believe that now is the time to rethink the premium structure of Medicare Part B.

As the baby boomers age, there will be an increasing reliance on and demand for the Medicare Program.

The number of people age 65 and older will more than double over the coming decades, rising from 37 million today to 70 million in 2030 and 82 million in 2050. Over the next 75 years, the Medicare program will cost 71 percent more than that provided under current law in order to meet its needs.

It is predicted the Medicare hospital trust fund will be insolvent by 2030. The CBO projects Medicare spending will nearly quadruple by 2075 in order to meet the growing need for the program, with budget outlays of $277 billion in 2003. This means spending for the program could reach $1.1 trillion by 2075.

With the legislation currently before the Senate, Congress is proposing some major changes to the Medicare Program. I am in full support of adding a drug benefit, but Congress should also rethink the financing mechanisms of the program, and this bill is short in that direction. High-income beneficiaries can afford to pay a larger share of Medicare's costs, at least of the premium. They can afford to pay for the benefits they receive.

In light of the fact the Federal Government has just provided tax cuts in the range of $1,841 for people with incomes between $77,000 and $154,000 and up to $30,000 for people with incomes above $374,000, it seems to me people with annual incomes above $200,000 can afford to pay $2,793, which is the annual premium for Medicare Part B this year.

We should focus funding so that 98 percent of Medicare beneficiaries who have an annual adjusted gross income of less than $100,000 can continue to access benefits. I think it is reasonable to ask those who can afford it to pay a greater share of the premium. We are still waiting for an official cost savings score from CBO, but I believe this amendment could save billions of dollars.

Once again, Mr. President, this amendment affects less than 2 percent and only those with incomes of more than $200,000 a year adjusted gross income would pay the full premium of about $2,900 a year. We think this is a reasonable proposal. It is scaled up. It impacts no one below $100,000 adjusted gross income a year, and at the maximum for people of over $200,000 a year in adjusted gross income, the premium would be just $2,900.

The income limits would be indexed to medical inflation and, according to current population survey data from 2002, only 2 percent, or about 1 million people of the 38 million Medicare beneficiaries, have incomes of over $100,000 a year. This would protect the tax subsidy for people who need it by encouraging those who have the dollars simply to pay either a greater share of the premium cost or the full premium cost.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I join with Senator FEINSTEIN, Senator NICKLES, and others in presenting this amendment this evening. I believe this income-related Part B premium for only the wealthiest of seniors, a little over 1 percent of the entire Medicare population, is necessary to sustain the long-term solvency of the Medicare Program.

I wish to make just three points on this issue. First, as Senator FEINSTEIN has said, previous Congresses have worked on this issue. In 1997, the Senate voted 70 to 30 to do exactly what we are doing here, and most of those Senators are still here today.

Second, many of these seniors can afford this added premium. Most seniors, it is safe to say, who are making over $100,000 a year have already paid off their mortgages. They have paid off their loans. They have educated their children. They can afford these higher premiums which would go from only $1,400 a year to $2,800 a year, at the most, depending on the income they make. So seniors who are making $100,000 at the most will pay only $1,400 a year, and those making $200,000 will pay $2,800 a year. I do not think that is too much to ask to help keep this program solvent.

Finally, if we do not do this today, some other Congress is going to do it. In 1997, the National Bipartisan Commission on the Future of Medicare was created to resolve the long-term insolvency facing the system. That was in 1997 and it was known as the Breaux-Frist Commission. They did not report their work to Congress. They fell short of the votes necessary to report their work to Congress.

However, it is interesting to note that one of the reasons they failed to get the votes to report to Congress was the President at the time, President Clinton, called for putting aside 15 percent of budget surpluses the next 15 years to pay down the debt and to shore up Medicare. Fifteen years of budget surpluses—when will we see those again?—to shore up Medicare. Because the Breaux-Frist plan did not include that, they did not get the votes necessary.

Mr. President, now is the time to adopt this amendment. If we do not adopt it, future Congresses will have to wrestle with this dilemma.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, for the information of our colleagues, I am going to make a couple comments on this amendment. There may be an amendment by the Senator from Pennsylvania that will require a vote on or in relation to Senator CORZINE's amendment. I think we are close to finishing. I hope we can. I just make those comments.

I compliment Senator FEINSTEIN and also Senator CHAFEE, Senator ALEXANDER, Senator MCCAIN, and others for supporting this amendment. Senator CHAFEE mentioned we passed the income-related Part B premium several years ago with 70 votes. I believe the majority of people, a strong majority—looking at the people who voted for it—are still here. I hope we vote for it again.

Medicare has some big problems long term. The bill before us has a lot of new subsidies but does not have a lot of reform to make it affordable for future generations.

Part B right now is subsidized by general revenues 3 to 1 Federal Government and individuals. The amendment before us on Part B says if individuals have income above $100,000, they should pay at least 50 percent. If they have income above $200,000, they should pay it all. For couples, that would be $400,000. A couple could make $400,000 before they pay all their Part B premium.

Surely we can do that. Why should we ask our kids and/or our grandkids, who might have incomes of $20,000 or $30,000, to be subsidizing individuals to that degree?

I compliment my colleagues for this amendment. I will read from the annual report of the board of trustees of the HI trust fund. It says:

> Similarly, SMI general revenues in the year 2002 were equivalent to about 7.8 percent of personal and corporate Federal income tax collected in that year. If such tax is to remain at the current level relative to the national economy, then SMI—

That is Part B—

general revenue financing in 2077 would represent roughly 32 percent of total income taxes.

That is almost one-third of total income taxes. That is not affordable. That is not sustainable. So I think the amendment we have before us by Senator FEINSTEIN and Senator CHAFEE and others is a small step in the right direction to try to make this system more affordable for future generations.

I compliment my colleagues for this amendment. I urge our colleagues to support this small step toward reform.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

IN REMEMBRANCE OF STROM THURMOND

Mr. FRIST. Mr. President, a few moments ago we were made aware that at 9:45 tonight a close friend, a confidant, a colleague to most of us in this body, Strom Thurmond, passed away.

It was a century ago when Mark Twain was alive and Teddy Roosevelt was President that James Strom Thurmond was born in South Carolina and at that time began a life unmatched in public service. Just about all of us in this body have had the real privilege of serving alongside Strom Thurmond. A long-time friend of Senator Thurmond, Hortense Woodson, once said of him:

> Everything he's done has been done in the full. There's no halfway doings about Strom.

Indeed, Strom Thurmond will forever be a symbol of what one person can accomplish when they live life, as we all know he did, to the fullest. To his family and his friends, we offer our sincerest sympathies.

It was unexpected that he would die this evening while we are in the middle of completing a very historic bill, and it would be clearly appropriate for us to make recognition of his passing for a moment now, with plans, either after completion of the bill tonight or tomorrow, for people to make more extended statements.

Again, we extend to his family our deepest sympathies and our continued prayers.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I join with the majority leader in expressing our heartfelt condolences to the family and to the State of Strom Thurmond. In many respects, he was a legend. Many of us had the good fortune to serve with him as a Senator. He was a Governor, a Presidential candidate, a soldier, a father, a citizen. In many respects, he fought, lived, contributed, and legislated in a way that will be written about and commented on for years and decades to come.

Much more will be said, but I think as we consider his contribution tonight we can say, as we consider the opportunity that we had to serve with him, Republicans and Democrats, that it was our privilege to do so.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. HOLLINGS. Mr. President, my friend and colleague of 36 years in the Senate is gone. A giant oak in the forest of public service has fallen.

I started with Senator Thurmond as a young law student in 1946 when he first ran for Governor and have been more or less with him over these many, many years. I will have a real recount of our work together later. That is the way it was even though we ended up on other sides of the aisle. There was never any doubt about the interests of South Carolina.

We have all this argument going on now with respect, for example, to judges. He and I got together very early. We agreed when his President was in office from his particular party that he had the appointment, but he always asked me about it and, of course, I in turn asked him about it. We checked with each other. That is the kind of way we worked together over the some 36 years.

I can say just a living legend of South Carolina now has been terminated. But I want to give Nancy and the children my heartfelt condolences. Peatsy and I have known them and been with them over the many, many years. I will have more to say at a later time. I thank the leadership for their recognition. I hope, perhaps, when we complete our work tonight, we might adjourn out of respect for our colleague.

Mr. FRIST. Why don't we take just a moment of silence in honor of Strom Thurmond.

(Moment of Silence.)

Mr. FRIST. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENT NO. 1132

Mr. SANTORUM. Mr. President, I call up amendment No. 1132 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Pennsylvania [Mr. SANTORUM] proposes an amendment numbered 1132.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow eligible beneficiaries in MedicareAdvantage plans to elect zero premium, stop-loss drug coverage protection)

On page 343, between lines 15 and 16, insert the following:

“(f) ZERO PREMIUM STOP-LOSS PROTECTION AND ACCESS TO NEGOTIATED PRICES FOR ELIGIBLE BENEFICIARIES ENROLLED IN MEDICAREADVANTAGE PLANS.—

“(1) IN GENERAL.—Notwithstanding any provision of this part or part D, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage otherwise required, the plan makes available such coverage with the following modifications:

“(A) NO PREMIUM.—Notwithstanding subsection (d) or sections 1860D–13(e)(2) and 1860D–17, the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage shall be zero.

“(B) BENEFICIARY RECEIVES ACCESS TO NEGOTIATED PRICES AND STOP-LOSS PROTECTION FOR NO ADDITIONAL PREMIUM.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

“(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

“(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4), except that in applying such subsection, ‘$5000.00’ shall be substituted for ‘$3,700’ in subparagraph (B)(i)(I) of such subsection.

“(iii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

“(C) APPLICATION OF LOW-INCOME SUBSIDIES.—Notwithstanding subsection (f) or section 1860D–19, the Administrator shall not apply the following provisions of subsection (a) of such section:

“(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

“(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

“(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

“(2) PENALTY FOR ENROLLING IN A ZERO PREMIUM STOP-LOSS PROTECTION PLANS AFTER INITIAL ELIGIBILITY FOR SUCH ENROLLMENT.—In the case of an eligible beneficiary that enrolled in a plan offered pursuant to this subsection at any time after the initial enrollment period described in section 1860D–2, the Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under such a plan but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under this paragraph in a manner that is similar to the manner such provisions apply to the penalty under part D.

"(3) PROCEDURES.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this subsection.

"(4) NO EFFECT ON MEDICARE DRUG PLANS.—This subsection shall have no effect on eligible beneficiaries enrolled under part D in a Medicare Prescription Drug plan or under a contract under section 1860D–13(e)."

Mr. SANTORUM. Mr. President, one of the key components that many Members on this side of the aisle would like to see accomplished is to draw as many people as possible into the competitive model set up in this bill. We believe it is the more efficient, higher quality delivery of health care services, the Medicare Advantage plan.

Unfortunately, through negotiations, a lot of the incentives the President has to encourage people to get into those plans and thereby make them work have been taken out in the current version on the floor. That is to the great consternation, I know, of the White House and many Members on this side of the aisle.

For quite some time I have been trying to think how they can create incentives—carrots, if you will, as opposed to sticks—to encourage people to get into these kinds of plans. Originally, I intended to offer a differential benefit—in other words, a benefit that would have what I call a standard benefit in the fee-for-service option and an enhanced benefit in the Medicare Advantage option. I was fairly convinced, in discussing with the people on my side of the aisle, we probably would not have a chance to succeed: that there were people who had made commitments that a differential benefit was not something for this time.

I went about trying to figure out, could we create incentives to people to come into Medicare Advantage, which I believe is the future of Medicare and the best way to run the system without creating a differential benefit. The amendment before the Senate does that. The amendment before the Senate creates an option for beneficiaries who participate in Medicare Advantage. It is a pharmaceutical option. Instead of just having no pharmaceutical benefit, which you could if you do not get into the Medicare Advantage Program, we have the standard benefit which is required if you participate in the PPOs, HMOs, and POSs that will be created here.

What I will do with this amendment is create another option for seniors who select Medicare Advantage. That option would be a zero premium catastrophic benefit. So you could choose between the standard benefit, the $35 premium, and the 50 percent copay, and the donut hole, and all the things described over and over again, or if you did not want to pay a premium but wanted some catastrophic coverage, wanted some benefit, no premium, no cost, you could join this.

The CBO scored this as attracting twice as many people into the PPOs and HMOs as the underlying bill. It would make those plans much more desirable for beneficiaries. I believe that should be one of the goals of this legislation, to make the new and improved and stronger plan a more robust plan.

Unfortunately, according to the Congressional Budget Office, when people move from the fee-for-service plan into the Medicare Advantage plan, the Congressional Budget Office assumes those plans will be more expensive. And because they will be more expensive, this amendment costs money. It doubles the participation but costs $20, to $25 billion, which is the back of the envelope. And God bless the CBO; that is the best they could do at this late hour.

I firmly believe this is a reasonable compromise between those who would not want to have the differential benefit and those who would because it is unfair to the fee-for-service participants and those who believe we need to have an incentive for people to get into the Medicare Advantage Program. This strikes the compromise. This is where we could go.

There are all sorts of things we have done to eliminate adverse selection and all the other problems inherent in offering two different benefits. We believe we actually address the vast majority of those problems in this amendment. Nevertheless, we have run into the roadblock that this bill has run into the entire time when it comes to the competitive model and CBO and their estimation of costs.

For the record, the White House does not see it that way. The White House sees the competitive model as saving money. Under their scoring, this would probably actually save money and move people into a higher quality, more efficient system.

AMENDMENT NO. 1132 WITHDRAWN

As a result of the fact of the score which is $20 to $25 billion, and we do not have that, I am going to withdraw my amendment and hope this idea which I believe is in the center here is a compromise between two competing ideas of how to structure this bill.

It will be considered in conference as a way of trying to bring the two sides together in something that does not disadvantage the fee-for-service plan but creates an opportunity for incentives to go to the Medicare Advantage plan.

Mr. President, with that I ask unanimous consent to withdraw my amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

The Senator from Oklahoma.

Mr. NICKLES. I compliment my colleague from Pennsylvania. Especially this late at night, when a lot of us are thinking about our departed friend and colleague, Senator Thurmond, I appreciate his withdrawing this amendment.

For the information of our colleagues, I think we are very close to finishing this bill. We may have one or two rollcall votes. I think we are just about ready to vote on the Feinstein-Chafee amendment and possibly one other amendment, and I think we are very close to be able to vote on final passage, for the information of our colleagues.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1060

Mr. KENNEDY. Mr. President, I will just take a moment to address the amendment of the Senator from California, Mrs. FEINSTEIN, and her colleagues, in terms of means testing the Medicare system. That is what we would be doing, changing what is effectively an insurance system into a welfare system. There is, really, no question about that.

The fact is, the Part B of the Medicare system is basically a progressive system as it is at the present time. Wealthy people are paying a great deal more into that system than they are taking out.

My concern is, if this passes, it is only a question of time before the healthiest individuals who can qualify under the Part B premium are going to leave the Medicare system and it is going to deteriorate into a general welfare system. The kind of Medicare system seniors relied on, day in and day out, would be destroyed. Make no mistake about it.

That is why the AARP is strongly opposed to it, as well as the National Committee to Preserve Social Security.

I hope this amendment is not accepted. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

AMENDMENT NO. 990, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that amendment No. 990, previously adopted, be modified with language I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

At the end of subtitle A of title II, add the following:

SEC. . IMPROVEMENTS IN MEDICARE-ADVANTAGE BENCHMARK DETERMINATIONS.

(c) Inclusion of Costs of DOD and VA Military Facility Services to Medicare-Eligible Beneficiaries in Calculation of MedicareAdvantage Payment Rates.—

(1) For purposes of calculating medicare+choice payment rates.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) Inclusion of costs of DOD and VA military facility services to medicare-eligible beneficiaries.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(2) For purposes of calculating local fee-for-service rates.—Section 1853(d)(5) (42 U.S.C. 1395w-23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(B) by adding at the end the following new subparagraph:

"(C) Inclusion of costs of DOD and VA military facility services to medicare-eligible beneficiaries.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.".

(d) Effective Date.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

AMENDMENT NO. 960, AS MODIFIED

Mr. GRASSLEY. Mr. President. I ask unanimous consent that Senator Dayton's amendment, No. 960, be modified with the modification that I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require a streamlining of the medicare regulations)

At the end of subtitle A of title V, add the following:

SEC. . STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) In General.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) Reduction in Regulations.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) Application of the Paperwork Reduction Act.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act") to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (b)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its infeasibility. He shall then establish a possible reduction to be achieved by January 1, 2005.

VITIATION OF VOTE ON AMENDMENT NO. 1041

Mr. GRASSLEY. Mr. President, I ask unanimous consent to vitiate the vote by which amendment No. 1040 was adopted.

Mr. BAUCUS. Amendment No. 1041.

Mr. GRASSLEY. I am sorry. No. 1041.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1096

Mr. GRASSLEY. I ask unanimous consent that the pending amendment be temporarily set aside, amendment No. 1096 be called up, adopted, and the motion to reconsider be laid on the table.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment (No. 1096) was agreed to, as follows:

(Purpose: To require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project)

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) Authority To Conduct Demonstration Project.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) Clinics Described.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) Definitions.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

AMENDMENT NO. 989, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Collins amendment, amendment No. 989, be modified with modifications that I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To increase medicare payments for home health services furnished in a rural area)

At the appropriate place in subtitle C of title IV, insert the following:

SEC. . INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) In General.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

"(f) Increase in Payment for Services Furnished in a Rural Area.—

"(1) In general.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

"(2) Waiver of budget neutrality.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).".

(b) Payment Adjustment.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following "Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.".

(c) Effective Date.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

AMENDMENTS NOS. 1122, 1074, 1023, 1114, 1115, 1045, 1058, 1117, 1044, 1056, 996, 1013, 1121, 989, AS MODIFIED, 1126, 996, 1118, 1085, 1017, 968, 948, 960 AS MODIFIED, 1054, AND 1030

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside and that the following amendments be called up en bloc: No. 1122, Brownback; No. 1074, Coleman; No. 1023, Collins; No. 1114, Kyl; No. 1115, Kyl; No. 1045, Chambliss; No. 1058, Craig; No. 1117, Baucus; No. 1044, Bayh; No. 1056, Shelby; No. 996, Reed of Rhode Island; Bond amendment No. 1013; Kyl, No. 1128; Collins, No. 989, as modified; Dole, No. 1126, with Edwards added as a cosponsor; Reed of Rhode Island, No. 996; Specter, No. 1118; Specter, No. 1085.

The PRESIDENT pro tempore. Is there objection?

Mr. BAUCUS. Mr. President, this side agrees.

The PRESIDENT pro tempore. Is there objection?

If not, the amendments will be considered en bloc.

The amendments are as follows:

(Amendments Nos. 1122 and 1117 are printed in today's RECORD under "Text of Amendments.")

(Amendments Nos. 1017, 968, 948, 1054 and 1030 are printed in a previous edition of the RECORD.)

AMENDMENT NO. 1074

(Purpose: To amend title XVIII of the Social Security Act to make improvements in the national coverage determination process to respond to changes in technology)

At the end of subtitle C of title IV, add the following:

SEC. . IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting "consistent with subsection (j)" after "the Secretary shall ensure"; and

(B) by adding at the end the following new subsection:

"(j) NATIONAL COVERAGE DETERMINATION PROCESS.—

"(1) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

"(2) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

"(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

"(B) provide a 30-day period for public comment on such draft;

"(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

"(D) include in such final decision summaries of the public comments received and responses thereto;

"(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

"(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C).

"(3) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term 'national coverage determination' has the meaning given such term in section 1869(f)(1)(B).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

AMENDMENT NO. 1023

(Purpose: To provide for the establishment of a demonstration project to clarify the definition of homebound)

At the appropriate place in subtitle B of title IV, insert the following:

SEC. . DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term "home health services" has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

AMENDMENT NO. 1114

(Purpose: To require the GAO to study the impact of price controls on pharmaceuticals)

At the appropriate place, insert the following:

SEC. . GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G-7 COUNTRIES.

(A) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance;

(2) The proportion of the costs for innovation borne by American consumers, compared with consumers in the other six countries;

(3) A review of how closely the observed prices in regulated markets correspond to

the prices that efficiently distribute common costs of production ("Ramsey prices");

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health;

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States;

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied;

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant; and

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violation of intellectual property rights for prescription medicines.

(B) Report.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (A).

AMENDMENT NO. 1115

(Purpose: To express the sense of the Senate concerning Medicare payments to physicians and other health professionals)

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) Findings.—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without Congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991-2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by Medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) Sense of the Senate.—It is the Sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

AMENDMENT NO. 1045

(Purpose: To provide for a demonstration project for the exclusion of brachytherapy devices from the prospective payment system for outpatient hospital services)

At the end of subtitle B of title IV, add the following:

SEC. . DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) Demonstration Project.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), the amount of payment for a device of brachytherapy furnished under the demonstration project shall be equal to the hospital's charges for each device furnished, adjusted to cost.

(b) Specification of Groups for Brachytherapy Devices.—The Secretary shall create additional groups of covered OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.

(c) Duration.—The Secretary shall conduct the demonstration project under this section for the 3-year period beginning on the date that is 90 days after the date of enactment of this Act.

(d) Report.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project conducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.

(f) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration project under this section.

(2) Budget neutrality.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration project under this section was not implemented.

AMENDMENT NO. 1058

(Purpose: To restore the Federal Hospital Insurance Trust Fund to the financial position it would have been in if a clerical bookkeeping error had not occurred)

At the appropriate place in title VI, insert the following:

SEC. . RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) Definitions.—In this section:

(1) Clerical error.—The term "clerical error" means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) Trust fund.—The term "Trust Fund" means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) Correction of Trust Fund Holdings.—

(1) In general.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) Obligations issued and redeemed.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) Appropriation.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

AMENDMENT NO. 1041

(Purpose: To adjust the urban health provider payment)

At the appropriate place, insert the following:

SEC. . URBAN HEALTH PROVIDER ADJUSTMENT.

(a) In General.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in subsection (b) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r-4(f)).

(b) Hospital Described.—A hospital is described in this subsection if the hospital—

(1) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(2) is located in Marion County, Indiana.

(c) Limitation.—The payment adjustment described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section

1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r-4(g)(1)(A)).

AMENDMENT NO. 1056

(Purpose: To prevent the Secretary of Health and Human Services from modifying the treatment of certain long-term care hospitals as subsection (d) hospitals)

At the end of subtitle A of title IV, add the following:

SEC. . TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) In General.—The last sentence of section 1886(d)(1)(B) is amended by inserting ", and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)" before the period at the end.

(b) Treatment of Proposed Revision.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) Effective Date.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

AMENDMENT NO. 1013

(Purpose: To ensure that patients are receiving safe and accurate dosages of compounded drugs)

At the appropriate place, insert the following:

SEC. . COMMITTEE ON DRUG COMPOUNDING.

(a) Establishment.—The Secretary of Health and Human Services shall establish an Committee on Drug Compounding (referred to in this section as the "Committee") within the Food and Drug Administration on drug compounding to ensure that patients are receiving necessary, safe and accurate dosages of compounded drugs.

(b) Membership.—The membership of the Advisory Committee shall be appointed by the Secretary of Health and Human Services and shall include representatives of—

(1) the National Association of Boards of Pharmacy;

(2) pharmacy groups;

(3) physician groups;

(4) consumer and patient advocate groups;

(5) the United States Pharmacopoeia; and

(6) other individuals determined appropriate by the Secretary.

(c) Report and Recommendations.—Not later than 1 year after the date of enactment of this Act, the Committee shall submit to the Secretary a report, concerning the recommendations of the Committee to improve and protect patient safety.

(d) Termination.—The Committee shall terminate on the date that is 1 year after the date of enactment of this Act.

AMENDMENT NO. 1121

(Purpose: To express the sense of the Senate concerning the structure of Medicare reform and the prescription drug benefit to ensure Medicare's long-term solvency and high quality of care)

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) Findings.—The Senate makes the following findings:

(1) America's seniors deserve a fiscally-strong Medicare system that fulfills its promise to them and future retirees.

(2) The impending retirement of the "baby boom" generation will dramatically increase the costs of providing Medicare benefits. Medicare costs will double relative to the size of the economy from 2 percent of GDP today to 4 percent in 2025 and double again to 8 percent of GDP in 2075. This growth will accelerate substantially when Congress adds a necessary prescription drug benefit.

(3) Medicare's current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease management programs, and host of other advances. Reforming Medicare to create a more self-adjusting, innovative structure is essential to improve Medicare's efficiency and the quality of the medical care it provides.

(4) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of America's seniors, not the government, and would create a powerful incentive for private-sector Medicare plans to provide the best quality health care to seniors at the most affordable price.

(5) The method by which the national preferred provider organizations in the Federal Employees Health Benefits Program have been reimbursed has proven to be a reliable and successful mechanism for providing Members of Congress and federal employees with excellent health care choices.

(6) Unlike the Medicare payment system, which has had to be changed by Congress every few years, the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress.

(b) Sense of the Senate.—It is the Sense of the Senate that Medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most.

(2) Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2006 to ensure the long and short term viability of such options for America's seniors.

(3) Develop a payment system for the Medicare Advantage preferred provider organizations similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program.

(4) Limit the addition of new unfunded obligations in the Medicare program so that the long-term solvency of this important program is not further jeopardized.

(5) Incorporate private sector, market-based elements, that do not rely on the inefficient Medicare price control structure.

(6) Keep the cost of structural changes and new benefits within the $400 billion provided for under the current Congressional Budget Resolution for implementing Medicare reform and providing a prescription drug benefit.

(7) Preserve the current employer-sponsored retiree health plans and not design a benefit which has the unintended consequences of supplanting private coverage.

(8) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(9) Restore the right of Medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the government contribution.

AMENDMENT NO. 989, AS MODIFIED

(Purpose: To increase medicare payments for home health services furnished in a rural area)

At the appropriate place in subtitle C of title IV, insert the following:

SEC. . INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) In General.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

"(f) Increase in Payment for Services Furnished in a Rural Area.—

"(1) In general.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

"(2) Waiver of budget neutrality.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).".

(b) Payment Adjustment.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following: "Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.".

(c) Effective Date.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

AMENDMENT NO. 1126

(Purpose: To provide for the treatment of certain entities for purposes of payments under the medicare program)

At the end of subtitle A of title IV, add the following:

SEC. . TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) Payments to Hospitals.—

(1) In general.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) Budget Neutral Within North Carolina.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such payments that would have been made in the year if this subsection had not been enacted.

(b) Payments to Skilled Nursing Facilities and Home Health Agencies.—

(1) In general.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1361(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act, Iredell County, North Carolina, and Rowan County, North Carolina, are

deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) APPLICATION AND BUDGET NEUTRAL WITHIN NORTH CAROLINA.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be implemented in a budget neutral manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the total amount of expenditures that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(c) CONSTRUCTION.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

AMENDMENT NO. 996

(Purpose: To modify the GAO study of geographic differences in payments for physicians' services relating to the work geographic practice cost index)

In section 445(a) of the bill, strike paragraph (6) and insert the following:

"(6) an evaluation of the appropriateness of extending such adjustment or making such adjustment permanent;

"(7) an evaluation of the adjustment of the work geographic practice cost index required under section 1848(e)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(A)(iii)) to reflect ¼ of the area cost difference in physician work;

"(8) an evaluation of the effect of the adjustment described in paragraph (7) on physician location and retention in higher than average cost-of-living areas, taking into account difference in recruitment costs and retention rates for physicians, including specialists; and

"(9) an evaluation of the appropriateness of the ¼ adjustment for the work geographic practice cost index.".

AMENDMENT NO. 1118

(Purpose: To express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries)

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

AMENDMENT NO. 1085

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating "tolerance" corridors for variations around the update target trend.

AMENDMENT NO. 960

(Purpose: To Require a Streamlining of the Medicare Regulations)

At the end of subtitle A of title V, add the following:

SEC. . STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act") to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers. If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (B)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its unfeasibility. He shall then establish a feasible reduction to be received by January 1, 2005.

Mr. GRASSLEY. I ask unanimous consent that these amendments and the following pending amendments be adopted en bloc and that the motion to reconsider be laid upon the table: Amendment No. 1017, Allard; No. 968, Harkin; No. 948, Graham of South Carolina; No. 960, Dayton; No. 1054, Feingold; No. 1030, Enzi.

The PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

The amendments were agreed to.

Mr. GRASSLEY. Thank you. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRAHAM of South Carolina. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

STROM THURMOND

Mr. GRAHAM of South Carolina. Mr. President, I rise to make a brief statement, like my colleague from South Carolina, Senator HOLLINGS, about the passing of Senator Thurmond. This is something I really don't know how to put in words. All of us from South Carolina knew Senator Thurmond in so many ways. But his colleagues in this body, the vast majority of you, have served with him for many years. You have great admiration and fondness for Senator Thurmond but I stand before you as his successor. I often state back home that we change Senators every 50 years and that so many people have been waiting to take Senator Thurmond's place. The jokes just go on and on about what a rich life he has lived.

Tonight his family is mourning his passing. Whether a person lives to be 100 or 200, it is difficult to lose your father. If you lose someone you love, it is always difficult. But when you think about Senator Thurmond, you always have a smile on your face.

He lived a rich life. He lived at times a controversial life. But the biggest testament I can give to Senator Thurmond is that he changed. He changed with the times.

Those of you who embraced him during difficult times your love was much appreciated. Recently people have tried to freeze Senator Thurmond in time which is unfair to him or anyone else. Those who knew him best understood that he changed with the times. And his legacy in my State across party lines, across racial lines, and across regional lines was that he was the go-to guy. If you had a problem with your family or with your business, the first thought in your mind, if the Government was involved, or if somebody was treating you unfairly, was get on the phone and call Senator Thurmond. You would get a phone call back, and he would go to bat for you. Whether you owned the company, or you were the janitor, whether you were black, white, rich or poor, his office and he as a person had a reputation of going to bat for individuals. To me, that is his greatest legacy.

I stand before you as his successor—but not only that, as his friend. He embraced my campaign in 1995. He came to campaign for me when he was 93 years of age. And I was worried to death about if he could make it through the day. Three days later I was glad to see him leave because he about killed me.

He had enthusiasm and passion like no one I have ever met in my life. He did things he didn't have to do. He was a sitting judge in South Carolina in his 40s. He left the judgeship to go volunteer for the Army. He landed in a glider on D-Day, he was shot up, the pilot was killed, and he fought the Germans until they quit, and then he went over to Japan and fought until they quit.

This man, your friend, my friend, South Carolina's favorite son, is gone but he will never be forgotten. His biggest legacy is in the small things he did—not the large things he did. There are so many large things he accomplished. But he lives on in families. Great relationships were established, and good constituent service. He won his last election by getting more African-American votes than any Republican in the South.

All I can say about Senator Thurmond is that we pray for his family, we mourn his loss, but we thank God that He provided us a great public servant.

Well done, Senator Thurmond.

Thank you, Mr. President.

Mr. NICKLES. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nomination on today's executive calendar:

Calendar No. 252, the nomination of Joshua Bolten to be Director of the Office of Management and Budget. I further ask unanimous consent that the nomination be confirmed, the motion to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

The nomination was considered and confirmed.

LEGISLATIVE SESSION

The PRESIDENT pro tempore. Under the previous order, the Senate will return to legislative session.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

Mr. BAUCUS. Mr. President, will the Chair state the regular order?

The PRESIDENT pro tempore. The pending amendment numbered 1060, as modified is the regular order.

Mr. BAUCUS. Mr. President, is that the Nickles-Feinstein amendment?

The PRESIDENT pro tempore. It is.

Mr. BAUCUS. Mr. President, I move to table the Nickles-Feinstein amendment, and I ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 38, nays 59, as follows:

[Rollcall Vote No. 261 Leg.]

YEAS—38

Akaka
Baucus
Bayh
Bingaman
Boxer
Breaux
Byrd
Cantwell
Clinton
Corzine
Daschle
Dorgan
Durbin
Edwards
Grassley

Harkin
Hollings
Inouye
Johnson
Kennedy
Lautenberg
Leahy
Levin
Lincoln
Mikulski
Miller
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Rockefeller
Sarbanes
Schumer
Snowe
Specter
Stabenow

NAYS—59

Alexander
Allard
Allen
Bennett
Biden
Bond
Brownback
Bunning
Burns
Campbell
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Conrad
Cornyn
Craig
Crapo
Dayton
DeWine
Dodd
Dole
Domenici
Ensign
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham (FL)
Graham (SC)
Gregg
Hagel
Hatch
Hutchison
Jeffords
Kohl
Kyl
Landrieu
Lott
Lugar
McCain
McConnell
Murkowski
Nickles
Roberts
Santorum
Sessions
Shelby
Smith
Stevens
Sununu
Talent
Thomas
Voinovich
Warner
Wyden

NOT VOTING—3

Inhofe
Kerry
Lieberman

The motion was rejected.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, what is the business before the Senate?

The PRESIDENT pro tempore. Amendment No. 1060, as modified.

Mr. GRASSLEY. I urge adoption of the amendment.

The PRESIDENT pro tempore. Is there further debate?

Mr. BAUCUS. Mr. President, will the Chair identify the sponsors of that amendment?

The PRESIDENT pro tempore. Senator BAUCUS for Senator FEINSTEIN, amendment No. 1060, Part B premium, subtitle (d).

Mr. BAUCUS. Mr. President, the Senate is ready to vote.

The PRESIDENT pro tempore. The question is on agreeing to the amendment.

The amendment (No. 1060), as modified, was rejected.

Mr. BAUCUS. I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDENT pro tempore. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I have a unanimous consent request to correct a previous unanimous consent request. In a previous unanimous consent request, I referred to amendment No. 990 when I meant to refer to the previously adopted Murray amendment No. 961.

I ask unanimous consent to make that change.

I referred to the Kyl amendment No. 1128 when I meant to refer to Kyl amendment No. 1121.

I also ask unanimous consent to make that change.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

AMENDMENT NO. 1133

Mr. GRASSLEY. Mr. President, I send an amendment to the desk.

The PRESIDENT pro tempore. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY] proposes an amendment numbered 1133.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDENT pro tempore. Without objection, it is so ordered.

(The amendment, No. 1133, is printed in today's RECORD under "Amendments Submitted.")

Mr. GRASSLEY. Mr. President, is there no discussion necessary on the amendment?

The PRESIDENT pro tempore. Who seeks recognition?

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I would just like to say that we have help for our teaching hospitals in the managers' amendment. It is not much. But I am working with all of the managers, the ranking member as well as the chairman, to try to increase funding for teaching hospitals.

I want to point out our teaching hospitals must have the support that is in this bill at a higher percentage if we are going to keep the young physicians trained and if our country will keep the greatest health care system in the world.

I thank the managers for helping me put that in the managers' amendment.

The PRESIDENT pro tempore. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I oppose the managers' amendment because of an amendment that is in the managers' amendment, the Corzine amendment which provides three States the opportunity to basically opt out of the Medicare Program for prescription drugs and have an entitlement flow of funding going to the States for the States to develop their own stand-alone drug benefit. As a result of that, States like mine and two others will not have the advantage of an integrated drug benefit which I fought very strongly for on this floor and which I believe will also lead potentially to this unlimited entitlement flow of funds to the States because of the way this language is drafted, the potential for lots of mischief in respect to double dipping, inter-government transfers, disproportionate share payments. We could be opening a virtual Pandora's box. Yes. For my States and two others. But I think, frankly, it is not good policy and does not do the kind of improvement of the overall Medicare program which my State should participate in as well as the other States represented here.

There is no Federal oversight by the Secretary of Health and Human Services for this plan.

There are a host of other problems with this amendment. It is my understanding that the managers gave a commitment that this amendment be included in the package. And so to honor the chairman's commitment, I will not object to this amendment nor call for a vote to strike the amendment. But I, unfortunately, will have to vote against this bill.

The PRESIDENT pro tempore. Is there further debate?

Mr. GRASSLEY. I ask unanimous consent that the amendment be agreed to.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

The amendment (No. 1133) was agreed to.

AMENDMENTS EN BLOC WITHDRAWN

Mr. GRASSLEY. Mr. President, I ask unanimous consent to withdraw the pending amendments.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendments (Nos. 953, 958, 934, 964, 965, 980, 979, 973, 986, 990, 977, 993, 962, 1004, 1019, 1020, 1021, 999, 954, 1037, 1039, 1051, 1012, 1061, 1075, 1076, 1077, 1024, 1073, 1088, 1089, 1090, 1091, 1110, and 1041) were withdrawn.

ADULT DAY CARE

Mr. BUNNING. Mr. President, during consideration of this bill in the Finance Committee, I submitted language regarding adult day care which I and my staff were told by Finance Committee staff was acceptable and included in S. 1, the Prescription Drug and Medicare Improvement Act of 2003, as part of the base bill to be considered on the Senate floor. I was very thankful for your consideration and approval of my language, Chairman GRASSLEY.

Mr. GRASSLEY. Yes, Senator BUNNING, I remember your submitted language regarding Adult Day Care.

Mr. BUNNING. After we voted to pass S. 1 out of the Finance Committee, I have since learned that the adult day care language accepted and made part of the bill is not the language I submitted at all, but instead it is language based on a bill introduced by Senator SANTORUM related to the same issue.

Mr. GRASSLEY. Yes, this is true, and I apologize for the inaccurate information and misunderstanding provided to you and your staff from the Finance Committee on this issue. The language included in the base bill instead is based on Senator SANTORUM's bill.

Mr. BUNNING. While Senator SANTORUM's adult day care proposal and my adult day care language are different, they both share the same goal of providing services to those special and needy adults who require extra attention and care. However, I have some differences with Senator SANTORUM's proposal, and he has some differences with my proposed language.

Mr. SANTORUM. Yes, we do share the same goal on this adult day care issue, and we do have some fundamental differences with one another's proposals and language on the matter.

Mr. GRASSLEY. Yes, that is my understanding, as well.

Mr. BUNNING. I am hopeful that once this bill gets to conference, we and our staffs can work out our differences on this adult day care issue and find a solution that is amenable to all of us. It is also my understanding the current version of the House of Representative's prescription drug benefit bill includes the adult day care language which is identical to my language.

Mr. SANTORUM. I am willing to work on this matter further, and do agree that since the Senate's and House of Representative's versions on the adult day care language will be different, we will have to find a solution to our differences on this important issue.

Mr. GRASSLEY. I will be happy to work with both of you and our staffs to rectify this problem. Adult day care is an important issue, and being that the Senate and House of Representatives will have different language on this issue, it must be conferenced in a way to ensure that all with interests in this matter, including interested provider and senior organizations, are involved and approving of the final adult day care language. I am looking forward to further working with both of you on this matter.

Mr. BUNNING. Thank you, Mr. Chairman and Senator SANTORUM. I appreciate both your willingness to revisit this matter and your leadership on this important legislation for our seniors.

FEE FOR SERVICE

Mr. FRIST. Mr. President, I believe in assuring the ability of seniors who choose to do so to add their own funds on top of the government contribution in order to participate in private fee-for-service plans under Medicare. I also believe that private fee-for-service plans should be able to provide an unmanaged form of the subsidized prescription drug benefit.

Accordingly, I am committed to ensuring that the bill reported from the conference committee that will consider S. 1 and H.R. 1 incorporates the functional equivalent of those provisions in H.R. 1 that permit private fee-for-service plans to provide the subsidized prescription drug benefit as an unmanaged benefit whose premium amount, just like the premium amount such plans charge for the core Medicare benefit under current law, is not subject to governmental review or approval.

Mr. GRASSLEY. I agree.

REPEAL OF THERAPY CAPS

Mr. ENSIGN. Mr. President, I will withdraw my amendment to repeal the arbitrary beneficiary caps on therapy. However, I would urge my colleague from Iowa, the Chairman of the Finance Committee, to work in conference to find a way to delay this law. As you know, the beneficiary caps will have one of three results—beneficiaries will either: (1) pay 100 percent out-of-their own pocket once the caps are exceeded; (2) self-ration therapy care; or (3) forgo medically necessary care altogether. Mr. President, I recognize that the Chairman has been a voice to eliminate these caps and hope that a final Medicare bill further delays implementation of them.

Mrs. LINCOLN. Mr. President, I would like the opportunity to join my colleague from Nevada to speak in support of repealing the caps on outpatient physical therapy, occupational therapy, and speech-language pathology.

The current therapy cap discriminates against the most vulnerable of Medicare beneficiaries. While the majority of enrollees will not exceed an annual $1,590 limitation on rehabilitation services, approximately 13 percent of seniors and individuals with disabilities covered by Medicare will be forced to pay for medically necessary services out of pocket.

This is a particularly burdensome situation for beneficiaries living in rural communities. Most likely to be harmed are beneficiaries who have experienced a stroke or hip fracture or who have Parkinson's disease or other conditions that require extensive rehabilitation following injury or illness.

I urge the Chairman and Ranking Member of the Finance Committee to work with me and my colleague, the Senator from Nevada, on repealing this cap or at least suspending it for 1 or 2 years. My colleague and I have sponsored legislation (S. 569) to permanently repeal this cap. Our bill has been cosponsored by 41 members of the Senate.

Again, I appreciate the opportunity to join my colleagues from Nevada today. It is my sincere hope, Mr. President, that we will be able to address the issue of the burdensome $1,590 cap on outpatient therapy services.

Mr. GRASSLEY. I thank both the Senator from Nevada and the Senator from Arkansas for their comments and for withdrawing the amendment. As you may know, I asked CMS Administrator Scully at the Finance Committee markup to further delay implementation of these beneficiary caps. Unfortunately, as a result of the Senate Budget Resolution constraints, I do not have Medicare dollars to repeal the beneficiary cap on therapy services. I agree that this arbitrary limit does not make sense and have sought to address this issue in the past. I will work in conference to enact a therapy cap moratorium and appreciate your hard work and passion on this issue.

Mr. ENSIGN. I appreciate the Chairman's leadership on this issue and I thank my colleague for agreeing, at a minimum, to work toward another moratorium on implementation of the therapy cap. I would also like to thank the Senator from Arkansas for her words of support. Mr. President, I yield the floor.

I ask unanimous consent that this full statement be included in the RECORD as if read.

Mr. HATCH. Mr. President, I strongly support Senator KYL's sense of the Senate resolution to S. 1. His resolution asks Congress to rectify problems with the formula that is used to update Medicare physician reimbursement.

Due to flaws in this formula, payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004. This cut in physician compensation would be the fifth since 1991 including a 5.4 percent decrease in 2002. According to Medicare's own conservative estimates, between the years 1991 and 2003, reductions for physicians and other health professionals resulted in Medicare physician reimbursement that equates to 14 percent below their actual practice costs. The 2004 reduction would decrease Utah physician income by $13 million which translates to $3003 per physician in 2004. And this is in addition to the $9 million decrease in reimbursement that Utah physicians received in 2002. Furthermore, unless we correct this formula, it is estimated that more cuts will occur in 2005, 2006, and 2007.

The Medicare Payment Advisory Commission, MedPAC, has stated that these reimbursement reductions are the result of a problem with the Sustained Growth Rate that is used as part of the calculation to adjust rates each year. The SGR expenditure target is linked to gross domestic product. Therefore, the formula may decrease Medicare reimbursement for physicians and other practitioners when health care volume increases outstrip increases in the gross domestic product. The problem is magnified when gross domestic product decreases. Essentially, the formula penalizes physicians for factors over which they have no control.

It is true that as the population of our country ages, the volume of Medicare health care services consumed increases. However, physicians have no control over this and our Medicare system penalizes them because of it. As a result, some physicians no longer take new Medicare patients, some decline to participate in the Medicare program altogether, and young people are considering other professions.

I would submit that as the baby-boomer generation ages and increasing numbers of Americans become Medicare beneficiaries, we need physicians and other health care providers more than ever. If anything, we should be rewarding our physicians, not penalizing them.

An additional problem with the Sustained Growth Rate calculation is that it does not account for many changes in health care that improve quality but increase physician work also. The federal government actively promotes new coverage decisions, quality improvement activities and other initiatives that benefit patients but are not taken into account by the Sustained Growth Rate calculation.

MedPAC's recommendation to Congress is that annual updates in physician payments should reflect increases in the Medicare Economic Index or MEI rather than the gross domestic product. Using the Medicare Economic Index would eliminate the penalty that physicians and other practitioners currently experience when the volume of health care services increases due to factors that they are unable to control.

What we have before us is a flawed formula that is threatening the health of Americans and the future of our country. Congress has addressed this problem before, but it seems that we were only putting a bandage over the wound; we never cured the disease that caused it. The wound continues to fester and it will continue to do so until we cure the problem. And the cure, it seems, is to revise the formula.

I for one, am tired of applying bandages to this wound. I believe that it is time to address this problem directly and definitively. I urge my colleagues to join with me in supporting this resolution and in working to correct this problem.

Mr. FEINGOLD. Mr. President, I joined my colleague, the distinguished Senator from Oregon, Mr. SMITH, in offering an amendment to promote better care for frail elderly and disabled. This amendment will allow the Secretary of the Department of Health and Human Services to designate health plans that disproportionately serve special needs beneficiaries as specialized Medicare Advantage plans.

A number of States have successfully chosen to serve seniors and the disabled by combining Medicare and Medicaid services through a waiver approved by the Department of Health and Human Services that integrates services under Medicare and Medicaid capitated financing arrangements. These programs provide beneficiaries with a comprehensive benefit package that combines the services traditionally provided by Medicare, Medicaid, and home and community based waiver programs.

In my home State of Wisconsin, the Wisconsin Partnership Program is one such success, a community-based program that has improved the quality, access, and cost-effectiveness of the care delivered to its beneficiaries. Perhaps most important to the beneficiaries, these programs help the disabled and the frail elderly remain in their own community, and avoid institutionalized care. Wisconsin is lucky to have four such programs across our State: Elder Care and Community Living Alliance of Dane County, Community Care for the Elderly of Milwaukee County, and Community Health Partnership Eau Claire, Dunn, and Chippewa Counties.

In order to qualify for these programs, a person must be Medicaid-eligible, have physical disabilities or frailties of aging, and require a level of care provided by nursing homes. Through programs such as the Wisconsin Partnership Program, these frail elderly and disabled beneficiaries are able to receive quality preventive care upfront, which allows more beneficiaries to stay in their communities and reduces the rate of hospitalization.

In Wisconsin, about 26 percent of all Medicaid recipients age 65 or older are in nursing homes. This rate drops dramatically for those enrolled in the Wisconsin Partnership Program, where only 5.9 percent of its recipients age 65 or older are in nursing homes.

While the Wisconsin Partnership Program is a success, we must ensure that the Federal Government continues to support these State-based solutions to our long-term care needs and other specialty managed care programs that focus on frail, chronically ill seniors. Last year I introduced the Frail Elderly Act of 2002, which promoted specialty managed care programs and helped those already in existence to continue to operate. This amendment will work to accomplish both goals by providing a population-based designation that allows plans to be recognized for specialization in services for special needs beneficiaries. By establishing this specialized designation, we hope to be able to more easily move specialized plans from demonstration status to mainstream provider status, helping to promote a more effective way of caring for the frail elderly and disabled.

Mr. President I also want to point out that this amendment does not change payments, does not change administrative rules, and therefore does not have a fiscal effect.

Fundamental long-term care reform is vital to any health care reform that Congress may consider. As part of these reforms, we must support State and local efforts to encourage care for the most vulnerable populations. We must provide our seniors and disabled with real choices. They are entitled to the opportunity to continue to live in the homes and communities that they helped build and sustain. I urge my colleagues to support this amendment that will help provide a measure of support for the most frail elderly and disabled to allow them to stay in their own homes.

Mr. President, I ask unanimous consent that two letters of support for this amendment, from the Community Health Partnership and Elder Care of Dane County be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

COMMUNITY HEALTH
PARTNERSHIP, INC.,
Eau Claire, WI, June 26, 2003.

Hon. RUSSELL FEINGOLD,
U.S. Senate,
Washington, DC.

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Community Health Partnership, Inc. (CHP) is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WPP) is an integrated program of acute and long-term care services designed to improve access to needed care, reduce fragmentation of care across providers and settings, and help people remain independent in the community, while achieving cost savings. The target populations for WPP include both elderly and physically disabled individuals who meet nursing home level of care criteria. CHP serves both populations in a 3 county, rural area. Participants must be Medicaid eligible or dually eligible for Medicare and Medicaid services. A hallmark of this program is the use of an inter-disciplinary care team comprised of a physician, nurse practitioner and social worker that help coordinate beneficiaries' care across all health care settings. The WPP also participates in the Medicare/Medicaid Integration Program, a demonstration to test strategies for integrating Medicare and Medicaid services. The goal of this program is to create a seamless system of care for beneficiaries and to reduce costs related to duplication of services and administrative functions across programs.

Like a number of other specialty Medicare+Choice programs, the WPP currently operates under demonstration authority, which expires at the end of next year. And, like virtually all Medicare demonstration programs, there is no mechanism for transitioning from demonstration status into the mainstream of Medicare. I understand that The Medicare Prescription Drug and Reform Act of 2003 begins to address this problem by establishing a special designation for specialized Medicare Advantage plans that exclusively serve special needs beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that disproportionately serve special needs beneficiaries.

The expansion of the specialized Medicare Advantage designation would provide CHP and other WPP members additional flexibility in expanding our unique program to other beneficiary groups such as those who are eligible for Medicare, but not Medicaid and "pre-duals"—those who are at risk of spending down to Medicaid based on health status and/or income limitations. Targeting healthy beneficiaries before they become frail or disabled would reduce long-run Medicare and Medicaid costs by preventing or delaying health care decline and the need for costly medical or long-term care services. Your amendment also would offer CHP a mechanism to serve non-special needs beneficiaries as a strategy for expanding our membership under a mainstream model or reducing our risk through a more representative cross-section of Medicare beneficiaries in West Central Wisconsin.

Your compassion for seniors, disabled and other special needs beneficiaries has been evident since you served as the Chair of the Senate Aging Committee in the State of Wisconsin. The amendment you are offering to the Senate Medicare bill only provides further evidence that you continue to be hard at work on behalf of Wisconsin's most vulnerable populations. Thank you for all of your work on behalf of Wisconsin's seniors.

Sincerely,

KAREN A. BULLOCK,
CEO.

ELDER CARE OF DANE COUNTY,
Madison, WI, June 24, 2003.

Hon. RUSSELL FEINGOLD,
U.S. Senate,
Washington, DC

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Elder Care of Dane County is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WWP) is an integrated program of acute and long-term care services designed to improve access to needed care, reduce fragmentation of care across providers, and settings, and help people remain independent in the community, while achieving cost savings. The target populations for WWP include both elderly and physically disabled individuals who meet nursing home level of care criteria. Elder Care Partnership serves frail elderly beneficiaries. Participants must be Medicaid eligible or dually eligible for Medicare and Medicaid services. A hallmark of this program is the use of an inter-disciplinary care team comprised of a physician, nurse practitioner and social worker that help coordinate beneficiaries' care across all health care settings. The WWP also participates in the Medicare/Medicaid Integration Program, a demonstration to test strategies for integrating Medicare and Medicaid services. The goal of this program is to create a seamless system of care for beneficiaries and to reduce costs related to duplication of services and administrative functions across programs.

Like a number of other speciality Medicare+Choice programs, the WWP currently operates under demonstration authority, which expires at the end of next year. And, like virtually all Medicare demonstration programs, there is no mechanism for transitioning from demonstration status into the mainstream of Medicare. I understand that The Medicare Prescription Drug and Reform Act of 2003 begins to address this problem by establishing a special designation for specialized Medicare Advantage plans that exclusively serve special needs beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that disproportionately serve special needs beneficiaries.

The expansion of the specialized Medicare Advantage designation would provide Elder Care and other WWP members additional flexibility in expanding our unique program to other beneficiary groups such as those who are eligible for Medicare, but not Medicaid and "pre-duals"—those who are at risk of spending down to Medicaid based on health status and/or income limitations. Targeting healthy beneficiaries before they become frail or disabled would reduce long-run Medicare and Medicaid costs by preventing or delaying health care decline and the need for costly medical or long-term care services. Your amendment also would offer Elder Care a mechanism to serve non-special needs beneficiaries as a strategy for expanding our membership under a mainstream model or reducing our risk through a more representative cross-section of Medicare beneficiaries in Madison.

Your compassion for seniors, disabled and other special needs beneficiaries has been evident since you served as the Chair of the Senate Aging Committee in the State of Wisconsin. The amendment you are offering to the Senate Medicare bill only provides further evidence that you continue to be hard at work on behalf of Wisconsin's most vulnerable populations. Thank you for all of your work on behalf of Wisconsin's seniors.

Sincerely,

KAREN MUSSER,
CEO.

Mr. HATCH. Mr. President, I rise to speak on the Gregg-Schumer amendment which was adopted last week. This amendment was based on a piece of legislation, S. 1225, the Greater Access to Affordable Pharmaceuticals Act of 2003, reported by the HELP Committee on June 11th.

I want to take this opportunity to explain why I cast the lone vote against this amendment. It is my hope that when my colleagues consider my explanation that they may be open to making additional changes to this very important amendment as the process moves forward.

Let me start by commending Senators GREGG, SCHUMER, MCCAIN, and KENNEDY for their work in developing this provision which I believe is a significant improvement on legislation that was adopted by the Senate last Congress, S. 812.

The Gregg-Schumer amendment relates to a complex and often admittedly confusing law I coauthored with my friend, Representative HENRY WAXMAN of California in 1984 the Drug Price Competition and Patent Term Restoration Act.

I chaired a hearing of the Senate Judiciary Committee in May of 2001 that helped document some abuses that were occurring in the law. Since our last hearing on this issue, much has happened.

Both the Federal Trade Commission and the Food and Drug Administration played a constructive role in attempting to end several mechanisms by which some research-based and generic drug firms were attempting to game the system put in place by the 1984 and subsequent court decisions to avoid competition in the marketplace.

The FTC succeeded in achieving several widely-publicized consent decrees with a variety of offending firms under the existing antitrust statutes.

In addition, the FTC conducted an exhaustive survey and study of how certain provisions of the 1984 Waxman-Hatch Act affected competition in the pharmaceutical industry.

The FTC study contained two major recommendations. The first addressed the use of the statutory 30-month stay granted by the 1984 law in situations where patents are challenged by generic competitors. The FTC recommended that the law:

> Permit only one automatic 30-month stay per drug product per ANDA to resolve patent infringement disputes over patent listed . . . prior to the filing date of the generic applicant's ANDA.

This was precisely the position that I suggested in testimony before the HELP Committee on May 8, 2002 and argued for last year during the Senate debate on the Edwards-Collins substitute amendment to the McCain-Schumer legislation.

I would note that the 30-month stay provision in the McCain-Schumer bill last year, S. 812, and in the Edwards-Collins substitute, were both at variance with this central recommendation of the FTC report.

The second major FTC recommendation responds to those situations in which R&D and generic firms were entering into agreements not to impede generic competition. The FTC recommended that Congress:

> Pass legislation to require brand-name and first generic companies applicants to provide copies of certain agreements to the Federal Trade Commission.

Senator LEAHY, working very closely with the FTC, developed legislation, the Drug Competition Act, S. 946, that squarely addressed this second recommendation.

During the 107th Congress, I worked with Senator LEAHY on refining that bill. I supported it in committee, and worked with him to pass it through the Senate late last year. I supported his efforts to have it attached to the Medicare vehicle earlier this week. I expect that the 108th Congress will adopt this measure.

The FTC study served an important purpose of cataloging the facts surrounding certain abuses of the 1984 act.

In formulating public policy, the facts should matter and a legislative or regulatory response should be tailored to fit the problem.

Unfortunately, the timing of the issuance of the FTC study did not allow the report to get the attention it deserved by the Senate. The FTC report was published only one day before the Senate adopted S. 812, the Greater Access to Affordable Pharmaceuticals Act of 2003, last July 31.

The GAAP Act, developed by Senators McCAIN and SCHUMER, was substantially altered by the Edwards-Collins substitute, with the active involvement of Senator KENNEDY.

While there is no question my colleagues were motivated by their goal of making drugs more affordable for seniors and all Americans, and despite the fact that it garnered 78 votes in the Senate, there were significant shortcomings in the bill.

Let me briefly review a few of the most troublesome provisions of the Edwards-Collins substitute to S. 812. The proposed legislation would have created for the first time a private right of action in the Federal Food, Drug, and Cosmetic Act. The last thing the already overburdened FDA staff needs is a bunch of trial lawyers bringing the agency to a screeching halt by second-guessing its judgment calls.

The bill that passed last year would have resulted in the waiver of patent rights apparently against even third parties—if pioneer drug firms did not file its patents with the FDA and, if challenged by a generic drug applicant, pursue expensive litigation within tight time frames.

In sharp contrast to the FTC recommendation, S. 812 basically made any patents listed with the FDA after a month from the date the pioneer drug application was approved by the FDA ineligible for the 30-month stay. In most cases, this is at least four years earlier than what I and the FTC recommended—freezing the Orange Book to patents listed before a generic drug application was filed.

The American Intellectual Property Law Association opposed S. 812. The patent-dependent biotech industry worked against the bill. The Patent and Trademark Office found that "S. 812 would forfeit unnecessarily the core right of patent holders—the right to exclude others from practicing the inventions for the entire patent term. After years of research and development and significant investment, the patent right is extinguished for the mere failure to satisfy an administrative task or respond in a timely manner."

Here is what the July 18, 2002 Statement of Administration Policy said about the Edwards-Collins-McCain-Schumer legislation:

> . . . the Administration opposes S. 812 in its current form because it will not provide lower drug prices. S. 812 would unnecessarily encourage litigation around the initial approval of new drugs and would complicate the process of filing and protecting patents on new drugs. The resulting higher costs and delays in making new drugs available will reduce access to new breakthrough drugs. Moreover, the new cause of action is not necessary to address patent process abuses. Clearly, the bill would benefit from consideration by the Senate's experts on Hatch-Waxman law on the Judiciary Committee, the proper committee of jurisdiction for this bill.

While S. 812 passed by a very wide margin, it was certainly not without its critics.

Comes now S. 1225. This bill emerged from the HELP Committee. Once again, it is entitled the Greater Access to Affordable Pharmaceuticals Act. Once again, it is cosponsored by Senators McCAIN, SCHUMER, and KENNEDY.

Due in large part to the leadership of Chairman GREGG, there are significant changes in the bill compared with last year's legislation.

While I have significant concerns over certain aspects of S. 1225 as adopted in its amended form on June 19, 2003, I must acknowledge Chairman GREGG and Majority Leader FRIST for their roles in working with the cosponsors of last year's bill to make substantial improvements in the legislation.

Likewise, I commend Senators SCHUMER, McCAIN and KENNEDY for abandoning many of the troublesome features of a bill that garnered 78 votes last Congress.

I can only believe that the factual presentation, analysis, and recommendations contained in the FTC report and subsequent public notice and comment process surrounding the recently issued FDA final rule on patent listings and the application of the statutory 30-month stay both played a constructive role in helping to form the basis of the Gregg-Schumer legislation.

It is appropriate to recognize the efforts of the Bush administration for tackling the problem of multiple, successive 30-months stays through rulemaking. Secretary Thompson, Commissioner McClellan, and FDA Chief Counsel Dan Troy, should be saluted for their roles in so promptly completing a rulemaking regarding patent listing that generally embraced the one-and-only-one 30-month stay policy recommended in the FTC Report. Chairman Muris and the FTC staff deserve credit for a report that helped shape a more carefully targeted policy response.

There can be no doubt that this year's vehicle, S. 1225, is superior to S. 812. This new Gregg-Schumer bill, S. 1225, embraces exactly the type of one-and-only-one 30-month stay policy that I suggested to the HELP Committee last May, argued for on the floor last July, and was ultimately recommended by the FTC.

The Gregg-Schumer legislation, S. 1225 in the form adopted by the Senate, also addresses some problems that the FDA rule perhaps did not resolve satisfactorily. As FDA Chief Counsel Dan Troy stated at the June 17th Judiciary Committee hearing:

> We tried as best we could to cut down on all opportunities for gaming. We did not succeed in cutting down all opportunities for gaming, because nothing, no legislation is so good, no rule could be so good as to cut down all opportunities for gaming, because there are unforeseen circumstances and unintended consequences.

I think Mr. Troy is correct about the nature of the inherent limitations of regulatory and legislative fixes for complex problems where there are powerful incentives to game the system to gain financial advantage. We need to keep this in mind as we analyze further the amendment the Senate adopted last week.

As I stated at the June 17th hearing, it was unfortunate that the PTO was unable to present a witness. Admittedly, the invitation was issued on short notice. I have asked PTO for its formal comments on the Gregg-Schumer amendment. I would also be interested in the PTOs comments on whatever language the House adopts. We would also be wise to hear from the Office of the United States Trade Representative if USTR finds that the legislation raises any concerns for international trade and intellectual property under the TRIPS provisions.

It is my understanding that FDA and FTC staff provided a great deal of what is known as "technical assistance" on the Gregg-Schumer amendment, a good deal of it between the markup on June 11th and the time the amendment was offered on June 19th. I am not aware whether PTO or USTR were consulted.

PTO and USTR should understand that this is a fast moving train, so they should be prepared to give us any comments they may have in short order. President Bush and the congressional leadership have made it plain that they expect the conference report on the Medicare bill to be completed as soon as possible.

One special area of concern to me as Chairman of the Judiciary Committee is that one provision of the amendment overwhelmingly adopted by the Senate raises significant issues with respect to civil justice policy, including a constitutional concern. Specifically, proposed section 271(e)(5) of title 35, would make the failure of a patentee to file a patent infringement action within a specified time frame sufficient to establish "an actual controversy" for the purpose of establishing subject matter jurisdiction for a declaratory judgement action by a generic drug firm challenging a patent.

Whether the Congress can, or should, by statute grant subject matter jurisdiction for a declaratory judgment based on the failure to bring a suit raises some interesting questions, particularly in light of manner in which the U.S. Courts of Appeals, including the Federal Circuit, have developed and applied the "reasonable apprehension" test. At our June 17th hearing, DOJ did not present the Judiciary Committee with its final opinion on the matter but Mr. Sheldon Bradshaw, Deputy Assistant Attorney General, Office of Legal Counsel, noted, "that the actual case of controversy requirement is constitutionally compelled rather than statutorily required. And as a result, Congress can't simply create a case or controversy by statute but the plaintiffs must establish the constitutional requirement for bringing the case." The committee has received a spirited correspondence that takes differing views on the case or controversy provision of the Gregg-Schumer amendment.

I have requested the Department of Justice for its formal views on this language. At this point, I think it premature to embrace this language. It is my understanding that the bill that the House will take up does not contain the controversial case or controversy language. I stand prepared to work with the sponsors of the amendment, DOJ and others on this important issue.

Yet another improvement of S. 1225 over the bill adopted by the Senate last year relates to the manner in which the 180-day rule is addressed. In short, I am pleased that the policy embraced last year, the rolling exclusivity policy, was replaced in favor of a "use it or lose it" approach. I have long stated a preference for the consumer friendlier "use it or lose it" rule over the too open-ended rolling exclusivity.

The Waxman-Hatch law provides an incentive for generic firms to challenge patents. To encourage generic competitors to pursue patent challenges in a vigorous fashion, the 1984 law provided 180 days of marketing exclusivity in situations where a generic drug firm could show the pioneer's patents were invalidated or not infringed. For many years it was thought, as intended, that this valuable 180-day period of exclusive marketing would be granted to the first generic firm to successfully invalidate or invent around the pioneer's patents.

FDA regulations issued in 1994 required that the first generic applicant had to defend successfully against a patent claim made by a brand name company to receive the 180-day exclusivity. In a 1998 D.C. Circuit case, Mova v. Shalala, the court construed the plain language of the statute to strike down the successful defense requirement. As a result FDA now makes 180-day exclusivity decisions by applying the literal words of the statute. This results in a system that rewards first filers, not necessarily successful challengers.

The Gregg-Schumer amendment retains the preference for first filers. I believe that re-instating the successful defense requirement may prove preferable than intentionally sanctioning a first filer regime.

Frankly, I am uncertain of the policy justification for S. 1225's retention of granting the 180-day reward to the first filer rather than the first successful defendant. I believe that there is a lot to be said for giving the reward to the actual winner in court or the first not to be sued, not just the first one to enter the Parklawn Building with an application.

The amendment places a high premium on being a first filer. At our hearing last week, FTC Chairman Muris characterized the rush to be a first filer as "the shantytown problem of people in line to file." FDA Chief Counsel Troy described that ". . . right now, there are sometimes limousines, sometimes vans, sometimes cars, sometimes even tents in the Metro North parking lot that come days, weeks, and in some cases even months in advance of a particular date. Why we should reward someone because they camp out longer in the parking lot is a good question?"

I am concerned that the language that passed the Senate could allow some unintended and, in fact, counterproductive, results. Changes in current law with respect to the court decision and commercial marketing triggering mechanisms for the 180-day exclusivity provision demand careful attention and analysis. The amendment does not appear to adopt all the FTC recommendations in this area.

Other questions should be raised. What if, for example, the generic applicant that successfully challenges the validity of the patent is not also a first filer? Why should such a non-first filing but successful invalidity challenger not be granted the 180 days exclusivity? Stated another way, why should the first filer—or in Chairman Muris' "shantytown" situation, a whole group of first-day, exclusivity-sharing, first-filers, gain while the actual successful challenger waits out the 180-days? I am not sure that such an outcome is fair or even rational. Moreover, such a system may not result in the most efficient or aggressive pursuit of patent challenges.

One thing is for sure: You can expect a lot more first filers to appear at the door of the FDA building on the first day that successful drugs become eligible for patent challenges. As I pointed out at the Judiciary Committee hearing, some have already suggested that the first to file system might result in an increase in willful infringement cases. In fact, there was a decision last month by a Federal court in Chicago that ruled against a generic firm which filed a generic drug challenge before obtaining the opinion of outside counsel on either non-infringement or invalidity.

Another type of potential problem could arise, and frankly I am not certain how it can be avoided, if a non-first filing generic drug challenger wins a court decision on grounds of non-infringement. Unless I am wrong in my understanding of the Gregg-Schumer amendment, a generic challenger that prevailed on a non-infringement theory would have to wait for the 180-days granted the first filer, or a group of first-day, first-filers, to expire before the non-infringing firm could enter the market. Such an outcome only hurts consumers by needlessly delaying introduction of the non-infringing generic product for 180 days.

Unlike a determination of patent invalidity, a finding of non-infringement does not accrue to third parties. It is important to understand that there are two ways for a generic firm patent challenger to be awarded the 180-day exclusivity under the law. First, the generic challenger can show that the pioneer's patent is invalid. And second, the generic challenger can demonstrate that its product will not infringe a pioneer's patent.

These are two very different theories. Al Engelberg, a highly successful and highly respected attorney engaged by generic drug firms to attack pioneer patents, has made the following observation about the difference between invalidity and non-infringement challenges:

> In cases involving an assertion of non-infringement, an adjudication in favor of one challenger is of no immediate benefit to any other challenger and does not lead to multi-source competition. Each case involving non-infringement is decided on the specific facts related to that challenger's product and provides no direct benefit to any other challenger. In contrast, a judgment of patent invalidity or enforceability creates an estoppel against any subsequent attempt to enforce the patent against any party. The drafters of the 180-day exclusivity provision failed to consider this important distinction.

As one of the drafters of the 1984 law, I must accept a measure of responsibility for this problem. It is not clear, however, that S. 1225 has addressed this issue in a satisfactory fashion. The language adopted in the Gregg-Schumer amendment does not appear to solve the problem created by the 1998 Mova decision that effectively eliminated the successful defense requirement.

Frankly, I think we need further thought on how best to address the implications of the distinction between invalidity and non-infringement claims in the context of Hatch-Waxman patent challenges and 180-day exclusivity awards. Specifically, I question the appropriateness of continuing to group together patent invalidity and patent non-infringement challenges, particularly in light of the fact that the latter may in practice extend longer than the purported 180-day award. From what I know now, there are strong arguments to prefer the reinstatement of the successful defense requirement over the establishment of a new system based on first filing.

Let me close by once again commending Senators GREGG, SCHUMER, McCAIN, and KENNEDY for all their hard work in reaching the compromise amendment that was so overwhelmingly adopted by the Senate. The Gregg-Schumer amendment represents significant improvement over the legislation passed by the Senate last year. I am pleased that the amendment adopts the one-and-only-one 30-month stay policy that I, and the FTC, advocated last year.

I am also pleased that the Senate has adopted Senator LEAHY's Drug Competition Act, which also addressed a major recommendation of the FTC. I have worked with Senator LEAHY to perfect and pass this measure.

As a co-author of the 1984 Drug Price Competition and Patent Term Restoration Act, I support efforts to bring affordable and innovative drugs to the American public. While I support the spirit and much of the letter of the Gregg-Schumer amendment, for the reasons I have set forth, I was unable to fully support this measure at this time.

Mr. BUNNING. Mr. President, during consideration of S. 1, an amendment was introduced by Senators SANTORUM and SCHUMER dealing with payments to the Medicare+Choice program. This amendment would have increased payments to the M+C plans over the next 2 years, to make sure they are still viable when the MedicareAdvantage program takes effect in 2006.

I realize the amendment was withdrawn because of the lack of funding in the Senate bill, but it is still an important issue I would like to lend my support to.

The Medicare+Choice program already provides a good prescription drug benefit to many seniors across the county, and gives these seniors another option to the Medicare fee-for-service program.

Unfortunately, many Medicare+Choice plans are pulling out of the program because their reimbursement levels are too low. This is leaving many seniors scrambling for a new Medicare+Choice plan or having to go back into fee-for-service Medicare which doesn't offer them the same types of benefits as their old M+C plan.

In fact, it seems like every year, more and more Medicare+Choice plans leave the market.

I am concerned if we do not provide these plans with enough funding over the next two years while the MedicareAdvantage program is being implemented, these M+C plans will continue to leave the program and more seniors will be left in the lurch.

This isn't fair to our seniors.

I had hoped we could provide some additional funding for the Medicare+Choice plans over the next 2 years so the plans currently in the program will remain and we might actually attract new plans to other areas that have not been served.

In Kentucky, we have a limited number of Medicare+Choice plans. In fact, only seniors in certain counties in Northern Kentucky and around Louisville have access to these plans. With higher payments to Medicare+Choice plans, we might actually get some more plans to come into our state and cover more counties.

We shouldn't give up on the Medicare+Choice plans, or the seniors enrolled in them. I hope this is an issue we can resolve during the conference with the House, and I commend Senators SANTORUM and SCHUMER for bringing this issue before the Senate.

Mr. LEAHY. Mr. President, I am pleased that late last night the Senate again supported lowering drug prices and maintaining a fair generic drug approval process by adding the Drug Competition Act of the Prescription Drug and Medicare Improvement Act of 2003, S. 1. Last November, the Drug Competition Act passed the Senate by unanimous consent. On Monday, Senator GRASSLEY and I, along with Senators CANTWELL, DURBIN, FEINGOLD, KOHL, and SCHUMER, offered our bill as an amendment to the larger Medicare bill. I hope that in this Congress it is actually enacted into law as part of the larger effort to improve the health care of millions of Americans. Prescription drug prices are rapidly increasing, and they are a source of considerable concern to many Americans, especially senior citizens and families. Generic drug prices can be as much as 80 percent lower than the comparable brand-name versions.

While the Drug Competition Act is small in terms of length, it is large in terms of impact. It will ensure that law enforcement agencies can take quick and decisive action against companies that are driven more by greed than by good sense. It gives the Federal Trade Commission and the Justice Department access to information about secret deals between drug companies that keep generic drugs off the market. This is practice that hurts American families, particularly senior citizens, by denying them access to low-cost generic drugs, and further inflating medical costs.

Last July, the Federal Trade Commission released to comprehensive report on barriers to the entry of generic drugs into the pharmaceutical marketplace. The FTC had two recommendations to improve the current situation and to close the loopholes in the law that allow drug manufacturers to manipulate the timing of generics' introduction to the market. One of those recommendations was simply to enact our bill, as the most effective solution to the problem of "sweetheart" deals between brand name and generic drug manufactures that keep generic drugs off the market, thus depriving consumers of the benefits of quality drugs at lower prices. Indeed, at a hearing just yesterday in the Judiciary Committee, Chairman Timothy Muris of the FTC praised the Drug Competition Act in his testimony and urged its passage. In short, this bill enjoys the unqualified endorsement of the current FTC, which follows on the support by the Clinton administration's FTC during the initial stages of our formulation of this bill. We can all have every confidence in the commonsense approach that our bill takes to ensuring that our law enforcement agencies have the information they need to take quick action, if necessary to protect consumers from drug companies that abuse the law.

Under current law, the first generic manufacturer that gets permission to sell a generic drug before the patent on the brand-name drug expires, enjoys protection from competition for 180 days—a head start on other generic companies. That was a good idea, but the unfortunate loophole exploited by a few is that secret deals can be made that allow the manufacturer of the generic drug to claim the 180-day grace period to block other generic drugs from entering the market, while at the same time, getting paid by the brand-name manufacturer not to sell the generic drug.

Our legislation closes this loophole for those who want to cheat the public but keeps the system the same for companies engaged in true competition. I think it is important for Congress not to overreact and throw out the good with the bad. Most generic companies want to take advantage of this 180-day provision and deliver quality generic drugs at much lower cost for consumers. We should not eliminate the incentive for them. Instead, we should let the FTC and Justice look at every deal that could lead to abuse, so that only the deals that are consistent with the intent of that law will be allowed to stand. The Drug Competition Act accomplishes precisely that goal, and helps ensure effective and timely access to generic pharmaceuticals that can lower the cost of prescription drugs for seniors, for families, and for all of us.

The effects of this amendment will only benefit the effort to bring quality health care at lower costs to more of our citizens. The Drug Competition Act enjoyed the unqualified support of the Senate last year, and I am pleased that my colleagues have recognized that it fits well within the framework of the Prescription Drug and Medicare Improvement Act of 2003. It is a good complement to the larger bill and does nothing to disrupt the bill's balance. I sincerely hope that this commonsense legislation is a part of any final agreement with the House on the larger Medicare prescription drug bill.

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

• Mr. KERRY. Mr. President, I wish to express my enthusiastic support for the amendment Senators SCHUMER and SANTORUM offered to increase funding for the Medicare+Choice Program in 2004 and 2005. This amendment addresses a critically important issue that has far-reaching implications affecting the health care benefits of millions of low-income and minority seniors. I am pleased to be a cosponsor of this amendment to ensure that this urgently needed funding increase is included in the Medicare bill.

I believe we must take bold action to address the fact that Congress has not provided adequate funding for the health care of Medicare beneficiaries who select HMOs and other private sector health plans. In many parts of Massachusetts, and in other parts of the country, funding for Medicare+Choice plans has been limited to annual increases of only 2 percent in most years since 1998. These increases are inadequate at a time when health care costs are rising by 8 to 10 percent annually. This level of inadequate funding is unfair to the 170,000 Medicare beneficiaries in Massachusetts who have selected private health plan options. I am a strong supporter of the wonderful health plans we have in Massachusetts—Harvard, Tufts, Blue Cross/Blue Shield, and Fallon Community Health Plan. We must step up to the plate to help these plans—nonprofit plans in my State—in their time of need.

The Schumer-Santorum-Kerry amendment takes important steps to address this problem. By providing funding now to stabilize existing private health plan options for Medicare beneficiaries, we can help ensure that the proposed Medicare Advantage Program will be successful in the future. Our amendment lays the groundwork for successful long-term efforts to provide beneficiaries with high-quality health care choices.

As the Senate continues to debate changes in Medicare, it is important for us to remember that, for more than 4.5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high-quality, comprehensive, affordable coverage that is not always available, or affordable under the Medicare fee-for-service program. These seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because they recognize the value they offer.

Seniors in Massachusetts have come to rely on the high-quality health care they receive through their Medicare+Choice plans. Prescription drugs coverage, disease management services, physician exams, vision benefits, and hearing aids are examples of the additional benefits that are routinely offered by their Medicare+Choice plans.

These additional benefits are valued by all seniors, but they are particularly important to low-income seniors who cannot afford other Medicare supplementary plans that might provide them such benefits but at a greater cost.

As the Medicare debate moves forward, it is important for Congress to remember that Medicare+Choice serves as a vital safety net for many of our Nation's most vulnerable seniors. For millions of beneficiaries who cannot afford to purchase a Medigap policy, Medicare+Choice is their only hope for obtaining comprehensive health coverage.

The Schumer-Santorum-Kerry amendment focuses on protecting this important option for seniors who have nowhere else to turn for the quality health coverage they need. I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare+Choice Program for seniors. This should be among our highest priorities in this year's Medicare debate.•

Mr. CARPER. Mr. President, when I ran for the U.S. Senate, I promised Delawareans that I would work in a bipartisan fashion to provide a Medicare prescription drug benefit for our Nation's seniors. I pledged that I would seek consensus around what is right with competing Republican and Democratic plans. Along with my Democratic colleagues, I would support voluntary coverage that is available and affordable for all seniors. Along with my Republican colleagues, I would support choice and competition to constrain costs. And to the extent we found ourselves constrained by limited resources, I would seek to provide the greatest assistance to those with the greatest needs.

The bill before us today achieves some of that vision. It is bipartisan. It will provide a benefit available to all seniors on a voluntary basis. It will harness market forces to strengthen the integrity of the Medicare Program for the future. And it will provide comprehensive health security to our most vulnerable, low-income seniors.

Still, the bill we have before us today is not everything I would have hoped for. The overriding priority of the current majority here in Congress has been to make dramatic reductions in Federal revenues without corresponding reductions in Federal spending. As a result, there is insufficient money in the budget under which we are currently operating to provide the kind of comprehensive coverage that all seniors—not just low-income seniors—truly deserve. This is an unfortunate choice of priorities, I think, but it is the choice that this President and this Congress have made.

Unfortunately, the consequences of the majority's misguided priorities are evident in this legislation. When Medicare was created, the idea was to provide seniors with health coverage that was similar to the coverage available to most working Americans through their employers. This is what seniors expect when we say that we are providing them with a Medicare prescription drug benefit. However, the majority has only set aside for this bill about half of what it would take, according to the Congressional Budget Office, to provide seniors a benefit comparable to standard employer-provided coverage. Thus, there is a very noticeable gap in this bill's coverage, reflective of a substantial hole in our Nation's budget.

When seniors reach $4,500 in prescription drug costs, the coverage in this bill gives out. It does not kick back in until total spending reaches $5,800. It is widely acknowledged that this makes no sense. It makes no sense from an insurance perspective. It certainly is not reflective of the standard either in private employer-provided coverage or in the coverage provided to those of us who are fortunate enough to serve as Members of Congress. Nobody likes this gap in coverage. Nobody, so far as I can tell, defends it. However, because the root of problem is the majority's failure to set aside sufficient resources for this program, efforts to deal with the problem have only created new and potentially more serious difficulties.

For example, the authors of this legislation have attempted to narrow the coverage gap by not allowing employer contributions to count towards the calculation of seniors' out-of-pocket spending in the gap. To see how this works, we need to understand how the coverage gap works. Once seniors reach $4,500 in total drug costs, they fall into the coverage gap. They then have to spend a certain amount of their own money—in the final bill reported out of the Finance Committee it is $1,300—before their coverage resumes, or they get out of the coverage gap.

The effect of not allowing seniors to count payments made by their retiree health plans toward this out-of-pocket requirement is to ensure that seniors will remain in the gap longer and fewer will get out of it. This allows the level of spending at which the gap ends to be set at a lower level than would otherwise be possible for the same budgetary cost. The problem with this, however, is that it also provides an unintended incentive for employers to drop or scale back their retiree drug coverage.

Thankfully, contributions from State prescription drug plans, like our Delaware Pharmacy Assistance Program, count toward the out-of-pocket requirement, which should encourage

States to "stay in the game." Employers, though, are effectively barred from wrapping their coverage around Medicare in the way that would be most beneficial for their retirees, which would be by filing Medicare's coverage gap.

In the course of our consideration of this legislation here on the floor of the Senate, I have urged my colleagues to address these shortcomings in the bill, even if that means reconsidering the majority's budget plan and the resource allocation for this program. I supported an amendment by Senator BOXER to eliminate the gap in coverage. And I cosponsored an amendment offered by Senator ROCKEFELLER to allow employer-provided coverage to wrap around the Medicare benefit and thus to eliminate the incentive for employers to drop coverage for their retirees.

The majority has made clear, however, that they are unwilling to reorder their priorities or to emplore the possibility of finding the necessary resources elsewhere in the budget to fix what they acknowledge are shortcomings in this legislation. Thus, the rest of us are left to choose between a prescription drug benefit that provides some, but not all, of the assistance that seniors deserve, or no prescription drug benefit at all.

Congress has been debating this issue for more than a decade. In many ways, it has been debating the issue since Medicare was first created back in 1965. I ran for the Senate in part because I was frustrated at the inability or unwillingness of the parties in Washington to come together to do what they could to solve problems and get things done. I am unwilling to walk away from the table this year with nothing for Delaware's seniors. They have waited too long and the need is too great.

In light of the budgetary priorities of the Republican majority, I am also very concerned about our future prospects. Should we let the present opportunity pass us by? I am concerned that if we do not act to get started with prescription drug coverage this year, even the limited resources that now remain may go out the door for other purposes—most likely another round of top-heavy, upper bracket tax cuts.

This is a first step. It is a downpayment. Just as I pledged when I ran for the Senate to work in a bipartisan fashion to get results, I pledge today to continue to work to build on these results. I continue to believe that we should provide our seniors with quality coverage without caps or gaps. I will work to ensure that filling the gap of coverage that exists in the present bill is given greater priority in future budgets than it was in this year's Republican budget. I also believe that it is a mistake to shun rather than welcome employer efforts to wrap around the new Medicare benefit, and I will work to rectify that mistake as we move toward implementation of this program over the next few years.

Mr. President, it is often said that politics is the art of the possible. The bounds of the possible are a bit narrower now than they need, thanks to our Republican friends. But, as the ranking member of the Budget Committee has said, this may be the best bill that could be written under the constraints of the Republican budget. For that reason, I commend the authors of this legislation—Chairman GRASSLEY and Senator BAUCUS, among others—for their work. I urge my colleagues to support this compromise as an important, if limited, first step toward addressing what clearly is a pressing priority, not just for our elderly population, but for our Nation as a whole.

Mr. JEFFORDS. Mr. President, as we debate the Prescription Drug and Medicare Improvement Plan of 2003, I would like to take a few minutes today to speak in support of the overall bill, but I would also like to highlight several provisions in the bill that are of particular importance to me and my State of Vermont.

Over the last several days, we have focused much of our discussion on the aspects of this bill related to prescription drugs and the Medicare Advantage Program. These are clearly among the most important provisions of this bill and these issues warrant the attention and debate they are receiving. I especially appreciate the close relationship this bill has to last year's tripartisan effort—which effectively is the parent of the current bill Last year, my friends—Senators GRASSLEY, SNOWE, HATCH, and BREAUX—and I set out to design a bill that provided a prescription drug benefit along with other improvements, what we called "enhancements," to the basic operations of the Medicare Program. The tripartisan bill was good legislation—something all of its original cosponsors were very proud to work on together.

This year, I am pleased to say that the Grassley-Baucus bill is even better than our effort from last year, and I commend Chairman GRASSLEY and Ranking Member BAUCUS for their leadership and initiative in bringing it to the Senate floor.

One of the most important reasons that the Prescription Drug and Medicare Improvement Act is stronger than the tripartisan plan from last year is because it includes provisions that begin to resolve longstanding inequities in payments to rural doctors, hospitals, and other provisions. This problem can be stated simply. Rural health care providers are paid less than providers in more densely populated areas for the same exact services. Earlier this year, I joined with my colleagues, Senators HATCH, GRASSLEY, LINCOLN, and BINGAMAN, in introducing the legislation that addressed geographic inequities for physician services by changes to the physician reimbursement formulas.

As many of our colleagues are aware, Senator GRASSLEY fought to include these rural provisions in the recent tax bill that was signed by the President. And although I strongly disagreed with enacting further tax cuts, I was doubly disappointed to see the rural health provisions stripped out in the conference with the House. These unfair geographic differences in reimbursement rates have gone on far too long, and I am especially pleased to see reimbursement issues for rural providers getting the attention they deserve—including the commitment from the President to my friend from Iowa pledging his support for rural health relief as part of the effort we have underway. I am, therefore, very pleased to see that these provisions are included in the chairman's mark and are now part of this bill.

I am also glad that Chairman GRASSLEY and Ranking Member BAUCUS have worked with me to address another inequity in the system. Critical access hospitals provide care in the most remote regions of my State of Vermont and all other rural States. These hospitals are small, yet serve as critical resources to their communities. The managers have agreed to include a provision in their amendment that will make a technical correction to current law, allowing hospitals like the Mt. Ascutney Hospital in Windsor, VT, to expand access to psychiatric and rehabilitative services to the most vulnerable citizens in that community.

I would also like to speak today in support of a provision in this bill that establishes Medicare demonstration programs to improve health care quality. I heard my friend from Montana speak yesterday about quality and geographic disparities, and I know how committed he is to improving the quality of services delivered under Medicare. Earlier in this Congress, I was pleased that Senators FRIST, BREAUX, and GREGG joined me in introducing S. 1148, the Medicare Quality Improvement Act. I want to thank Chairman GRASSLEY and Ranking Member BAUCUS for including this provision in this bill.

I became concerned about the issue of health care quality after reading the work of Dr. Jack Wennberg of Dartmouth, which has shown that higher levels of Medicare spending do not lead to better health outcomes. Let me repeat this finding. Higher levels of Medicine spending do not lead to better health outcomes. Instead, spending tends to vary by region—generally reflecting the availability of physicians and hospitals—rather than the health or needs of the population.

I have followed Dr. Wennberg's work for a very long time. One of his early studies looked at rates of surgical procedures at Vermont hospitals. He found that communities in Vermont that had many more medical procedures were not necessarily healthier. I saw how this result led Vermont health care providers to join with the business community in achieving high quality, supportable outcomes. I also saw how our State government used this effort to improve health care across our State. Today, I am happy to say that Vermonters enjoy some of the highest quality health care in the United States, at a cost that is among the lowest in the country.

As we prepare to vote for the bill before us, I think it is critically important for us to consider some of the lessons learned from Vermont. Some of my colleagues have expressed concern about the costs of the bill before us. Others have expressed concern that the bill does not go far enough. The quality demonstration program in this bill will give us some of the answers we need to these funding questions.

The need for these demonstrations is critical. RAND Health published a study today in the New England Journal of Medicine that describes the problems with overuse and underuse of needed medical care services in the United States. The RAND study will make it clear that every American is at risk—not only for failing to receive needed medical care, but also for receiving care that is not needed and may even be harmful. This is a problem that belongs to each and every one of us, and we must find ways to fix it.

The legislation before us closes a significant gap in the health benefit package available to our Nation's seniors. However, providing coverage for health care services is not enough. We must do a better job of ensuring that people are getting the care they need, and also that they need the care they get.

In closing, I would like to urge my colleagues from both sides of the aisle to support this bill as we move forward. This bill will establish a drug benefit that is universal, comprehensive, affordable, and sustainable. This bill restores necessary and long-needed fairness to our physicians and providers in rural areas. And, the bill will improve the quality of care offered under Medicare.

Mr. DORGAN. Mr. President, over the last 2 weeks the Senate has debated the most significant changes to the Medicare Program since it was created in 1965. Today, we passed this legislation by a 76 to 21 vote, and I would like to take a few minutes to explain why I supported this bill.

This bill will, for the first time, provide the option of modest prescription drug coverage for nearly 39 million Medicare beneficiaries, including about 103,000 beneficiaries in North Dakota. It is also intended to give Medicare beneficiaries more choices of health plans. And it takes significant steps towards equalizing the Medicare payments that rural health care providers receive, compared to their urban counterparts.

There is no question that, if Medicare were being created today, it would include prescription drug coverage. Prescription medicines are a vital part of modern medicine. Last year alone, pharmaceutical companies introduced 26 new prescription medicines into the marketplace. But these advancements in medicine mean little if Americans cannot afford to access them. That is especially true for senior citizens who have reached their declining income years.

For years now, Congress has been debating proposals to add a prescription drug benefit to Medicare. Unfortunately, however, in past years we have not been able to reach agreement on just how to do this. With each passing year, older Americans continue to struggle to pay for their medicine. In North Dakota, about 48,000 Medicare beneficiaries have no prescription drug coverage, and many more have limited drug coverage. I hear from North Dakota seniors regularly who tell me that they have to choose between taking the medicines their doctor prescribed for them and other necessities such as food and heat.

These older North Dakotans say that they want and need Medicare drug coverage, and they want and need it now. If Congress doesn't enact legislation this year, chances are that several more years will go by before there is another serious opportunity to consider this issue. In other words, we could pass the legislation before the Senate today or we could do nothing for yet another year. In my judgment, doing nothing is not an option.

The prescription drug benefit in this bill is not as helpful to seniors as I would like or as generous as I think Medicare beneficiaries deserve—but it is a start.

Frankly, I think our budget priorities have been wrong. If I had my way, Congress would have reduced the size of the tax cuts for the very wealthy and instead set aside more money for improving and modernizing Medicare. During the Senate's debate earlier this year on the budget, I offered an amendment to set aside a total of $620 billion over the next 10 years for a Medicare prescription drug benefit. This is the amount of funding I felt was needed to provide a more generous and reliable benefit. Unfortunately, the majority in the Senate rejected my amendment, so we are limited to a package of just $400 billion over 10 years. When you consider that Medicare beneficiaries are projected to spend $1.8 trillion on prescription drugs over the next 10 years, it is impossible to develop a robust benefit within the $400 billion budget constraint, in my judgment.

The benefit provided for in this legislation is better than that which President Bush proposed in several key respects. Most importantly, this bill will not force seniors to leave the traditional Medicare Program—and the doctors they depend on—in order to get the prescription drug coverage they also need. I could not support a bill that coerces seniors out of the traditional Medicare Program that virtually all of North Dakota's Medicare beneficiaries rely on.

In addition, this bill provides extra assistance above the basic drug benefit for those older or disabled beneficiaries who have low incomes or very high drug expenses. Medicare beneficiaries with incomes below about $14,400 for individuals and $19,400 for couples—about 40 percent of North Dakota's beneficiaries—would qualify for extra assistance. And those with the highest drug costs—totaling more than about $5,800—would qualify for the catastrophic drug coverage. About 7 percent of North Dakota Medicare beneficiaries would reach this threshold.

Despite these improvements over the President's proposal, there are other concerns that I worked to address during the Senate's debate. In some instances, we were able to make changes to address these concerns, and in other cases, those efforts were rejected. In those instances where concerns still exist, I intend to continue working to fix them in conference with the House of Representatives.

For instance, as I have already mentioned, I am concerned that this coverage is not as generous as it should be, and in fact, there are some holes in the coverage. Under this benefit, seniors will have to reach a $275 deductible before their Medicare drug coverage starts. In addition, seniors whose drug expenses reach $4,500 will have to pay 100 percent of their drug costs between $4,501 and $5,800. Then, when their drug spending reaches $5,800, the catastrophic drug coverage will kick in and Medicare will pay 90 percent of their drug expenses after that. This means that there could be periods—in some cases as much as 3 months—when Medicare beneficiaries will have paid a premium for drug coverage but will be getting no benefit.

That makes no sense to me. No other insurance plans that I am aware of include such gaps in coverage. I supported various amendments on the Senate floor to close these coverage gaps or at least ensure that seniors don't have to pay premiums for the periods when they aren't receiving coverage. Regrettably, however, those efforts were rejected.

I am also concerned that rural Medicare beneficiaries may not receive a benefit that is as stable or as generous as other beneficiaries receive. This bill envisions that seniors will basically have two options for receiving drug coverage. First, this bill creates a new Medicare Advantage Program through which beneficiaries could choose to get their drug coverage, as well as the rest of their medical care, through an HMO or a PPO. Frankly, however, I am very skeptical that HMOs or PPOs will want to serve rural areas, and even if they do, I don't think most North Dakota beneficiaries will want to leave the traditional Medicare Program.

Those seniors who want to remain in the traditional Medicare Program will be able to do so and get their prescription drug coverage through private "drug only" insurance plans. Budget experts estimate that Medicare beneficiaries who sign up for these drug-only plans will pay an average monthly premium of about $35. However, this is only an estimate, and the actual premium that seniors pay could vary substantially from area to area. That is already the case in the current Medicare HMO program—for instance, a Medicare HMO with drug coverage currently charges $99 per month in Connecticut and only $16 a month in Florida. I am worried that it would be rural seniors who would pay the highest premiums, even though they paid the same Medicare payroll taxes as other beneficiaries.

To address this concern, I supported an amendment by Senator DASCHLE that would have limited the variation in premiums to only 10 percent above the national average, no matter where beneficiaries live. In other words, insurance companies could charge beneficiaries a lower premium but they couldn't charge them more than 10 percent above the national average. Unfortunately, however, Senator DASCHLE's amendment was rejected.

In areas where there are not at least two private drug-only plans offered to Medicare beneficiaries in any given year, Medicare would step in and ensure that there is a "fallback" plan available. This is a vital guarantee for beneficiaries in rural States like North Dakota where I believe it is unlikely that there will be two stable drug-only plans available. But even with this fallback plan, seniors could still be bounced back and forth between different plans, depending on how private plans move in and out of an area.

I supported an amendment that would have addressed this concern by allowing all Medicare beneficiaries to choose the fallback option, no matter how many private plans are available where they live. When that amendment failed, I cosponsored an amendment with Senator CONRAD that would at least allow seniors who have the fallback option to remain in that plan for 2 years, not just 1 year. That amendment was also rejected.

Even though this bill doesn't require Medicare beneficiaries to leave traditional Medicare, I know there are some concerns that Medicare beneficiaries will be getting their drug coverage through private plans. I, too, would strongly have preferred that all seniors be able to choose from a Medicare-administered benefit.

However, let me say this if I felt that by structuring the drug coverage the way it is in this bill, we were undermining the entire underlying Medicare Program, I would not support it. Medicare has been a wonderful success, and in our efforts to modernize it, we should exercise extreme caution not to undermine it. However, virtually all of the major Medicare prescription drug proposals would have used a private entity in some way to provide the drug benefit. Indeed, the traditional Medicare Program currently contracts with private insurance companies to pay the millions of Medicare claims that come in each year. Furthermore, the Congressional Budget Office estimates that only 1 to 2 percent more beneficiaries will choose the new Medicare Advantage option, so it seems clear that the vast majority of seniors will continue to rely on the traditional Medicare Program for the bulk of their medical care.

One area where we had some success in improving the bill during the Senate's debate is in the area of reducing drug costs. This bill relies largely on private insurance companies to negotiate lower drug prices. However, we have seen from prior experience that insurance companies have not been able to keep drug spending from increasing by nearly double digits every year 9.7 percent in 2002, 17 percent in 2001, 18.8 percent in 2000, and 16 percent in 1999.

To help put downward pressure on drug prices, I offered an amendment that was passed by the Senate by a 62-to-28 vote to allow for the reimportation of lower-priced, FDA-approved medicines from Canada. As many North Dakotans know first hand, the same FDA-approved prescription drug that costs $1 in the United States costs only 62 cents in Canada, even though it is the exact same drug, in the same bottle, made by the same manufacturer.

It is not my intention with this amendment to require Americans to go to Canada in order to get lower drug prices. Rather, by allowing U.S. licensed pharmacists and drug distributors to do the importing for them, Americans can stay at home, and by breaking the monopoly that the drug companies currently have on drug pricing in this country, we will force a repricing of drugs here in the United States.

I also supported an amendment that will help to make more affordable generic drugs more readily available. Generic drugs are safe, effective, and lower priced alternatives to heavily advertised brand-name prescription drugs. Unfortunately, however, some of the big brand-name drug companies use loopholes in the patent laws to keep generic drugs off the market for longer than intended. This amendment, which passed the Senate by a 94-to-1 vote, will close these loopholes and thereby speed consumers' access to generic medicines.

I am also pleased that this bill improves Medicare's coverage of preventive services, especially by including a provision that I authored to provide for a cholesterol screening benefit for Medicare beneficiaries. I have felt for a long time that Medicare needs to do a better job of preventing disease, rather than just paying to treat it. In the case of cholesterol screening in particular, high cholesterol is one of the major, changeable risk factors for heart attacks, stroke and other cardiovascular diseases. Yet when Americans turn 65 and enter the Medicare Program, their coverage for cholesterol screening stops unless they already have cardiovascular disease. That makes no sense, and I am glad the Senate has taken steps to provide this coverage.

Finally, I am very happy that this bill includes a range of provisions that will make Medicare reimbursement more fair and equitable for our rural hospitals, physicians, and other health care providers. It is simply not right that Medicare has historically reimbursed urban health care providers at a much higher rate than their urban counterparts. This inequity in Medicare reimbursement has very real consequences for hospitals and clinics in rural States like ours. They have to reduce services, have greater difficulty recruiting staff, are less able to make capital improvements, struggle to give their patients access to the latest innovations in medical care, and in same instances, they even have to close.

I have been fighting for a long time to correct this inequity. In fact, some of the provisions in this bill are similar to legislation that I introduced in the Senate earlier this year, and I am glad they have been included in this bill.

I know there will be some who feel that this bill should have been rejected by the Senate because it relies too heavily on private plans and others because it does not place enough emphasis on enrolling seniors in private plans. Others will feel that the Medicare benefit is not generous enough, and some feel its coverage is too liberal. I agree that this legislation isn't perfect—far from it, in fact. In the coming months and years, I will continue working to improve it. But it is a start in the right direction, and that is why I have supported it.

The House of Representatives is also expected to pass its version of Medicare legislation this week. The House and the Senate will now need to have a conference committee to work out the differences between the two bills. I have some serious concerns about the

House-passed bill. I hope these concerns and the concerns that I have with the Senate bill can be resolved in the final bill, so that we can send a bill to the President for his signature this year.

Mr. SARBANES. Mr. President, I rise today to speak on S. 1, the Prescription Drug and Medicare Improvement Act of 2003. I applaud my colleagues in working toward enactment of legislation to provide prescription drug coverage under Medicare. However, I am deeply concerned that the bill before us today would not ensure an affordable, guaranteed benefit that would cover seniors' outpatient prescription drug expenses.

Under this legislation, the Secretary of the Department of Health and Human Services would temporarily issue prescription drug discount cards for seniors until the drug benefit begins in 2006. At that time, all Medicare beneficiaries would receive a standard prescription drug benefit whether they remained in traditional fee-for-service or in a private plan. For a $275 deductible and an estimated $35 per month, 50 percent of a beneficiary's drug costs would be covered up to $4,500. A beneficiary would receive no coverage for drug costs between $4,501 and $5,800, though they are still responsible for paying the monthly premium during this coverage gap. Furthermore, any assistance provided by employer-sponsored plans or third parties on behalf of the beneficiary does not count toward the out-of-pocket costs. After drug expenses reach $5,801, the plan would cover 90% of drug expenses.

The bill creates a new Medicare Advantage program, which would replace Medicare+Choice, and create a new agency, the Center for Medicare Choices, CMC, with authority parallel to the existing Centers for Medicare and Medicaid Services. The CMC would administer the Medicare Advantage program and the prescription drug plans. The drug plans would be administered through private plans, but when no private plans exist, the government would provide a fallback plan for seniors in fee-for-service. However, if a new private plan decides to enter an area, beneficiaries would again be forced to receive their coverage through that plan.

If this sounds terribly confusing, it is. One hundred Senators and their staffs found it difficult to work through this bill and understand exactly how the benefit would work. Seniors who don't sign up as soon as they are eligible are subject to a penalty similar to the penalty imposed on those who delay enrollment in Part B. It is unfair to expect seniors and their families to work through this web to make an informed decision.

The complexity of this drug plan is only one of numerous flaws with this bill. S. 1 does not provide a national fixed premium. The bill sets out an estimate of a $35 monthly premium, but there is no guarantee for seniors that they will not have to pay much more than that estimate.

The bill has the serious potential to cause a number of retirees to lose existing employer-sponsored prescription drug coverage. CBO estimates that as many as 37 percent of Medicare beneficiaries would lose existing coverage. This is an unacceptable consequence of legislation that is supposed to make life easier for seniors. This serious deficiency is the number one concern of constituents who have called into my office about this bill.

The bill before us leaves a large gap in coverage and forces seniors to continue premium coverage during that gap period. Seniors may have to face months without any assistance, waiting to reach the limit where catastrophic coverage begins. The seniors who fall into this coverage gap are among the most ill, with severe chronic conditions and prescription needs. It is difficult to support legislation that would cease coverage for prescription drugs for seniors at the very time when it is needed most.

Finally, because this proposal relies on private plans to deliver the drug benefit, seniors could be forced to shift from plan-to-plan, year-to-year as they did when Medicare+Choice HMOs pulled out of the Medicare program a few years ago. In my own State of Maryland, insurance companies left the Medicare program, abandoning more than 100,000 seniors.

This legislation makes our Nation's seniors the subject of an experiment to which none of us should be willing to subject our parents and grandparents. We don't know what the benefit is under this bill. We don't know how much it will cost. We don't know how private plans will participate and make a profit. We don't know how many seniors would lose existing coverage. What we know is we are prepared to spend approximately $400 billion over 10 years to create an inadequate drug benefit, a new bureaucracy, and subsidies for private insurance companies.

With modest additional resources, we could have closed the coverage gaps in this bill. Amendments offered by my colleagues to provide stability for seniors, move up the start date of the drug benefit, eliminate beneficiary premiums during the coverage gap period, and improve a variety of shortcomings have been defeated. We have lost so many opportunities to make this bill something all Medicare beneficiaries can support. I am hopeful that in the future we can improve upon this and create a system that is easier for seniors to understand, more affordable, and more reliable than what is offered today.

I want to highlight one amendment that would have provided Medicare beneficiaries with a substantial, reliable and straightforward prescription drug benefit. I cosponsored and voted for this amendment offered by my colleague from Illinois, Senator DURBIN. His alternative would have provided a Medicare-delivered drug benefit that allows the Secretary of HHS to employ negotiating strategies used by the VA and other government entities to bring down drug prices. Under Senator DURBIN's plan, seniors would have no deductible, pay only 30 percent of costs until reaching the catastrophic limit, and face no coverage gap. In addition, employer contributions would count toward out-of-pocket limits so there would be much less risk of employers dropping retiree coverage. This was the proposal we should be working from today, but unfortunately the Durbin alternative was defeated by a vote of 56 to 39.

Those opposed to providing a richer benefit argue we don't have the money. The selective amnesia of these so-called fiscal conservatives is baffling. Not too long ago, this body passed a tax cut that primarily benefited the wealthiest Americans. Where was their sense of fiscal responsibility then? As my colleagues Senators DURBIN and HARKIN noted yesterday, this is about priorities. I'm sure others have raised this very good point as well. We can risk greater budget deficits to give huge tax cuts to Americans who are already prospering, but we cannot provide the necessary resources for millions of Medicare beneficiaries to get an affordable, reliable drug benefit that they can understand?

I have long been a strong supporter of providing older Americans and disabled individuals who rely on Medicare an affordable, comprehensive, reliable and voluntary prescription drug benefit. However, I want to ensure we do so in a way that does not worsen the situation in which many seniors find themselves as they face rapidly rising drug costs. As we consider proposals to expand our Nation's major health entitlement programs, it is appropriate to follow a guiding principle in the practice of medicine—do no harm. Our seniors deserve a drug benefit that is a real improvement, not a complex experiment that may cause more trouble than it's worth. We must not enact a law intended to help that might eventually harm millions. The American people deserve better.

Mrs. BOXER. Mr. President, for over 35 years, Medicare has been a savior for our senior citizens. It has helped pay their doctor bills, their hospital bills, and their home health bills.

But it has not paid for their prescription drug bills, and millions of seniors across the country have been waiting a long time for the day when prescription drug coverage is offered through Medicare. That day is getting closer.

I am supporting—and the Senate will soon pass—a Medicare prescription drug benefit.

Let me tell you why this is important. In California, four million people are enrolled in Medicare. Every day, far too many of them are forced into the difficult choice of paying for their prescriptions or putting food on the table.

I want to tell you a few of their stories.

I recently heard from a California woman who told me she struggles to survive on $950 a month income. She cannot, she says, afford all of her prescription drugs. She is, unfortunately, all too typical.

A constituent from San Marcos, CA told me that her annual costs for prescription drugs this year will top $10,000.

Another constituent from Indio, CA told me that she has made five trips to Mexico over the last several years to purchase her prescriptions. She drives all day long to Mexico in order to purchase affordable heart medication. She wanted me to remind my colleagues that "thousands of seniors are forced to do this."

A retired physician from Marina Del Rey told me that a pill he takes for his heart disease has gone up 600 percent from $15 per month to $85.

These seniors—all of our seniors—need and deserve to have Medicare help pay for their prescription drugs. We need to end this situation where seniors are cutting their pills in half or forgoing their medications altogether or skipping meals in order to pay for their prescription drugs. That is unacceptable.

Today, we are making a prescription drug benefit a part of Medicare. And that is why I am supporting this bill—because, at long last, it puts a Medicare prescription drug benefit on the books.

But, this bill is wanting. It has problems. And I have voted for amendment after amendment to fix those problems.

I offered an amendment to close the benefit shutdown. Under this bill, even when seniors have paid and continue to pay premiums, Medicare stops covering prescription drugs, forcing seniors to pay the entire cost. When that failed, I offered an amendment to ensure that seniors with cancer would never have their benefit stopped.

I supported an amendment by Senator STABENOW to ensure that all seniors could get prescription drug coverage from Medicare itself—the tried and proven system—rather than from a private insurance company.

I supported an amendment by Senator GRAHAM to stop charging seniors premiums when they are not getting any benefits.

I supported an amendment by Senator LAUTENBERG to start this benefit next year not 2 and a half years from now.

I supported an amendment by Senator DODD to encourage employers not to drop their retiree health coverage so seniors who have good coverage can keep it. And the Levin amendment, which I also supported, would have ensured that if employers did drop such coverage, Medicare would be there to provide prescription drugs.

I supported an amendment by Senator DORGAN to reduce the premiums that beneficiaries must pay each month. And I supported an amendment by Senator DASCHLE to limit the disparities in premiums so that seniors in different parts of the country are not paying different premiums for the same benefit.

These amendments would have made the Medicare drug benefit a better drug benefit for seniors. Unfortunately, none of them passed.

But we should not—and I will not—stop trying to make it the best benefit it can be.

The good news is that Medicare will soon, for the first time ever, cover prescription drugs. The better news will be when we fix the problems with this bill and improve the coverage for our seniors. I look forward to the day when enough of my colleagues will join me in that effort.

Finally, let me say that I hope the conference report on this bill—the final version of the bill before it goes to the President—does not come back to the Senate in a way that would provide even less help to seniors or in a way that would undermine the entire Medicare program.

Ms. MIKULSKI. Mr. President, senior citizens are facing a crisis—a crisis in affording health care and a crisis in affording prescription drugs.

I have been in communities all over Maryland. Listening to seniors who are desperate. Listening to their families in the diners—who want to help their parents, yet face stresses of their own. Listening to the employers in the boardrooms—who want to help their retirees, but can no longer afford to.

Here is what they tell me. They say: We need a prescription drug benefit in Medicare. We need a safety net for seniors and families. Congress must enact a Medicare prescription drug benefit, and must do it now.

I absolutely agree. It is time Congress made Medicare prescription drug coverage a national priority.

For so many years, Congress has talked about prescription drugs and Medicare. Talk, talk, talk. You can't talk yourself out of high cholesterol; you need Lipitor. You can't talk your way out of diabetes; you need insulin.

The problem with the Senate is—when all gets said and done—more gets said than gets done. Finally—the Congress is acting.

Here are my principles. These principles are the yardstick by which I measure any proposal.

The benefit must be for seniors, not for insurance companies. That means the cornerstone must be Medicare. This bill does that. It does not force seniors to give up the Medicare they love to get the drugs they need.

It must help the majority of Marylanders. I work for Marylanders. So I did the numbers—570,000 Marylanders are on Medicare. According to Johns Hopkins, 68 percent of these seniors would benefit from this legislation. That means 394,000 would benefit from this bill.

It must be voluntary. And the answer is, yes, this bill is voluntary. No one should be coerced or forced into a private program or forced to give up coverage they currently have.

It must be affordable. I am not so sure. I am concerned about the significant deductible—$275 a year and the hefty premiums—almost $400 a year. It also has a coverage gap. Once you spend $4,500 a year—you get no help until you spend $5,800. This will cost too much. That is why I supported the Durbin amendment, which would have provided a better benefit at less cost to seniors.

It must be accessible. It must be available to all seniors, regardless of where they live. This bill does that.

It must be meaningful. It must cover the kind of drugs your doctor says you need, not what an insurance executive thinks you should get. This bill does that by creating a medical necessity override. This means your doctor has the final say on which drugs you get, not an insurance company. I feel pretty good about that.

I tried to improve the bill. I voted for amendments to improve the bill. For example: For the Durbin substitute which would have created a stronger, more comprehensive benefit at a lower cost to seniors.

For an amendment to get rid of the coverage gap. This would guarantee that seniors would have continuous coverage for their prescription drug costs.

For an amendment to provide seniors with a guaranteed prescription plan that is under Medicare. This would allow seniors to stay in a prescription drug plan that is operated by Medicare and not have to move in and out of private plans and a Medicare fallback plan that is only available when the private plans leave the market.

For amendments to protect the benefits of retirees who already have drug coverage. These amendments would help employers to continue to be able to offer quality health care to their retirees.

For an amendment to implement the drug benefit next year—instead of waiting until 2006 to start these benefits.

I am sorry all these amendments failed on party line votes.

This legislation is a beginning. It is something we can build on. What it comes down to for me is—will it help the majority of seniors in Maryland? The answer is, yes; it will help over 394,000 people. For people who spend at least $1,110 a year on prescription drugs—it will help. For someone who is facing a catastrophic disease like cancer and has very high drug costs—it will help. So I will vote for this bill. It is not the bill I want. Yet we can't let the perfect be the enemy of the good. We can't do nothing—as seniors struggle to pay for the drugs they need.

But let me be very clear, this is as far as I will go. If this bill comes back from conference and it is a benefit for insurance companies—say goodbye to my vote. If it increases costs for seniors, say goodbye to my vote. If it cuts benefits, say goodbye to my vote.

So I will vote for this legislation tonight because I don't want to say goodbye to this opportunity to provide a Medicare prescription drug benefit for seniors.

Mr. HOLLINGS. Mr. President, I rise today in opposition to the Prescription Drug and Medicare Improvement Act of 2003.

The Senate has spent the last 2 weeks debating how to help our Nation's senior citizens afford their prescription drugs. The Kaiser Family Foundation estimates that average annual out-of-pocket drug spending for Medicare beneficiaries grew from $644 3 years ago to $999 this year and will reach $1,454 by the time this bill takes effect in 2006. As a result, 25 percent of seniors without drug coverage declined to fill a prescription and 27 percent of seniors without drug coverage skipped doses to make their prescriptions last longer. This is unacceptable. These citizens deserve affordable, comprehensive, and reliable drug coverage. Unfortunately, the legislation now before us fails to provide sufficient coverage.

From the outset this proposal will confuse seniors. Enrollees in private plans better not get too comfortable because their plans could be gone in 2 years if the HMOs find them unprofitable just like they have with Medicare+Choice in my state of South Carolina. The same goes for enrollees in fallback plans. They will be kicked out of their plan in as early as a year if enough private plans enter their area. This volatile system could force seniors to move in between three separate plans, with three separate formularies, in 3 years. This bill should create a sense of stability in the system and reduce the confusion over coverage. That is why I supported first the Stabenow amendment and then the Lincoln-Conrad amendment, which would have extended the availability of fallback plans to ensure that seniors will have access to stable drug coverage.

Senior citizens will need to hire an accountant just to comprehend the benefits available to them under this legislation. Once seniors select their Medicare drug plan, they will have to maneuver a maze of premiums, deductibles and copayments for benefits that contain huge gaps in coverage. On top of their premiums, which will vary from region to region and plan to plan, seniors will get no help for the first $275 of their drug costs, pay half of costs from $276 to $4,500, pay all the costs from $4,501 to at least $5,813, and then pay a tenth of costs above $5,288. With a breakeven point of $1,115, many healthier Medicare beneficiaries will opt not to participate. With a coverage gap of $1,302, many of the sickest patients will still have to continue paying premiums even though they may have to resort to rationing their care until they can spend their way out of the "doughnut."

Once again, the Senate defeated a number of amendments that I supported that would have brought much needed simplicity and fairness to the bill including the Boxer amendment, which would have closed the coverage gap for all seniors, and the Daschle amendment, which would have limited the regional variation among premiums to 110 percent of the national average. Finally, we chose to provide $13 billion in new subsidies to PPOs and HMOs instead of using that money to reduce premiums or fill in the coverage gap for cancer or Alzheimer's patients. All in all, the bill provides Medicare beneficiaries with a benefit valued at about $1,000 less than the drug coverage available to Federal employees.

This is a plan only Washington could dream up. It should come as no surprise that the authors of this convoluted mess and their friends in the White House have decided to wait until after the 2004 election before allowing Medicare beneficiaries to see what they are in for.

I should also note that this Nation is more than $6.6 trillion in debt. This bill is part of budget resolution and economic plan that will run up an average deficit of $600 billion a year for the next 10 years. Make no mistake about it, we will borrow every red cent to pay for this program. And what do we get in return? Massive subsidies for HMOs, spotty drug coverage for senior citizens, and a lack of attention to the factors driving the rapid increase of health care costs in this country. If we are going to borrow from future generations to pay for this benefit, we should get it right.

Now that we have disposed of all amendments and final passage appears imminent, I have concluded taxpayers and Medicare beneficiaries would be better served if we go back to the drawing board. We should come back with a proposal with affordable premiums and cost sharing requirements with no gaps in coverage that is administered in a manner that gives seniors the same sense of security they receive under the current Medicare program. I have heard many of my colleagues say this is an important first step and it is important that we get something on the books. Nonsense. Thirty months will pass before the first beneficiary receives coverage. That was enough time to draft and ratify the Constitution. It was enough time to complete the Manhattan Project. Thirty months should be more than enough time for us to create a real, meaningful prescription drug benefit for our senior citizens.

I hope this body will have the wisdom to vote no and do this right.

Mr. FEINGOLD. Mr. President, I will vote for passage of the Medicare prescription drug bill that has been debated over the past several weeks.

I do so, however, with great reservations about many of the provisions in the bill.

I am voting for this measure for two principal reasons.

First, I believe that we owe our seniors a Medicare prescription drug benefit. I believe such a benefit is long overdue for our Nation's seniors. For years we have promised them we would give them the crucial help they need with their skyrocketing prescription drug costs. And I believe that it is finally time to deliver on that promise.

It has taken Congress too many years to act on this pressing need. We have been debating for years about the best way to provide this benefit, and I am afraid that if we do not take the opportunity in front of us today, it will take us even longer to provide seniors the help they deserve. Our seniors cannot wait any longer.

The costs of prescription drugs are soaring, and the financial toll they take on our seniors means that too often seniors must choose between eating and taking the medication that will help them live productive, healthy lives. Our seniors should not have to make that choice. They contributed to the Medicare system over their lifetimes. That system, which is supposed to provide health care to all seniors, needs to be able to help them obtain the prescription drugs they need to preserve their health.

The second reason I am voting for this benefit is that it takes a big step in addressing what I see as one of the biggest flaws of the current Medicare system—the geographic inequities within the Medicare reimbursement system. We need to end Medicare's continued discrimination against Wisconsin's seniors. As I have previously discussed on this floor, Wisconsin seniors already receive the short end of the stick when it comes to Medicare. Wisconsinites pay the same payroll taxes to Medicare as all American workers do, but receive fewer benefits in return. Instead, Wisconsinites' Medicare dollars are used to subsidize higher reimbursements in other parts of the country.

Wisconsin Medicare beneficiaries receive on average $4,318 in Medicare benefits per year, the eighth lowest in the country. By contrast, beneficiaries in the State with the greatest per capita reimbursement receive $7,209. This distribution of Medicare dollars among the 50 States is grossly unfair to Wisconsin. I thank the leadership of the Finance Committee for including provisions to begin to address this inequity in this prescription drug bill. But I know that we still have more to do to reverse the Medicare discrimination against States like Wisconsin.

I am pleased that key provisions have been accepted that greatly improve this bill. The Senate adopted the Gregg-Schumer-McCain-Kennedy amendment, which I was proud to cosponsor and support, which will bring more competition to the prescription drug market by preventing pharmaceutical companies from blocking generic drugs from entering the market. This amendment is one of the only provisions that will help to bring cost savings to seniors.

By adopting Senator DORGAN's amendment relating to the reimportation of prescription drugs from Canada, the Senate will help seniors obtain affordable prescription drugs. This legislation helps both consumers who buy prescription drugs and businesses which sell them. I supported this provision, both in its earlier legislative form and in this amendment, because it is the right thing to do. Our seniors and other Americans in need of affordable prescription drugs deserve no less.

I also supported Senator ENZI's amendment, which passed overwhelmingly, that will make sure that community pharmacies, like the ones in my home State of Wisconsin, can still operate within this new prescription drug program. Smaller pharmacies will be protected from being shut out by larger pharmacies through this amendment, and that means helping seniors to access the prescription drugs they need in their own communities.

I also worked with Senator ALLARD on an amendment to provide regulatory relief for home health care providers that the Senate adopted. Our amendment enables home health care providers to spend more time with patients and less time on paperwork. This is particularly important at a time when some home health care providers are leaving the home health industry because of burdensome paperwork requirements.

And I am pleased that an amendment I offered to bring some clarity to the Medicare Program for our seniors was adopted. The Medicare Program is already full of bureaucratic red tape, often creating barriers for seniors looking for basic information about their health care options. This prescription drug benefit is the biggest expansion of the Medicare Program since its inception in 1965. We are adding an entire new part to the program, and we need to help guide our seniors through it.

My amendment is simple. It establishes a Medicare Beneficiary Advocate Office within the Department of Health and Human Services, with the sole function of providing clear information to all Medicare beneficiaries. The office will serve as a one-stop information source on all of Medicare for our seniors.

This new office will provide a toll-free phone number, a regularly updated Web site and regional publications that will give our seniors all of the information they need to make informed health care decisions.

That is the good news. But as I said earlier, I have many reservations about this bill. This is not the bill I would have proposed.

This bill does not go far enough to deliver on our promise to give seniors a meaningful prescription drug benefit. It fails to provide any assistance after a senior's prescription drug costs total $3,450, until they spend another $1,850 on prescription drugs, or $5,300 total. And it adds insult to injury by making beneficiaries continue to pay a premium even during the time they receive no benefit.

I am also troubled that this bill does not provide clear, uniform benefits and premiums for all seniors. Many aspects of the benefits provided in the bill remain uncertain, and will continue to remain uncertain after the plan goes into effect. Under this bill, the premiums are not defined. The premiums for the Medicare prescription drug plan will be dictated by the private insurers who will offer the plans. The only thing we know for sure is that the Congressional Budget Office estimates that the national average for premiums will be $35. However, those premiums may vary dramatically. Just look at Medicare HMO premiums. Medicare HMO premiums in Connecticut are $99, but in Florida they are only $16.

Who will offer the plans is also uncertain. There is no guarantee that plans will be offered in regions where there may not be enough profit. History again shows us that private companies do not always find rural and smaller urban areas profitable enough to move in. All too often, private companies that do move into less desirable Medicare markets end up deciding to leave the region, leaving Medicare beneficiaries scrambling to figure out where they will turn for coverage.

Furthermore, my understanding is that this plan only offers a guaranteed Medicare-administered plan, or "fallback plan," if there are less than two private plans in a region. This means that, if only one private plan offers a prescription drug benefit in the region that includes Almena, WI, a Medicare beneficiary living in Almena may instead choose the Medicare-administered fallback plan. While on the fallback plan, my Almena constituent would become familiar with the medications that are included in their formulary and the cost of their premiums. If a second private plan subsequently decides to move into that region, my understanding is that my constituent will be dropped from the Medicare fallback plan, and forced to join one of the private plans even if those plans have higher premiums, or do not include their prescriptions in their formularies.

Further, my Almena constituent can be forced to leave the plan that he or she has come to know, if that plan leaves the region. This leads to instability and uncertainty for seniors.

Benefits are also uncertain under this proposal. Again, benefit packages will be determined by the private insurers who offer the plans. And we can assume, from experience with the Medicare+Choice Program, that the benefits will vary widely. I am concerned about what this may mean for States like my home State of Wisconsin, States that have had a difficult time attracting and keeping private Medicare plans. Some Medicare prescription drug plans may be able to offer more brand name drugs at a lower cost to beneficiaries, while others in less profitable areas may limit the amount of brand name drugs they can offer at affordable rates.

I fear that as with Medicare HMOs, Wisconsin seniors may be faced with little choice with Medicare prescription drug plans.

And I am concerned that the uncertainty in this bill regarding monthly premiums, the possible differences in benefits packages and the stability of private plans that will deliver these benefits may lead to more inequity for Wisconsin seniors.

I was disappointed that Senator DURBIN's amendment, the MediSAVE Act, was not adopted in the Senate. Senator DURBIN's amendment, which I strongly supported, would have fixed most of the errors that exist in this bill. The MediSAVE Act would have made this benefit one that would truly help all seniors with all of their prescription drug benefit. Senator DURBIN's proposal offered a meaningful, enhanced prescription drug benefit that would have covered all seniors regardless of whether their prescription drug costs are high, low, or somewhere in between.

The MediSAVE Act not only put forth cost controls so that taxpayers as well as seniors could save money, but it also would have given seniors certainty. Seniors would have known exactly what their premiums and benefits were and would have the certainty of knowing that a Medicare-administered prescription drug benefit would be available to them, no matter what private plans were offered to them. Most importantly, the MediSAVE Act provided the certainty that a senior would have assistance with their prescription drug costs year-round and would never be caught in the so-called "donut hole" of coverage that this bill provides.

I am voting for this bill because something, some help for our seniors with their pressing prescription drug costs, is better than nothing. I will support this legislation with the intention of working with my colleagues over the next 2 years to improve this bill and finally deliver on our promise to give seniors a meaningful prescription drug benefit under Medicare.

Mr. JEFFORDS. Mr. President, this bill is a landmark piece of legislation the most significant modernization of the Medicare Program since its inception in 1965. Its passage by the Senate is a major accomplishment on the path toward enacting a prescription drug benefit for our Nation's seniors. It is the result of years of bipartisan, I might even say tripartisan, effort and it puts in place many long-sought changes. It has many significant features for the citizens of my home State of Vermont. It provides a sustainable, universal, and comprehensive prescription drug benefit. It guarantees access to traditional Medicare for all beneficiaries. It allows Medicare beneficiaries to participate, if they choose, in new systems of care that better reflect today's dynamic health care environment. The bill recognizes the high cost of providing quality care in rural settings and closes the reimbursement gap between rural providers and their urban counterparts. Finally, it contains a provision that will allow us to better understand how to provide quality health care—not care driven by using more and more resources, but instead one based on ensuring quality patient outcomes.

Over the past 2 weeks, I have applauded the work of my colleagues who have labored over this bill. Today, I have the pleasure of congratulating them on their success and thanking them for their efforts.

I have worked for more than 3 years with my good friends, Chairman GRASSLEY and Senators SNOWE, BREAUX, and HATCH. In many meetings over many months, we delved into the details of what came to be called the Tripartisan Bill. This has been one of the finest experiences of my many years in Congress. I am very proud to have been a part of that group and that our efforts led the way to our success today.

I especially want to salute the efforts of Senator BAUCUS and Senator KENNEDY without whose hard work and commitment to working through an agreement we would not have accomplished this remarkable victory, and they deserve our accolades.

A bill such as this is the result of great effort on the part of many different people who are not elected to this body, but upon whom we all rely. I would like to recognize the staff members who have worked so hard on this bill and deserve much of the credit for its successful passage.

On Senator GRASSLEY's staff: Ted Tottman, Linda Fishman, Colin Roskey, Mark Hayes, Jennifer Bell, and Leah Kegler, and on Senator BAUCUS' staff Jeff Forbes, Liz Fowler, Jon Blum, Pat Bousliman, Kate Kirschgraber, and Andrea Cohen deserve considerable recognition for their tireless efforts. Catherine Finley, Tom Geier, and Carolyn Holmes from my friend Senator SNOWE's staff; Patricia DeLoatche and Trecia Knight of Senator HATCH's office; and most especially Senator BREAUX's legislative director Sarah Walters deserve enormous credit for this bill. Finally, we would not be claiming a victory today if it were not for the contributions of Senator KENNEDY's staff, especially, David Nexon and Michael Meyers.

On my own staff, I particularly want to recognize the contributions of Paul Harrington during the last Congress, and most especially the work of Sean Donohue who took up that effort on the tripartisan bill and who has continued to see it through to today's success, with the recent assistance of Daniel Crimmins, our Robert Wood Johnson Health Policy Fellow. Each and all have worked tirelessly to gather the input, analyze the issues, and build a consensus toward achieving this final product.

Mr. LEVIN. Mr. President, I support making a prescription drug benefit available to seniors. Most Members of the Senate do. However, there are honest disagreements about how to get it done and whether the bill before us will strengthen or weaken Medicare.

My principles are simple. The benefit should be voluntary, guaranteed, universal, and affordable.

Perhaps my greatest concern with the bill before us is the effect its passage is likely to have on retirees who currently have prescription drug coverage provided by their former employers. Many retirees currently enjoy good prescription drug coverage from their former employer. However, the Congressional Budget Office has indicated that if we adopt the legislation before us approximately 37 percent of retirees who are currently receiving prescription drug coverage from their former employers will lose that coverage. Specifically, on June 12, the Director of the Congressional Budget Office, CBO, Mr. Douglas Holtz-Eakin, who previously served for 18 months as chief economist for President Bush's Council of Economic Advisers, testified at a Finance Committee markup that 37 percent of retirees would be dropped from their former employers coverage. At that same markup, the Administrator of HHS' Center of Medicare and Medicaid Services, CMS, Mr. Tom Scully, stated that for current retirees "who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped." During the debate so far, amendments to strengthen incentives for employers to maintain their prescription drug coverage for their retirees have failed.

Also very troubling is what I call the yo-yo effect. To participate in the proposed plan, a senior in any service area where two or more private plans are offered, no matter what the premium, would only have the option of purchasing private insurance. The reason is that only if there are not two private plans offered in the region is the so-called Medicare fallback plan available. So let's assume that there are two plans offered in 2006 in a particular service area and a senior opts in. Assume further that in 2008, one of the two insurance companies pulls out of the service area and the so-called Medicare fallback plan is then available. So the senior opts for the Medicare fallback plan. However, if two private plans become available a later time, say 2009, the Medicare fallback plan is no longer available to the senior and she would then be required to again enroll in one of the private plans to retain coverage. This yo-yo effect could be repeated forcing seniors to deal again and again with different programs with different costs and different benefits and lots of paperwork. This is totally unacceptable. Seniors want stability and continuity in their Medicare Program. They want a program on which they can trust and rely.

In addition, the legislation we are considering has a large gap in the prescription drug coverage. Once a senior's total drug spending reaches $4,500 for the year, she will have to pay 100 percent of the cost of their prescriptions until her total drug spending reaches $5,800. This has come to be called the donut hole. This coverage gap will leave many seniors to pay the full cost of prescriptions at a time when they most need assistance. I know of no other insurance program that is so unfairly structured in that way. There is a gaping hole in coverage but no gap in the requirement to pay premiums. That obligation continues even during the period that benefits are halted.

The bill before the Senate also has an unspecified premium that could fluctuate from service area to service area as well as from year to year. Premium amounts are left up to the insurance companies. I believe there should be a cap on those premiums. The effort to adopt one failed.

Adding a prescription drug benefit to Medicare is one of the most important things Congress can do this or any other year. We spend more on prescription drugs than we do on hospital costs. Members of Congress have been promising for years that we would pass a Medicare prescription drug benefit for seniors. The only way to assure that the benefit will be available reliably and without complications to our seniors is to make it a guaranteed part of Medicare. The bill before us falls short of that. We should at least do no harm. When CBO estimated 37 percent of seniors currently receiving a prescription drug benefit from their former employer are going to lose the benefit because of this legislation, that is real harm.

I hope the major flaws of this bill are somehow corrected in conference so I can vote for a conference report. But I cannot vote for the version before us.

Ms. COLLINS. Mr. President, I was pleased to join my colleagues, Senators BOXER, COLEMAN, LANDRIEU, KOHL and MURRAY in offering an amendment to authorize a Medicare demonstration project on pancreatic islet cell transplantation to help advance this tremendously important research that holds the promise of a cure for more than 1 million Americans with Type 1 or juvenile diabetes.

As the founder and cochair of the Senate Diabetes Caucus, I have learned a great deal about this serious disease and the difficulties and heartbreak that it causes for so many Americans and their families as they await a cure. Earlier this week, I had the privilege of chairing a hearing featuring young delegates from the Juvenile Diabetes Research Foundation's Children's Congress who had traveled to Washington from every State in the country to tell Congress what it is like to have diabetes, just how serious it is, and how important it is that we find a cure.

Diabetes is a devastating, lifelong condition that affects people of every age, race, and nationality. It is the leading cause of kidney failure, blindness in adults, and amputations not related to injury. Moreover, a study released by the American Diabetes Association earlier this year estimates that diabetes cost the Nation $132 billion last year and that health spending for people with diabetes is almost double what it would be if they did not have diabetes.

The burden of diabetes is particularly heavy for people with juvenile diabetes. Juvenile diabetes is the second most common chronic disease affecting children. Moreover, it is one that they never outgrow.

In individuals with juvenile diabetes, the body's immune system attacks the pancreas and destroys the islet cells that produce insulin. While the discovery of insulin was a landmark breakthrough in the treatment of people with diabetes, it is not a cure, and people with juvenile diabetes face the constant threat of developing life-threatening complications as well as a drastic reduction in their quality of life.

Thankfully, there is good news for people with diabetes. We have seen some tremendous breakthroughs in diabetes research in recent years, and I am convinced that diabetes is a disease that can be cured and will be cured.

I am encouraged by the development of the Edmonton Protocol, an experimental treatment developed at the University of Alberta involving the transplantation of insulin-producing pancreatic islet cells, which has been hailed as the most important advance in diabetes research since the discovery of insulin in 1921. Of the 257 patients who have been treated using variations of the Edmonton Protocol, all have seen a reversal of their life-disabling hypoglycemia, and 80 percent have maintained normal glucose levels without insulin shots for more than 1 year. Amazingly, many of the transplant recipients have even reported a reversal of some of their complications, such as improved vision and less pain from neuropathy.

Earlier this year, I joined with my colleague from Washington, Senator PATTY MURRAY, as well as my colleague and cochair of the Senate Diabetes Caucus, Senator JOHN BREAUX, in introducing the Pancreatic Islet Cell Transplantation Act of 2003, which will help to advance this significant research that holds the promise of a cure for the more than 1 million Americans with juvenile diabetes. The amendment we are introducing today is based on one of the provisions of that bill, which currently has 43 Senate cosponsors.

Diabetes is the most common cause of kidney failure, accounting for 40 percent of new cases, and a significant percentage of individuals with Type 1 diabetes will experience kidney failure and become Medicare-eligible before they are 65. Medicare currently covers both kidney transplants and simultaneous pancreas-kidney transplants for these individuals. To help Medicare decide whether it should cover pancreatic islet cell transplants, the amendment authorizes a 5-year demonstration project to test the efficacy of pancreatic islet cell transplantation for individuals with Type 1 diabetes who are eligible for Medicare because they have end-stage renal disease, ESRD.

The cost of this demonstration would not be high. The Health Strategies Consultancy LLC, a highly regarded independent health policy firm, estimates that the net Federal cost of the proposal would be about $6.2 million in 2004 and about $84 million over 10 years.

The cost of the demonstration project is low because the number of islet cell transplants that could be performed is limited. Islet cells are extracted from a donated pancreas, and the number of pancreas donors is extremely small when compared to the number of Medicare beneficiaries who could benefit from islet cell transplants. In 2002, there were 1,875 pancreas donations, but there were over 27,000 Medicare beneficiaries who have diabetes as the primary cause of their end-stage renal disease and who might potentially benefit from islet cell transplants.

The Health Strategies' cost estimate does not include the financial benefits that would accrue to Medicare for the reduced medical care costs that would occur for beneficiaries who receive islet cell transplants and, as a result, suffer fewer diabetes-related complications such as kidney failure, heart disease, blindness and amputation. Since diabetes currently accounts for one out of every four Medicare dollars, I believe that this amendment actually holds much promise for reducing Medicare spending in the future.

I understand this demonstration project has been included in the Medicare prescription drug legislation that is being considered by the House. I hope that the Senate demonstrates similar wisdom, and I urge all of my colleagues to support it.

Mr. KOHL. Mr. President, I rise to oppose S. 1, the Prescription Drug and Medicare Improvement Act. This bill is good for drug companies, insurance companies, and people who make TV ads for politicians—but it is not good for Wisconsin seniors.

I know that many of my colleagues will vote for this legislation and that it will pass the Senate. I know that many of my colleagues believe that this is a first step, if an imperfect one. I would like to agree with them. I would like to vote for a bipartisan compromise that delivers even a part of the drug benefit our seniors rightly demand. But this is not that bill. This is, instead, an empty promise of straightforward help for seniors struggling with crippling drug costs. When they figure out the details—when they see the costs—when they understand the limited benefit provided—when they work through the complicated formulas determining whether they ought to sign up—when they see the drug industry continue to raise their prices and reap record profits—they will—rightly, rightly—revolt.

I warn my colleagues, this is no bird in the hand—it is a vulture. And I cannot support it.

I cannot support a so-called benefit that asks many seniors, for months at a time, to pay premiums but receive absolutely no help with their drug costs. I cannot support a "benefit" that could cause up to 37 percent of retirees to lose their retiree health plans, leaving their former employees worse off than before we passed this bill. And I cannot support a "benefit" which is denied to low-income seniors eligible for both Medicaid and Medicare. A "benefit" of no benefit for seniors above average drug costs, for seniors with decent retiree plans, for seniors who are poor.

I also cannot support a plan that neither I nor anyone in this body can explain because its details depend on the vagaries of a private market that doesn't exist yet. Under this system, seniors could be forced into a different plan, pay a different premium, and have different medicines covered every year. Insurance companies can come in and out, leaving seniors lost and confused in a maze of paperwork and choices every year. And we know that for those insurance companies that do participate, premiums are sure to increase because there is no limitation on premiums in this law.

I also cannot support a plan that relies so heavily on the private sector to offer something they have never been willing to offer before. Drug-only plans are virtually nonexistent in today's marketplace. And the Medicare+Choice experiment, which also uses private insurance companies, has not worked in Wisconsin and in many other States. I cannot support a plan that has to pay insurance companies huge subsidies in order to offer a drug benefit. Not only is there no guarantee that they will participate; but precious Medicare dollars that could be used to pay directly for medicines are wasted, funneled to a drug industry that, last I checked, was not in need of a Federal handout. Even worse, this plan does not take advantage of the potential for controlling drug costs by utilizing the purchasing power of the millions of Medicare beneficiaries.

I do want to point out that aside from the Medicare drug benefit, there are several provisions that I strongly support in this bill. I am very pleased that the bill includes long-needed reforms that will finally take a strong step toward fixing the distorted Medicare system we have today—a system that penalizes Wisconsin health care providers by paying them less than other States, and a system that penalizes Wisconsin seniors by offering them fewer benefits than seniors in other States enjoy. Not only is this unfair for people in the Medicare system; it also increases costs for Wisconsin businesses, employees, and families, who pay higher costs to make up the Medicare shortfall. The bill before us changes many of Medicare's payment systems, especially for rural areas, and goes a long way toward making Medicare fair for seniors and providers, no matter where they live.

I am also pleased that the bill includes provisions to make generic drugs more available to all Americans. It will close loopholes in our current law that keep generics off the market and keep drug prices too high for too long. The CBO estimates that this provision will save Americans $60 billion over 10 years.

I hope, but don't expect, that these two important provisions will survive the upcoming conference with the House of Representatives. And while I continue to hope that the conference will come back with a better Medicare drug benefit, I regret that it is unlikely to be the case. The House bill is in many ways even worse than the Senate bill before us.

Mr. President, I regret that none of the amendments that I supported during this debate prevailed. These amendments would have greatly improved this bill and provided a real prescription drug benefit to seniors—a benefit we could all have been proud of. Instead, this bill is an empty promise to seniors and the disabled on Medicare. This is not the kind of plan they have been asking for or have a right to expect. We could and should have done better. But at minimum, we could and should be able to hold our work here to the standard set in the Hippocratic Oath: do no harm. And we have failed.

I yield the floor.

Ms. COLLINS. Mr. President, I want to thank the chairman of the Finance Committee for including provisions in S. 1 that will provide a measure of relief to rural health care providers, and in particular to home health agencies serving patients in rural areas. I am concerned, however, that the underlying bill does not go quite far enough and have filed an amendment with Senator BOND to increase the rural add-on payment for home health agencies to 10 percent. This was the amount of the payment prior to its expiration on April 1, and I believe it is the amount that is necessary to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

Home health has become an increasingly important part of our health care system. The kinds of highly skilled—and often technically complex—services that our Nation's home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors. Because of the longer travel times, rural caregivers are unable to make as many visits in a day as their urban counterparts. Saundra Scott-Adams, the executive director of the Visiting Nurses of Aroostook in Aroostook County, ME, where I am from, tells me her agency covers 6,600 square miles with a population of only 72,000. Her costs are understandably much higher than the average agency due to the long distances her staff must drive to see clients. And, her staff is not able to see as many patients.

Agencies in rural areas are also frequently smaller than their urban counterparts, which means that their relative costs are higher due to smaller scale operations. Smaller agencies with fewer patients and fewer visits mean that fixed costs, particularly those associated with meeting regulatory requirements, are spread over a smaller number of patients and visits, increasing overall per-patient and per-visit costs.

Moreover, in many rural areas, home health agencies are the primary caregivers for homebound beneficiaries with limited access to transportation. These rural patients often require more time and care than their urban counterparts, and are understandably more expensive for agencies to serve. If the rural add-on payment is not reinstated, agencies may be forced to make decisions not to accept rural patients with greater care needs, and access will suffer further.

The loss of the rural add-on has already caused many agencies to reduce their service areas. Some are eliminating services altogether in remote areas. There are some counties in Montana, for example, that have no home health services. And agencies in my home State of Maine have had to eliminate delivery of services to some of our outlying islands.

If the 10 percent rural add-on payment is not restored, it will only put more pressure on rural home health agencies that are already operating on very narrow margins and could force more of these agencies to close. Many home health agencies operating in rural areas are the only home health providers in a vast geographic area. If any of these agencies are forced to close, the Medicare patients in that region will lose complete access to home care.

There is strong support in the Senate for restoring the rural add-on. Earlier this month, 55 Senators joined me in sending a letter to the chair and ranking member of the senate Finance Committee urging that they extend the 10 percent rural add-on for home health agencies, and I ask unanimous consent that this letter be printed in the RECORD.

The chairman of the Finance Committee and his staff have been working with us to try to accommodate my amendment, and I am very appreciative of their efforts. I am hopeful that we will be able to work this out so that we will be able to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, June 5, 2003.
Hon. CHARLES E. GRASSLEY, *Chairman,*
Hon. MAX BAUCUS, *Ranking Member,*
Senate Committee on Finance, Dirksen Senate Office Building, Washington, DC.

DEAR SENATORS GRASSLEY AND BAUCUS: Home health has become an increasingly important part of our health care system. The kinds of highly skilled and often technically complex services that our nation's home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

By the late 1990s, home health was the fastest growing component of Medicare spending. The rapid growth in home health spending understandably prompted the Congress and the Administration—as part of the Balanced Budget Act of 1997—to initiate changes that were intended to slow this growth in spending and make the program more cost-effective and efficient. These measures however, produced cuts in home health spending far beyond what Congress intended. Home health spending dropped to $10 billion in FY 2002, nearly half the 1997 amount, and it is clear that the savings goals set for home health in the Balanced Budget Act have not only been met, but far surpassed.

According to the Congressional Budget Office (CBO), the post-Balanced Budget Act reductions in home health spending totaled more than $72 billion between fiscal years 1998 and 2002. This is over four times the $16 billion that the CBO originally estimated for that time period and is a clear indication that the Medicare home health cutbacks have been far deeper than Congress intended.

As a consequence of these cutbacks, over 3,400 home health agencies nationwide have either closed or stopped serving Medicare beneficiaries. Moreover, the number of Medicare patients receiving home health care nationwide has dropped by 1.3 million—more than one-third. Which points to the central and most critical issue—cuts of this magnitude simply cannot be sustained without ultimately affecting patient care.

On October 1, 2002, home health agencies received an additional across-the-board cut in Medicare home health payments, and the Centers for Medicare & Medicaid Services has dramatically reduced projections for home health spending under the Medicare program over the next ten years. We are concerned that any further cuts in payments for home health services simply cannot be sustained without affecting patient care, particularly for those Medicare beneficiaries with complex care requirements.

As you begin consideration of a Medicare modernization package, we urge that you avoid any further cuts in payments for home health services and preserve the full market basket update for payments for home health services for 2004. In addition, we urge that you extend the 10 percent add-on payment for home health services in rural areas that expired on April 1, 2003. Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors. Extension of this add-on payment will therefore help to ensure that Medicare patients in rural areas continue to have access to the home health services they need.

Thank you for your consideration, and we look forward to working with you to ensure that elderly and disabled Americans continue to have access to quality home health services.

Sincerely,

Susan M. Collins; Christopher S. Bond; Wayne Allard; Gordon Smith; Robert F. Bennett; Richard Lugar; Jack Reed; Russell D. Feingold; Patty Murray; John W. Warner; James Talent; Carl Levin.

Charles Schumer; Chuck Hagel; Barbara Mikulski; Jon Corzine; Tim Johnson; Patrick Leahy; Herb Kohl; Mary Landrieu; Evan Bayh; Dianne Feinstein; Hillary Rodham Clinton; Maria Cantwell; Frank Lautenberg; Ron Wyden; John Kerry; Ben Nelson; Debbie Stabenow; Mark Dayton; Ben Nighthorse Campbell; Mike DeWine.

Arlen Specter; George Voinovich; James Jeffords; Bill Nelson; Saxby Chambliss; Conrad Burns; Christopher Dodd; Joseph Lieberman; Blanche L. Lincoln; Larry Craig; Paul Sarbanes; Lincoln Chafee; Mike Crapo; Richard Durbin; Barbara Boxer.

Tom Harkin; Pat Roberts; Jim Bunning; Ted Kennedy; Sam Brownback; Byron Dorgan; Thad Cochran; and Richard Shelby.

Mr. DODD. Mr. President, I rise today to speak in support of S. 1, the Prescription Drug and Medicare Improvement Act of 2003. However, I do so with great trepidation. While I intend to vote for the bill that is presently before the Senate, I believe that drastic changes are still necessary to make the benefit created by this legislation one that meets the needs of our senior citizens.

I am also deeply concerned that Members on the other side of the aisle—as well as those in the House of Representatives, and the administration—will attempt to move this bill in a destructive direction during conference. Let me reiterate what I said in an earlier statement on this issue: we must not approve any Medicare reform measure that would force seniors to join private plans in order to receive a more generous prescription drug benefit. Such a measure would signal an end to the Medicare Program as we know it and should be rejected out of hand. I urge my colleagues to protect the Medicare that our seniors have come to rely on, and I urge the President not to sign any bill that privatizes Medicare. If such changes are made, I will not hesitate to oppose the conference report.

Given these concerns, it is reasonable to ask why I am supporting this bill. The answer is quite simple—seniors in my home State of Connecticut and across the country have been waiting far too long for a prescription drug benefit under Medicare. And it is time that we in Congress heard them.

Over the past month I had the opportunity to convene a series of forums on senior health care in Connecticut in an attempt to frame the scope of this debate. At these forums I heard from my constituents on many matters regarding their health care. But the present lack of coverage for prescription drugs under the Medicare program was by far the issue raised most often.

At these forums I heard from seniors who literally could not afford to fill prescriptions called for by their doctors. I heard from elderly Medicare beneficiaries forced to choose between purchasing groceries or filling their prescriptions. I heard from seniors who were forced to skip dosages of their medicines in an attempt to stretch their limited supplies of needed medicines. I heard from Medicare beneficiaries requiring more than 10 prescribed medicines a day unable to afford even half of these prescriptions. Clearly, what I heard from hundreds of Connecticut's more than 500,000 Medicare beneficiaries is their grave concern over the present lack of a prescription drug benefit under the Medicare Program.

I believe that the legislation about to be approved by this body offers an answer to those concerns. It is not the most complete answer, but it is a start—based on which we can improve in the future. It is a start because it will make so many seniors better off than they are today. And that should be our ultimate goal as legislators—to make people's lives better. Often this must be done incrementally, in steps. This bill is a positive first step.

What do I mean when I say that it will make people better off? In Connecticut, one-third of all Medicare beneficiaries have incomes below 160 percent of poverty. For many of these seniors, drug costs can be crippling. They are forced to choose between putting food on the table, and buying the medicines that they need to live healthy lives. With the passage of this bill, these seniors will no longer have to make this choice. The new Medicare prescription drug benefit will cover most, if not all, of their drug costs. I congratulate Senator GRASSLEY and Senator BAUCUS, and other members of the Senate Finance Committee for including in this bill such a generous benefit for those low-income seniors.

This legislation is not as clear cut for those seniors who have incomes above 160 percent of poverty. However, I believe that the majority will be helped by passage of this bill. The break even for this benefit—the point where an individual is better off with the benefit rather than just paying for all prescription drugs our of their own pocket—is about $1,100 in total annual drug costs. The average Medicare beneficiary spends approximately $2,300 on prescription medicines today. That number will undoubtedly be higher when this new benefit goes into effect in 2006. With the benefit created by this bill, that average beneficiary will realize nearly $600 in savings. The savings will be even greater for the 11 percent of beneficiaries who spend more than $5,000 per year on prescription drugs.

These are the seniors facing the most sever health problems, and most in need of financial assistance. That is what this bill provides—even if it is not to the extent that many of us would have liked.

I am voting for this bill because so many seniors in Connecticut and throughout the country stand to benefit. However, no bill is perfect and S. 1 clearly still leaves much room for improvement even as it moves toward final Senate passage. I am particularly disheartened that, despite numerous attempts over the past 2 weeks, we have failed to address concerns over the present bill's lack of adequate provisions to ensure that those companies presently providing their retirees with prescription drug coverage receive adequate Federal support for their laudable efforts. While the creation of a prescription drug benefit under the Medicare program is laudable, it should not come at the price of displacing the employer-based benefits that so many seniors have come to rely on.

Additionally, I remain concerned that the gap in coverage in the present bill, the so-called donut hole, will leave many Medicare beneficiaries facing high prescription drug costs with no assistance at the very time when it is most needed. Over the past 2 weeks, I have both offered and supported amendments designed to provide assistance to those with prescription drug costs within the hole, especially those with lower incomes who can least afford any gap in coverage, that have failed to win support by the Senate. Failure to close this gap, in my view, constitutes a glaring failure, one that I hope can be reversed as this bill moves into conference.

I also am concerned that S. 1 fails to adequately protect Medicare beneficiaries form the very understandable confusion and uncertainty that may surround them just as they begin to navigate the intricacies of a brand-new program. Specifically, if enacted the underlying bill will require Medicare beneficiaries choosing a prescription drug plan to stay with that plan for a minimum of 1 year. With the enactment of such broad and weeping changes to the Medicare program, I am fearful that many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular needs. For this reason, I offered an amendment to S. 1 that would have simply granted Medicare beneficiaries navigating this new benefit for the very first time the ability to switch plans as they seek to determine which plan fits their particular health care needs in the first 2 years of the bill's benefit. Unfortunately, this amendment was not agreed to and I remain concerned that without its protections, senior Medicare beneficiaries will be unfairly locked into plans that do not meet their needs.

Mr. President, I am pleased that S. 1 represents a significant departure from previous plans supported by the administration that would have required Medicare beneficiaries to leave the traditional fee-for-service Medicare Program in order to receive coverage for their prescribed medicines. Such a move would be unconscionable as 89 percent of all Medicare beneficiaries today are in the traditional program. To force these beneficiaries to leave their present system of coverage, and most likely the doctor that they have come to know and trust, would not only create great disruption, it would also for the first time since the program's inception create a tiered benefit system under Medicare that would more greatly reward those who choose to join a private preferred provider organization, PPO, or health maintenance organization, HMO.

And while I am pleased that the bill before us soundly rejects a tiered benefit system, I am deeply concerned that the plan presently taking shape in the House of Representatives appears to rely on such a flawed plan. As I said earlier, such a measure should be soundly rejected.

So it is with great caution that we come to the final moments of debate on this important issue. Medicare's nearly 41 million beneficiaries clearly need assistance in affording their needed medicines. The result of our efforts over the past 2 weeks, and more important, the result of the coming conference committee on this legislation will greatly determine to what extent we assist our Nation's Medicare beneficiaries to afford their needed medicines.

Clearly, a great opportunity is presently before us. As the underlying bill moves to conference committee, I look forward to working with my colleagues to ensure that we seize this opportunity by strengthening the underlying bill. With passage of the bill presently before us, we now face a choice. We can insist on the good start that we have made here with passage of S. 1, and work to strengthen its provisions. Or, conversely, we can accede to the House legislation that in my view unfairly jeopardizes the traditional Medicare Program by tilting the system in favor of risky privatization schemes and against seniors.

I ask my colleagues to join with me in working to ensure that any Medicare prescription drug legislation passed by this Congress is at least as strong as the bill we are about to vote on. A tilt toward the House-drafted language would signify not a strengthening of Medicare, but rather a weakening of this vital program's foundation and must be avoided at all costs.

Nearly 38 years ago on July 9, 1965, this body passed the legislation creating the Federal Medicare Program sending it to a conference committee with the House. On that day, President Lyndon Baines Johnson remarked, "This is a great day for older Americans. And it is a great day for America. For we have proved, once again, that the vitality of our democracy can shape the oldest of our values to the needs and obligations of today." Nearly four decades later, we are on the cusp of a similar challenge. Let us move Medicare toward the future without threatening its proven ability to provide for the health and well being of this Nation's senior citizens.

Mr. COLEMAN. Mr. President, I am proud to mark this extraordinary day by coming to the floor of the Senate to celebrate the imminent passage of a prescription drug benefit for Medicare. This is a triumph not for a party or a President, but for America's seniors and their families. This is an incredibly hopeful day for all Americans who long for a national government that can get things done for people.

Thirty-eight years ago Congress voted to create a health care program that would be the primary source of health insurance for this Nation's seniors. Most people would agree that this program has served us well for almost four decades. However, the practice of medicine has changed. Drug therapies, medical devices, and human genome research all hold great hope for breaking through physical limitations that hinder many seniors' ability to enjoy the later years of life.

The question we now ask is what level of care are we going to provide our seniors and is the current system equipped to provide the type of care our seniors need and deserve.

The benefits provided under Medicare, considered generous at its inception in 1965, pale in comparison to those enjoyed by Federal employees and most workers in the private sector today. A recent report submitted by the Joint Economic Committee found that Medicare has the least generous benefit package among leading forms of insurance. Medicare covers 56 percent of total health care expenses, while typical employment-based health insurance covers 70 percent.

Seniors need prescription drug coverage. Seniors need better access to preventative care and disease management. Seniors need more choices in their health care options than they have today. Without updating, it may take years to add this kind of care to the current program—after all, it has taken over 30 years to add a prescription drug benefit.

The Prescription Drug and Medicare Improvement bill is a step toward meeting the needs of this Nation's seniors.

This bill provides a solid drug benefit that will provide assistance to every senior struggling to pay for prescription drugs as well as the security of knowing they are covered for unforeseen drug expenses.

Under this plan, the average senior's annual drug costs will be reduced by 53 percent each year. That amounts to $1,677 each year back in the pocket of our seniors. And seniors with the greatest needs will receive additional assistance through increased cost-sharing, and reduced or waived monthly premiums and deductible.

Equally important, this plan provides seniors with the security of knowing that they are covered in the event something happens and they find themselves facing exorbitant drug costs. At $3,700 in out of pocket drug costs, stop-loss coverage kicks in and the senior is only responsible for 10 percent of costs beyond this amount.

This bill is also about expanding options for this generation and future generations of seniors. The incremental improvements to the Medicare program have largely been the result of legislative action over the last 40 years. The legislative process, however, is not a quick process, and it is simply not possible to keep the program current in the first parcel environment we currently live.

The Medicare Advantage program included in this bill offers seniors the choice of receiving their health care benefits in a Preferred Provider Organization, PPO, the same type of health plan enjoyed by many families.

Under this health care option—not mandate—seniors will have increased access to the latest advances in care such as desire management and better preventive screenings. Additionally, seniors who chose this option will also have a lower deductible for inpatient and hospital care than those in traditional Medicare.

This bill lays the foundation for a Medicare program that is better able to respond to an evolving health care system by harnessing the efficiencies of the health care market, while preserving traditional Medicare for those seniors who are satisfied with their current coverage.

This bill is about expanding options for seniors so our parents and grandparents have access to the type of care best suited for them.

Is this bill everything everyone wants? Of course not. Are there decisions still to be made as it is implemented and we see how it actually works in the marketplace? Certainly. But this bill says we are not going to let the lack of perfection stop us from doing real good for people as soon and as effectively as we practically can.

I would be remiss if I didn't express my appreciation to Senators GRASSLEY and BAUCUS for their leadership in including many provisions in this bill to strengthen rural health care.

The availability of health care in rural areas in Minnesota is absolutely critical to the stability and viability of many communities.

The provisions in this bill to improve payments to hospitals in rural areas and reduce the geographic disparity in physician payments are critical to ensuring that these hospitals that threat not only seniors, but entire communities continued to receive care.

I am pleased that we did not allow perfect to be the enemy of good as we considered this package.

This is a substantial and dependable benefit for America's seniors. Again, it's not everything everyone wants. There are still decisions to be made as it is implemented and we monitor how it works in the marketplace. But today we are delivering on a promise to provide quality care to our seniors.

I am hopeful that with bipartisan support this landmark legislation will pass the Senate and the House of Representatives by the July 4th holiday. When it does, there may not be any fireworks and parades but millions of seniors will be able to declare their independence from worrying about getting the prescription drugs they need to live a quality life.

Mr. BIDEN. Mr. President, after many years of preparation and deliberation, and following weeks of debate and discussion on the floor this year and last, we in the Senate are about to vote on a bill providing some prescription drug benefits for Medicare beneficiaries that is widely expected to pass.

Seniors have been demanding prescription drug coverage for many years now. They need it and they deserve it, and I believe what we should be passing here today is a bill that will bring the American people the type of prescription drug benefit they have been seeking—one that is easy to understand and use, one that covers a substantial portion of all their costs, and one that is affordable.

But to the many Medicare beneficiaries who will read the details of this bill and say, "there isn't much in here for me and it will cost me more than I am now paying for drugs," I would say: I hear you. This bill is not enough, not nearly enough.

I have a lot of concerns about this bill. There is no uniformity from region to region in the benefit package or beneficiary payments. Seniors in the East could be paying far higher premiums than their relatives in the Midwest.

The drug plan relies on private insurance companies to provide a type of insurance policy that they have already said they are unwilling to sell. I am skeptical that these private plans will stay, and that could mean seniors will have no stability in their coverage. The bill does allow traditional Medicare to step in and fill the gap but seniors might have to move back to a private drug plan if new ones come to the region.

There is also a gap in coverage which I think is unfair and will surprise a lot of people.

Finally, the bill falls short in its efforts to induce employers not to abandon their retiree prescription drug coverage, a situation that too many retirees have already faced in recent years.

In summary, I view this bill not as a situation where we would say that the glass is half full and half empty; to my thinking, the glass is only about one-quarter full. In 2003, prescription drugs are as important in medical care as surgery; consequently, it seems logical to me that if Medicare pays for the bulk of the cost of a heart bypass operation for all beneficiaries, it should similarly pay the bulk of the cost of the drugs used to lower the cholesterol, and which would prevent the need for the bypass operation, for all beneficiaries. This bill does not achieve that commonsense goal. Not even close.

But we need to start somewhere. This is the first step in gradually moving the health plan that covers nearly 40 million seniors and disabled individuals into the 21st century. And it is, very frankly, the best that we can expect to pass this Congress and that the President will sign.

There are some good provisions in this bill. All Medicare beneficiaries will have access to a prescription drug plan. Individuals with low incomes, below 160 percent of Federal poverty level, will have access to prescription drug coverage at very little cost. Those with very high prescription drug expenses, in the many thousands of dollars, will have stop-loss protection to help protect them against catastrophic drug costs. And no one is forced to abandon the traditional Medicare Program for their basic health care, with which they are so familiar, in order to obtain prescription drug coverage.

During the Senate deliberation on this bill, I have voted for amendments that would improve the prescription drug coverage and decrease the cost to beneficiaries. Almost all of these amendments were not adopted, mostly with the rationale that there was not enough money. I do not feel constrained by some arbitrary $400 billion cost limit on this bill. I never agreed to such a limit. In fact, my sense of values tells me that prescription drug benefits are a high priority, and I would be willing to spend more than $400 billion for a good prescription drug plan, while cutting budget items of lower priority, such as tax cuts for the very wealthy.

In the end, I decided to vote for this bill, despite its severe limitations. Given the many past years of fruitless discussions on this matter, I feel it is critical to put something into law now that can serve as a starting point for development of a true prescription drug plan. But that is not to say that I will accept any lesser of a bill, and my colleagues should not count on my continued support, if the final version of this bill that comes out of negotiations with the House of Representatives undercuts the Medicare Program or moves toward reducing protections for beneficiaries.

We also need to remember, this bill comes with a warning to all of us: the public is a lot smarter than they are sometimes given credit for, and if we do not work diligently to improve what we have begun, they will rightly take out their anger on us. We need to ensure that this bill is the first step, not the last step.

Mr. GRASSLEY. Mr. President, parliamentary inquiry. Are we now ready for third reading?

The PRESIDENT pro tempore. The question is on agreeing to the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The PRESIDENT pro tempore. The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that following passage of S. 1, the bill be held at the desk; further, when the Senate receives from the House the companion measure to S. 1 the Senate proceed to its consideration, all after the enacting clause be stricken, and the text of S. 1 as passed be inserted in lieu thereof; the bill then be read a third time and passed with the motion to reconsider laid upon the table; further, that the Senate then insist on its amendments and request a conference with the House, and the Chair be authorized to appoint conferees with a ratio of 5 to 4; finally, with that action, I ask unanimous consent that passage of S. 1 be vitiated and the bill be placed back on the calendar.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I want to take a few moments to return to the basics of what this bill is all about. Let's keep our eyes on the ball.

We are working here to make a meaningful improvement in health care for seniors. We are working to bring prescription drug coverage to Medicare beneficiaries.

Too many seniors do without drug coverage. The Congressional Budget Office reports that roughly a quarter of Medicare beneficiaries have no drug coverage. Ten million people. They have to pay all of their drug costs out of their own pockets. They pay full price.

Lack of coverage means poorer health. Seniors who get along without drug coverage get fewer of the healing benefits that prescription drugs provide. CBO reports that when seniors do not have drug coverage, they fill about a quarter fewer prescriptions, on average, than do those who have coverage.

But whether seniors have coverage or not, they still need a significant amount of prescription drugs. CBO says that in 1999, Medicare beneficiaries who had coverage filled an average of 32 prescriptions a year. Those without coverage still filled an average of 25 prescriptions a year.

These prescriptions cost seniors a good deal of money. The average Medicare beneficiary spends about $2,500 a year on prescription drugs. That's a big number—especially as the median income for all elderly households in 2001 was less than $19,000.

Those costs are rising fast. CBO projects that the average Medicare beneficiary's drug costs will rise at a rate of more than 10 percent a year over the next decade. That is far faster than the cost of living. That means that without this legislation, seniors will need to devote larger and larger shares of their income to paying prescription drug bills.

So we are here to try to make prescription drugs more affordable for seniors. And we are here to extend coverage to the roughly 10 million seniors who have no prescription drug coverage at all.

We are here to try to end seniors' painful choice between filling prescriptions and buying food. Seniors should not have to choose among the necessities to maintain their health. We are here to do something about that today.

Let me review what this bill would do.

This bill would make available prescription drug insurance to all seniors.

This bill would ensure that 44 percent of Medicare beneficiaries—those with the lowest incomes—would have truly affordable prescription drug coverage with minimal out-of-pocket costs. For these lower-income seniors, with incomes up to 160 percent of the poverty level, copayments would never exceed 20 percent of the cost of drugs.

Let me take some examples. Let's look at what this bill would do for beneficiaries with what will likely be average drug spending of $3,155 in 2006.

For seniors with average drug expenses, even with higher incomes, this bill would save them $1,677. That is a 40 percent savings in out-of-pocket costs.

The savings would be greater for lower income seniors. For an individual making $14,000 or a couple making $19,000 a year, with average drug spending, they would save $2,842. That is a 90 percent savings in out-of-pocket costs.

For an individual making $12,000 or couple making $16,000 a year with average drug spending, they would save $2,842 in out-of-pocket costs. That would be a savings of 96 percent in out-of-pocket costs.

This bill would thus ensure that those who have been least able to receive the healing benefits of prescription drugs would now be able to do so. Millions of people would have a better quality of life. Lives would be saved.

This bill would create a strong Government fallback. Seniors would have access to at least two private plans for a prescription drug benefit, or the Government would provide a standard fallback plan. If there is not true competition, then traditional Medicare would provide a fallback.

The Department of Health and Human Services would continue to oversee these plans. The plans would operate within tightly controlled limits. This bill includes strong consumer protections.

And this bill does not tilt the playing field. This bill does not make private plans a better deal than traditional Medicare.

This bill would make a nearly $400 billion expansion of a major entitlement program. This is a historic opportunity to make a fundamental change for the better for millions of Americans.

In so doing, this bill would finally do something that the overwhelming majority of industrialized nations have already done.

This is a broad compromise. This is not a bill of the left or a bill of the right. This is a weaving together of approaches, in the finest American tradition.

This is a historic opportunity. Let us finally seize that opportunity, and improve health care for our seniors. Let us finally seize the opportunity, and bring prescription drug coverage to all.

Mr. GRASSLEY. Mr. President, we are about to take a historical vote.

Since 1965, Medicare hasn't covered prescription drugs. Now, 38 years later, we're changing that—on a strong bipartisan basis.

Because of this bill, on January 1, 2004, seniors across America will have immediate help with prescription drug costs. Moreover, on January 1, 2006, seniors will have access to affordable, comprehensive drug coverage as a permanent part of Medicare.

No longer will seniors have to make hard choices when it comes to paying for prescription drugs.

This bill also strengthens and improves Medicare, giving seniors more choices and better benefits than they have today.

At the same time, it brings long overdue Medicare equity to the people of Iowa and to other rural States.

We are on the verge of a major victory.

I urge my colleagues to support S. 1.

Mr. BAUCUS. Mr. President, we are about to vote. I want to thank all Senators for their tremendous patience. It is not an easy task. I particularly thank the chairman of the committee but also all Senators.

Second, I thank the staff who have not had any sleep in the last two or three weeks. I don't know how they are still standing. A lot of people have been working on this bill. My thanks. I know I speak for all the Senators in thanking all the staff that worked so hard to help achieve this end.

The PRESIDENT pro tempore. The bill having been read the third time, the question is, shall it pass?

Mr. HOLLINGS. Mr. President, I ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 76, nays 21, as follows:

[Rollcall Vote No. 262 Leg.]

YEAS—76

Akaka
Alexander
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Boxer
Breaux
Brownback
Bunning
Burns
Campbell
Cantwell
Carper
Chafee
Chambliss
Cochran
Coleman
Collins
Conrad
Corzine
Craig
Crapo
Daschle
Dayton
DeWine
Dodd
Dole
Domenici
Dorgan
Durbin
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Grassley
Hagel
Hatch
Hutchison
Inouye
Jeffords
Johnson
Kennedy
Kyl
Landrieu
Lautenberg
Leahy
Lincoln
Lugar
McConnell
Mikulski
Miller
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Pryor
Reid
Roberts
Schumer
Sessions
Shelby
Smith
Snowe
Specter
Stabenow
Stevens
Talent
Thomas
Voinovich
Warner
Wyden

NAYS—21

Allard
Byrd
Clinton
Cornyn
Edwards
Ensign
Graham (FL)
Graham (SC)
Gregg
Harkin
Hollings
Kohl
Levin
Lott
McCain
Nickles
Reed
Rockefeller
Santorum
Sarbanes
Sununu

NOT VOTING—3

Inhofe
Kerry
Lieberman

The bill (S. 1), as amended, was passed.

(The bill will be printed in a future edition of the RECORD.)

The PRESIDENT pro tempore. Without objection, the title amendment is agreed to.

The title was amended so as to read: "A bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes.".

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

The PRESIDENT pro tempore. The Chair, in my capacity as a Senator from the State of Alaska, moves to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. INHOFE. Mr. President, because of urgent business back in my State of Oklahoma, I will be unable to be in attendance to vote on S. 1. It makes no difference, however, because I would have voted against it.

Last week, I addressed this Chamber regarding S. 1, the Prescription Drug and Medicare Improvement Act. At that time, I said I could not support the legislation in its current form and expressed my hope that it could be improved on the floor. Unfortunately, that has not occurred. I am restating my opposition to this legislation.

This is simply another Federal entitlement program designed to balloon past expected costs of $400 billion. For example, in the past, Medicare expenses have soared nearly five times the projected costs. I remember that well because I remember in 1965 when it was passed. This trend will only escalate if we continue to add unfunded obligations without ensuring the long-term solvency of the entire program.

We must examine the necessity of such obligations prior to placing the burden on the backs of the future taxpayers. And is a full prescription drug benefit necessary? Currently, 76 percent of seniors already have some form of prescription drug coverage. A recent Zogby poll found that three-fourths of seniors thought the coverage offered under this plan would be no better than what they currently have. In fact, less than one-half would even purchase the option if given the choice. However, with the passage of S. 1, those individuals may not be given that choice. CBO estimates that one-third of Medicare beneficiaries with employer-sponsored coverage will lose those benefits once the bill takes effect. Seniors who currently have private coverage that they like will be forced to buy the Government-sponsored benefit simply because it is the only thing that will be available.

There is something wrong with that picture. The Government should not be replacing coverage that already exists. However, this legislation opens the door for continued Government intervention. With the inclusion of the fallback provision, this benefit has the potential to become fully federalized if private plans do not surface. Once again, we are placing more and more expense at the door of the taxpayers, our children, and our grandchildren.

I am concerned about the effect this bill could have on the future of the entire Medicare Program. I have worked with my colleagues to support improvements to this legislation. I and many of my colleagues have signed letters to both Senator FRIST and President Bush outlining the principles that need to be included in the final version of this bill. I also cosponsored an amendment with Senators ENSIGN, HAGEL, and LOTT to provide a more reasonable prescription drug benefit that does not create a massive entitlement program. I believe the House of Representatives is on the right track with this issue.

I am hopeful that with the passage of S. 1, the conferees will work to see that the final legislation adheres to the principles stated in the letters to President Bush and Senator FRIST and the proposal supported by the House. At that time, I will look forward to supporting this legislation.

The PRESIDENT pro tempore. The majority leader.

Mr. FRIST. Mr. President, for years Congress has debated providing prescription drug coverage to seniors and how to strengthen and improve the Medicare Program. Tonight we have acted. Tonight America is one step closer to being a more caring society for millions of seniors and individuals with disabilities. Tonight seniors and individuals with disabilities, through this bill, will get relief from high prescription drug costs and outdated, often inadequate medical care. Tonight we are one step closer to providing real health care security to seniors all across the Nation.

We stand on the shoulders of many in this body and in the House of Representatives who have labored mightily to improve the Medicare Program. We have reached this point of success because of the commitment of the leadership in the House as well as the Senate. Above all, we are indebted to the bold leadership of the President of the United States without whom we would not be transforming or improving the system.

Indeed, the bill we have just passed is nothing less than historic. By dramatically expanding opportunities for private sector innovation, it offers genuine reform that will dramatically improve the quality of health care for all seniors. At the same time, the legislation preserves traditional Medicare so that those who wish can remain in traditional Medicare and keep exactly what they have today.

This bill combines the best of the public and private sectors and positions Medicare to evolve with the medical treatments of the future. It is entirely voluntary.

I am very pleased by the overwhelming majority of this body who tonight voted to move this legislation towards a more competitive private model but a partnership between the public and private sector.

I am also pleased that the amendment maintained the balance that has been so important in what I set out a few weeks ago, to be a truly bipartisan effort. The bill devotes increased resources and expands opportunities within the traditional Medicare Program for chronic care coordination, for disease management, for preventive care.

As many people have stated, it is not a perfect bill, but we will continue to move this legislation forward now to conference once, later in the evening or in the hours of the morning, after the House passes its legislation, we will have the opportunity to make the private sector provisions more flexible, indeed more competitive, and more like the Federal Employees Health Benefits Plan. All of us in this body are familiar with the impressive record of that plan, the Federal employees plan. Every Member of Congress and over 8 million other Federal workers and retirees enjoy the ability to choose the plan that best suits their medical needs.

Indeed, as we go through conference and once the bill is signed by the President of the United States, all seniors will have that same opportunity to voluntarily choose the plan that best meets their medical needs.

I look forward to working with my colleagues on both sides of the aisle to improve this legislation and to make sure that it does not inadvertently displace good private health care coverage that exists today—options that are available to millions of Medicare beneficiaries, including employer-sponsored health coverage.

Compromise and debate are the cornerstone of this great democratic system of government. I commend my colleagues for their admirable show of bipartisan spirit. Thanks to the leadership of our colleagues in the Senate and the commitment of President Bush, America's seniors will finally receive the health coverage they need and the security they deserve.

I want to take a brief moment to thank all of my colleagues for their hard work and dedication over the last several weeks. It has been about 3 months ago that I set out that we would address Medicare for these 2 weeks—the 2 weeks prior to the July 4 recess. Many people said we were trying to do too much in too short a period of time. Others said it is something that has been debated for weeks and months, and indeed years, and there is no way we can finish it before July 4.

Yet through the hard work of our colleagues—again, on both sides of the aisle—we have fulfilled that vision. Again, it is a first step, a step that will be improved in that conference before us. Nevertheless, we succeeded in what we set out to do with the legislation that is built upon the work of many Members of the Senate, as well as the House of Representatives and, in particular, the members of the Senate Finance Committee. I do want to thank especially Senators HATCH, NICKLES, LOTT, SNOWE, KYL, THOMAS, SANTORUM, SMITH, BUNNING, and BREAUX for their hard work and leadership.

In particular, of course, I thank Chairman GRASSLEY and Senator BAUCUS, the managers, who for the last 2 weeks have so capably managed the bill on the floor. Their cooperation and their leadership has been invaluable. Without it, we would not be here so close to the finish line.

I would like to recognize all of the staff who have contributed to this effort:

First, I would like to thank my chief of staff, Lee Rawls; my policy director, Eric Ueland; and my health policy director, Dean Rosen. Paul Jacobson, Bob Stevenson, Nick Smith, Bill Hoagland, and Amy Holmes of my Leadership office also made important contributions. I also would like to recognize the other members of my health team who worked so hard to help make possible the passage of this legislation: Elizabeth Scanlon, Craig Burton, Susan Goelzer, Shana Christrup, Allison Winnike, and Jennifer Romans.

The Majority Whip's staff deserves special recognition, especially Kyle Simmons, Michael Solon, and Amy Swonger, for the long hours they put in and for the guidance they provided to our Finance Committee Chairman and our entire Republican leadership team.

As I have said, passage of this legislation was made possible in the United States Senate because of the genuine spirit of bipartisan cooperation. Both the Republican and Democratic staff of the Senate Finance Committee worked incredibly hard, long hours these past several weeks and months. Their expertise, support, and stamina has been invaluable.

I would like to thank Kolan Davis, Ted Totman, Linda Fishman, Colin Roskey, Leah Kegler, Mark Hayes, Jennifer Bell, and Alicia Ziemiecki of Chairman GRASSLEY's staff.

And I would also like to thank Jeffrey Forbes, Elizabeth Fowler, Bill Dauster, John Blum, Pat Bousilman, Kate Kirchgraber, and Andrea Cohen of Senator BAUCUS' staff for their contributions.

Hazen Marshall, Stacey Hughes, and Megan Hauck of the Senate Budget Committee staff are also commended for their efforts.

Thank you to you all.

I look forward to working with Chairman GRASSLEY and our colleagues in the House of Representatives to produce a conference report that can pass both Houses and be signed by the President in a timely manner later this year.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER TO PRINT S. 1

Mr. FRIST. Mr. President, I ask unanimous consent that S. 1, as passed, be printed.

The PRESIDING OFFICER. Without objection, it is so ordered.

(This bill will be printed in a future edition of the RECORD.)

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

INDEPENDENCE DAY

Mr. BYRD. Madam President, the Senate is poised to adjourn, but before we adjourn, I want to call us away from the onrushing press of Senate business and impending airline schedules to pay tribute to Independence Day. Next Friday is the glorious Fourth of July, that most patriotic and star-spangled of holidays. With the Fourth of July holiday, summer is at its Halcyon best, with temperatures still enjoyable, skies richly blue, and trees and lawns still lush and green, and gardens coming into bewildering abundance. In fields and along the roadsides, wildflowers bloom in profusion, and wild blackberries earn our forgiveness for their thorns by offering the tender treasures of their glossy berries.

It is a golden period of enjoyment for students on summer holiday, the respite still feels luxuriously long, full of golden days of enjoyment.

The Fourth of July this year falls on a Friday, easily making a long weekend for summer pleasure. With luck, the Fourth will be clear and cooler, comfortable for marching bands and hometown parades, bathed in glorious sunshine for family picnics and perfect for evening symphonies and fireworks to compete with the glittering stars above.

If the weather is sweltering, however, then we might be better able to empathize with the Delegates to the Second Continental Congress, who met in Philadelphia in the spring and summer of 1776. In hot and muggy summer weather, clad in heavy styles that were designed for a cooler European summer, the Delegates debated and amended, reportedly fending off flies from a nearby stable that swarmed the Hall and bit the Delegates through the silk hose on their lower legs. But they persevered in their momentous task.

On June 7, 1776, Richard Henry Lee of Virginia offered a motion to declare independence from England. His resolution declared:

> These United Colonies are and of right ought to be free and independent States.

His resolution passed on July 2 by a 12–0 vote, with New York temporarily abstaining.

The next day, on July 3, John Adams wrote to his wife, Abigail, rejoicing over the decision to secede. To Abigail, he wrote:

> The 2nd of July will be a memorable epoch in the history of America. I am apt to believe that it will be celebrated by succeeding generations as the Great Anniversary Festival.

He further suggested that it ought to be commemorated as the day of deliverance, by solemn acts of devotion to God Almighty.

This is John Adams speaking. This is not some rustic boob like I was when I came to the House more than half a century ago. Listen to him again:

> It ought to be commemorated as the day of deliverance by solemn acts of devotion to God Almighty.
>
> It ought to be solemnized with pomp, shows, games, sports, guns, bells, bonfires, illuminations, from one end of this Continent to the other, from this time forward, forever.

How remarkably prescient. Adams was off on the date, as we celebrate the approval of the Declaration of Independence rather than of the adoption of the motion, but he certainly knew how Americans like to celebrate. As well, he accurately predicted the explosive growth of an embryonic nation into a continent-spanning colossus.

That vision took great courage, coming as it did on the eve of putting his signature to a document that could easily become his death warrant. Every signer of that Declaration of Independence committed treason against England, against the King of England, against the crown. Every signer could have been arrested, put in chains and sent by boat to England; tried, convicted, and hanged. The delegates to the Continental Congress had, with this act, committed treason against the crown and set their nascent nation-state on the road to war. After the failed Jacobite uprising against England in 1745 under Bonnie Prince Charles, only 31 years before the delegate met in Philadelphia, the Scottish leaders had been beheaded in public ceremonies.

One Delegate to the Congress, John Witherspoon, put it thus:

> There is a tide in the affairs of men, a nick of time. We perceive it now before us. To hesitate is to consent to our own slavery. That noble instrument upon your table, that insures immortality to its author, should be subscribed this very morning by every pen in this house. He that will not respond to its accents, and strain every nerve to carry into effect its provisions, is unworthy of the name of free man. For my own part, of property, I have some; of reputation, more. That reputation is staked, that property is pledged on the issue of this contest; and although these grey hairs must soon descend into the sepulcher, I would infinitely rather that they descend thither by the hand of the executioner than desert at this crisis the sacred cause of my country.

What beautiful words. The signers knew full well what risks they were running.

The first anniversary of the adoption of the Declaration of Independence took place in a nation at war, with our battle fortunes at low ebb. But Americans still celebrated in Philadelphia. U.S. ships of war were decked in red, white, and blue. At 1 o'clock, each ship fired a salvo of 13 cannons to honor the 13 States. Members of Congress dined in state with other civil and military dignitaries and made toasts to liberty and to fallen patriots. After dinner, the Members and officers of the Army reviewed the troops, followed by a ringing of bells and a show of fireworks.

In 1788, Philadelphia was serving as the U.S. Capital. On that year, not only was the Declaration of Independence celebrated, but also the U.S. Constitution, which had recently been ratified by 10 States. This July Fourth celebration included another new feature—a parade with horse-drawn floats. One float, that of an enormous eagle, carried the Justices of the Supreme Court in lieu of today's beauty pageant queens.

In 1826, the Nation achieved a milestone when the 50th Independence Day celebration was being planned. The mayor of Washington wrote to invite the surviving ex-Presidents and Signers of the Declaration to attend the festivities. The five men, John Adams, Thomas Jefferson, James Madison, James Monroe, and Charles Carroll, were unable to attend. Why? Because of age or infirmity, or other reasons. Indeed, at 10 minutes before 1 o'clock on July 4, 1826, Thomas Jefferson, principal drafter of the Declaration, passed away.

John Adams, too, breathed his last on the same day. In his 90s and gravely ill, he had determined to hold on until the 50th anniversary of independence. That morning, he roused long enough to confirm to a servant that he knew that "it is the glorious Fourth of July. God bless it. God bless you all," before fading into unconsciousness. Rousing later that afternoon, he confided unknowingly as he passed on to that other shore that "Thomas Jefferson still survives." He did not know that Jefferson had died earlier that day.

James Monroe, who fought in the Revolutionary War and became the fifth President of the United States, also died on July 4, in 1831. James Madison, the fourth President, died a week short of the 60th anniversary of Independence Day, on June 28, 1836.

The last living Signer of the Declaration of Independence, Charles Carroll, performed one of his last public acts on July 2, 1828. He participated in a ground breaking ceremony initiating construction of the Baltimore and Ohio Railway, the first important railroad in the Nation. He died in 1832, at the age of 95. Also in 1828, President John Quincy Adams led an unusual 4th of July parade, up the Potomac River and the old Washington Canal to the site where construction was to start on the Chesapeake and Ohio Canal. These two acts underscore the vital link between the Declaration of Independence, the Constitution which followed it, and the vibrant economy which has made and kept the United States economy vibrant and strong for so many years.

Our Nation is a union of disparate States, each of which has considerable power within its boundaries. But across those boundaries, linking the Union into a seamless web of bustling commerce and economic might, is the national infrastructure. Just as the Constitution provides for the common defense, so it promotes the common good by linking markets and people across States. Over the years, Federal support for great infrastructure projects, from the Chesapeake and Ohio Canal to the National Highway System, have woven the Nation into a unified economic structure. Federal support for rural electrification and rural telephone and Internet access have spread opportunity and progress from border to border and coast to coast, just as John Adams foretold in 1776.

This 4th of July, as we all visit national parks, tour Federal monuments, drive on interstate highways, call friends and family around the country, and buy picnic goods grown all over the United States—as we celebrate a national Federal holiday under the protective watch of the U.S. military and Federal law enforcement agencies—we unconsciously enjoy the benefits of the Federal Government and of belonging to a union that is the United States.

Each star on the flag, the flag beside the Presiding Officer's desk, we salute so proudly represents a single state, but only when they are aligned together in the constellation of 50 do we feel the strength and the glory that were won for us, beginning on July 4, 1776. This Independence Day, we would all do well to read and cherish the Declaration of Independence. Even more, we would do well as a Nation to study and cherish our Constitution, by which our freedom, so dearly won and so costly held, lives on.

Too often in recent years and months have I seen unwise attempts to erode the checks and balances of the Constitution, unknowing or unthinking efforts to dissolve the institutions and practices established to make our Nation the free and representative government by our Founding Fathers. Attacks on the United States from without are met with instant, unhesitating defense by all Americans, but we are not so knowledgeable vigilant against the insidious weakening from within, even within this Chamber. We are all of us, with our voices and our votes, the last, best guardians of American freedom and independence. We lack only the weapons of knowledge and awareness.

I close with a poem by Henry Wadsworth Longfellow, entitled "O Ship of State."

Thou, too, sail on, O Ship of State!
Sail on, O Union, strong and great!
Humanity with all its fears,
With all the hopes of future years,
Is hanging breathless on thy fate!
We know what Master laid thy keel!
What Workmen wrought thy ribs of steel,
Who made each mast, and sail, and rope,
What anvils rang, what hammers beat,
In what a forge and what a heat
Were shaped the anchors of thy hope!
Fear not each sudden sound and shock,
'Tis of the wave and not the rock;
'Tis but the flapping of the sail,
And not a rent made by the gale!
In spite of rock and tempest's roar,
In spite of false lights on the shore,
Sail on, nor fear to breast the sea!
Our hearts, our hopes, are all with thee.
Our hearts, our hopes, our prayers, our tears,
Our faith triumphant o'er our fears,
Are all with thee—are all with thee!

Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

THANKING SENATOR BYRD

Mr. REID. Mr. President, I wish that I were able to express myself in a manner that is worthy of my feelings about the Senator from West Virginia. I can't do that, but I can do the best I can.

There isn't a day that goes by that I don't recognize personally how fortunate I am to live in this country and to represent the sovereign State of Nevada and to be a Member of the Senate. It is a blessing that I have had, for whatever reasons. Whether I am worthy or not, that is for someone else to determine. But one of the most important aspects of my life has been my association, my friendship, my service with the Senator from West Virginia, a man who served in the Congress for more than 50 years, who, like clockwork, comes to the Senate floor on special occasions like the Fourth of July or Thanksgiving, and makes us all feel better for having had the opportunity to listen to a speech by the Senator from West Virginia.

As I look back over the time I spent here on the Senate floor, listening to the Senator from West Virginia, I am drawn to a number of things I will never forget. I remember the speeches—and I sat with every one of them. I missed a couple of them, but I watched them in my office—the speeches on the fall of the Roman Empire that were based on the line-item veto. The Senator from West Virginia was indicating the line-item veto would be the beginning of the end of the Senate.

The Senator delivered those speeches without a note. I didn't realize at the time, but the Senator knew every word he intended to say. They were not extemporaneous in the sense I would give an extemporaneous speech. He knew before he gave the speech, beforehand, every word he was going to deliver.

I was so impressed with that series of speeches that I sent them to the head of the political science then at the University of Nevada at Las Vegas, Andrew Tuttle. Tuttle was so impressed—I sent him the speeches so he could watch them—he started a course at UNLV based on the lectures of Senator BYRD.

I am not going to go on, other than to say our country is so much better as a result of the service granted by the people of West Virginia to the Senator from West Virginia. People may not always agree with the Senator from West Virginia, but no one can take away the fact he is the epitome of the Senate. And when the history books are written—and they will be written—there will be a place where they will list the great Senators of this body, and in the top two or three will be the Senator from West Virginia.

Mr. BYRD. Mr. President, I thank my dear friend, the distinguished Senator from Nevada, who is also the Democratic whip here in the Senate.

Tennyson in Ulysses says:

I am a part of all that I have met.

Mr. President, I don't know how long the great God of the universe will spare me. But however long it may be, the distinguished Senator from Nevada, Mr. REID, will always be a part of me.

HONORING SENATOR STROM THURMOND

Mr. HATCH. Mr. President, I wish to take a minute to say a few words in honor of Strom Thurmond, our friend and former colleague, who passed away today.

From the moment Strom Thurmond set foot in this Chamber in 1954, he has been setting records. He was the only person ever elected to the U.S. Senate on a write-in vote. He set the record for the longest speech on the Senate floor, clocked at an astounding 24 hours and 18 minutes. He was the longest serving Senator in the history of the Senate. He was also the oldest serving Senator. Many of my colleagues will recall the momentous occasion in September of 1998 when he cast his 15,000th vote in the Senate. With these and so many other accomplishments over the years, he has appropriately been referred to as "an institution within an institution."

In 1902, the year Strom Thurmond was born, life expectancy was 51 years—and today it is 77 years. Strom continued to prove that, by any measure, he was anything but average.

He saw so much in his life. To provide some context, let me point out that during his lifetime, Oklahoma, New Mexico, Arizona, Alaska and Hawaii gained Statehood, and 11 amendments were added to the Constitution. The technological advancements he witnessed, from the automobile to the airplane to the Internet, literally spanned a century of progress. Conveniences we have come to take for granted today were not always part of Strom Thurmond's world. Perhaps this explains why, during Judiciary Committee hearings, he was often heard asking witnesses who were too far away from the microphone to "please speak into the machine."

The story of his remarkable political career truly could fill several volumes. It began with a win in 1928 for the Edgefield County Superintendent of Schools. Eighteen years later, he was Governor of South Carolina. Strom was even a Presidential candidate in 1948, running on the "Dixiecrat" ticket against Democrat Harry Truman.

I must admit, he came a long way in his political career, given that he originally came to the Senate as a Democrat. I was happy to say that wisdom came within a few short years when Strom saw the light and joined the Republican Party.

When I first arrived in the Senate in January of 1977, he was my mentor. As my senior on the Judiciary Committee, it was Strom Thurmond who helped me find my way and learn how the committee functioned. He was not only a respected colleague, but a personal friend.

During his tenure as chairman of the Judiciary Committee, Strom Thurmond left an indelible mark on the committee and the laws that came through it. He became known and respected for many fine qualities and positions—his devotion to the Constitution, his toughness on crime, his sense of fairness.

He was famous for his incredible grip. Many of us in this Chamber had the experience of Strom Thurmond holding our arm tightly as he explains a viewpoint and asked for our support. I might add that this proved to be a very effective approach.

Strom was also known to have a kind word or greeting for everyone who came his way, and for being extremely good to his staff. Despite his power and influence, he never forgot the importance of small acts of kindness. For example, whenever he ate in the Senate dining room, he grabed two fistfuls of candy. When he returned to the floor of the Senate, he handed the candy out to the Senate pages. Unfortunately, it was usually melted into a keleidoscope of sugar by then. I have a feeling that the pages preferred it when Strom took them out for ice cream.

Strom Thurmond was truly a legend—someone to whom the people of South Carolina owe an enormous debt of gratitude for all his years of service.

Clearly, the people of South Carolina recognize the sacrifices he made and are grateful for all he did for them. In fact, you cannot mention the name Strom Thurmond in South Carolina without the audience bursting into spontaneous applause. He truly was an American political icon.

Abraham Lincoln once said that "The better part of one's life consists of friendships." With a friend like Strom Thurmond, this sentiment could not be more true. I am a great admirer of Strom Thurmond, and I am proud to have called him my friend.

One final note about Strom Thurmond. He was a great patriot. A decorated veteran of World War II who fought at Normandy on D-day, Strom Thurmond loved this country. Let me close by saying that this country loved him, too.

A SALUTE TO PAUL GALIS

Mr. BYRD. Mr. President, the great State of West Virginia has produced numerous individuals who have dedicated their lives to the service of the Nation. These sons and daughters of West Virginia have contributed to the betterment of their communities, their State and their country. One such public servant is Paul L. Galis, who for 35 years has served admirably in the Federal Aviation Administration, and has contributed to the development of an aviation system unsurpassed in the world.

Mr. Galis retires in July as the Deputy Associate Administrator for Airports in FAA. In this position as well as his previous position of Director of the Office of Airport Planning and Program, Mr. Galis has overseen the planning and development of over 3,000 airports in the national plan for airports. This has been no small task and Mr. Galis has served with distinction.

All of us in the State of West Virginia salute Mr. Galis for his career and wish him the best in his future endeavors. Our country is better for the work he has done and the example of public service he has provided. His able leadership and steady hand will be missed.

OREGON'S TANF WAIVER

Mr. WYDEN. Mr. President, on June 12, 2003, I published a notice in the CONGRESSIONAL RECORD of my intent to object to moving to H.R. 2350, a bill to extend the Temporary Assistance for Needy Families, or "TANF," our Nation's welfare program. My good friend from Oregon, Senator SMITH, joined in this effort because the legislation does not contain a provision critical to Oregon's welfare program: a waiver of certain provisions that gives Oregon flexibility to operate a successful welfare program. Because of its waiver, which expires on June 30, 2003, Oregon has reduced its welfare rolls nearly 60 percent since 1994. It is clear that the waiver has allowed Oregon to meet local needs and craft what has been heralded as one of the best welfare programs in the country.

Since Senator SMITH and I announced our public holds, the distinguished chairman of the Finance Committee, Senator GRASSLEY, and the ranking member, Senator BAUCUS, have worked closely with us to find a way so that Oregon can continue to operate under its waiver until TANF is fully reauthorized. They have helped obtain a letter from Department of Health & Human Services Secretary Tommy Thompson to Oregon Governor Ted Kulongoski, myself and Senator SMITH assuring us that Oregon can continue to operate without penalty under its waiver. I believe this letter provides Oregon the assurances necessary to continue to operate as if the waiver were still in place, and ask unanimous consent to insert the letter in the RECORD.

Mr. SMITH. I join Senator WYDEN in expressing deep pride in Oregon's TANF program and in thanking the chairman and ranking member of the Finance Committee, on which I serve, for their cooperation. I share his assessment that this letter will enable Oregon to maintain its TANF program without penalty until the program is reauthorized.

I also express my appreciation to Senators GRASSLEY and BAUCUS for their efforts on TANF reauthorization. We have been working together for months to ensure that all TANF proposals, including those elements which have made Oregon's TANF program so successful, are carefully considered as we move toward TANF reauthorization.

Oregon's TANF program, often called the Oregon Option, works because it recognizes local barriers to work and works with individuals to assess their needs and get them onto a path toward independence. For example, Oregon allows individuals with severe substance abuse problems to seek treatment. This helps people address the root of their problems—not just the symptons. The Oregon Option has put people into real work situations—not just make work—and this has helped Oregon move people off the welfare rolls and into real, sustainable jobs. I believe the Senate can learn from the lessons of Oregon's program, and I will continue to work with my colleagues to ensure that all state TANF programs have the flexibility they need to operate successfully.

Mr. GRASSLEY. Mr. President, I understand the concerns of the Senators from Oregon, and look forward to working with them to reauthorize the TANF program in the coming months. I appreciate their concern for the need for Oregon to retain flexibility in TANF. I hope the Senator from Montana will agree that the Finance Committee, on both sides of the aisle, should discuss this issue as we move to reauthorize the TANF program.

Mr. BAUCUS. I agree with the chairman and look forward to moving on these issues. My home State of Montana is currently operating under a waiver that expires on December 31st of this year. I know that Montana, like Oregon, has been able to craft a successful TANF program because of its waiver, and I look foward to working with my distinguished colleagues to see that it is retained.

RECOGNIZING SENATOR TED STEVENS, THE RECIPIENT OF THE ARLEIGH BURKE AWARD FROM THE CENTER FOR STRATEGIC AND INTERNATIONAL STUDIES

Mr. INOUYE. Mr. President, our distinguished colleague, the Honorable TED STEVENS, was presented with the Arleigh Burke Award on June 11, 2003, by the Center for Strategic and International Studies. The award, named after the famed Admiral, who was the longest serving Chief of Naval Operations, recognizes Senator STEVENS's leadership in the fields of strategy, resources, and maritime affairs, as well as his hard work and selfless dedication to promote public service and the ideals of freedom.

When Senator STEVENS accepted the Burke Award, he delivered a thoughtful speech that underscored Admiral Burke's conviction that duty to country is more important than duty to the Commander-in-Chief, and that we should oppose the concentration of power.

I ask unanimous consent that Senator STEVENS's speech be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SPEECH BY SENATOR TED STEVENS AT THE CSIS ARLEIGH BURKE MEMORIAL DINNER ON JUNE 11, 2003, IN WASHINGTON, DC

Good evening. Thanks to my good friend and colleague Senator Warner for that warm introduction.

My congratulations to General Keene, the Army's new Acting Chief of Staff. I wish him success in the coming months.

It is a tremendous honor to receive an award named after Admiral Burke. Like many of you, I am familiar with the Admiral's distinguished life of dedication, service, and achievement. When I served in China during World War II, he was an admiral in the Navy, and the battles that made him one of that war's greatest combat leaders were well-known.

I met Admiral Burke during the Eisenhower Administration. I was working on statehood for Alaska and Hawaii in the Department of Interior in those days. Admiral Burke was the Chief of Naval Operations. Like everything he did, Admiral Burke served as CNO with tremendous distinction. He was the youngest and longest serving CNO in history, and during his tenure he fought for technologies and strategies that continue to form the foundation of our Armed Services.

To refresh my memory of Admiral Burke's accomplishments, I went back to E.B. Potter's book about him.

Potter reported that in January of 1958, the year Alaska's Statehood Bill was enacted, Burke opposed the Gaither Report, which recommended streamlining and centralization of defense. At the National Press Club he warned against control of all U.S. forces by “one man, a military Solomon.”

Notwithstanding that position of the CNO, in April 1958, and I quote from Potter's book on Arleigh Burke:

“. . . Eisenhower sent to Congress a special message on reorganization of the Department of Defense. Its chief recommendations were (1) to remove the Service Chiefs from the operation chain of command; (2) to restrict Service Secretaries to administration, relieving them of responsibility for military operations; (3) to restrict duties of Joint Chiefs of Staff mainly to advising the Secretary of Defense; (4) to enlarge the Joint Staff; and (5) to limit control of operating forces to the President and the Secretary of Defense.”

Eisenhower sent word through Secretary of Defense McElroy that he wanted all senior officers and officials to support his plan.

Arleigh was called before the Senate Armed Services Committee. As Potter stated, Admiral Burke “put duty to country over duty to the Commander-in-Chief,” and opposed this concentration of power in the Secretary of Defense.

The Defense Reorganization Act of 1958 did not rubber stamp the Gaither Report. It followed many of Admiral Burke's suggestions.

To his great credit, Ike appointed Admiral Burke to a third term as CNO in August 1959.

It is my hope that in reviewing the current proposals from D.O.D. before Congress, senior officers and officials of D.O.D. and all members of Congress will follow the great traditions Admiral Burke upheld.

Arliegh Burke lived his life by principles which guided him through the perils of World War II and still pertain today.

He once described his philosophy as:

“An old-time philosophy—a philosophy of realism. You must always ask yourself the question, ‘What is important in life? . . . I don't think it's very important to be remembered. . . . The ideas I stood for should be remembered.”

Admiral Burke also demonstrated his loyalty to the men under his command. The spirit of Admiral Burke's commitment to his sailors is reflected in the steps the Congress has taken to support our troops and honor our promises to our veterans.

Admiral Burke was a hero and a visionary, and I can think of no greater honor than to be your guest at this evening's event. Thanks again for this award.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in New Bedford, MA. On June 22, 2003, Saurabh Bhalerao, a 24-year-old graduate student, was ambushed by four men and savagely beaten when the assailants mistook the student for a Muslim. Mr. Bhalerao, a Hindu Indian, works part-time as a pizza delivery man. One of the suspects placed a phone order at the local pizzeria where Mr. Bhalerao is employed. When Mr. Bhalerao arrived with the order, two men shoved him into the apartment and pushed him to the floor. After Mr. Bahlerao was lying on the floor, the attackers kicked and beat him. At one point, one suspect hit him with a kitchen chair. The perpetrators also burned Mr. Bhalerao's body with lit cigarettes. According to court documents, one of the attackers told Mr. Bhalerao to “Go back to your own country.” Mr. Bhalerao eventually escaped from the trunk of an assailant's car after he managed to loosen the fisherman's rope binding his hands and feet. He is currently in the intensive care unit at a local hospital.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

NOMINATION OF JOSHUA BOLTEN TO BE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET

Mr. CONRAD. Mr. President, I rise in support of Joshua Bolten as Director of the Office of Management and Budget, and to urge Mr. Bolten to do everything within his power to help put the Federal budget back on sound footing.

The position of OMB Director is always one of the most demanding posts in our Government, but it is especially so right now. The tax cuts pushed through by the President over the last 2½ years, combined with the continuing economic slowdown and increased spending to respond to the September 11 terrorist attacks and prosecute the military efforts in Afghanistan and Iraq, have pushed the budget deep into deficit. And despite the fact that we desperately need to get our fiscal house in order to be ready for the imminent retirement of the baby-boom population, this administration and its allies in Congress have not yet accepted that the policies they have advocated are leading us in the wrong direction.

I support the nomination of Joshua Bolten as OMB Director because I believe he is a very capable and honorable man, with a distinguished record both in public service—including service as a Senate staffer—and in the private sector. I sincerely hope he will take to heart the duty of the OMB Director to be an advocate for fiscal responsibility—to be willing to present the President with the facts where the budget is heading even if those facts are unpleasant, and to recommend policies to the President that will put the budget back on a sustainable path even if those policies may be politically difficult.

In a written response to a question by the Governmental Affairs Committee, Mr. Bolten reiterated the position of the Bush administration about the deficits facing us, stating that: “Our current deficit—as measured as a percentage of gross domestic product (GDP)—is not large by historical standards and is manageable within the overall context of our economy.”

I hope when Mr. Bolten assumes his post as head of OMB, he recognizes the reality of the budget situation and leads the administration to reassess that position. That reality is that the deficit we are currently facing is enormous by any standard. According to CBO, the total deficit will exceed $400 billion this year, more than $100 billion higher than the all-time record deficit of $290 billion recorded in 1992. As a percentage of GDP, the deficit will be about 4 percent, a level that has been reached only eight times in the 57 years since the end of World War II. More troubling, when Social Security is excluded from the calculation, this year's deficit is likely to total about 5.5 percent—a level reached only twice in the last 57 years.

I hope Mr. Bolten accepts how serious the budget situation is and how important it is that we do not delay beginning to deal with the situation. I hope that he will advise the President to work with the Congress in a truly bipartisan way to reach agreement on and enact policies that will put the budget back on track.

COMBATING TORTURE AND ASSISTING VICTIMS OF TORTURE

Mr. CAMPBELL. Mr. President, I rise to address the barbaric practices that constitute torture as we mark the United Nations Day in Support of the Victims of Torture. Astonishingly, an estimated 500,000 victims of torture live in the United States today, including many in my home State of Colorado. The United States has provided vital leadership in the campaign to prevent torture around the world. The

United States must not equivocate on this most basic of human rights.

While the United States has consistently spoken out forcefully against the use of torture around the world, serious questions have been raised suggesting U.S. complicity in torture as part of the war against terrorism. This prompted me to join other members of the Helsinki Commission in writing to the White House recently urging an investigation of "serious allegations that the United States is using torture, both directly and indirectly, during interrogations of those suspected of terrorism." Against this backdrop, I urge the administration to issue a forthright statement on torture. In his State of the Union Address, President Bush described the horrific forms of torture employed by the Hussein regime and concluded, "If this is not evil, then evil has no meaning." Even as experts document the scope of torture in Iraq, there must be no doubt concerning U.S. policy and practice.

As Cochairman of the Helsinki Commission, I am particularly concerned that torture remains a tolerated if not promoted practice by come countries, even within the membership of the 55-nation Organization for Security and Cooperation in Europe, OSCE.

In some places, like Uzbekistan, members of the political opposition or religious minorities are especially likely to be the victims of torture. Tragically, two more people there have joined the long list of those who have died in custody amid credible allegations of abuse and torture, just weeks after the European Bank for Reconstruction and Development hosted a prestigious meeting in Tashkent, and days after the Secretary of State determined Uzbekistan is eligible for continued U.S. assistance. Moreover, the shortsighted practice of making martyrs out of Islamic extremists may have exactly the opposite effect the government claims to be seeking in its efforts to combat terrorism.

In Georgia, torture and abuse comes hand in hand with police corruption. In the most recent State Department Country Report on human rights in Georgia, the Department stated: "[s]ecurity forces continued to torture, beat, and otherwise abuse detainees. . . . NGOs also blamed several deaths in custody on physical abuse, torture, or inhumane and life-threatening prison conditions." Even President Shevardnadze has, in the past, acknowledged the prevalence of abuse against detainees and prisoners. I welcome a new initiative of the OSCE Mission in Georgia to combat torture, but I would also note that antitorture initiatives have come and gone in Georgia with little to show for it. Without real political will, I am afraid this latest initiative may end up like the others.

In Turkey—a country which has been given particular attention by the Helsinki Commission—even the doctors who treat the victims of torture have become targets themselves. Their offices have been raided, records seized, and even some doctors have been arrested and tortured. Moreover, the patients of these doctors, all of whom have already suffered at the hands of the authorities, have often been rearrested, retortured and recharged based on their testimonies given to the medical authorities.

As a result of these practices, Turkey has been repeatedly sanctioned by the European Court of Human Rights. The Turkish nongovernmental organization, the Human Rights Foundation, appears to be making some headway in defending these doctors. Last year, Turkey's Grand National Assembly has passed significant legislation with severe penalties for those convicted of torture. A major effort still needs to be made to conform the application of the law in the regional courts of Turkey with the intent of the parliamentarians. The Helsinki Commission will continue to monitor developments in Turkey and the implementation of this law.

In the 1999 OSCE Istanbul Charter, the participating States committed themselves to "eradicating torture and cruel, inhumane or degrading treatment or punishment throughout the OSCE area. To this end, we will promote legislation to provide procedural and substantive safeguards and remedies to combat these practices. We will assist victims and cooperate with relevant international organizations and nongovernmental organizations, as appropriate."

Clearly a strategy to confront and combat torture must emphasize prevention of torture, prosecution of those who commit torture, and assistance for the victims of torture. As we mark the United Nations Day in Support of the Victims of Torture, I note the good work being done by the Rocky Mountain Survivors Center, located in Denver. The center is part of a nationwide network committed to assisting the victims of torture living in the United States.

HONORING PRIVATE FIRST CLASS MICHAEL DEUEL

Mr. JOHNSON. Mr. President, I am saddened to report the passing of Private First Class Michael Deuel of Nemo, SD. PFC. Deuel was killed on June 18, 2003, while serving in Operation Iraqi Freedom.

Michael moved from his home in Cheyenne, WY to attend school at Boxelder Job Corps in South Dakota in May 2000. His friends and teachers described him as an unassuming, yet confident student. Focused and hard working, Michael was determined to perform well in school. He received his general education diploma and certification from the culinary arts program shortly before enlisting in the Army. Following service in the military, he dreamed of becoming a chef and owning his own restaurant.

After enlisting in the Army, Michael entered airborne school to become an Airborne Ranger. He went on to Army Ranger School and became a member of the Army's 325th Infantry Regiment of the 82nd Airborne Division, which is based in Fort Bragg, NC.

On February 13, 2003, he was deployed to Iraq. While protecting a propane-distribution center in Baghdad, he was killed by enemy fire.

The lives of countless people were enormously enhanced by Michael's goodwill and service. Although he did not live to see his dreams realized, he continued to inspire all those who knew him. Our Nation and South Dakota are far better places because of his life, and the best way to honor his life is to emulate his commitment to our country.

I join with all South Dakotans in expressing my sympathies to the family of Private First Class Deuel. I know he will always be missed, but his service to our Nation will never be forgotten.

NEW HOMESTEAD ECONOMIC OPPORTUNITY ACT

Mr. SMITH. Mr. President, I rise today with great concern. As you are aware, President Bush named June National Homeownership Month 2003. I am proud that our President has seen fit to promote an aggressive homeownership campaign, and I support this administration's efforts to see more Americans reach the American Dream of homeownership. As a member of the Finance Committee, I have had the opportunity to learn of important ways that we can make that a reality. In January I introduced the New Homestead Economic Opportunity Act, better known as the Homeownership Tax Credit. This legislation will create a single-family housing tax credit for developers who build in low income areas, and allow more Americans to reach their dreams of homeownership. It will also encourage developers of single family units to invest in low income areas and improve our communities.

The Department of Housing and Urban Development has stated that one of its goals is to allow every citizen—regardless of race, creed, color, or place of birth—the opportunity to own their own home. To reach this goal, there must be affordable homes to purchase.

In his testimony before the Senate Committee on Banking, Housing, and Urban Arrairs earlier this month, James Rayburn, the Vice President of the National Association of Home Builders stated that the Homeownership Tax Credit proposal seeks to close the gap in homeownership rates among

Americans. While 82 percent of households earning 100 percent or more of the national median income now own homes, only 53 percent of households earning less than the national median are homeowners. The homeownership rate for families earning 80 percent or less of the national median is only 40 percent to 45 percent. Homeownership for whites is 75 percent, while the ownership rate for African Americans is just below 48 percent and 48 percent for Hispanics.

We can all agree that the quality of life in distressed neighborhoods can be improved dramatically by increasing home ownership. Existing buildings in these neighborhoods often need extensive renovation before they can provide decent owner-occupied housing. It is also difficult for renovations to occur because the costs involved exceed the prices at which the housing units could be sold. Similarly, the costs of new construction may exceed its market value. Properties sit vacant and neighborhoods remain devastated. The New Homestead Economic Opportunity Act bridges the gap between development costs and market prices and will revitalize these areas.

I would like to see every American given the opportunity to succeed at the goal of owning their own home. I am proud to be the sponsor of this legislation, and I plan to continue to work to see it become law. I urge my colleagues to join me in supporting the American Dream by supporting S. 198.

HONORING MAYNARD H. JACKSON, JR.

Mr. CHAMBLISS. Mr. President, as Atlanta's first black mayor, Maynard Jackson dedicated his career and his life to healing the racial inequalities that surrounded him and ensuring that the city of Atlanta was a thriving, inclusive community.

Working to expand Hartsfield International Airport, Maynard fought for equal treatment for minority workers and businesses. He sought to bring diversity to government as well as Atlanta's business community. Through the equality he sought for all racial groups, he was able to foster economic expansion and growth for Atlanta and greater equality for her citizens.

Working to secure the 1996 Olympics, Maynard ensured that Atlanta shined for the world and was recognized as a city that offered opportunity for everyone regardless of race or socio-economic class.

Serving as the president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials, he became a role model for young African Americans hoping to someday make their mark on this world and worked tirelessly to improve interracial relationships in the South's largest city.

His contributions and accomplishments to help our State thrive economically and to expand opportunities for minorities will be remembered for generations to come. The legacy he leaves behind is one of a greater respect for all people, greater opportunity for all people and greater hope for the world.

Our thoughts and prayers are with his loved ones left behind, and his memory will forever be with us.

IN SUPPORT OF THE PLEDGE OF ALLEGIANCE

Mr. ALEXANDER. Mr. President, recently, I visited with Reverend Jacob Bazzel Mull and his wife, Elizabeth, in Knoxville, TN. They host the Mull Singing Convention, a popular gospel radio program.

Reverend Mull is a legend with an interesting story to tell. He was born in 1914 in Burke County, NC, into a musical family. When he was 11 months old, he lost his eyesight after falling into an open-pit fireplace. As a child, he played in a gospel group made up of his mother, father, brothers and sisters.

He began preaching in 1939 and hasn't stopped since. In 1942, he moved to Knoxville to start his first radio program, and the rest is history. He became well-known nationwide during the 25 years he sold Chuck Wagon Gang Records on several 50,000-watt radio stations.

This year, all of his many accomplishments were recognized when he was honored by the Gospel Music Association for his "outstanding contributions to gospel music."

During our visit in April, Reverend Mull gave me 2,000 letters and a number of petitions with thousands of names on them from Americans angry over the Ninth Circuit's decision declaring the Pledge of Allegiance unconstitutional. Reverend Mull solicited these letters from his listeners across the country, and I was delighted to see the passion people across America have for the Pledge. It made me proud to answer all of those letters.

It is inspiring to me that every day Reverend Mull brings out the best in America. He challenges us to think, and he encourages us to be involved in issues. He also reminds us to turn to our religious faith for guidance. I ran for the U.S. Senate because I wanted to find out how to bring out the best in people in Tennessee and across this country, all day, every day.

I believe the answer to how we do that lies with the people. In August of 2002, I spent the night with Jim Coley, a Tennessee Government high school teacher, and his family. One idea that came out of that visit was the importance of putting the teaching of American history and civics back into our classrooms. From that discussion, we came up with the framework for the American History and Civics Act of 2003 that just passed the Senate.

The bill establishes summer residential academies for teachers and students to encourage the teaching and learning of American history and civics in a more inspired way than is happening today. We can't expect our students to learn what it means to be an American if we don't teach them.

I would also like to see students in every classroom across this Nation beginning each schoolday with the Pledge of Allegiance. That could be followed with a student or teacher explaining in his or her own words what it means to them to be an American.

After the terrorist attacks of September 11, 2001, we saw how quickly we Americans could come together as one people, united in purpose, despite our diverse backgrounds. Although we are almost 2 years removed from that time, there is no reason this sense of unity and purpose cannot continue as part of our lives every day. Americans have a reputation for being resourceful, resilient, and having common sense. These are good qualities for helping to bring out the best in the entire Nation.

I thank Reverend Mull for his commitment to this country, for inviting me to visit with him, and for sharing American's outpouring of support in favor of the basic values and principles on which this Nation was founded. I also appreciate the opportunity to bring Reverend Mull's good work to the attention of our country.

WELCOME BACK TO ALASKA, MR. CONSUL GENERAL

Ms. MURKOWSKI. Mr. President, next week the people of Alaska will welcome Mr. Yossi Amrani, the Consul General of the State of Israel for the Pacific Northwest, back to our State. He will begin his trip in Fairbanks, meeting with students and members of the community at the University of Alaska, visiting with members of Congregation Or Hatzafon, which has the northernmost synagogue building in the world, and speaking to the Greater Fairbanks Chamber of Commerce. He will also visit Anchorage on this trip and I look forward to meeting with him then.

This is not Mr. Amrani's first visit to my State, but it is his first visit to Fairbanks, the "Golden Heart City." Although the Fairbanks Jewish community is small in numbers, the fundamental Jewish values of tikkun olam, making the world a better place; tzedakah, charity; and chesed, kindness, are deeply ingrained in the Fairbanks culture, as they are in the culture of Alaska as a whole.

Like the Fairbanks Jewish community, the Alaska Jewish community is small in numbers, but large in spirit. In the late 1990s, Professor Bernard Reisman from Brandeis University visited Alaska on several occasions to learn more about our Jewish community. He concluded that in virtually all areas, the Alaska Jewish community has a higher level of identity than do American Jews generally. He found this to be true not only in places like Anchorage, Fairbanks and Juneau, which have functioning congregations, but also in the smaller communities, where "conveners" organize regular get togethers, especially on Jewish holidays.

Members of the Jewish community occupy a prominent role in the social, economic, cultural and political life of Alaska. A few weeks ago, I welcomed the internationally known holocaust scholar, Dr. Michael Schuldiner of the University of Alaska Fairbanks, to my office in Washington. Dr. Schuldiner discussed his work with the United States Holocaust Memorial. Another UAF scholar, Dr. Michael Krauss, has worked closely with the Alaska congressional delegation for many years in efforts to preserve Alaska Native languages. And let us not forget the many contributions of the Gottstein family to virtually every aspect of Alaska's fabric.

This is not a new phenomenon. The beautiful municipal library in Anchorage is named for Zachary J. Loussac, a Russian Jewish immigrant, who served as Mayor of Anchorage. The Girl Scout camp in Fairbanks is named for Jessie Bloom, who along with her husband Robert, are regarded as the founding leaders of the Fairbanks Jewish community. In 1926, Jessie started the first Girl Scout troop in Alaska, while Robert was a founder of what was later to become the University of Alaska. Our striking new courthouse in Fairbanks is named for Jay Rabinowitz who served for many years on the Alaska Supreme Court.

The survival of the State of Israel is important to the people of Alaska as it is to the American Jewish community and the American people. In Washington, I stand shoulder to shoulder with my colleagues in praying for peace in the Middle East while standing firm on the principle that terrorism is morally and politically unacceptable. Terrorism will not undo Israel's future. When the Senate returns in July, it will consider comprehensive energy legislation and I am hopeful that my amendment to guarantee that Israel will have a secure source of petroleum in the event it cannot independently acquire it due to an embargo will be in the bill when it passes the Senate.

During this visit to Alaska, as on previous visits, the Consul General will encounter the vast natural beauty of our state. But he will also discover, as in previous visits, that it is the people of Alaska that make this place truly special. Shalom, Mr. Consul General. I hope that you will visit with Alaskans often.

Mr. President, I ask unanimous consent that the message of Consul General Yossi Amrani be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MESSAGE OF CONSUL GENERAL YOSSI AMRANI TO THE PEOPLE OF ALASKA

The friendship and alliance between the United States and Israel have many varied faces, moral, political, economic and strategic. The partnership is on the federal and state level alike. Israeli consulates in the country, local Jewish communities together with state level administrations aim at fostering and nurturing the relationship for the benefit of both countries. In the state of Alaska, thousands of miles apart, the Consulate General of Israel to the Pacific Northwest Region works with state leaders and the Jewish community to bring the two nations together in sharing the values, ideals and concerns of both people. The Consulate provides seminars and speaking engagements in different campuses, churches and temples to educate public opinion on the complexity of the situation in the Middle East and the importance of the U.S. role in that region. The Consulate also promotes Israeli culture and business opportunities. Mutual values are the corner stones of the relationship and affinity between the people of Alaska and Israel. As we maintain U.S. support for Israel's existence and well being, we aspire to continue building stronger relations.

HONORING THE LATE DAVID BRINKLEY

Mrs. DOLE. Mr. President, I am honored today to talk about a pioneer for North Carolina in the field of journalism . . . the late David Brinkley. David died on June 12, at the age of 82, from complications resulting from a fall. He was laid to rest in his beloved home, Wilmington, North Carolina . . . beside his father—William Graham Brinkley and mother—Mary MacDonald West Brinkley.

David was born in Wilmington . . . He attended high school at New Hanover High School. While there . . . and after several long hours pouring over books in the Wilmington Library . . . David got an itch for journalism.

He didn't wait. He took a part-time job while still in high school, working for the Wilmington Morning Star and its afternoon edition, the Wilmington News. He said he made about $11 a week.

But the young boy, who once made extra money by changing light bulbs and running a soft-drink stand at Wrightsville Beach's Lumina Pavillion, went on to become an icon for millions of viewers who watched him each night. He and co-anchor Chet Huntley had the highest rated news program on American television during the 1960's with "The Huntley-Brinkley Report." Many of us still remember their familiar sign-off of "Good night, Chet," "Good night, David."

David went on to host "This Week With David Brinkley," until he retired in 1996.

Mr. President, at a time when we often get news that is too short, too sensationalized and sometimes too slanted, David Brinkley was the consummate newsman. He knew the issues, and his intelligence, quick wit and thirst for answers kept us all glued to the television.

I had the pleasure of personally knowing David Brinkley, and in addition to sharing a distinctive Southern twang, we shared a fondness for our home state. David wrote about Wilmington in his 1995 memoirs and even with all this success, all his fame, David and his wife, Susan, returned to his home in North Carolina often and supported his hometown. He was an ardent supporter of downtown Wilmington preservation. The University of North Carolina at Wilmington presented him with an honorary Doctor of Letters degree in 1974. He was added to Wilmington's Walk of Fame in 2001.

As much as David loved North Carolina—North Carolina loved him, too. His life has been a model for so many North Carolinians—the local boy doing good . . . remembering his roots.

We will forever be indebted to David Brinkley for solid Washington reporting and his wry sense of humor. The Senate passed a resolution, which I cosponsored, honoring the life and accomplishments of David Brinkley. May his legacy live on and inspire those who follow in his footsteps.

In an interview 11 years ago, David said this of his profession, "People go and find out what is happening, and then tell what they have seen. That's all a reporter ever did. I think it's a very honorable thing to do."

Indeed, it is, David, indeed, it is.

Mr. President, I send out my heartfelt condolences—and those of all North Carolinians—to Susan and to David Brinkley's family.

ADDITIONAL STATEMENTS

WIND RIVER INDIAN RESERVATION'S 140TH ANNIVERSARY

• Mr. THOMAS. Mr. President, I rise today to recognize the 140th Anniversary of the Wind River Reservation.

On July 2, 1863, the U.S. Government and the Shoshone people signed the Fort Bridger Treaty, creating the Shoshone Reservation, which included over 44 million acres in what is now Colorado, Utah, Idaho, and Wyoming. This area was reduced to roughly 3 million acres by the second Fort Bridger Treaty of July 3, 1868, and was later renamed the Wind River Reservation during the 1930s. Today, the reservation is roughly more than 2 million acres, one of the largest in the country, and is located in central Wyoming's beautiful Wind River Basin. It remains the contemporary home of the Eastern Shoshone and Northern Arapaho tribes.

Chief Washakie, a distinguished statesman of the Shoshone people, was one of the few Indian leaders to successfully negotiate with the U.S. Government in determining the reservation's location. For centuries, American Indians who traveled through this area referred to it the Warm Valley of the Wind River because of surrounding hot springs. Renowned for his courage on the battlefield, and talent in diplomacy, the people of Wyoming selected Chief Washakie to represent our State, in the U.S. Capitol Building, as one of our two contributions to Statuary Hall.

The northern band of Arapahos began to make the Wind River Reservation a more permanent home during the last 1870s, though they were not signatories to either of the Fort Bridger Treaties. Under the leadership of men such as Black Coal, Sharp Nose, Little Wolf and White Horse, the Northern Arapahos settled in Wyoming, while the southern band of Arapahos was moved to a reservation in western Oklahoma. Wind River country encompasses mountains, streams, lakes and forests, and was favored by the Northern Arapaho over the hot and arid Oklahoma landscape.

The Wind River Indian Reservation is one of Wyoming's great historical, cultural, and natural treasures. A grave site for Sacajawea, the young Shoshone woman who helped guide the Lewis and Clark expedition through Shoshone lands in the early 1800s, can be visited on the reservation. Both tribes continue to host several powwows during the spring and summer months that draw visitors and members of tribes from across the country. Later this week, the Eastern Shoshone will be celebrating the Treaty Days Powwow.

As we look back on the past 140 years, I would like to pay tribute to the important contribution American Indians have made to our history and our culture. Throughout my time in Congress, I have had the pleasure to work with tribal leaders from both tribes on the Wind River Reservation. I would like to thank Vernon Hill, chairman of the Eastern Shoshone Business Council and Burton Hutchinson, Sr., chairman of the Northern Arapaho Business Council, for their leadership as we work to ensure the prosperity of the Wind River Reservation for future generations.●

A GREAT MONTANAN—ANTHONY J. PREITE

● Mr. BAUCUS. Mr. President, I rise today in celebration of a great Montanan and American, Anthony J. Preite.

Today, Mr. Preite, the director of the Denver Regional Office of the U.S. Department of Commerce Economic Development Administration is retiring. I have known Tony Preite for about 30 years. He was raised on Montana's "High Line" in Havre, MT. After a short time as a high school teacher and coach, he was lured by the Bear Paw Development Corporation, an EDA designated economic development district, to come to work for them in 1968. A year later, he became the executive director of that fledgling organization and thus began a career in economic development that is virtually unparalleled today. Under Tony's leadership, Bear Paw Development Corporation quickly developed a reputation as one of this Nation's premiere economic development organizations. Tony spearheaded literally hundreds of economic and community development projects and programs in that part of northern Montana. These projects resulted in hundreds of jobs, scores of infrastructure improvements, and other activities that have improved the lives of people in that area. Among his other accomplishments at Bear Paw, he was a founding member of the Montana Economic Developer's Association, served on the Montana Private Industry Council, and was chairman of the Governor's Economic Development Council.

Tony's work at Bear Paw Development Corporation was so successful that I felt the need to bring the benefit of his expertise and enthusiasm to more Montanans. That is why, in 1993, I recommended his appointment by President Clinton as State Director of the Montana Farmers Home administration. Through a reorganization at the U.S. Department of Agriculture, Tony led a successful transformation of the Farmers Home Administration Agency to the current Rural Development agency. While at the U.S. Department of Agriculture, Tony served on many national committees within the rural Development Agency, helping to guide the agency during its formative years. The success of the Rural Development Agency and the value of its programs today are largely due to the efforts that Tony made during his tenure there.

In December 1999, Tony accepted the position as Regional Director for the economic Development Administration. In this position, Tony has continued to impart his expertise and enthusiasm to a 10 State region. In his professional life, Tony has received accolades and awards too numerous to mention here. Instead, let me say that I have not met anyone as dedicated to public service as Tony Preite. Tony does not leave his work at the office. He lives and breathes "public service" every day, all day. It's immediately apparent to anyone who meets him that he always cares about the people he serves. His works has made an enormous difference for Montana and for all of us who work and play there.

While Tony's retirement is a sad occasion to all of us who work with him, it is well deserved. I can take comfort that he will be returning to Montana and that he will find some other way to continue to serve his State. I wish Tony and his wife Betty all the best and I thank him for more than 35 years of public service. Good luck, Tony, and welcome back to Montana!●

AL BRAIMAN: DEPAUL UNIVERSITY CLASS OF 2003

● Mr. DURBIN. Mr. President, I rise today to honor Al Braiman, graduate of DePaul University's Class of 2003. Al was the oldest graduate of DePaul's Class of 2003 when he graduated on June 14. Al completed a degree in liberal arts at DePaul's College of New Learning with a grade point average of 3.92 out of a possible 4.0.

Born in Kiev, Russia, in 1920, Al immigrated to the United States at the age of one. His family took up residency in Chicago, where he lived most of his life. After high school, Al turned down an academic scholarship for college to support his family. Al joined the Army and served with distinction in World War II, spending most of his time on Guadalcanal.

After leaving the Army, Al owned and operated Lakeview Grocerland until the mid 1960s when he became an insurance salesman with Equitable Life Insurance Company. He became a certified life underwriter and chartered financial consultant. Al won many awards in the industry, including induction into the Equitable Hall of Fame.

After retiring in 1985, Al decided to earn a college degree, something he promised his mother earlier in his life. Al's interest in politics led him to take many political science and history courses at DePaul University. Some of his favorites included a class on American presidents and a course on race relations. He also enjoyed learning many new things such as use of the Internet, photography, and art. Al has proven that it is never too late to learn and we could all learn a great deal from his perseverance.

I know my fellow Senators will join me in congratulating Al Braiman, DePaul Class of 2003. His story contains all the elements of a great American life and I am honored to share it with my colleagues in the Senate.●

HONORING SUPERINTENDENT GERALD WAYNE COBB, ED.D

● Ms. LANDRIEU. Mr. President, every session in Congress we spend a large amount of time discussing education in this country. Debates range from accountability to school construction to teacher recruitment. While our discussions are of the utmost importance, it is the implementation of our decisions by the individuals within the education system that changes how our children learn. Today I rise to honor a man who had dedicated his life to improving education for children in Louisiana, Dr. Gerald Wayne Cobb.

In 1960, Dr. Cobb received his bachelor's degree in health and physical education from Louisiana Tech University. Since that time he has been a crucial part of school improvements within the Lincoln Parish School System. Dr. Cobb has served as principal of Hillcrest Elementary School, Simsboro High School, and Ruston High School. He has worked as visiting associate professor at Louisiana State University and Louisiana Tech University.

Dr. Cobb has also served in the Louisiana Department of Education, working as the director of secondary education, the executive director of academic programs, and the executive assistant to the superintendent. While with the Louisiana Department of Education, Dr. Cobb was instrumental in developing the Compensatory Education Program in Louisiana which provided remediation for students not meeting the passing scores on the State's Basic Skills Testing Program. Dr. Cobb also revised Bulletin 741, which is the Louisiana Handbook for School Administration and served as the basis for the State's accreditation program. Dr. Cobb worked to increase in-service training for principals by coauthoring the Louisiana Academy for School Administrators Program and representing Louisiana at the Leadership Training for Principals.

After working with the Department of Education and serving as principal for schools throughout Lincoln Parish, Dr. Cobb continued his public service in the area of education by serving as superintendent for the Lincoln Parish School System. For the past 15 years, Dr. Cobb has immensely helped the 14 schools and 6,865 students in the Lincoln Parish School System. During his tenure, Dr. Cobb helped to construct the Lincoln Parish Secondary Alternative School at no cost to local taxpayers. He saw the students in Lincoln Parish receive the highest ACT scores throughout the State in 1996. In 2000, Ruston High School graduated seven National Merit Finalists, the most of any public, nonmagnet high school in the State. Dr. Cobb helped to expand the preschool program, implement the Even Start Program, construct a Parental Involvement Center, initiate the Career Options Program, wire all schools with the Internet, and implement 4x4 block scheduling in high schools.

The gifts that Dr. Cobb has given the Lincoln Parish School System and all of Louisiana go far beyond those that I have named above. Dr. Cobb has spent the past 43 years giving his kindness, his leadership, his vision, his service. It is to educators like Dr. Cobb that we owe many of the successes of our education policy. My best wishes are with Dr. Cobb and his family as he enters retirement.•

HONORING LOUIS AND LuJUANNA CARNEY

• Mr. CRAPO. Mr. President, I rise today to congratulate my good friend, Louis Carney and his wife LuJuanna. Just last week, the Carneys, who live near my family's home in Idaho Falls, celebrated their 50th wedding anniversary. I am honored to know them and pleased that I was asked to join the celebration.

I can think of no better way to commemorate their 50 years together than to mention that they are the proud parents of eight children, six who are still with us—Don, Nancy, Bob, Terry, Kevin, and Kenneth; and two who have rejoined their Heavenly Father—Laurie Ann and Jean Marie; the even prouder grandparents of fifteen; and the great grandparents of one. It speaks very highly of their commitment to each other and their family that so many of their family members were on hand to mark the occasion. Louis has been a very good friend to me over the years, and I appreciate his wisdom and guidance on many matters. He has been a strong supporter of the Boy Scouts of America program, and I share his enthusiasm for this program which can be so important in helping young men to learn new skills and achieve goals.

Louis and LuJuanna have been important members of our community. They are always available for those who are in need. They radiate happiness and contentment, and can be counted on by not only their friends, but so many others. I am proud to mark their anniversary, and even more pleased to call them friends.•

TRIBUTE TO GARY R. COOPER

• Mr. GREGG. Mr. President, I rise today to recognize and commend Gary R. Cooper upon his retirement after serving for 20 years as Executive Director of SEARCH, the National Consortium for Justice Information and Statistics.

SEARCH is a national organization dedicated to enhancing the use of information and identification technology in law enforcement. SEARCH provides invaluable no-cost technical assistance, training and support to criminal justice agencies all over the country. The organization's members are Governors appointees from each State and their common goal is to ensure that the criminal justice community has access to services that will allow them to use the best technology for communications, information sharing, and criminal identification. SEARCH has been a tremendous asset to our Nation's law enforcement and this is due in no small part to the work of Gary Cooper.

Under Gary's leadership over the past 20 years, SEARCH has truly become a leader in encouraging States to participate in national information and identification technology programs. For instance, under Gary's leadership, SEARCH made a profound contribution to the States' effective participation in the Interstate Identification Index and the National Fingerprint File, and the National Crime Information Center 2000 (NCIC 2000) program.

Through SEARCH, Gary has also helped to implement policies on the national level. While Gary has headed SEARCH, it has made a profound contribution to the development and implementation of the National Criminal Background Check System. SEARCH also played a pivotal role in the development and enactment of the Crime Identification Technology Act which today creates the legal and funding platform for the Federal /State criminal justice technology partnership. Because of Gary, SEARCH was, and is, the primary State voice in support of the successful and ongoing national adoption of the Interstate Identification Index and Privacy Compact and the development of the Compact Council.

At every important moment in the past 20-year history of criminal justice information and identification technology, Gary Cooper has been a courageous leader, an untiring champion and an insightful and influential national voice.

On the occasion of his retirement, I thank Gary R. Cooper for all that he has accomplished on behalf of criminal justice in the United States.•

HONORING HUGH BRADY

• Mr. CRAPO. Mr. President, I rise today to congratulate Mr. Hugh Brady of Boise, Idaho who will be inducted into the Idaho High School Activities Hall of Fame on August 6th, 2003. In 1954 Mr. Brady started working at Idaho Sporting Goods, and he has been dedicated to helping young people in Idaho participate in athletics ever since. Mr. Brady, who later became the owner of the sporting goods store, has sponsored Little League baseball teams, football teams, basketball teams, soccer teams, softball teams, and bowling teams. He also took the time to coach many teams over the years.

Mr. Brady has demonstrated extraordinary support for athletics and the youth of Idaho. There have been numerous instances when a student could not afford the cost of equipment to participate in a sport and Mr. Brady made sure that they got it. Mr. Brady, you make Idaho proud!

For the past 4 years, Mr. Brady has battled lung cancer. My wife, Susan, and I along with many Idahoans will keep him in our thoughts and prayers.•

HONORING VICTIMS OF GUN VIOLENCE

• Mr. LEVIN. Mr. President, earlier this week, more than 35 dedicated cyclists with People Pedaling Peace made the 200-mile trip from Hampton, VA, to Washington, DC, to honor and remember victims of gun violence. In partnership with the Alliance for Justice, the People Pedaling Peace cyclists rode not only in honor of the victims of gun violence, but for stronger, more sensible gun safety laws in America and to raise awareness of violence against children in this country.

Pedaling for Peace was started in 2001 by Sandra and Mike McSweeney whose daughter, Stephanie, was killed while walking out of a roller rink in Hampton, VA. Mr. and Mrs. McSweeny, as well as several other individuals affected by gun violence and violence against children made the journey this year. Others who made the trip include Craig Scott, whose sister Rachel is a Columbine survivor; Amber Hensley, a student at Thurston High School in Eugene, OR, who witnessed the shootings; and Lorraine Reed, mother of two daughters, one of whom was murdered and one of whom was seriously assaulted. Unfortunately, the total number of people like them who have lost family and friends to gun violence continues to grow.

According to the Centers for Disease Control and Prevention, the total number of gun deaths in the United States has been dropping since 1993, when it peaked at nearly 40,000, to around 28,000 annually 1999 through 2001. However, guns still kill more young people in America than the most common diseases of our time. Thousands more children are injured, lose a loved one, or live in fear of gun violence.

I hope my colleagues will join me in commending all of the cyclists who pedaled for peace, and join me in supporting sensible gun safety legislation.•

DELBERT L. LATTA POST OFFICE BUILDING

• Mr. VOINOVICH. Mr. President, I rise today on behalf of a bill considered by the Senate, H.R. 985, to designate a post office in Bowling Green, OH, as the Delbert L. Latta Post Office Building. I strongly support this bill honoring a long-time member of the Ohio congressional delegation. Naming this post office after Del Latta is a fitting way to honor him. The building that houses this post office also served as a district office for Mr. Latta during his 30 years of service in Congress.

Delbert Latta is a native and lifelong resident of Ohio. Born in the small northwestern town of Weston, OH, Mr. Latta attended Findlay College and Ohio Northern University Law School.

Mr. Latta began his service to our Nation as a member of the Ohio National Guard. During World War II, Mr. Latta served with the U.S. Marine Corps Reserves.

After his military service, Mr. Latta practiced law in Bowling Green, but in 1953, he again answered the call to public service by running for the State legislature. Mr. Latta was elected to the Ohio State Senate. After serving three terms, Mr. Latta was elected by the people of Ohio's fifth congressional district to the U.S. House of Representatives. During his long and distinguished career in Congress, Mr. Latta fought hard against wasteful government spending and to balance the Federal budget, a passion that I share.

During his 30 years in Congress, Mr. Latta earned prominent committee assignments in the House, including serving as the ranking member of the Budget Committee, and as a member of the powerful Rules Committee, and the Agriculture Committee.

Naming this post office the Delbert L. Latta Post Office Building is a wonderful tribute to a man who served Ohio and our Nation with distinction throughout his life.

I thank my colleagues for their consideration of this matter.•

TRIBUTE TO ARTHUR G. STEPHENSON

• Mr. SHELBY. Mr. President, I rise today to recognize the outstanding accomplishments and distinguished career of Mr. Arthur G. Stephenson upon his retirement as the Director of the NASA Marshall Space Flight Center. It has been a privilege for me to get to know Art. While retirement announcements are things that we do not like to hear when it involves someone who has been as vital to the success of an organization as Art has been to Marshall's, I would like to say how much I have enjoyed working with Art and his staff during his tenure as the Director of the Marshall Space Flight Center.

As the Director of one of NASA's largest field installations, with more than 6,500 civil service and contract employees and an annual budget in excess of $2 billion, Art successfully managed a very broad range of activities for the U.S. space program. Some of these critical NASA initiatives included development of new reusable launch vehicles, space shuttle propulsion, advanced space transportation systems, second and third generation propulsion technology development programs, research in microgravity, and science payload operations aboard the International Space Station. He also oversaw the establishment of the National Space Science Technology Center, a partnership with universities and Federal agencies to conduct cutting-edge research. Art also oversaw the planning and establishment of the Propulsion Research Laboratory, a world-class laboratory for research into future space transportation and propulsion technology. Art has led the Marshall Center in numerous successful space shuttle launches in which Marshall was responsible for all propulsion elements. Under Art's direction, the Marshall Center has completed testing of the truss and pressurized modules for the International Space Station, and provided support for the construction and operation of the International Space Station, including Marshall's Payload Operations Center which controls all the science experiments aboard the space station.

Art brought more than 35 years of experience in the space industry to NASA and used it to the great benefit of the Marshall Center and the U.S. space program. I could list many additional achievements and professional accomplishments, and I believe that success is directly attributable to Art's record as an extraordinary leader throughout his career.

Art has been an important and respected member of the Huntsville community. I know that I speak for many people in Huntsville and everyone in the NASA family when I say that we all thank Art for his tireless commitment to NASA and to Marshall. We sincerely hope that he and his family will remain part of the Huntsville community for many years to come.•

ARTHUR LEVITT, JR.

• Mr. SARBANES. Mr. President, earlier this month the Franklin D. Roosevelt Distinguished Public Service Award was presented to Arthur Levitt, Jr., the widely respected former chairman of the Securities and Exchange Commission. The award is made annually by the Franklin D. and Eleanor Roosevelt Institute, on whose board I am privileged to serve.

The speaker at the presentation was Conrad Black, now Lord Black, chairman of the Telegraph Group, Limited. Lord Black is active in numerous nonprofit boards, foundations and councils.

In his remarks Lord Black spoke vividly and in detail about Depression-era America, and the "bold experimentation," as he put it, of the New Deal years.

I ask unanimous consent that the text of Lord Black's remarks be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ADDRESS OF LORD BLACK AT FRANKLIN DELANO ROOSEVELT DISTINGUISHED PUBLIC SERVICE AWARD DINNER

On election night, 1932, unemployment stood at approximately 30%. There was minimal direct government relief for the 14 million or so unemployed. Their condition was alleviated by private sector charity, and by theft and begging.

The Soviet Union advertised in the United States for 6,000 skilled workers to go to Russia in 1932 for a period of several years; its

New York office was swamped with 100,000 applications. The natives of West Africa sent New York City $3.77 to help with relief for the poor. When the city of Birmingham, Alabama, advertised for 750 ditch-diggers to work ten-hour days for $2 per day, 12,000 applications arrived in two days.

In the coal-mining regions of Kentucky and West Virginia, over 90% of children were suffering from malnutrition. The country had suffered a general deflation of more than 20%. Millions of Americans faced the distinct possibility of death by starvation or exposure to the elements. Large numbers of people lived from the scraps and leftovers thrown out in the garbage by restaurants and hotels.

The volume of cheque transactions and of stock market transactions in the United States had declined by 60% since 1929. The amount of new capital financing had declined by over 95% since 1929. The volume of new building contracts had declined by 75%. By inauguration day in March 1933, the Dow-Jones Industrial Average was down by 90% from its high in September, 1929.

BANK FAILURES

There had been 5,000 bank failures in three years, wiping out nine million individual bank accounts. Steel production was under 20% of capacity, and United States Steel Corporation, which had had 225,000 full-time employees in 1929, now had no full-time employees, apart from those in the executive offices.

Total non-agricultural production was less than half of its 1929 level. Manufacturing income had shrunk by 65%. Agricultural production, while approximately equal in physical volume to that of 1929, had shrunk in farm income from $12 billion to slightly over $5 billion.

About 45% of the residential homes in America had been or were in danger of being foreclosed by mortgage-holders. Through the first six months of 1933, 250,000 homes were foreclosed, well over a thousand per day, the families pitched out into the streets. The money supply, deflation-adjusted, had declined by 25% in four years.

Many local and state governments, including Chicago and Georgia, could not pay their schoolteachers. Georgia closed over a thousand schools attended by 170,000 students. Most rural Alabama white schools were closed through the early months of 1933.

On the day before inauguration day, 32 states had closed all their banks indefinitely. Six other states had closed almost all their banks. In the other ten states and in the District of Columbia, withdrawals were limited to 5% of deposits and in Texas to $10 per day. The U.S. financial system had reached the last extremity before it would collapse completely, taking the life's savings of tens of millions of people and what was left of the international economic system with it.

American literature achieved a virtual golden age with writers such as John Steinbeck, Erskine Caldwell, Edmund Wilson, and John Dos Passos describing depression conditions.

FRANKLIN D. ROOSEVELT'S FIRST INAUGURAL ADDRESS

Over 400,000 people came out to hear Franklin D. Roosevelt's famous first inaugural address; they covered 40 acres of lawns adjacent to the Capitol. For the first time since the Civil War, soldiers in full combat gear and machine gun emplacements surrounded by sand-bags were visibly guarding the main public buildings of Washington.

Roosevelt promised bold experimentation. In the Hundred Days of the spring of 1933, the Roosevelt administration reorganized and reopened the banks and guaranteed their deposits, a great monetary step as bank deposits now joined most definitions of the money supply.

The legislation of the Hundred Days incentivized price and wage increases, reduced the working week, cut government salaries, increased some marginal taxes, tolerated a degree of cartelism to raise prices and avoid over-production, encouraged collective bargaining, and engaged in massive workfare schemes that employed nearly half the unemployed in projects of conservation and public works. In the first year of these programs, 500,000 miles of roads and 40,000 schools, 3,500 parks and 1,000 airfields were built or upgraded. The Civilian Conservation Corps, through the 'thirties, thinned four million acres of trees, stocked one billion fish, and built 30,000 animal shelters.

Ordinary unemployment declined by four million through 1933, partly due to the reduction in the work week. Farmers voted by category to approve production cutbacks, permitting farm price increases, and some of the agricultural surplus was taken for distribution to the needy. The Tennessee Valley Authority was launched and great progress began on rural electrification, flood control, and drought control.

The Hundred Days also refinanced the nation's mortgages, effectively departed the gold standard, exchanged embassies with the Soviet Union, and repealed Prohibition.

THE SECOND NEW DEAL

The second New Deal, in 1934 and 1935, was built around Social Security and included the Labour Relations Act, the Securities and Exchange Commission, a comprehensive modernization of the Federal Reserve, and what was called, but was not really, a Wealth Tax. It outraged William Randolph Hearst and stole the thunder of Huey Long and other radicals, as it was designed to do.

After a pause, when unemployment again began to rise, Roosevelt brought in the third New Deal in 1938 with the Fair Labor Standards Act and massive public works and conservation employment schemes. These were successful and reduced unemployment in mid-1939 to about 8%, less than two points above where it stands today, if the public sector relief workers are considered to be employed people.

Thereafter, like other countries, the United States relied on rearmament and the selective service to reduce unemployment, which fell by up to 500,000 per month coming up to the 1940 election, and had almost vanished before the entry of the United States into the war in 1941.

THE GI BILL OF RIGHTS

Finally, came the GI Bill of Rights, which greatly subsidized the education, and home and farm and business ownership of veterans. In the late 'forties, nearly half the male university students of the United States were beneficiaries of that act and the barriers to advancement for working class families were largely removed.

I yield to few people in my enthusiasm for the capitalist system, but we must all remember that in 1933, capitalism in America had failed, and the political system was in danger of failing with it.

Roosevelt developed a refrain in his later elections that served him well and was unanswerable. It want: "You are, most of you, old enough to remember what things were like in 1933.

"You remember the closed banks and the breadlines and the starvation wages; the foreclosures of homes and farms, and the bankruptcies of business; the 'Hoovervilles,' and the young men and women of the Nation facing a hopeless, jobless, future; the closed factories and mines and mills; the ruined and abandoned farms; the stalled railroads and the empty docks; the blank despair of a whole Nation, and the utter impotence of the Federal Government."

The voters did remember, as people remember a horrible nightmare; but it had not been a dream; it was the United States in 1933.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 11:59 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, without amendment.

S. 858. An act to extend the Abraham Lincoln Bicentennial Commission, and for other purposes.

The message also announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1511. An act to award a congressional gold medal to Prime Minister Tony Blair.

H.R. 2474. An act to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal year 2003 and 2004.

H.J. Res. 49. A joint resolution recognizing the important service to the Nation provided by the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary.

The message further announced that the House had agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 49. Concurrent resolution expressing the sense of the Congress that the sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences.

At 6:19 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2559. An act making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

At 7:50 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 531. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP).

MEASURES REFERRED

The following bill and joint resolution were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1511. An act to award a congressional gold medal to Prime Minister Tony Blair; to the Committee on Banking, Housing, and Urban Affairs.

H.J. Res. 49. Joint resolution recognizing the important service to the Nation provided by the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary; to the Committee on Agriculture, Nutrition, and Forestry.

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 49. Concurrent resolution expressing the sense of the Congress that the sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences; to the Committee on Foreign Relations.

MEASURES PLACED ON THE CALENDAR

The following bills were read the first and second times by unanimous consent, and placed on the calendar:

H.R. 2559. An act making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

H.R. 531. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP).

MEASURES READ THE FIRST TIME

The following bill was read the first time:

S. 11. A bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2961. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Amendment to Class E Airspace: Windsor Locks, Bradley International Airport, CT" ((RIN2120–AA66)(2003–0100)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2962. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "IFR Altitudes: Miscellaneous Amendments (13)" ((RIN2120–AA63)(2003–0002)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2963. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "IFR Altitudes: Miscellaneous Amendments (60)" ((RIN2120–AA63)(2003–0003)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2964. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Airbus Model A319 131, 132, and 133; A320, 232, and 233, and A321 231 Series Airplanes; Equipped with International Aero Engines V2500 A5 Series Engines" ((RIN2120–AA64)(2003–0250)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2965. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Dassault Model Mystere-Falcon 50 Series Airplanes" ((RIN2120–AA64)(2003–0249)) received on June 19 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–2966. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Raytheon Aircraft Company Model 390 Airplanes" ((RIN2120–AA64)(2003–0248)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2967. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: CFM International CFM56 Series Turbofan Engines" ((RIN2120–AA64)(2003–0247)) received on June 19 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–2968. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Dornier Weke CmbH Model DO 27Q–6 Airplanes" ((RIN2120–AA64)(2003–0246)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2969. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Dowty Aerospace Propellers, Models R354, R375, R389, and R390 Propellers" ((RIN2120–AA64)(2003–0239)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2970. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Hartzell Propeller Inc. Model HC B3TN 5 Propellers" ((RIN2120–AA64)(2003–0238)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2971. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Hartzell Propeller Inc. Model HD E6C 3B/E13890" ((RIN2120–AA64)(2003–0237)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2972. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Bombardier Model C1 600 2C10 Series Airplanes" ((RIN2120–AA64)(2003–0236)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2973. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Raytheon Aircraft Company Model 1900D Airplanes" ((RIN2120–AA64)(2003–0235)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2974. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Bell Helicopter Textron Canada Model 427 Helicopters" ((RIN2120–AA64)(2003–0234)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2975. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Fokker Model F 28 Mark 1000, 2000, 3000, and 4000 Series Airplanes" ((RIN2120–AA64)(2003–0233)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2976. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Eurocopter France Model SA341G and SA342IJ Helicopters" ((RIN2120–AA64)(2003–0232)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2977. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Bell Helicopter Textron Canada Limited Model 427 Helicopters" ((RIN2120–AA64)(2003–0231)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2978. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Agusta SpA Model A109E Helicopters" ((RIN2120–AA64)(2003–0230)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2979. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Sikorsky Aircraft Corp Model S76A, B, and C Helicopters'' ((RIN2120–AA64)(2003–0229)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2980. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: McDonnell Douglas Model MD 90 30 Airplanes'' ((RIN2120–AA64)(2003–0228)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2981. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Bombardier Model CL 600 2B19 Series Airplanes'' ((RIN2120–AA64)(2003–0227)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2982. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: McDonnell Douglas Model 717–200 Airplanes'' ((RIN2120–AA64)(2003–0226)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2983. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Schweizer Aircraft Corporation Model 269D Helicopters'' ((RIN2120–AA64)(2003–0225)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2984. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: McDonnell Douglas Model DC 9 10, 20, 30, 40, and 50 Series Airplanes; and DC 9 81, 82, 83, 87, and MD 88 Airplanes'' ((RIN2120–AA64)(2003–0224)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2985. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Cessna Aircraft Company Models 441 and F406 Airplanes'' ((RIN2120–AA64)(2003–0223)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2986. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Rolls Royce Deutschland Ltd and Co KG Models BR700 710 A10 and BR700 710 A2 20 Turbofan Engines'' ((RIN2120–AA64)(2003–0222)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2987. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Rolls Royce Deutschland Ltd and Co KG Models BR700 710 A1 10 and BR700 710 A2 20 Turbofan Engines'' ((RIN2120–AA64)(2003–0221)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2988. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Rolls Royce Corporation 501–D Series Turboprop Engines'' ((RIN2120–AA64)(2003–0220)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2989. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Boeing Model 747–200B and 200F Series Airplanes Powered by Pratt and Whitney JT9D–70 Series Engines'' ((RIN2120–AA64)(2003–0219)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2990. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Raytheon Model DH 125, HS 125, and BH 125 Series Airplanes; Model BAe 125 Series 800A, 800A (C–29A), 800A (U–125), 800B, 1000A, and 1000B Airplanes; and Models Hawker 800, 800 (including variant U–125A), and 1000, and 8000 XP Airplanes'' ((RIN2120–AA64)(2003–0218)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2991. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled ``Airworthiness Directives: Raytheon Aircraft Company Beech Models 1900, 1900C, and 1900D Airplanes'' ((RIN2120–AA64)(2003–0217)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2992. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ``Establishment of Class E Airspace; Ridgely, MD'' ((RIN2120–AA66)(2003–0109)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2993. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ``Modification of Class D Airspace; and Modification of Class E Airspace; Topeka Philip Billard Unicipa: Airport, KS'' ((RIN2120–AA66)(2003–0108)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2994. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ``Modification of Class E Airspace; Clinton, IA'' ((RIN2120–AA66)(2003–0107)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2995. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ``Modification of Class E Airspace; Davenport, IA'' ((RIN2120–AA66)(2003–0106)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2996. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ``Modification of Class E Airspace; Independence, IA'' ((RIN2120–AA66)(2003–0105)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2997. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ``Modification of Class E Airspace; Muskegon, MI'' ((RIN2120–AA66)(2003–0104)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2998. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ``Modification of Class E Airspace; Eureka, KS'' ((RIN2120–AA66)(2003–0103)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2999. A communication from the Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ``Implementation of the Understandings Reached at the June 2002 Australia Group (AG) Meeting and the AG Intersessional Decision on Cross Flow Filtration Equipment—Chemical and Biological Weapons Controls in the Export Administration Regulations'' (RIN0694–AC70) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3000. A communication from the Secretary, Office of the General Counsel, Federal Trade Commission, transmitting, pursuant to law, the report of a rule entitled ``Privacy Act System Notice for the National Do Not Call Registry System'' received on June 24 , 2003; to the Committee on Commerce, Science, and Transportation .

EC–3001. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ``Closure of the Third Season Apportionment of Directed Fishing for Yellowfin Sole by Vessels Using Trawl Gear in the Bering Sea and Aleutian Islands Management Area (BSAI)'' received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3002. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ``Fisheries Off West Coast States and in the Western Pacific; Pacific Coast Groundfishery; Annual Specifications and Management Measures; Trip Limit Adjustments'' received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3003. A communication from the Counsel, National Institute of Standards and Technology, Department of Commerce, transmitting , pursuant to law, the report of a rule entitled ``Procedures for Implementation of the National Construction Safety Team Act'' (RIN0693–AB52) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3004. A communication from the Counsel, National Institute of Standards and Technology, Department of Commerce, transmitting , pursuant to law, the report of a rule entitled ``Procedures for Implementation of the National Construction Safety Team Act'' (RIN0693–AB52) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–3005. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ``Fisheries of the Northeastern United States; Atlantic Mackerel, Squid and Butterfish Fisheries; Framework Adjustment 3'' (RIN0648–AQ57) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC-3006. A communication from the Assistant Administrator for Fisheries, National Oceanic and Atmospheric Administration, Department of Commerce, transmitting, pursuant to law, the 1999 Annual Report regarding the administration of the Marine Mammal Protection Act of 1972; to the Committee on Commerce, Science, and Transportation.

EC-3007. A communication from the Chairman, Federal Communications Commission, transmitting, pursuant to law, a report relative to 700 MHz auctions, digital television, and mobile communications services; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. WARNER, from the Committee on Armed Services, with amendments:

S. 1025. An original bill to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes (Rept. No. 108-80).

By Mr. SPECTER, from the Committee on Appropriations, without amendment:

S. 1356. An original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes (Rept. No. 108-81).

By Mrs. HUTCHISON, from the Committee on Appropriations, without amendment:

S. 1357. An original bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes (Rept. No. 108-82).

By Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, without amendment:

S. 888. A bill to reauthorize the Museum and Library Services Act, and for other purposes (Rept. No. 108-83).

By Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, with an amendment:

S. 650. A bill to amend the Federal Food, Drug, and Cosmetic Act to authorize the Food and Drug Administration to require certain research into drugs used in pediatric patients (Rept. No. 108-84).

By Mr. LUGAR, from the Committee on Foreign Relations, without amendment and with a preamble:

S. Res. 62. A resolution calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

By Mr. LOTT, from the Committee on Rules and Administration, without amendment:

S. Res. 138. A resolution to amend rule XXII of the Standing Rules of the Senate relating to the consideration of nominations requiring the advice and consent of the Senate.

By Mr. LUGAR, from the Committee on Foreign Relations, without amendment and with an amended preamble:

S. Res. 149. A resolution expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate.

By Mr. HATCH, from the Committee on the Judiciary, without amendment and with a preamble:

S. Res. 174. A resolution designating Thursday, November 20, 2003, as "Feed America Thursday".

S. Res. 175. A resolution designating the month of October 2003, as "Family History Month".

By Mr. LOTT, from the Committee on Rules and Administration, without amendment:

S. Res. 178. A resolution to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate wing of the Capitol and Senate office buildings for personal use.

S. 148. A bill to provide for the Secretary of Homeland Security to be included in the line of Presidential succession.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. WARNER for the Committee on Armed Services.

Army nomination of Lt. Gen. John P. Abizaid.

Army nominations beginning Brigadier General George A. Alexander and ending Colonel Matthew J. Whittington, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Col. William J. Germann.

Army nomination of Col. William M. Jacobs.

Marine Corps nominations beginning Brig. Gen. John W. Bergman and ending Brig. Gen. John J. McCarthy, Jr., which nominations were received by the Senate and appeared in the Congressional Record on April 2, 2003.

Air Force nomination of Col. Thomas F. Deppe.

Navy nomination of Adm. William J. Fallon.

Air Force nomination of Maj. Gen. Michael M. Dunn.

Army nomination of Maj. Gen. Keith B. Alexander.

Marine Corps nomination of Lt. Gen. Wallace C. Gregson, Jr.

Navy nomination of Capt. Terry L. McCreary.

Navy nominations beginning Capt. Martin J. Brown and ending Capt. Michael J. Lyden, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Captain John M. Bird and ending Captain Peter J. Williams, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Air Force nomination of Gen. Robert H. Foglesong.

Air Force nomination of Maj. Gen. Daniel P. Leaf.

Air Force nomination of Brig. Gen. Joseph E. Kelley.

Air Force nomination of Brig. Gen. Douglas Burnett.

Air Force nomination of Col. Craig S. Ferguson.

Navy nomination of Vice Adm. Michael G. Mullen.

Air Force nomination of Lt. Gen. William T. Hobbins.

Air Force nomination of Maj. Gen. Randall M. Schmidt.

Air Force nomination of Maj. Gen. Walter E. L. Buchanan III.

Army nomination of Lt. Gen. Dan K. McNeill.

Army nomination of Maj. Gen. William G. Boykin.

Marine Corps nomination of Maj. Gen. Robert R. Blackman, Jr.

Mr. WARNER. Mr. President, for the Committee on Armed Services I report favorably the following nomination list which was printed in the RECORD on the date indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that this nomination lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Army nomination of Kenneth S. Azarow.

Air Force nominations beginning Rebecca G. Abraham and ending Jeffrey Yuen, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning Brian J. Acker and ending Angela D. Washington, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning Paul M. Barzler and ending Charles W. Williamson III, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nomination of James R. Burkhart.

Air Force nominations beginning Charles M. Belisle and ending Brett A. Wyrick, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Air Force nominations beginning Glenn D. Addison and ending Daniel J. Zachman, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Air Force nomination of Thomas K. Hunter, Jr.

Air Force nomination of Jeffrey J. King.

Air Force nominations beginning Jean B. Dorval and ending Gary M. Walker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Richard J. Delorenzo, Jr.

Air Force nomination of Gerald M. Schneider.

Air Force nomination of Jane B. Taylor.

Air Force nominations beginning Darrell A. Jesse and ending Norbert S. Walker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nominations beginning Thomas C. Barnett and ending Jean A. Vargo, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Edward C. Callaway.

Air Force nomination of H. Michael Tennerman.

Air Force nomination of Steven E. Ritter.

Air Force nomination of Bryan A. Keeling.

Air Force nomination of Robert L. Zabel, Jr.

Air Force nominations beginning Darryl G. Elrod, Jr. and ending Kevin R. Vanvalkenburg, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Drew Y. Johnston, Jr.

Air Force nomination of Rachel L. Beck.

Air Force nomination of Larry J. Mastin.

Air Force nominations beginning Robert L. Daugherty, Jr. and ending Charles V. Rath, Jr., which nominations were received by the Senate and appeared in the Congressional Record on June 16, 2003.

Army nominations beginning Craig M Anderson and ending Diane M Zierhoffer, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nominations beginning Anuli L Anyachebelu and ending Donald G Zugner, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nominations beginning Doreen M Agin and ending Bonnita D Wilson, which nominations were received by the Senate and appeared in the Congressional Record on January 1.

Army nominations beginning Kevin R Armstrong and ending Nancy A Vincentjohnson, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nomination of James A. Decamp.

Army nomination of Timothy H. Sughrue.

Army nominations beginning Leslie J. Mitkos, Jr. and ending Berris D. Samples, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Army nominations beginning Patricia J. Mcdaniel and ending Nicholas K. Stravelakis, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Army nomination of Scott D. Kothenbeutel.

Army nomination of Glenn T. Bessinger.

Army nominations beginning Jane M. Anderholt and ending Jay A. Whitaker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Army nominations beginning Rodney A. Armon and ending Mark W. Thackston, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Army nomination of Anthony Sullivan.

Army nomination of Bryan C. Sleigh.

Army nomination of Michael F. McDonough.

Navy nomination of Michael U. Rump.

Navy nominations beginning William A. Davies and ending Gary S. Tollerene, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Douglas W. Fenske and ending Michael J. Kautz, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Brian H. Miller and ending Perry T. Tuey, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Gerald W. Clusen and ending Mark A. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Kenneth J. Braithwaite and ending Andrew H. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Christopher M. Ballister and ending Carl M. M. Lee, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Jeffrey D. Adamson and ending Marcus K. Neeson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Danford S. K. Afong and ending Theodore A. Wyka, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Scott F. Bohnenkamp and ending Christopher L. Wall, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Charles L. Collins and ending Cynthia R. Sugimoto, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Gregory S. Adams and ending Peter A. Withers, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Bradford E. Ableson and ending Olric R. Wilkins, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Christopher A. Barnes and ending Scott M. Stanley, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Thomas M. Balestrieri and ending Robert S. Wright, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Lisa L. Arnold and ending Peggy W. Williams, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Scott W. Bailey and ending Kevin R. Wheelock, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Matthew R. Beebe and ending Steven M. Wirsching, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Evan A. Applequist and ending Richard D. Wright, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning William B. Adams and ending Daniel J. Zinder, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Rebecca E. Brenton and ending Warren C., Graham III, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Kathy A. Baran and ending Margaret A. Taylor, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Michael D. Disano and ending Vincent M. Scott, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Nancy R. Dillard and ending Christopher L. Vance, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Jean E. Benfer and ending Cynthia L. Widick, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning David L. Bailey and ending Russell L. Shaffer, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Robert W. Archer and ending Jim O. Romano, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Christopher L. Abbott and ending William A., Wright III, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Charles S. Anderson and ending Philip A. Yates, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Brian K. Antonio and ending Thomas L. Vanpetten, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Eugene M. Abler and ending Michael E. Zamesnik, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nomination of Judy L. Miller.

Navy nominations beginning Thomas W. Harrington and ending Robert L. Young, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Matthew O. Foley III and ending Frank G. Usseglio II, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Craig E. Bundy and ending Cliff P. Watkins, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning William M. Arbaugh and ending Richard E. Wolfe, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Daniel M. Bleskey and ending William E. Vaughan, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Bartley G. Cilento, Jr. and ending James L. White, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Nancy J. Bates and ending Lloyd G. Wingfield, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Annemarie Adamowicz and ending Mary A. White, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Sherry L. Breland and ending Julia D. Worcester, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Navy nominations beginning Raul D. Bantog and ending Donna M. Willoughby, which nominations were received by the Senate and appeared in the Congressional Record on June 16, 2003.

Navy nominations beginning Linsly G. M. Brown and ending Denise M. Shorey, which nominations were received by the Senate and appeared in the Congressional Record on June 18, 2003.

By Mr. LUGAR for the Committee on Foreign Relations.

*Marsha E. Barnes, of Maryland, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Suriname.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Marsha E. Barnes

Post: Paramaribo, Suriname.

Contributions, amount, date, and donee:

1. Self, none.
2. Spouse, none.
3. No children.
4. Parents deceased.
5. Grandparents deceased.
6. Brother and spouse: Malcolm Samuel John Barnes and Shirley Barnes, none.
7. No sisters.

*Robert W. Fitts, of New Hampshire, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Papua New Guinea, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to the Solomon Islands and Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Vanuatu.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Robert W. Fitts.

Post: U.S. Ambassador—Papua New Guinea.

Contributions, amount, date, and donee:

1. Self, N/A.
2. Spouse, N/A.
3. Children and spouses: none.
4. Parents: N/A.
5. Grandparents: N/A.
6. Brothers and spouses: Gary Allen Fitts, $100, 2000, Nat Goldharber (VP); James Andrew Fitts, $50, 2002, Craig Benson (NH Gov).
7. Sisters and Spouses, none.

*John E. Herbst, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Ukraine.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: John E. Herbst.

Post: Ukraine.

Contributions, amount, date, and donee:

1. Self, none.
2. Spouse, none.
3. Children and spouses: Maria Herbst, Ksenia Herbst, Aleksandra Herbst, Nicholas Herbst, John Herbst, none.
4. Parents: Christopher Herbst, deceased; Mary Herbst, deceased.
5. Grandparents: John Herbst and Sadie Herbst, deceased; Egidio Vaccheli and Irene Vaccheli, deceased.
6. Brothers and spouses: none.
7. Sisters and spouses: Christine Herbst, none; Mitchell Stern, none.

*William B. Wood, of New York, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Colombia.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: William B. Wood.

Post: Ambassador to Colombia.

Contributions, amount, date, and donee:

1. Self, none.
2. Spouse: Never married.
3. Children and spouses: No children.
4. Parents: Both deceased more than 20 years.
5. Grandparents: Deceased more than 20 years.
6. Brothers and spouses: Peter R. Wood, not married.
7. Sisters and spouses: No sisters.

*Tracey Ann Jacobson, of the District of Columbia, a Foreign Service Officer of Class One, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Turkmenistan.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee Tracey Ann Jacobson.

Post: COM, Ashgabat, Turkmenistan.

Contributions, amount, date, and donee:

1. Self, none.
2. Spouse, Lars Johansson, none.
3. Children and spouses: stepdaughter, Emmelie Johansson, none.
4. Parents: Winifred B. Thomas and John C. Thomas, none.
5. Grandparents, none.
6. Brothers and spouses, none.
7. Sisters and spouses: Teri and Terry Dermody, none.

*George A. Krol, of New Jersey, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Belarus.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: George Albert Krol.

Post: Minsk, Belarus.

Contributions, amount, date, and donee:

1. Self, none.
2. Spouse, none.
3. Children and spouses, none.
4. Parents, Anthony and Ann Krol, none.
5. Grandparents, deceased.
6. Brothers: David Krol, none; Anthony Krol, none, Alice Milrod (spouse), none.
7. Sisters, none.

*Greta N. Morris, of California, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of the Marshall Islands.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Greta N. Morris.

Post: Majuro.

Contributions, amount, date, and donee:

1. Self, none.
2. Spouse, Charles H. Morris, deceased, none.
3.Children and spouses, none.
4. Parents: Gretchen W. Nance, Kendall W. Nance, both deceased, none.
5. Grandparents: Willis and Augusta Wiesmore, James Flemming and Frances Nance, none.
6. Brothers and spouses, N/A.
7. Sisters and spouses, Ernestine D. Nance, none.

*John F. Maisto, of Pennsylvania, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee John Francis Maisto.

Post Permanent Representative of the U.S. to the Organization of American States.

Contributions, amount, date, and donee:

1. Self, John F. Maisto, none.
2. Spouse, Maria Consuelo G. Maisto, none.
3. Children and spouses: John J. Maisto and Karen Nelson, none; Maria C. Maisto and Edward Lynch, none; M. Cristina Maisto, none.
4. Parents: John Maisto, deceased; Mary P. Maisto, none.
5. Grandparents: Elpedio and Luisa Maisto, Petronilla and Luigi Tomaino, all deceased.
6. Brothers and spouses, Alberto L. and Mary Jean Maisto, none.
7. Sisters and spouses, N/A.

*Roger Francisco Noriega, of Kansas, to be an Assistant Secretary of State (Western Hemisphere Affairs).

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Roger F. Noriega.

Post: Assistant Secretary of State for Western Hemisphere Affairs.

Contributions, amount, date, and donee:

1. Self, $250, 10/10/95, Bob Dole for President.
2. Spouse, N/A.

3. Children and spouses: N/A.

4. Parents names: Richard Noriega, and Lucille Noriega, none.

5. Grandparents: all deceased, none.

6. Brothers and spouses names: James P. Noriega, and Carolos R. Noriega, both deceased.

7. Sisters and spouses names: Rita and Michael Prahm, none; Rosalie and Douglas Jackson, none; Emilie Palmer, divorced, none.

Mr. LUGAR. Mr. President, for the Committee on Foreign Relations I report favorably the following nomination lists which were printed in the RECORDS on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Foreign Service nominations beginning Ali Abdi and ending Lawrence C. Mandel, which nominations were received by the Senate and appeared in the Congressional Record on May 22, 2003.

Foreign Service nominations beginning Beth A. Salamanca and ending Peter H. Chase, which nominations were received by the Senate and appeared in the Congressional Record on June 3, 2003.

By Ms. COLLINS for the Committee on Governmental Affairs.

Fern Flanagan Saddler, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

*Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.

Judith Nan Macaluso, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

By Mr. CAMPBELL for the Committee on Indian Affairs.

*John Richard Grimes, of Massachusetts, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring May 19, 2006.

*Lisa Genevieve Nason, of Alaska, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring October 18, 2004.

*Georgianna E. Ignace, of Wisconsin, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring October 18, 2004.

*Charles W. Grim, of Oklahoma, to be Director of the Indian Health Service, Department of Health and Human Services, for a term of four years.

By Mr. HATCH for the Committee on the Judiciary.

Thomas M. Hardiman, of Pennsylvania, to be United States District Judge for the Western District of Pennsylvania.

Diane M. Stuart, of Utah, to be Director of the Violence Against Women Office, Department of Justice.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. ENSIGN (for himself, Mr. FRIST, Mr. MCCONNELL, Mr. KYL, Mr. BUNNING, Mr. ENZI, Mr. THOMAS, Mr. VOINOVICH, Mr. HAGEL, Mr. CORNYN, and Mr. INHOFE):

S. 11. A bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

By Mr. LEVIN:

S. 1338. A bill to decrease the matching funds requirement and authorize additional appropriations for Keweenaw National Historical Park in the State of Michigan; to the Committee on Energy and Natural Resources.

By Mr. BREAUX (for himself and Mr. ROBERTS):

S. 1339. A bill to amend title 5, United States Code, to provide for appropriate overtime pay for National Weather Service employees who perform essential services during severe weather events; to the Committee on Governmental Affairs.

By Mr. GRAHAM of Florida (for himself and Mr. NELSON of Florida):

S. 1340. A bill to authorize additional judgeships in the middle and southern districts of Florida, and for other purposes; to the Committee on the Judiciary.

By Mrs. HUTCHISON (for herself and Mr. CORNYN):

S. 1341. A bill to name the Department of Veterans Affairs in Houston, Texas, as the "Michael E. DeBakey Department of Veterans Affairs Medical Center"; to the Committee on Veterans' Affairs.

By Mrs. FEINSTEIN:

S. 1342. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Indian Affairs.

By Mr. EDWARDS:

S. 1343. A bill to amend title 11, United States Code, to provide for the avoidance of certain transfers, and the alternative prosecution of certain actions, relating to certain retirement benefits; to the Committee on the Judiciary.

By Mr. CORZINE (for himself, Mr. SCHUMER, Mr. AKAKA, and Mrs. BOXER):

S. 1344. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mrs. MURRAY (for herself, Mrs. BOXER, Ms. CANTWELL, Mrs. CLINTON, Mr. CORZINE, Mr. EDWARDS, Mrs. FEINSTEIN, Mr. KENNEDY, Mr. LAUTENBERG, Mr. SCHUMER, and Mr. HOLLINGS):

S. 1345. A bill to extend the authorization for the ferry boat discretionary program, and for other purposes; to the Committee on Environment and Public Works.

By Ms. CANTWELL (for herself and Ms. COLLINS):

S. 1346. A bill to amend the Workforce Investment Act of 1998 to provide for strategic sectoral skills gap assessments, strategic skills gap action plans, and strategic training capacity enhancement seed grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1347. A bill to amend the Workforce Investment Act of 1998 to provide for training service and delivery innovation projects; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1348. A bill to amend the Higher Education Act of 1965 to modify the computation of eligibility for certain Federal Pell Grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SMITH (for himself, Mr. KOHL, Mrs. BOXER, Mr. CORNYN, Mr. FEINGOLD, Mrs. HUTCHISON, Ms. MURKOWSKI, and Mr. WYDEN):

S. 1349. A bill to amend the Internal Revenue Code of 1986 with respect to the eligibility of veterans for mortgage bond financing, and for other purposes; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1350. A bill to require Federal agencies, and persons engaged in interstate commerce, in possession of electronic data containing personal information, to disclose any unauthorized acquisition of such information; to the Committee on the Judiciary .

By Mr. FRIST:

S. 1351. A bill to amend the Tennessee Valley Authority Act of 1933 to modify provisions relating to the Board of Directors of the Tennessee Valley Authority, and for other purposes; to the Committee on Environment and Public Works.

By Mr. WYDEN (for himself and Mrs. FEINSTEIN):

S. 1352. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. BROWNBACK (for himself and Mr. DEWINE):

S. 1353. A bill to establish new special immigrant categories; to the Committee on the Judiciary.

By Ms. MURKOWSKI (for herself and Mr. STEVENS):

S. 1354. A bill to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SMITH (for himself and Mr. WYDEN):

S. 1355. A bill to authorize the Bureau of Reclamation to participate in the rehabilitation of the Wallowa Lake Dam in Oregon, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SPECTER:

S. 1356. An original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mrs. HUTCHISON:

S. 1357. An original bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mr. AKAKA (for himself, Mr. GRASSLEY, Mr. LEVIN, Mr. LEAHY, and Mr. DURBIN):

S. 1358. A bill to amend chapter 23 of title 5, United States Code, to clarify the disclosure of information protected from prohibited personnel practices, require a statement in non-disclosure policies, forms, and agreements that such policies, forms, and agreements conform with certain disclosure protections, provide certain authority for the Special Counsel, and for other purposes; to the Committee on Governmental Affairs.

By Mrs. BOXER:

S. 1359. A bill to allow credit unions to provide international money transfer services and to require disclosures in connection with international money transfers from all money transmitting service providers; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. GRAHAM of Florida:

S. 1360. A bill to amend section 7105 of title 38, United States Code, to clarify the requirements for notices of disagreement for appellate review of Department of Veterans Affairs activities; to the Committee on Veterans' Affairs.

By Mr. SMITH:

S. 1361. A bill to amend the Internal Revenue Code of 1986 to provide that foreign base company shipping income shall include only income from aircraft and income from certain vessels transporting petroleum and related products; to the Committee on Finance.

By Mrs. BOXER:

S. 1362. A bill to authorize the Port Passenger Accelerated Service System (Port PASS) as a permanent program for land border inspection under the Immigration and Nationality Act, and for other purposes; to the Committee on the Judiciary.

By Mr. REID:

S. 1363. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service; to the Committee on Energy and Natural Resources.

By Ms. MURKOWSKI:

S. 1364. A bill to amend the Alaska National Interest Lands Conservation Act to authorize the payment of expenses after the death of certain Federal employees in the State of Alaska; to the Committee on Energy and Natural Resources.

By Mr. McCONNELL (for himself, Mr. KYL, and Mr. LEAHY):

S. 1365. A bill to provide increased foreign assistance for Cambodia under certain circumstances, and for other purposes; to the Committee on Foreign Relations.

By Mr. ALLARD (for himself, Mr. FEINGOLD, and Mr. CRAPO):

S. 1366. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Environment and Public Works.

By Mr. McCONNELL (for himself, Mr. BAYH, and Mr. FITZGERALD):

S. 1367. A bill to amend the Richard B. Russell National School Lunch Act to establish programs to promote increased consumption of milk in schools and to improve the nutrition and health of children; to the Committee on Agriculture, Nutrition, and Forestry.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LUGAR (for himself, Mr. SARBANES, and Mr. FEINGOLD):

S. Res. 187. A resolution expressing the sense of the Senate regarding the centenary of the Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation.

By Mr. CHAMBLISS (for himself and Mr. MILLER):

S. Res. 188. A resolution honoring Maynard Holbrook Jackson, Jr., former Mayor of the City of Atlanta, and extending the condolences of the Senate on his death.

By Mr. FRIST (for himself and Mr. DASCHLE):

S. Res. 189. A resolution electing Doctor Barry C. Black, of Baltimore, Maryland, as Chaplain of the United States Senate.

By Mr. AKAKA (for himself, Mr. INHOFE, Mr. WARNER, Mr. LEVIN, Mrs. MURRAY, Mr. DODD, Ms. LANDRIEU, Mr. PRYOR, Mr. DASCHLE, Mr. BIDEN, Mr. KENNEDY, Mr. FEINGOLD, Mr. DURBIN, Mr. NELSON of Nebraska, Mr. NELSON of Florida, Mr. REED, Mr. CHAMBLISS, Ms. CANTWELL, Mr. SARBANES, Mrs. CLINTON, Mr. ROBERTS, Mr. LAUTENBERG, Mr. LIEBERMAN, Mr. DAYTON, Ms. MURKOWSKI, Mr. INOUYE, Mr. HAGEL, Ms. COLLINS, and Mr. STEVENS):

S. Res. 190. A resolution commending General Eric Shinseki of the United States Army for his outstanding service and commitment to excellence.

By Mr. CORZINE (for himself, Mr. WARNER, Mr. LAUTENBERG, and Mrs. CLINTON):

S. Con. Res. 56. A concurrent resolution expressing the sense of the Congress that a commemorative postage stamp should be issued honoring Gunnery Sergeant John Basilone, a great American hero; to the Committee on Governmental Affairs.

By Ms. LANDRIEU:

S. Con. Res. 57. A concurrent resolution honoring Dr. Norman Christopher Francis, president of Xavier University of Louisiana, for his longstanding dedication and service specific to Xavier University and to education as a whole; to the Committee on Health, Education, Labor, and Pensions.

ADDITIONAL COSPONSORS

S. 56

At the request of Mr. JOHNSON, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 56, a bill to restore health care coverage to retired members of the uniformed services.

S. 392

At the request of Mr. REID, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 392, a bill to amend title 10, United States Code, to permit retired members of the Armed Forces who have a service-connected disability to receive both military retired pay by reason of their years of military service and disability compensation from the Department of Veterans Affairs for their disability.

S. 478

At the request of Mr. SARBANES, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 478, a bill to grant a Federal charter to Korean War Veterans Association, Incorporated, and for other purposes.

S. 491

At the request of Mr. REID, the names of the Senator from Rhode Island (Mr. CHAFEE) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 491, a bill to expand research regarding inflammatory bowel disease, and for other purposes.

S. 596

At the request of Mr. ENSIGN, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 596, a bill to amend the Internal Revenue Code of 1986 to encourage the investment of foreign earnings within the United States for productive business investments and job creation.

S. 611

At the request of Mr. CRAIG, his name was added as a cosponsor of S. 611, a bill to amend the Internal Revenue Code of 1986 to treat gold, silver, and platinum, in either coin or bar form, in the same manner as stocks and bonds for purposes of the maximum capital gains rate for individuals.

S. 623

At the request of Mr. WARNER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 623, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 640

At the request of Mr. LEAHY, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 640, a bill to amend subchapter III of chapter 83 and chapter 84 of title 5, United States Code, to include Federal prosecutors within the definition of a law enforcement officer, and for other purposes.

S. 684

At the request of Mr. SMITH, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 684, a bill to create an office within the Department of Justice to undertake certain specific steps to ensure that all American citizens harmed by terrorism overseas receive equal treatment by the United States Government regardless of the terrorists' country of origin or residence, and to ensure that all terrorists involved in such attacks are pursued, prosecuted, and punished with equal vigor, regardless of the terrorists' country of origin or residence.

S. 777

At the request of Mr. INHOFE, the name of the Senator from Montana

(Mr. BURNS) was added as a cosponsor of S. 777, a bill to amend the impact aid program under the Elementary and Secondary Education Act of 1965 to improve the delivery of payments under the program to local educational agencies.

S. 835

At the request of Ms. LANDRIEU, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 835, a bill to amend the Higher Education Act of 1965 to provide student loan borrowers with a choice of lender for loan consolidation, to provide notice regarding loan consolidation, and for other purposes.

S. 847

At the request of Mr. SMITH, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 847, a bill to amend title XIX of the Social Security Act to permit States the option to provide medicaid coverage for low income individuals infected with HIV.

S. 893

At the request of Mr. SANTORUM, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 893, a bill to amend title VII of the Civil Rights Act of 1964 to establish provisions with respect to religious accommodation in employment, and for other purposes.

S. 894

At the request of Mr. WARNER, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Hawaii (Mr. INOUYE) were added as cosponsors of S. 894, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 230th Anniversary of the United States Marine Corps, and to support construction of the Marine Corps Heritage Center.

S. 902

At the request of Ms. LANDRIEU, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 902, a bill to declare, under the authority of Congress under Article I, section 8, of the Constitution to "provide and maintain a Navy", a national policy for the naval force structure required in order to "provide for the common defense" of the United States throughout the 21st century.

S. 953

At the request of Ms. LANDRIEU, the name of the Senator from Louisiana (Mr. BREAUX) was added as a cosponsor of S. 953, a bill to amend chapter 53 of title 5, United States Code, to provide special pay for board certified Federal Employees who are employed in health science positions, and for other purposes.

S. 977

At the request of Mr. FITZGERALD, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 977, a bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage from treatment of a minor child's congenital or developmental deformity or disorder due to trauma, infection, tumor, or disease.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 982

At the request of Mr. SANTORUM, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 982, supra.

S. 985

At the request of Mr. DODD, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 985, a bill to amend the Federal Law Enforcement Pay Reform Act of 1990 to adjust the percentage differentials payable to Federal law enforcement officers in certain high-cost areas, and for other purposes.

S. 1001

At the request of Mr. BIDEN, the names of the Senator from Wisconsin (Mr. FEINGOLD) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 1001, a bill to make the protection of women and children who are affected by a complex humanitarian emergency a priority of the United States Government, and for other purposes.

S. 1046

At the request of Mr. STEVENS, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1115

At the request of Mrs. MURRAY, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1115, a bill to amend the Toxic Substances Control Act to reduce the health risks posed by asbestos-containing products.

S. 1129

At the request of Mrs. FEINSTEIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1137

At the request of Mr. LOTT, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1137, a bill to establish a Mississippi Gulf Coast National Heritage Area in the State of Mississippi, and for other purposes.

S. 1139

At the request of Mr. DEWINE, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1139, a bill to direct the National Highway Traffic Safety Administration to establish and carry out traffic safety law enforcement and compliance campaigns, and for other purposes.

S. 1196

At the request of Mrs. HUTCHISON, the name of the Senator from Nevada (Mr. ENSIGN) was added as a cosponsor of S. 1196, a bill to eliminate the marriage penalty permanently in 2003.

S. 1245

At the request of Ms. COLLINS, the names of the Senator from Nebraska (Mr. HAGEL) and the Senator from Montana (Mr. BURNS) were added as cosponsors of S. 1245, a bill to provide for homeland security grant coordination and simplification, and for other purposes.

S. 1248

At the request of Mr. GREGG, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1293

At the request of Mr. LEAHY, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 1293, a bill to criminalize the sending of predatory and abusive e-mail.

S. 1299

At the request of Ms. SNOWE, the name of the Senator from Alaska (Mr. STEVENS) was added as a cosponsor of S. 1299, a bill to amend the Trade Act of 1974 to provide trade readjustment and development enhancement for America's communities, and for other purposes.

S. 1315

At the request of Mr. CRAIG, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 1315, a bill to amend the Federal Land Policy and Management Act of 1976 to provide owners of non-Federal lands with a reliable method of receiving compensation for damages resulting from the spread of wildfire from nearby forested National Forest System lands or Bureau of Land Management lands, when those forested Federal lands are not maintained in the forest health status known as condition class 1.

S. 1317

At the request of Mr. SMITH, the name of the Senator from Vermont

(Mr. LEAHY) was added as a cosponsor of S. 1317, a bill to amend the American Servicemember's Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance.

S. 1321

At the request of Mrs. CLINTON, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 1321, a bill to authorize resources to foster a safe learning environment that supports academic achievement for all students by improving the quality of interim alternative educational settings, providing more behavioral supports in schools, and supporting whole school interventions.

S. 1323

At the request of Mr. GRASSLEY, the names of the Senator from Missouri (Mr. BOND) and the Senator from Nebraska (Mr. HAGEL) were added as cosponsors of S. 1323, a bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

S. 1324

At the request of Mr. GRASSLEY, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 1324, a bill to amend the Trade Act of 1974 to establish procedures for identifying countries that deny market access for agricultural products of the United States, and for other purposes .

S. 1325

At the request of Mr. BURNS, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 1325, a bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies.

S. 1331

At the request of Mr. CONRAD, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 1331, a bill to clarify the treatment of tax attributes under section 108 of the Internal Revenue Code of 1986 for taxpayers which file consolidated returns.

S. 1331

At the request of Mr. SANTORUM, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 1331, supra.

S. CON. RES. 25

At the request of Mr. VOINOVICH, the names of the Senator from New York (Mr. SCHUMER) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. Con. Res. 25, a concurrent resolution recognizing and honoring America's Jewish community on the occasion of its 350th anniversary, supporting the designation of an "American Jewish History Month", and for other purposes.

S. CON. RES. 40

At the request of Mrs. CLINTON, the names of the Senator from Florida (Mr. NELSON), the Senator from Illinois (Mr. DURBIN) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as "National Purple Heart Recognition Day".

S. RES. 62

At the request of Mr. ENSIGN, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. Res. 62, a resolution calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

S. RES. 153

At the request of Mrs. MURRAY, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. Res. 153, a resolution expressing the sense of the Senate that changes to athletics policies issued under title IX of the Education Amendments of 1972 would contradict the spirit of athletic equality and the intent to prohibit sex discrimination in education programs or activities receiving Federal financial assistance.

S. RES. 169

At the request of Mrs. CLINTON, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. Res. 169, a resolution expressing the sense of the Senate that the United States Postal Service should issue a postage stamp commemorating Anne Frank.

S. RES. 170

At the request of Mr. DODD, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. Res. 170, a resolution designating the years 2004 and 2005 as "Years of Foreign Language Study".

S. RES. 184

At the request of Mr. SANTORUM, his name was added as a cosponsor of S. Res. 184, a resolution calling on the Government of the People's Republic of China immediately and unconditionally to release Dr. Yang Jianli, and for other purposes.

AMENDMENT NO. 975

At the request of Mr. SCHUMER, his name was added as a cosponsor of amendment No. 975 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 975

At the request of Mr. CORZINE, his name was added as a cosponsor of amendment No. 975 proposed to S. 1, supra.

AMENDMENT NO. 979

At the request of Mr. AKAKA, the name of the Senator from Virginia (Mr. ALLEN) was added as a cosponsor of amendment No. 979 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 980

At the request of Mr. AKAKA, the name of the Senator from New Mexico (Mr. DOMENICI) was added as a cosponsor of amendment No. 980 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 989

At the request of Ms. COLLINS, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of amendment No. 989 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1004

At the request of Mr. CHAMBLISS, his name was added as a cosponsor of amendment No. 1004 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1017

At the request of Mr. ALLARD, the names of the Senator from Wisconsin (Mr. KOHL) and the Senator from Vermont (Mr. LEAHY) were added as cosponsors of amendment No. 1017 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1031

At the request of Mr. CRAPO, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of amendment No. 1031 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1033

At the request of Ms. MIKULSKI, the names of the Senator from Maryland (Mr. SARBANES), the Senator from Wisconsin (Mr. KOHL) and the Senator from California (Mrs. BOXER) were added as cosponsors of amendment No. 1033 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1040

At the request of Mr. SCHUMER, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of amendment No. 1040 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1060

At the request of Mr. ALEXANDER, his name was added as a cosponsor of amendment No. 1060 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1060

At the request of Mr. MCCAIN, his name was added as a cosponsor of amendment No. 1060 proposed to S. 1, supra.

AMENDMENT NO. 1063

At the request of Ms. COLLINS, the names of the Senator from Washington (Mrs. MURRAY), the Senator from Minnesota (Mr. COLEMAN), the Senator from California (Mrs. BOXER), the Senator from Nebraska (Mr. HAGEL), the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Wisconsin (Mr. KOHL) were added as cosponsors of amendment No. 1063 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1065

At the request of Mr. GRAHAM of Florida, his name was added as a cosponsor of amendment No. 1065 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1073

At the request of Mr. SMITH, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of amendment No. 1073 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1086

At the request of Mrs. MURRAY, her name was added as a cosponsor of amendment No. 1086 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LEVIN:

S. 1338. A bill to decrease the matching funds requirement and authorize additional appropriations for Keweenaw National Historical Park in the State of Michigan; to the Committee on Energy and Natural Resources.

Mr. LEVIN. Mr. President, I ask unanimous consent that the text of the Keweenaw National Historical Park bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1338

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FUNDING FOR KEWEENAW NATIONAL HISTORICAL PARK.

(a) MATCHING FUNDS.—Section 8(b) of Public Law 102–543 (16 U.S.C. 410yy–7(b)) is amended by striking "$4" and inserting "$1".

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 10(a) of Public Law 102–543 (16 U.S.C. 410yy–9(a)) is amended—

(1) by striking "$25,000,000" and inserting "$50,000,000"; and

(2) by striking "$3,000,000" and inserting "$25,000,000".

Mr. GRAHAM of Florida. Mr. President, I rise today to introduce legislation that will authorize additional judgeships in the Middle and Southern Federal Judicial Districts of Florida.

Additional judgeships are needed in these two districts in order to deal with a large volume of filings, heavy pending caseloads, the considerable number of senior judges, and a rapidly growing population. It is vital that we add two additional permanent and one temporary judgeship in the Middle District and four additional permanent judgeships in the Southern District of Florida.

Florida's Middle District is one of the busiest Federal district courts in the Nation. In 2001 it was ranked fifth in the Nation for the number of criminal defendants charged with fraud and drug related offenses among all district courts. It handles cases filed in three of the four largest cities in the State of Florida, Jacksonville, Orlando and Tampa, which comprise 60 percent of the State's population.

In 1999 four judges were added to the Middle District of Florida. The numbers of weighted filings and pending caseload both decreased in 2000. However, numbers quickly rose again in 2001. A biennial judgeship survey conducted in 2003 showed that in 2001 there were 553 weighted filings in this district versus the national average of 490. In addition, the United States Department of Justice has identified Central Florida as a High Intensity Drug Trafficking Enforcement Area.

The Southern and Middle Districts are parallel in some of the challenges that they face. Despite the additional judgeships that were created in the Southern District in 2001, the amount of weighted filings continues to rise. Since 1994, civil and criminal filings per judgeship have stayed above the national average, with civil filings rising by 67 percent and criminal filings increasing by 58 percent. Many of these increases in criminal filings are linked to the increase in fraud, drugs, firearms and immigration prosecutions.

The administration of justice will continue to be a challenge in Florida's Federal courts unless adequate resources are committed. It is projected that by 2015 Florida may surpass third-ranked New York in population. As the population increases, so do the number of people seeking justice from the Federal courts in our State. I ask that my colleagues join me in supporting this important legislation.

By Mrs. FEINSTEIN:

S. 1342. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Indian Affairs.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce legislation to amend the Graton Rancheria Restoration Act to give the State of California and the local communities of Sonoma, Napa, and Marin counties the opportunity for input and review of the tribe's plan for a major casino in the Bay Area.

I am offering this legislation because the Boards of Supervisors of the local communities impacted by this planned casino have asked me to amend the Graton Rancheria Restoration Act. The Boards of Supervisors of Sonoma, Marin, and Napa counties have each unanimously passed resolutions seeking a change in Federal law to restore the Secretary of Interior's discretion in approving land into trust and allowing the State and local government to have a voice in the process.

Prior to today's introduction I have met with the Presidents of the Sonoma and Marin Boards of Supervisors, the Graton tribe, and Senators CAMPBELL and INOUYE the Chairman and Ranking Member of the Indian Affairs Committee.

This week I had a very spirited and frank conversation with Graton Tribal Chairman Greg Sarris and representatives from the casino investors. During the meeting Chairman Sarris committed to work with the local Boards of Supervisors and he committed to look at alternative sites for the casino. Chairman Sarris also said the Tribe and the casino investors would conduct an environmental review based on the criteria laid out in the National Environmental Policy Act, NEPA, before a site is selected. These are positive signs and I have told both the Boards of Supervisors and the Tribe that I would like to see them continue to work together.

This legislation guarantees that the local and State officials have a voice in the process. Without this change to the Graton Rancheria Restoration Act they do not have that voice.

In 2000, Congress passed the Graton Rancheria Restoration Act to restore Federal recognition to the 355 members of the Federated Indians of the Graton Rancheria.

The Graton Tribe's original Rancheria was in the northern Sonoma County town of Graton on land purchased by the Bureau of Indian Affairs, BIA, in 1920 for the "village home" of otherwise homeless Miwok and Pomo Indians. The Rancheria was terminated in 1958 when the BIA approved a plan to distribute the assets to resident Indians and remove the Rancheria from Federal trust.

The original version of the Graton restoration bill, H.R. 946, sponsored by Congresswoman LYNN WOOLSEY in the 106th Congress, passed the House of Representatives with a gaming restriction, to which the Tribe agreed.

In testimony before the House Resources Committee in May 2000, and in other public comments, Graton Chairman Greg Sarris stated that the Tribe had no intention of conducting gaming.

In fact, before the House Resources Committee, Chairman Sarris stated, "Many may think our motives for restoration have been influenced by the opportunity gaming affords some other recognized tribes. Because our local political constituency, both democratic and republican has opposed any sort of development for environmental reasons, we agreed with these local political forces to not develop a gaming complex. So, as proof, we voted as a tribe to include a non-gaming clause in our bill, stipulating that we will not be a gaming tribe."

Furthermore, in an article in the Marin Independent Journal on September 21, 2000, Chairman Sarris said, "All we want is to be formally recognized as Indians and have the same rights that other Indians do for education and health care. We are not interested in gambling." I ask unanimous consent to print a copy of this article in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Marin Independent Journal, Sept. 21, 2000]

GAMBLING DISPUTE THREATENS MIWOK BILL

(By Gannet News Service)

WASHINGTON.—Legislation to formally re-establish the identity and standing of Marin's band of Coast Miwok Indians appears all but dead in the face of a House-Senate dispute over how tight guarantees must be that the tribe will never allow casino gambling.

"This is insane, this is frustrating, and I just can't see why we can't find a way out of this," said Greg Sarris, the tribe's chief who is an English professor at UCLA.

Rep. Lynn Woolsey, the Petaluma Democrat who authored the original bill, said she shares the frustration but sees little hope other than the fact that "down the road there will be other Congresses."

The problem is that the bill to restore the all-but-vanquished tribe, approved by the full House in June, included specific language that waived in perpetuity any right to establish gaming on the tribe's remaining one-acre ancestral plot in the Sonoma County town of Graton.

Woolsey sought that waiver in agreement with the tiny tribe. In hearings last spring and summer, she and Sarris said the tribe was happy to agree to the waiver. They were not interested in gaming, and their acreage was too small even if they were interested. Additionally, the fine print in a state-passed referendum in California to divide gaming resources among tribes prevents them from operating any kind of casino.

Adding a federal gaming ban on top of an existing state ban was an easy and harmless layer of extra insurance to reassure the community that the tribe would not be bringing high-stakes bingo to Marin.

"All we want is to be formally recognized as Indians and have the same rights that other Indians do for education and health care," said Sarris, one of some 300 descendants of the tribe that the government declared extinct in the 1950s. "We are not interested in gambling."

But when the bill reached the Senate as an identical version of the bill sponsored by Sen. Barbara Boxer, D-Calif., numerous Indian advocates and the government's Bureau of Indian Affairs objected. The surrender of sovereignty by the Miwoks, however well-intentioned, would set a precedent that could be used against other tribes in other states—in effect a means to pressure tribes on the sensitive issue of gambling.

"It's not that we don't have sympathy with what the Miwoks want to do, or in this case don't want to do. It's a question of eroding the hard-won sovereignty that is the legal basis for the gambling that has been an important resource of many tribes," said John Sanchez, an expert on Indian sovereignty at Pennsylvania State University and a member of the Apache tribe.

Boxer's spokesman, David Sandretti, said his bill was still hopeful, but the key lawmaker on the issue is Sen. Daniel Inouye of Hawaii, vice chairman of the Indian Affairs Committee and long a powerful voice on behalf of American Indians and native Hawaiians. Without his support, the bill wouldn't survive in the Senate, Sandretti said.

Inouye made it clear this week that the bill is dead unless Woolsey agreed to drop the gambling ban in her legislation.

"If you set that precedent, that creates a lot of problems," Inouye said. "I would prefer to see a measure without the waiver, and if I do I'd be likely to support it."

Inouye added that it's a meaningless, symbolic waiver to begin with, because the tribe is already prevented from opening a casino by state law. "I just don't think this is something that the federal government should be involved in," he said.

Woolsey said she has no intention of agreeing to anything that doesn't include the anti-gaming clause as written.

"I got it out of the House, and now it's in the Senate, and I guess that's just where it is," Woolsey said. "I've heard some proposals for compromise, but I haven't seen anything that would offer the level of protection against gaming that the community and the 6th Congressional District would be prepared to accept."

Gene Buvelot of Novato, vice chairman of the Federated Indians of Graton Rancheria, said his group is disappointed in Woolsey, because members believe she should allow the bill to go forward without the clause.

"We're disappointed, deeply disappointed with Woolsey because she seems to be the one who's dropped the ball on this, not Barbara Boxer," he said. "It's a shame that it's getting this far and that Woolsey is letting it bog down like this."

Coast Miwok tribal elder Joanne Campbell, a former Marin resident now living in Daly City, said she often visited her great aunt at the Miwok's Graton Rancheria in Sonoma County.

"I'm really steamed, I'm just so upset that this bill maybe will not pass," Campbell said. "I think it's a just bill and it's about time we got some recognition because we have all these other issues to deal with, Health issues, education issues, and we need this recognition to move forward."

The bill would make the tribe eligible for a wide range of U.S. and California health, education and housing grants and assistance from various federal agencies, give the tribe the right to establish a reservation and exempt the tribe from some local, state, or federal taxes and local zoning ordinances on reservation land.

If the bill is not passed by Oct. 5, when the Senate recesses, a new restoration bill would have to wait until the next Congress.

Camobell described Woolsey's refusal to drop the redundant anti-gaming clause from the Senate version as "unrelenting" and "unreasonable."

Mrs. FEINSTEIN. Senator BOXER sponsored legislation identical to Congresswoman WOOLSEY'S in the Senate, but the gaming restriction was stricken when the bill was ultimately passed as part of the Omnibus Indian Advancement Act of 2000.

The day the legislation passed on December 11, 2000, Senator BOXER stated on the Senate Floor that dropping the gaming restriction was necessary because of opposition to the no-gaming clause by the Senate Committee on Indian Affairs and the Clinton Administration and because, according to Senator BOXER, "Senator INOUYE asserts that the no-gaming clause is unnecessary because the Graton Rancheria have no intention of conducting gaming."

So what has changed one might ask? Well, even though the Gratons voluntarily and repeatedly took a no-gaming pledge while their restoration bill was under consideration by Congress, on April 23, 2003, the Tribe and its partner, Stations Casinos of Las Vegas, announced plans to purchase approximately 2,000 acres of land in Southern

Sonoma County near Sears Point for the development of a casino.

This site is located on environmentally sensative open space and San Francisco—North Bay tidelands which have been the subject of a decades-long conservation effort by environmentalists and local residents.

This site is roughly 30 miles from San Francisco—along the gateway to Sonoma that leads thousands of travelers into the beautiful wine country each day.

The Tribe's casino proposal has outraged local elected officials and residents who had sympathized with the Tribe's plight and supported their restoration on the condition that they not seek to develop a casino. The Sonoma and Marin County Boards of Supervisors have each passed unanimous resolutions objecting to the Graton casino proposal. In fact, even the Board of Supervisors of neighboring Napa has also passed a resolution against the casino proposal. I ask unanimous consent to print these resolutions and letters from the counties in the RECORD.

There being no objection, the materials were ordered to be printed in the RECORD, as follows:

MARIN COUNTY, SAN RAFAEL, CA
AND SONOMA COUNTY, SANTA
ROSE, CA.

May 29, 2003.

Senator DIANNE FEINSTEIN,
U.S. Senate,
San Francisco, CA.

DEAR SENATOR FEINSTEIN: We write this joint letter to request your assistance with an urgent matter facing Marin and Sonoma counties. As you are aware, the Graton Rancheria Tribe has announced plans to acquire lands adjacent to the San Pablo Bay National Wildlife Refuge and to construct a major casino in partnership with Stations Casinos of Las Vegas. The proposal came as a shock to us since, at the time it sought restoration in 2000, the Graton tribe represented to Congress that it would not engage in gaming. It now appears that the Secretary of the Interior believes she must take into trust any land within our counties acquired by the tribe, and that gaming will be permitted on these lands without consultation with local governments or discretionary review by the Secretary.

We ask that you sponsor legislation to require that tribal trust land acquisitions be subject to consultation with local governments and an appropriate administrative review. We ask that restored tribal land acquired for gaming be subject to the two part test that it is not detrimental to the community and is supported by the Governor. Finally, we ask that the Secretary be given discretion with respect to accepting land into trust for the benefit of the Graton tribe. County Counsel from our two counties have prepared a letter to you providing background and supporting details regarding our proposals.

We know that you share our concern about the proliferation of casinos in California, especially those which are close to metropolitan areas or have impacts on sensitive lands.

We look forward to working with you to bring about changes in the law which can advance the economic interests of tribes without harm to the local community.

Very truly yours,
ANNETTE ROSE,
President, Marin County Board of Supervisors.
PAUL KELLEY,
Chairman, Sonoma County Board of Supervisors.

RESOLUTION NO. 03-0512

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay;

Whereas, the agricultural lands along Lakeville Highway afford an invaluable agricultural and scenic resource, not only to the people of Sonoma County but to the populace of the entire Bay Area;

Whereas, such lands provide one of the Bay Area's most cherished community separators, and represent an important scenic gateway to Sonoma County;

Whereas, these bay, agriculture and wet lands have been the focus of preservation and conservation efforts by environmentalists and local communities for many years;

Whereas, based upon press reports, approximately 2,000 acres of such lands are presently in imminent danger of being withdrawn from County land use control and placed into trust for the purposes of casino development—including the potential of an extensive gaming complex, including a hotel, parking and other support services as well as possible residential development, by Station Casinos, a Las Vegas-based developer and the Federated Indians of the Graton Rancheria ("Tribe");

Whereas, the Tribe was restored in 2000 based, in part, on its promise not to engage in Indian casino gaming;

Whereas, the federal legislation restoring the Tribe contains language that could be used to circumvent the normally required environmental review and administrative regulatory process for taking land into trust by the United States government on behalf of the Tribe;

Whereas, the Tribe's gaming plans were announced in the media without any government to government consultation with affected local communities;

Whereas, the Board and Tribe have initiated communication regarding the proposed casino but details regarding the project and siting have not yet been made available;

Whereas, the proposed project could overwhelm the local infrastructure in the area in which the casino project is proposed;

Whereas, the environmental impacts of the prosed project have the potential of being are reaching and of such a magnitude that they would negatively affect a significant portion of the North Bay, including grossly aggravating existing traffic problems along State Highways 37 and 101 (as well as County roads in the project vicinity), pose severe water quality risks, and have profound negative visual impacts in the scenic area;

Whereas, when California voters approved Proposition 1A (Indian Gaming) in March of 2000 as a means of supporting the laudable goal of Indian economic development and self-sufficiency, they were not aware that such approval would allow Nevada developers to seize prized off-reservation environmental resources of intense development without regarding to locally approved general plans or any meaningful environmental review or protection;

Whereas, under the provisions of Proposition 1A and the Tribal-State Compact, local communities have been granted no effective input into the development of proposed tribal casinos that threaten their rights and the State appears to have no effective redress for significant environmental impacts these gambling casinos impose on local communities: Now, therefore, be it

Resolved, That the Sonoma County Board of supervisors, based on the information currently available, strongly opposes the creation of a gambling casino on the site proposed by the Tribe; and be it further

Resolved, That County staff is directed to enter into good faith discussions with tribal representatives for the purposes of facilitating government to government communications, exploring casino development and reviewing alternative sites, as well as minimizing and mitigating environmental impacts of any casino project; be it further

Resolved, That County staff is authorized to take all reasonably required action, including submitting comments to agencies involved in considering the trust application and casino proposal, requesting assistance from State and Federal elected representative, proposing legislation, participating in administrative proceedings, and initiating litigation to insure that any proposed gaming project in Sonoma County complies with the county General Plan and meets all federal and state environmental, public health, and public safety requirements that otherwise would apply to a non-Indian development project, and to require that any land proposed to be taken into trust goes through a thorough regulatory and environmental review process.

RESOLUTION NO. 2003-70

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly in to the Bay; and

Whereas, the Federated Indians of Graton Rancheria have announced their intention to acquire 2000 acres of land along Highway 37 and develop a casino, hotel, housing and related development on this precious natural resource; and

Whereas, the impact on traffic of a development of this magnitude will be felt throughout the North Bay, with this single development jeopardizing all traffic capacity with local jurisdictions have husbanded for purposes consistent with their respective General Plans; and

Whereas, when Congress passed the Graton Rancheria Restoration Act, the Federated Indians of Graton had pledged not to engage in gaming on any lands placed in trust by the federal government; and

Whereas, the Federated Indians of the Graton Rancheria take the position that under the provisions of the Graton Rancheria Restoration Act, and the tribal state compact, local residents have no effective input into the development of the proposed tribal casino, yet these residents nevertheless bear the resultant environmental, societal, traffic, infrastructure, public safety, and other burdens which these gambling casinos impose on their communities: Now, therefore, be it

Resolved, that the Board of Supervisors of the County of Marin calls on its elected members of the United States Senate, Dianne Feinstein and Barbara Boxer, and its elected member of the House of Representative, Lynn Woolsey, to assist the residents of Marin and the entire North Bay to preserve their environment by introducing legislation that would amend the Graton Rancheria Restoration Act and/or the Indian Gaming Regulatory Act to stop the unregulated creation of tribal lands and to subject any development of tribal lands in the newly acquired tribal lands by the Indian Gaming Regulatory Act.

RESOLUTION NO. 03-94

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay; and

Whereas, the agricultural lands along Lakeville Highway afford an invaluable agricultural and scenic resource, not only to the people of Sonoma County but also to the populace of the entire Bay Area; and

Whereas, such lands provide one of the Bay Area's most cherished community separators, enjoyed and remembered by all who traverse Highway 37; and

Whereas, these agricultural lands, bay and wetlands have been the focus of preservation and conservation efforts by environmentalists and local communities for many years; and

Whereas, such land are presently in imminent danger of intense development—including an enormous casino, a high-rise hotel, an amphitheater, a residential development, and acres of parking—by Station Casinos, a Las Vegas-based developer, and

Whereas, the impact on traffic of a development of this magnitude will be felt throughout the North Bay, with this single development jeopardizing all traffic capacity, which local jurisdictions have husbanded for purposes consistent with their respective General Plans; and

Whereas, when California voters approved Proposition 1A (Indian Gaming) in March 2000 as a means of supporting the laudable goal of Indian economic development and self-sufficiency, they had no way of knowing that such approval would allow Nevada developers to seize our most prized environmental resources for intense development in violation of all local zoning controls and health and safety ordinances; and

Whereas, under the provisions of Proposition 1A and the tribal state compact, local residents have been granted no effective input into the development of proposed tribal casinos that threaten their civil and property rights, yet these residents must nevertheless bear the resultant environmental, societal, traffic, infrastructure, public safety, and other burdens that these gambling casinos impose on their communities: Now, therefore, be it

Resolved, That the Board of Supervisors of the County of Napa strongly oppose the creation of a gambling casino along highway 37 or Lakeville Highway; and be it further

Resolved, That the Board of Supervisors of the County of Napa calls on Governor Davis, the California State Legislature, the U.S. Congress, and the U.S. Department of the Interior to take any and all steps within their powers and prerogatives to block the creation of new tribal land bases that are intended for gambling casinos and other development inconsistent with local zoning and controls and to require that all commercial development on new and existing tribal lands comply with federal, state, and local laws and regulations intended to safeguard the environment and to protect public health and safety.

Mrs. FEINSTEIN. Let me just read one part of the Resolution from Marin County which will give you an idea of the opposition to the Graton tribe's proposed casino:

RESOLVED, that the Board of Supervisors of the County of Marin calls on its elected members of the United States Senate, DIANNE FEINSTEIN and BARBARA BOXER, and its elected member of the House of Representatives, LYNN WOOLSEY, to assist the residents of Marin and the entire North Bay to preserve their environment by introducing legislation that would amend the Graton Rancheria Restoration Act and/or the Indian Gaming Regulatory Act to stop the unregulated creation of tribal lands and to subject development of tribal lands in the Marin and Sonoma Counties at a minimum to the regulatory and approval processes applicable to newly acquired tribal lands by the Indian Gaming Regulatory Act.

While the counties acknowledge that the Graton have a right to be recognized, they object to the site selected by the tribe and they especially object to language in the Restoration Act that precludes the local community, the Governor, or the Secretary of the Interior from providing input on the suitability of this location for land taken into trust for gaming purposes.

There is a problematic section of the Restoration Act that states, "Upon application by the Tribe, the Secretary shall accept into trust for the benefit of the Tribe any real property located in Marin or Sonoma County . . ." According to the Department of the Interior, this language removes any discretion by the Secretary as well as any tribal obligations for consultation with the surrounding community or environmental review, as required by the normal process under the Indian Gaming Regulatory Act for newly acquired land taken into trust for gaming purposes.

According to the Department of the Interior, the tribe must only conduct a hazardous materials review and show title to the land for land to be taken into trust. This could be completed in 9 months—and it is an inadequate review in my opinion.

Since the local communities are seeking a remedy which would restore the Secretary's discretion in approving its land trust application and allow local government to provide input in the process, I am introducing this legislation today that will change the "shall take land into trust" to "may take land into trust." This legislation will also require the two-part test that is standard under the Indian Gaming Regulatory Act of 1988 to apply so that the State and local communities have input in the process.

There is precedent for this change. In 1994, legislation was passed restoring the United Auburn Tribe with the same directive to the Secretary of the Interior, requiring that land "shall" be taken into trust for the Tribe. One of the restoration act's sponsors, Congressman JOHN DOOLITTLE sponsored an amendment to change "shall" to "may" after it had been passed, thereby affording the Secretary of Interior discretion in accepting particular parcels of land into trust and local government officials an opportunity to weigh in on the Tribe's proposed site.

The result of that change was that the Auburn Tribe and Placer County officials successfully cooperated in not only identifying a mutually agreeable site, but they signed a Memorandum of Understanding to mitigate potential impacts from the proposed Thunder Valley Casino. And earlier this month, the tribe opened its casino.

Today California is home to 109 federally recognized tribes. 61 tribes have gaming compacts with the State and there are 54 tribal casinos. With more than 50 tribes seeking Federal recognition and approximately 23 recognized tribes seeking gaming compacts from the Governor, revenues from California's tribal gaming industry are expected to surpass Nevada's by the end of the decade.

The dramatic growth in tribal gaming in California has the potential to yield much needed benefits for tribal members in terms of healthcare, education and general welfare, as Congress and California voters intended. However, the question is not whether gaming should be permitted, but rather how and where. Those questions were asked and answered in the Indian Gaming Regulatory Act of 1988, IGRA. But without the modest change made by this legislation, the Graton tribe will be allowed to develop an off-reservation casino outside the requirements established in IGRA, the first time such an exception has ever been made for a California tribe. Allowing this to happen would set a dangerous precedent not only for California, but every State where tribal gaming is permitted.

The changes we are seeking today are extremely modest. We are not reversing any restoration of the tribe. We are not infringing on Native American sovereignty. We are not even blocking the casino proposal. We are only seeking to give the State and the local communities a voice in the process. They were promised the tribe would not open a casino. That promise was broken, so the least we can do is ensure a normal review will take place.

I hope my colleagues will support this legislation and I look forward to working with the Chairman and Ranking Member of the Indian Affairs Committee to pass this legislation quickly.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1342

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. AMENDMENT TO GIVE SECRETARY DISCRETION CONCERNING LANDS TAKEN INTO TRUST.

(a) Review.—Section 1404 of the Graton Rancheria Restoration Act (25 U.S.C. 1300n–2) is amended by adding at the end the following new subsection:

"(f) Review.—No land taken into trust for the benefit of the Tribe shall be construed to satisfy the terms for an exception under section 20(b)(1)(B) of the Indian Gaming Regulatory Act (25 U.S.C. 2719(b)(1)(B)) to the prohibition on gaming on lands acquired by the Secretary in trust for the benefit of an Indian tribe after October 17, 1988, under section 20(a) of such Act (25 U.S.C. 2719(a)).".

(b) Land Into Trust.—Section 1405(a) of the Graton Rancheria Restoration Act (25 U.S.C. 1300n–3(a)) is amended by striking "shall" and inserting "may".

By Mr. CORZINE (for himself, Mr. Schumer, Mr. Akaka, and Mrs. Boxer):

S. 1344. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. CORZINE. Mr. President, today, along with my distinguished colleagues Senators Schumer, Akaka, and Boxer, I am introducing "The Money Wire Improvement and Remittance Enhancement Act" (The "Money WIRE Act"), legislation that will protect consumers who send cash remittances through international money wire transmitters by providing them with increased disclosure of the exchange rate and service fees, as well as hidden costs, for those transactions. The legislation also expands access to mainstream money wiring, check cashing, and other important services for millions of the unbanked in America, particularly immigrants, through our Nation's credit unions.

Every year, thirty million Americans send their friends and relatives $40 billion in cash remittances through wire transfers. The majority of these transfers are remittances sent to their native countries by immigrants to the United States. For these individuals, many of whom are in low-to-minimum wage jobs, sending this money only increases their own personal financial burdens—but they do so to aid their families and their loved ones.

Unfortunately, these immigrants increasingly find themselves being preyed upon by the practices of some money wire transfer providers who not only charge consumers with an upfront charge for the money wire transfer service, but also hit them on the back end with hidden costs. Many of these charges are extracted when the dollars sent by the consumer are converted to the foreign currency value that is supposed to be paid out to the friend of the family member.

This exploitation is especially pervasive in Latin American and Caribbean countries, where much of these types of transactions occur. According to the Multilateral Investment Fund and the Inter-American Development Bank, Latin American and Caribbean immigrants sent a record $32 billion to their home countries in 2002—a dramatic increase compared with $23 billion in 2001. Many of these dollars were used to pay for basic needs, such as food, medicine, and schooling, and to alleviate the suffering of loved ones during a difficult economic year.

To bring this amount into even greater perspective, the remittances that flowed into Latin America and the Caribbean last year equaled roughly the amount of direct foreign investment that flowed into the region, and exceeded the amount of development aid to Latin America from all sources. For this decade alone, Latin America and the Caribbean could receive more than $300 billion. And experts believe that number is likely to grow significantly in coming years.

These large cash flows have proven to be a powerful incentive for greed in the case of some wire transfer companies. Customers wiring money to Latin America and elsewhere in the world lose billions of dollars annually to undisclosed "currency conversion fees," and other service costs.

In fact, many large companies aggressively target immigrant communities, often advertising "low fee" or "no fee" rates for international transfers. But these misleading ads do not always clearly disclose the fees charged when the currency is exchanged.

While large wire service companies typically obtain foreign currencies at bulk rates, they charge a significant currency conversion fee to their U.S. customers. For example, customers wiring money to Mexico are charged an exchange rate that routinely varies from the benchmark by as much as 15 percent. These hidden fees create staggering profits, allowing companies to reap billions of dollars on top of the stated fees they charge for the wire transfer services.

Last year alone, immigrants who sent money to Latin America and the Caribbean paid approximately $4 billion in transaction costs to the money wire transfer companies that dominate this business. In other words, for every $100 that an immigrant sent home, to help their family and loved ones, $12 was siphoned off by these businesses in order to "service" that transaction.

That adds up to a $20-$30 average cost, occasionally it can be considerably more, for poor, hard-working folks for whom the typical remittance—around $250 to $300 a month—represents a significant percentage of their monthly income.

Multiplied by millions, these excessive charges constitute a significant major economic force. These millions could have otherwise been used to feed children, house a family, or invest in a small business—all of which markedly improve overall quality of life.

The "Money WIRE Act" would require money wire transmitting businesses to disclose to senders, and receivers, of international money wire transfers the exchange rate used in association with the transaction; any surcharges, commissions or fees charged to the customer for the service; and the exact amount of the foreign currency to be received by the recipient in the foreign country.

It also requires that that rate and fee information be prominently displayed at the wire transmitting service location and on all receipts associated with the money wire transaction—and it ensures that those disclosures occur in the same language as that principally used by the business to advertise its money transmitting services, if that language is other than English.

The bill also requires Federal banking regulators and the Department of Treasury to conduct a study, and submit a report to Congress, of the fees and fees disclosure at traditional financial institutions compared to those that occur at money transmitting businesses for money wire transactions.

Finally, the Act includes a provision that expands the "field of membership" definition for credit unions to give nonmembers, particularly unbanked and immigrant communities, access to credit unions for international money transfer, money order, and check cashing services, where the costs for these services are significantly less.

This legislation does more than merely provide better information to consumers—it actually helps them and their families financially. Consumers will see increased competition among wire transfer service providers because they are better-informed and more knowledgeable. That competition will result in lower fees for the wire transfer services that will free up a greater portion of these cash remittances to go to the friends and families that they were originally intended for.

In short, this is sound public policy that empowers those who do their part to help America's economy move forward.

I hope that my colleagues will support this legislation and I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1344

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Money Wire Improvement and Remittance Enhancement Act of 2003" (or the "Money WIRE Act of 2003").

SEC. 2. DISCLOSURE OF EXCHANGE RATES IN CONNECTION WITH INTERNATIONAL MONEY TRANSFERS.

(a) IN GENERAL.—The Electronic Fund Transfer Act (15 U.S.C. 1693 et seq.) is amended—

(1) by redesignating sections 918, 919, 920, and 921 as sections 919, 920, 921, and 922, respectively; and

(2) by inserting after section 917 the following new section:

"SEC. 918. DISCLOSURE OF EXCHANGE RATES IN CONNECTION WITH INTERNATIONAL MONEY TRANSFERS.

"(a) DEFINITIONS.—

"(1) INTERNATIONAL MONEY TRANSFER.—The term 'international money transfer' means any money transmitting service involving an international transaction which is provided by a financial institution or a money transmitting business.

"(2) MONEY TRANSMITTING SERVICE.—The term 'money transmitting service' has the meaning given to such term in section 5330(d)(2) of title 31, United States Code.

"(3) MONEY TRANSMITTING BUSINESS.—The term 'money transmitting business' means any business which—

"(A) provides check cashing, currency exchange, or money transmitting or remittance services, or issues or redeems money orders, travelers' checks, and other similar instruments; and

"(B) is not a depository institution (as defined in section 5313(g) of title 31, United States Code).

"(b) EXCHANGE RATE AND FEES DISCLOSURES REQUIRED.—

"(1) IN GENERAL.—Any financial institution or money transmitting business which initiates an international money transfer on behalf of a consumer (whether or not the consumer maintains an account at such institution or business) shall provide the following disclosures in the manner required under this section:

"(A) The exchange rate used by the financial institution or money transmitting business in connection with such transaction.

"(B) The exchange rate prevailing at a major financial center of the foreign country whose currency is involved in the transaction, as of the close of business on the business day immediately preceding the date of the transaction (or the official exchange rate, if any, of the government or central bank of such foreign country).

"(C) All commissions and fees charged by the financial institution or money transmitting business in connection with such transaction.

"(D) The exact amount of foreign currency to be received by the recipient in the foreign country, which shall be disclosed to the consumer before the transaction is consummated and printed on the receipt referred to in paragraph (3).

"(2) PROMINENT DISCLOSURE INSIDE AND OUTSIDE THE PLACE OF BUSINESS WHERE AN INTERNATIONAL MONEY TRANSFER IS INITIATED.—The information required to be disclosed under subparagraphs (A), (B), and (C) of paragraph (1) shall be prominently displayed on the premises of the financial institution or money transmitting business both at the interior location to which the public is admitted for purposes of initiating an international money transfer and on the exterior of any such premises.

"(3) PROMINENT DISCLOSURE IN ALL RECEIPTS AND FORMS USED IN THE PLACE OF BUSINESS WHERE AN INTERNATIONAL MONEY TRANSFER IS INITIATED.—The information required to be disclosed under paragraph (1) shall be prominently displayed on all forms and receipts used by the financial institution or money transmitting business when initiating an international money transfer in such premises.

"(c) ADVERTISEMENTS IN PRINT, BROADCAST, AND ELECTRONIC MEDIA AND OUTDOOR ADVERTISING.—The information required to be disclosed under subparagraphs (A) and (C) of subsection (b)(1) shall be included—

"(1) in any advertisement, announcements, or solicitation which is mailed by the financial institution or money transmitting business and pertains to international money transfer; or

"(2) in any print, broadcast, or electronic medium or outdoor advertising display not on the premises of the financial institution or money transmitting business and pertaining to international money transfer.

"(d) DISCLOSURES IN LANGUAGES OTHER THAN ENGLISH.—The disclosures required under this section shall be in English and in the same language as that principally used by the financial institution or money transmitting business, or any of its agents, to advertise, solicit, or negotiate, either orally or in writing, at that office if other than English.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect at the end of the 3-month period beginning on the date of the enactment of this Act.

SEC. 3. STUDY ON FEE DISCLOSURES FOR MONEY WIRE TRANSMISSIONS.

(a) STUDY.—The Federal banking agencies (as defined in section 3 of the Federal Deposit Insurance Act) and the Secretary of the Treasury shall jointly conduct a study on fees charged and fee disclosures for money wire transmissions.

(b) COMPARISON OF PRICES.—The study required by subsection (a) shall compare the disclosures provided by federally insured depository institutions for money wire transmissions with disclosures provided by money transmitting businesses (as defined in section 5330(d)(1) of title 31, United States Code) for such transmissions.

(c) REPORT REQUIRED.—The Federal banking agencies and the Secretary of the Treasury shall jointly submit a report on the study required under subsection (a) to the Congress before the end of the 1-year period beginning on the date of enactment of this Act.

SEC. 4. FEDERAL CREDIT UNION ACT AMENDMENT.

Paragraph (12) of section 107 of the Federal Credit Union Act (12 U.S.C. 1757(12)) is amended to read as follows:

"(12) in accordance with regulations prescribed by the Board—

"(A) to sell, to persons in the field of membership, negotiable checks (including travelers checks), money orders, and other similar money transfer instruments; and

"(B) to cash checks and money orders for persons in the field of membership for a fee;".

Mr. AKAKA. Mr. President, I rise as a cosponsor of the Money Wire Improvement and Remittance Enhancement Act introduced by my colleague, Senator CORZINE. I thank Senator CORZINE for his leadership on this issue.

Immigrants often send a portion of their hard-earned wages to their relatives abroad. Remittances are often used to improve the standard of living of recipients by increasing access to health care, education, and essentials of daily life. In addition, remittances contribute significantly to the economic development of nations. For example, Philippines workers across the globe sent an estimated $6.4 billion back to the Philippines in 2001.

Despite the tremendous importance of remittances, people who send them are often unaware of the fees and exchange rates assessed in these transactions which reduce the amount of money received by their family members. Fees for sending remittances often can be ten to twenty percent of the value of the transaction. Also, the exchange rate used in the transaction can be significantly lower than the market rate.

Consumers and their families cannot afford to remain uninformed about their financial service options and the fees placed on their transactions. This legislation would ensure that each customer is fully informed of all of the fees and the exchange rates used in sending money.

I am hopeful that the enactment of this legislation will result in more people utilizing banks and credit unions for remittances because these institutions do not charge the exorbitant fees often associated with remittances processed by certain other entities. In addition, if unbanked immigrants take advantage of the remittance services offered by banks and credit unions, they will be more likely to open up an account. This would allow immigrants to take advantage of the opportunities for saving and borrowing found at mainstream financial institutions and offer them alternatives to fringe banking products, such as check cashing services.

The Money Wire Improvement and Remittance Enhancement Act has special significance to my home State of Hawaii. Hawaii is home to significant numbers of recent immigrants from many nations, including the Philippines, who send remittances to their relatives abroad. We must do what we can to ensure that their hard-earned dollars are not eroded by unnecessary fees or a lack of transparency regarding exchange rates.

I encourage my colleagues to support this much-needed legislation.

By Mrs. MURRAY (for herself, Mrs. BOXER, Ms. CANTWELL, Mrs. CLINTON, Mr. CORZINE, Mr. EDWARDS, Mrs. FEINSTEIN, Mr. KENNEDY, Mr. LAUTENBERG, Mr. SCHUMER, and Mr. HOLLINGS):

S. 1345. A bill to extend the authorization for the ferry boat discretionary program, and for other purposes; to the Committee on Environment and Public Works.

Mrs. MURRAY. Mr. President, I rise today to introduce legislation that will greatly enhance Federal participation in financing and improving our Nation's ferry transportation system.

Today I am introducing the Ferry Transportation Enhancement Act. I am proud to have Senators BOXER, CANTWELL, CORZINE, CLINTON, EDWARDS, FEINSTEIN, HOLLINGS, KENNEDY, LAUTENBERG, and SCHUMER as original cosponsors. This bill will provide significantly more resources to state governments, public ferry systems, and public entities responsible for developing facilities for ferries.

Specifically, the bill would: provide $150 million a year for the Federal Highway Administration's Ferry Boat Discretionary Program for fiscal years 2004 through 2009. This is approximately four times the $38 million a year that is currently being provided under this program; add "ferry maintenance facilities" to the list of allowable use of funds under this program; add "ferries" to the Clean Fuels Program; establish a Ferry Joint Program Office to coordinate Federal programs affecting ferry boat and ferry facility construction, maintenance, and operations and to promote ferry service as a component of the Nation's transportation system; establish an information database on ferry systems, routes, vessels, passengers and vehicles carried; and establish an institute for ferries to conduct R&D, conduct training programs, encourage collaborative efforts to promote ferry service, and preserve historical information. This will parallel institutes that now exist for highways, transit, and rail.

Currently, the Federal investment in ferries is only one-tenth of one percent of the total Surface Transportation Program. There is virtually no coordination at the Federal level to encourage and promote ferries as there are for other modes of transportation.

We need better coordinated ferry services because it's the sole means of surface transportation in many areas of the country, including Hawaii, Alaska and my home State of Washington.

Ferries are also the preferred, and the only feasible, method of commuting from home to work in places like Washington State, New York/New Jersey, North Carolina, Hawaii and Alaska.

Finally, in many States—like my home State of Washington—they are an important part of the tourism industry and represent a part of our cultural identity.

The symbol of ferries moving people and vehicles on the waterways of the Puget Sound is as much a part of our cultural identity as computers, coffee, commercial aircraft and the Washington Apple.

Ferry use is growing.

In Washington State our ferry system—the Nation's largest—currently transports 26 million passengers each year and carries 11 million vehicles.

Other systems that serve New York/New Jersey, North Carolina, San Francisco, and Alaska also have significant numbers of passengers using the ferries.

The Nation's six largest ferry systems carried 73 million people and 13 million vehicles last year.

The growth projection for ferry use is very high. For these larger systems, it is projected that by 2009 there will be a 14-percent increase in passengers and a 17-percent increase in vehicles being carried by ferries compared to 2002.

In San Francisco, that projection is a 46-percent increase.

It is clear that many people are using ferries and more will be using them in the future.

This is all with very little help from the Federal Government.

Our investment in ferries pails in comparison to the Federal investments in highways and other forms of mass transit.

Our bill would provide the needed funding for these growing systems for new ferry boat construction, for ferry facilities and terminals, and for maintenance facilities.

The bill also would make ferries eligible under the Clean Fuels Program.

Like busses, ferries are a form of mass transit that is environmentally cleaner than mass use of cars and trucks. Making them eligible for the Clean Fuels Program will encourage boat makers to design cleaner and more efficient vessels in the future. This will make ferry travel an even more environmentally friendly means of transportation than it already is today.

Finally, setting up a Ferry Joint Program Office, keeping track of ferry statistics, and establishing a National Ferry Institute will increase the profile of ferries as part of our Nation's infrastructure and provide a method to analyze and research ways to improve their use.

In the end, I hope this proposal can be included in the TEA-21 Reauthorization.

Ferries are an important part of our Nation's transportation infrastructure. This bill recognizes their importance by providing the resources and support they need to grow and serve passengers.

I urge the Senate support this bill, and I look forward to working with my colleagues to see it passed.

By Ms. CANTWELL (for herself and Ms. COLLINS):

S. 1346. A bill to amend the Workforce Investment Act of 1998 to provide for strategic sectoral skills gap assessments, strategic skills gap action plans, and strategic training capacity enhancement seed grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1347. A bill to amend the Workforce Investment Act of 1998 to provide for training service and delivery innovation projects; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL:

S. 1348. A bill to amend the Higher Education Act of 1965 to modify the computation of eligibility for certain Federal Pell Grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Ms. CANTWELL. Mr. President, I come to the floor today to discuss a topic that I believe is critical to our Nation's economic growth and future competitiveness—the training of our workforce.

We are living in tough economic times. The economy of the State of Washington and the Nation at large are suffering through a recession where jobs are scarce and workers are scrambling to pay the bills. The most recent employment data available from the Bureau of Labor Statistics have offered little comfort in Washington where the unemployment rate is 7.3 percent. Washington, along with the other Pacific Northwest States of Oregon and Alaska, continues to have among the highest unemployment rates in the nation.

Just a month ago, the Senate moved quickly to extend the temporary extension of unemployment compensation program, so that approximately four million workers across this country will not lose their Federal extended unemployment benefits. I am proud that the Senate acted quickly to extend this important program. This means that over 100,000 unemployed workers in Washington State will receive 26 weeks of Federal extended benefits. I am disappointed, however, that we were not able to pass coverage for the estimated 1.1 million unemployed workers who have entirely exhausted their State and Federal benefits. Therefore, I am fighting to pass a bill that would extend coverage to the long-term unemployed, so that help is available to the hardest hit workers in this weak economy.

Nonetheless, our efforts should not stop with an unemployment insurance extension. We must continue to pursue long-term strategies for a sustained economic recovery. The fundamental strength of our economy lies in the working men and women of this Nation whose innovation and hard work propelled the massive economic expansion of the past decade.

The competitive edge that will keep our workers ahead in this changing global economy is their skills. Our economy is global, linked by international markets and communications networks. The sustained success of U.S. companies depends on adaptability and innovation, which means that workers themselves need to remain flexible and continually update job skills.

Even in this time of high unemployment, businesses throughout the country cannot find workers with the skills they need. According to a study completed by Heldrich Work Trends Survey, American employers are finding it difficult to hire qualified workers. Nearly half, 46 percent, of American businesses say they have had trouble finding workers with the necessary skills. At the same time, over three million workers are laid off each year, but well under 500,000 receive any sort of training to learn the skills demanded by those businesses that face worker shortages. Job training is an answer to meeting those skill demands and bridging the skills gaps that persist. However, it will not occur widely without a strong financial commitment from the Federal Government to ensure access to job training programs, and ongoing efforts to maximize the effectiveness of those funds that we already invest.

Investment in job training must be our first priority not our last—the decisions we make today to invest in our workers will pay off many times over in the form of stronger local economies, healthier communities, and improved quality of life.

But the reality is that we are delivering a trickle of funding while faced with a tidal wave of need. I have traveled across my state, from Olympia to Kelso, Vancouver to Bellingham, the Tri-cities to Spokane and received a great deal of feedback from Washingtonians who are seeking training, are providing it, or are serving as employers who need to hire skilled workers. And I heard similar concerns repeated in each of these areas: first, as our economy continues to evolve, the demand for new skills has grown; second, the enormous increase in demand for skills training by individual workers who are upgrading skills or changing jobs is a trend that appears to be widespread throughout the Nation; but third, far too many of those workers seeking access to training cannot get the training they need due to limited space at training institutions and the limited tuition assistance.

Last year, my office released a study of this apparent shortfall in capacity of training systems in my State, and the results of that study were staggering to me. There are over 110,000 dislocated workers in my state, the majority of whom want to upgrade their skills but cannot do so because of budgetary limitations that prevent institutions from offering enough courses, and the limited numbers of available training vouchers.

To make things worse, this year, the State of Washington received approximately 40 percent less in Workforce Investment Act, WIA, formula funding compared to last year. This drastic cut in WIA funding means that services will be cut back at a time when the demand is at an all time high. It is imperative that during this time of State deficits, States receive additional help from the Federal Government for important services such as education and job training.

As my colleagues know, the Workforce Investment Act is up for reauthorization this year. The WIA system is clearly the centerpiece of the Federal job training programs. It provides a one-stop delivery system designed to meet a broad range of worker needs, and it emerged from years of bipartisan work by Congress to consolidate over 33 Federal programs into one system for delivering employment and training services.

Today, I am introducing three bills that are designed to build upon the existing workforce structure to expand opportunities for training and improve its effectiveness.

The first piece of legislation would change the Pell Grant program to make certain that student financial aid is available to recently laid off workers. Under current law, the standard practice in the determination of Pell Grant eligibility for student aid is to base grant awards upon the applicant's income during the previous year. The use of tax forms for this purpose, in many cases, is the most appropriate and easiest administrative method of obtaining a clear and official statement of financial need. But, as a result, many recently laid-off workers are not eligible for critical financial assistance at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current-year income levels for applicants seeking training through Pell Grant-eligible programs. It does this in a very narrow way, by only allowing institutions in States with high unemployment rates to consider current year financial circumstances rather than previous year income.

The second bill addresses issues of distance-learning and delivery of training to hard to reach areas in a comprehensive manner. While many distance-learning technologies have been developed in recent years, those technologies have not necessarily reached many of those who are most in need of training. Many workers in need of training may not be aware of online distance learning opportunities and may not be able to take advantage of them even if they do know about them. I believe, it is not enough to create a distance learning curriculum and passively provide it through an educational institution website. Rather, comprehensive solutions need to be developed that integrate curriculum innovations, technological access, and the promotion and linkage of workers in need of training with such opportunities, especially to help workers in rural areas. That's why my bill encourages the local workforce development boards to plan a comprehensive approach to improve access to and delivery of employment training services by using technology and online resources to connect workers with the information and tools they need to upgrade their skills.

The third bill that I am introducing today is designed to help local workforce development boards better understand regional labor market dynamics and improve system performance by identifying emerging sectors and industries with chronic worker shortages. My legislation encourages local workforce development boards to target employment and training resources so that workers can get training in occupations where employers need workers.

My legislation provides new resources to the state level so that states can direct funding down to the local workforce development boards to form partnerships with employers, unions, service providers and other key players in order to develop a strategic plan for addressing regional industry and workforce needs.

I want to make clear that this legislation is not intended to reinvent the wheel for areas that are already developing sectoral approaches within existing workforce development systems. In fact, Washington State is a leader in sector approaches: in 2000, the Washington State Legislature enacted legislation to support industry skills panels known as the "Skills Initiative." The Skills Initiative provides grants to local workforce development councils to engage business and industry in strategies to close the skill gaps in my State. My legislation emphasizes this work by providing funding to support these partnerships.

This is a first step on a long journey as we work to improve Federal job training systems, and it is critical, now more than ever, that Congress increase funding for the job training programs under the Workforce Investment Act. By providing the necessary resources, we send a strong message to the American public that our government must invest in our greatest resource—the American worker. Each of these bills is an important component of that broader strategy, and I look forward to working with my colleagues as we begin to look at the reauthorization of WIA and the Higher Education Act this year and next.

Mr. President, I ask unanimous consent that the text of each bill be printed in the RECORD.

There being no objection, the bills were ordered to be printed in the RECORD, as follows:

S. 1346

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Sectoral Market Assessment for Regional Training Enhancement and Revitalization Act".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) More than ⅓ of the Nation's current workforce lacks the basic skills necessary to succeed in today's labor market.

(2) Globalization of the economy is leading to losses of jobs in key domestic industries, as well as challenges to competitiveness and productivity in other domestic industries.

(3) To remain economically vital and competitive, the Nation must invest in generating jobs and train a workforce skilled enough to contribute productively to the United States economy.

(4) Strategic planning that links workforce development and economic development, and the targeting of resources to industries that can build strong regional economies and create jobs with living wages for workers, need to be priorities for the workforce investment system.

(5) States and local workforce investment boards can play lead roles in guiding a more strategic process for achieving economic growth through workforce development.

SEC. 3. SKILLS GAP CAPACITY ENHANCEMENT GRANTS.

Subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.) is amended—

(1) by redesignating section 137 as section 138; and

(2) by inserting after section 136 the following:

"SEC. 137. SKILLS GAP CAPACITY ENHANCEMENT GRANTS.

"(a) PURPOSES.—The purposes of this section are—

"(1) to assist States and local boards in better focusing funds provided under this subtitle on activities and programs that address labor shortages and meet the emerging demand for skills in high-quality jobs in area industries;

"(2) to enhance the efficiency of the one-stop delivery systems and providers of training services;

"(3) to establish and improve partnerships between local boards, industry sectors, economic development agencies, providers of training services (including secondary schools, postsecondary educational institutions, community-based organizations, business associations, and providers of joint labor-management programs), providers of supportive services, and other related public and private entities;

"(4) to strengthen integration of workforce development strategies and economic development strategies in States, local areas, and labor markets;

"(5) to retain vital industries in the local areas and regions involved, avoid dislocation of workers, and strengthen the competitiveness of key industries; and

"(6) to encourage the development of career ladders and advancement efforts in local industries.

"(b) DEFINITIONS.—In this section:

"(1) CONSORTIUM.—The term 'consortium' means a consortium of local boards, established as described in subsection (d)(3).

"(2) REGION.—The term 'region' means 2 or more local areas that comprise a common labor market for an industry sector or group of related occupations.

"(3) TRAINING SERVICES.—The term 'training services' means services described in section 134(d)(4).

"(c) GRANTS TO STATES.—

"(1) IN GENERAL.—The Secretary shall make grants to States, to enable the States to assist local boards and consortia in carrying out the activities described in subsection (e).

"(2) FORMULA.—

"(A) IN GENERAL.—The Secretary shall make the grants in accordance with the formula used to make grants to States under section 132(b)(1)(B) (other than clause (iv)), subject to subparagraph (B).

"(B) SMALL STATE MINIMUM ALLOTMENT.—The Secretary shall ensure that no State shall receive an allotment under this paragraph for a fiscal year that is less than ½ of 1 percent of the funds made available to carry out this section for that fiscal year.

"(d) GRANTS TO LOCAL BOARDS.—

"(1) IN GENERAL.—A State that receives a grant under subsection (c)—

"(A) shall use the funds made available through the grant to make grants to local boards and consortia to carry out the activities described in subsection (e); and

"(B) may use not more than 15 percent of the funds made available through the grant, at the election of the State, to prepare strategic sectoral skills gap assessments, as described in subsection (e)(2), in the local areas or regions involved, or to provide technical assistance to local boards, consortia, or partnerships described in subsection (e)(3).

:"(2) CONSIDERATION.—In making the grants, the State may take into account the size of the workforce in each local area or region.

"(3) CONSORTIA.—States shall encourage local boards to aggregate, to the maximum extent practicable, into consortia representing regions, for purposes of carrying out activities described in subsection (e). Nothing in this paragraph shall be construed to require local boards to aggregate into such consortia.

"(4) APPLICATIONS.—To be eligible to receive a grant under this section, a local board or consortium shall submit an application to the State, at such time and in such manner as the State may require, containing—

"(A) information identifying the members of the partnership described in subsection (e)(3) that will carry out the activities described in subsection (e); and

"(B) an assurance that the board or consortium will use, or ensure that the partnership uses, the funds to carry out the activities described in subsection (e).

"(e) USE OF FUNDS.—

"(1) IN GENERAL.—A local board or consortium that receives a grant under this section—

"(A) shall ensure that the partnership described in paragraph (3) uses the funds made available through the grant to—

"(i) prepare a strategic sectoral skills gap assessment, as described in paragraph (2), unless the State elects to prepare the assessment;

"(ii) develop a strategic skills gap action plan, as described in paragraph (4); and

"(iii) provide strategic training capacity enhancement seed grants to providers of training services specified in subsection (a)(3), one-stop operators, and other appropriate intermediaries, as described in paragraph (5); and

"(B) may use funds made available through the grant to ensure that activities carried out under this subtitle are carried out in accordance with the strategic skills gap action plan.

"(2) STRATEGIC SECTORAL SKILLS GAP ASSESSMENT.—

"(A) IN GENERAL.—Except as provided in subparagraph (E), the local board or consortium (or, at the election of the State, that State) shall prepare a strategic sectoral skills gap assessment, which shall—

"(i) identify areas of current and expected demand for labor and skills in a specific industry sector or group of related occupations that is—

"(I) producing high-quality jobs in the local area or region involved;

"(II) developing emerging jobs in that area or region; or

"(III) suffering chronic worker shortages;

"(ii) identify the current and expected supply of labor and skills in that sector or group in the local area or region; and

"(iii) identify gaps between the current and expected demand and supply of labor and skills in that sector or group in the local area or region.

"(B) SPECIFIC CONTENTS.—The assessment shall contain data regarding—

"(i)(I) specific high-quality employment opportunities offered by industries in the local area or region; and

"(II) specific skills desired for such opportunities;

"(ii)(I) occupations and positions in the local area or region that are difficult to fill; and

"(II) specific skills desired for such occupations and positions;

"(iii)(I) areas of growth and decline among industries and occupations in the local area or region; and

"(II) specific skills desired for such growth areas; and

"(iv) specific inventories of skills of unemployed or underemployed individuals in the local area or region.

"(C) INFORMATION.—The assessment shall contain current (as of the date of preparation of the assessment) information including specific information from multiple employers in the sector or group described in subparagraph (A)(i), labor organizations, and others connected to the businesses and workers in that sector or group, to illuminate local needs of both employers and workers. To the maximum extent possible, the information shall be regularly updated information.

"(D) SURVEY.—The assessment shall contain the results of a survey or focus group interviews of employers and labor organizations and other relevant individuals and organizations in the local area or region.

"(E) EXCEPTION.—

"(i) STATE.—A State shall not be required to use the funds made available through a grant received under this section, to prepare an assessment described in this paragraph.

"(ii) LOCAL BOARD OR CONSORTIUM.—A local board or consortium shall not be required to use the funds made available through a grant received under this section, to prepare an assessment described in this paragraph, if the local board or consortium demonstrates that, within the 2 years prior to receiving the grant, an assessment that meets the requirements of this paragraph has been prepared for the local area or region involved.

"(3) SKILLS PARTNERSHIP.—In carrying out this section, local boards and consortia shall enter into partnerships that include—

"(A) representatives of the local boards for the local area or region involved;

"(B) representatives of multiple employers for a specific industry sector or group of related occupations, and related sectors or occupations, identified through the assessment described in paragraph (2) as having identified gaps between the current and expected demand and supply of labor and skills in the industry sector or group of related occupations in the local area or region involved;

"(C) representatives of economic development agencies for the local area or region;

"(D) representatives of providers of training services described in subsection (a)(3) in the local area or region;

"(E) representatives nominated by State labor federations or local labor federations; and

"(F) other entities that can provide needed supportive services tailored to the needs of workers in the sector or group.

"(4) STRATEGIC SKILLS GAP ACTION PLAN.—The partnership shall develop a strategic skills gap action plan, based on the assessment, that—

"(A)(i) identifies specific barriers to adequate supply of labor and skills in demand in a specific industry sector or group of related occupations that is producing high-quality jobs in the local area or region involved; and

"(ii) identifies activities (which may include the provision of needed supportive services) that will remove or alleviate the barriers described in clause (i) that could be undertaken by one-stop operators and providers of training services described in subsection (a)(3);

"(B) specifies how the local board (or consortium) and economic development agencies in the partnership will integrate the board's or consortium's workforce development strategies with local or regional economic development strategies in that sector or group; and

"(C) identifies resources and strategies that will be used in the local area or region to address the skill gaps for both unemployed and incumbent workers in that sector or group.

"(5) STRATEGIC TRAINING CAPACITY ENHANCEMENT SEED GRANTS.—

"(A) IN GENERAL.—The local board or consortium, after consultation with the partnership, shall make grants to providers of training services described in subsection (a)(3), one-stop operators, and other appropriate intermediaries to pay for the Federal share of the cost of—

"(i) developing curricula to meet needs identified in the assessment described in paragraph (2) and to overcome barriers identified in the plan described in paragraph (4);

"(ii) modifying the programs of training services offered by the providers in order to meet those needs and overcome those barriers;

"(iii) operating pilot training efforts that demonstrate new curricula, or modifications to curricula, described in clause (i);

"(iv) expanding capacity of providers of training services in sectors or groups described in paragraph (2)(A)(i);

"(v) reorganizing service delivery systems to better serve the needs of employers and workers in the sectors or groups; or

"(vi) developing business services to ensure retention and greater competitiveness of the sectors or groups.

"(B) FEDERAL SHARE.—

"(i) IN GENERAL.—The Federal share of the cost described in subparagraph (A) shall be 75 percent.

"(ii) NON-FEDERAL SHARE.—The non-Federal share of the cost may be provided in cash or in kind, fairly evaluated, including plant, equipment, or services.".

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

Section 138 of the Workforce Investment Act of 1998 (29 U.S.C. 2872), as redesignated by section 3(1), is amended by adding at the end the following:

"(d) SKILLS GAP CAPACITY ENHANCEMENT GRANTS.—In addition to any amounts authorized to be appropriated under subsection (a), (b), or (c), there are authorized to be appropriated to carry out section 137 such sums as may be necessary for fiscal years 2004 through 2007.".

SEC. 5. CONFORMING AMENDMENTS.

(a) TABLE OF CONTENTS.—The table of contents in section 1(b) of the Workforce Investment Act of 1998 is amended by striking the item relating to section 137 and inserting the following:

"Sec. 137. Skills gap capacity enhancement grants.
"Sec. 138. Authorization of appropriations.".

(b) REFERENCES TO AUTHORIZATION OF APPROPRIATIONS.—

(1) YOUTH ACTIVITIES.—Subsections (a) and (b)(1) of section 127 of the Workforce Investment Act of 1998 (29 U.S.C. 2852) are amended by striking "section 137(a)" each place it appears and inserting "section 138(a)".

(2) ADULT EMPLOYMENT AND TRAINING ACTIVITIES.—Section 132(a)(1) of the Workforce Investment Act of 1998 (29 U.S.C. 2862(a)(1)) is amended by striking "section 137(b)" and inserting "section 138(b)".

(3) DISLOCATED WORKER EMPLOYMENT AND TRAINING ACTIVITIES.—Subsections (a)(2) and (b)(2)(A)(i) of section 132 of the Workforce Investment Act of 1998 (29 U.S.C. 2862) are amended by striking "section 137(c)" each place it appears and inserting "section 138(c)".

S. 1347

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TRAINING SERVICE AND DELIVERY INNOVATION PROJECTS.

Section 171(b)(1)(D) of the Workforce Investment Act of 1998 (29 U.S.C. 2916(b)(1)(D)) is amended to read as follows:

"(D) targeted innovation projects that improve access to and delivery of employment and training services, with emphasis given to projects that incorporate advanced technologies to facilitate the connection of individuals to the information and tools they need to upgrade skills, including projects that link individuals in need of training to opportunities for self-guided learning, and with priority given to projects that—

"(i) actively promote sources of information about training opportunities and training content by providing technology directly to eligible training recipients;

"(ii) provide for the conduct of online eligibility determinations for Federal and State training programs, and direct individuals to the appropriate programs in the area; and

"(iii) integrate high-quality employment and training services information with the delivery of information regarding other social services and health care programs;".

S. 1348

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Pell Grant Eligibility Clarification Act of 2003".

SEC. 2. CONSIDERATION OF CURRENT YEAR CIRCUMSTANCES.

Section 480(a) of the Higher Education Act of 1965 (20 U.S.C. 1087vv(a)) is amended—

(1) in paragraph (1), by striking "paragraph (2)" and inserting "paragraphs (2) and (3)"; and

(2) by adding at the end the following:

"(3) CONSIDERATION OF CURRENT YEAR CIRCUMSTANCES FOR CERTAIN PELL GRANT AWARDS.—

"(A) IN GENERAL.—If a student is a resident of a State that is in an extended benefit period (within the meaning of section 203 of the Temporary Extended Unemployment Compensation Act of 2002 (Public Law 107–147)), then for purposes of calculating total income under paragraph (1) for a student seeking assistance under subpart 1 of part A, the Secretary shall reduce the student's total income by an amount by which—

"(i) the adjusted gross income plus untaxed income and benefits for the preceding tax year minus excludable income (as defined in subsection (e)), exceeds

"(ii) the projected gross income plus untaxed income and benefits for the current tax year minus the projected excludable income (as defined in subsection (e)).

"(B) ANTI-FRAUD PROCEDURES.—The Secretary shall establish procedures to ensure that computations made pursuant to subparagraph (A) are not fraudulent.".

By Mr. SMITH (for himself, Mr. KOHL, Mrs. BOXER, Mr. CORNYN, Mr. FEINGOLD, Mrs. HUTCHISON, Ms. MURKOWSKI, and Mr. WYDEN):

S. 1349. A bill to amend the Internal Revenue Code of 1986 with respect to the eligibility of veterans for mortgage bond financing, and for other purposes; to the Committee on Finance.

Mr. SMITH. Mr. President, on behalf of myself and my colleagues, Mr. KOHL of Wisconsin, Mrs. BOXER of California, Mr. CORNYN of Texas, Mr. FEINGOLD of Wisconsin, Mrs. HUTCHISON of Texas, Ms. MURKOWSKI of Alaska, and Mr. WYDEN of Oregon, I ask unanimous consent that the text of the bill, the "Veterans American Dream Home Ownership Act" be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1349

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ALL VETERANS ELIGIBLE FOR STATE HOME LOAN PROGRAMS FUNDED BY QUALIFIED VETERANS' MORTGAGE BONDS.

(a) IN GENERAL.—Section 143(l)(4) of the Internal Revenue Code of 1986 (defining qualified veteran) is amended—

(1) by striking "at some time before January 1, 1977" in subparagraph (A), and

(2) by striking subparagraph (B) and inserting the following:

"(B) who applied for the financing before the date 30 years after the last on which such veteran left active service.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to financing provided and mortgage credit certificates issued after June 30, 2003.

SEC. 2. REVISION OF STATE VETERANS LIMIT.

(a) IN GENERAL.—Subparagraph (B) of section 143(l)(3) of the Internal Revenue Code of 1986 (relating to volume limitation) is amended to read as follows:

"(B) STATE VETERANS LIMIT.—A State veterans limit for any calendar year is the amount equal to—

"(i) $425,000,000 for the State of Texas,

"(ii) $537,000,000 for the State of California,

"(iii) $200,000,000 for the State of Oregon,

"(iv) $200,000,000 for the State of Wisconsin, and "(v) $200,000,000 for the State of Alaska.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to bonds issued after December 31, 2003.

SEC. 3. ELECTIVE CARRYFORWARD OF UNUSED LIMITATION.

(a) IN GENERAL.—Section 143(l)(3) of the Internal Revenue Code of 1986 (relating to volume limitation) is amended by adding at the end the following:

"(D) ELECTIVE CARRYFORWARD OF UNUSED LIMITATION.—

"(i) IN GENERAL.—If—

"(I) a State veterans limit for any calendar year after 2002, exceeds

"(II) the aggregate amount of qualified veterans' mortgage bonds issued by such State,

such State may irrevocably elect to treat such excess as a carryforward for qualified veterans' mortgage bonds.

"(ii) USE OF CARRYFORWARD.—

"(I) IN GENERAL.—If a State elects a carryforward under clause (i), qualified veterans' mortgage bonds issued during the 3 calendar years following the calendar year in which the carryforward arose shall not be taken into account under subparagraph (A) to the extent the amount of such bonds does not exceed the amount of the carryforward so elected.

"(II) ORDER IN WHICH CARRYFORWARD USED.—Carryforwards elected shall be used in the order of the calendar years in which such carryforwards arose.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to bonds issued and carryforward elections made after December 31, 2003.

By Mrs. FEINSTEIN:

S 1350. A bill to require Federal agencies, and persons engaged in interstate commerce, in possession of electronic data containing personal information, to disclose any unauthorized acquisition of such information; to the Committee on the Judiciary.

Mrs. FEINSTEIN. Mr. President, I rise to introduce the Notification of Risk to Personal Data Act of 2003. This legislation will require that individuals are notified when their most sensitive personal information is stolen from a corporate or government database.

Specifically, the bill would require government or private entities to notify individuals if a data breach has compromised their Social Security number, driver's license number, credit card number, debit card number, or financial account numbers.

In most cases, if authorities know that someone is a victim of a crime, the victim is notified. But that isn't the case if an individual's most sensitive personal information is stolen from an electronic database.

Unfortunately, data breaches are becoming all too common. Consider the following incidents which have compromised the records of hundreds of thousands of Americans.

On April 5, 2002, a hacker broke into the electronic records of Steven P. Teale Data Center, the payroll facility for California State employees. The hacker compromises files containing the first initials, middle initials, and last names, Social Security numbers, and payroll deduction information of approximately 265,000 people. Despite the breathtaking potential harm of the crime, the breach was not publicly acknowledged and State employees were not made aware of their vulnerability to identify theft until May 24, 2002—17 days later.

On December 14, 2002, TriWest Health Care Alliance, a company that provides health care coverage for military personnel and their families, was burglarized at its Phoenix, AZ offices. Thieves broke into a management suite and stole laptop computers and computer hard drives containing the names, addresses, telephone numbers, birth dates and Social Security numbers of 562,000 military service members, dependents and retirees, as well as medical claims records for people on active duty in the Persian Gulf.

In February 2003, a hacker gained access to 10 million Visa, MasterCard, American Express Card and Discovery Card numbers from the databases of a credit processor, DPI Merchant services of Omaha, NE. Company officials maintained that the intruder did not obtain any personal information for these card numbers such as the account holder's name, address, telephone number or Social Security number. However, at least one bank canceled and replaced 8,800 cards when it found out about the security breach.

And in March of this year, a University of Texas student was charged with hacking into the university's computer system and stealing 55,000 Social Security numbers.

These are just some examples of the types of breaches that are occurring today. Except for California, which as a notification law going into effect in July, no State or Federal law requires companies or agencies to tell individuals of the misappropriation of their personal data.

I strongly believe Americans should be notified if a hacker gets access to their most personal data. This is both a matter of principle and a practical measure to curb identity theft.

Let me take a moment to describe the proposed legislation.

The Notification of Risk to Personal Data Act will set a national standard for notification of consumers when a data breach occurs.

Specifically, the legislation requires a business or government entity to notify an individual when there is a reasonable basis to conclude that a hacker or other criminal has obtained unencrypted personal data maintained by the entity.

Personal data is defined by the bill as an individual's Social Security number, State identification number, driver's license number, financial account number, or credit card number.

The legislation's notification scheme minimizes the burdens on companies or agencies that must report a data breach.

In general, notice would have to be provided to each person whose data was compromised in writing or through e-mail. But there are important exceptions.

First, companies that have developed their own reasonable notification policies are given a safe harbor under the bill and are exempted from its notification requirements.

Second, encrypted data is exempted.

Third, where it is too expensive or impractical, e.g., contact address information is incomplete, to notify every individual who is harmed, the bill allows entities to send out an alternative form of notice called "substitute notice." Substitute notice includes posting notice on a website or notifying major media.

Substitute notice would be triggered if any of the following factors exist: 1. the agency or person demonstrates that the cost of providing direct notice would exceed $250,000; 2. the affected class of subject persons to be notified exceeds 500,000; or 3. the agency or person does not have sufficient contact information to notify people whose information is at risk.

The bill has a tough, but fair enforcement regime. Entities that fail to comply with the bill will be subject to fines by the Federal Trade Commission of $5,000 per violation or up to $25,000 per day while the violation persists. State Attorneys General can also file suit to enforce the statute.

Additionally, the bill would allow California's new law to remain in effect, but preempt conflicting State laws. It is my understanding that legislators in a number of States are developing bills modeled after the California law. Reportedly, some of these bills have requirements that are inconsistent with the California legislation. It is not fair to put companies in a situation that forces them to comply with database notification laws of 50 different States.

I strongly believe individuals have a right to be notified when their most sensitive information is compromised—because it is truly their information. Ask the ordinary person on the street if he or she would like to know if a criminal had illegally gained access to their personal information from a database—the answer will be a resounding yes.

Enabling consumers to be notified in a timely manner of security breaches involving their personal data will help combat the growth scourge of identity theft. According to the Identity Theft Resources Center, a typical identity theft victim takes six to 12 months to discover that a fraud has been perpetuated against them.

As Linda Foley, Executive Director of the Identity Theft Resources center puts it: "Identity theft is a crime of opportunity and time is essential at every junction. Every minute that passes after the breach until detection and notification increases the damage done to the consumer victim, the commercial entities, and law enforcement's ability to track and catch the criminals. It takes less than a minute to fill out a credit application and to start an action that could permanently affect the victim's life. Multiply that times hundreds of minutes, hundreds of opportunities to use or sell the information stolen and you just begin to understand the enormity of the problem that the lack of notification can cause."

If individuals are informed of the theft of their Social Security numbers or other sensitive information, they can take immediate preventative action.

They can place a fraud alert on their credit report to prevent crooks from obtaining credit cards in their name; they can monitor their credit reports to see if unauthorized activity has occurred; they can cancel any affected financial or consumer or utility accounts; they can change their phone numbers if necessary.

I look forward to working with my colleagues to pass this vitally needed legislation. This bill will give ordinary Americans more control and confidence about the safety of their personal information. Americans will have the security of knowing that should a breach occur, they will be notified and be able to take protective action.

I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1350

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Notification of Risk to Personal Data Act".

SEC. 2. DEFINITIONS.

In this Act, the following definitions shall apply:

(1) Agency.—The term "agency" has the same meaning given such term in section 551(1) of title 5, United States Code.

(2) Breach of security of the system.—The term "breach of security of the system"—

(A) means the compromise of the security, confidentiality, or integrity of computerized data that results in, or there is a reasonable basis to conclude has resulted in, the unauthorized acquisition of and access to personal information maintained by the person or business; and

(B) does not include good faith acquisition of personal information by an employee or agent of the person or business for the purposes of the person or business, if the personal information is not used or subject to further unauthorized disclosure.

(3) Person.—The term "person" has the same meaning given such term in section 551(2) of title 5, United States Code.

(4) Personal information.—The term "personal information" means an individual's last name in combination with any 1 or more of the following data elements, when either the name or the data elements are not encrypted:

(A) Social security number.

(B) Driver's license number or State identification number.

(C) Account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account.

(5) Substitute notice.—The term "substitute notice" means—

(A) e-mail notice, if the agency or person has an e-mail address for the subject persons;

(B) conspicuous posting of the notice on the Internet site of the agency or person, if the agency or person maintains an Internet site; or

(C) notification to major media.

SEC. 3. DATABASE SECURITY.

(a) Disclosure of Security Breach.—

(1) In general.—Any agency, or person engaged in interstate commerce, that owns or licenses electronic data containing personal information shall, following the discovery of a breach of security of the system containing such data, notify any resident of the United States whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person.

(2) Notification of owner or licensee.—Any agency, or person engaged in interstate commerce, in possession of electronic data containing personal information that the agency does not own or license shall notify the owner or licensee of the information if the personal information was, or is reasonably believed to have been, acquired by an unauthorized person through a breach of security of the system containing such data.

(3) Timeliness of notification.—Except as provided in paragraph (4), all notifications required under paragraph (1) or (2) shall be made as expediently as possible and without unreasonable delay following—

(A) the discovery by the agency or person of a breach of security of the system; and

(B) any measures necessary to determine the scope of the breach, prevent further disclosures, and restore the reasonable integrity of the data system.

(4) Delay of notification authorized for law enforcement purposes.—If a law enforcement agency determines that the notification required under this subsection would impede a criminal investigation, such notification may be delayed until such law enforcement agency determines that the notification will no longer compromise such investigation.

(5) Methods of notice.—An agency, or person engaged in interstate commerce, shall be in compliance with this subsection if it provides the resident, owner, or licensee, as appropriate, with—

(A) written notification;

(B) e-mail notice, if the person or business has an e-mail address for the subject person; or

(C) substitute notice, if—

(i) the agency or person demonstrates that the cost of providing direct notice would exceed $250,000;

(ii) the affected class of subject persons to be notified exceeds 500,000; or

(iii) the agency or person does not have sufficient contact information for those to be notified.

(6) Alternative notification procedures.—Notwithstanding any other obligation under this subsection, an agency, or person engaged in interstate commerce, shall be deemed to be in compliance with this subsection if the agency or person—

(A) maintains its own reasonable notification procedures as part of an information security policy for the treatment of personal information; and

(B) notifies subject persons in accordance with its information security policy in the event of a breach of security of the system.

(7) Reasonable notification procedures.—As used in paragraph (6), with respect to a breach of security of the system involving personal information described in section 2(4)(C), the term "reasonable notification procedures" means procedures that—

(A) use a security program reasonably designed to block unauthorized transactions before they are charged to the customer's account;

(B) provide for notice to be given by the owner or licensee of the database, or another party acting on behalf of such owner or licensee, after the security program indicates that the breach of security of the system has resulted in fraud or unauthorized transactions, but does not necessarily require notice in other circumstances; and

(C) are subject to examination for compliance with the requirements of this Act by 1 or more Federal functional regulators (as defined in section 509 of the Gramm-Leach Bliley Act (15 U.S.C. 6809)), with respect to the operation of the security program and the notification procedures.

(b) Civil Remedies.—

(1) Penalties.—Any agency, or person engaged in interstate commerce, that violates this section shall be subject to a fine of not more than $5,000 per violation, to a maximum of $25,000 per day while such violations persist.

(2) Equitable relief.—Any person engaged in interstate commerce that violates, proposes to violate, or has violated this section may be enjoined from further violations by a court of competent jurisdiction.

(3) Other rights and remedies.—The rights and remedies available under this subsection are cumulative and shall not affect any other rights and remedies available under law.

(c) Enforcement.—The Federal Trade Commission is authorized to enforce compliance with this section, including the assessment of fines under subsection (b)(1).

SEC. 4. ENFORCEMENT BY STATE ATTORNEYS GENERAL.

(a) In General.—

(1) Civil actions.—In any case in which the attorney general of a State has reason to believe that an interest of the residents of that State has been or is threatened or adversely affected by the engagement of any person in a practice that is prohibited under this Act, the State, as parens patriae, may bring a civil action on behalf of the residents of the State in a district court of the United States of appropriate jurisdiction to—

(A) enjoin that practice;

(B) enforce compliance with this Act;

(C) obtain damage, restitution, or other compensation on behalf of residents of the State; or

(D) obtain such other relief as the court may consider to be appropriate.

(2) Notice.—

(A) In general.—Before filing an action under paragraph (1), the attorney general of the State involved shall provide to the Attorney General—

(i) written notice of the action; and

(ii) a copy of the complaint for the action.

(B) Exemption.—

(i) IN GENERAL.—Subparagraph (A) shall not apply with respect to the filing of an action by an attorney general of a State under this subsection, if the State attorney general determines that it is not feasible to provide the notice described in such subparagraph before the filing of the action.

(ii) NOTIFICATION.—In an action described in clause (i), the attorney general of a State shall provide notice and a copy of the complaint to the Attorney General at the time the State attorney general files the action.

(b) CONSTRUCTION.—For purposes of bringing any civil action under subsection (a), nothing in this Act shall be construed to prevent an attorney general of a State from exercising the powers conferred on such attorney general by the laws of that State to—

(1) conduct investigations;

(2) administer oaths or affirmations; or

(3) compel the attendance of witnesses or the production of documentary and other evidence.

(c) VENUE; SERVICE OF PROCESS.—

(1) VENUE.—Any action brought under subsection (a) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

(2) SERVICE OF PROCESS.—In an action brought under subsection (a), process may be served in any district in which the defendant—

(A) is an inhabitant; or

(B) may be found.

SEC. 5. EFFECT ON STATE LAW.

The provisions of this Act shall supersede any inconsistent provisions of law of any State or unit of local government relating to the notification of any resident of the United States of any breach of security of an electronic database containing such resident's personal information (as defined in this Act), except as provided under sections 1798.82 and 1798.29 of the California Civil Code.

SEC. 6. EFFECTIVE DATE.

This Act shall take effect on the expiration of the date which is 6 months after the date of enactment of this Act.

By Mr. FRIST:

S. 1351. A bill to amend the Tennessee Valley Authority Act of 1933 to modify provisions relating to the Board of Directors of the Tennessee Valley Authority, and for other purposes; to the Committee on Environment and Public Works.

Mr. FRIST. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1351

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CHANGE IN COMPOSITION, OPERATION, AND DUTIES OF THE BOARD OF DIRECTORS OF THE TENNESSEE VALLEY AUTHORITY.

(a) IN GENERAL.—The Tennessee Valley Authority Act of 1933 (16 U.S.C. 831 et seq.) is amended by striking section 2 and inserting the following:

“SEC. 2. MEMBERSHIP, OPERATION, AND DUTIES OF THE BOARD OF DIRECTORS.

“(a) MEMBERSHIP.—

“(1) APPOINTMENT.—The Board of Directors of the Corporation (referred to in this Act as the ‘Board’) shall be composed of 9 members appointed by the President by and with the advice and consent of the Senate, who shall be legal residents of the service area.

“(2) CHAIRMAN.—The members of the Board shall select 1 of the members to act as chairman of the Board.

“(b) QUALIFICATIONS.—

“(1) IN GENERAL.—To be eligible to be appointed as a member of the Board, an individual—

“(A) shall be a citizen of the United States;

“(B) shall have widely recognized experience or applicable expertise in the management of or decisionmaking for a large corporate structure;

“(C) shall not be an employee of the Corporation;

“(D) shall have no substantial direct financial interest in—

“(i) any public-utility corporation engaged in the business of distributing and selling power to the public; or

“(ii) any business that may be adversely affected by the success of the Corporation as a producer of electric power; and

“(E) shall profess a belief in the feasibility and wisdom of this Act.

“(2) PARTY AFFILIATION.—Not more than 5 of the 9 members of the Board may be affiliated with a single political party.

“(c) RECOMMENDATIONS.—In appointing members of the Board, the President shall—

“(1) consider recommendations from such public officials as—

“(A) the Governors of States in the service area;

“(B) individual citizens;

“(C) business, industrial, labor, electric power distribution, environmental, civic, and service organizations; and

“(D) the congressional delegations of the States in the service area; and

“(2) seek qualified members from among persons who reflect the diversity and needs of the service area of the Corporation.

“(d) TERMS.—

“(1) IN GENERAL.—A member of the Board shall serve a term of 5 years, except that in first making appointments after the date of enactment of this paragraph, the President shall appoint—

“(A) 2 members to a term of 2 years;

“(B) 1 member to a term of 3 years; and

“(C) 2 members to a term of 4 years.

“(2) VACANCIES.—A member appointed to fill a vacancy in the Board occurring before the expiration of the term for which the predecessor of the member was appointed shall be appointed for the remainder of that term.

“(3) REAPPOINTMENT.—

“(A) IN GENERAL.—A member of the Board that was appointed for a full term may be reappointed for 1 additional term.

“(B) APPOINTMENT TO FILL VACANCY.—For the purpose of subparagraph (A), a member appointed to serve the remainder of the term of a vacating member for a period of more than 2 years shall be considered to have been appointed for a full term.

“(e) QUORUM.—

“(1) IN GENERAL.—Six members of the Board shall constitute a quorum for the transaction of business.

“(2) MINIMUM NUMBER OF MEMBERS.—A vacancy in the Board shall not impair the power of the Board to act, so long as there are 6 members in office.

“(f) COMPENSATION.—

“(1) IN GENERAL.—A member of the Board shall be entitled to receive—

“(A)(i) a stipend of $30,000 per year; plus

“(ii) compensation, not to exceed $10,000 for any year, at a rate that does not exceed the daily equivalent of the annual rate of basic pay prescribed under level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day the member is engaged in the actual performance of duties as a member of the Board at meetings or hearings; and

“(B) travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in Government service under section 5703 of title 5, United States Code.

“(2) ADJUSTMENTS IN STIPENDS.—The amount of the stipend under paragraph (1)(A)(i) shall be adjusted by the same percentage, at the same time and manner, and subject to the same limitations as are applicable to adjustments under section 5318 of title 5, United States Code.

“(g) DUTIES.—

“(1) IN GENERAL.—The Board shall—

“(A) establish the broad goals, objectives, and policies of the Corporation that are appropriate to carry out this Act;

“(B) develop long-range plans to guide the Corporation in achieving the goals, objectives, and policies of the Corporation and provide assistance to the chief executive officer to achieve those goals, objectives, and policies, including preparing the Corporation for fundamental changes in the electric utilities industry;

“(C) ensure that those goals, objectives, and policies are achieved;

“(D) approve an annual budget for the Corporation;

“(E) establish a compensation plan for employees of the Corporation in accordance with subsection (i);

“(F) approve the salaries, benefits, and incentives for managers and technical personnel that report directly to the chief executive officer;

“(G) ensure that all activities of the Corporation are carried out in compliance with applicable law;

“(H) create an audit committee, composed solely of Board members independent of the management of the Corporation, which shall—

“(i) recommend to the Board an external auditor;

“(ii) receive and review reports from the external auditor; and

“(iii) make such recommendations to the Board as the audit committee considers necessary;

“(I) create such other committees of Board members as the Board considers to be appropriate;

“(J) conduct public hearings on issues that could have a substantial effect on—

“(i) the electric ratepayers in the service area; or

“(ii) the economic, environmental, social, or physical well-being of the people of the service area; and

“(K) establish the electricity rate schedule.

“(2) MEETINGS.—The Board shall meet at least 4 times each year.

“(h) CHIEF EXECUTIVE OFFICER.—

“(1) APPOINTMENT.—The Board shall appoint a person to serve as chief executive officer of the Corporation.

“(2) QUALIFICATIONS.—To serve as chief executive officer of the Corporation, a person—

“(A) shall be a citizen of the United States;

“(B) shall have management experience in large, complex organizations;

“(C) shall not be a current member of the Board or have served as a member of the Board within 2 years before being appointed chief executive officer; and

"(D) shall have no substantial direct financial interest in—

"(i) any public-utility corporation engaged in the business of distributing and selling power to the public; or

"(ii) any business that may be adversely affected by the success of the Corporation as a producer of electric power; and

"(3) TENURE.—The chief executive officer shall serve at the pleasure of the Board.

"(i) COMPENSATION PLAN.—

"(1) IN GENERAL.—The Board shall approve a compensation plan that specifies salaries, benefits, and incentives for the chief executive officer and employees of the Corporation.

"(2) ANNUAL SURVEY.—The compensation plan shall be based on an annual survey of the prevailing salaries, benefits, and incentives for similar work in private industry, including engineering and electric utility companies, publicly owned electric utilities, and Federal, State, and local governments.

"(3) CONSIDERATIONS.—The compensation plan shall provide that education, experience, level of responsibility, geographic differences, and retention and recruitment needs will be taken into account in determining salaries of employees.

"(4) SUBMISSION TO CONGRESS.—No salary shall be established under a compensation plan until after the compensation plan and the survey on which it is based have been submitted to Congress and made available to the public for a period of 30 days.

"(5) POSITIONS AT OR BELOW LEVEL IV.—The chief executive officer shall determine the salary and benefits of employees whose annual salary is not greater than the annual rate payable for positions at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(6) POSITIONS ABOVE LEVEL IV.—On the recommendation of the chief executive officer, the Board shall approve the salaries of employees whose annual salaries would be in excess of the annual rate payable for positions at level IV of the Executive Schedule under section 5315 of title 5, United States Code.".

(b) CURRENT BOARD MEMBERS.—A member of the board of directors of the Tennessee Valley Authority who was appointed before the effective date of the amendment made by subsection (a)—

(1) shall continue to serve as a member until the date of expiration of the member's current term; and

(2) may not be reappointed.

SEC. 2. CHANGE IN MANNER OF APPOINTMENT OF STAFF.

Section 3 of the Tennessee Valley Authority Act of 1933 (16 U.S.C. 831b) is amended—

(1) by striking the first undesignated paragraph and inserting the following:

"(a) APPOINTMENT BY THE CHIEF EXECUTIVE OFFICER.—The chief executive officer shall appoint, with the advice and consent of the Board, and without regard to the provisions of the civil service laws applicable to officers and employees of the United States, such managers, assistant managers, officers, employees, attorneys, and agents as are necessary for the transaction of the business of the Corporation."; and

(2) by striking "All contracts" and inserting the following:

"(b) WAGE RATES.—All contracts".

SEC. 3. CONFORMING AMENDMENTS.

(a) The Tennessee Valley Authority Act of 1933 (16 U.S.C. 831 et seq.) is amended—

(1) by striking "board of directors" each place it appears and inserting "Board of Directors"; and

(2) by striking "board" each place it appears and inserting "Board".

(b) Section 9 of the Tennessee Valley Authority Act of 1933 (16 U.S.C. 831h) is amended—

(1) by striking "The Comptroller General of the United States shall audit" and inserting the following:

"(c) AUDITS.—The Comptroller General of the United States shall audit"; and

(2) by striking "The Corporation shall determine" and inserting the following:

"(d) ADMINISTRATIVE ACCOUNTS AND BUSINESS DOCUMENTS.—The Corporation shall determine".

SEC. 4. EFFECTIVE DATE.

The amendments made by this Act take effect, and 7 additional members of the Board of Directors of the Tennessee Valley Authority shall be appointed so as to commence their terms on, the first date following the date of enactment of this Act on which the term of a member of the Board of Directors of the Tennessee Valley Authority expires.

By Mr. WYDEN (for himself and Mrs. FEINSTEIN);

S. 1352. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. WYDEN. Mr. President: Today, I introduce, for myself and Mrs. FEINSTEIN, the Community and Forest Protection Act. I ask unanimous consent that the text of the bill to be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

(a) FINDINGS.—Congress finds that:

(1) In 2002, approximately six and one half million acres of forest lands in the U.S. burned with varying degrees of severity, 21 people lost their lives, and over 3000 structures were destroyed. The Forest Service and Bureau of Land Management spent more than $1 billion fighting these fires.

(2) 73 million acres of public lands are classified as condition class 3 fire risks. This includes 23 million acres that are in strategic areas designated by the U.S. Forest Service for emergency treatment to withstand catastrophic fire.

(3) The forest management policy of fire suppression has resulted in an accumulation of fuel loads, dead and dying trees, and non-native species that create fuel ladders which allow fires to reach the crowns of large old trees and cause catastrophic fire.

(4) The U.S. Forest Service and the Department of the Interior should immediately undertake an emergency program to reduce the risk of catastrophic fire.

(5) This emergency program should prioritize the protection of homes and communities and the restoration of forest health on lands at the highest risk of catastrophic fire. All fuel reduction treatments should protect old growth stands and large trees to ensure a rich and continued species diversity in the nation's forests.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Community and Forest Protection Act".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1 Short title; table of contents.
Sec. 2 Hazardous fuels reduction projects.
Sec. 3 Expedited process.
Sec. 4 Judicial review in the United States District Courts.
Sec. 5 Contracting.
Sec. 6 Biomass grants.
Sec. 7 Forest stands inventory and monitoring program.
Sec. 8 Emergency fuels reduction grants.
Sec. 9 Market incentives for home protection.
Sec. 10 Ongoing projects and existing authorities.
Sec. 11 Preference to communities that have ordinances on fire prevention.
Sec. 12 Sunset.
Sec. 13 Authorization of appropriations.
Sec. 14 Definitions.

SEC. 2. HAZARDOUS FUELS REDUCTION PROJECTS.

(a) IN GENERAL.—The Secretaries of Agriculture and the Interior shall conduct immediately and to completion hazardous fuels reduction projects consistent with the Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risks to Communities and the Environment on an aggregate area of 20 million acres of federal land.

(1) These projects shall be conducted on the priority lands identified in subsection (d), using the expedited procedures in section 3.

(2) The Secretaries shall protect old growth stands and large trees pursuant to subsection (h).

(b) SELECTION OF PROJECTS.—The Secretaries of Agriculture and the Interior shall jointly select hazardous fuels reduction projects identified by the Implementation Plan of the Comprehensive Strategy.

(c) CONSISTENCY WITH EXISTING FOREST MANAGEMENT PLANS AND ENVIRONMENTAL LAWS.—Any project carried out pursuant to this Act shall be consistent with the applicable forest plan, resource management plan, or other applicable agency plans or environmental laws except as specifically amended by this Act.

(d) PRIORITY LANDS.—In implementing projects under this Act, the Secretaries of Agriculture and the Interior shall give highest priority to:

(1) Wildland-urban interface: Condition class 3 or condition class 2 federal lands or, where appropriate, non-federal lands;

(2) Municipal watersheds: Condition class 3 federal lands located in such proximity to a municipal water supply system that a hazardous fuels reduction project must be carried out to reduce the risk of harm to such system resulting from wildfire;

(3) Fire Regime I lands: Federal lands that are condition class 3; and

(4) Fire Regimes II and III lands: Condition class 3 federal lands identified by the Secretary as an area where windthrow or blowdown, or the existence of disease or insect infestation, pose a significant threat to forest health or adjacent private lands.

(e) PUBLIC NOTICE AND PUBLIC RESPONSE.—

(1) QUARTERLY NOTICE.—The Secretary shall provide quarterly notice of each hazardous fuels reduction project which uses the streamlined processes established by this Act. The quarterly notice shall be provided for all projects in the Federal Register and on an agency website and in a local paper of record for local projects. The Secretary may combine this quarterly notice with other quarterly notices otherwise issued regarding federal forest management.

(2) Content.—For each hazardous fuels reduction project for which the processes established by this Act are to be used the notice required by paragraph (1) shall include at a minimum:

(A) identification of each project as a hazardous fuels reduction project for which the processes established by this Act are to be used;

(B) a description of the project, including as much information on its geographic location as practicable;

(C) the approximate date on which scoping for the project will begin; and

(D) information regarding how interested members of the public can take part in the development of the project, including, but not limited to, project related public meeting notification.

(3) Public meeting.—Following publication of each quarterly notice under paragraph (1), but before the beginning of scoping under section 3(a), the Secretary shall conduct a public meeting at an appropriate location in each administrative unit of the federal lands regarding those hazardous fuels reduction projects contained in the quarterly notice that are proposed to be conducted in that administrative unit. The Secretary shall provide advance notice of the date and time of the meeting in the quarterly notice or using the same means described in paragraph (1).

(4) Public response to notice of Projects.—

(A) In general.—A federally formed resource advisory committee may petition, with supporting evidence, the Secretary to better assess ground conditions of land to be covered by projects, during scoping or public comment on specific hazardous fuels reduction projects identified under subsection (b).

(B) Priority lands included in the projects.—For specific hazardous fuels reduction projects the petitioner may seek to correct the inclusion or exclusion of priority lands identified in subsection (d). The petitioner may also seek designation of large trees or old growth stands to be protected under subsection (h).

(C) Secretarial response.—The Secretary must respond to the petition within 30 days by. public notice by the same means described in paragraph (1). The Secretary shall provide a public viewing of the area in question if requested in the petition within 90 days of receipt. of the petition, with the petitioner and any other interested parties.

(D) Determination of petition.—The Secretary must accept or deny the petition within 120 days of its receipt, based on site-specific review of historic ecological conditions, forest type, present fuel loads, and determination of whether the area properly qualifies as priority lands under subsection (d).

(5) Final agency action.—The Secretary shall provide notice by the same means described in paragraph (1) of any final agency action regarding a hazardous fuels reduction project for which the processes established by this Act are used.

(f) Priority Hazardous Fuels Reduction Funding.—The Secretaries shall expend no less than 70 percent of funds under this Act on projects within the wildland-urban interface, provided that the Secretaries may adjust this funding formula for a particular State at the request of its governor. In no event shall the Secretaries expend less than 50 percent or greater than 75 percent of funds within the wildland-urban interface for a particular State.

(g) Monitoring.—The Secretaries shall establish a multiparty monitoring process with representation from resource industries, environmentalists, independent scientists, community-based organizations, and other interested parties in order for Congress to assess a representative sampling of the hazardous fuels reduction projects implemented pursuant to this Act.

(h) Limitations.—In implementing hazardous fuels reduction projects under this Act the Secretary:

(1) shall not undertake any hazardous fuels reduction projects in wilderness study areas or components of the National Wilderness Preservation System;

(2) shall not construct new roads in inventoried roadless areas as part of any hazardous fuels reduction project;

(3) shall fully maintain the structure, function, processes and composition of structurally complex older forests (old growth) according to each ecosystem type; and

(4) outside old growth stands:

(A) shall focus on small diameter trees and thin from below to modify fire behavior as measured by rate of spread, height to live crown, and flame length; and

(B) shall maximize the retention of large trees to the extent that they promote fire-resistant stands and species diversity as appropriate for the forest type and site.

SEC. 3. EXPEDITED PROCESS.

(a) Scoping.—The Secretary shall conduct scoping for each hazardous fuels reduction project implemented pursuant to this Act.

(b) Categorical Exclusions in the Wildland-Urban Interface.—

(1) In general.—The wildland-urban interface hazardous fuels reduction projects authorized by this Act are conclusively determined to be categorically excluded from further analysis under the National Environmental Policy Act of 1969 ("NEPA"), 42 U.S.C. 4332, and the Secretary need not make any findings as to whether the projects individually or cumulatively have a significant effect on the environment.

(2) Varied treatments.—The Secretary shall vary the treatments and avoid clear cuts inside the wildland-urban interface to ensure forest health. The Secretary shall also protect old growth and large trees pursuant to subsection 2(h).

(3) Extraordinary circumstances exception.—For all hazardous fuels reduction projects implemented pursuant to this subsection, if there are extraordinary circumstances, the Secretary shall follow agency procedures related to categorical exclusions and extraordinary circumstances. For the purposes of this subsection, a project's location within a municipal watershed shall not be considered an extraordinary circumstance.

(4) Appeals.—No hazardous fuels reduction projects implemented pursuant to this subsection shall be subject to appeal requirements of the Appeals Reform Act (section 322 of Public Law 102-381) or the Department of the Interior Office of Hearings and Appeals.

(c) Environmental Assessments Outside the Wildland-Urban Interface.—

(1) In general.—For hazardous fuels reduction projects implemented pursuant to this Act on priority lands identified in section 2(d), if a categorical exclusion does not apply, the Secretary shall determine, consistent with NEPA, whether an environmental assessment is sufficient and use the procedures set forth in the Council on Environmental Quality "Guidance for Environmental Assessments of Forest Health Projects," of December 9, 2002, or as amended.

(2) Issuance of documentation and shortened appeals.—Notwithstanding the Appeals Reform Act, section 322 of the Department of the Interior and Related Agencies Appropriations Act, 1993 (Public Law 102 381; 16 U.S.C. 1612 note), or regulations pertaining to the Department of the Interior Office of Hearings and Appeals procedures, for hazardous fuels reduction projects implemented by environmental assessments pursuant to subsection (c)(1):

(A) The Secretary may issue the environmental documentation and the decision document for the project simultaneously without public comment. Such issuance shall begin the administrative appeals process immediately.

(B) Persons must file any administrative appeal of projects under this subsection within 30 days after the date of issuance of a decision;

(C) The Secretary shall resolve any appeal not later than 30 days after the closing date for filing an appeal;

(D) If the review officer determines that an appeal has merit, in lieu of remanding the proposed agency action, the review officer, in consultation with the parties, may sign a new decision; and (E) The Secretary shall stay implementation of the project for 15 days beginning on the date on which the Secretary resolves any administrative appeal that complies with the requirements in subsection (d).

(d) Standing to Appeal.—If a draft document prepared pursuant to NEPA for a hazardous fuels reduction project was available for public comment, or the project had scoping, the Secretary may require that a person filing an administrative appeal with respect to the project must have been involved in the public comment process for the project by submitting specific and substantive written comments with regard to the project or must have participated in the scoping of the project.

(e) Salvage Monitoring Pilot Program.—

(1) Salvage pilot.—The Secretary is authorized to use the administrative appeals authorities under this subsection, pursuant to paragraph (2), for salvage hazardous fuels reduction projects in the area popularly known as the Biscuit Fire and reference on the map entitled and dated   on file at the Forest Service   office.

(2) Monitoring.—The Secretary shall require that any salvage hazardous fuels reduction project on the Biscuit Fire be subject to ecological and economic monitoring of its effects, including on-site evaluation and inspections. The monitoring shall be conducted by a group with representation from independent scientists, industry representatives, environmentalists, community-based organizations, and other interested parties. Group selection shall be through the Western Governors Association Collaborative process. The group shall report to the public under section 2(e)(1) on the ecological and economic effects of individual salvage hazardous fuels projects.

SEC. 4. JUDICIAL REVIEW IN THE UNITED STATES DISTRICT COURTS.

(a) Venue.—A hazardous fuels reduction project conducted under this Act shall be subject to judicial review only in the United States district court for the district in which the federal lands to be treated by the hazardous fuels reduction project are located, notwithstanding 28 U.S.C. 1391 or any other applicable venue statutes.

(b) Expeditious Completion of Judicial Review.—Congress intends and encourages any court in which is filed a lawsuit or appeal of a lawsuit concerning an authorized hazardous fuels reduction project to expedite, to the maximum extent practicable, the proceedings in such lawsuit or appeal with the goal of rendering a final determination on jurisdiction, and if jurisdiction exists, a final determination on the merits, as soon as possible from the date the complaint or appeal is filed.

(c) Duration of Injunction.—Any temporary injunctive relief granted regarding a project undertaken pursuant to this Act shall be limited to 60 days, with authority to renew each temporary injunction without limitation. For each injunctive renewal the parties shall present the court with updates on the status of the project.

(d) Standard of Review.—Nothing in this section shall change the standards of judicial review for any action concerning a project authorized under this Act.

SEC. 5. CONTRACTING.

(a) Best Value Contracting.—The Secretary shall use best value contracting criteria in awarding at least fifty percent of contracts and agreements for hazardous fuels reduction projects pursuant to this Act. Best value contract criteria will include, but not be limited to:

(1) the ability of the contractor to meet the ecological goals of the projects;

(2) the use of equipment that will minimize or eliminate impacts on soils; and (3) benefit to local economies in performing the restorative treatments and ensuring that wood byproducts are processed locally.

(b) Monitoring.—The Forest Service shall monitor the business and employment impacts of hazardous fuels reduction projects including the total dollar value of contracts and agreements awarded to qualifying entities.

(c) Public Lands Corps.—

(1) Contracts and Agreements.—

(A) In general.—The Secretaries are authorized to enter into contracts or cooperative agreements with a Public Lands Corps

(i) to implement and complete projects prioritized in section 2(b) and (d) of this Act; and

(ii) to perform appropriate rehabilitation, enhancement, or beautification projects with the Department of Natural Resources, Department of Forestry or Department of Agriculture of any State.

(B) Indian Lands.—Such projects may also be carried out on Indian lands with the approval of the relevant Indian tribe.

(C) Preference.—The Secretaries shall give preference to those projects which take place on lands identified as priorities in section 2(d) of this Act and can be planned and initiated promptly.

(D) Supportive services.—The Secretaries are authorized to provide such services as the Secretaries deem necessary to carry out the purposes of this Act.

(E) Technical assistance.—The Secretaries shall work with the National Association of Service and Conservation Corps to provide technical assistance, oversight, monitoring, and evaluation to the United States Departments of Agriculture and the Interior, State Departments of Natural Resources and Agriculture, and Public Lands Corps.

(2) Nondisplacement.—The nondisplacement requirements of Section 177 of the National and Community Service Trust Act of 1990 shall be applicable to all activities carried out under this Act by the Public Lands Corps.

(3) Authorization of appropriations.—For the purposes of this subsection there are authorized to be appropriated $12,500,000 annually for 5 years after the enactment of this Act.

(d) Definitions.— For the purposes of this section—

(1) Contracts and agreements.—The term "contracts and agreements" means service contracts, timber sale contracts, construction contracts, supply contracts, emergency equipment rental agreements, architectural and engineering contracts, challenge cost-share agreements, cooperative agreements, and participating agreements.

(2) Qualifying entity.—The term "qualifying entity" means—

(A) a natural-resource related small or micro-enterprise;

(B) a Youth Conservation Corps or Public Lands Corps crew or related partnership with State, local and other non-federal conservation corps;

(C) an entity that will hire and train local people to complete the contract or agreement;

(D) an entity that will re-train non-local traditional forest workers to complete the contract or agreement; or

(E) a local entity that meets the criteria to qualify for the Historically Underutilized Business Zone Program under section 32 of the Small Business Act (15 U.S.C. 657a).

(3) Public lands corps.—The term "Public Lands Corps" means any organization established by a state or local government, nonprofit organization, or Indian tribe that:

(A) has demonstrated the ability:

(i) to provide labor intensive productive work to individuals;

(ii) to recruit and train economically disadvantaged or at-risk youth;

(iii) to give participants a combination of work experience, basic and life skills, education, training and support services; and

(iv) to provide participants with the opportunity to develop citizenship values through service to their communities and the United States; and

(B) has also successfully completed, or is engaged in, a peer-reviewed, standards based program assessment process.

(4) State.—The term "State" means any State of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands of the United States, or the Commonwealth of the Northern Mariana Islands.

SEC. 6. BIOMASS GRANTS.

(a) Definitions.—For the purposes of this section:

(1) Eligible operation.—The term "eligible operation" means a facility, that is located within the boundaries of an eligible community and uses biomass from federal or Tribal lands as a raw material to produce electric energy, sensible heat, transportation fuels, or substitutes for petroleum-based products.

(2) Biomass.—The term "biomass" means pre-commercial thinnings of trees and woody plants, or non-merchantable material, from hazardous fuels reduction projects.

(3) Green ton.—The term "green ton" means 2,000 pounds of biomass that has not been mechanically or artificially dried.

(4) Eligible community.—The term "eligible community" means any Indian Reservation, or any county, town, township, municipality, or other similar unit of local government that has a population of not more than 50,000 individuals and is determined by the Secretary to be located in an area near federal or Tribal lands which is at significant risk of catastrophic wildfire, disease, or insect infestation or which suffers from disease or insect infestation.

(5) Indian tribe.—The term "Indian tribe" has the meaning given the term in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)).

(b) Biomass Commercial Utilization Grant Program.—

(1) In general.—The Secretary may make grants to any individual, community, Indian tribe, small business or corporation, or nonprofit that owns or operates an eligible operation to offset capital expenses and costs incurred to purchase biomass for use by such eligible operation with priority given to operations using biomass from the highest risk areas.

(2) Limitation.—No grant provided under this subsection shall be paid at a rate that exceeds $20 per green ton of biomass delivered.

(3) Records.—Each grant recipient shall keep such records as the Secretary may require to fully and correctly disclose the use of the grant funds and all transactions involved in the purchase of biomass. Upon notice by the Secretary, the grant recipient shall provide the Secretary reasonable access to examine the inventory and records of any eligible operation receiving grant funds.

(4) Authorization of appropriations.—For the purposes of this subsection, there are authorized to be appropriated $12,500,000 each to the Secretary of the Interior and the Secretary of Agriculture for each fiscal year for five years after the date of enactment of this Act.

(c) Improved Biomass Utilization Program.—

(1) In general.—The Secretary may make grants to persons in eligible communities to offset the costs of developing or researching proposals to improve the use of biomass or add value to biomass utilization.

(2) Selection.—Grant recipients shall be selected based on the potential for the proposal to—

(A) develop affordable thermal or electric energy resources for the benefit of an eligible community;

(B) provide opportunities for the creation or expansion of small businesses within an eligible community;

(C) create new job opportunities within an eligible community, and

(D) reduce the hazardous fuels from the highest risk areas.

(3) Limitation.—No grant awarded under this subsection shall exceed $500,000.

(4) Authorization of appropriations.—For the purposes of this subsection, there are authorized to be appropriated $12,500,000 each to the Secretary of the Interior and the Secretary of Agriculture for each fiscal year for the five years after enactment of this Act.

(d) Report.—Not later than 3 years after the date of enactment of this Act, the Secretary of the Interior and the Secretary of Agriculture shall jointly submit to the Congress a report that describes the interim results of the programs authorized under this section.

SEC. 7. FOREST STANDS INVENTORY AND MONITORING PROGRAM.

(a) In General.—The Secretary of Agriculture and the Secretary of the Interior shall carry out, in conjunction with the National Aeronautics and Space Administration and other relevant agencies and research facilities (including the Forest Service Research Stations and academic institutions), a comprehensive program to inventory and assess forest stands on federal forest land and, with the consent of the owner, private forest land. The objective of this program shall be to evaluate current and future forest health conditions and address ecological impacts of insect, disease, invasive species, fire and weather-related episodic events. Emphasis shall be placed upon coordinating, reconciling, and field verification of existing data (including remotely sensed and modeled data utilized to characterize vegetation/cover types, density, fire regimes, fire effects, and condition classes), and improving the accuracy of such data to assist in management activities.

(b) Location.—The facility for this program shall be located at the Ochoco National Forest Headquarters in Prineville, Oregon.

(c) Authorization of Appropriations.—For the purposes of this section, there are authorized to be appropriated $5,000,000 each fiscal year for the five years after enactment of this Act.

SEC. 8. EMERGENCY FUELS REDUCTION GRANTS.

(a) In General.—The Secretary of Agriculture shall establish an Emergency Fuels Reduction Grant program to provide State and local agencies with financial assistance for hazardous fuels reduction projects addressing threats of catastrophic fire that have been determined by the United States Forest Service to pose a serious threat to human life.

(b) Eligibility.—Fuels reduction projects eligible for funding under the Emergency Fuels Reduction Grant program shall:

(1) be surrounded by or immediately adjacent to national forest boundaries;

(2) have been determined to be of paramount urgency by virtue of declarations of emergency by both local officials and the governor of the State in which they are located; and

(3) remove fuel loading determined to pose a serious threat to human life by the United States Forest Service.

(c) Use of Grant Funds.—Funds authorized under this section shall be limited to the following uses:

(1) removal of trees, shrubs or other potential fuels adjacent to primary evacuation routes;

(2) removal of trees, shrubs or other potential fuels adjacent to emergency response centers, emergency communication facilities or sites designated as shelter-in-place facilities; and

(3) evacuation drills and preparation.

(d) Revolving Fund.—For work done on private property and county lands, the grant recipients shall deposit into a revolving fund any proceeds from sale of the timber or biomass from the projects funded under this section. The revolving fund shall be used to assist with subsequent grants under this section.

(e) Emergency Fuels Reduction Grants.—For the purposes of funding the Emergency Fuels Reduction Grant program under this Act, there are authorized to be appropriated to the Secretary of Agriculture $50,000,000 each fiscal year that this Act is in effect. Subject to section 13, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

SEC. 9. MARKET INCENTIVES FOR HOME PROTECTION.

It is the Sense of Congress that insurers should reduce premiums for homeowners in condition class 2 and condition class 3 areas within the wildland-urban interface who:

(1) clear brush and other flammable material in the vicinity of their homes;

(2) use non-flammable building materials for roofs and other critical structures; or

(3) otherwise improve the defensibility of their homes against catastrophic fire.

SEC. 10. ONGOING PROJECTS AND EXISTING AUTHORITIES.

Nothing in this Act shall affect projects begun prior to enactment of this Act or affect authorities otherwise granted to the Secretaries under existing law.

SEC. 11. PREFERENCE TO COMMUNITIES THAT HAVE ORDINANCES ON FIRE PREVENTION.

(a) In General.—In determining the allocation of funding for the Community and Private Land Fire Assistance Program (16 USC 2106c/PL–171 Sec. 10A(b)), the Secretary shall prioritize funding to those communities which have taken proactive steps through the enactment of ordinances and other means, including those that have developed a comprehensive fire protection plan encompassing all ownerships, to encourage property owners to reduce fire risk on private property.

(b) Private Lands.—Nothing in this Act shall affect existing authorities to use appropriations authorized by this Act to carry out the provisions under this Act on non-federal lands with the consent of the land owner.

SEC. 12. SUNSET.

The provisions of this Act shall expire five years after the date of enactment, except that projects for which a decision notice has been issued by that date may continue to be implemented.

SEC. 13. AUTHORIZATION OF APPROPRIATIONS.

(a) National Forest System Lands.—For the purposes of planning and conducting hazardous fuels reduction projects under this Act on National Forest System Lands, there are authorized to be appropriated to the Secretary of Agriculture $1,943,100,000 during the five-fiscal year period beginning October 1, 2003. Subject to section 12, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

(b) BLM Lands.—For the purpose of planning and conducting hazardous fuels reduction projects under this Act on Federal lands managed by the Secretary of the Interior, there are authorized to be appropriated to the Secretary of the Interior $1,888,000,000 during the five-fiscal year period beginning October 1, 2003. Subject to section 12, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

SEC. 14. DEFINITIONS.

(a) Land Types and Fire Regime Areas.—In this Act definitions of land types and fire regimes originate from the U.S. Forest Service Rocky Mountain Research Station, as follows—

(1) Condition Class 2.—The term "condition class 2" refers to lands on which—

(A) fire frequencies have been moderately altered and have departed from historic fire return frequencies (either increased or decreased) by one or more return interval, which results in moderate changes to fire size, frequency, intensity, severity or landscape patterns;

(B) there exists a moderate risk of losing key ecosystem components; and

(C) vegetation attributes have been moderately altered from their historic range.

(2) Condition Class 3.—The term "condition class 3" refers to lands on which—

(A) fire regimes have been significantly altered from their historic range, which results in dramatic changes to fire size, frequency, intensity, severity, or landscape patterns;

(B) there exists a high risk of losing key ecosystem components; and

(C) vegetation attributes have been significantly altered from their historic range.

(3) Fire Regime I.—The term "fire regime I" refers to lands on which historically fire recurs in 0–35 year intervals and burns with low severity.

(4) Fire Regime II.—The term "fire regime IP" refers to lands on which historically fire recurs in 0–35 year intervals and replaces existing vegetation.

(5) Fire Regime III.—The term "fire regime III" refers to lands on which historically fire recurs in 35–100 year intervals and burns with mixed severity.

(b) At-Risk Community.—The term "at-risk community" means a geographic area designated by the Secretary as any area—

(1) defined as an interface community in Volume 66, page 753, of the January 4, 2001 Federal Register;

(2) on which conditions are conducive to large-scale wildland fire disturbance events; and

(3) for which a significant threat to human life exists as a result of wildland fire disturbance events.

(c) Best Value Contracting.—The term "best value contracting" means the contracting process described in section 15.101 of title 48, Code of Federal Regulations, which allows the inclusion of non-cost factors in the federal contract process.

(d) Comprehensive Strategy.—The term "Comprehensive Strategy" means the Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risks to Communities and the Environment, dated May 2002, including by reference the related Implementation Plan, which was developed pursuant to the conference report to accompany the Department of Interior and Related Agencies Appropriations Act, 2001 (House Report 106–646).

(e) Federal Lands.—The term "federal lands" means National Forest System lands and public forested lands administered by the Secretary of the Interior acting through the Bureau of Land Management.

(f) Geographic Feature.—The term "geographic feature" means a ridge top, road, stream, or other landscape feature which can serve naturally as a firebreak, staging ground for firefighting, or boundary affecting fire behavior.

(g) Hazardous Fuels Reduction Project.—The term "hazardous fuels reduction project" means a project—

(1) undertaken for the purpose of reducing the amount of hazardous fuels resulting from alteration of a natural fire regime as a result of fire suppression or other management activities; and

(2) accomplished through the use of prescribed burning or mechanical treatment, or a combination thereof.

(h) Inventoried Roadless Area.—The term "inventoried roadless area" means one of the areas identified in the set of inventoried roadless area maps contained in the Forest Service Roadless Areas Conservation, Final Environmental Impact Statement, Volume 2, dated November, 2000.

(i) Local Preference Contracting.—The term "local preference contracting" means the federal contracting process that gives preference to local businesses described in section 333 of the Department of Interior and Related Agencies Appropriations Act, 2003 (division F of Public Law 108–7, 117 Stat. 277).

(j) Municipal Water Supply System.—The term "municipal water supply system" means reservoirs, canals, ditches, flumes, laterals, pipes, pipelines, or other surface facilities and systems constructed or installed for the impoundment, storage, transportation, or distribution of drinking water for a community.

(k) Secretary.—The term "Secretary" means the Secretary of Agriculture, or the

Secretary's designee, with respect to National Forest System lands; and the Secretary of the Interior, or the Secretary's designees, with respect to public lands administered by the Secretary through the Bureau of Land Management.

(1) WILDLAND-URBAN INTERFACE.—The term "wildland-urban interface" means the area either within an at-risk community or within the area.

(1) extending out to a geographic feature, if there is such a feature within approximately three-quarters of a mile of the community boundary; or

(2) if there is no such geographic feature, extending out one-half mile from the community boundary.

Mrs. FEINSTEIN. I rise to introduce with Senator WYDEN a bill to reduce the risk of catastrophic fire in our country's magnificent national forests.

No one who watched last week as Arizona's community of Summerhaven on Mount Lemmon burned can doubt the importance of this issue. My heart goes out to the residents of Summerhaven, and to the others who will be displaced by the fires yet to come this summer.

Americans know that there is something wrong with our national forests. For too long we have suppressed fires, gradually letting brush and small trees multiply until many of our forests are now choked by a dense thicket.

Today, there are 57 million acres of Federal lands at the highest risk of catastrophic forest fires. If we do not take action now, these forests could go up in smoke. This bill we are introducing today is balancing, and it will reduce the risk of catastrophic fire in our country's magnificent national forests.

This legislation would speed up the environmental review process—without sacrificing the most important environmental protections. It also would protect the communities which face the highest risk and safeguard old growth stands and large trees. And it would include sensible provisions on judicial review that will help projects go forward quickly without compromising our independent judiciary. These are provisions that makes sense, and I hope that my colleagues will support the bill.

We have crafted our bill around three fundamental principles:

We should focus limited Federal resources on protecting communities and on the forest lands truly most at risk;

We should speed up the environmental review process, but without sacrificing the most important environmental protections; and

We should protect old growth stands and large trees.

Let me show how the bill achieves these three goals.

First, the bill prioritizes our efforts. Many people believe that we should protect communities first. The bill does so. Seventy percent of the funding is directed to the wildland-urban interface near communities.

Of course, conditions vary by State. The bill allows Governors to adjust the percentage of work that is to be done within the wildland—urban interface for their State, up to a maximum of 75 percent, or down to a minimum of 50 percent.

By way of contrast, H.R. 1904, which passed the House, includes no focus on protecting communities. All the money can be spent far from communities under H.R. 1904, even if the Governor of a State wishes otherwise.

Senator WYDEN and I believe that in addition to protecting communities, there are some forest lands that should be thinned to ensure that catastrophic fires do not devastate the forest and eliminate habitat for the species that live there.

In the last century, Americans have rigorously suppressed fires, stamping them out whenever they start. In certain forests like ponderosa pine, these fires would naturally have cleared out the brush and small trees every 10 or 20 years or so.

In the absence of these fires, brush has grown into "doghair thickets" with dangerous levels of fuel loadings. When fires burn now in these forests, they will be so hot that they won't just clear out the brush but will kill the large trees and often scorch the soil.

These are the forests where we need to focus our efforts. We thus target thinning projects to forests that are both Fire Regime I and Condition Class 3. Fire Regime I forests are those that used to have low-intensity, brush-clearing fires; and Condition Class 3 forests are the most altered from their natural condition. The combination of Fire Regime I and Condition Class 3 are the highest priority lands for treatment.

We also direct projects to municipal watersheds and diseased or windblown forests that are in Condition Class 3. If we don't protect the municipal watersheds, catastrophic fires could strip off the tree cover that prevents soils from eroding into creeks and lakes. Municipalities' water quality could suffer.

In contrast to our bill, H.R. 1904 fails to prioritize brush-clearing projects for the areas that need it the most. Instead, H.R. 1904 provides expedited processes for lands that are only moderately altered by fire suppression—Condition Class 2 lands in addition to Condition Class 3.

In many of the forests where H.R. 1904 would direct brush-clearing work, there naturally would have been severe fires that burned all the trees in the stand. After a thinning project, fires in these forests will still behave the same way, scorching and killing most of the trees. Thus, much of the thinning called for in H.R. 1904 would have little effect on the fire behavior or forest health.

Senator WYDEN and I have worked very hard to develop a bill that speeds up the review process so important work can get done without sacrificing environmental protections.

Almost everyone agrees that we need to work quickly to protect the areas immediately around communities. There is little controversy or debate over these projects.

The Forest Service has proposed an analytical short-cut for these projects, which requires very little environmental analysis and no formal pubic comment process or administrative appeal.

There is some uncertainty, however, over the Forest Service's proposed approach. People can claim that laws Congress has previously passed will require some of these projects to be held up by more environmental analysis or administrative appeals.

Our bill eliminates this uncertainty. When the Forest Service works in the immediate vicinity of a community, the bill would make absolutely clear that there need to be no environmental analysis or administrative appeals. The only exception is where there might be extraordinary circumstances, such as a major threat to endangered species. We also prohibit the Forest Service from conducting clearcuts around communities, requiring them to focus on clearing out the brush.

By way of comparison, the House-passed bill does not provide any assistance to thinning projects in the immediate vicinity of communities, even though everyone agrees on the need for these projects.

Senator WYDEN and I have also sped up the process for projects outside the immediate vicinity of communities. These projects are more controversial, so we want to make sure that the public has some opportunity for input.

In the past, the Forest Service and the Department of the Interior have been able to conduct the majority of brush-clearing mechanical treatment following a National Environmental Policy Act process known as environmental assessments. Our bill simplified these environmental assessments in several ways.

The bill provides one round of public comment—the administrative appeal process—rather than two.

The bill shortens the time frame for administrative appeals from 90 to 60 days.

Finally, the appeal deciding offer can make necessary changes rather than having to send the project back to the original decisionmaker for further time-consuming review.

Together, these changes will likely speed up the process by a few months or more. We do all this without eliminating public comment or gutting core parts of the environmental analysis.

In contrast, the House-passed bill would eliminate the requirement that the Forest Service consider alternatives to the proposed project as part of its environmental analysis. In other words, the Forest Service doesn't have to study other, less damaging ways of undertaking the project—it can just do the project the way it wants.

Many people think that public debate over alternatives is the core of the National Environmental Policy Act. Our bill does not eliminate this important environmental protection.

Another important part of our bill is its protection of magnificent old growth stands. The remaining groves of these trees provide a connection to nature untrammeled by human activity, a connection that many of us cherish.

Our bill would require full protection of these old growth stands. In addition, outside old growth stands, the bill focuses on small-diameter trees and protects large trees that promote fire-resistant stands and species diversity.

By way of contrast, H.R. 1904 provides no protection for these magnificent resources.

Let me now talk about judicial review. No one wants court cases to go on too long. In addition, people should not be able to tie up projects by gaming the system and picking and choosing the friendliest courts to hear their lawsuits.

Our bill addresses these problems. The bill encourages courts, to the maximum extent practicable, to resolve lawsuits over brush-clearing projects quickly. These are important projects for the safety of our communities and our forests, and it is appropriate to give them some priority.

In addition, we require that potential litigants file suit in the same judicial district where a fuels reduction project takes place, No one can game the system by looking for a friendly judge somewhere else.

Finally, we limit temporary injunctions that are typically issued at the outset of a case to 60 days. They can be renewed if necessary—but the challengers to a projects must submit updates explaining why the injunctions should be extended. This provision prevents projects from being held up any longer than is strictly necessary.

These changes will expedite the process—but they still respect our court system's essential autonomy. As a member of the Judiciary Committee, I spend much of my time trying to make sure our court system is as fair as possible.

Americans count on a judiciary independent of the executive branch to preserve their liberties and to right any wrongs that their government commits. I think it is very important that we do not interfere with the independence of our judiciary.

The House-passed bill would require the courts to give weight to certain findings by the Forest Service and the Department of the Interior. Even if projects had been found to violate the environmental laws, courts would be told to give weight to the agencies' findings and allow many of the projects to go ahead anyway.

This is a dangerous provision for a bill to include, and I cannot support it. I believe our bill includes more sensible provisions on judicial review that will help projects go forward quickly without compromising the independence of our judiciary.

Our bill includes several provisions to address forest health problems on private and State lands.

We authorize $50 million annually in emergency grants to States and localities where lives are at risk. The last few years have seen vast insect epidemics killing millions of trees in Southern California, Arizona, and elsewhere.

In places like Lake Arrowhead, Big Bear and Idyllwild in Southern California, communities are surrounded by dead and dying trees that are perfect kindling for a catastrophic fire. There is a real threat to people's lives that we must address.

There is now no good funding source for clearing evacuation routes and clearing around schools and other emergency shelters that are on State and private lands. The emergency grants in the bill would authorize funds for these essential purposes.

The bill also includes two measures to encourage homeowners to clear brush around their houses and install non-flammable roofs. A study of Southern California fires by Forest Service researcher Jack Cohen has shown that these measures could reduce a blaze's threat to homes by as much as 85 to 95 percent.

Our bill would encourage these home-saving practices in two ways:

The bill would prioritize grants to those communities that encourage brush-clearing and use of non-flammable roofs or develop comprehensive fire plans.

The bill would record the Sense of Congress that insurers should offer lower premiums to homeowners who take steps to protect their homes.

Our bill would also include grants to encourage the use of woody material, or biomass, for energy production. Biomass-to-energy plants serve multiple beneficial purposes: one, they are a clean and renewable source of energy; and two, they make brush-clearing projects more cost-effective, so we can protect more with the finite Federal dollars available.

Finally, our bill would also include contracting provisions to benefit rural communities. The Forest Service and the Department of the Interior would be required to use "best value contracting" for brush-clearing projects under the Act.

This contracting approach requires the agencies to consider other factors besides the price of the bid in awarding contractors. Bidders would be rewarded for such factors as their commitment to hire local workers, and their past record of environmental stewardship.

I would like to close by saying that this is truly a bipartisan issue. All of us, Democrat and Republican, have an interest in clearing out dangerous accumulations of brush in our national forests. All of us have an interest as well in protecting the magnificent old growth stands and species habitat that Americans cherish, and in upholding our environmental laws.

I look forward to working with my colleagues on both sides of the aisle to pass a bill as soon as possible.

By Mr. BROWNBACK (for himself and Mr. DEWINE):

S. 1353. A bill to establish new special immigrant categories; to the Committee on the Judiciary.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1353

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Widows and Orphans Act of 2003".

SEC. 2. NEW SPECIAL IMMIGRANT CATEGORY.

(a) CERTAIN CHILDREN AND WOMEN AT RISK OF HARM.—Section 101(a)(27) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(27)) is amended—

(1) in subparagraph (L), by inserting a semicolon at the end;

(2) in subparagraph (M), by striking the period at the end and inserting "; or"; and

(3) by adding at the end the following:

"(N) subject to subsection (j), an immigrant who is not present in the United States—

"(i) who is—

"(I) referred to a consular, immigration, or other designated official by a United States Government agency, an international organization, or recognized nongovernmental entity designated by the Secretary of State for purposes of such referrals; and

"(II) determined by such official to be a minor under 10 years of age (as determined under subsection (j)(5))—

"(aa) for whom no parent or legal guardian is able to provide adequate care;

"(bb) who faces a credible fear of harm related to his or her age;

"(cc) who lacks adequate protection from such harm; and

"(dd) for whom it has been determined to be in his or her best interests to be admitted to the United States; or

"(ii) who is—

"(I) referred to a consular or immigration official by a United States Government agency, an international organization or recognized nongovernmental entity designated by the Secretary of State for purposes of such referrals; and

"(II) determined by such official to be a female who has—

"(aa) a credible fear of harm related to her sex; and

"(bb) a lack of adequate protection from such harm.".

(b) STATUTORY CONSTRUCTION.—Section 101 of the Immigration and Nationality Act (8 U.S.C. 1101) is amended by adding at the end the following:

“(j)(1) No natural parent or prior adoptive parent of any alien provided special immigrant status under subsection (a)(27)(N)(i) shall thereafter, by virtue of such parentage, be accorded any right, privilege, or status under this Act.

“(2)(A) No alien who qualifies for a special immigrant visa under subsection (a)(27)(N)(ii) may apply for derivative status or petition for any spouse who is represented by the alien as missing, deceased, or the source of harm at the time of the alien's application and admission. The Secretary of Homeland Security may waive this requirement for an alien who demonstrates that the alien's representations regarding the spouse were bona fide.

“(B) An alien who qualifies for a special immigrant visa under subsection (a)(27)(N) may apply for derivative status or petition for any sibling under the age of 10 years or children under the age of 10 years of any such alien, if accompanying or following to join the alien. For purposes of this subparagraph, a determination of age shall be made using the age of the alien on the date the petition is filed with the Department of Homeland Security.

“(3) An alien who qualifies for a special immigrant visa under subsection (a)(27)(N) shall be treated in the same manner as a refugee solely for purposes of section 412.

“(4) The provisions of paragraphs (4), (5), and (7)(A) of section 212(a) shall not be applicable to any alien seeking admission to the United States under subsection (a)(27)(N), and the Secretary of Homeland Security may waive any other provision of such section (other than paragraph 2(C) or subparagraph (A), (B), (C), or (E) of paragraph (3) with respect to such an alien for humanitarian purposes, to assure family unity, or when it is otherwise in the public interest. Any such waiver by the Secretary of Homeland Security shall be in writing and shall be granted only on an individual basis following an investigation. The Secretary of Homeland Security shall provide for the annual reporting to Congress of the number of waivers granted under this paragraph in the previous fiscal year and a summary of the reasons for granting such waivers.

“(5) For purposes of subsection (a)(27)(N)(i)(II), a determination of age shall be made using the age of the alien on the date on which the alien was referred to the consular, immigration, or other designated official.

“(6) The Secretary of Homeland Security shall waive any application fee for a special immigrant visa for an alien described in section 101(a)(27)(N).”.

(c) ALLOCATION OF SPECIAL IMMIGRANT VISAS.—Section 203(b)(4) of the Immigration Nationality Act (8 U.S.C. 1153(b)(4)) is amended by striking “(A) or (B) thereof” and inserting “(A), (B), or (N) thereof”.

(d) EXPEDITED PROCESS.—Not later than 45 days from the date of referral to a consular, immigration, or other designated official as described in section 101(a)(27)(N) of the Immigration and Nationality Act, as added by subsection (a), special immigrant status shall be adjudicated and, if granted, the alien shall be paroled to the United States pursuant to section 212(d)(5) of that Act (8 U.S.C. 1182(d)(5)) and allowed to apply for adjustment of status to permanent residence under section 245 of that Act (8 U.S.C. 1255) within 1 year of the alien's arrival in the United States.

(e) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this section, the Secretary of Homeland Security shall report to the Committees on the Judiciary of the Senate and the House of Representatives on the progress of the program, including—

(1) data related to the implementation of this section;

(2) data regarding the number of placements of females and children at risk of harm as referred to in section 101(a)(27)(N) of the Immigration and Nationality Act, as added by subsection (a); and

(3) any other appropriate information that the Secretary of Homeland Security determines to be appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section and the amendments made by this section.

By Ms. MURKOWSKI (for herself and Mr. STEVENS):

S. 1354. A bill to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, I rise today to reintroduce a bill that passed the Senate with bipartisan support in the 107th Congress. This legislation addresses an equity issue for one of Alaska's rural village corporations.

Cape Fox Corporation is an Alaskan Village Corporation organized pursuant to the Alaska Native Claims Settlement Act, by the Native Village of Saxman, near Ketchikan, AK. As with other ANCSA village corporations in Southeast Alaska, Cape Fox was limited to selecting 23,040 acres under Section 16. However, unlike other village corporations, Cape Fox was further restricted from selecting lands within 6 miles of the boundary of the home rule city of Ketchikan. All other ANCSA corporations were restricted from selecting within 2 miles of such a home rule of city.

The 6-mile restriction went beyond protecting Ketchikan's watershed and damaged Cape Fox by preventing the corporation from selecting valuable timber lands, industrial sites, and other commercial property, not only in its core township, but in surrounding lands far removed from Ketchikan and its watershed. As a result of the 6-mile restriction, only the mountainous northeast corner of Cape Fox's core township, which is nonproductive and of no economic value, was available for selection by the corporation. Cape Fox's land selections were further limited by the fact that the Annette Island Indian Reservation is within its selection area, and those lands were unavailable for ANCSA selection. Cape Fox is the only ANCSA village corporation affected by this restriction.

Clearly, Cape Fox was placed on unequal economic footing relative to other village corporations in Southeast Alaska. Despite its best efforts during the years since ANCSA was signed into law, Cape Fox has been unable to overcome the disadvantage the law built into its land selection opportunities by this inequitable treatment.

To address this inequity, I have introduced the Cape Fox Land Entitlement Adjustment Act of 2003. This bill will address the Cape Fox problem by providing three interrelated remedies:

(1) The obligation of Cape Fox to select and seek conveyance of the approximately 160 acres of unusable land in the mountainous northeast corner of Cape Fox's core township will be annulled.

(2) Cape Fox will be allowed to select and the Secretary of the Interior will be directed to convey 99 acres of timber land adjacent to Cape Fox's current holdings on Revilla Island.

(3) Cape Fox and the Secretary of Agriculture will be authorized to enter into an equal value exchange of lands in Southeast Alaska that will be of mutual benefit to the Corporation and the U.S. Forest Service. Lands conveyed to Cape Fox in this exchange will not be timberlands, but will be associated with a mining property containing existing Federal mining claims, some of which are patented. Lands anticipated to be returned to Forest Service ownership will be of wildlife habitat, recreation and watershed values and will consolidate Forest Service holdings in the George Inlet area of Revilla Island.

The land exchange provisions of this bill will help rectify the long-standing inequities associated with restrictions placed on Cape Fox in ANCSA. It will help allow this Native village corporation to make the transition from its major dependence on timber harvest to a more diversified portfolio of income-producing lands.

The bill also provides for the resolution of a long-standing land ownership problem with the Tongass National Forest. The predominant private landowner in the region, Sealaska Corporation, holds the subsurface estate on several thousand acres of National Forest System lands. This split estate poses a management problem which the Forest Service has long sought to resolve. Efforts to address this issue go back more than a decade. Provisions in the Cape Fox Land Entitlement Act of 2003 will allow the agency to consolidate its surface and subsurface estate and greatly enhance its management effectiveness and efficiency in the Tongass National Forest. I urge my colleagues to support this important legislation. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1354

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 1. SHORT TITLE.

This Act may be cited as the "Cape Fox Land Entitlement Adjustment Act of 2003".

SEC. 2. FINDINGS.

Congress finds that:

(1) Cape Fox Corporation (Cape Fox) is an Alaska Native Village Corporation organized pursuant to the Alaska Native Claims Settlement Act (ANCSA) (43 U.S.C. 1601 et seq.) for the Native Village of Saxman.

(2) As with other ANCSA village corporations in Southeast Alaska, Cape Fox was limited to selecting 23,040 acres under section 16 of ANCSA.

(3) Except for Cape Fox, all other Southeast Alaska ANCSA village corporations were restricted from selecting within two miles of a home rule city.

(4) To protect the watersheds in the vicinity of Ketchikan, Cape Fox was restricted from selecting lands within six miles from the boundary of the home rule City of Ketchikan under section 22(1) of ANCSA (43 U.S.C. 1621(1)).

(5) The six mile restriction damaged Cape Fox by precluding the corporation from selecting valuable timber lands, industrial sites, and other commercial property, not only in its core township but in surrounding lands far removed from Ketchikan and its watershed.

(6) As a result of the 6 mile restriction, only the remote mountainous northeast corner of Cape Fox's core township, which is nonproductive and of no known economic value, was available for selection by the corporation. Selection of this parcel was, however, mandated by section 16(b) of ANCSA (43 U.S.C. 1615(b)).

(7) Cape Fox's land selections were further limited by the fact that the Annette Island Indian Reservation is within its selection area, and those lands were unavailable for ANCSA selection. Cape Fox is the only ANCSA village corporation affected by this restriction.

(8) Adjustment of Cape Fox's selections and conveyances of land under ANCSA requires adjustment of Sealaska Corporation's (Sealaska) selections and conveyances to avoid creation of additional split estate between National Forest System surface lands and Sealaska subsurface lands.

(9) Sealaska is the Alaska native regional corporation for Southeast Alaska, organized under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

(10) There is an additional need to resolve existing areas of Sealaska/Tongass split estate, in which Sealaska holds title or conveyance rights to several thousand acres of subsurface lands that encumber management of Tongass National Forest surface lands.

(11) The Tongass National Forest lands identified in this Act for selection by and conveyance to Cape Fox and Sealaska, subject to valid existing rights, provide a means to resolve some of the Cape Fox and Sealaska ANCSA land entitlement issues without significantly affecting Tongass National Forest resources, uses or values.

(12) Adjustment of Cape Fox's selections and conveyances of land under ANCSA through the provisions of this Act, and the related adjustment of Sealaska's selections and conveyances hereunder, are in accordance with the purposes of ANCSA and otherwise in the public interest.

SEC. 3. WAIVER OF CORE TOWNSHIP REQUIREMENT FOR CERTAIN LANDS.

Notwithstanding the provisions of section 16(b) of ANCSA (43 U.S.C. 1615(b)), Cape Fox shall not be required to select or receive conveyance of approximately 160 acres of Federal unconveyed lands within Section 1, T. 75 S., R. 91 E., C.R.M.

SEC. 4. SELECTION OUTSIDE EXTERIOR SELECTION BOUNDARY.

(a) Selection and Conveyance of Surface Estate.—In addition to lands made available for selection under ANCSA, within 24 months after the date of enactment of this Act, Cape Fox may select, and, upon receiving written notice of such selection, the Secretary of the Interior shall convey approximately 99 acres of the surface estate of Tongass National Forest lands outside Cape Fox's current exterior selection boundary, specifically that parcel described as follows:

(1) T. 73 S., R. 90 E., C.R.M.

(2) Section 33: SW portion of SE¼: 38 acres.

(3) Section 33: NW portion of SE¼: 13 acres.

(4) Section 33: SE¼ of SE¼: 40 acres.

(5) Section 33: SE¼ of SW¼: 8 acres.

(b) Conveyance of Subsurface Estate.—Upon conveyance to Cape Fox of the surface estate to the lands identified in subsection (a), the Secretary of the Interior shall convey to Sealaska the subsurface estate to the lands.

(c) Timing.—The Secretary of the Interior shall complete the interim conveyances to Cape Fox and Sealaska under this section within 180 days after the Secretary of the Interior receives notice of the Cape Fox selection under subsection (a).

SEC. 5. EXCHANGE OF LANDS BETWEEN CAPE FOX AND THE TONGASS NATIONAL FOREST.

(a) General.—The Secretary of Agriculture shall offer, and if accepted by Cape Fox, shall exchange the Federal lands described in subsection (b) for lands and interests therein identified by Cape Fox under subsection (c) and, to the extent necessary, lands and interests therein identified under subsection (d).

(b) Lands To Be Exchanged to Cape Fox.—The lands to be offered for exchange by the Secretary of Agriculture are Tongass National Forest lands comprising approximately 2,663.9 acres in T. 36 S., R. 62 E., C.R.M. and T. 35 S., R. 62 E., C.R.M., as designated upon a map entitled "Proposed Kensington Project Land Exchange", dated March 18, 2002, and available for inspection in the Forest Service Region 10 regional office in Juneau, Alaska.

(c) Lands To Be Exchanged to the United States.—Cape Fox shall be entitled, within 60 days after the date of enactment of this Act, to identify in writing to the Secretaries of Agriculture and the Interior the lands and interests in lands that Cape Fox proposes to exchange for the Federal lands described in subsection (b). The lands and interests in lands shall be identified from lands previously conveyed to Cape Fox comprising approximately 2,900 acres and designated as parcels A–1 to A–3, B–1 to B–3, and C upon a map entitled "Cape Fox Corporation ANCSA Land Exchange Proposal", dated March 15, 2002, and available for inspection in the Forest Service Region 10 regional office in Juneau, Alaska. Lands identified for exchange within each parcel shall be contiguous to adjacent National Forest System lands and in reasonably compact tracts. The lands identified for exchange shall include a public trail easement designated as D on said map, unless the Secretary of Agriculture agrees otherwise. The value of the easement shall be included in determining the total value of lands exchanged to the United States.

(d) Valuation of Exchange Lands.—The Secretary of Agriculture shall determine whether the lands identified by Cape Fox under subsection (c) are equal in value to the lands described in subsection (b). If the lands identified under subsection (c) are determined to have insufficient value to equal the value of the lands described in subsection (b), Cape Fox and the Secretary shall mutually identify additional Cape Fox lands for exchange sufficient to equalize the value of lands conveyed to Cape Fox. Such land shall be contiguous to adjacent National Forest System lands and in reasonably compact tracts.

(e) Conditions.—The offer and conveyance of Federal lands to Cape Fox in the exchange shall, notwithstanding section 14(f) of ANCSA, be of the surface and subsurface estate, but subject to valid existing rights and all other provisions of section 14(g) of ANCSA.

(f) Timing.—The Secretary of Agriculture shall attempt, within 90 days after the date of enactment of this Act, to enter into an agreement with Cape Fox to consummate the exchange consistent with this Act. The lands identified in the exchange agreement shall be exchanged by conveyance at the earliest possible date after the exchange agreement is signed. Subject only to conveyance from Cape Fox to the United States of all its rights, title and interests in the Cape Fox lands included in the exchange consistent with this title, the Secretary of the Interior shall complete the interim conveyance to Cape Fox of the Federal lands included in the exchange within 180 days after the execution of the exchange agreement by Cape Fox and the Secretary of Agriculture.

SEC. 6. EXCHANGE OF LANDS BETWEEN SEALASKA AND THE TONGASS NATIONAL FOREST.

(a) General.—Upon conveyance of the Cape Fox lands included in the exchange under section 5 and conveyance and relinquishment by Sealaska in accordance with this title of the lands and interests in lands described in subsection (c), the Secretary of the Interior shall convey to Sealaska the Federal lands identified for exchange under subsection (b).

(b) Lands To Be Exchanged to Sealaska.—The lands to be exchanged to Sealaska are to be selected by Sealaska from Tongass National Forest lands comprising approximately 9,329 acres in T. 36 S., R. 62 E., C.R.M., T. 35 S., R. 62 E., C.R.M., and T. 34 S., Range 62 E., C.R.M., as designated upon a map entitled "Proposed Sealaska Corporation Land Exchange Kensington Lands Selection Area", dated April 2002 and available for inspection in the Forest Service Region 10 Regional Office in Juneau, Alaska. Within 60 days after receiving notice of the identification by Cape Fox of the exchange lands under section 5(c), Sealaska shall be entitled to identify in writing to the Secretaries of Agriculture and the Interior the lands that Sealaska selects to receive in exchange for the Sealaska lands described in subsection (c). Lands selected by Sealaska shall be in no more than two contiguous and reasonably compact tracts that adjoin the lands described for exchange to Cape Fox in section 5(b). The Secretary of Agriculture shall determine whether these selected lands are equal in value to the lands described in subsection (c) and may adjust the amount of selected lands in order to reach agreement with Sealaska regarding equal value. The exchange conveyance to Sealaska shall be of the surface and subsurface estate in the lands selected and agreed to by the Secretary but subject to valid existing rights and all other provisions of section 14(g) of ANCSA.

(c) Lands To Be Exchanged to the United States.—The lands and interests therein to be exchanged by Sealaska are the subsurface estate underlying the Cape Fox exchange lands described in section 5(c), an additional approximately 2,506 acres of the subsurface estate underlying Tongass National Forest surface estate, described in Interim Conveyance No. 1673, and rights to be additional approximately 2,698 acres of subsurface estate of Tongass National Forest lands remaining to be conveyed to Sealaska from Group 1, 2 and 3 lands as set forth in the Sealaska Corporation/United States Forest Service Split Estate Exchange Agreement of November 26, 1991, at Schedule B, as modified on January 20, 1995.

(d) Timing.—The Secretary of Agriculture shall attempt, within 90 days after receipt of the selection of lands by Sealaska under subsection (b), to enter into an agreement with Sealaska to consummate the exchange consistent with this Act. The lands identified in the exchange agreement shall be exchanged by conveyance at the earliest possible date after the exchange agreement is signed. Subject only to the Cape Fox and Sealaska conveyances and relinquishments described in subsection (a), the Secretary of the Interior shall complete the interim conveyance to Sealaska of the Federal lands selected for exchange within 180 days after execution of the agreement by Sealaska and the Secretary of Agriculture.

(e) Modification of Agreement.—The executed exchange agreement under this section shall be considered a further modification of the Sealaska Corporation/United States Forest Service Split Estate Exchange Agreement, as ratified in section 17 of Public Law 102-415 (October 14, 1992).

SEC. 7. MISCELLANEOUS PROVISIONS.

(a) Equal Value Requirement.—The exchanges described in this Act shall be of equal value. Cape Fox and Sealaska shall have the opportunity to present to the Secretary of Agriculture estimates of value of exchange lands with supporting information.

(b) Title.—Cape Fox and Sealaska shall convey and provide evidence of title satisfactory to the Secretary of Agriculture for their respective lands to be exchanged to the United States under this Act, subject only to exceptions, reservations and encumbrances in the interim conveyance or patent from the United States or otherwise acceptable to the Secretary of Agriculture.

(c) Hazardous Substances.—Cape Fox, Sealaska, and the United States each shall not be subject to liability for the presence of any hazardous substance in land or interests in land solely as a result of any conveyance or transfer of the land or interests under this Act.

(d) Effect on ANCSA Selections.—Any conveyance of Federal surface or subsurface lands to Cape Fox or Sealaska under this Act shall be considered, for all purposes, land conveyed pursuant to ANCSA. Nothing in this Act shall be construed to change the total acreage of land entitlement of Cape Fox or Sealaska under ANCSA. Cape Fox and Sealaska shall remain charged for any lands they exchange under this Act and any lands conveyed pursuant to section 4, but shall not be charged for any lands received under section 5 or section 6. The exchanges described in this Act shall be considered, for all purposes, actions which lead to the issuance of conveyances to Native Corporations pursuant to ANCSA. Lands or interests therein transferred to the United States under this Act shall become and be administered as part of the Tongass National Forest.

(e) Effect on Statehood Selections.—Lands conveyed to or selected by the State of Alaska under the Alaska Statehood Act (Public Law 85-508; 72 Stat. 339; 48 U.S.C. note prec. 21) shall not be eligible for selection or conveyance under this Act without the consent of the State of Alaska.

(f) Maps.—The maps referred to in this Act shall be maintained on file in the Forest Service Region 10 Regional Office in Juneau, Alaska. The acreages cited in this Act are approximate, and if there is any discrepancy between cited acreage and the land depicted on the specified maps, the maps shall control. The maps do not constitute an attempt by the United States to convey State or private land.

(g) Easements.—Notwithstanding section 17(b) of ANCSA, Federal lands conveyed to Cape Fox or Sealaska pursuant to this Act shall be subject only to the reservation of public easements mutually agreed to and set forth in the exchange agreements executed under this Act. The easements shall include easements necessary for access across the lands conveyed under this Act for use of national forest or other public lands.

(h) Old Growth Reserves.—The Secretary of Agriculture shall add an equal number of acres to old growth reserves on the Tongass National Forest as are transferred out of Federal ownership as a result of this Act.

SEC. 8. AUTHORIZATION OF APPROPRIATIONS.

(a) Department of Agriculture.—There are authorized to be appropriated to the Secretary of Agriculture such sums as may be necessary for value estimation and related costs of exchanging lands specified in this Act, and for road rehabilitation, habitat and timber stand improvement, including thinning and pruning, on lands acquired by the United States under this Act.

(b) Department of the Interior.—There are authorized to be appropriated to the Secretary of the Interior such sums as may be necessary for land surveys and conveyances pursuant to this Act.

By Mr. AKAKA (for himself, Mr. GRASSLEY, Mr. LEVIN, Mr. LEAHY, and Mr. DURBIN):

S. 1358. A bill to amend chapter 23 of title 5, United States Code, to clarify the disclosure of information protected from prohibited personnel practices, require a statement in non-disclosure policies, forms, and agreements that such policies, forms, and agreements conform with certain disclosure protections, provide certain authority for the Special Council, and for other purposes; to the Committee on Governmental Affairs.

Mr. AKAKA. Mr. President, I rise today to discuss the Federal Employee Protection of Disclosures Act. I offered legislation under this title earlier this month. I am modifying that measure, S. 1229, by introducing a new bill today which is cosponsored by Senators GRASSLEY, LEVIN, LEAHY, and DURBIN. This bill, as with S. 1229, amends the Whistleblower Protection Act, WPA. These amendments are necessary to safeguard Federal employees from retaliation and protect American taxpayers from government waste, fraud, and abuse. Our bill follows S. 995 and S. 3070, the latter of which was favorably reported by the Governmental Affairs Committee in the 107th Congress. The bill we introduce today is the result of a bipartisan compromise to protect our Federal whistleblowers.

Our bill would codify the repeated and unequivocal statements of congressional intent that Federal employees are to be protected when making "any disclosure" evidencing violations of law, gross mismanagement, or a gross waste of funds. The bill would also clarify the test that must be met to prove that a Federal employee reasonably believed that his or her disclosure was evidence of wrongdoing. The clear language of the WPA says that an employee is protected for disclosing information he or she reasonably believes evidences a violation. However, the Federal Circuit Court of Appeals, which has sole jurisdiction over whistleblower cases, ruled in 1999 that the reasonableness review must begin with the presumption that public officers perform their duties in good faith and that this presumption stands unless there is "irrefragable proof" to the contrary. As irrefragable means impossible to refute, our bill replaces this excessively high burden with the more reasonable standard of substantial evidence.

The measure would also provide independent litigating authority to the Office of Special Counsel, OSC. Under current law, OSC has no authority to request the Merit Systems Protection Board, MSPB, to reconsider its decision or to seek review of a MSPB decision by the Federal Circuit. The limitation undermines both OSC's ability to protect whistleblowers and the integrity of the WPA. As such, our bill would provide OSC authority to appear in any civil action brought in connection with the WPA and obtain review of any MSPB order where OSC determines MSPB erred and the case will impact the enforcement of the WPA.

Our bill would codify an "anti-gag" provision that Congress has passed annually since 1988 as part of the appropriations process. The yearly appropriations language bars agencies from implementing or enforcing any nondisclosure policy, form, or agreement that does not contain specified language preserving open government statutes. In addition, the bill would make it a prohibited personnel practice to enforce a non-disclosure agreement that does not comply with open government statutes.

Enactment of the Federal Employee Protection of Disclosures Act will strengthen the rights and protections afforded to Federal whistleblowers and encourage the disclosure of information vital to an effective government. Following the events of September 11, we realized that whistleblowing is even more important when our national security is at stake. In many instances, the security of our Nation depends upon those who step forward to blow the whistle on significant lapses in our efforts to protect the United States against potential terrorist attacks. Congress should act quickly to assure whistleblowers that disclosing illegal activities and mismanagement within their agencies will not be met with retaliation. I urge my colleagues to join with me in protecting our Federal whistleblowers.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1358

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PROTECTION OF CERTAIN DISCLOSURES OF INFORMATION BY FEDERAL EMPLOYEES.

(a) SHORT TITLE.—This Act may be cited as the "Federal Employee Protection of Disclosures Act".

(b) CLARIFICATION OF DISCLOSURES COVERED.—Section 2302(b)(8) of title 5, United States Code, is amended—

(1) in subparagraph (A)—

(A) by striking "which the employee or applicant reasonably believes evidences" and inserting ", without restriction to time, place, form, motive, context, or prior disclosure made to any person by an employee or applicant, including a disclosure made in the ordinary course of an employee's duties, that the employee or applicant reasonably believes is evidence of"; and

(B) in clause (i), by striking "a violation" and inserting "any violation";

(2) in subparagraph (B)—

(A) by striking "which the employee or applicant reasonably believes evidences" and inserting ", without restriction to time, place, form, motive, context, or prior disclosure made to any person by an employee or applicant, including a disclosure made in the ordinary course of an employee's duties, to the Special Counsel, or to the Inspector General of an agency or another employee designated by the head of the agency to receive such disclosures, of information that the employee or applicant reasonably believes is evidence of"; and

(B) in clause (i), by striking "a violation" and inserting "any violation (other than a violation of this section)"; and

(3) by adding at the end the following:

"(C) a disclosure that—

"(i) is made by an employee or applicant of information required by law or Executive order to be kept secret in the interest of national defense or the conduct of foreign affairs that the employee or applicant reasonably believes is direct and specific evidence of—

"(I) any violation of any law, rule, or regulation;

"(II) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety; or

"(III) a false statement to Congress on an issue of material fact; and

"(ii) is made to—

"(I) a member of a committee of Congress having a primary responsibility for oversight of a department, agency, or element of the Federal Government to which the disclosed information relates and who is authorized to receive information of the type disclosed;

"(II) any other Member of Congress who is authorized to receive information of the type disclosed; or

"(III) an employee of Congress who has the appropriate security clearance and is authorized to receive information of the type disclosed.".

(c) COVERED DISCLOSURES.—Section 2302(b) of title 5, United States Code, is amended—

(1) in the matter following paragraph (12), by striking "This subsection" and inserting the following:

"This subsection"; and

(2) by adding at the end the following:

"In this subsection, the term 'disclosure' means a formal or informal communication or transmission.".

(d) REBUTTABLE PRESUMPTION.—Section 2302(b) of title 5, United States Code, is amended by adding after the matter following paragraph (12) (as amended by subsection (c) of this section) the following:

"For purposes of paragraph (8), any presumption relating to the performance of a duty by an employee who has authority to take, direct others to take, recommend, or approve any personnel action may be rebutted by substantial evidence.".

(e) NONDISCLOSURE POLICIES, FORMS, AND AGREEMENTS; SECURITY CLEARANCES; AND RETALIATORY INVESTIGATIONS.—

(1) PERSONNEL ACTION.—Section 2302(a)(2)(A) of title 5, United States Code, is amended—

(A) in clause (x), by striking "and" after the semicolon; and

(B) by redesignating clause (xi) as clause (xiv) and inserting after clause (x) the following:

"(xi) the implementation or enforcement of any nondisclosure policy, form, or agreement;

"(xii) a suspension, revocation, or other determination relating to a security clearance;

"(xiii) an investigation of an employee or applicant for employment because of any activity protected under this section; and".

(2) PROHIBITED PERSONNEL PRACTICE.—Section 2302(b) of title 5, United States Code, is amended—

(A) in paragraph (11), by striking "or" at the end;

(B) in paragraph (12), by striking the period and inserting a semicolon; and

(C) by inserting after paragraph (12) the following:

"(13) implement or enforce any nondisclosure policy, form, or agreement, if such policy, form, or agreement does not contain the following statement:

"'These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by Executive Order No. 12958; section 7211 of title 5, United States Code (governing disclosures to Congress); section 1034 of title 10, United States Code (governing disclosure to Congress by members of the military); section 2302(b)(8) of title 5, United States Code (governing disclosures of illegality, waste, fraud, abuse, or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential Government agents); and the statutes which protect against disclosures that could compromise national security, including sections 641, 793, 794, 798, and 952 of title 18, United States Code, and section 4(b) of the Subversive Activities Control Act of 1950 (50 U.S.C. 783(b)). The definitions, requirements, obligations, rights, sanctions, and liabilities created by such Executive order and such statutory provisions are incorporated into this agreement and are controlling.'; or

"(14) conduct, or cause to be conducted, an investigation of an employee or applicant for employment because of any activity protected under this section.".

(3) BOARD AND COURT REVIEW OF ACTIONS RELATING TO SECURITY CLEARANCES.—

(A) IN GENERAL.—Chapter 77 of title 5, United States Code, is amended by inserting after section 7702 the following:

"§ 7702a. Actions relating to security clearances

"(a) In any appeal relating to the suspension, revocation, or other determination relating to a security clearance, the Merit Systems Protection Board or any reviewing court—

"(1) shall determine whether section 2302 was violated;

"(2) may not order the President to restore a security clearance; and

"(3) subject to paragraph (2), may issue declaratory relief and any other appropriate relief.

"(b)(1) If, in any final judgment, the Board or court declares that any suspension, revocation, or other determination with regards to a security clearance was made in violation of section 2302, the affected agency shall conduct a review of that suspension, revocation, or other determination, giving great weight to the Board or court judgment.

"(2) Not later than 30 days after any Board or court judgment declaring that a security clearance suspension, revocation, or other determination was made in violation of section 2302, the affected agency shall issue an unclassified report to the congressional committees of jurisdiction (with a classified annex if necessary), detailing the circumstances of the agency's security clearance suspension, revocation, or other determination. A report under this paragraph shall include any proposed agency action with regards to the security clearance.

"(c) An allegation that a security clearance was revoked or suspended in retaliation for a protected disclosure shall receive expedited review by the Office of Special Counsel, the Merit Systems Protection Board, and any reviewing court.".

(B) TECHNICAL AND CONFORMING AMENDMENT.—The table of sections for chapter 77 of title 5, United States Code, is amended by inserting after the item relating to section 7702 the following:

"7702a. Actions relating to security clearances.".

(f) EXCLUSION OF AGENCIES BY THE PRESIDENT.—Section 2302(a)(2)(C) of title 5, United States Code, is amended by striking clause (ii) and inserting the following:

"(ii)(I) the Federal Bureau of Investigation, the Central Intelligence Agency, the Defense Intelligence Agency, the National Imagery and Mapping Agency, the National Security Agency; and

"(II) as determined by the President, any Executive agency or unit thereof the principal function of which is the conduct of foreign intelligence or counterintelligence activities, if the determination (as that determination relates to a personnel action) is made before that personnel action; or".

(g) ATTORNEY FEES.—Section 1204(m)(1) of title 5, United States Code, is amended by striking "agency involved" and inserting "agency where the prevailing party is employed or has applied for employment".

(h) DISCIPLINARY ACTION.—Section 1215 of title 5, United States Code, is amended in subsection (a), by striking paragraph (3) and inserting the following:

"(3)(A) A final order of the Board may impose—

"(i) disciplinary action consisting of removal, reduction in grade, debarment from

Federal employment for a period not to exceed 5 years, suspension, or reprimand;

"(ii) an assessment of a civil penalty not to exceed $1,000; or

"(iii) any combination of disciplinary actions described under clause (i) and an assessment described under clause (ii).

"(B) In any case in which the Board finds that an employee has committed a prohibited personnel practice under section 2302(b)(8) or (9), the Board shall impose disciplinary action if the Board finds that the activity protected under section 2302(b) (8) or (9) was a significant motivating factor, even if other factors also motivated the decision, for the employee's decision to take, fail to take, or threaten to take or fail to take a personnel action, unless that employee demonstrates, by preponderance of evidence, that the employee would have taken, failed to take, or threatened to take or fail to take the same personnel action, in the absence of such protected activity.".

(i) DISCLOSURES TO CONGRESS.—Section 2302 of title 5, United States Code, is amended by adding at the end the following:

"(f) Each agency shall establish a process that provides confidential advice to employees on making a lawful disclosure to Congress of information that is specifically required by law or Executive order to be kept secret in the interest of national defense or the conduct of foreign affairs.".

(j) AUTHORITY OF SPECIAL COUNSEL RELATING TO CIVIL ACTIONS.—

(1) REPRESENTATION OF SPECIAL COUNSEL.—Section 1212 of title 5, United States Code, is amended by adding at the end the following:

"(h) Except as provided in section 518 of title 28, relating to litigation before the Supreme Court, attorneys designated by the Special Counsel may appear for the Special Counsel and represent the Special Counsel in any civil action brought in connection with section 2302(b)(8) or subchapter III of chapter 73, or as otherwise authorized by law.".

(2) JUDICIAL REVIEW OF MERIT SYSTEMS PROTECTION BOARD DECISIONS.—Section 7703 of title 5, United States Code, is amended by adding at the end the following:

"(e)(1) Except as provided under paragraph (2), this paragraph shall apply to any review obtained by the Special Counsel. The Special Counsel may obtain review of any final order or decision of the Board by filing a petition for judicial review in the United States Court of Appeals for the Federal Circuit if the Special Counsel determines, in the discretion of the Special Counsel, that the Board erred in deciding a case arising under section 2302(b)(8) or subchapter III of chapter 73 and that the Board's decision will have a substantial impact on the enforcement of section 2302(b)(8) or subchapter III of chapter 73. If the Special Counsel was not a party or did not intervene in a matter before the Board, the Special Counsel may not petition for review of a Board decision under this section unless the Special Counsel first petitions the Board for reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceedings before the Court of Appeals. The granting of the petition for judicial review shall be at the discretion of the Court of Appeals.

"(2) During the 5-year period beginning on the effective date of the Federal Employee Protection of Disclosures Act, this paragraph shall apply to any review obtained by the Special Counsel. The Special Counsel may obtain review of any final order or decision of the Board by filing a petition for judicial review in the United States Court of Appeals for the Federal Circuit or any court of appeals of competent jurisdiction as provided under subsection (b)(2) if the Special Counsel determines, in the discretion of the Special Counsel, that the Board erred in deciding a case arising under section 2302(b)(8) or subchapter III of chapter 73 and that the Board's decision will have a substantial impact on the enforcement of section 2302(b)(8) or subchapter III of chapter 73. If the Special Counsel was not a party or did not intervene in a matter before the Board, the Special Counsel may not petition for review of a Board decision under this section unless the Special Counsel first petitions the Board for reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceedings before the court of appeals. The granting of the petition for judicial review shall be at the discretion of the court of appeals.".

(k) JUDICIAL REVIEW.—

(1) IN GENERAL.—Section 7703(b) of title 5, United States Code, is amended by striking paragraph (1) and inserting the following:

"(b)(1)(A) Except as provided in subparagraph (B) and paragraph (2) of this subsection, a petition to review a final order or final decision of the Board shall be filed in the United States Court of Appeals for the Federal Circuit. Notwithstanding any other provision of law, any petition for review must be filed within 60 days after the date the petitioner received notice of the final order or decision of the Board.

"(B) During the 5-year period beginning on the effective date of the Federal Employee Protection of Disclosures Act, a petition to review a final order or final decision of the Board shall be filed in the United States Court of Appeals for the Federal Circuit or any court of appeals of competent jurisdiction as provided under subsection (b)(2). Notwithstanding any other provision of law, any petition for review must be filed within 60 days after the date the petitioner received notice of the final order or decision of the Board.".

(2) REVIEW OBTAINED BY OFFICE OF PERSONNEL MANAGEMENT.—Section 7703 of title 5, United States Code, is amended by striking subsection (d) and inserting the following:

"(d)(1) Except as provided under paragraph (2), this paragraph shall apply to any review obtained by the Director of the Office of Personnel Management. The Director of the Office of Personnel Management may obtain review of any final order or decision of the Board by filing, within 60 days after the date the Director received notice of the final order or decision of the Board, a petition for judicial review in the United States Court of Appeals for the Federal Circuit if the Director determines, in his discretion, that the Board erred in interpreting a civil service law, rule, or regulation affecting personnel management and that the Board's decision will have a substantial impact on a civil service law, rule, regulation, or policy directive. If the Director did not intervene in a matter before the Board, the Director may not petition for review of a Board decision under this section unless the Director first petitions the Board for a reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceeding before the Court of Appeals. The granting of the petition for judicial review shall be at the discretion of the Court of Appeals.

"(2) During the 5-year period beginning on the effective date of the Federal Employee Protection of Disclosures Act, this paragraph shall apply to any review obtained by the Director of the Office of Personnel Management. The Director of the Office of Personnel Management may obtain review of any final order or decision of the Board by filing, within 60 days after the date the Director received notice of the final order or decision of the Board, a petition for judicial review in the United States Court of Appeals for the Federal Circuit or any court of appeals of competent jurisdiction as provided under subsection (b)(2) if the Director determines, in his discretion, that the Board erred in interpreting a civil service law, rule, or regulation affecting personnel management and that the Board's decision will have a substantial impact on a civil service law, rule, regulation, or policy directive. If the Director did not intervene in a matter before the Board, the Director may not petition for review of a Board decision under this section unless the Director first petitions the Board for a reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceeding before the court of appeals. The granting of the petition for judicial review shall be at the discretion of the Court of Appeals.".

(l) NONDISCLOSURE POLICIES, FORMS, AND AGREEMENTS.—

(1) IN GENERAL.—

(A) REQUIREMENT.—Each agreement in Standard Forms 312 and 4414 of the Government and any other nondisclosure policy, form, or agreement of the Government shall contain the following statement: "These restrictions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by Executive Order No. 12958; section 7211 of title 5, United States Code (governing disclosures to Congress); section 1034 of title 10, United States Code (governing disclosure to Congress by members of the military); section 2302(b)(8) of title 5, United States Code (governing disclosures of illegality, waste, fraud, abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential Government agents); and the statutes which protect against disclosure that may compromise the national security, including sections 641, 793, 794, 798, and 952 of title 18, United States Code, and section 4(b) of the Subversive Activities Act of 1950 (50 U.S.C. 783(b)). The definitions, requirements, obligations, rights, sanctions, and liabilities created by such Executive order and such statutory provisions are incorporated into this agreement and are controlling."

(B) ENFORCEABILITY.—Any nondisclosure policy, form, or agreement described under subparagraph (A) that does not contain the statement required under subparagraph (A) may not be implemented or enforced to the extent such policy, form, or agreement is inconsistent with that statement.

(2) PERSONS OTHER THAN GOVERNMENT EMPLOYEES.—Notwithstanding paragraph (1), a nondisclosure policy, form, or agreement that is to be executed by a person connected with the conduct of an intelligence or intelligence-related activity, other than an employee or officer of the United States Government, may contain provisions appropriate

to the particular activity for which such document is to be used. Such form or agreement shall, at a minimum, require that the person will not disclose any classified information received in the course of such activity unless specifically authorized to do so by the United States Government. Such nondisclosure forms shall also make it clear that such forms do not bar disclosures to Congress or to an authorized official of an executive agency or the Department of Justice that are essential to reporting a substantial violation of law.

(m) CLARIFICATION OF WHISTLEBLOWER RIGHTS FOR CRITICAL INFRASTRUCTURE INFORMATION.—Section 214(c) of the Homeland Security Act of 2002 (Public Law 107-296) is amended by adding at the end the following: "For purposes of this section a permissible use of independently obtained information includes the disclosure of such information under section 2302(b)(8) of title 5, United States Code.".

(n) EFFECTIVE DATE.—This Act shall take effect 30 days after the date of enactment of this Act.

Mr. LEVIN. Mr. President, I am pleased to join Senators AKAKA, GRASSLEY, LEAHY, and DURBIN today in introducing the Federal Employees Protection of Disclosures Act. Our bill strengthens the law protecting employees who blow the whistle on fraud, waste, and abuse in federal programs.

Whistleblowers play a crucial role in ensuring that Congress and the public are aware of serious cases of waste, fraud, and mismanagement in government. Whistleblowing is never more important than when our national security is at stake. Since the terrorist attacks of September 11, 2001, courageous individuals have stepped forward to blow the whistle on significant lapses in our efforts to protect the United States against potential future attacks. Most notably, FBI Agent Coleen Rowley alerted Congress to serious institutional problems at the FBI and their impact on the agency's ability to effectively investigate and prevent terrorism.

In another example, two Border Patrol agents from my State of Michigan, Mark Hall and Bob Lindemann, risked their careers when they blew the whistle on Border Patrol and INS policies that were compromising security on the Northern Border. Their disclosure led to my holding a hearing at the Permanent Subcommittee on Investigations in November 2001, that exposed serious deficiencies in the way Border Patrol and INS were dealing with aliens who were arrested while trying to enter the country illegally. Since the hearing, some of the most troublesome policies have been changed, improving the security situation and validating the two agents' concerns. Despite the fact that their concerns proved to be dead on, shortly after they blew the whistle, disciplinary action was proposed against the two agents. Fortunately in this case, whistleblower protections worked. The Office of Special Counsel conducted an investigation and the decision to discipline the agents was reversed. However, that disciplinary an action was proposed in the first place is a troubling reminder of how important it is for us to both strengthen protections for whistleblowers and empower the Office of Special Counsel to discipline managers who seek to muzzle employees.

Agent Rowley, Mark Hall and Bob Lindermann are simply the latest in a long line of Federal employees who have taken great personal risks in blowing the whistle on government waste, fraud, and mismanagement. Congress has long recognized the obligation we have to protect a Federal employee when he or she discloses evidence of wrongdoing in a Federal program. If an employee reasonably believes that a fraud or mismanagement is occurring, and that employee has the courage and the sense of responsibility to make that fraud or mismanagement known, it is our duty to protect the employee from any reprisal. We want Federal employees to identify problems so we can fix them, and if they fear reprisal for doing so, then we are not only failing to protect the whistleblower, but we are also failing to protect the taxpayer.

I sponsored the Whistleblower Protection Act in 1989 which strengthened and clarified whistleblower rights, as well as the bill passed by Congress to strengthen the law further in 1994. Unfortunately, however, repeated holdings by the United States Court of Appeals for the Federal Circuit have corrupted the intent of Congress, with the result that additional clarifying language is sorely needed. The case of LaChance versus White represents perhaps the most notable example of the Federal Circuit's misinterpretation of the whistleblower law.

In LaChance, decided on May 14, 1999, the court imposed an unfounded and virtually unattainable standard on Federal employee whistleblowers in proving their cases. In that case, John E. White was an education specialist for the Air Force who spoke out against a new educational system that purported to mandate quality standards for schools contracting with the Air Force bases. White criticized the new system as counterproductive because it was too burdensome and seriously reduced the education opportunities available on base. After making these criticisms, local agency officials reassigned White, relieving him of his duties and allegedly isolating him. However, after an independent management review supported White's concerns, the Air Force canceled the program White had criticized. White appealed the reassignment in 1992 and the case has been in litigation ever since.

The administrative judge initially dismissed White's case, finding that his disclosures were not protected by the Whistleblower Protection Act. The MSPB, however, reversed the administrative judge's decision and remanded the case back to the administrative judge, holding that since White disclosed information he reasonably believed evidenced gross mismanagement, this disclosure was protected under the Act. On remand, the administrative judge found that the Air Force had violated the Whistleblower Protection Act and ordered the Air Force to return White to his prior status; the MSPB affirmed the decision of the administrative judge. OPM petitioned the Federal Circuit for a review of the board's decision. The Federal Circuit subsequently reversed the MSPB's decision, holding that there was not adequate evidence to support a violation under the Whistleblower Protection Act. The Federal Circuit held that the evidence that White was a specialist on the subject at issue and aware of the alleged improper activities and that his belief was shared by other employees was not sufficient to meet the "reasonable belief" test in the law. The court held that "the board must look for evidence that it was reasonable to believe that the disclosures revealed misbehavior" by the Air Force. The court went on to say: "In this case, review of the Air Force's policy and implementation via the QES standards might well show them to be entirely appropriate, even if not the best option. Indeed, this review would start out with a presumption that public officers perform their duties correctly, fairly, in good faith, and in accordance with the law and governing regulations. * * * And this presumption stands unless there is 'irrefragable proof to the contrary'."

It was appropriate for the Federal Circuit to remand the case to the MSPB to have it reconsider whether it was reasonable for White to believe that what the Air Force did in this case involved gross mismanagement. However, the Federal Circuit went on to impose a clearly erroneous and excessive standard for him to demonstrate his "reasonable belief"—requiring him to provide "irrefragable" proof that the Air Force had engaged in gross mismanagement.

Irrefragable means "undeniable, incontestable, incontrovertible, incapable of being overthrown." How can a Federal employee meet a standard of "irrefragable" in proving gross mismanagement? It is virtually impossible standard of proof to meet. Moreover, there is nothing in the law or legislative history that even suggests such a standard applies to the Whistleblower Protection Act. The intent of the law is not for a federal employee to act as an investigator and compile "irrefragable" proof that the Federal Government, in fact, committed fraud, waste or abuse. Rather, under the clear language of the statute, the employee needs only to have "a reasonable belief" that there is fraud, waste or abuse occurring in order to make a protected disclosure.

LaChance is only one example of the Federal Circuit misinterpreting the law. Our bill corrects LaChance and as well as several other Federal Circuit holdings. In addition, the bill strengthens the Office of Special Counsel and creates additional protections for federal employees who are retaliated against for blowing the whistle.

One of the most important issues addressed in the bill is to clarify again that the law is intended to protect a broad range of whistleblower disclosures. The legislative history supporting the 1994 Whistleblower Protection Act amendments emphasized: "[I]t also is not possible to further clarify the clear language in section 2302(b)(8) that protection for 'any' whistleblowing disclosure truly means 'any'. A protected disclosure may be made as part of an employee's job duties, may concern policy or individual misconduct, and may be oral or written and to any audience inside or outside the agency, without restriction to time, place, motive or content."

Despite this clear Congressional intent that was clearly articulated in 1994, the Federal Circuit has acted to push a number of whistleblower disclosures outside the protections of the whistleblower law. For example, in Horton versus the Department of the Navy, the Federal Circuit ruled that a whistleblower's disclosures to co-workers, or to the wrong-doer, or to a court ruled that a whistleblower's disclosures to official in the agency chain of command or those made in the course of normal job duties were not protected. In Huffman versus Office of Personnel Management, the Federal Circuit reaffirmed Horton and Willis. And in Meuwissen versus Department of Interior, the Federal Circuit held that a whistleblower's disclosures of previously known information do not qualify as "disclosures" under the WPA. All of these rulings violate clear Congressional intent to afford broad protection to whistleblower disclosures.

In order to make "it clear that any lawful disclosure that an employee or job applicant reasonably believes is evidence of waste, fraud, abuse, or gross mismanagement is covered by the WPA, the bill codifies previous statements of Congressional intent. Using the 1994 legislative history, it amends the whistleblower statute to cover any disclosure of information without restriction to time, place, form, motive or context, or prior disclosure made to any person by an employee or applicant, including a disclosure made in the ordinary course of an employee's duties that the employee or applicant reasonably believes is credible evidence of any violation of any law, rule, or regulation, or other misconduct specified in the whistleblower law. I want to emphasize here that, other than the explicitly listed exceptions identified in the statute, we intend for there to be no exceptions, inferred or otherwise, as to what is a protected disclosure. And the prohibition on inferred exceptions is intended to apply to all protected speech categories in section 2302(b)(8) of the law. The intent here, again, is to make it clear that when the WPA speaks of protecting disclosures by Federal employees "any" means "any."

The bill also addresses the clearly erroneous standard established by the Federal Circuit's LaChance decision I mentioned earlier. Rather than needing "irrefragable proof" to overcome the presumption that a public officer performed his or her duties correctly, fairly, in good faith, and in accordance with the law and regulations, the bill makes it clear that the whistleblower can rebut this presumption with "substantial evidence." This burden of proof is a far more reasonable and appropriate standard for whistleblowing cases.

The Federal Circuit's repeated misinterpretations of the whistleblower law are unacceptable and demand Congressional action. In response to the court's inexplicable and inappropriate rulings, our bill would suspend for five years the Federal Circuit's exclusive jurisdiction over whistleblower appeals. It would instead allow a whistleblower to file a petition to review a final order or final decision of the MSPB in the Federal Circuit or in any other United States appellate court of competent jurisdiction and defined under 5 U.S.C. 7703(b)(2). In most cases, using another court would mean going to the federal circuit where the contested personnel action took place. This five-year period would allow Congress to evaluate whether other appellate courts would issue whistleblower decisions which are consistent with the Federal Circuit's interpretation of WPA protections and guide Congressional efforts to clarify the law if necessary.

In addition to addressing jurisdictional issues and troublesome Federal Circuit precedents, our bill would also make important additions to the list of protected disclosures. First, it would subject certain disclosures of classified information to whistleblower protections. However, in order for a disclosure of classified information to be protected, the employee would have to possess a reasonable belief that the disclosure was direct and specific evidence of a violation of law, rule or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, a substantial and specified danger to public health or safety, or a false statement to Congress on an issue of material fact. A whistleblower must also limit the disclosure to a member of Congress or staff of the executive or legislative branch holding the appropriate security clearance and authorized to receive the information disclosed. Federal agencies covered by the WPA would be required to establish a process to provide confidential advice to employees on how to lawfully make a protected disclosure of classified information to Congress.

Current law permits Federal employees to file a case at the MSPB when they feel that a manager has taken a personnel action against them in retaliation for blowing the whistle. The legislation would add three new personnel actions to the list of adverse actions that cannot be taken against whistleblowers for engaging in protected activity. These actions would include enforcement of any nondisclosure policy, form or agreement against a whistleblower for making a protected disclosure; the suspension, revocation, or other determination relating to a whistleblower's security clearance; and an investigation of an employee or applicant for employment if taken due to their participation in whistleblowing activity.

It is important to note that, if it is demonstrated that a security clearance was suspended or revoked in retaliation for whistleblowing, the legislation limits the relief that the MSPB and reviewing court can order. The bill specifies that the MSPB or reviewing court may issue declaratory and other appropriate relief but may not direct a security clearance to be restored. Appropriate relief may include back pay, an order to reassign the employee, attorney fees, or any other relief the Board or court is authorized to provide for other prohibited personnel practices. In addition, if the Board finds an action on a security clearance to have been illegal, it may bar the agency from directly or indirectly taking any other personnel action based on that illegal security clearance action. Our legislation would also require the agency to review and provide a report to Congress detailing the circumstances of the agency's security clearance decision, and authorizes expedited MSPB review of whistleblower cases where a security clearance was revoked or suspended. The latter is important because a person whose clearance has been suspended or revoked and whose job responsibilities require clearance may be unable to work while their case is being considered.

Our bill would also add two prohibited personnel practices of the whistleblower law. First, it would codify the "anti-gag" provision that has been in force since 1988, by virture of its inclusion in appropriations bills. Second, it would prohibit a manager from initiating an investigation of an employee or applicant for employment because they engage in a protected activity, including whistleblowing.

Another issue addressed in the bill involves certain employees who are excluded from the WPA. Among these are employees who hold "confidential policy-making positions." In 1994, Congress amended the WPA to keep agencies from designating employees confidential policymakers after the employees filed whistleblower complaints. The WPA also allows the President to exclude from WPA jurisdiction any agency whose principal function is the conduct of foreign intelligence or counterintelligence activities. Our legislation maintains this authority but makes it clear that a decision to exclude an agency from WPA protections must also be made prior to a personnel action being taken against a whistleblower from that agency. This provision is necessary to ensure that agencies cannot argue that employees are exempt from whistleblower protections after an employee files a claim that they were retaliated against.

Another key section of the bill would strengthen the Office of Special Counsel. OSC is the independent federal agency responsible for investigating and prosecuting federal employee complaints of whistleblower retaliation. Current law, however, limits OSC's ability to effectively enforce and defend whistleblower laws. For example, the law provides the OSC with no authority to request the Merit Systems Protection Board to reconsider one of its decisions or to seek appellate review of an MSPB decision. Even when another party petitions for a review of an MSPB decision, OSC is typically denied the right to participate in the proceedings.

Our bill would provide explicit authority for the Office of Special Counsel to appear in any civil action brought in connection with the whistleblower law. In addition, it would authorize OSC to obtain circuit court review of any MSPB order in a whistleblowing case if the OSC determines the Board erred and the case would have a substantial impact on the enforcement of the whisltleblower statute. In a letter to me addressing these provisions, special Counsel Elaine Kaplan said, "I believe that these changes are necessary, not only to ensure OSC's effectiveness, but to address continuing concerns about the whittling away of the WPA's protections by narrow judicial interpretations of the law." I ask unanimous consent that the OSC letter be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

OFFICE OF SPECIAL COUNSEL,
Washington, DC, September 11, 2002.

Hon. CARL LEVIN,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR LEVIN: Thank you for giving me the opportunity to comment on the proposed Title VI of H.R. 5005, concerning the protection of federal employee whistleblowers.

As the head of the U.S. Office of Special Counsel (OSC), the independent federal agency that is responsible for investigating and prosecuting federal employees' complaints of whistleblower retaliation, I share your recognition that it is crucial to ensure that the laws protecting whistleblowers are strong and effective. Federal employees are often in the best position to observe and identify official misconduct or malfeasance as well as dangers to the public health and safety, and the national security.

Now, perhaps more than ever before, our national interest demands that federal workers feel safe to come forward to bring appropriate attention to these conditions so that they may be corrected. Further, and again more than ever, the public now needs assurance that the workforce which is carrying out crucial operations is alert, and that its leaders welcome and encourage their constructive participation in making the government a highly efficient and effective steward of the public interest.

To these ends, Title VI contains a number of provisions that will strengthen the Whistleblower Protection Act (WPA) and close loopholes in the Act's coverage. The amendment would reverse the effects of several judicial decisions that have imposed unduly narrow and restrictive tests for determining whether employees qualify for the protection of the WPA. These decisions, among other things, have held that employees are not protected against retaliation when they make their disclosures in the line of duty or when they confront subject officials with their suspicions of wrongdoing. They have also made it more difficult for whistleblowers to secure the Act's protection by interposing what the Court of Appeals for the Federal Circuit has called an "irrefragable" presumption that government officials perform their duties lawfully and in good faith.

In addition to reversing these rulings, Title VI would grant the Special Counsel independent litigating authority and the right to request judicial review of decisions of the Merit Systems Protection Board (MSPB) in cases that will have a substantial impact upon the enforcement of the WPA. I firmly believe that these changes are necessary, not only to ensure OSC's effectiveness, but to address continuing concerns about the whittling away of the WPA's protections by narrow judicial interpretations of the law. The changes would ensure that OSC, the government agency charged with protecting whistleblowers, will have a meaningful opportunity to participate in the shaping of the law.

Further, Title VI would strengthen OSC's capacity to use its disciplinary action authority to deter agency supervisors, managers, and other officials from engaging in retaliation, and to punish those who do so. The amendment does this in two ways. First, it clarifies the burden of proof in disciplinary action cases that OSC brings by employing the test first set forth by the Supreme Court in Mt. Healthy School District v. Board of Education. Under this test, in order to secure discipline of an agency official accused of engaging in whistleblower retaliation, OSC would have to show that protected whistleblowing was a "significant, motivating factor" in the decision to take or threaten to take a personnel action. If OSC made such a showing, the MSPB would order appropriate discipline unless the official showed, by preponderant evidence, that he or she would have taken or threatened to take the same action even had there been no protected activity.

This change is necessary in order to ensure that the burden of proof in these cases is not so onerous as to make it virtually impossible to secure discipline against retaliators. Under current law, OSC bears the unprecedented burden of demonstrating that protected activity was the but-for cause of an adverse personnel action against a whistleblower. The amendment would correct the imbalance by imposing the well-established Mt. Healthy test in these cases.

In addition, the bill would relieve OSC of attorney fee liability in disciplinary action cases in which it ultimately does not prevail. The amendment would shift liability for fees to the manager's employing agency, where an award of fees would be in the interest of justice. The employing agency would indemnify the manager for these costs which would have been incurred by him in the course of performing his official duties.

Under current law, if OSC ultimately does not prevail in a case it brings against a manager whom our investigation shows has engaged in retaliation, then we must pay attorney fees, even if our prosecution decision was an entirely reasonable one. For a small agency like OSC, with a limited budget, the specter of having to pay large attorney fee awards simply because we do not ultimately prevail in a case, is a significant obstacle to our ability to use this important authority to hold managers accountable. It is, moreover, an unprecedented burden; virtually all fee shifting provisions which could result in an award of fees against a government agency, depend upon a showing that the government agency has acted unreasonably or in bad faith.

In addition to these provisions, the bill would also provide that for a period of five years, beginning on February 1, 2003, there would be multi-circuit review of decisions of the MSPB, just as there is now multi-circuit review of decisions of the MSPB's sister agency, the Federal Labor Relations Authority. This experiment will give Congress the opportunity to judge whether providing broader perspectives of all of the nation's courts of appeals will enhance the development of the law under the WPA.

There are several other provisions of the amendments that would strengthen the Act's coverage and remedies. The amendments, for example, would extend coverage of the WPA to circumstances in which an agency initiated an investigation of an employee or applicant in reprisal for whistleblowing or where an agency implemented an illegal nondisclosure form or policy. The amendments also would authorize an award of compensatory damages in federal employee whistleblower cases. Such awards are authorized for federal employees under the civil rights acts, and for environmental and nuclear whistleblowers, among others, under other federal statutes. Given the important public policies underlying the WPA, it seems appropriate that the same sort of make whole relief should be available to federal employee whistleblowers.

Finally, Title VI contains a provision that would provide relief to employees who allege that their security clearances were denied or revoked because of protected whistleblowing, without interfering with the longstanding authority of the President to make security clearance determinations. The amendment would allow employees to file OSC complaints alleging they suffered a retaliatory adverse security clearance determination. OSC would be given the authority to investigate such complaints and the MSPB would have the authority to issue declaratory and appropriate relief other than ordering the restoration of the clearance. Further, where the Board found retaliation, the employing agency would be required to conduct its own investigation of the revocation and report back to Congress.

This amendment provides a balance resolution of the tension between protecting national security whistleblowers against retaliation and maintaining the President's traditional prerogative to decide who will have access to classified information. Especially in light of the current heightened concerns about issues of national security, this change in the law is clearly warranted.

Thank you again for providing me with an opportunity to comment on these amendments, and for your continuing interest in the work of the Office of Special Counsel.

Sincerely,

Elaine Kaplan.

Mr. LEVIN. OSC currently has the authority to pursue disciplinary action against managers who retaliate against whistleblowers. However, Federal Circuit decisions, like LaChance, have undermined the agency's ability to successfully pursue such cases. The Special Counsel has said that "change is necessary in order to ensure that the burden of proof in these cases is not so onerous as to make it virtually impossible to secure disciplinary action against retaliators." In addition to it being difficult to win, if the OSC loses a disciplinary case, it has to pay the legal fees of those against whom OSC initiates disciplinary action. In its letter, OSC said that "the specter of having to pay large attorney fee awards . . . is a significant obstacle to our ability to use this important authority to hold managers accountable." Our bill addresses these problems by establishing a reasonable burden of proof for disciplinary actions and requiring the employing agency, not the OSC, to reimburse the prevailing party for attorney fees in a disciplinary proceeding.

Finally, the bill addresses a new issue that has arisen in connection with the recent enactment of the Homeland Security Act or HSA. To evaluate the vulnerability to terrorist attack of certain critical infrastructure such as chemical plants, computer networks and other key facilities, the HSA asks private companies that own these facilities to submit unclassified information about them to the government. In doing so, the law also created some ambiguity on the question of whether Federal employee whistleblowers would be protected by the WPA if they should disclose information that has been independently obtained by the whistleblower about such facilities but which may also have been disclosed to the government under the critical infrastructure information program.

While I believe it was Congress's intent to extend whistleblower protections to Federal employees who disclose such independently obtained information, the law's ambiguities are troublesome in the context of the tendency of the Federal Circuit to narrowly construe the scope of protections afforded by the WPA. Our bill would thus clarify that whistleblower protections do extend to Federal employees who disclose independently obtained information that may also have been disclosed to the government as part of the critical infrastructure information program

We need to encourage Federal employees to blow the whistle on waste, fraud and abuse in Federal Government agencies and programs. These people take great risks and often face enormous obstacles in doing what they believe is right. The Congress and the country owe a particular debt of gratitude to those whistleblowers who put their careers on the line to protect national security. Since September 11, 2001, we have seen a number of examples of how crucial people like Coleen Rowley, Mark Hall and Bob Lindermann are to keeping our country safe. I request unanimous consent that a letter from Agent Rowley be printed in the RECORD. In the letter she says that when she blew the whistle, she was lucky enough to garner the support of many of her colleagues and members of Congress. However, her letter warns that for every Coleen Rowley, "there are many more who do not benefit from the relative safety of public notoriety." It is to protect those responsible, courageous many that we offer this legislation. We need more like them.

I ask unanimous consent that the text of the letter from Ms. Rowley be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

September 2, 2002.

Dear Senators: I have proudly served in federal law enforcement for over 21 years. Prior to my personal involvement in a specific matter, I did not fully appreciate the strong disincentives that sometimes keep government employees from exposing waste, fraud, abuse, or other failures they witness on the job. Nor did I appreciate the strong incentives that do exist for agencies to avoid institutional embarrassment.

The decision to step forward with information that exposed my agency to scrutiny was one of the most difficult of my career. I did not come to it quickly or lightly. I first attempted to warn my superiors through regular channels. Only after those warnings failed to bring about the necessary response and congressional inquiry was initiated, did I go outside the agency with my concerns. I had no intention or desire to be in the public spotlight, so I did not go to the news media. I provided the information to Members of Congress with oversight responsibility. I felt compelled to do so because my responsibility is to the American people, not to a government agency.

Unfortunately, the cloak of secrecy which is necessary for the effective operation of government agencies involved in national security and criminal investigations fosters an environment where the incentives to avoid embarrassment and the disincentives to step forward combine. When that happens, the public loses. We need laws that strike a better balance, that are able to protect effective government operation without sacrificing accountability to the public. I was lucky enough to garner a good deal of support from my colleagues in the Minneapolis office and Members of Congress. But for every one like me, there are many more who do not benefit from the relative safety of public notoriety. They need credible, functioning rights and remedies to retain the freedom to warn.

I also need to state that I write this letter in my personal capacity, and that it reflects my personal views only, not those of the government agency for which I work.

Thank you for your consideration,

Coleen Rowley.

I ask unanimous consent to print in the RECORD a section-by-section explanation of the bill.

There being no objection, the analysis was ordered to be printed in the RECORD, as follows:

Section-by-Section Analysis of the Federal Employee Protection of Disclosures Act

The Federal Employee Protection of Disclosures Act would strengthen protections for Federal employees who blow the whistle on waste, fraud and abuse in the Federal Government.

Protected Whistleblower Disclosures—To correct court decisions improperly limiting the disclosures protected by the Whistleblower Protection Act, WPA, section (b) of the bill would clarify Congressional intent that the law covers "any" whistleblowing disclosure, whether that disclosure is made as part of an employee's job duties, concerns policy or individual misconduct, is oral or written, or is made to any audience inside or outside an agency, and without restriction to time, place, motive or context. This section would also protect certain disclosures of classified information to Congress when the disclosure is to a Member or legislative staff holding an appropriate security clearance and authorized to receive the type of information disclosed.

Informal Disclosures.—Section (c) would clarify the definition of "disclosure" to include a formal or informal communication or transmission.

Irrefragable Proof.—In *LaChance v. White*, the U.S. Court of Appeals for the Federal Circuit imposed an erroneous standard for determining when an employee makes a protected disclosure under the WPA. Under the clear language of the statute, an employee need only have a reasonable belief that he or she is providing evidence of fraud, waste or abuse to make a protected disclosure. But the court ruled that an employee had to have "irrefragable proof"—meaning undeniable and incontestable proof—to overcome the presumption that a public officer is performing their duties in accordance with law. Section (d) would replace this unreasonable standard of proof by providing that a whistleblower can rebut the presumption with "substantial evidence."

Prohibited Personnel Actions.—Section (e)(1) would add three actions to the list of prohibited personnel actions that may not be taken against whistleblowers for protected disclosures: enforcement of a nondisclosure policy, form or agreement; suspension, revocation, or other determination relating to an employee's security clearance; and investigation of an employee or applicant for employment due to protected whistleblowing activities.

Nondisclosure Actions Against Whistleblowers.—Section (e)(2) would bar agencies from implementing or enforcing against whistleblowers any nondisclosure policy, form or agreement that fails to contain specified language preserving the right of federal employees to disclose certain protected information. It would also prohibit a manager from initiating an investigation of an employee or applicant for employment because they engaged in protected activity.

Retaliations Involving Security Clearances.—Section (e)(3) would make it a prohibited personnel practice for a manager to suspend, revoke or take other action with respect to an employee's security clearance in retaliation for whistleblowing. This section would also authorize the Merit Systems Protection Board, MSPB, to conduct an expedited review of such matters and issue declaratory and other appropriate relief, but would not empower MSPB to restore a security clearance. If MSPB or a reviewing court were to find that a security clearance decision was retaliatory, the agency involved would be required to review its security clearance decision and issue a report to Congress explaining it.

Exclusions From WPA.—Current law allows the President to exclude certain employees and agencies from the WPA if they perform certain intelligence related or policy making functions. In 1994, Congress amended the WPA to stop agencies from removing employees from WPA coverage after the employees filed whistleblower complaints. Section (f) would also require that removal of an agency from the WPA be made prior to a personnel action being taken against a whistleblower at that agency.

Attorney Fees.—The Office of Special Counsel, OSC, has authority to pursue disciplinary action against managers who retaliate against whistleblowers. Currently, if OSC loses a disciplinary case, it must pay the legal fees of those against whom it initiated the action. Because the amounts involved could significantly deplete OSC's limited resources, section (g) would require the employing agency, rather than OSC, to reimburse the manager's attorney fees.

Burden of Proof in Disciplinary Actions.—Currently, when OSC pursues disciplinary action against managers who retaliate against whistleblowers, OSC must demonstrate that an adverse personnel action would not have occurred "but for" the whistleblower's protected activity. Section (i) would establish a more reasonable burden of proof by requiring OSC to demonstrate that the whistleblower's protected disclosure was a "significant motivating factor" in the decision by the manager to take the adverse action, even if other factors also motivated the decision. This standard would be equivalent of the Mt. Healthy standard.

Disclosures to Congress.—Section (j) would require agencies to establish a process to provide confidential advice to employees on how to lawfully make a protected disclosure of classified information to Congress.

Authority of Special Counsel.—Under current law, OSC has no authority to request MSPB to reconsider a decision or seek appellate review of a MSPB decision. This limitation undermines OSC's ability to protect whistleblowers and integrity of the WPA. Section k would authorize OSC to appear in any civil action brought in connection with the WPA and request appellate review of any MSPB order where OSC determines MSPB erred and the case would have a substantial impact on WPA enforcement.

Judicial Review.—In 1982, Congress replaced normal Administrative Procedures Act appellate review of MSPB decisions with exclusive jurisdiction in the U.S. Court of Appeals for the Federal Circuit. While the 1989 WPA and its 1994 amendments strengthened and clarified whistleblower protections, Federal Circuit holdings have repeatedly misinterpreted key provisions of the law. Subject to a five year sunset , section (l) would suspend the Federal Circuit's exclusive jurisdiction over whistleblower appeals and allow petitions for review to be filed either in the Federal Circuit or any other federal circuit court of competent jurisdiction.

Nondisclosure Restrictions on Whistleblowers.—Section (m) would require all federal nondisclosure policies, forms and agreements to contain specified language preserving the right of federal employees to disclose certain protected information. This section would codify the so-called anti-gag provision that has been included in federal appropriations bills since 1988.

Critical Infrastructure Information.—Section (n) would clarify that section 214(c) of the Homeland Security Act, HSA, maintains existing WPA rights for independently obtained information that may also qualify as critical infrastructure information under the HSA.

By Mrs. BOXER:

S. 1359. A bill to allow credit unions to provide international money transfer services and to require disclosures in connection with international money transfers from all money transmitting service providers; to the Committee on Banking, Housing, and Urban Affairs.

Mrs. BOXER. Mr. President, today, I am introducing the International Remittances Services Enhancement and Protection Act of 2003.

Remittances are the funds that immigrants send to their families abroad to help those relatives meet their basic needs. In the Latino community, 47 percent of all Latinos born outside the United States regularly send money to their country of origin. But since 43 percent to 58 percent of those who send remittances abroad regularly do not have a bank account, much of their hard earned money is lost in fees paid to check cashing agencies and wire transfer companies. They rely on check cashing services to cash their paychecks at hefty fees and then pay another fee to send some portion of that money through a wire service to their relatives in Latin America and elsewhere at varying exchange rates.

This legislation will increase competition and transparency in the remittances market. It will provide immigrants with access to more choices for sending remittances by allowing credit unions to provide wire transfer and check cashing services to nonmembers. It will also provide immigrants with access to information in more than one language from all money transmitters about the fees and exchange rates that they pay. That information will make it easier for consumers to compare the value of the services they can receive from different service providers.

The larger goal is to provide immigrants with more control over their finances. I believe this bill with encourage financial institutions to develop better services for immigrants and build stronger relationships with immigrant communities.

According to the Multilateral Investment Fund, immigrants living in the United States sent $23 billion to Latin America in 2001. More than $3 billion of that total was consumed in fees paid to money transfer agencies. If current growth rates in remittance transfers are maintained, cumulative remittances to Latin America could reach $300 billion for the 10-year period ending in 2010. We need to work to ensure that competition in the market and modern technology come together to lower the portion of those monies lost in fees and instead are used for productive purposes.

By Mr. GRAHAM of Florida:

S. 1360. A bill to amend section 7105 of title 38, United States Code, to clarify the requirements for notices of disagreement for appellate review of Department of Veterans Affairs activities; to the Committee on Veterans' Affairs.

Mr. GRAHAM of Florida. Mr. President, I rise today to introduce legislation that will remove a significant and arbitrary barrier to appellate review of veterans' benefits claims. In 1988, when Congress created judicial review for veterans' claims it intended to provide "an opportunity for those aggrieved by VA decisions to have such decisions reviewed by a court" and found such review "necessary in order to provide such claimants with fundamental justice."

A veteran or survivor of a veteran seeking VA benefits must file a claim for such benefits, generally at a VA Regional Office. If the VA denies the claim for benefits, the claimant must file a "Notice of Disagreement," or NOD, as defined in section 7105 of title 38 of the United States Code. This NOD initiates appellate review by the agency and begins a series of events where VA communicates the basis of the denial to the claimant and allows various levels of review of this denial at the regional office. If the claimant still disagrees with the VA decision, the claimant may file a "Substantive Appeal" that vests jurisdiction of the claim with the Board of Veterans' Appeals, the appellate arm of VA.

Section 7105 defines what is required of a valid NOD. It must be filed within 1 year from the notice of the initial denial, in writing, and filed with the regional office that issued the decision over which there is disagreement. The NOD may be filed by the claimant or the claimant's guardian or representative.

VA has promulgated regulations to implement section 7105. In Section 20.201 or title 38 of the Code of Federal Regulations, the Secretary defined a

NOD to not require special wording. The regulation does require that the NOD "must be in terms which can be reasonably construed as disagreement with the determination and a desire for appellate review." The second component of that sentence—"a desire for appellate review"—is not required under the statute.

In 1997, Raymond Gallegos, a veteran, again filed an application for service connection for post-traumatic stress disorder that had been previously denied. The VA regional office granted his claim. However, Mr. Gallegos believed the effective date assigned to his claim was wrong and filed what was then thought to be a NOD. He appealed this issue to the Board, which reasoned that the letter expressing his disagreement was not a valid NOD because it did not express his desire for appellate review. Mr. Gallegos appealed the Board's determination to the United States Court of Appeals for Veterans Claims, or the CAVC.

In 2000, the CAVC determined in Gallegos v. Gober that the VA regulation was invalid because it required more of the claimant than Congress required in statute. Last year, in Gallegos v. Principi, the United States Court of Appeals for the Federal Circuit reversed the CAVC and upheld the VA regulation, finding that the agency interpretation was entitled to deference because Congressional intent was not clear in limiting the requirements of a NOD to those in section 7105.

Congress never intended to require that level of formality from veterans, in this uniquely pro-claimant system. Therefore, I offer legislation that would specify that if a claimant's filing meets the criteria defined in section 7105 of title 38 of the United States Code, the document will be deemed a Notice of Disagreements with all the rights and procedures that accompany that determination. It will also ensure that claimants whose NODs were found to be defective since the court decision will have the opportunity to have their NOD reevaluated under this new provision.

This is very significant because there are two key consequences of not having a valid, timely NOD. First, if a claimant fails to file a timely, valid NOD, the VA denial becomes final. The claimant will need to submit "new and material evidence" that VA erred in order to reopen the case. If successful, the claimant will only be able to receive benefits dating to the beginning of the newly reopened claim, potentially losing years of retroactive benefits. This may affect a veteran's ability to receive VA health care, a dependent's ability to use educational benefits, and all the other benefits that flow from a finding of service-connection.

Second, if a claimant has not been deemed to file a NOD, there can be no appeal of the VA decision. A NOD is required to initiate an appeal. It is a prerequisite to review by the Board of Veterans' Appeals and ultimately judicial review at the CAVC. This contravenes Congress's intent to remove arbitrary barriers to judicial review as it did in Public Law 107–103.

We face the tragic fact that in 2002, America lost 646,264 veterans. The many aging veterans who still await justice cannot afford this debate. I ask my colleagues to support this critical measure and restore this fundamental justice to our veterans.

I ask unanimous consent that the text of this bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1360

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CLARIFICATION OF NOTICE OF DISAGREEMENT FOR APPELLATE REVIEW OF DEPARTMENT OF VETERANS AFFAIRS ACTIVITIES.

(a) CLARIFICATION.—Section 7105(b) of title 38, United States Code, is amended by adding at the end the following new paragraph:

"(3) A document that meets the requirements of the second sentence of paragraph (1) and the first sentence of paragraph (2) shall be recognized as a notice of disagreement for purposes of this section.".

(b) EFFECTIVE DATE.—(1) Except as specifically provided otherwise, paragraph (3) of section 7105(b) of title 38, United States Code (as added by subsection (a) of this section), shall apply to any document—

(A) filed under section 7105 of such title on or after the date of the enactment of this Act; or

(B) filed under section 7105 of such title before the date of the enactment of this Act and not rejected by the Secretary of Veterans Affairs as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations, as of that date.

(2) In the case of a document described in paragraph (3) of this subsection, the Secretary shall, upon the request of the claimant or the Secretary's own motion, order the document treated as a notice of disagreement under section 7105 of such title as if the document had not been rejected by the Secretary as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations.

(3) A document described in this paragraph is a document that—

(A) was filed as a notice of disagreement under section 7105 of such title during the period beginning on March 15, 2002, and ending on the date of the enactment of this Act; and

(B) was rejected by the Secretary as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations.

(4) A document may not be treated as a notice of disagreement under paragraph (2) unless a request for such treatment is filed by the claimant, or a motion is made by the Secretary, not later than one year after the date of the enactment of this Act.

By Mr. SMITH:

S. 1361. A bill to amend the Internal Revenue Code of 1986 to provide that foreign base company shipping income shall include only income from aircraft and income from certain vessels transporting petroleum and related products; to the Committee on Finance.

Mr. SMITH. Mr. President, today I am introducing legislation which would deal with a real problem facing our Nation, the decline of our U.S.-owned shipping fleet. A U.S. owned shipping fleet is essential as a matter of national and economic security. My bill would help make U.S. based shipping companies more competitive in the global market.

This is important to our country and to my state. Oregon plays a key role as a facilitator of international commerce. The Port of Portland is one of the most active ports in the world. It is a key link for trade between the United States and the Pacific Rim. In addition to its key role enabling global commerce, Portland is home to U.S. owned shipping companies, shipyards, and numerous support businesses.

As a result of tax-law changes enacted in 1975 and 1986, U.S. shipping companies must pay tax on income earned by subsidiaries overseas immediately rather than when such income is later brought back to the United States. This treatment represents a sharp departure from the generally applicable income tax principle of "deferral" and places U.S.-based owners of international fleets at a distinct tax disadvantage compared to their foreign-based competitors.

Controlled foreign corporations engaged in ocean transport are one of the only active businesses that are not eligible for general rule of deferral. My bill would amend the Internal Revenue Code to allow U.S. companies that own foreign-flagged ships to treat income earned by their controlled foreign corporations in the same manner as all other U.S. companies. In short, it would allow American shipping companies to defer the payment of tax on income that they derive from shipping activities outside the United States until that income is repatriated to the United States.

Most foreign-based carriers pay no home-country taxes on income they earn abroad from international shipping. As a result of this competitive imbalance, U.S. companies now hold precious little share of the world shipping marketplace. Indeed, U.S. ownership of international shipping trades dropped precipitously in the aftermath of the 1975 and 1986 tax-law changes. Before 1975, the U.S.-owned share of the world's open-registry shipping fleet stood at 26 percent. By 1986, the U.S. share had dropped to 14 percent. By 1996, the U.S. share had dropped to 5 percent.

Other security concerns also are raised by the decline in U.S. ownership of the international shipping trade.

The U.S. military, in times of emergency, relies on the ability to requisition U.S.-owned foreign-flagged tankers, bulk carriers, and other vessels to carry oil, gasoline, and other materials in defense of U.S. interests overseas. These vessels comprise the Effective United States Control, EUSC, fleet. The sharp decline in the EUSC fleet since the 1975 and 1986 tax-law changes, and the resulting adverse strategic consequences, have been confirmed in a recent MIT study conducted for the Navy Department. The study recommended that in the short term, the most practical and cost-effective means of reversing this trend would be to "revise legislation to reflect tax deferment of income for some or all EUSC vessels."

U.S. security also depends in no small part on our ability to maintain adequate domestic oil supplies in times of emergency. The United States consumes approximately 19.6 million barrels of oil per day, of which roughly 55 percent, mostly crude, is imported into the United States. It is estimated that 95 percent of all oil imported into the United States by sea is now imported on foreign-owned tankers. This means that one half of every gallon of oil consumed in the United States is carried on foreign-owned vessels. This growing dependence on foreign parties—who may not be sympathetic to U.S. interests—to deliver our oil in times of global crisis is cause for potential alarm. In recent years, two of the largest American shipping companies have been purchased by foreign companies, thereby making their shipping operations more competitive than the remaining American companies.

The time has come for us to make changes in the tax law that will allow our domestic companies to compete fairly in the global marketplace. I urge my colleagues to join me to enact this needed legislation. I ask unanimous consent that the text of the legislation be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1361

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "RAFT (Restore Access to Foreign Trade) Act of 2003".

SEC. 2. ELIMINATION OF MOST VESSEL SHIPPING INCOME FROM FOREIGN BASE COMPANY INCOME.

(a) FOREIGN BASE COMPANY SHIPPING INCOME TO INCLUDE ONLY INCOME FROM AIRCRAFT AND PETROLEUM VESSELS.—Subsection (f) of section 954 of the Internal Revenue Code of 1986 (relating to foreign base company income) is amended—

(1) by inserting "petroleum" before "vessel" each place it appears, and

(2) by adding at the end the following new sentence: "For purposes of this subsection, the term 'petroleum vessel' means any vessel engaged in the carriage of petroleum or related products or byproducts if the controlled group (as defined in section 267(f)(1) without regard to section 1563(b)(2)(C)) of which the taxpayer is a member is engaged principally in the trade or business of exploring for, or extracting, refining or marketing of, petroleum or related products or byproducts.".

(b) RETENTION OF SEPARATE FOREIGN TAX CREDIT BASKET FOR ALL SHIPPING INCOME.—Subparagraph (D) of section 904(d)(2) of the Internal Revenue Code of 1986 is amended by striking "(as defined in section 954(f))" and inserting ", as defined in section 954(f), if references in such section to petroleum vessels included references to all vessels".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years of foreign corporations beginning after December 31, 2002, and to taxable years of United States shareholders (within the meaning of section 951(b) of the Internal Revenue Code of 1986) within which or with which such taxable years of such foreign corporations end.

By Mrs. BOXER:

S. 1362. A bill to authorize the Port Passenger Accelerated Service System (Port PASS) as a permanent program for land border inspection under the Immigration and Nationality Act, and for other purposes; to the Committee on the Judiciary.

Mrs. BOXER. Mr. President, today, I am introducing legislation that will strengthen national security, promote commerce, and provide assistance to our dedicated agents at the border.

Thousands of San Diego and Tijuana residents cross the border every day as commuters, shoppers, or visitors. Unfortunately, our border infrastructure has not kept pace with the increasing traffic volume, and travelers frequently encounter delays and congestion at the border.

The tragic events of September 11 further intensified these challenges along the border. Increased security measures severely over-extended inspection resources and resulted in longer waiting times for crossing the border.

The Secure Electronic Network for Travelers' Rapid Inspection, SENTRI, program was created to help alleviate the congestion at the border.

SENTRI is a dedicated commuter lane program. It allows pre-screened travelers to move quickly through the inspection process at the United States-Mexican border. After participants pass a background check, they can move more quickly through a dedicated lane.

SENTRI accepts only travelers who pass both an extensive background check to verify their eligibility and a thorough inspection of their vehicle.

Delays at crossing the border were often an hour or more prior to SENTRI But, with the program, the delays for participants are 5 to 15 minutes. Travelers in other lanes also benefit because the prescreened SENTRI crossers move swiftly through the border, reducing the number of motorists using general commuter lanes.

Expediting inspections through SENTRI is actually helping to improve border security, as Customs and Border Patrol agents can focus more attention on nonscreened drivers and passengers.

Unfortunately, SENTRI has become a victim of its own success. SENTRI needs a greater investment of resources to keep up with the current and future demand. Enrollment increased by more than 100 percent after September 11. Currently, prospective applicants must wait approximately 8 months to participate in the program.

For innovative programs, such as SENTRI, to work, we must provide them with the tools and resources they need to succeed. This is why I am introducing the Secure and Fast Entry at the Border Act or SAFE Border Act.

The SAFE Border Act recognizes the contribution of SENTRI to border security and the agents who administer the program. My bill would extend the length of a SENTRI pass from 1 to 2 years—enabling border agents to process more new applicants and reduce the current enrollment wait. The SAFE Border Act also recommends the appointment of dedicated SENTRI staff to expedite application processing, and encourages the creation of a dedicated commuter lane for prescreened, low-risk pedestrian crossers.

In addition, to ensure security at our borders, my legislation bans a person convicted of a felony or under active criminal investigation from participating in the program.

Our agents at the border shoulder an enormous responsibility every day. I believe we owe them the appropriate resources and support they need to carry out their duties.

Our Nation's economic and overall security is heavily linked to smooth and secure border crossings. The SAFE Border Act provides a way for trusted travelers to cross the border securely and quickly.

By Mr. REID:

S. 1363. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service; to the Committee on Energy and Natural Resources.

Mr. REID. Mr. President, as thousands of families look forward to summer vacations at our beautiful national parks, we must address an issue that could one day ruin their experience: privatization of the National Park Service.

The Park Service has worked hard to preserve Nevada's unique landscapes at the Great Basin National Park, Death Valley, and Lake Mead National Recreation Area. Instead of applauding the Park Service for a job well done, the Administration wants to study 1,800 jobs in the Park Service for privatization.

Many of these Park Service jobs have direct contact with visitors to our parks. They not only collect fees and maintain parks but also give directions, fight wildfires when necessary, and provide emergency medical assistance to injured park visitors. They are not required to do these things; they are driven by a love for the parks and a commitment to public service that contractors lack.

Privatizing the Park Service would jeopardize our national parks. Members of the Park Service have a career-long interest in maintaining the parks and perform their jobs because they are dedicated to serving the public. They often go beyond the call of duty to fix a problem in the middle of the night or change a tire for an unlucky park visitor. Can we be sure that a contractor would do the same? No.

In addition, the Park Service receives tens of thousands of hours of volunteer work every year. At the Lake Mead National Recreation Area alone, volunteers provided 92,000 hours of work, the equivalent of 44 full-time employees. Will a contractor find volunteers to provide it with 92,000 hours of assistance. Not likely.

Privatization will waste taxpayer money. Privatization studies cost about $3,000 per position studied, and privatization does not save money.

Nevadans visiting the national parks this summer want members of the Park Service, not profit-minded corporations, enriching their experience by directing them to the famous sites and best kept secrets of our parks.

I oppose privatizing the Park Service because it would hurt Nevadans, endanger our national parks, and waste taxpayer money.

This bill will keep our dedicated Park Service members running our national parks. It stops costly privatization studies and redirects the funds to address the maintenance backlog that President Bush promised to eliminate.

I am committed to protecting our parks, and I am proud to introduce this bill that will ensure that the Park Service can preserve them for generations to come.

I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1363

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PARK PROFESSIONALS PROTECTION.

(a) Short Title.—This Act may be cited as the "Park Professionals Protection Act".

(b) Findings.—Congress finds the following:

(1) The National Park System is recognized throughout the world as a model for the conservation and enjoyment of natural, scenic, recreational, cultural, and historic resources.

(2) The National Park System would never have achieved such status, nor could the system maintain such status, without the professionalism, dedication, and passion of the men and women of the National Park Service.

(3) Current plans to privatize thousands of jobs within the National Park Service ignore the unique contributions made by the men and women of the National Park Service and threaten to undermine the entire National Park System.

(4) Scarce park operations and maintenance resources are being diverted to pay private consultants to study the current privatization scheme. According to the National Park Service, these studies cost approximately $3000 for each position proposed to be privatized.

(5) Despite the millions of taxpayer dollars diverted to these studies, not a single report has been published documenting any cost savings to be generated by the privatization of park operations.

(6) The current privatization scheme raises serious questions regarding the ability of temporary workers, provided by the lowest bidder, to adequately fulfill the responsibilities of professional National Park Service employees in the areas of conservation, interpretation, emergency fire and rescue, and homeland security.

(7) The current privatization scheme appears to affect minority employees disproportionately, threatening to significantly reduce the number of minority employees within the National Park Service.

(8) Pendency of the current privatization scheme is having detrimental impacts on the morale of current employees and is discouraging high quality candidates from applying for positions within the National Park Service.

(c) Prohibition.—Notwithstanding any other provision of law, the Secretary is prohibited from studying or implementing any plan to privatize, divest, or transfer any part of what is, as of the date of the enactment of this section, the mission, function, or responsibility of the National Park Service.

(d) Reallocation of Funds.—Notwithstanding any other provision of law, the Secretary shall withhold any funds currently dedicated to the activities prohibited under subsection (c) and shall reallocate those funds to the operations and maintenance accounts within the National Park Service.

(e) No Effect on Certain Plans.—Nothing in this section shall affect the authority, as of the date of the enactment of this section, of a National Park Service Superintendent to develop and implement concessions management plans and commercial services plans covering, in whole or in part, the area managed by that Superintendent.

(f) Secretary Defined.—The term "Secretary" means the Secretary of the Interior and any person employed by the Secretary of the Interior in any capacity.

By Ms. MURKOWSKI:

S. 1364. A bill to amend the Alaska National Lands Conservation Act to authorize the payment of expenses after the death of certain Federal employees in the State of Alaska; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, on the morning following the annual candlelight vigil to honor fallen law enforcement officers, I came to the floor to speak about three brave Alaskans whose names were inscribed on the National Law Enforcement Officers' Memorial at Judiciary Square this year. One of these brave Alaskans was a National Park Service ranger who lost his life when the aircraft he was piloting crashed in a remote part of Alaska. Today, I am introducing legislation which I hope will help the surviving family members of this ranger in their recovery from this tragic loss and provide authority for the Federal Government to help the surviving family members of other similarly situated Federal employees should a similar tragedy occur in the future.

This ranger I am speaking about was assigned to the Katmai National Park and Preserve in the Bristol Bay region of Alaska and lived in the community of Naknek. Naknek is not connected to the rest of North America by road. It is what we in Alaska call a "bush" community. But it was home to the ranger and became the adopted home of his widow who did not grow up in the area. The ranger about whom I am speaking was hired under a special hiring authority in the Alaska National Interest Lands Conservation Act, ANILCA, which authorizes the Federal land managers to extend a hiring preference to those with special knowledge about a Conservation System Unit. He was regarded as a "local hire."

Under the Federal Travel Regulation, when a federal employee dies outside of the Continental United States, the Federal Government will reimburse the members of his or her household for the cost of relocating to their permanent residence. Alaska is regarded as "outside of the Continental United States" under this regulation.

Thus, if the National Park Service ranger who died in the line of duty came from the Lower 48 before being assigned to the Katmai National Park and Preserve then the Federal Government, as I read the regulation, could reimburse the surviving family members for the cost of relocating to Anchorage. This cost can be fairly substantial since one cannot hire a moving van to ship the personal effects from South Naknek to Anchorage. There are no roads which connect the bush village of South Naknek to Anchorage. The personal effects need to be transported by air.

However, if the deceased employee is a local hire employee, the Federal Travel Regulation does not authorize the Federal Government to reimburse the surviving family members for their relocation cost because the deceased employee's hometown is deemed to be the local hire location. This works an inequity where, as in the present case, the deceased employee's surviving spouse does not have ties to the duty station community, but rather to another community in Alaska. In this instance, the surviving spouse desires to relocate to Anchorage, which is Alaska's largest city, and continue to raise her three children there.

The legislation that I am introducing today is intended to cure this inequity. It would amend ANILCA, the same legislation which contains the local hire authority, to provide that if a local hire employee dies in the line of duty, the Federal Government will reimburse the surviving immediate family for the cost of transporting the remains to a location in Alaska of their choosing and will also relocate the immediate family members to a community in the State of Alaska which is selected by the surviving head of household. I think that this is the least we can do for the survivors of local hire employees who go to work everyday in the harsh climate and conditions of bush Alaska but sadly sometimes do not return home.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1364

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PAYMENT OF EXPENSES AFTER THE DEATH OF CERTAIN FEDERAL EMPLOYEES IN THE STATE OF ALASKA.

Section 1308 of the Alaska National Interest Lands Conservation Act (16 U.S.C. 3198) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

"(c) PAYMENT OF EXPENSES AFTER DEATH OF AN EMPLOYEE.—

"(1) DEFINITION OF IMMEDIATE FAMILY MEMBER.—In this subsection, the term "immediate family member" means a person related to a deceased employee that was a member of the household of the deceased employee at the time of death.

"(2) PAYMENTS.—If an employee appointed under the program established by subsection (a) dies in the performance of any assigned duties on or after October 1, 2002, the Secretary may—

"(A) pay reasonable expenses for the preparation and transportation of the remains of the deceased employee to a location in the State of Alaska which is selected by the surviving head of household of the deceased employee;

"(B) pay reasonable expenses for transporting immediate family members and the baggage and household goods of the deceased employee and immediate family members to a community in the State of Alaska which is selected by the surviving head of household of the deceased employee.".

By Mr. McCONNELL (for himself, Mr. KYL, and Mr. LEAHY):

S. 1365. A bill to provide increased foreign assistance for Cambodia under certain circumstances, and for other purposes; to the Committee on Foreign Relations.

Mr. McCONNELL. Mr. President, today, along with my colleagues Senators KYL and LEAHY, I offer the "Cambodia Democracy and Accountability Act of 2003". This Act is particularly timely, given that national elections are scheduled in that country on July 27th.

Cambodia is on its third round of parliamentary elections since the 1991 Paris Peace Accords, with previous elections having been funded by the United Nations in 1993 and by the Cambodian governments in 1998. Despite the billions of dollars spent on elections in that country—over $2 billion by the U.N. alone—there has yet to be a credible poll that accurately reflects the will of the Cambodian people.

My colleagues will remember that the U.N.-sponsored elections resulted in a large voter turnout—but also an unworkable power sharing deal brokered between the winning royalist FUNCINPEC party and the hard line Cambodian People's Party, CPP, that quickly dissolved into open hostilities, including a bloody grenade attack against a peaceful, pro-democracy rally and a CPP sponsored coup d'etat in 1997.

The debilitating hangover from this coup—destroyed party offices, dead activists, and a palpable climate of fear and repression—undermined prospects for free and fair elections in 1998 even before the first ballots were cast.

Fatigued and frustrated, the international community found it expedient to endorse the flawed elections, even as students and Buddhist monks erected a "democracy square" in Phnom Penh to protest the polls. A CPP crackdown left many of these peaceful protestors killed, beaten or harassed.

It is time that Prime Minister Hun Sen—as the self-proclaimed strongman of Cambodia—is held accountable for the murder of political activists, Buddhist monks, civilians, and students. There is no rule of law, if the leaders of the government are not subject to it.

A second "coalition" government between royalists and hard liners was cobbled together in the aftermath of the 1998 elections. This time, there was no pretext of power sharing, and for the past 5 years CPP has been firmly and completely in control of the country.

Nevertheless, in the months and weeks before the upcoming July elections, the political marriage between FUNCINPEC and CPP is fraying. In an effort to harass and intimidate his opponents, in late January Prime Minister Hun Sen whipped up nationalistic sentiment against Thailand, let loose the so-called Pagoda Boys, government-paid thugs, and destroyed $50 million worth of Thai public and private interests in Phnom Penh.

Despite frantic pleas for assistance, the Thai ambassador and other diplomatic personnel escaped injury by scaling the embassy's walls and scurrying to safety. In the aftermath of the riots, Hun Sen arrested and intimidated students, independent broadcasters, and political activists. A senior opposition figure sought—and was granted— refuge in the U.S. Embassy.

In February, former royalist parliamentarian Om Radsady was gunned down in a mafia-style murder in Phnom Penh. Well liked and respected by his colleagues from all Cambodian political parties, Radsady's assassination sent a not so subtle message that no one is immune from the black hand of CPP.

It is time Hun Sen is held accountable for his complicity in actions that grossly violate international and domestic laws, and the human rights and dignity of the people of Cambodia.

The fundamental question facing the Cambodian people today is whether the July 27th elections will be a meaningful exercise in democracy, or another lost opportunity to chart a new course for that beleaguered country.

Last week, Prime Minister Hun Sen assured Secretary of State Colin Powell that Cambodia would hold free and fair elections. Secretary Powell should not be duped by these hollow promises. A preponderance of evidence suggests that CPP is actively trying to steal the elections before July 27th: political activists continue to be murdered and intimidated, creating a chilling tone of fear and repression; the CPP continues to directly influence and manipulate the election machinery, with members of the National Election Commission, NEC, nominated in a closed manner by the co-Ministers of Interior and the NEC already failing to investigate allegations of election improprieties; and, opposition political parties continue to lack access to media, with several broadcast outlets in Cambodia unwilling to sell air time to CPP's challengers.

Let me take a moment to describe what the Cambodian Democracy and Accountability Act does—and does not—do.

The Act provides additional foreign assistance to Cambodia—an increase by half (or $21.5 million) over the fiscal year 2004 budget request of $43 million—if new leadership has been elected in free and fair elections, and if Hun Sen is no longer Prime Minister. It has been apparent to me that Hun Sen has long been part of Cambodia's problems—and not part of the solution.

The Act does not preclude the Cambodian people from voting for the political party of their choice. Ballot secrecy must be ensured—as well as transparency in the process of vote counting and tabulation—in order that the will of the Cambodian people is accurately expressed. It is my fear that CPP pre-election chicanery may already have violated the integrity of the election process.

If I wanted to interfere with the elections I would have offered legislation that restricts all assistance to Cambodia unless a specific political party or parties was elected. This Act does not do this. It does not cut any assistance—not a single penny—to Cambodia included in the fiscal year 2004 budget request. It simply provides that if the major obstacle to democracy and development in the country—namely Prime Minister Hun Sen—is out of power, additional foreign aid will be forthcoming.

It is important to recall that Hun Sen's coup resulted in severe restrictions on assistance to Cambodia—that continue to this day. If given an opportunity through free and fair elections, the Cambodian people will make the right choices that will ensure a dawn for development in that country.

Why will they make the right choice? Over the many decades he has been in power, Hun Sen has ruled Cambodia through violence, fear and repression. Under his watch, the country has become a haven for sexual predators and pedophiles, the criminal underworld, and international terrorists. Hun Sen has repeatedly abused the most basic of freedoms protected by the Cambodian Constitution, attacked his political opposition, and perpetuated a climate of impunity that stifles the advancement of freedom and free markets.

And he has never—not once—been held accountable for his actions.

In addition to increasing foreign assistance under certain conditions, the Act restricts assistance to a Khmer Rouge tribunal unless the President determines that, among other things, the tribunal is supported by democratic Cambodian political parties and is not under the control or influence of the CPP. It also requires the Federal Bureau of Investigations to resume its investigation of the March 30, 1997 grenade attack against opposition leader Sam Rainsy that killed and injured scores of Cambodians.

I should remind my colleagues that American democracy worker Ron Abney was injured in this act of terrorism, reportedly carried out by the CPP. Ron—and all the victims of this attack—are still waiting for justice.

Secretary Powell wrote in a June 24 op-ed that Zimbabwean dictator Robert Mugabe's "time has come and gone." As democracy is similarly under siege in both Zimbabwe and Cambodia, dictator Hun Sen's time has also come and gone.

By Mr. ALLARD (for himself, Mr. FEINGOLD, and Mr. CRAPO):

S. 1366. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Environment and Public Works.

Mr. ALLARD. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1366

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Chronic Wasting Disease Financial Assistance Act of 2003".

SEC. 2. DEFINITION AND FINDINGS.

(a) CHRONIC WASTING DISEASE DEFINED.—In this Act, the term "chronic wasting disease" means the animal disease afflicting deer and elk that—

(1) is a transmissible disease of the nervous system resulting in distinctive lesions in the brain; and

(2) belongs to the group of diseases known as transmissible spongiform encephalopathies, which group includes scrapie, bovine spongiform encephalopathy, and Cruetzfeldt-Jakob disease.

(b) FINDINGS.—Congress finds the following:

(1) The States retain undisputed primacy and policy-making authority with regard to wildlife management, and nothing in this Act interferes with or otherwise affects the primacy of the States in managing wildlife generally, or managing, surveying, and monitoring the incidence of chronic wasting disease in animal populations.

(2) Chronic wasting disease is a fundamental threat to the health and vibrancy of deer and elk populations, and the increased occurrence of chronic wasting disease in the United States necessitates government action to manage and eradicate this lethal disease.

(3) As the States and tribal government move to manage existing incidence of chronic wasting disease and insulate non-infected wild cervid populations from the disease, it is appropriate for the Federal Government to support their efforts with financial assistance.

SEC. 3. STATE CHRONIC WASTING DISEASE MANAGEMENT CAPACITY BUILDING GRANTS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to State wildlife management agencies to assist States in developing and implementing long term management strategies to address chronic wasting disease in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of a State whose comprehensive wildlife conservation plan includes chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) States in which chronic wasting disease has been detected and States located adjacent or in proximity to States in which chronic wasting disease has been detected.

(2) States that have expended State funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to those States that have shown the greatest financial commitment to managing, monitoring, surveying, and researching chronic wasting disease.

(3) States with comprehensive and integrated policies and programs focused on chronic wasting disease management between involved State wildlife and agricultural agencies and tribal governments, with additional priority given to States that have integrated the programs and policies of all involved agencies related to chronic wasting disease management.

(4) States that are seeking to develop a rapid response capacity to address outbreaks of chronic wasting disease, whether occurring in States in which chronic wasting disease is already found or States with first infections, for the purpose of containing the disease in any new area of infection.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $7,500,000 to carry out this section.

SEC. 4. GRANTS FOR STATES WITH CHRONIC WASTING DISEASE OUTBREAKS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to State wildlife management agencies to assist States in responding to chronic wasting disease outbreaks in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of a State whose comprehensive wildlife conservation plan includes chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) State expenditures on chronic wasting disease management, monitoring, surveillance, and research in response to management of an ongoing outbreak.

(2) The number of chronic wasting disease cases detected in the State.

(3) The wild cervid population of the State.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 to carry out this section.

SEC. 5. TRIBAL CHRONIC WASTING DISEASE MANAGEMENT GRANTS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to tribal wildlife management agencies to assist Indian tribes in developing and implementing long term management strategies to address chronic wasting disease in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of an Indian tribe whose comprehensive wildlife conservation plan includes chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) Tribal governments managing lands on which cervids with chronic wasting disease have been detected, or managing lands located adjacent or in proximity to lands on which cervids with chronic wasting disease have been detected.

(2) Tribal governments that have expended tribal funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to tribal governments that have shown the greatest financial commitment to managing, monitoring, and surveying chronic wasting disease.

(3) Tribal governments with cooperative arrangements with Federal and State wildlife and agricultural agencies and State governments, with additional priority given to tribal governments that are working with other involved agencies on issues of chronic wasting disease management.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 to carry out this section.

SEC. 6. ADMINISTRATION.

The Secretary of the Interior shall carry out this Act acting through the Director, United States Fish and Wildlife Service. Funds appropriated to carry out this Act shall be administered through the Federal Assistance Program in the United States Fish and Wildlife Service. Not more than three percent of such funds may be expended for administrative expenses of the United States Fish and Wildlife Service to carry out this Act.

Mr. FEINGOLD. Mr. President, I am pleased to join with my colleague from Colorado, Mr. ALLARD, as a cosponsor of the Chronic Wasting Disease Financial Assistance Act of 2003. This legislation is similar to legislation, S. 1036, the Chronic Wasting Disease Support Act of 2003, that we introduced earlier this year.

The House Resources Committee held a hearing on June 19, 2003 on the issue of chronic wasting disease, or CWD. At that hearing, state agency representatives argued strongly that Congress should create a new grant program to provide assistance to states for the management of CWD. They also expressed an interest in having those funds distributed using an existing distribution mechanism. This legislation responds directly to these comments. In total, the bill directs the U.S. Fish and Wildlife Service to provide $20.5 million in Federal grants to State and tribal governments for CWD management in wild deer and elk, $10.5 million more in resources than were included in the bill Senator ALLARD and I introduced earlier this year.

The bill creates three new Federal CWD grant programs. The first program is a new nationwide CWD capacity grant, authorized at a total of $7.5 million. This program would provide grants to States so that they can fund CWD management programs. Preference would be given to States with comprehensive and integrated chronic wasting disease management programs involving all relevant state agencies.

The second grant program would provide an additional $10 million in grant assistance to states like Colorado and Wisconsin that already have detected chronic wasting disease in their wild deer and elk. These States need additional help. Wisconsin has undertaken significant measures to combat CWD at significant expense, and this program acknowledges that outbreaks are expensive to manage and require Federal financial assistance.

Finally, the bill would create a third $3 million grant program to provide CWD management grants directly to tribal governments. To be eligible for these programs, States and tribes are given the ability under the bill to use an existing mechanism, the U.S. Fish and Wildlife Service Federal Assistance Act procedures, to expedite the receipt of grant funds.

This bill is needed because State wildlife departments and tribal governments do not have the financial resources to adequately confront the problem. Their resources are spread too thin as they attempt to prevent the disease from spreading. Federal help in the form of management funding is urgently needed. Federal funding will help States and tribes to protect and safeguard our valued wild deer and elk from this disease.

I look forward to working with the Senate to secure passage of this measure. This is a good bill, and it deserves the Senate's support.

By Mr. McCONNELL (for himself, Mr. BAYH, and Mr. FITZGERALD):

S. 1367. A bill to amend the Richard B. Russell National School Act to establish programs to promote increased consumption of milk in schools and to improve the nutrition and health of children; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. McCONNELL. Mr. President, I rise today to introduce a very important piece of legislation that could provide great benefits for the health of our young people while simultaneously strengthening the future viability of dairy producers throughout the United States.

My bill, the Child Nutrition Improvement Act of 2003, would provide incentives for schools to encourage the consumption of milk as part of the school lunch program and supply needed flexibility for schools to offer a wide variety of milk products and flavors.

There is no doubt that the eating habits we develop when we are young affect our habits and nutritional choices for the rest of our lives. The school lunch program has provided a key tool in promoting healthy eating habits among young people, which have both health and educational benefits.

Milk has been a critical component of the school lunch program because it is the principal source of calcium and a leading source of several other important nutrients in our diet. That was true when the federal program began in 1946 and it is still true today.

With 9 out of 10 teenage girls and 7 out of 10 teenage boys currently not getting enough calcium, milk's importance is perhaps greater today than ever before. Serving milk with the school lunch is a critical step in addressing the calcium crisis. Federal child health experts who are on the frontlines fighting the calcium crisis recognize milk's central role in addressing the problem. Study after study emphasize the need for growing children and teens to consume more milk for healthy bones, and the American Academy of Pediatrics has urged its members to recommend their patients get enough milk, cheese, yogurt and other calcium-rich foods to help build bone mass.

As a result of these recommendations, we have seen a push for more milk in more places in school, like vending machines and school stores. There's a real concern about nutritious choices for school children, and many local school districts and state legislatures are pushing to add more healthful beverage choices like milk.

A large school vending test in 2001 demonstrated that kids will eagerly buy milk from vending machines in schools when it is offered. The test was heralded by school nutritionists and helped stimulate nationwide interest in getting milk vending machines into more schools.

A pilot test conducted in 146 schools with 100,000 students showed dramatic increases in milk consumption—15 percent in elementary schools and 22 percent in secondary schools—when simple improvements were made in the way milk was packaged and presented to students. The milk was served colder and kids loved the addition of a third flavor; it was usually strawberry. No only did kids drink more milk, more kids ate in the cafeteria. That meant they not only got milk, they also got improved nutrition through greater intake of vegetables, fruits and other nutritionally important foods.

Milk has an unsurpassed nutrient package for young children and teens. Milk has nine essential vitamins and minerals, including calcium, vitamins A, D and B12, protein, potassium, riboflavin, niacin and phosphorus. These nutrients are critical to good health and the prevention of chronic disease. In addition, it is the primary way that growing children get the calcium they need. In fact, according to the U.S. Department of Agriculture, about 75 percent of the calcium in our food supply comes from milk and foods made with milk. By about age 20, the average young person has acquired about 98 percent of his or her skeletal mass. Building strong bones during childhood and adolescence is one of the best defenses against developing osteoporosis later in life.

In addition to the bone-building benefits of milk, research indicates that a diet rich in low-fat milk may help reduce the risk of high blood pressure and heart disease and help prevent breast cancer, colon cancer and even help in the fight against obesity.

Milk's role in a nutritious diet has long been noted by the nutrition and science community, including the American Academy of Pediatrics, the American Dietetic Association, the National Institute of Child Health and Human Development, the National Osteoporosis Foundation, the U.S. Department of Agriculture, and many other reputable health organizations.

As I have already mentioned, government statistics indicate that we have a calcium crisis among our children and youth. Nearly 90 percent of teenage girls and almost 70 percent of teenage boys fail to get enough calcium in their diets. During the teen years nearly half of all bone is formed and about 15 percent of your adult height is added. As a national health priority, for proper growth and development, we need to be doing all we can to encourage our children and youth to drink milk, and that is the goal of the legislation I am introducing today.

I ask my colleagues for your support of this important piece of legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1367

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Child Nutrition Improvement Act of 2003".

SEC. 2. CONSUMPTION OF MILK IN SCHOOLS.

(a) FLUID MILK.—

(1) IN GENERAL.—Section 9(a) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(a)) is amended by striking paragraph (2) and inserting the following:

"(2) FLUID MILK.—

"(A) IN GENERAL.—Lunches served by schools participating in the school lunch program under this Act—

"(i) shall offer students fluid milk; and

"(ii) shall offer students a variety of flavored and unflavored milk, as determined by the school.

"(B) FLUID MILK PRODUCTS.—A school or institution that participates in the school lunch program under this Act—

"(i) may offer a la carte fluid milk products to be sold in addition to and, at the option of the school, adjacent to fluid milk offered as part of a reimbursable meal; and

"(ii) shall not directly or indirectly restrict the sale or marketing of fluid milk products by the school (or by a person approved by the school) at any time or any place—

"(I) on the school premises; or

"(II) at any school-sponsored event.".

(2) APPLICATION.—The amendment made by paragraph (1) applies to an agreement or contract entered into on or after the date of enactment of this Act.

(b) INCREASED CONSUMPTION OF MILK IN SCHOOLS.—Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760) is amended by adding at the end the following:

"(q) INCREASED CONSUMPTION OF MILK IN SCHOOLS.—

"(1) IN GENERAL.—To encourage healthier nutritional environments in schools and institutions receiving funds under this Act and the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.) (other than section 17 of that Act (42 U.S.C. 1786)), the Secretary shall establish a program under which any such school or institution may (in accordance with paragraph (3)) receive an increase in the reimbursement rate for free and reduced price meals otherwise payable under this Act and the Child Nutrition Act of 1966, if the school or institution implements a plan for improving the nutritional value of meals consumed in the school or institution by increasing the consumption of fluid milk in the school, as approved by the Secretary in accordance with criteria established by the Secretary.

"(2) PLANS.—

"(A) IN GENERAL.—For purposes of the program established under paragraph (1), the Secretary shall establish criteria for the approval of plans of schools and institutions for increasing consumption of fluid milk.

"(B) CRITERIA.—An approved plan may—

"(i) establish targeted goals for increasing fluid milk consumption throughout the school or institution or at school or institution activities;

"(ii) improve the accessibility, presentation, positioning, or promotion of fluid milk throughout the school or institution or at school or institution activities;

"(iii) improve the ability of a school or institution to tailor the plan to the customs and demographic characteristics of—

"(I) the population of the school or institution; and

"(II) the area in which the school or institution is located; and

"(iv) provide—

"(I) packaging, flavor variety, merchandising, refrigeration, and handling requirements that promote the consumption of fluid milk; and

"(II) increased standard serving sizes for fluid milk consumed in middle and high schools.

"(C) ADMINISTRATION.—In establishing criteria for plans under this subsection, the Secretary shall—

"(i) take into account relevant research; and

"(ii) consult with school food service professionals, nutrition professionals, food processors, agricultural producers, and other groups, as appropriate.

"(3) REIMBURSEMENT RATES AND INCENTIVES.—

"(A) IN GENERAL.—For purposes of administering the program established under paragraph (1), the Secretary shall annually provide reimbursement rates and incentives for free and reduced price meals otherwise payable under this Act and the Child Nutrition Act of 1966 of not less than 2 cents and not more than 10 cents per meal, to reflect the additional costs incurred by schools and institutions in increasing the consumption of fluid milk under the program.

"(B) CRITERIA.—The Secretary may vary the increase in reimbursement rates and incentives for free and reduced price meals based on the degree to which the school or institution adopts the criteria established by the Secretary under paragraph (2).".

SEC. 4. IMPROVED NUTRITION AND PHYSICAL ACTIVITY LEVEL OF CHILDREN.

Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760) (as amended by section 2(b)) is amended by adding at the end the following:

"(r) IMPROVED NUTRITION AND PHYSICAL ACTIVITY LEVEL OF CHILDREN.—

"(1) DEFINITION OF HEALTHY SCHOOL ENVIRONMENT PROGRAM.—In this subsection, the term 'healthy school environment program' means a program that—

"(A) is designed to improve the environment of a school with respect to the nutrition and physical activity level of children enrolled in the school; and

"(B) includes steps to improve and make available healthy food choices (including fruits, vegetables, and dairy products).

"(2) PROGRAM.—The Secretary shall carry out a program to provide grants to schools that implement healthy school environment programs.

"(3) ADMINISTRATION.—In carrying out the program, the Secretary may enter into cooperative agreements with—

"(A) nonprofit organizations;

"(B) educational and scientific institutions;

"(C) Federal, State, and local agencies; and

"(D) other entities that contribute funds or in-kind services for the program.

"(4) ACCEPTANCE OF FUNDS.—Notwithstanding any other provision of law, the Secretary may accept funds from an entity referred to in paragraph (3) solely for use in carrying out the program under this subsection.".

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 187—EXPRESSING THE SENSE OF THE SENATE REGARDING THE CENTENARY OF THE RHODES SCHOLARSHIPS IN THE UNITED STATES AND THE ESTABLISHMENT OF THE MANDELA RHODES FOUNDATION

Mr. LUGAR (for himself, Mr. SARBANES, and Mr. FEINGOLD) submitted the following resolution; which was agreed to.

S. RES. 187

Whereas the Rhodes Scholarships, the oldest international fellowships, were initiated after the death of Cecil Rhodes in 1902, and now bring outstanding students from the United States, Australia, Bangladesh, Bermuda, Canada, the Commonwealth Caribbean, Germany, Hong Kong, India, Jamaica, Kenya, Malaysia, New Zealand, Pakistan, Singapore, South Africa, Uganda, Zambia, and Zimbabwe to the University of Oxford;

Whereas the first American Rhodes Scholars were elected in 1904, and since that time distinguished American Rhodes alumni have included over 20 members of Congress, a President of the United States, 3 Supreme Court justices, cabinet members, military leaders, 80 heads of colleges or universities, and prominent artists, scientists, and business people;

Whereas the Mandela Rhodes Foundation, a partnership between the Rhodes Trust and the Nelson Mandela Foundation, was established in February, 2002;

Whereas after a lifetime of struggle against apartheid and the momentous challenge of governing the new South Africa as its first democratically elected President, Nobel Peace Prize Laureate Nelson Rolihlahla Mandela continues to be devoted to building a society characterized by justice and opportunity in the Republic of South Africa;

Whereas President Mandela's efforts have manifested themselves in the work of the Nelson Mandela Children's Fund, established in the wake of President Mandela's pledge to devote ⅓ of his Presidential salary to projects aimed at improving the quality of life of South Africa's disadvantaged children; and

Whereas in Cape Town in February, 2002, President Mandela noted that the partnership between the Rhodes Trust and the new Mandela Foundation signals "the closing of the circle and the coming together of 2 strands in our history": Now, therefore, be it

Resolved, That the Senate—

(1) celebrates the centenary of the Rhodes Scholarships in the United States;

(2) welcomes the establishment of the Mandela Rhodes Foundation, which embodies the spirit of reconciliation and shared

commitment that is one of South Africa's greatest assets;

(3) shares the Foundation's commitment to support initiatives aimed at increasing educational opportunities, fostering leadership, and promoting human resource development throughout Africa; and

(4) affirms the support of the United States for these worthy goals throughout the sub-Saharan region, and asserts that the pursuit of these goals is in the shared interest of the American and African people.

SENATE RESOLUTION 188—HONORING MAYNARD HOLBROOK JACKSON, JR. FORMER MAYOR OF THE CITY OF ATLANTA, AND EXTENDING THE CONDOLENCES OF THE SENATE ON HIS DEATH

Mr. CHAMBLISS (for himself and Mr MILLER) submitted the following resolution; which was agreed to.

S. RES. 188

Whereas the Honorable Maynard Holbrook Jackson, Jr. was born on March 23, 1938, in Dallas, Texas, and at the age of 14 entered Morehouse College as a Ford Foundation Early Admission Scholar;

Whereas the Honorable Maynard Holbrook Jackson, Jr. graduated *cum laude* from North Carolina Central University School of Law;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became the first African-American Vice Mayor of the City of Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. proved to be a gifted and brilliant political leader, and he later became the first African-American Mayor of the City of Atlanta;

Whereas, during his years in office, the Honorable Maynard Holbrook Jackson, Jr. was the catalyst for the design of a $400 million terminal at Atlanta's Hartsfield International Airport;

Whereas the Honorable Maynard Holbrook Jackson, Jr. helped to secure Atlanta's selection as the site of the 1996 Summer Olympics;

Whereas the Honorable Maynard Holbrook Jackson, Jr. served as president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became Chair of the National Voting Rights Institute of the Democratic National Committee;

Whereas the Honorable Maynard Holbrook Jackson, Jr. established the American Voters League, a nonpartisan organization committed to increasing voter turnout;

Whereas upon being elected Mayor of Atlanta, the Honorable Maynard Holbrook Jackson, Jr. began encouraging and fostering interracial understanding in Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a strong supporter of affirmative action, civil rights, and the expansion of social and economic gains for minorities;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a great champion for diversity, inclusion, and fairness—not just in government and business, but also in all areas of life;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a wonderful human being who never wavered from the principles that guided his life and career;

Whereas the efforts of the Honorable Maynard Holbrook Jackson, Jr. on behalf on the City of Atlanta and all Americans earned him the esteem and high regard of his colleagues; and

Whereas the untimely death of the Honorable Maynard Holbrook Jackson, Jr. has deprived his community, the City of Atlanta, the State of Georgia, and the entire Nation of an outstanding leader: Now, therefore, be it

Resolved: That the Senate—

(1) honors the life and accomplishments of the Honorable Maynard Holbrook Jackson, Jr.;

(2) recognizes the legendary compassion exhibited by the Honorable Maynard Holbrook Jackson, Jr. as a civil rights leader; and

(3) extends its condolences to the Jackson family and the City of Atlanta on the death of a remarkable man.

SENATE RESOLUTION 189—ELECTING DOCTOR BARRY C. BLACK, OF BALTIMORE, MARYLAND, AS CHAPLAIN OF THE UNITED STATES SENATE

Mr. FRIST (for himself and Mr. DASCHLE) submitted the following resolution; which was agreed to.

S. RES. 189

Resolved, That Doctor Barry C. Black, of Baltimore, Maryland, be, and he is hereby, elected Chaplain of the Senate, effective Monday, July 7, 2003.

SENATE RESOLUTION 190—COMMENDING GENERAL ERIC SHINSEKI OF THE UNITED STATES ARMY FOR HIS OUTSTANDING SERVICE AND COMMITMENT TO EXCELLENCE

Mr. AKAKA (for himself, Mr. INHOFE, Mr. WARNER, Mr. LEVIN, Mrs. MURRAY, Mr. DODD, Ms. LANDRIEU, Mr. PRYOR, Mr. DASCHLE, Mr. BIDEN, Mr. KENNEDY, Mr. FEINGOLD, Mr. DURBIN, Mr. NELSON of Nebraska, Mr. NELSON of Florida, Mr. REED, Mr. CHAMBLISS, Ms. CANTWELL, Mr. SARBANES, Mrs. CLINTON, Mr. ROBERTS, Mr. LAUTENBERG, Mr. LIEBERMAN, Mr. DAYTON, Ms. MURKOWSKI, Mr. INOUYE, Mr. HAGEL, Ms. COLLINS, and Mr. STEVENS) submitted the following resolution; which was agreed to

S. RES. 190

Whereas General Eric Shinseki, the Army's 34th Chief of Staff, retired in June 2003, from active military duty after 37 distinguished years of service;

Whereas General Shinseki, a native of Hawaii, graduated from the United States Military Academy, West Point, in 1965 and served in a variety of assignments, including 2 combat tours in Vietnam, and was wounded twice in combat while serving his country;

Whereas General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with oak leaf clusters), Bronze Star Medal with "V" Device (with 2 oak leaf clusters), Purple Heart (with oak leaf cluster), Meritorious Service Medal (with 2 oak leaf clusters), Air Medal, Army Commendation Medal (with oak leaf cluster), Army Achievement Medal, Parachutist Badge, Ranger Tab, Office of the Secretary of Defense Identification Badge, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge;

Whereas General Shinseki has spent the last 4 years of his career in the highest position attainable in the Army and has proven himself a tremendous leader who has demonstrated unselfish devotion to this Nation and the soldiers he leads;

Whereas General Shinseki focused the Army on improved readiness in preparation for war and transformed the Army into the lean, agile, lethal fighting force that achieved victories during Operations Enduring Freedom and Iraqi Freedom;

Whereas General Shinseki provided the vision to set the Army on a path of transformation that will provide the Nation with an Army that is more lethal, agile, deployable, and flexible; capable of fighting and winning this Nation's wars in all future threat environments.

Whereas General Shinseki exemplifies the trademark characteristics exhibited by all great leaders and is a remarkable man of integrity, courage, and honor;

Whereas General Shinseki is an American hero who has been selfless in his service to his country through war, peace, and personal trial, and epitomizes the spirit of aloha; and

Whereas John F. Kennedy, the 35th President of the United States once said, "When at some future date the high court of history sits in judgment of each one of us—recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to 4 questions—were we truly men of courage . . . were we truly men of judgment . . . were we truly men of integrity . . . were we truly men of dedication?" and whereas when history looks back at the Army's 34th Chief of Staff, it will be clear that this was truly a man of courage, judgment, integrity, and dedication: Now, therefore, be it

Resolved,

SECTION 1. COMMENDATION.

The Senate—

(1) thanks General Eric Shinseki of the United States Army on behalf of a grateful Nation; and

(2) commends General Eric Shinseki for his extraordinary dedication to service to this great country and for his lifetime of commitment to excellence.

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to General Eric Shinseki.

Mr. AKAKA. Mr. President, I rise today to honor a great American hero, General Eric Shinseki, the Army's 34th Chief of Staff. General Shinseki, a native of Hawaii, attained the Army's highest position as the Army's Chief of Staff in June 1999 and retired in June 2003.

Ric Shinseki graduated from the United States Military Academy, West Point, in 1965. He served two combat tours in Vietnam and was wounded twice in combat. Throughout his 37 years of service to this country, he has given his personal best, serving with great pride and dignity. His legacy to this Nation will live on for years to come.

Over the span of his career, I've watched his progress as a soldier and was privileged to participate in his promotion ceremony to Colonel. At that time, I thought he had a stellar career as a "soldier's soldier." I was very proud to witness his four years of service as the Army's Chief of Staff. He was the perfect soldier to lead our Army into the 21st century.

This remarkable man and distinguished decorated soldier set a new standard for the Army. With extraordinary vision, he transformed the Army into an agile, lean, flexible, and lethal fighting force. This man of honor, integrity, and courage set a higher standard for all to follow, all while embodying the spirit of aloha. With his deep sense of pride and dedication to service, he made our Army stronger, one able to achieve swift victories during Operations Enduring Freedom and Iraqi Freedom.

As I quoted in the Senate Resolution, President John F. Kennedy once said, "When at some future date the high court of history sits in judgment of each one of us—recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to four questions—were we truly men of courage ... were we truly men of judgment ... were we truly men of integrity ... were we truly men of dedication?" When history looks back at the Army's 34th Chief of Staff, it will be clear that this was truly a man of courage, judgment, integrity, and dedication.

General Shinseki is to be commended for his patriotism, unwavering commitment to this Nation, and his meritorious service to this country.

SENATE CONCURRENT RESOLUTION 56—EXPRESSING THE SENSE OF THE CONGRESS THAT A COMMEMORATIVE POSTAGE STAMP SHOULD BE ISSUED HONORING GUNNERY SERGEANT JOHN BASILONE, A GREAT AMERICAN HERO

Mr. CORZINE (for himself, Mr. WARNER, Mr. LAUTENBERG, and Mrs. CLINTON) submitted the following concurrent resolution; which was referred to the Committee on Governmental Affairs:

S. CON. RES. 56

Whereas Gunnery Sergeant John Basilone was born in 1916 in Buffalo, New York, son of Salvatore and Dora Basilone, one of 10 children;

Whereas John Basilone was raised and educated in Raritan, New Jersey;

Whereas, at the age of 18, John Basilone enlisted in the United States Army, principally seeing garrison service in the Philippines;

Whereas, after his honorable discharge in 1937, Sergeant Basilone, known by his comrades as "Manila John", returned to Raritan;

Whereas, seeing the storm clouds of war hovering over the Nation, and believing that his place was with this country's fighting forces, Sergeant Basilone enlisted in the United States Marine Corps in July 1940;

Whereas, on October 24 and 25, 1942, on Guadalcanal, Solomon Islands, Sergeant Basilone was a member of "C" Company, 1st Battalion, 7th Regiment, 1st Marine Division, and was in charge of 2 sections of heavy machine guns defending a narrow pass that led to Henderson Airfield;

Whereas, although Sergeant Basilone and his machine gunners were vastly outnumbered and without available reinforcements, Sergeant Basilone and his fellow Marines fought valiantly to check the savage and determined assault by the Japanese Imperial Army;

Whereas, for this action, Sergeant Basilone was awarded the Congressional Medal of Honor and sent home a hero;

Whereas, in December 1944, Sergeant Basilone's restlessness to rejoin his fellow Marines, who were fighting the bloody island-to-island battles en route to the Philippines and Japan, prompted him to volunteer again for combat;

Whereas, on Iwo Jima, on February 19, 1945, Sergeant Basilone again distinguished himself by single-handedly destroying an enemy blockhouse while braving heavy-caliber fire;

Whereas, minutes later, an artillery shell killed Sergeant Basilone and 4 of his platoon members;

Whereas Sergeant Basilone was posthumously awarded the Navy Cross and Purple Heart, and a life-sized bronze statue stands in Raritan, New Jersey, where "Manila John" is clad in battle dress and cradles a machine gun in his arms;

Whereas, in 1949, the United States Government commissioned a destroyer the U.S.S. Basilone, and in November 1951, Governor Alfred E. Driscoll posthumously awarded Sergeant Basilone the State of New Jersey's highest decoration;

Whereas, following World War II, Sergeant Basilone's remains were reinterred in the Arlington National Cemetery;

Whereas Sergeant Basilone was the first recipient of the Congressional Medal of Honor awarded in World War II;

Whereas Sergeant Basilone was also awarded the Navy Cross and the Purple Heart, giving him the distinction of being the only enlisted Marine in World War II to receive all 3 medals; and

Whereas commemorative postage stamps have been commissioned to honor other great heroes in American history: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that—

(1) a commemorative postage stamp should be issued by the United States Postal Service honoring Gunnery Sergeant John Basilone; and

(2) the Citizens' Stamp Advisory Committee should recommend to the Postmaster General that such a stamp be issued.

Mr. CORZINE. Mr. President, I rise today to submit a concurrent resolution calling on the United States Postal Service to issue a commemorative postage stamp honoring an extraordinary American hero: Gunnery Sergeant John Basilone. Basilone is the only person in American history to be awarded both the Congressional Medal of Honor and the Navy Cross. Only one USPS stamp has ever commemorated an individual Marine, a stamp featuring John Phillip Sousa; it bears noting that although Sousa was a Marine, he was not selected for his service on the battlefield. It is time to remember the tremendous sacrifice of at least one individual Marine, John Basilone, an American Patriot.

John Basilone was raised in Raritan, NJ, one of ten children in a large Italian-American family. Soon after he turned 18, Basilone heeded the patriotic call and enlisted in the U.S. Army. Basilone was immediately sent to the Philippines where he earned a nickname that would stick with him for the rest of his career: "Manila John."

Following his tour of duty in 1937, Basilone returned to Raritan. But he wouldn't stay there long. In July 1940—with much of Europe at war and the United States on the brink—"Manila John" left New Jersey, enlisting in the military once again, this time joining the United States Marine Corps.

On October 24, 1942, Basilone earned his Congressional Medal of Honor. He was sent to a position on the Tenaru River at Guadalcanal and placed in command of two sections of heavy machine guns. Sergeant Basilone and his men were charged with defending Henderson Airfield, an important American foothold on the island. Although the Marine contingent was vastly outnumbered and without needed support, Basilone and his men successfully repelled a Japanese assault. Other survivors reported that their success can be attributed to one man: "Manila John." He crossed enemy lines to replenish a dangerously low stockpile of ammunition, repaired artillery pieces, and steadied his troops in the midst of torrential rain. He went several days and nights without food or sleep, and the U.S. military was able to carry the day. His exploits became Marine lore, and served as a patriotic inspiration to others facing daunting challenges in the midst of war.

For his courage under fire and profound patriotism, Basilone was the first enlisted Marine to be awarded the Congressional Medal of Honor. When he returned to the United States, he was heralded as a hero and quickly sent on tour around the country to help finance the war through the sale of war bonds. The Marine Corps offered to commission Basilone as an officer and station him far away from the frontlines.

But Basilone was not interested in riding out the war in Washington, DC. He was quoted as saying, "I ain't no officer, and I ain't no museum piece. I belong back with my outfit." In December 1944, he got his wish and returned to the frontlines.

General Douglas MacArthur called him "a one-man army," and on February 19, 1945 at Iwo Jima, Basilone once again lived up to that reputation. Basilone destroyed an enemy stronghold, a blockhouse on that small Japanese island and commanded his young troops to move the heavy guns off the beach. Unfortunately, less than two hours into the assault on that fateful day in February, Basilone and four of his fellow Marines were killed when an enemy mortar shell exploded nearby.

When Gunnery Sergeant John Basilone died he was only 27, but he had already earned the Congressional Medal of Honor, the Navy Cross, the Purple Heart, and the appreciation of his Nation. Basilone is a true American patriot whose legacy should be preserved.

Now more than ever, the United States needs to honor and praise the courageous efforts put forth by the men and women of our military. I strongly urge my colleagues to support this resolution as an important message to our soldiers that we appreciate and admire all of their efforts in the war on terrorism.

SENATE CONCURRENT RESOLUTION 57—HONORING DR. NORMAN CHRISTOPHER FRANCIS, PRESIDENT OF XAVIER UNIVERSITY OF LOUISIANA, FOR HIS LONGSTANDING DEDICATION AND SERVICE SPECIFIC TO XAVIER UNIVERSITY AND TO EDUCATION AS A WHOLE

Ms. LANDRIEU submitted the following concurrent resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. CON. RES. 57

Whereas Dr. Norman C. Francis, an educator and institution builder, earned a Bachelor of Science degree from Xavier University of Louisiana, received a Juris Doctorate degree from Loyola University of the South Law School, and served in the Third Armored Division of the United States Army;

Whereas Dr. Norman C. Francis has served as president of Xavier University of Louisiana for 34 years, which ranks him among the most tenured of college presidents now serving in the United States;

Whereas Dr. Norman C. Francis embodies a spirit of greatness and leadership in his roles as an outstanding president and advocate for academic excellence at Xavier University;

Whereas Dr. Norman C. Francis has created an environment at Xavier University that gives students the opportunity to gain valuable knowledge and skills that are necessary for success in today's challenging world; and

Whereas Dr. Norman C. Francis has diligently served the African-American and other minority communities: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring),

SECTION 1. COMMENDATION.

That Congress—

(1) is grateful to Dr. Norman Christopher Francis;

(2) honors Dr. Francis for his steadfast commitment and dedication to education;

(3) commends Dr. Francis for recognizing the need for diversity in education; and

(4) hopes that Dr. Norman C. Francis, an educator and institution builder, continues to be a leader of the best and brightest students and educators.

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to Dr. Norman Christopher Francis.

Ms. LANDRIEU. Mr. President, I rise to make a few remarks concerning an individual who has longstanding dedication and service specific to Xavier University and to education as a whole. Dr. Francis is being honored by the Urban League of Greater New Orleans on June 28, 2003, for his leadership at Xavier University as an outstanding President and advocate for academic excellence.

Mr. President, I wish to recognize Dr. Norman C. Francis who has exhibited a spirit of greatness and for his leadership at Xavier University of Louisiana as an outstanding President and advocate for academic excellence.

It is certainly important to reflect upon his accomplishments as Dr. Francis is still motivated to new levels, to enhance educational opportunities throughout our colleges and universities and throughout the community at large.

AMENDMENTS SUBMITTED & PROPOSED

SA 1094. Mr. SESSIONS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table.

SA 1095. Mr. REID (for Mr. JOHNSON (for himself and Mr. COCHRAN)) proposed an amendment to the bill S. 1, supra.

SA 1096. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra.

SA 1097. Mr. MCCONNELL proposed an amendment to the bill S. 1, supra.

SA 1098. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1099. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1100. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1101. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1102. Mr. MCCONNELL proposed an amendment to the bill S. 1, supra.

SA 1103. Mr. DORGAN (for himself and Mr. PRYOR) proposed an amendment to amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, supra.

SA 1104. Mr. KOHL (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1105. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1106. Mr. HATCH (for himself and Mr. WYDEN) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1107. Mr. COCHRAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1108. Mr. DURBIN proposed an amendment to the bill S. 1, supra.

SA 1109. Mr. BURNS (for himself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1110. Mr. BAUCUS (for Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1111. Mr. BAUCUS (for Mr. LEVIN (for himself, Ms. STABENOW, and Mrs. CLINTON)) proposed an amendment to the bill S. 1, supra.

SA 1112. Mr. KERRY submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1113. Mr. GRASSLEY proposed an amendment to the bill S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

SA 1114. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

SA 1115. Mr. KYL (for himself, Mr. HATCH, and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1116. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1117. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1118. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1121. Mr. KYL (for himself, Mr. NICKLES, Mr. GREGG, Mr. THOMAS, and Mr. LOTT) proposed an amendment to the bill S. 1, supra.

SA 1122. Mr. BROWNBACK (for himself and Mr. NELSON, of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1123. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1124. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1125. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1126. Mrs. DOLE (for herself and Mr. EDWARDS) submitted an amendment intended to be proposed by her to the bill S. 1, supra.

SA 1127. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1128. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1129. Mr. DASCHLE (for Mr. KERRY) submitted an amendment intended to be proposed by Mr. Daschle to the bill S. 1 , supra; which was ordered to lie on the table.

SA 1130. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1131. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1132. Mr. SANTORUM proposed an amendment to the bill S. 1 , supra.

SA 1133. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, supra.

TEXT OF AMENDMENTS

SA 1094. Mr. SESSIONS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 637, line 1, strike "no debt" and all that follows through line 5, and insert the following: "the sponsor of such an alien shall be responsible for paying 100 percent of the costs attributable to the provision of such assistance, unless the sponsor demonstrates that the sponsor has an extreme and unusual financial hardship that prevents the sponsor from paying such costs."

SA 1095. Mr. REID (for himself and Mr. COCHRAN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. . MEDICATION THERAPY MANAGEMENT ASSESSMENT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 geographic areas, each containing not less than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(3) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the program not later than January 1, 2005, but may not implement the assessment program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as an assessment site under subsection (a)(2) may participate in the assessment program under this section if such beneficiary identifies a qualified pharmacist who agrees to furnish medication therapy management services to the eligible beneficiary under the assessment program.

(c) CONTRACTS WITH QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF QUALIFIED PHARMACISTS.—The Secretary may contract with more than 1 qualified pharmacist at each site.

(d) PAYMENT TO QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—Under a contract entered into under subsection (c), the Secretary shall pay qualified pharmacists a fee for providing medication therapy management services.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The Secretary shall, in consultation with national pharmacists and pharmacy associations, design the fee paid under paragraph (1) to test various payment methodologies applicable with respect to medication therapy management services, including a payment methodology that applies a relative value scale and fee-schedule with respect to such services that take into account the differences in—

(A) the time required to perform the different types of medication therapy management services;

(B) the level of risk associated with the use of particular outpatient prescription drugs or groups of drugs; and

(C) the health status of individuals to whom such services are provided.

(e) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the assessment program under this section.

(2) BUDGET NEUTRALITY.—In conducting the assessment program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the assessment program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the assessment program under this section.

(g) AVAILABILITY OF DATA.—During the period in which the assessment program is conducted, the Secretary annually shall make available data regarding—

(1) the geographic areas and sites designated under subsection (a)(2);

(2) the number of eligible beneficiaries participating in the program under subsection (b) and the level and types medication therapy management services used by such beneficiaries;

(3) the number of qualified pharmacists with contracts under subsection (c), the location of such pharmacists, and the number of eligible beneficiaries served by such pharmacists; and

(4) the types of payment methodologies being tested under subsection (d)(2).

(h) REPORT.—

(1) IN GENERAL.—Not later than 6 months after the completion of the assessment program under this section, the Secretary shall submit to Congress a final report summarizing the final outcome of the program and evaluating the results of the program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The final report submitted under paragraph (1) shall include an assessment of the feasibility and appropriateness of the various payment methodologies tested under subsection (d)(2).

(i) DEFINITIONS.—In this section:

(1) MEDICATION THERAPY MANAGEMENT SERVICES.—The term "medication therapy management services" means services or programs furnished by a qualified pharmacist to an eligible beneficiary, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual's understanding of the appropriate use of medications;

(C) to increase the individual's compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications; and

(E) to reduce the need for other costly medical services through better management of medication therapy.

(2) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) receiving, in accordance with State law or regulation, medication for—

(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or

(ii) such other chronic diseases as the Secretary may specify.

(3) QUALIFIED PHARMACIST.—The term "qualified pharmacist" means an individual who is a licensed pharmacist in good standing with the State Board of Pharmacy.

SA 1096. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend the title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SA 1097. Mr. MCCONNELL proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medical program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. . PROTECTING SENIORS WITH CANCER.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cancer shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D-19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D-19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D-19(4)(C) of such Act) who is diagnosed with cancer, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D-17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D-19(a)(4)(D) of such Act) who is diagnosed with cancer, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D-19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D-19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cancer, such individual shall have access to qualified prescription drug coverage (as described in section 1860D-6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D-6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

SA 1098. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

. Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

"(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

"(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

"(B) ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the transportation originates in a rural area described in subparagraph (C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by the higher of either 20 percent of the rate determined after the application of subparagraph (C), in addition to the increase provided under subparagraph (A).

"(C) DETERMINATION OF RURAL AREAS BASED ON POPULATION DENSITY WITHIN POSTAL ZIP CODES.—With respect to ground ambulance services described in subparagraph (B), during the period described in that subparagraph, paragraph (9) shall be applied by substituting '(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)' for '(as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725))'. Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 221(b)(3) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and shall establish the classification system required by the application of this subparagraph. The Secretary shall provide such increased payment for services furnished on or after the earlier of 30 days after the establishment of such classification system or December 31, 2003.

"(D) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

"(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.".

SEC. 426A. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1099. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) of the Social Security Act (42 U.S.C. §1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs.

"(10) TEMPORARY INCREASE FOR AMBULANCE SERVICES.—

"(A) GROUND AMBULANCE SERVICES.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004 and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established shall be increased by 21.5 percent.

"(B) ADDITIONAL INCREASE FOR SERVICES FURNISHED IN A RURAL AREA.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004 and before January 1, 2007, for which the transportation originates in a rural area described in paragraph (10)(C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established shall be increased by the higher of either 20 percent or the following section:

"(C) BASING RURAL AREAS ON POPULATION DENSITY BY POSTAL ZIP CODES."

(a) IN GENERAL.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) is amended in paragraph (9), as so redesignated by section 2(a)(1), by striking "(as defined in section 1886(d)(2)(D)" and all that follows through "(57 Fed. Reg. 6725)" and inserting "(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)".

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services, taking into account the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall implement such increase in addition to the increase under subparagraph (A). The Secretary shall establish the classification system described in the amendment made by subsection (a) by not later than December 31, 2003. Such amendment shall apply to services furnished on or after such date, not later than 30 days after the establishment of such system, as the Secretary shall provide by regulation.

"(D) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph."

"(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor."

SA 1100. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title I, add the following:

SEC. . INCREASE IN DRUG BENEFIT.

Notwithstanding any other provision of law, the Secretary shall use $12,000,000,000 to improve the prescription drug benefit added under part D of title XVIII of the Social Security Act (as added by section 101) by eliminating coverage gaps, reducing the premium or cost-sharing, or expanding subsidies for low-income beneficiaries in lieu of conducting any demonstration projects or making any increased payments to providers authorized under this Act or the amendments made by this Act.

SA 1101. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; which was ordered to lie on the table; as follows:

On page 134, strike line 9 and insert the following:

under paragraph (1).

"(d) IMPLEMENTATION OF PART D.—

"(1) IN GENERAL.—Notwithstanding section 1860D–1(a)(4) or any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part on January 1, 2005, unless the Secretary certifies in writing to Congress, by not later than March 1, 2004, that such implementation is not possible. If such implementation is possible by January 1, 2005, the Secretary shall carry out this part until the Administrator is appointed and able to carry out this part. The Secretary shall implement sections 1807 and 1807A until the date of implementation as certified by the Secretary.

"(2) CERTIFICATION REQUIREMENTS.—A certification by the Secretary under paragraph (1) that implementation of this part is not possible by January 1, 2005, shall declare the reasons for the impossibility and a new date certain (which in no event shall be later than January 1, 2006) for implementation of this part.

SA 1102. Mr. McCONNELL proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. . PROTECTING SENIORS WITH ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with Alzheimer's disease, such individual shall receive sliding scale

premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

SA 1103. Mr. DORGAN (for himself and Mr. PRYOR) proposed an amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other, purposes; as follows:

In lieu of the matter proposed to be inserted, insert the following:

SEC. . AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:

“(d) AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall for each year (beginning with 2009) determine a percentage which—

“(1) shall apply in lieu of the applicable percent otherwise determined under subsection (c) for that year, and

“(2) will result in a decrease of $2,400,000,000 for that year in the aggregate monthly beneficiary obligations otherwise required of all eligible beneficiaries enrolled in a Medicare Prescription Drug Plan or a Medicare Advantage plan that provides qualified prescription drug coverage.5

This subsection shall not apply in determining the applicable percent under subsection (c) for purposes of section 1860D–21.”.

SA 1104. Mr. KOHL (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. 6 . ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—

(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:

“(8) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

“(A) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

“(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

“(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(6); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(i) IN GENERAL.—A skilled nursing facility may not knowingly employ any skilled nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a skilled nursing facility may provide for a provisional period of employment for a skilled nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the covered individual during the worker's provisional period of employment.

“(iii) EXCEPTION FOR SMALL RURAL SKILLED NURSING FACILITIES.—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of skilled nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) REPORTING REQUIREMENTS.—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) USE OF INFORMATION.—

“(i) IN GENERAL.—A skilled nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility that, in denying employment for an individual selected for hiring as a skilled nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) CIVIL PENALTY.—

“(i) IN GENERAL.—A skilled nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, $2,000; and

“(II) for the second and each subsequent violation within any 5-year period, $5,000.

“(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a skilled nursing facility that—

“(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

“(F) DEFINITIONS.—In this paragraph:

“(i) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

"(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

"(II) such other types of acts as the Secretary may specify in regulations.

"(iv) SKILLED NURSING FACILITY WORKER.—The term 'skilled nursing facility worker' means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.".

(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396r(b)) is amended by adding at the end the following new paragraph:

"(8) SCREENING OF NURSING FACILITY WORKERS.—

"(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a nursing facility selects an individual for a position as a nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

"(i) give the worker written notice that the facility is required to perform background checks with respect to provisional employees;

"(ii) require, as a condition of employment, that such worker—

"(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

"(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

"(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

"(IV) provide any other identification information the Secretary may specify in regulation;

"(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

"(iv) if that system does not contain any such disqualifying information—

"(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(8); and

"(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

"(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

"(i) IN GENERAL.—A nursing facility may not knowingly employ any nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

"(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a nursing facility may provide for a provisional period of employment for a nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the worker during the worker's provisional period of employment.

"(iii) EXCEPTION FOR SMALL RURAL NURSING FACILITIES.—

"(I) IN GENERAL.—In the case of a small rural nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

"(C) REPORTING REQUIREMENTS.—A nursing facility shall report to the State any instance in which the facility determines that a nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

"(D) USE OF INFORMATION.—

"(i) IN GENERAL.—A nursing facility that obtains information about a nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

"(ii) IMMUNITY FROM LIABILITY.—A nursing facility that, in denying employment for an individual selected for hiring as a nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

"(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

"(E) CIVIL PENALTY.—

"(i) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

"(I) for the first such violation, $2,000; and

"(II) for the second and each subsequent violation within any 5-year period, $5,000.

"(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that—

"(I) knowingly continues to employ a nursing facility worker in violation of subparagraph (A) or (B); or

"(II) knowingly fails to report a nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

"(F) DEFINITIONS.—In this paragraph:

"(i) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

"(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

"(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

"(ii) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

"(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a nursing facility worker has committed—

"(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

"(II) such other types of acts as the Secretary may specify in regulations.

"(iv) NURSING FACILITY WORKER.—The term 'nursing facility worker' means any individual (other than a volunteer) that has access to a patient of a nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.".

(2) FEDERAL RESPONSIBILITIES.—

(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisional employee at a nursing facility may complete and Federal and State agencies may use to conduct the criminal background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b), 1396r(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b), 1396r(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate response to long-term care providers using the system.

(3) NO PREEMPTION OF STRICTER STATE LAWS.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i-3(b)(8), 1396r(b)(8)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1128E(g)(6) of the Social Security Act (as added by subsection (e)) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as so defined) to conduct a background check prior to employing an individual in an employment position that is not included in the positions for which a background check is required under such sections.

(4) TECHNICAL AMENDMENTS.—Effective as if included in the enactment of section 941 of BIPA (114 Stat. 2763A-585), sections 1819(b) and 1919(b) (42 U.S.C. 1395i-3(b), 1396r(b)), as amended by such section 941 are each amended by redesignating the paragraph (8) added by such section as paragraph (9).

(b) FEDERAL AND STATE REQUIREMENTS CONCERNING BACKGROUND CHECKS.—

(1) MEDICARE.—Section 1819(e) (42 U.S.C. 1395i-3(e)) is amended by adding at the end the following:

"(6) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

"(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

"(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

"(C) STATE REPORTING OF INFORMATION TO SKILLED NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

"(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

"(ii) immediately report to the skilled nursing facility in writing the results of such review; and

"(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

"(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

"(i) AUTHORITY TO CHARGE FEES.—

"(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation until expended.

"(II) STATE.—A State may charge a skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

"(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

"(E) REGULATIONS.—

"(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(9), including regulations regarding the security confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

"(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

"(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

"(i) the number of requests for searches and exchanges of records made under this section;

"(ii) the disposition of such requests; and

"(iii) the cost of responding to such requests.".

(2) MEDICAID.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

"(8) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

"(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

"(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

"(C) STATE REPORTING OF INFORMATION TO NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

"(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

"(ii) immediately report to the nursing facility in writing the results of such review; and

"(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

"(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

"(i) AUTHORITY TO CHARGE FEES.—

"(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation, until expended.

"(II) STATE.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

"(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

"(E) REGULATIONS.—

"(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

"(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

"(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

"(i) the number of requests for searches and exchanges of records made under this section;

"(ii) the disposition of such requests; and

"(iii) the cost of responding to such requests.".

(c) APPLICATION TO OTHER ENTITIES PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES.—

(1) MEDICARE.—Part D of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

"APPLICATION OF SKILLED NURSING FACILITY PREVENTIVE ABUSE PROVISIONS TO ANY PROVIDER OF SERVICES OR OTHER ENTITY PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES

"SEC. 1897. (a) IN GENERAL.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a 'medicare beneficiary').

"(b) SUPERVISION OF PROVISIONAL EMPLOYEES.—

"(1) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1819(b)(8)(B)(ii) or 1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

"(2) REQUIREMENTS.—The regulations required under paragraph (1) shall provide the following:

"(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a medicare beneficiary.

"(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

"(i) Follow-up telephone calls to the medicare beneficiary.

"(ii) Unannounced visits to the medicare beneficiary's home while the provisional employee is serving the medicare beneficiary.

"(iii) To the extent practicable, limiting the provisional employee's duties to serving only those medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the medicare beneficiary is present.

"(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such regulations should encourage the provision of monitoring and oversight activities whenever practicable with respect to such an entity, and if such activities would not impose an unreasonable cost or other burden on the entity.".

(2) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a), as amended by section 104(a), is amended—

(A) in paragraph (65), by striking "and" at the end;

(B) in paragraph (66), by striking the period and inserting "; and"; and

(C) by inserting after paragraph (66) the following:

"(67) provide that any entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services for which medical assistance is available under the State plan to individuals requiring long-term care complies with the requirements of subsections (b)(8) and (e)(8) of section 1919 and section 1897(b) (in the same manner as such section applies to a medicare beneficiary).".

(3) EXPANSION OF STATE NURSE AIDE REGISTRY.—

(A) MEDICARE.—Section 1819 (42 U.S.C. 1395i-3) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking "NURSE AIDE REGISTRY" and inserting "EMPLOYEE REGISTRY";

(II) in subparagraph (A)—

(aa) by striking "By not later than January 1, 1989, the" and inserting "The";

(bb) by striking "a registry of all individuals" and inserting "a registry of (i) all individuals"; and

(cc) by inserting before the period the following: ", (ii) all other skilled nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property"; and

(III) in subparagraph (C), by striking "a nurse aide" and inserting "an individual"; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: "The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a skilled nursing facility employee of a resident in a skilled nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii)."; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "NURSE AIDE"; and

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (i)(I), by striking "nurse aide" and inserting "individual".

(B) MEDICAID.—Section 1919 (42 U.S.C. 1396r) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking "NURSE AIDE REGISTRY" and inserting "EMPLOYEE REGISTRY";

(II) in subparagraph (A)—

(aa) by striking "By not later than January 1, 1989, the" and inserting "The";

(bb) by striking "a registry of all individuals" and inserting "a registry of (i) all individuals"; and

(cc) by inserting before the period the following: ", (ii) all other nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of an entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property"; and

(III) in subparagraph (C), by striking "a nurse aide" and inserting "an individual"; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: "The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility employee of a resident in a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii)."; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "NURSE AIDE"; and

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (i)(I), by striking "nurse aide" and inserting "individual".

(d) REIMBURSEMENT OF COSTS FOR BACKGROUND CHECKS.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1819(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1395i-3(b)(8), 1396r(b)(8)), as added by this section.

(e) INCLUSION OF ABUSIVE ACTS WITHIN A LONG-TERM CARE FACILITY OR PROVIDER IN THE NATIONAL HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.—

(1) IN GENERAL.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a-7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

"(v) A finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient's or resident's property.".

(2) COVERAGE OF LONG-TERM CARE FACILITY OR PROVIDER EMPLOYEES.—Section 1128E(g)(2) (42 U.S.C. 1320a-7e(g)(2)) is amended by inserting ", and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, providing services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)" before the period.

(3) REPORTING BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

(A) IN GENERAL.—Section 1128E(b)(1) (42 U.S.C. 1320a-7e(b)(1)) is amended by striking "and health plan" and inserting ", health plan, and long-term care facility or provider".

(B) Correction of information.—Section 1128E(c)(2) (42 U.S.C. 1320a–7e(c)(2)) is amended by striking "and health plan" and inserting ", health plan, and long-term care facility or provider".

(4) Access to reported information.—Section 1128E(d)(1) (42 U.S.C. 1320a–7e(d)(1)) is amended by striking "and health plans" and inserting ", health plans, and long-term care facilities or providers".

(5) Mandatory check of database by long-term care facilities or providers.—Section 1128E(d) (42 U.S.C. 1320a–7e(d)) is amended by adding at the end the following:

"(3) Mandatory check of database by long-term care facilities or providers.—A long-term care facility or provider shall check the database maintained under this section prior to hiring under an employment or other contract, or both, (other than in a provisional status) any individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, that will provide services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants).".

(6) Definition of long-term care facility or provider.—Section 1128E(g) (42 U.S.C. 1320a–7e(g)) is amended by adding at the end the following:

"(6) Long-term care facility or provider.—The term 'long-term care facility or provider' means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(dd)(1)), a long-term care hospital (as described in section 1886(d)(1)(B)(iv)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, home health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program under title XVIII or the medicaid program under title XIX.".

(7) Authorization of appropriations.—There is authorized to be appropriated to carry out the amendments made by this subsection, $10,200,000 for fiscal year 2004.

(f) Prevention and Training Demonstration Project.—

(1) Establishment.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) Eligibility.—To be eligible to receive a grant under paragraph (1), an entity shall be a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) Use of funds.—Amounts received under a grant under this subsection shall be used to—

(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsman programs, the long-term care industry, and local community members;

(B) examine patient care issues relating to regulatory oversight, community involvement, and facility staffing and management with a focus on staff training, staff stress management, and staff supervision;

(C) examine the use of patient abuse prevention training programs by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used; and

(D) identify and disseminate best practices for preventing and reducing patient abuse.

(4) Authorization of appropriations.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(g) Effective Date.—

(1) In general.—With respect to a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) or a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 6 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2006.

(2) Long-term care facilities and providers.—With respect to a long-term care facility or provider (as defined in section 1128E(g)(6) of the Social Security Act (42 U.S.C. 1320a–7e(g)(6)) (as added by subsection (e)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 18 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2007.

SA 1105. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 486, line 3, insert "and" after the semicolon at the end.

On page 486, line 4, insert "(I)" after "(ii)".

On page 486, line 8, strike "and" and insert "or".

On page 486, line 9, strike "(iii)" and insert "(II)".

SA 1106. Mr. HATCH (for himself and Mr. Wyden) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, insert the following:

SEC. . HEALTH CARE THAT WORKS FOR ALL AMERICANS-CITIZENS HEALTH CARE WORKING GROUP.

(a) Findings.—Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.

(b) Purposes.—The purposes of this Act are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) Establishment.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens' Health Care Working Group (referred to in this Act as the "Working Group").

(d) Appointment.—Not later than 45 days after the date of enactment of this Act, the Speaker and Minority Leader of the House of Representatives and the Majority Leader and Minority Leader of the Senate (in this section referred to as the "leadership") shall each appoint individuals to serve as members of the Working Group in accordance with subsections (e), (f), and (g).

(e) Membership Criteria.—

(1) Appointed members.—

(A) Separate appointments.—The Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate, shall each appoint 1 member of the Working Group described in subparagraphs (A), (G), (J), (K), and (M) of paragraph (2).

(B) Joint appointments.—Members of the Working Group described in subparagraphs (B), (C), (D), (E), (F), (I), and (N) of paragraph (2) shall be appointed jointly by the leadership.

(C) Combined appointments.—Members of the Working Group described in subparagraphs (H) and (L) shall be appointed in the following manner:

(i) One member of the Working Group in each of such subparagraphs shall be appointed jointly by the leadership.

(ii) The remaining appointments of the members in each of such subparagraphs shall be divided equally such that the Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate each appoint an equal number of members.

(2) CATEGORIES OF APPOINTED MEMBERS.—Members of the Working Group shall be appointed as follows:

(A) 2 members shall be patients or family members of patients who, at least 1 year prior to the date of enactment of this Act, have had no health insurance.

(B) 1 member shall be a representative of children.

(C) 1 member shall be a representative of the mentally ill.

(D) 1 member shall be a representative of the disabled.

(E) 1 member shall be over the age of 65 and a beneficiary under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(F) 1 member shall be a recipient of benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(G) 2 members shall be State health officials.

(H) 3 members shall be employers, including—

(i) 1 large employer (an employer who employed 50 or more employees on business days during the preceding calendar year and who employed at least 50 employees on the first of the year);

(ii) 1 small employer (an employer who employed an average of at least 2 employees but less than 50 employees on business days in the preceding calendar year and who employs at least 2 employees on the first of the year); and

(iii) 1 multi-state employer.

(I) 1 member shall be a representative of labor.

(J) 2 members shall be health insurance issuers.

(K) 2 members shall be health care providers.

(L) 5 members shall be appointed as follows:

(i) 1 economist.

(ii) 1 academician.

(iii) 1 health policy researcher.

(iv) 1 individual with expertise in pharmacoeconomics.

(v) 1 health technology expert.

(M) 2 members shall be representatives of community leaders who have developed State or local community solutions to the problems addressed by the Working Group.

(N) 1 member shall be a representative of a medical school.

(3) SECRETARY.—The Secretary, or the designee of the Secretary, shall be a member of the Working Group.

(f) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include members of Congress or other elected government officials (Federal, State, or local) other than those individuals specified in subsection (e). To the extent possible, individuals appointed to the Working Group shall have used the health care system within the previous 2 years and shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(g) APPOINTMENT CRITERIA.—

(1) HOUSE OF REPRESENTATIVES.—The Speaker and Minority Leader of the House of Representatives shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the House of Representatives:

(A) The Committee on Ways and Means.

(B) The Committee on Energy and Commerce.

(C) The Committee on Education and the Workforce.

(2) SENATE.—The Majority Leader and Minority Leader of the Senate shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the Senate:

(A) The Committee on Finance.

(B) The Committee on Health, Education, Labor, and Pensions.

(h) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a term of 2 years. Such term is renewable and any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(i) APPOINTMENT OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d), the leadership shall make a joint designation of the chairperson of the Working Group. If the leadership fails to make such designation within such time period, the Working Group Members shall, not later than 10 days after the end of such time period, designate a chairperson by majority vote.

(j) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(k) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of appointment of the chairperson under subsection (i), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this Act. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, "The Health Report to the American People". Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Working Group shall initiate health care community meetings throughout the United States (in this section referred to as "community meetings"). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) MEETING REQUIREMENTS.—

(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) TOPICS.—The community meetings shall, at a minimum, address the following issues:

(I) The optimum way to balance costs and benefits so that affordable health coverage is available to as many people as possible.

(II) The identification of services that provide cost-effective, essential health care services to maintain and improve health and which should be included in health care coverage.

(III) The cost of providing increased benefits.

(IV) The mechanisms to finance health care coverage, including defining the appropriate financial role for individuals, businesses, and government.

(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(l) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (k)(4)(D), the Working Group shall submit to Congress and the President a final set of recommendations.

(m) ADMINISTRATION.—

(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this Act. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) POSTAL SERVICES.—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(n) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(o) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(p) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(q) SUNSET OF WORKING GROUP.—The Working Group shall terminate when the report described in subsection (l) is submitted to Congress.

(r) ADMINISTRATION REVIEW AND COMMENTS.—Not later than 45 days after receiving the final recommendations of the Working Group under subsection (l), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for such legislation and administrative actions as the President considers appropriate.

(s) REQUIRED CONGRESSIONAL ACTION.—Not later than 45 days after receiving the report submitted by the President under subsection (r), each committee of jurisdiction of Congress shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (l).

(t) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this Act, other than subsection (k)(3), $3,000,000 for each of fiscal years 2004, 2005, and 2006.

. (2) HEALTH REPORT TO THE AMERICAN PEOPLE.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (k)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SA 1107. Mr. COCHRAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. . AUTHORIZATION OF APPROPRIATIONS TO CONTINUE THE EXISTING CMS MEDICATION MONITORING SYSTEM.

There are authorized to be appropriated such sums as are necessary to continue the Prescription Continuity of Care medication monitoring system in cooperation with the CMS Mississippi Quality Improvement Organization, Information Healthcare, and the University of Mississippi.

SA 1108. Mr. DURBIN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES UNDER PART D.

Section 1860D–26, as added by section 101, is amended by adding at the end the following:

"(d) ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES.—

"(1) PROGRAM.—Subject to paragraph (2), the Administrator shall implement a program (for the period beginning on January 1, 2009, and ending on September 30, 2013) to provide additional assistance to applicable eligible beneficiaries who have reached the initial coverage limit described in section 1860D–6(c)(3) for the year but have not reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)) for the year in order to reduce the cost-sharing requirement during this coverage gap.

"(2) FUNDING LIMITATION.—The Administrator shall implement the program described in paragraph (1) in such a manner that will result in a decrease of $12,000,000,000 in cost-sharing for covered drugs under part D by applicable eligible beneficiaries during the period described in such paragraph. The Administrator shall take appropriate steps to ensure that the costs of the program during such period do not exceed $12,000,000,000.

"(3) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'applicable eligible beneficiary' means an eligible beneficiary with cardiovascular disease, diabetes and its complications, cancer, or Alzheimer's disease who is enrolled under part D.".

SA 1109. Mr. BURNS (for himself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on table; as follows:

On page 68, between lines 5 and 6, insert the following:

"(E) Not be less than 1,000,000 eligible beneficiaries shall reside in each service area.

On page 354, between lines 19 and 20, insert the following:

"(F) Not be less than 1,000,000 MedicareAdvantage eligible individuals shall reside in each region.

SA 1110. Mr. BAUCUS (for Mr. LEVIN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan or entering private insurance under this act.

SA 1111. Mr. BAUCUS (for Mr. LEVIN (for himself, Ms. STABENOW, and Mrs. CLINTON)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that the 37%

of current retirees who have prescription drug coverage, estimated by the Congressional Budget Office who will lose their current employer retiree coverage as a result of the enactment of this legislation will have the option to enter either a Medicare backup plan or private insurance under this act.

SA 1112. Mr. KERRY submitted an amendment intended to by proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

After section 404, insert the following:

SEC. 404A. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) Disproportionate Share Adjustment Percentage.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking "35 percent" and inserting "35 percent (or, for discharges occurring on or after October 1, 2003, 40 percent)".

(b) Capital Costs.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) in clause (iii), by striking "and" at the end;

(2) in clause (iv), by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new clause:

"(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).".

SA 1113. Mr. GRASSLEY proposed an amendment to the bill S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Programs; as follows:

At the end, add the following:

SEC. 2. TECHNICAL CORRECTION.

(a) Temporary Increase of the Medicaid FMAP.—Section 401(a)(6)(A) of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027) is amended by inserting "after September 2, 2003," after "(42 U.S.C. 1315))".

(b) Retroactive Effective Date.—The amendment made by subsection (a) shall take effect as if included in the enactment of section 401 of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108–027).

SA 1114. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G–7 COUNTRIES.

(a) Study.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance;

(2) The proportion of the cost for innovation borne by American consumers compared with consumers in the other six countries;

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production ("Ramsey prices");

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health;

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States;

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied;

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant; and

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violation of intellectual property rights for prescription medicines.

(b) Report.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the Untied States shall submit to Congress a report on the study conducted under subsection (A).

SA 1115. Mr. KYL (for himself, Mr. Hatch, and Ms. Murkowski) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) Findings.—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without Congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2% in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4% cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991–2003, payment rates for physicians and health professionals fell 14% behind practice cost inflation as measured by Medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) Sense of the Senate.—It is the Sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

SA 1116. Mr. DAYTON (for himself, Mr. Coleman, and Mr. Smith) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

"(10) Temporary increase for ground ambulance services.—

"(A) In general.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

"(B) Additional increase for services furnished in a rural area.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the transportation originates in a rural area described in subparagraph (C), the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by the higher of either 20 percent of the rate determined after the application of subparagraph (C), in addition to the increase provided under subparagraph (A).

"(C) Determination of rural areas based on population density within postal zip codes.—With respect to ground ambulance services described in subparagraph (B), during the period described in that subparagraph, paragraph (9) shall be applied by substituting '(as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas)' for '(as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725))'. Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 221(b)(3) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and shall establish the classification system required by the application of this subparagraph. The Secretary shall provide such increased payment for services furnished on or after the earlier of 30 days after the establishment of such classification system or December 31, 2003.

"(D) Application of increased payments after 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

"(11) Conversion factor adjustments.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.".

SEC. 426A. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) Technical Amendment Concerning Secretary's Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) In general.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) Authority to make conditional payment.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) Clarifying Amendments to Conditional Payment Provisions.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) Clerical Amendments.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1117. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, add the following:

SEC. . SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) In General.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

"Part D—Safety Net Organizations and Patient Advisory Commission

"SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"Sec. 1181. (a) Establishment.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

"(b) Review of Health Care Safety Net Programs and Reporting Requirements.—

"(1) Review.—The Commission shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

"(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

"(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

"(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

"(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

"(E) supporting the development of new data systems where existing data are insufficient or inadequate;

"(F) developing criteria and indicators of impending core health care safety net failure;

"(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

"(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

"(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

"(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

"(ii) the degree to which these plans may be overburdened by adverse selection; and

"(iii) the degree to which emergency departments are used by enrollees of these plans; and

"(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

"(2) Reports.—

"(A) Annual reports.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

"(i) the health care needs of the uninsured; and

"(ii) the financial and infrastructure stability of the Nation's core health care safety net.

"(B) Agenda and additional reviews.—

"(i) Agenda.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

"(ii) Additional reviews.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

"(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

"(II) If the Commission deems such additional reviews and reports appropriate.

"(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(3) DEFINITIONS.—In this section:

"(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term 'appropriate committees of Congress' means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

"(B) CORE HEALTH CARE SAFETY NET.—The term 'core health care safety net' means any health care provider that—

"(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

"(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

"(C) HEALTH CARE SAFETY NET PROGRAMS.—The term 'health care safety net programs' includes the following:

"(i) MEDICAID.—The medicaid program under title XIX.

"(ii) SCHIP.—The State children's health insurance program under title XXI.

"(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

"(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(1)(2)(B)) receives funds.

"(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(1)(1)) receives funds.

"(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

"(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

"(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

"(D) VULNERABLE POPULATIONS.—The term 'vulnerable populations' includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

"(c) MEMBERSHIP.—

"(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the 'Comptroller General'), in consultation with the appropriate committees of Congress.

"(2) QUALIFICATIONS.—

"(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

"(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

"(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

"(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

"(3) TERMS.—

"(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

"(i) four to serve a term of 1 year;

"(ii) four to serve a term of 2 years; and

"(iii) five to serve a term of 3 years.

"(B) VACANCIES.—

"(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

"(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

"(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

"(4) COMPENSATION.—

"(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

"(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

"(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

"(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

"(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

"(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

"(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

"(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(4) make advance, progress, and other payments which relate to the work of the Commission;

"(5) provide transportation and subsistence for persons serving without compensation; and

"(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(e) POWERS.—

"(1) OBTAINING OFFICIAL DATA.—

"(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

"(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

"(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

"(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

"(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

"(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

“(4) Periodic audit.—The Commission shall be subject to periodic audit by the Comptroller General.

“(f) Application of FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

“(g) Authorization of Appropriations.—

“(1) Request for appropriations.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

“(2) Authorization.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.”.

(b) Effective Date.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SA 1118. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) Findings.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) Sense of the Senate.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 443 and insert the following:

SEC. 443. MEDICARE COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.

(a) Part B Coverage of Care Coordination and Assessment Services.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking “and” at the end;

(2) in subparagraph (V)(iii), by adding “and” after the semicolon at the end; and

(3) by adding at the end the following new subparagraph:

“(W) care coordination and assessment services (as defined in subsection (ww)).”.

(b) Care Coordination and Assessment Services Defined.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Care Coordination and Assessment Services

“(ww)(1) The term ‘care coordination and assessment services’ means services that are furnished to an eligible individual (as defined in paragraph (2)) by a care coordinator (as defined in paragraph (3)) under a plan of care prescribed by such care coordinator for the purpose of care coordination and assessment, which may include any of the following services:

“(A) an initial assessment of an individual’s medical condition, functional and cognitive capacity and environmental and psychological needs and an annual assessment thereafter.

“(B) Management of transitions of care across practice settings and between providers.

“(C) Coordination of, and referral for, medical and other health-related services, including—

“(i) multidisciplinary care conferences;

“(ii) coordination with other providers, including telephone consultations with physicians; and

“(iii) monitoring and management of medications, with special emphasis on clients using multiple prescriptions (including coordination with the entity managing benefits for the individual).

“(D) Patient and family care-giver education and counseling (through office visits or telephone consultation), including self-management services and risk appraisal to identify behavioral risk factors through self assessment.

“(E) Providing information about end of life care, including referral to hospice services, when appropriate, including patient and family caregiver education and counseling about hospice, and managing and facilitating transition to hospice when elected.

“(F) Referral to and coordination with community resources.

“(G) Such other services for which payment would not otherwise be made under this title as the Secretary shall determine to be appropriate including, but not limited to, activities to facilitate continuity of care and patient adherence to plans of care.

“(2) For purposes of this subsection, the term ‘eligible individual’ means an individual who a care coordinator annually certifies has multiple chronic conditions and meets eligibility criteria determined by the Secretary.

“(3)(A) For purposes of this subsection, the term ‘care coordinator’ means an individual or entity that—

“(i) is—

“(I) a physician who provides care to at least 50 eligible individuals; or

“(II) an independent nurse practitioner who provides care to at least 50 eligible individuals;

“(ii) has entered into a care coordination agreement with the Secretary; and

“(iii) has appropriate office staffing, operating under the direction of the eligible provider, which is sufficient in size and expertise to address the complex clinical care coordination needs of participating beneficiaries in the practice;

“(iv) has an ability and process to identify eligible beneficiaries;

“(v) has an ability to coordinate care for participating beneficiaries;

“(vi) has an ability to maintain and update patient records to ensure that care provided by other treating providers (including the instructions of other treating providers and any related lab results, prescription orders, and ancillary treatment services) is included in the record;

“(vii) has an ability to periodically review the medical record of participating beneficiaries to identify problems related to transitions, poly-pharmacy, and care continuity and to respond to resolve identified problems;

“(viii) is capable of referring to and coordinating with community-based supportive services;

“(ix) has an ability to communicate with participating beneficiaries or family caregivers as needed and appropriate, using telephonic and/or electronic communications; and

“(x) agrees to coordinate care for participating beneficiaries, consult with other treating providers (including but not limited to other treating physicians, other medical professionals involved in patient care, residential and inpatient facilities, and pharmacies), and community service providers;

“(xi) agrees to recognize patient treatment preferences; and

“(xii) is certified by the Secretary as meeting standards defined by the Secretary and being capable of coordinating clinical care for eligible beneficiaries.

"(B) For purposes of subparagraph (A)(ii), each care coordination agreement shall—

"(i) be entered into for a period of 1 year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in subparagraph (A);

"(ii) contain such other terms and conditions as the Secretary may require.

"(4) For purposes of this subsection, the Secretary shall send quarterly reports to each eligible provider that inform, in aggregate, on the provider's participating beneficiary caseload, using measures determined by the Secretary that are derived from existing Medicare date sources. In preparing the reports under this paragraph, the Secretary shall consider—

"(A) the average number of emergency room and nursing home visits relative to geographic norms for all eligible beneficiaries; and

"(B) the average number of unique physician visits relative to geographic norms for all eligible beneficiaries.

"(5) For purposes of this subsection, the term 'functional limitations' means each of the following:

"(A) Eating.

"(B) Toileting.

"(C) Transferring.

"(D) Bathing.

"(E) Dressing.

"(F) Continence.

"(6) Rural health clinics and Federally qualified health centers shall be eligible sites at which care coordination and assessment services may be provided.

"(7) For purposes of this subsection, the term 'chronic condition' means an illness, functional limitation, or cognitive impairment that is expected to last at least 1 year and limits what a person can do, and requires ongoing care.

"(8) For purposes of this subsection, the Secretary shall establish eligibility criteria for the care management benefit that would target approximately 5 percent of elderly medicare fee-for-service enrollees. The eligibility criteria should identify enrollees who need care management because they have multiple chronic conditions that result in high use of Medicare services, high use of prescription medications, and high Medicare costs. Inability to manage one's own care due to cognitive impairment should be considered as an additional indicator of need for care management.

(c) PAYMENT AND ELIMINATION OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and" before "(U)"; and

(B) by inserting before the semicolon at the end the following: ", and (V) with respect to assessment services described in section 1861(s)(2)(W), the amounts paid shall be 100 percent of the lesser of the actual charge for the service or the amount determined under the payment basis determined under section 1848 by the Secretary for such service and an administrative fee shall be developed for care coordination services".

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting "(2)(W)," after "(2)(S),".

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after "1861(s)(10)(A)" the following: ", with respect to care coordination and assessment services (as defined in section 1861(ww)(1)),".

(d) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

"(vii) A care coordinator (as defined in section 1861(ww)(3)) that is not a physician.".

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

"(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICARE.—In the case of a designated health service, if the designated health service is—

"(A) a care coordination and assessment service (as defined in section 1861(ww)(1)); and

"(B) provided by a care coordinator (as defined in paragraph (3) of such section).".

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms and establish such procedures as the Secretary determines necessary to implement the provisions of this section.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to care coordination and assessment services furnished on or after January 1, 2006, and before January 1, 2011.

At the end of subtitle B of title IV, add the following:

SEC. . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 426 and insert the following:

SEC. 426. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

"(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

"(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007 for which the transportation originates in—

"(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

"(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent

"(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.".

SA 1121. Mr. KYL (for himself, Mr. NICKLES, Mr. GREGG, Mr. THOMAS, and Mr. LOTT) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) FINDINGS.—The Senate makes the following findings:

(1) America's seniors deserve a fiscally-strong Medicare system that fulfills its promise to them and future retirees.

(2) The impending retirement of the "baby boom" generation will dramatically increase the costs of providing Medicare benefits. Medicare costs will double relative to the size of the economy from 2% of GDP today to 4% in 2025 and double again to 8% of GDP in 2075. This growth will accelerate substantially when Congress adds a necessary prescription drug benefit.

(3) Medicare's current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease management programs, and a host of other advances. Reforming Medicare to create a more self-adjusting, innovative structure is essential to improve Medicare's efficiency and the quality of the medical care it provides.

(4) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of America's seniors, not the government, and would create a powerful incentive for private-sector Medicare plans to provide the best quality health care to seniors at the most affordable price.

(5) The method by which the national preferred provider organizations in the Federal Employees Health Benefits Program have been reimbursed has proven to be a reliable and successful mechanism for providing Members of Congress and federal employees with excellent health care choices.

(6) Unlike the Medicare payment system, which has had to be changed by Congress every few years, the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most.

(2) Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2006 to ensure the long and short term viability of such options for America's seniors.

(3) Develop a payment system for the Medicare Advantage preferred provider organizations similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program.

(4) Limit the addition of new unfunded obligations in the Medicare program so that the long-term solvency of this important program is not further jeopardized.

(5) Incorporate private sector, market-based elements, that do not rely on the inefficient Medicare price control structure.

(6) Keep the cost of structural changes and new benefits within the $400 billion provided for under the current Congressional Budget Resolution for implementing Medicare reform and providing a prescription drug benefit.

(7) Preserve the current employer-sponsored retiree health plans and not design a benefit which has the unintended consequences of supplanting private coverage.

(8) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(9 Restore the right of Medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the government contribution.

SA 1122. Mr. BROWNBACK (for himself, and Mr. NELSON of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals that furnish rural community hospital services to medicare beneficiaries.

(2) DESIGNATION OF RCHS.—

(A) APPLICATION.—Each hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) DESIGNATION.—The Secretary shall designate any hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section as a rural community hospital for purposes of the demonstration program.

(C) DEMONSTRATION AREAS.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) PAYMENT.—

(1) INPATIENT HOSPITAL SERVICES.—The amount of payment under the demonstration program for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge; or

(B) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(2) OUTPATIENT SERVICES.—The amount of payment under the demonstration program for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U) of the Social Security Act (42 U.S.C. 1395x(v)(1)(U)); or

(B) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(3) HOME HEALTH SERVICES.—In determining payments under the demonstration program for home health services furnished by a qualified RCH-based home health agency (as defined in paragraph (2))—

(A) the agency may make a one-time election to waive application of the prospective payment system established under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to such services furnished by the agency; and

(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(4) CONSOLIDATED BILLING.—The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(5) EXEMPTION FROM 30 PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—In determining the reasonable costs for rural community hospitals, section 1861(v)(1)(T) of the Social Security Act (42 U.S.C. 1395x(v)(1)(T)) shall not apply.

(6) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under the demonstration program shall be as follows:

(A) For items and services that would have been paid under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

(B) For items and services that would have been paid under section 1833(h) of such Act (42 U.S.C. 1395l(h)) if furnished by a provider or supplier, no cost-sharing shall apply.

(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.

(7) Return on equity.—

(A) In general.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(B) Services described.—The services referred to in subclause (I) are rural community hospital services.

(C) Disregard of proprietary provider status.—Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(8) Removing barriers to establishment of distinct part units by RCH facilities.—Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit rural community hospitals to establish distinct part units for purposes of applying such section.

(c) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) Budget neutrality.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) Report.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) Definitions.—In this section:

(1) Rural community hospital.—

(A) In general.—The term "rural community hospital" means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to subparagraph (B), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services;

(iv) subject to subparagraph (C), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2003; and

(v) applies to the Secretary for such designation.

(B) Treatment of psychiatric and rehabilitation units.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(C) Types of hospitals that may participate.—Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

(i) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) with the same service area (as defined by the Secretary in regulations in effect on such date).

(ii) A facility obtaining a new provider number pursuant to a change of ownership.

(iii) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2003.

(D) Inclusion of CAHs.—Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)) and section 1866 of such Act (42 U.S.C. 1395cc).

(2) Qualified RCH-based home health agency defined.—The term "qualified RCH-based home health agency" is a home health agency that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554; Appendix F, 114 Stat. 2763A–506)) of a rural community hospital that is located—

(A) in a county in which no main or branch office of another home health agency is located; or

(B) at least 35 miles from any main or branch office of another home health agency.

SEC.   . CRITICAL ACCESS HOSPITAL IMPROVEMENT DEMONSTRATION PROGRAM.

(a) Establishment of Critical Access Hospital Demonstration Program.—

(1) In general.—The Secretary shall establish a demonstration program to test various methods to improve the critical access hospital program under section 1820 of the Social Security Act (42 U.S.C. 1395i–4).

(2) Critical access hospital improvement.—In conducting the demonstration program under this section, the Secretary shall apply rules with respect to critical access hospitals participating in the program as follows:

(A) Exclusion of certain beds from bed count.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subsections (c)(2)(B)(iii) and (f) of section 1820 of the Social Security Act (42 U.S.C. 1395i–4), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.

(B) Exclusion from home health PPS.—Notwithstanding section 1895 of the Social Security Act (42 U.S.C. 1395fff), in determining payments under the demonstration program for home health services furnished by a home health agency that is owned and operated by a critical access hospital participating in the demonstration program—

(i) the agency may make an election to waive application of the prospective payment system established under such section to such services furnished by the agency; and

(ii) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(C) Exemption of CAH facilities from PPS.—Notwithstanding section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), in determining payments under this part for covered skilled nursing facility services furnished by a skilled nursing facility that is a distinct part unit of a critical access hospital participating in the demonstration program or is owned and operated by a critical access hospital participating in the demonstration program—

(i) the prospective payment system established under such section shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(D) Consolidated billing.—The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(E) Exemption of certain distinct part psychiatric or rehabilitation units from cost limits.—Notwithstanding section 1886(b) of the Social Security Act (42 U.S.C. 1395ww(b)), in determining payments under the demonstration program for inpatient hospital services furnished by a distinct part psychiatric or rehabilitation unit (described in the matter following section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v))) of a critical access hospital participating in the demonstration program—

(i) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(F) Return on equity.—

(i) In general.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a critical access hospital participating in the demonstration program for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(ii) Services described.—The services referred to in subclause (I) are inpatient critical access hospital services, outpatient critical access hospital services, extended care services, posthospital extended care services, home health services, ambulance services, and inpatient hospital services.

(iii) Disregard of proprietary provider status.—Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(G) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CAH FACILITIES.—Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit critical access hospitals participating in the demonstration program to establish distinct part units for purposes of applying such section.

(3) PARTICIPATION OF CAHS.—

(A) APPLICATION.—Each critical access hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) PARTICIPATION.—The Secretary shall permit any critical access hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section to participate in the demonstration program.

(C) DEMONSTRATION AREAS.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

(4) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(5) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(d) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

SA 1123. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . SENSE OF THE SENATE REGARDING THE PRESERVATION OF BENEFICIARY CHOICES UNDER MEDICAREADVANTAGE; ESTABLISHMENT OF STANDARDS.

(a) SENSE OF THE SENATE.—It is the sense of the Senate that medicare beneficiaries should have a choice among multiple types of health plans under the MedicareAdvantage program, including regional preferred provider organizations and local health maintenance organization plans in markets where such plans naturally occur.

(b) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards with respect to the participation of private health plans in the MedicareAdvantage program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) that—

(1) encourage fair competition among such plans;

(2) ensure that beneficiaries who desire to elect health benefits coverage under such a plan are provided with benefits that are actuarially equivalent to the benefits provided under other beneficiary options for health benefits coverage available under the medicare program; and

(3) equally apply incentives to promote health plan participation to all plans desiring to participate in the MedicareAdvantage program.

SA 1124. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 159, line 19, insert the following before the closing quotation: "As part of such review, the Commission shall hold 3 field hearings in 2007.".

SA 1125. Mr. HATCH submitted an amendment intended to be proposed by him the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike title V and insert the following:

TITLE V—MEDICARE EDUCATION, REGULATORY REFORM, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 500. SHORT TITLE.

This title may be cited as the "Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003".

SEC. 501. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

"(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

"(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

"(C)(i) Except as provided in clause (ii), a substantive change may not take effect until not earlier than the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

SEC. 502. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 501(a)(1), is amended by adding at the end the following new subsection:

"(e)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of communications and correspondence, including the communications and correspondence required under section 1874A.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

SEC. 503. STATUS OF PENDING INTERIM FINAL REGULATIONS.

Section 1871 (42 U.S.C. 1395hh) as amended by sections 501 and 502, is amended by adding at the end the following new subsection:

"(f) The Secretary shall publish in the Federal Register at least once every 6 months a list that provides the status of each interim final regulation for which no final regulation has been published. Such list shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.".

Subtitle B—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) Submission of Transition Plan.—

(1) In general.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) Contents.—The plan shall include information on the following:

(A) Workload.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) Cost projections and financing.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) Transition timetable.—A timetable for tne transition.

(D) Regulations.—The establishment of specific regulations to govern the appeals process.

(E) Case tracking.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) Feasibility of precedential authority.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) Access to administrative law judges.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) Independence of judges.—The steps that should be taken to ensure that judges who perform the administrative law judge functions after the transfer under the plan maintain their independence from the Centers for Medicare & Medicaid Services and its contractors.

(I) Geographic distribution.—The steps that should be taken to provide for an appropriate geographic distribution of judges performing the administrative law judge functions that are transferred under the plan throughout the United States to ensure timely access to such judges.

(J) Hiring.—The steps that should be taken to hire judges (and support staff) to perform the administrative law judge functions that are transferred under the plan.

(K) Performance standards.—The establishment of performance standards for judges performing the administrative law judge functions that are transferred under the plan with respect to timelines for decisions in cases under title XVIII.

(L) Shared resources.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) Training.—The training that should be provided to judges performing the administrative law judge functions that are transferred under the plan with respect to laws and regulations under title XVIII.

(3) Additional information.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO Evaluation.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress a report on such evaluation.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) In General.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision"; and

(2) by adding at the end the following new paragraph:

"(2) Expedited access to judicial review.—

"(A) In general.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

"(B) Prompt determinations.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

"(C) Access to judicial review.—

"(i) In general.—If the appropriate review entity—

"(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that the Departmental Appeals Board does not have authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) Deadline for filing.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) Venue.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

"(iv) Interest on any amounts in controversy.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

"(D) Review entity defined.—For purposes of this subsection, the term 'review entity' means an entity of up to 3 qualified reviewers drawn from existing appeals levels other than the redetermination level.".

(b) Application to Provider Agreement Determinations.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) Conforming Amendment.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

"(ii) Reference to expedited access to judicial review.—For the provision relating to expedited access to judicial review, see paragraph (2).".

(d) Effective Date.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. COST REPORT REFORM.

(a) Report.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives a report recommending specific ways to modernize the cost reporting system under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such report shall be consistent with the recommendations of the Secretary's Advisory Committee on Regulatory Reform, including the use of Generally Accepted Accounting Principles.

(b) CONSULTATION.—In developing the report submitted under subsection (a), the Secretary shall consult with representatives of the hospital industry, the Medicare Payment Advisory Commission, the General Accounting Office, and such other individuals and entities as the Secretary determines to be appropriate.

SEC. 514. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i-3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 515. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

"(3) TIMELY COMPLETION OF THE RECORD.—

"(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

"(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

"(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

"(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

"(i) written or testimonial evidence, or both, submitted by the person filing the request,

"(ii) written or oral argument, or both,

"(iii) the decision of, and the record for, the prior level of appeal, and

"(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.".

(b) REVISIONS TO APPEALS TIMEFRAMES.—Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking "30-day period" each place it appears and inserting "60-day period";

(2) in subsection (c)(3)(C)(i), by striking "30-day period" and inserting "60-day period";

(3) in subsection (d)(1)(A), by striking "90-day period" and inserting "120-day period"; and

(4) in subsection (d)(2)(A), by striking "90-day period" and inserting "120-day period".

(c) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

(d) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

"(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

"(A) the reasons for the determination, including, as appropriate—

"(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

"(ii) upon request, in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

"(B) the procedures for obtaining additional information concerning the determination or redetermination; and

"(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.".

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

"(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

"(i) to the extent appropriate, an explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

"(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

"(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the decision.".

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting "; NOTICE" after "SECRETARY"; and

(B) by adding at the end the following new paragraph:

"(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

"(A) the specific reasons for the determination; and

"(B) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.".

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking "such information as is required for an appeal" and inserting "the record for the appeal".

(e) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting "(except in the case of a utilization and quality control peer review organization, as defined in section 1152)" after "means an entity or organization that"; and

(ii) by striking the period at the end and inserting the following: "and meets the following requirements:

"(A) GENERAL REQUIREMENTS.—

"(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

"(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

"(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

"(B) INDEPENDENCE REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

"(I) is not a related party (as defined in subsection (g)(5));

"(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

"(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional."; and

(B) in paragraph (3)(A), by striking ", and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection".

(2) ELIGIBILITY REQUIREMENTS OF REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) in subsection (c)(3)(B)(i), by striking "a panel of physicians or other appropriate health care professionals" and inserting "a physician or another appropriate health care professional";

(B) by striking subsection (c)(3)(D) and inserting the following:

"(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals)."; and

(C) by adding at the end the following new subsection:

"(g) QUALIFICATIONS OF REVIEWERS.—

"(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall ensure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

"(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review described in subsection (c)(3)(B) and conducted by a physician or another health care professional (each in this subsection referred to as a 'reviewing professional'), that the reviewing professional meets the qualifications described in paragraph (4).

"(2) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(I) a nonaffiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

"(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

"(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

"(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

"(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

"(C) The health care professional that provides the items or services involved in the case.

"(D) The institution at which the items or services (or treatment) involved in the case are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

"(F) Any other party determined under any regulations to have a substantial interest in the case involved.".

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking "12" and inserting "4".

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

"(d) EFFECTIVE DATE.—

"(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after January 1, 2005.

"(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—The amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003 under the following provisions:

"(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

"(B) Subsection (c)(3)(C)(iii) of such section.

"(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

"(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.".

(2) CONFORMING AMENDMENT.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 516. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORF CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

"(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

"(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

"(2) a provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.".

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of the enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 501, 502, and 503, is amended by adding at the end the following new subsection:

"(g) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.".

SEC. 517. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

"(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination and the provider of services, physician, practitioner, or other supplier would be prejudiced by the determination.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 518. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

"(5) AGGRIEVED PARTY DEFINED.—In this section, with respect to a national or local coverage determination, the term 'aggrieved party' means—

“(A) an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; or

“(B) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.”.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting “, including, where appropriate, a clear explanation of the reasons for the denial” before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 515(d)(2)(B), is amended by adding at the end the following new subsection:

“(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

“(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

“(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term ‘provider local coverage determination request’ means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

“(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

“(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

“(B) each reversal described in subparagraph (A) involves substantially similar material facts;

“(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

“(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

“(4) APPROVAL OR REJECTION OF REQUEST.—

“(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

“(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.”.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after January 1, 2004;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of the enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

“CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

“SEC. 1874A. (a) AUTHORITY.—

“(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

“(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

“(A) the entity has demonstrated capability to carry out such function;

“(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

“(C) the entity has sufficient assets to financially support the performance of such function; and

“(D) the entity meets such other requirements as the Secretary may impose.

“(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

“(A) IN GENERAL.—The term ‘medicare administrative contractor’ means an agency, organization, or other person with a contract under this section.

“(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the ‘appropriate’ medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

“(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and beneficiary services functions as follows:

“(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

“(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

“(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

“(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

“(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

‘‘(F) Provider education and technical assistance.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

‘‘(G) Additional functions.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

‘‘(5) Relationship to MIP contracts.—

‘‘(A) Nonduplication of activities.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

‘‘(B) Construction.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

‘‘(6) Application of federal acquisition regulation.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

‘‘(b) Contracting Requirements.—

‘‘(1) Use of competitive procedures.—

‘‘(A) In general.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

‘‘(B) Renewal of contracts.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures, unless laws with general applicability to Federal acquisition and procurement or the Federal Acquisition Regulation authorize the use of other procedures, under such a contract not less frequently than once every 8 years.

‘‘(C) Transfer of functions.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

‘‘(D) Incentives for quality.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

‘‘(2) Compliance with requirements.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

‘‘(3) Performance requirements.—

‘‘(A) Development of specific performance requirements.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

‘‘(B) Considerations.—The Secretary shall include, as one of the standards, provider and beneficiary satisfaction levels.

‘‘(C) Inclusion in contracts.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

‘‘(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

‘‘(ii) shall be used for evaluating contractor performance under the contract; and

‘‘(iii) shall be consistent with the written statement of work provided under the contract.

‘‘(4) Information requirements.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

‘‘(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

‘‘(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

‘‘(5) Surety bond.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

‘‘(c) Terms and Conditions.—

‘‘(1) In general.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

‘‘(2) Prohibition on mandates for certain data collection.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

‘‘(d) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

‘‘(1) Certifying officer.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

‘‘(2) Disbursing officer.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

‘‘(3) Liability of medicare administrative contractor.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

‘‘(4) Relationship to false claims act.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ‘‘False Claims Act’’).

‘‘(5) Indemnification by secretary.—

‘‘(A) In general.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

‘‘(B) Conditions.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

‘‘(C) Scope of indemnification.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

‘‘(D) Written approval for settlements.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

"(E) Construction.—Nothing in this paragraph shall be construed—

"(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

"(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.".

(2) Consideration of incorporation of current law standards.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) Conforming Amendments to Section 1816 (Relating to Fiscal Intermediaries).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) Conforming Amendments to Section 1842 (Relating to Carriers).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services,"; and

(II) by striking "carrier" and inserting "medicare administrative contractor";

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,";

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), by striking "carrier" and inserting "medicare administrative contractor";

(E) in paragraph (5), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier" and "carrier responses" and inserting "contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor" and "contractor responses", respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) Effective Date; Transition Rule.—

(1) Effective date.—

(A) In general.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) Construction for current contracts.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) Deadline for competitive bidding.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) General transition rules.—

(A) Authority to continue to enter into new agreements and contracts and waiver of provider nomination provisions during transition.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) Appropriate transition.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) Authorizing continuation of MIP activities under current contracts and agreements and under transition contracts.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) References.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) Secretarial Submission of Legislative Proposal.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) Reports on Implementation.—

(1) Proposal for implementation.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) Status of implementation.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) Coordination of Education Funding.—

(1) In general.—Title XVIII is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"Sec. 1889. (a) Coordination of Education Funding.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) Incentives To Improve Contractor Performance.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

"(e) Incentives To Improve Contractor Performance in Provider Education and Outreach.—

"(1) Methodology to measure contractor error rates.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

"(2) IG review of methodology.—The Inspector General of the Department of Health and Human Services shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

"(3) Medicare contractor defined.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.".

(c) Improved Provider Education and Training.—

(1) Increased funding for enhanced education and training through medicare integrity program.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)";

(B) in subparagraph (B), by striking "The amount appropriated" and inserting "Subject to subparagraph (C), the amount appropriated"; and

(C) by adding at the end the following new subparagraph:

"(C) Enhanced provider education and training.—

"(i) In general.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

"(ii) Use.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.".

(2) Tailoring education and training for small providers or suppliers.—

(A) In general.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

"(b) Tailoring Education and Training Activities for Small Providers or Suppliers.—

"(1) In general.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

"(2) Small provider of services or supplier.—In this subsection, the term 'small provider of services or supplier' means—

"(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.".

(B) Effective date.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) Additional Provider Education Provisions.—

(1) In general.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

"(c) Encouragement of Participation in Education Program Activities.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

"(d) Construction.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

"(1) of the screens used for identifying claims that will be subject to medical review; or

"(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(e) Definitions.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) In General.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

"(f) Communicating With Beneficiaries and Providers.—

"(1) Communication process.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

"(2) Response to written inquiries.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within a contractual timeframe established by the Secretary.

"(3) Response to toll-free lines.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) Monitoring of contractor responses.—

"(A) In general.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) Development of standards.—

"(i) In general.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2004.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).

SEC. 533. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 501, is amended by adding at the end the following new paragraph:

"(2) If—

"(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

"(i) by the Secretary; or

"(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

"(B) the Secretary determines that—

"(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

"(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

"(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of the enactment of this Act.

SEC. 534. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; MEDICARE PROVIDER OMBUDSMAN";

(2) by inserting "PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)" after "(a)";

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) MEDICARE PROVIDER OMBUDSMAN.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman who shall have experience in health care. The Ombudsman shall—

"(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration);

"(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers; and

"(C) recommendations to improve communication between providers, contractors, and the Centers for Medicare & Medicaid Services.

"(c) STAFF.—The Secretary shall provide appropriate staff to assist in performing the duties described in subsection (b).".

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following new section:

"MEDICARE BENEFICIARY OMBUDSMAN

"SEC. 1807. (a) IN GENERAL.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman (including support staff) who shall have expertise and experience in the fields of health care and advocacy.

"(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

"(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

"(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

"(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

"(B) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

"(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.".

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: "By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.".

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 3 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local social security offices.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

"(g) CONDUCT OF PREPAYMENT REVIEW.—

"(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

"(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

"(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

"(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of the enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

"(h) RECOVERY OF OVERPAYMENTS.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

"(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

"(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

"(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

"(ii) there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

"(2) LIMITATION ON RECOUPMENT.—

"(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

"(B) PAYMENT OF INTEREST.—

"(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

"(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

"(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

"(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

"(3) PAYMENT AUDITS.—

"(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

"(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

"(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

"(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be over utilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

"(5) Standard Methodology for Probe Sampling.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

"(6) Consent Settlement Reforms.—

"(A) In general.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

"(B) Opportunity to Submit Additional Information Before Consent Settlement Offer.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

"(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) Consent Settlement Offer.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) Consent Settlement Defined.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.".

(b) Effective Dates and Deadlines.—

(1) Not later than 1 year after the date of the enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of overutilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of the enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) In General.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) Deadline.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

SEC. 545. RECOVERY OF OVERPAYMENTS.

(a) In General.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

"(f) Limitation on Use of Extrapolation.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

"(1) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

"(2) documented educational intervention has failed to correct the payment error (as determined by the Secretary).".

(b) Effective Date.—Section 1893(f) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) In General.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services and inpatient hospital services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) Inclusion of Information in Certain Hospital Discharge Plans.—

(1) In general.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking "hospice services" and inserting "hospice care and post-hospital extended care services"; and

(B) by inserting before the period at the end the following: "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides".

(2) Effective date.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management physician services under title XVIII of Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 554. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) Council for Technology and Innovation.—Section 1868 (42 U.S.C. 1395ee), as amended by section 301(a), is amended by adding at the end the following new subsection:

"(c) Council for Technology and Innovation.—

"(1) Establishment.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) Composition.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) Duties.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.".

(b) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

"(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

"(B) Determinations under subparagraph (A) shall be made only after the Secretary—

"(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis cf whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

SEC. 555. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 556. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

"(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

"(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.".

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting "or in terminating a hospital's participation under this title" after "in imposing sanctions under paragraph (1)"; and

(B) by adding at the end the following new sentences: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 557. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term "EMTALA" refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 558. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other nonroutine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

"(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services provided by or under the supervision of a registered professional nurse and are provided nonroutinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.".

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 559. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting "; and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) for individuals who are terminally ill and who have not made an election under subsection (d)(1), services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

"(A) an evaluation of the individual's need for pain and symptom management, including the need for hospice care;

"(B) counseling the individual with respect to end-of-life issues, the benefits of hospice care, and care options; and

"(C) if appropriate, advising the individual regarding advanced care planning.".

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under part A shall be the amount determined under a fee schedule established by the Secretary.".

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: "and services described in section 1812(a)(5)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 560. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking "and" at the end;

(B) in subparagraph (S), by striking the period at the end and inserting ", and"; and

(C) by inserting after subparagraph (S) the following new subparagraph:

"(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 or a State occupational safety and health plan that is approved under section 18(b) of such Act, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated)."; and

(2) by adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

"(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

"(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.".

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 561. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking "established under section 1114(f)"; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking "under subsection (f)"; and

(ii) by striking "section 1862(a)(1)" and inserting "subsection (a)(1)".

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking "policy" and inserting "determination"; and

(B) in subclause (IV), by striking "medical review policies" and inserting "coverage determinations".

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C)) is amended by striking "policy" and "POLICY" and inserting "determination" each place it appears and "DETERMINATION", respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking "subclause (I), (II), or (III)" and inserting "clause (i), (ii), or (iii)";

(2) in subparagraph (B), by striking "clause (i)(IV)" and "clause (i)(III)" and inserting "subparagraph (A)(iv)" and "subparagraph (A)(iii)", respectively; and

(3) in subparagraph (C), by striking "clause (i)", "subclause (IV)" and "subparagraph (A)" and inserting "subparagraph (A)", "clause (iv)" and "paragraph (1)(A)", respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c-3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 562. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

"(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

"(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 563. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: "(ii) where the service was provided under a contractual arrangement between such physician or other person and a qualified entity (as defined by the Secretary) or other person, to the entity or other person if under such arrangement such entity or individual submits the bill for such service and such arrangement (I) includes joint and several liability for overpayment by such physician or other person and such entity or other person, and (II) meets such other program integrity and other safeguards as the Secretary may determine to be appropriate,".

(b) CONFORMING AMENDMENTS.—

(1) The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "except to an employer or facility as described in clause (A)" and inserting "except to an employer, entity, or other person as described in subparagraph (A)".

(2) Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: "Nothing in subparagraph (A)(ii) shall be construed to prohibit requirements for joint and several liability for contractual arrangements where such requirements are not explicitly stated in a statute.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after 1 year after the date of the enactment of this Act.

SEC. 564. GAO STUDY AND REPORT REGARDING ILLINOIS COUNCIL DECISION.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the access of health care providers and beneficiaries under the medicare program under title XVIII of the Social Security Act to judicial review of the actions of the Secretary of Health and Human Services and the effects of the decision of the Supreme Court of the United States in Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (1999) on such access.

(a) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

SA 1126. Mrs. DOLE (for herself, and Mr. EDWARDS) submitteed an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) BUDGET NEUTRAL WITHIN NORTH CAROLINA.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such payments that would have been made in the year if this subsection had not been enacted.

(b) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act, Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) APPLICATION AND BUDGET NEUTRAL WITHIN NORTH CAROLINA.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be implemented in a budget neutral manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the total amount of expenditures that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(c) CONSTRUCTION.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

SA 1127. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . BRACHYTHERAPY DEVICES.

(a) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(1) in subparagraph (F), by striking "and" at the end;

(2) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(H) with respect to devices of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number of such devices furnished separately for palladium-103 and iodine-125.".

(b) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(13)(B) of the Social Security Act, as added by subsection (a), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this subsection, and shall include specific recommendations for appropriate payments for such devices.

SA 1128. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 133, after line 25, insert the following:

"(3) COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

"(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

"(B) ELECTION.—Under the process established under section 1860D-3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or MedicareAdvantage plan through the existing State pharmaceutical assistance program.

"(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—In this paragraph, the term 'existing State pharmaceutical assistance program' means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004.

SA 1129. Mr. DASCHLE (for Mr. KERRY) submitted an amendment intended to be proposed by Mr. DASCHLE to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . SENSE OF THE SENATE REGARDING PARITY OF MENTAL HEALTH SERVICES UNDER MEDICARE.

(a) FINDINGS.—The Senate finds the following:

(1) Beneficiaries of the Medicare program under title XVIII of the Social Security Act pay 50 percent coinsurance for outpatient psychiatric services.

(2) In comparison, such beneficiaries pay 20 percent coinsurance for all other medical services.

(3) There is no scientific or medical justification for this discriminatory inequity.

(b) Sense of the Senate.—It is the sense of the Senate that Congress should work to achieve parity under the Medicare program under title XVIII of the Social Security Act between mental health services and other medical services as soon as practicable.

SA 1130. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill to S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table, as follows:

At the appropriate place in title II, insert the following:

SEC. . STUDY ON TRENDS IN EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.

(a) Study.—The Comptroller General of the United States, in consultation with employers, health benefit experts, academia, human resource professionals, State and local government officials, and employer consulting firms, shall conduct a study to determine the effect of the amendments made by this Act on the provision of employment-based retiree health coverage (as such term is defined in section 1860D-20(e)(4)(B) of the Social Security Act). Such study shall examine the following:

(1) Trends in employment-based retiree health coverage, as such trends relate to retirees who are eligible for coverage under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) The extent to which health care coverage, including coverage under Medicare+Choice, MedicareAdvantage, and fee-for-service prescription drug plans under the medicare program, are available to retirees who are eligible for coverage under the medicare program.

(3) The extent to which geographic location plays a role in the structure and availability of retiree health benefit coverage.

(4) Whether incentives built into this Act (and the amendments made by this Act) are sufficient to induce employers to maintain employment-based retiree health coverage, and whether other voluntary incentives exist to encourage employers to maintain such coverage.

(5) Whether obstacles exist to employers providing employment-based retiree health coverage, including administrative burden, the cost of prescription drugs, and the increasing overall health care costs.

(6) Whether—

(A) employment-based retiree health coverage has changed because of the implementation of the MedicareAdvantage and medicare fee-for-service programs under the amendments made by this Act;

(B) such coverage continues to maintain the employment-based retiree health benefit packages that were available prior to the implementation of such programs;

(C) employers conduct health fairs or provide other educational opportunities for their retirees to encourage retirees to obtain coverage under MedicareAdvantage or other prescription drug plans that are available; and

(D) employers offer retirees financial incentive to obtain coverage under MedicareAdvantage or other prescription drug plans, including premium subsidies.

(7) Whether the availability of MedicareAdvantage and medicare fee-for-service prescription drug coverage acts as an incentive to employers that did not previously offer employment-based retiree health coverage to offer such coverage to retirees.

(8) Whether other tools are used by employers to help future employees afford health benefits and prescription drug coverage once such employees reach retirement age.

(b) Information.—In conducting the study under subsection (a), the Comptroller General shall determine the effect of the amendments made by this Act on the provision of employment-based retiree health coverage using information available for the period—

(1) beginning on the date of enactment of this Act and ending on January 1, 2005; and

(2) beginning on January 1, 2006 and ending on January 1, 2007.

(c) Report.—Not later than July 1, 2007, the Comptroller General shall submit to the Secretary and the appropriate committees of Congress a report based on the study conducted under subsection (a).

SA 1131. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES.

(a) In General.—The Secretary shall revise the regulation promulgated under section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–350) so that, in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4), the Secretary recognizes all costs of clinical staff employed by cardio-thoracic surgeons (net of any reimbursements for staff for whom there is direct reimbursement under part B of such Act (42 U.S.C. 1395j et seq.)), regardless of the site at which such costs are incurred and notwithstanding any other provision of law or regulation. For purposes of revising such regulation, the Secretary shall use validated data collected by organizations and entities (other than the Department of Health and Human Services) on all costs incurred by physicians, including data from the Socioeconomic Monitoring System of the American Medical Association and from supplemental surveys accepted by the Department of Health and Human Services as consistent with sound data practices prior to the date of enactment of this Act.

(b) Effective Date.—The regulation revised under subsection (a) shall apply with respect to payments for physicians' services furnished on and after January 1, 2004.

SA 1132. Mr. SANTORUM proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; as follows:

On page 343, between lines 15 and 16, insert the following:

"(f) Zero Premium Stop-Loss Protection and Access to Negotiated Prices For Eligible Beneficiaries Enrolled in MedicareAdvantage Plans.—

"(1) In general.—Notwithstanding any provision of this part or part D, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage otherwise required, the plan makes available such coverage with the following modifications:

"(A) No premium.—Notwithstanding subsection (d) or sections 1860D–13(e)(2) and 1860D–17, the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage shall be zero.

"(B) Beneficiary receives access to negotiated prices and stop-loss protection for no additional premium.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

"(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

"(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4), except that in applying such subsection, '$ ' shall be substituted for '$3,700' in subparagraph (B)(i)(I) of such subsection.

"(iii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

"(C) Application of low-income subsidies.—Notwithstanding subsection (f) or section 1860D–19, the Administrator shall not apply the following provisions of subsection (a) of such section:

"(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

"(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

"(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

"(2) Penalty for enrolling in a zero premium stop-loss protection plans after initial eligibility for such enrollment.—In the case of an eligible beneficiary that enrolled in a plan offered pursuant to this subsection at any time after the initial enrollment period described in section 1860D–2, the Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under such a plan but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under this paragraph in a manner that is similar to the manner such provisions apply to the penalty under part D.

"(3) Procedures.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this subsection.

"(4) NO EFFECT ON MEDICARE DRUG PLANS.—This subsection shall have no effect on eligible beneficiaries enrolled under part D in a Medicare Prescription Drug plan or under a contract under section 1860D–13(e)."

SA 1133. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 8, line 12, insert "(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator)" before the semicolon.

On page 46, line 9, after the end period insert: "Such requirement shall not apply to enrollees of a Medicare Prescription Drug plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement."

On page 51, line 19, insert "(but only with respect to the percentage of such costs that the individual is responsible for under that section)" after "1860D–19".

On page 56, strike lines 3 through 19, and insert the following:

"(B) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part—

"(i) the medical assistance for such a drug shall be disregarded for purposes of a rebate agreement entered into under section 1927 which would otherwise apply to the provision of medical assistance for the drug under title XIX; and

"(ii) the prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a MedicareAdvantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(e)(1)(C).

On page 74, strike lines 14 through 16, and insert the following:

the plan;

"(D) the average aggregate projected cost of covered drugs under the plan relative to other Medicare Prescription Drug plans and MedicareAdvantage plans; or

"(E) other factors determined appropriate by the Administrator.

Beginning on page 88, strike lines 9 through page 89, line 10, and insert the following:

"(ii) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under clause (i) for the year—

"(I) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

"(II) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

"(B) CERTAIN EXPENSES NOT INCLUDED.—The amount under subparagraph (A)(i) may not include—

"(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

"(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2);

"(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20; or

"(iv) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in subparagraph (A)(i).

On page 78, beginning on line 20, strike "An entity" and all that follows through line 24.

On page 84, line 6, strike "(including a contract under)".

Beginning on page 92, strike line 20 through page 93, line 25, and insert the following:

"(3) ESTABLISHMENT OF ALLOWABLE COSTS.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year.

On page 116, strike lines 11 and 12, and insert the following:

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1905(p)(1), as determined under such plan (or under a waiver of plan); and

On page 117, strike lines 1 and 2, and insert the following:

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iii), as determined under such plan (or under a waiver of plan); and

On page 117, strike lines 14 through 17, and insert the following:

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX), as determined under such plan (or under a waiver of such plan); and

On page 120, line 11, strike "such individuals" and insert "in the case of such an individual who is not a resident of the 50 States or the District of Columbia, such individual".

Beginning on page 123, strike line 10 through page 124, line 6, and insert the following:

"(B) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under subparagraph (A) for the year—

"(i) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

"(ii) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

"(2) CERTAIN EXPENSES NOT INCLUDED.—The amount under paragraph (1)(A) may not include—

"(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A);

"(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2); or

"(C) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in paragraph (1)(A).

On page 124, on line 15, insert "(or 65 percent with respect to a qualifying covered individual described in subsection (e)(2)(D))" after "80 percent".

Beginning on page 124, strike line 18 through page 125, line 13, and insert the following:

"(2) ESTABLISHMENT OF ALLOWABLE COSTS.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year.

Beginning on page 126, strike line 7 through page 127, line 9, and insert the following:

"(2) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

"(A) is enrolled in this part and in a Medicare Prescription Drug plan;

"(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage);

"(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan; or

"(D) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified State pharmaceutical assistance program.

"(3) QUALIFYING ENTITY.—The term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

"(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

"(B) A MedicareAdvantage organization offering a MedicareAdvantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

"(C) The sponsor of a qualified retiree prescription drug plan.

"(D) A State offering a qualified State pharmaceutical assistance program.

On page 127, beginning with line 18, strike all through page 128, line 2, and insert:

"(i) ATTESTATION OF ACTUARIAL VALUE OF COVERAGE.—The sponsor of the plan shall, annually or at such other time as the Administrator may require, provide the Administrator an attestation, in accordance with the procedures established under section 1860D–6(f), that the actuarial value of prescription drug coverage under the plan is at least equal to the actuarial value of standard prescription drug coverage.

"(ii) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Administrator access to) such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this part to and by the plan.

On page 128, between lines 12 and 13, insert the following:

"(6) QUALIFIED STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—

"(A) IN GENERAL.—The term 'qualified State pharmaceutical assistance program' means a State pharmaceutical assistance program if, with respect to a qualifying covered individual who is covered under the program, the following requirements are met:

"(i) ASSURANCE.—The State offering the program shall, annually or at such other times as the Administrator may require, provide the Administrator an attestation that, in accordance with the procedures established under section 1860D–6(f), that—

"(I) the actuarial value of prescription drug coverage under the program is at least equal to the actuarial value of standard prescription drug coverage; and

"(II) the actuarial value of subsidies to individuals provided under the program are at least equal to the actuarial value of the subsidies that would apply under section 1860D–19 if the individual was enrolled under this part rather than under the program.

"(ii) DISCLOSURE OF INFORMATION.—The State complies with the requirements described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

"(B) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—For purposes of subparagraph (A), the term 'State pharmaceutical assistance program' means a program—

"(i) that is in operation as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003;

"(ii) that is sponsored and financed by a State; and

"(iii) that provides coverage for outpatient drugs for individuals in the State who meet income- and resource-related qualifications specified under such program.

On page 128, between lines 15 and 16, insert the following:

"(g) DISTRIBUTION OF REINSURANCE PAYMENT AMOUNTS.—

"(1) IN GENERAL.—Any sponsor meeting the requirements of subsection (e)(3) with respect to a quarter in a calendar year, but which is not an employer, shall distribute the reinsurance payments received for such quarter under subsection (c) to the employers contributing to the qualified retiree prescription drug plan maintained by such sponsor during that quarter, in the manner described in paragraphs (2) and (3).

"(2) ALLOCATION.—The reinsurance payments to be distributed pursuant to paragraph (1) shall be allocated proportionally among all employers who contribute to the plan during the quarter with respect to which the payments are received. The share allocated to each employer contributing to the plan during a quarter shall be determined by multiplying the total reinsurance payments received by the sponsor for the quarter by a fraction, the numerator of which is the total contributions made by an employer for that quarter, and the denominator of which is the total contributions required to be made to the plan by all employers for that quarter. Any share allocated to an employer required to contribute for a quarter who does not make the contributions required for that quarter on or before the date due shall be retained by the sponsor for the benefit of the plan as a whole.

"(3) TIMING.—Reinsurance payments required to be distributed to employers pursuant to this subsection shall be distributed as soon as practicable after received by the sponsor, but in no event later than the end of the quarter immediately following the quarter in which such reinsurance payments are received by the sponsor.

"(4) REGULATIONS.—The Secretary shall promulgate regulations providing that any sponsor subject to the requirements of this subsection who fails to meet such requirements shall not be eligible for a payment under this section.

On page 130, between lines 7 and 8, insert the following:

"DIRECT SUBSIDIES FOR QUALIFIED STATE OFFERING A STATE PHARMACEUTICAL ASSISTANCE PROGRAM FOR PROGRAM ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

"SEC. 1860D–22. (a) DIRECT SUBSIDY.—

"(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical assistance program (as defined in section 1860D–20(e)(6)) for each qualifying covered individual (described in subparagraph (D) of section 1860D–(e)(2)) enrolled in the program for each month for which such individual is so enrolled.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the amount of payment for the area and year made under section 1860D–21(a)(2).

:"(b) ADDITIONAL SUBSIDY.—

"(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical program (as defined in section 1860D–20(e)(6)) for each applicable low-income individual enrolled in the program for each month for which such individual is so enrolled.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be the amount the Administrator estimates would have been made to an entity or organization under section 1860D–19 with respect to the applicable low-income individual if such individual was enrolled in this part and under a Medicare Prescription Drug plan or a MedicareAdvantage plan.

"(B) MAXIMUM PAYMENTS.—In no case may the amount of the payment determined under subparagraph (A) with respect to an applicable low-income individual exceed, as estimated by the Administrator, the average amounts made in a year under section 1860D–19 on behalf of an eligible beneficiary enrolled under this part with income that is the same as the income of the applicable low-income individual.

"(3) APPLICABLE LOW-INCOME INDIVIDUAL.—For purposes of this subsection, the term 'applicable low-income individual' means an individual who is both—

"(A) a qualifying covered individual (described in subparagraph (D) of section 1860D–(e)(2)); and

"(B) a qualified medicare beneficiary, a specified low income medicare beneficiary, or a subsidy-eligible individual, as such terms are defined in section 1860D–19(a)(4).

"(c) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

"(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

"(d) CONSTRUCTION.—Nothing in this section or section 1860D–20 shall effect the provisions of section 1860D–26(b).

On page 134, between lines 9 and 10, insert:

"(d) WAIVER AUTHORITY.—The Secretary shall have authority similar to the waiver authority under section 1857(i) to facilitate the offering of Medicare Prescription Drug plans by employer or other group health plans as part of employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)), including the authority to establish separate premium amounts for enrollees in a Medicare Prescription Drug plan by reason of such coverage."

On page 142, beginning on line 16, strike "in a manner" and all that follows through line 19 and insert a semicolon.

On page 143, beginning on line 15, strike "in a manner" and all that follows through line 18 and insert a semicolon.

On page 144, between lines 10 and 11, insert the following:

"(4) SCREEN AND ENROLL INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—As part of making an eligibility determination required under paragraph (1) or (2), screen an individual who applies for such a determination for eligibility for medical assistance for any medicare cost-sharing described in section 1905(p)(3) and, if the individual is eligible for any such medicare cost-sharing, enroll the individual under the State plan (or under a waiver of such plan).

On page 147, line 1, insert "and notwithstanding section 1905(b)," after "(4)".

On page 147, beginning on line 6, strike "Secretary" and all that follows through "paying" on line 8, and insert "Federal medical assistance percentage shall be".

On page 147, line 8, strike "of the" and insert "for".

On page 147, strike lines 13 through 16, and insert the following:

"(B) whose income is at least the income required for an individual to be an eligible individual under section 1611 for purposes of the supplemental security income program (as determined under section 1612), but does not exceed 100 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.,

On page 149, line 1, insert "and notwithstanding section 1905(b)," after "(2)".

On page 149, beginning on line 6, strike "Secretary" and all that follows through "paying" on line 8, and insert "Federal medical assistance percentage shall be".

On page 149, line 8, strike "of the" and insert "for".

On page 151, line 9, strike "$22,500,000" and insert "$37,500,000".

On page 151, line 11, strike "$30,000,000" and insert "$50,000,000".

On page 152, strike lines 8 through 11, and insert the following:

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting "and subsections (c)(1) and (d)(1) of section 1935" after "1933(d)".

(B) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

On page 157, line 17, strike "and".

On page 157, line 20, strike the period and insert "; and".

On page 157, between lines 20 and 21, insert the following:

(C) by adding at the end the following:

"(3) AGREEMENTS TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD OFFICES.—

"(A) IN GENERAL.—The Commissioner shall enter into an agreement with each State operating a State plan under title XIX (including under a waiver of such plan) to establish information and enrollment sites within all the Social Security field offices located in the State for purposes of—

"(i) the State determining the eligibility of individuals residing in the State for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933, the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19; and

"(ii) enrolling individuals who are determined eligible for such medical assistance, program, or subsidies in the State plan (or waiver), the transitional prescription drug assistance card program under section 1807A, or the appropriate category for premium and cost-sharing subsidies under section 1860D–19.

"(B) AGREEMENT TERMS.—The Secretary and the Commissioner jointly shall develop terms for the State agreements required under subparagraph (A) that shall specify the responsibilities of the State and the Commissioner in the establishment and operation of such sites.

"(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Commissioner, such sums as may be necessary to carry out this paragraph.".

On page 159, line 19, insert the following before the closing quotation: "As part of such review, the Commission shall hold 3 field hearings in 2007.".

On page 174, line 14, insert "(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Secretary)" before the comma.

Beginning on page 195, strike line 16 through page 196, line 7, and insert the following:

"(A) PATIENT MAY REQUEST A WRITTEN PRESCRIPTION.—The standards provide that—

"(i) a prescription shall be written and not transmitted electronically if the patient makes such a request; and

"(ii) no additional charges may be imposed on the patient for making such a request.

On page 199, strike lines 10 through 14, and insert the following:

"(A) IN GENERAL.—Individuals or entities that transmit or receive prescriptions electronically shall comply with the standards adopted or modified under this part.

On page 200, between lines 16 and 17, insert the following:

"(e) NO REQUIREMENT TO TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—Nothing in this part shall be construed to require an individual or entity to transmit or receive prescriptions electronically.

On page 254, line 25, insert "(other than deemed contracts or agreements under subsection (j)(6))" before "with a sufficient number".

On page 255, line 7, before the period, insert the following: ", except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan".

On page 297, strike lines 5 through 9, and insert the following:

"(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

"(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting '102' for '103' in clause (v).

On page 323, strike lines 1 through 3, and insert the following:

"(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3), or, with respect to a private fee-for-service plan (as described in section 1851(a)(2)(C)) under subparagraph (A)(i), (A)(ii)(III), or (B) of paragraph (2).

On page 326, line 11, after the end period insert: "Subject to the provisions of section 1858(h), such requirement shall not apply to enrollees of a MedicareAdvantage plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement.".

On page 328, line 3, strike "or (C)".

On page 328, line 20, strike "or (C)".

On page 343, strike lines 22 through 24, and insert:

Section 1858(h) (as added by section 211) is amended—

(1) by inserting "(including subsection (i) of such section)" after "section 1857"; and

(2) by adding at the end the following new sentence: "In applying the authority under section 1857(i) pursuant to this subsection, the Administrator may permit MedicareAdvantage plans to establish separate premium amounts for enrollees in an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B))."

On page 349, between lines 4 and 5, insert the following:

(3) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

"(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

"(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting '102' for '103' in clause (v).".

On page 379, strike lines 9 through 13, and insert:

"(A) IN GENERAL.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

"(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

"(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

Beginning on page 411, strike line 5 through page 414, line 9, and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking "(iv) For discharges" and inserting "(iv)(I) Subject to subclause (II), for discharges"; and

(2) by adding at the end the following new subclause:

"(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.".

(b) APPLICATION TO SUBSECTION (D) PUERTO RICO HOSPITALS.—Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "and" after the comma at the end;

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "and before October 1, 2003" after "October 1, 1997"; and

(ii) in the matter following clause (III), by striking the period at the end and inserting ", and"; and

(iii) by adding at the end the following new clause:

"(iii) for discharges in a fiscal year beginning on or after October 1, 2003, 50 percent of the national standardized rate (determined under paragraph (3)(D)(iii)) for hospitals located in any area.";

(2) in subparagraph (C)—

(A) in clause (i)—

(i) by striking "(i) The Secretary" and inserting "(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary; and

(ii) by adding at the end the following:

"(II) For discharges in fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in an urban area, increased by the applicable percentage increase under subsection (b)(3)(B) for fiscal year 2004.

"(III) For discharges in a fiscal year after fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any are of Puerto Rico that is equal to the average standardized amount computed under subclause (II) or this subclause for the previous fiscal year, increased by the applicable percentage increase under subsection (b)(3)(B), adjusted to reflect the most recent case mix data.";

(B) in clause (ii), by inserting "(or for fiscal year 2004 and thereafter, the standardized amount)" after "each of the average standardized amounts"; and

(C) in clause (iii)(I), by striking "for hospitals located in an urban or rural area, respectively".

(c) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "IN DIFFERENT AREAS";

(B) in the matter preceding clause (i), by striking “, each of”;

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2004,” before “for hospitals”; and

(ii) in subclause (II), by striking “and” after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2004,” before “for hospitals”; and

(ii) in subclause (II), by striking the period at the end and inserting “; and”; and

(E) by adding at the end the following new clause:

“(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

“(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

“(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.”.

(2) Technical conforming sunset.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting “, for fiscal years before fiscal year 1997,” before “a regional adjusted DRG prospective payment rate”; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting “, for fiscal years before fiscal year 1997,” before “a regional DRG prospective payment rate for each region,”.

On page 430, strike lines 19 through 21, and insert the following:

(b) Permitting Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialist to Review Hospice Plans of Care.—Section 1814(a)(7)(B) is amended by inserting “(or by a physician assistant, nurse practitioner or clinical nurse specialist who is not an employee of the hospice program, and whom the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care)” after “and is periodically reviewed by the individual's attending physician”.

(c) Effective Date.—The amendments made by this section shall apply to hospice care furnished on or after October 1, 2004.

On page 438, between lines 10 and 11, insert the following:

SEC. 414. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(a) In General.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking “and” after the semicolon at the end;

(2) in subclause (VII)—

(A) by striking “on or after October 1, 2002” and inserting “during fiscal year 2003”; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subclauses:

“(VIII) during each of fiscal years 2004 and 2005, ‘c’ is equal to 1.36; and

“(IX) on or after October 1, 2005, ‘c’ is equal to 1.355.”.

(b) Conforming Amendment Relating to Determination of Standardized Amount.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking “1999 or” and inserting “1999,”; and

(2) by inserting “, or the Prescription Drug and Medicare Improvement Act of 2003” after “2000”.

(c) Effective Date.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 415. CALCULATION OF WAGE INDICES FOR HOSPITALS.

(a) In General.—Notwithstanding any other provision of law, in the calculation of a wage index in a State for purposes of making payments for discharge waive such other criteria for re-classification as deemed appropriate by the Secretary.

SEC. 416. CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting “(which regulations shall exclude any cost incurred for the provision of services pursuant to a contract with an eligible entity (as defined in section 1860D(4)) operating a Medicare Prescription Drug plan or with an entity with a contract under section 1860D–13(e), for which payment is made by the entity)” after “the Secretary may prescribe in regulations”.

SEC. 417. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) Disproportionate Share Adjustment Percentage.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking “35 percent” and inserting “35 percent (or, for discharges occurring on or after October 1, 2003, 40 percent)”.

(b) Capital Costs.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) in clause (iii), by striking “and” at the end;

(2) in clause (iv), by striking the period at the end and inserting “, and”; and

(3) by adding at the end the following new clause:

“(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).”.

SEC. 418. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) In General.—The last sentence of section 1886(d)(1)(B) is amended by inserting “, and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)” before the period at the end.

(b) Treatment of Proposed Revision.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) Effective Date.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

On page 440, line 2, insert closing quotation marks and a period after the period at the end.

Beginning on page 441, strike line 19 and all that follows through page 442, line 2.

Beginning on page 445, strike line 5 and all that follows through page 446, line 6, and insert the following:

SEC. 426. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

“(10) Temporary increase for ground ambulance services.—

“(A) In general.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2005, and before January 1, 2008, for which the transportation originates in—

“(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

“(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent.

“(B) Application of increased payments after 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

“(11) Conversion factor adjustments.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.”.

Beginning on page 470, strike line 21 and all that follows through page 471, line 13, and insert the following:

“(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased by 1.6 percent.

“(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent and further increased by 1.6 percent.

“(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 and all subsequent years, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year, increased by 0.05 percent.

On page 486, line 3, insert “and” after the semicolon at the end.

On page 486, line 4, insert “(I)” after “(ii)”.

On page 486, line 8, strike “and” and insert “or”.

On page 486, line 9, strike “(iii)” and insert “(II)”.

On page 488, after line 25, add the following:

(c) Limitation of Expenditures in Years Prior to 2014.—

(1) In general.—The Secretary shall ensure that the total amount of expenditures under title XVIII of the Social Security Act (including amounts expended by reason of this section) in a year prior to 2014 does not exceed the sum of—

(A) the total amount of expenditures under such title XVIII that would have made if this section had not been enacted; and

(B) the applicable amount.

(2) Applicable amount.—For purposes of paragraph (1), the term “applicable amount” means—

(A) for 2005, $32,000,000;

(B) for 2006, $34,000,000;

(C) for 2007, $36,000,000;

(D) for 2008, $38,000,000;

(E) for 2009, $40,000,000;

(F) for 2010, $42,000,000;

(G) for 2011, $44,000,000;

(H) for 2012, $48,000,000; and

(I) for 2013, $50,000,000.

(3) STEPS TO ENSURE FUNDING LIMITATION NOT VIOLATED.—If the Secretary determines that the application of this section will result in the funding limitation described in paragraph (1) being violated for any year, the Secretary shall take appropriate steps to stay within such funding limitation, including through limiting the number of clinical trials deemed under subsection (a) and only covering a portion of the routine costs described in such subsection.

On page 516, after line 22, add the following:

SEC. 446. AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) IN GENERAL.—Section 1880(e) (42 U.S.C. 1395qq(e)) is amended—

(1) in paragraph (1)(A), by striking "for services described in paragraph (2)" and inserting "for all items and services for which payment may be made under such part";

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

SEC. 447. COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V)(iii), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) cardiovascular screening tests (as defined in subsection (ww)(1));".

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Cardiovascular Screening Tests

"(ww)(1) The term 'cardiovascular screening tests' means the following diagnostic tests for the early detection of cardiovascular disease:

"(A) Tests for the determination of cholesterol levels.

"(B) Tests for the determination of lipid levels of the blood.

"(C) Such other tests for cardiovascular disease as the Secretary may approve.

"(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

"(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 448. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by inserting "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

"(ii) a self-injected drug that is used to treat multiple sclerosis;".

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting ", except for any drug or biological described in subparagraph (W)," after "which".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

SEC. 449. EXTENSION OF MEDICARE SECONDARY PAYER RULES FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.

Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting ", and before January 1, 2004" after "prior to such date)"; and

(2) by adding at the end the following new sentence: "Effective for items and services furnished on or after January 1, 2004 (with respect to periods beginning on or after June 1, 2002), clauses (i) and (ii) shall be applied by substituting '36-month' for '12-month' each place it appears in the first sentence.

SEC. 450. REQUIRING THE INTERNAL REVENUE SERVICE TO DEPOSIT INSTALLMENT AGREEMENT AND OTHER FEES IN THE TREASURY AS MISCELLANEOUS RECEIPTS.

Notwithstanding any other provision of law, the Secretary of the Treasury is required to deposit in the Treasury as miscellaneous receipts any fee receipts, including fees from installment agreements and restructured installment agreements, collected under the authority provided by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-329, the Treasury, Postal Service and General Government Appropriations Act, 1995. Fees collected under this section shall be available for use by the Internal Revenue Service only to the extent that such authority is provided in advance in an appropriations Act.

SEC. 450A. INCREASING TYPES OF ORIGINATING TELEHEALTH SITES AND FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

"(VI) A skilled nursing facility (as defined in section 1819(a)).

"(VII) An assisted-living facility (as defined by the Secretary).

"(VIII) A board-and-care home (as defined by the Secretary).

"(IX) A county of community health clinic (as defined by the Secretary).

"(X) A community mental health center (as described in section 1861(ff)(2)(B)).

"(XI) A long-term care facility (as defined by the Secretary).

"(XII) A facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) directly, or under contract or other arrangement.".

(b) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—

(1) IN GENERAL.—For purposes of expediting the provision of telehealth services for which payment is made under the medicare program under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), across State lines, the Secretary shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of State provisions allowing for multistate practitioner licensure across State lines.

(2) DEFINITIONS.—In this subsection:

(A) TELEHEALTH SERVICE.—The term "telehealth service" has the meaning given that term in subparagraph (F)(i) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(B) PHYSICIAN, PRACTITIONER.—The terms "physician" and "practitioner" have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(C) MEDICARE PROGRAM.—The term "medicare program" means the program of health insurance administered by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 450B. DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term "surgical first assisting services" means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term "certified registered nurse first assistant" means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) PAYMENT RATES.—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) for the same services if furnished by a physician.

(d) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in 5 States selected by the Secretary.

(e) DURATION.—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the project under this section.

(2) BUDGET NEUTRALITY.—In conducting the project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the project under this section was not implemented.

(i) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 450C. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

SEC. 450D. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(b) (42 U.S.C. 1395w-4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "paragraph (2)" and inserting "paragraphs (2) and (4)"; and

(2) by adding at the end the following new paragraph:

"(4) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.—

"(A) IN GENERAL.—With respect to physicians' services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, the fee schedule for such services shall be determined as follows:

"(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

"(I) in the case of services furnished in calendar year 2004, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

"(II) in the case of services furnished in calendar year 2005, the amount determined under subclause (I) for 2004, increased by the annual update determined under subsection (d) for the year involved.

"(ii) In the case of a service for which there was no VA Alaska fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to the sum of—

"(I) the amount of payment for the service that would otherwise apply under this section; plus

"(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

"(B) VA ALASKA FEE SCHEDULE AMOUNT.—For purposes of this paragraph, the term 'VA Alaska fee schedule amount' means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians' services associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38.

"(C) APPLICABLE PERCENT.—For purposes of this paragraph, the term 'applicable percent' means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount for physicians' services exceeded the amount of payment for such services under this section that applied in Alaska in 2001.".

SEC. 450E. DEMONSTRATION PROJECT TO EXAMINE WHAT WEIGHT LOSS WEIGHT MANAGEMENT SERVICES CAN COST EFFECTIVELY REACH THE SAME RESULT AS THE NIH DIABETES PRIMARY PREVENTION TRIAL STUDY: A 50 PERCENT REDUCTION IN THE RISK FOR TYPE 2 DIABETES FOR INDIVIDUALS WHO HAVE IMPAIRED GLUCOSE TOLERANCE AND ARE OBESE.

(a) IN GENERAL.—Inasmuch as the NIH Diabetes Primary Prevention Trial study proved that the risk of type 2 diabetes could be cut in half when the Institute of Medicine definition of successful weight loss (5 percent weight loss maintained for a year) is achieved by individuals at risk for type 2 diabetes due to obesity and impaired glucose tolerance, the Secretary shall conduct a demonstration project to examine the cost effectiveness and health benefits of providing group weight loss management services to achieve the same result for beneficiaries under the medicare program under title XVIII of the Social Security Act who are obese and have impaired glucose tolerance.

(b) LIMITATION.—The cost of the group weight loss management services provided under subsection (a) shall not exceed the cost per recipient per year of the medical nutritional therapy benefit currently available to medicare beneficiaries.

(c) SCOPE OF SERVICES.—

(1) DURATION.—The project shall be conducted for a period of 2 fiscal years.

(2) SITES.—The Secretary shall designate the sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in—

(A) rural areas; or

(B) areas that have a high concentration of Native Americans with type 2 diabetes.

(3) FUNDING.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(B) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $2,500,000 for each fiscal year in which the project is conducted under paragraph (1).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, medical nutrition therapy services furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.).

(2) PAYMENT.—Payment for such services shall be made at a rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the fee schedule amount provided under section 1848 of the Social Security Act (42 U.S.C. 139w-4) for the same services if such services were furnished by a physician.

(3) APPLICATION OF LIMITS OF BILLING.—The provisions of section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) shall apply to a group weight loss management professional furnishing services under the project in the same manner as they to a practitioner described in subparagraph (C) of such section furnishing services under title XVIII of such Act.

(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project not later than the date that is 6 months after the date on which the project concludes. The final report shall include an evaluation of the impact of the use of group weight loss management services as part of medical nutrition therapy on medicare beneficiaries and on the medicare program, including any impact on reducing costs under the program and improving the health of beneficiaries.

(f) DEFINITIONS.—For purposes of this section:

(1) The term "obesity" means that an individual has a Body Mass Index (BMI) of 30 and above.

(2) GROUP WEIGHT LOSS MANAGEMENT SERVICES.—The term "group weight loss management services" means comprehensive services furnished to individuals who have been diagnosed and referred by a physician as having impaired glucose tolerance and who are obese that consist of—

(A) assessment and treatment based on the needs of individuals as determined by a group weight loss management professional; or

(B) a specific program or method that has demonstrated its efficacy to produce and maintain weight loss through results published in peer-reviewed scientific journals using recognized research methods and statistical analysis that provides—

(i) assessment of current body weight and recording of weight status at each meeting session;

(ii) provision of a healthy eating plan;

(iii) provision of an activity plan;

(iv) provision of a behavior modification plan; and

(v) a weekly group support meeting.

(3) GROUP WEIGHT LOSS MANAGEMENT PROFESSIONAL.—The term "group weight loss management professional" means an individual who has completed training to provide a program or method that has completed clinical trials and has demonstrated its efficacy through publications in peer-reviewed scientific journals who—

(A)(i) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) in nutrition social work, psychology with experience in behavioral modification methods to reduce obesity; or

(ii) has completed a curriculum of training for a specific behavioral based weight management program as described in section (4)(A)(2) and recommended in the NIH Clinical Guidelines on Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, chapter 4, section H, parts 1, 2, 3, 4, and pursuant to guidelines by the Secretary; and

(B)(i) is licensed or certified as a group weight loss management professional by the State in which the services are performed; or

(ii) is certified by an organization that meets such criteria as the Secretary establishes with—

(I) national organizations representing consumers such as the American Obesity Association and the elderly; and

(II) such other organizations as the Secretary determines appropriate.

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SEC. 456. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SEC. 457. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

SEC. 458. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

"(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

"(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

"(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).".

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following:"Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

SEC. 459. SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without congressional action, medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007. From 1991 through 2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities, and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts in 2004 and the following years that result from the SGR formula.

On page 542, strike lines 18 through 23, and insert the following:

"(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term 'review entity' means an entity of up to 3 qualified reviewers drawn from existing appeals levels other than the redetermination level.".

On page 569, between lines 3 and 4, insert the following:

SEC. 518. REVISIONS TO APPEALS TIMEFRAMES.

Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking "30-day period" each place it appears and inserting "60-day period";

(2) in subsection (c)(3)(C)(i), by striking "30-day period" and inserting "60-day period";

(3) in subsection (d)(1)(A), by striking "90-day period" and inserting "120-day period"; and

(4) in subsection (d)(2)(A), by striking "90-day period" and inserting "120-day period".

SEC. 519. ELIMINATION OF REQUIREMENT TO USE SOCIAL SECURITY ADMINISTRATION ADMINISTRATIVE LAW JUDGES.

The first sentence of section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking "of the Social Security Administration".

SEC. 520. ELIMINATION OF REQUIREMENT FOR DE NOVO REVIEW BY THE DEPARTMENTAL APPEALS BOARD.

Section 1869(d)(2) (42 U.S.C. 1395ff(d)(2)) is amended to read as follows:

"(2) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.".

On page 595, strike lines 1 through 6.

On page 603, after line 25, insert the following:

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).

On page 625, between lines 19 and 20, insert the following:

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services and inpatient hospital services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of enactment of this Act.

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking "hospice services" and inserting "hospice care and post-hospital extended care services"; and

(B) by inserting before the period at the end the following: "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management physician services under title XVIII of Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 554. COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395ee), as amended by section 534(a), is amended by adding at the end the following new subsection:

"(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

"(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.".

SEC. 555. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

"(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

"(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of enactment of this Act.

On page 629, between lines 17 and 18, insert the following:

(d) URBAN HEALTH PROVIDER ADJUSTMENT.—

(1) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to paragraph (3), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in paragraph (2) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

(2) HOSPITAL DESCRIBED.—A hospital is described in this paragraph if the hospital—

(A) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(B) is located in Marion County, Indiana.

(3) LIMITATION.—The payment adjustment described in paragraph (1) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(1)(A)).

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r–4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).".

On page 676, after line 22, add the following:

SEC. 615. EMPLOYER FLEXIBILITY.

(a) MEDICARE.—Nothing in part D of title XVIII of the Social Security Act, as added by section 101, shall be construed as—

(1) preventing employment-based retiree health coverage (as defined in section 1860D–20(e)(4)(B) of such Act, as so added) from providing coverage that is supplemental to the benefits provided under a Medicare Prescription Drug plan under such part or a MedicareAdvantage plan under part C of such title, as amended by this Act; or

(2) requiring employment-based retiree health coverage (as so defined) that provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act or under a plan maintained by a State or an agency thereof to provide medical benefits, or the same medical benefits, to retired participants who are so eligible.

(b) ADEA.—

(1) IN GENERAL.—Section 4(l) of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 623(l)) is amended by adding at the end the following:

"(4) An employee benefit plan (as defined in section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3))) shall not be treated as violating subsection (a), (b), (c), or (e) solely because the plan provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a plan maintained by a State or an agency thereof, but does not provide medical benefits, or the same medical benefits, to retired participants who are so eligible."

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply as of the date of the enactment of this Act.

SEC. 616. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ", and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider" before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SEC. 617. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking "until December 31, 2002", and

(2) by striking "Kent Community Hospital Complex in Michigan or."

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SEC. 618. GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G-7 COUNTRIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. The study shall include the following:

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance.

(2) The proportion of the cost for innovation borne by American consumers, compared with consumers in the other 6 countries.

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production ("Ramsey prices").

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health.

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States.

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied.

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant.

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violations of intellectual property rights for prescription medicines.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).

SEC. 619. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

"PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

"(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

"(1) REVIEW.—The Commission shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

"(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

"(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

"(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

"(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

"(E) supporting the development of new data systems where existing data are insufficient or inadequate;

"(F) developing criteria and indicators of impending core health care safety net failure;

"(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

"(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

"(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

"(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

"(ii) the degree to which these plans may be overburdened by adverse selection; and

"(iii) the degree to which emergency departments are used by enrollees of these plans; and

"(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

"(2) Reports.—

"(A) Annual reports.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

"(i) the health care needs of the uninsured; and

"(ii) the financial and infrastructure stability of the Nation's core health care safety net.

"(B) Agenda and additional reviews.—

"(i) Agenda.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

"(ii) Additional reviews.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

"(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

"(II) If the Commission deems such additional reviews and reports appropriate.

"(C) Availability of reports.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(3) Definitions.—In this section:

"(A) Appropriate committees of Congress.—The term 'appropriate committees of Congress' means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

"(B) Core health care safety net.—The term 'core health care safety net' means any health care provider that—

"(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

"(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

"(C) Health care safety net programs.—The term 'health care safety net programs' includes the following:

"(i) Medicaid.—The medicaid program under title XIX.

"(ii) SCHIP.—The State children's health insurance program under title XXI.

"(iii) Maternal and child health services block grant program.—The maternal and child health services block grant program under title V.

"(iv) FQHC programs.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(1)(2)(B)) receives funds.

"(v) RHC programs.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(1)(1)) receives funds.

"(vi) DSH payment programs.—Each federally funded program under which a disproportionate share hospital receives funds.

"(vii) Emergency medical treatment and active labor act.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

"(viii) Other health care safety net programs.—Such term also includes any other health care program that the Commission determines to be appropriate.

"(D) Vulnerable populations.—The term 'vulnerable populations' includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

"(c) Membership.—

"(1) Number and appointment.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the 'Comptroller General'), in consultation with the appropriate committees of Congress.

"(2) Qualifications.—

"(A) In general.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

"(B) Inclusion.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

"(C) Majority nonproviders.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

"(D) Ethical disclosure.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

"(3) Terms.—

"(A) In general.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

"(i) four to serve a term of 1 year;

"(ii) four to serve a term of 2 years; and

"(iii) five to serve a term of 3 years.

"(B) Vacancies.—

"(i) In general.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

"(ii) Appointment.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

"(iii) Terms.—A member may serve after the expiration of that member's term until a successor has taken office.

"(4) Compensation.—

"(A) Members.—While serving on the business of the Commission (including travel time), a member of the Commission—

"(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

"(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

"(B) Treatment.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(5) Chair; vice chair.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

"(6) Meetings.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

"(d) Director and Staff; Experts and Consultants.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

"(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

"(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(4) make advance, progress, and other payments which relate to the work of the Commission;

"(5) provide transportation and subsistence for persons serving without compensation; and

"(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(e) Powers.—

"(1) Obtaining official data.—

"(A) In general.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

“(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

“(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

“(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

“(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

“(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

“(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

“(g) AUTHORIZATION OF APPROPRIATIONS.—

“(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

“(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.”.

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SEC. 620. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—

(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:

“(8) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

“(A) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

“(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

“(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(6); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(i) IN GENERAL.—A skilled nursing facility may not knowingly employ any skilled nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a skilled nursing facility may provide for a provisional period of employment for a skilled nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the covered individual during the worker's provisional period of employment.

“(iii) EXCEPTION FOR SMALL RURAL SKILLED NURSING FACILITIES.—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of skilled nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) REPORTING REQUIREMENTS.—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) USE OF INFORMATION.—

“(i) IN GENERAL.—A skilled nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility that, in denying employment for an individual selected for hiring as a skilled nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) CIVIL PENALTY.—

“(i) IN GENERAL.—A skilled nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, $2,000; and

“(II) for the second and each subsequent violation within any 5-year period, $5,000.

“(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a skilled nursing facility that—

“(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

“(F) DEFINITIONS.—In this paragraph:

“(i) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

“(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

“(II) such other types of acts as the Secretary may specify in regulations.

“(iv) SKILLED NURSING FACILITY WORKER.—The term ‘skilled nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.”.

(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396r(b)) is amended by adding at the end the following new paragraph:

“(8) SCREENING OF NURSING FACILITY WORKERS.—

“(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a nursing facility selects an individual for a position as a nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give the worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

“(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

“(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(8); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(i) IN GENERAL.—A nursing facility may not knowingly employ any nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a nursing facility may provide for a provisional period of employment for a nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the worker during the worker's provisional period of employment.

“(iii) EXCEPTION FOR SMALL RURAL NURSING FACILITIES.—

“(I) IN GENERAL.—In the case of a small rural nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) REPORTING REQUIREMENTS.—A nursing facility shall report to the State any instance in which the facility determines that a nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) USE OF INFORMATION.—

“(i) IN GENERAL.—A nursing facility that obtains information about a nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) IMMUNITY FROM LIABILITY.—A nursing facility that, in denying employment for an individual selected for hiring as a nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) CIVIL PENALTY.—

“(i) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, $2,000; and

“(II) for the second and each subsequent violation within any 5-year period, $5,000.

“(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that—

“(I) knowingly continues to employ a nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

“(F) DEFINITIONS.—In this paragraph:

“(i) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a nursing facility worker has committed—

“(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

“(II) such other types of acts as the Secretary may specify in regulations.

“(iv) NURSING FACILITY WORKER.—The term ‘nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.”.

(2) FEDERAL RESPONSIBILITIES.—

(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisional employee at a nursing facility may complete and Federal and State agencies may use to conduct the criminal background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate response to long-term care providers using the system.

(3) NO PREEMPTION OF STRICTER STATE LAWS.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8), 1396r(b)(8)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1128E(g)(6) of the Social Security Act (as added by subsection (e)) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as so defined) to conduct a background check prior to employing an individual in an employment position that is not included in the positions for which a background check is required under such sections.

(4) TECHNICAL AMENDMENTS.—Effective as if included in the enactment of section 941 of BIPA (114 Stat. 2763A–585), sections 1819(b) and 1919(b) (42 U.S.C. 1395i–3(b), 1396r(b)), as amended by such section 941 are each amended by redesignating the paragraph (8) added by such section as paragraph (9).

(b) FEDERAL AND STATE REQUIREMENTS CONCERNING BACKGROUND CHECKS.—

(1) MEDICARE.—Section 1819(e) (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following:

“(6) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

“(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

“(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

“(C) STATE REPORTING OF INFORMATION TO SKILLED NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

“(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

“(ii) immediately report to the skilled nursing facility in writing the results of such review; and

“(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

“(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

“(i) AUTHORITY TO CHARGE FEES.—

“(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation until expended.

“(II) STATE.—A State may charge a skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

“(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

“(E) REGULATIONS.—

“(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(9), including regulations regarding the security confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

“(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

“(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

“(i) the number of requests for searches and exchanges of records made under this section;

“(ii) the disposition of such requests; and

“(iii) the cost of responding to such requests.”.

(2) MEDICAID.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

“(8) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

“(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

“(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

“(C) STATE REPORTING OF INFORMATION TO NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

“(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

“(ii) immediately report to the nursing facility in writing the results of such review; and

“(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

“(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

“(i) AUTHORITY TO CHARGE FEES.—

“(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation, until expended.

“(II) STATE.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

“(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

“(E) REGULATIONS.—

“(i) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

“(ii) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

“(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

“(i) the number of requests for searches and exchanges of records made under this section;

“(ii) the disposition of such requests; and

“(iii) the cost of responding to such requests.”.

(c) APPLICATION TO OTHER ENTITIES PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES.—

(1) MEDICARE.—Part D of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

“APPLICATION OF SKILLED NURSING FACILITY PREVENTIVE ABUSE PROVISIONS TO ANY PROVIDER OF SERVICES OR OTHER ENTITY PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES

“SEC. 1897. (a) IN GENERAL.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a 'medicare beneficiary').

“(b) SUPERVISION OF PROVISIONAL EMPLOYEES.—

“(1) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1819(b)(8)(B)(ii) or 1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

"(2) REQUIREMENTS.—The regulations required under paragraph (1) shall provide the following:

"(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a medicare beneficiary.

"(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

"(i) Follow-up telephone calls to the medicare beneficiary.

"(ii) Unannounced visits to the medicare beneficiary's home while the provisional employee is serving the medicare beneficiary.

"(iii) To the extent practicable, limiting the provisional employee's duties to serving only those medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the medicare beneficiary is present.

"(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such regulations should encourage the provision of monitoring and oversight activities whenever practicable with respect to such an entity, and if such activities would not impose an unreasonable cost or other burden on the entity.".

(2) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a), as amended by section 104(a), is amended—

(A) in paragraph (65), by striking "and" at the end;

(B) in paragraph (66), by striking the period and inserting "; and"; and

(C) by inserting after paragraph (66) the following:

"(67) provide that any entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services for which medical assistance is available under the State plan to individuals requiring long-term care complies with the requirements of subsections (b)(8) and (e)(8) of section 1919 and section 1897(b) (in the same manner as such section applies to a medicare beneficiary).".

(3) EXPANSION OF STATE NURSE AIDE REGISTRY.—

(A) MEDICARE.—Section 1819 (42 U.S.C. 1395i-3) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking "NURSE AIDE REGISTRY" and inserting "EMPLOYEE REGISTRY";

(II) in subparagraph (A)—

(aa) by striking "By not later than January 1, 1989, the" and inserting "The";

(bb) by striking "a registry of all individuals" and inserting "a registry of (i) all individuals"; and

(cc) by inserting before the period the following: ", (ii) all other skilled nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property"; and

(III) in subparagraph (C), by striking "a nurse aide" and inserting "an individual"; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: "The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a skilled nursing facility employee of a resident in a skilled nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii)."; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "NURSE AIDE"; and

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (i)(I), by striking "nurse aide" and inserting "individual".

(B) MEDICAID.—Section 1919 (42 U.S.C. 1396r) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking "NURSE AIDE REGISTRY" and inserting "EMPLOYEE REGISTRY";

(II) in subparagraph (A)—

(aa) by striking "By not later than January 1, 1989, the" and inserting "The";

(bb) by striking "a registry of all individuals" and inserting "a registry of (i) all individuals"; and

(cc) by inserting before the period the following: ", (ii) all other nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of an entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property"; and

(III) in subparagraph (C), by striking "a nurse aide" and inserting "an individual"; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: "The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility employee of a resident in a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii)."; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "NURSE AIDE"; and

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (i)(I), by striking "nurse aide" and inserting "individual".

(d) REIMBURSEMENT OF COSTS FOR BACKGROUND CHECKS.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1819(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1395i-3(b)(8), 1396r(b)(8)), as added by this section.

(e) INCLUSION OF ABUSIVE ACTS WITHIN A LONG-TERM CARE FACILITY OR PROVIDER IN THE NATIONAL HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.—

(1) IN GENERAL.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a-7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

"(v) A finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient's or resident's property.".

(2) COVERAGE OF LONG-TERM CARE FACILITY OR PROVIDER EMPLOYEES.—Section 1128E(g)(2) (42 U.S.C. 1320a-7e(g)(2)) is amended by inserting ", and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, providing services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)" before the period.

(3) REPORTING BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

(A) IN GENERAL.—Section 1128E(b)(1) (42 U.S.C. 1320a-7e(b)(1)) is amended by striking "and health plan" and inserting ", health plan, and long-term care facility or provider".

(B) CORRECTION OF INFORMATION.—Section 1128E(c)(2) (42 U.S.C. 1320a-7e(c)(2)) is amended by striking "and health plan" and inserting ", health plan, and long-term care facility or provider".

(4) ACCESS TO REPORTED INFORMATION.—Section 1128E(d)(1) (42 U.S.C. 1320a-7e(d)(1)) is amended by striking "and health plans" and inserting ", health plans, and long-term care facilities or providers".

(5) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—Section 1128E(d) (42 U.S.C. 1320a-7e(d)) is amended by adding at the end the following:

"(3) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—A long-term care facility or provider shall check the database maintained under this section prior to hiring under an employment or other contract, or both, (other than in a provisional status) any individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, that will provide services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants).".

(6) DEFINITION OF LONG-TERM CARE FACILITY OR PROVIDER.—Section 1128E(g) (42 U.S.C. 1320a–7e(g)) is amended by adding at the end the following:

"(6) LONG-TERM CARE FACILITY OR PROVIDER.—The term 'long-term care facility or provider' means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(dd)(1)), a long-term care hospital (as described in section 1886(d)(1)(B)(iv)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, home health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program under title XVIII or the medicaid program under title XIX.".

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the amendments made by this subsection, $10,200,000 for fiscal year 2004.

(f) PREVENTION AND TRAINING DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall be a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to—

(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsman programs, the long-term care industry, and local community members;

(B) examine patient care issues relating to regulatory oversight, community involvement, and facility staffing and management with a focus on staff training, staff stress management, and staff supervision;

(C) examine the use of patient abuse prevention training programs by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used; and

(D) identify and disseminate best practices for preventing and reducing patient abuse.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—With respect to a skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a)) or a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 6 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2006.

(2) LONG-TERM CARE FACILITIES AND PROVIDERS.—With respect to a long-term care facility or provider (as defined in section 1128E(g)(6) of the Social Security Act (42 U.S.C. 1320a–7e(g)(6)) (as added by subsection (e)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 18 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2007.

SEC. 621. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking "and" after the comma at the end;

(2) in paragraph (4), by inserting "and" after the comma at the end; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.".

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to conduct a hearing during the session of the Senate on Thursday, June 26, 2003. The purpose of this hearing will be to review H.R. 1904, the Healthy Forests Restoration Act of 2003.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 26, 2003, at 10 a.m. to conduct a hearing on "Affiliate Sharing Practices and Their Relationship with the Fair Credit Reporting Act."

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on June 26, 2003, at 9:30 a.m. on pending committee business.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session on Thursday, June 26, 2003, at 10:00 a.m., to hear testimony on the Nominations of Josette Sheeran Shiner, to Deputy United States Trade Representative, Executive Office of the President and James J. Jochum, to be Assistant Secretary, Department of Commerce.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 26, 2003, at 9:15 a.m. to hold a Business Meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 26, 2003, at 2 p.m. to hold a hearing on the Department of State's Office of Children's Issues—Responding to International Parental Abduction.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Thursday, June 26, 2003, at a time and location to be determined to consider the nominations of Joshua B. Bolten to be Director of the Office of Management and Budget; Fern Flanagan Saddler to be an Associate Judge of the Superior Court of the District of Columbia; and Judith Nan Macaluso to be an Associate Judge of the Superior Court of the District of Columbia.

Agenda

Nominations: Joshua B. Bolten to be Director of the Office of Management and Budget; Fern Flanagan Saddler to be an Associate Judge of the Superior Court for the District of Columbia; and Judith Nan Macaluso to be an Associate Judge of the Superior Court for the District of Columbia.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Thursday, June 26, 2003, at 11 a.m., in room 485 of the Russell Senate Office Building to conduct a business meeting on pending committee matters.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. MCCONNELL. I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on Thursday, June 26, 2003, at 9:30 a.m., in SDG 50.

I. Continuation of S. 1125, Fairness in Asbestos Injury Resolution Act of 2003 ("The FAIR Act") mark-up.

II. Nominations: William H. Pryor, Jr., to be United States Circuit Judge for the Eleventh Circuit; Diane M. Stuart to be Director, Violence Against Women Office, United States Department of Justice; and Thomas M. Hardiman to be United States District Judge for the Western District of Pennsylvania.

III. Bills: S.J. Res. 1, a joint resolution proposing an amendment to the constitution of the United States to protect the rights of crime victims [Kyl, Chambliss, Cornyn, Craig, DeWine, Feinstein, Graham, Grassley]; S. 1280, a bill to amend the Protect Act to clarify the liability of the National Center for Missing and Exploited Children [Hatch, Biden]; S. 174, a resolution designating Thursday, November 20, 2003, as "Feed America Thursday" [Hatch]; and S. 175, a resolution designating the month of October 2003, as "Family History Month" [Hatch].

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON TERRORISM, TECHNOLOGY, AND HOMELAND SECURITY

Mr. McCONNELL. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on Terrorism, Technology, and Homeland Security be authorized to meet to conduct a hearing on "Terrorism: Growing Wahhabi Influence in the United States" on Thursday, June 26, 2003 at 2 p.m., in Dirksen 226.

Panel I: David Aufhauser, General Counsel, U.S. Treasury Department, Washington, DC; and Larry A. Mefford, Assistant Director, Counterterrorism Division, Federal Bureau of Investigation, Washington, DC.

Panel 2: Dr. Alex Alexiev, Distinguished Fellow, Center for Security Policy, Washington, DC; and Stephen Schwartz, Senior Fellow, Foundation for Defense of Democracies, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS-CONSENT REQUEST—EXECUTIVE CALENDAR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nominations on today's Executive Calendar: Calendar Nos. 48 and 49, the nominations of Daniel Pearson and Charlotte A. Lane, to be members of the U.S. International Trade Commission, which have been pending on the Executive Calendar since March 5. I further ask unanimous consent that the nominations be confirmed, the motions to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDING OFFICER. Is there objection.

Mr. FRIST. Mr. President, on behalf of my colleagues on the other side of the aisle, I object to my own request.

The PRESIDING OFFICER. Objection is heard.

IMPROVING THE EFFICIENCY OF THE NATION'S PAYMENTS SYSTEM

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 168, S. 1334.

The PRESIDING OFFICER. The clerk will state the bill by title.

The legislative clerk read as follows:

A bill (S. 1334) to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. Mr. President, I ask unanimous consent that the bill be read the third time, the Banking Committee be discharged from further consideration of H.R. 1474, and the Senate proceed to its immediate consideration; that all after the enacting clause be stricken and the text of S. 1334 be inserted in lieu thereof; that the bill, as amended, be read the third time and passed; that the motion to reconsider be laid upon the table, and that any statements regarding the measure be printed in the RECORD. I further ask unanimous consent that S. 1334 be returned to the calendar.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 1474), as amended, was passed, as follows:

Resolved, That the bill from the House of Representatives (H.R. 1474) entitled "An Act to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes.", do pass with the following amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Check Truncation Act of 2003".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings and purposes.
Sec. 3. Definitions.
Sec. 4. General provisions governing substitute checks.
Sec. 5. Substitute check warranties.
Sec. 6. Indemnity.
Sec. 7. Expedited recredit for consumers.
Sec. 8. Expedited recredit procedures for banks.
Sec. 9. Delays in an emergency.
Sec. 10. Measure of damages.
Sec. 11. Statute of limitations and notice of claim.
Sec. 12. Consumer awareness.
Sec. 13. Effect on other law.
Sec. 14. Regulations.
Sec. 15. Study and report on funds availability.
Sec. 16. Evaluation and report by the Comptroller General.
Sec. 17. Variation by agreement.
Sec. 18. Effective date.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) the Expedited Funds Availability Act (12 U.S.C. 4001 et seq.)—

(A) directs the Board to consider establishing regulations requiring Federal reserve banks and depository institutions to provide for check truncation, in order to improve the check processing system;

(B) authorizes the Board to regulate all aspects of the payment system, including the receipt, payment, collection, and clearing of checks, and related functions of the payment system pertaining to checks; and

(C) directs that the exercise of such authority by the Board shall supersede any State law, including the Uniform Commercial Code, as in effect in any State; and

(2) check truncation is no less desirable in 2003 for both financial service customers and the financial services industry, to reduce costs, improve efficiency in check collections, and expedite funds availability for account holders than it was in 1987, when Congress first directed the Board to consider establishing such a process.

(b) PURPOSES.—The purposes of this Act are—

(1) to facilitate check truncation by authorizing substitute checks;

(2) to foster innovation in the check collection system without mandating receipt of checks in electronic form; and

(3) to improve the overall efficiency of the Nation's payments system.

SEC. 3. DEFINITIONS.

In this Act, the following definitions shall apply:

(1) ACCOUNT.—The term "account" means a deposit account at a bank.

(2) BANK.—The term "bank"—

(A) means any person located in a State engaged in the business of banking, including any depository institution; and

(B) includes—

(i) any Federal reserve bank;

(ii) any Federal home loan bank; and

(iii) to the extent that it acts as a payor—

(I) the Treasury of the United States;

(II) the United States Postal Service;

(III) a State government; and

(IV) a unit of general local government.

(3) BANKING TERMS.—

(A) COLLECTING BANK.—The term "collecting bank" means any bank handling a check for collection except the paying bank.

(B) DEPOSITARY BANK.—The term "depositary bank" means—

(i) the first bank to which a check is transferred, even if such bank is also the paying bank or the payee; or

(ii) a bank to which a check is transferred for deposit in an account at such bank, even if the check is physically received and endorsed first by another bank.

(C) DEPOSITORY INSTITUTION.—The term "depository institution" has the same meaning as in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A)).

(D) PAYING BANK.—The term "paying bank" means—

(i) the bank by which a check is payable, unless the check is payable at or through another bank and is sent to the other bank for payment or collection; or

(ii) the bank at or through which a check is payable and to which the check is sent for payment or collection.

(E) RETURNING BANK.—

(i) IN GENERAL.—The term "returning bank" means a bank (other than the paying or depositary bank) handling a returned check or notice in lieu of return.

(ii) TREATMENT AS COLLECTING BANK.—No provision of this Act shall be construed as affecting the treatment of a returning bank as a collecting bank for purposes of section 4–202(b) of the Uniform Commercial Code.

(4) BOARD.—The term "Board" means the Board of Governors of the Federal Reserve System.

(5) BUSINESS DAY.—The term "business day" has the same meaning as in section 602(3) of the Expedited Funds Availability Act (12 U.S.C. 4001(3)).

(6) CHECK.—The term "check"—

(A) means a draft, payable on demand and drawn on or payable through or at an office of a bank, whether or not negotiable, that is handled for forward collection or return, including a substitute check and a travelers check; and

(B) does not include a noncash item or an item payable in a medium other than United States dollars.

(7) CONSUMER.—The term "consumer" means an individual who—

(A) with respect to a check handled for forward collection, draws the check on a consumer account; or

(B) with respect to a check handled for return, deposits the check into, or cashes the check against, a consumer account.

(8) CONSUMER ACCOUNT.—The term "consumer account" has the same meaning as in section 602(10) of the Expedited Funds Availability Act (12 U.S.C. 4001(10)).

(9) CUSTOMER.—The term "customer" means a person having an account with a bank.

(10) FORWARD COLLECTION.—The term "forward collection" means the transfer by a bank of a check to a collecting bank for settlement or the paying bank for payment.

(11) INDEMNIFYING BANK.—The term "indemnifying bank" means a bank that is providing an indemnity under section 6 with respect to a substitute check.

(12) MICR LINE.—The term "MICR line" or "magnetic ink character recognition line" means the numbers, which may include the bank routing number, account number, check number, check amount, and other information, that are printed near the bottom of a check in magnetic ink in accordance with generally applicable industry standards.

(13) NONCASH ITEM.—The term "noncash item" has the same meaning as in section 602(14) of the Expedited Funds Availability Act (12 U.S.C. 4001(14)).

(14) PERSON.—The term "person" means a natural person, corporation, unincorporated company, partnership, government unit or instrumentality, trust, or any other entity or organization.

(15) RECONVERTING BANK.—The term "reconverting bank" means—

(A) the bank that creates a substitute check; or

(B) if a substitute check is created by a person other than a bank, the first bank that transfers or presents such substitute check.

(16) SUBSTITUTE CHECK.—The term "substitute check" means a paper reproduction of the original check that—

(A) contains an image of the front and back of the original check;

(B) bears a MICR line containing all the information appearing on the MICR line of the original check, except as provided under generally applicable industry standards for substitute checks to facilitate the processing of substitute checks;

(C) conforms, in paper stock, dimension, and otherwise, with generally applicable industry standards for substitute checks; and

(D) is suitable for automated processing in the same manner as the original check.

(17) STATE.—The term "State" has the same meaning as in section 3(a) of the Federal Deposit Insurance Act (12 U.S.C. 1813(a)).

(18) TRUNCATE.—The term "truncate" means to remove an original paper check from the check collection or return process and send to a recipient, in lieu of such original paper check, a substitute check or, by agreement, information relating to the original check (including data taken from the MICR line of the original check or an electronic image of the original check), whether with or without subsequent delivery of the original paper check.

(19) UNIFORM COMMERCIAL CODE.—The term "Uniform Commercial Code" means the Uniform Commercial Code in effect in a State.

(20) UNIT OF GENERAL LOCAL GOVERNMENT.—The term "unit of general local government" has the same meaning as in section 602(24) of the Expedited Funds Availability Act (12 U.S.C. 4001(24)).

(21) OTHER TERMS.—Unless the context requires otherwise, terms used in this Act that are not defined in this section shall have the same meanings as in the Uniform Commercial Code.

SEC. 4. GENERAL PROVISIONS GOVERNING SUBSTITUTE CHECKS.

(a) NO AGREEMENT REQUIRED.—A person may deposit, present, or send for collection or return a substitute check without an agreement with the recipient, to the extent that the bank has made the warranties described in section 5 with respect to the substitute check.

(b) LEGAL EQUIVALENCE.—A substitute check shall be the legal equivalent of an original check for all purposes, including any provision of any Federal or State law, and for all persons, if the substitute check—

(1) accurately represents all of the information on the front and back of the original check as of the time at which the original check was truncated; and

(2) bears the legend: "This is a legal copy of your check. You can use it the same way you would use the original check.".

(c) ENDORSEMENTS.—A reconverting bank shall ensure that the substitute check for which the bank is the reconverting bank bears all endorsements applied by parties that previously handled the check (whether in electronic form or in the form of the original paper check or a substitute check) for forward collection or return.

(d) IDENTIFICATION OF RECONVERTING BANK.—A reconverting bank shall identify itself as a reconverting bank on any substitute check for which the bank is a reconverting bank, so as to preserve any previous reconverting bank identifications, in conformance with generally applicable industry standards.

(e) APPLICABLE LAW.—A substitute check that is the legal equivalent of the original check under subsection (b) shall be subject to any provision, including any provision relating to the protection of consumers, of part 229 of title 12, Code of Federal Regulations (or any successor thereto), the Uniform Commercial Code, and any other applicable Federal or State law that would apply if the substitute check were the original check, to the extent that such provision of law is not inconsistent with this Act.

SEC. 5. SUBSTITUTE CHECK WARRANTIES.

A bank that transfers, presents, or returns a substitute check and receives consideration for the check warrants to the transferee, any subsequent collecting or returning bank, the depositary bank, the drawee, the drawer, the payee, the depositor, and any endorser (regardless of whether the warrantee receives the substitute check or another paper or electronic form of the substitute check or original check) that—

(1) the substitute check meets all the requirements for legal equivalence under section 4(b); and

(2) no depositary bank, drawee, drawer, or endorser will receive presentment or return of the substitute check, the original check, or a copy or other paper or electronic version of the substitute check or original check such that it will be asked to make a payment based on a check it has already paid.

SEC. 6. INDEMNITY.

(a) INDEMNITY.—A reconverting bank and each bank that subsequently transfers, presents, or returns a substitute check in any electronic or paper form, and receives consideration for such transfer, presentment, or return shall indemnify the transferee, any subsequent collecting or returning bank, the depositary bank, the drawee, the drawer, the payee, the depositor, and any endorser, up to the amounts described in subsections (b) and (c), as applicable, to the extent of any loss incurred by any recipient of a substitute check if that loss occurred due to the receipt of a substitute check instead of the original check.

(b) INDEMNITY AMOUNT.—

(1) AMOUNT IN EVENT OF BREACH OF WARRANTY.—The amount of the indemnity under subsection (a) shall be the amount of any loss (including costs and reasonable attorney fees and other expenses of representation) proximately caused by a breach of a warranty established under section 5.

(2) AMOUNT IN ABSENCE OF BREACH OF WARRANTY.—In the absence of a breach of a warranty established under section 5, the amount of the indemnity under subsection (a) shall be the sum of—

(A) the amount of any loss, up to the amount of the substitute check; and

(B) interest and expenses (including costs and reasonable attorney fees and other expenses of representation).

(c) COMPARATIVE NEGLIGENCE.—

(1) IN GENERAL.—If a loss under subsection (a) results in whole or in part from the negligence or failure to act in good faith on the part of an indemnified party, then the indemnification of that party under this section shall be reduced in proportion to the amount of negligence or bad faith attributable to that party.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection reduces the rights of a consumer or any other person under the Uniform Commercial Code or other applicable provision of Federal or State law.

(d) EFFECT OF PRODUCING ORIGINAL CHECK OR SUBSTITUTE CHECK.—

(1) IN GENERAL.—If the indemnifying bank produces the original check or a copy of the original check (including an image or a substitute check) that accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated), or is otherwise sufficient to determine whether or not a claim is valid, the indemnifying bank shall—

(A) be liable under this section only for losses covered by the indemnity that are incurred up to the time that the original check or copy is provided to the indemnified party; and

(B) have a right to the return of any funds it has paid under the indemnity in excess of those losses.

(2) COORDINATION OF INDEMNITY WITH IMPLIED WARRANTY.—The production of the original check, substitute check, or copy under paragraph (1) by an indemnifying bank shall not absolve the bank from any liability on a warranty established under this Act or any other provision of law.

(e) SUBROGATION OF RIGHTS.—

(1) IN GENERAL.—Each indemnifying bank shall be subrogated to the rights of any indemnified party to the extent of the indemnity.

(2) RECOVERY UNDER WARRANTY.—A bank that indemnifies a party under this section may attempt to recover from another party based on a warranty or other claim.

(3) Duty of indemnified party.—Each indemnified party shall have a duty to comply with all reasonable requests for assistance from an indemnifying bank in connection with any claim that the indemnifying bank brings against a warrantor or other party related to a check that forms the basis for the indemnification.

SEC. 7. EXPEDITED RECREDIT FOR CONSUMERS.

(a) Recredit Claims.—

(1) In general.—A consumer may make a claim for expedited recredit from the bank that holds the account of the consumer with respect to a substitute check, if the consumer asserts in good faith that—

(A) the bank charged the consumer account for a substitute check that was provided to the consumer;

(B) either—

(i) the check was not properly charged to the consumer account; or

(ii) the consumer has a warranty claim with respect to such substitute check;

(C) the consumer suffered a resulting loss; and

(D) the production of the original check or a better copy of the original check is necessary to determine the validity of any claim described in subparagraph (B).

(2) 40-day period.—Any claim under paragraph (1) with respect to a consumer account may be submitted by a consumer before the end of the 40-day period beginning on the later of—

(A) the date on which the financial institution mails or delivers, by a means agreed to by the consumer, the periodic statement of account for such account which contains information concerning the transaction giving rise to the claim; or

(B) the date on which the substitute check is made available to the consumer.

(3) Extension under extenuating circumstances.—If the ability of the consumer to submit the claim within the 40-day period under paragraph (2) is delayed due to extenuating circumstances, including extended travel or the illness of the consumer, the 40-day period shall be extended by a reasonable amount of time.

(b) Procedures for Claims.—

(1) In general.—To make a claim for an expedited recredit under subsection (a) with respect to a substitute check, the consumer shall provide to the bank that holds the account of such consumer—

(A) a description of the claim, including an explanation of—

(i) why the substitute check was not properly charged to the subject consumer account; or

(ii) the warranty claim with respect to such check;

(B) a statement that the consumer suffered a loss and an estimate of the amount of the loss;

(C) the reason why production of the original check or a better copy of the original check is necessary to determine the validity of the charge to the subject consumer account or the warranty claim; and

(D) sufficient information to identify the substitute check and to investigate the claim.

(2) Claim in writing.—

(A) In general.—The bank holding the consumer account that is the subject of a claim by the consumer under subsection (a) may, in the discretion of the bank, require the consumer to submit the information required under paragraph (1) in writing.

(B) Means of submission.—A bank that requires a submission of information under subparagraph (A) may permit the consumer to make the submission electronically, if the consumer has agreed to communicate with the bank in that manner.

(c) Recredit to Consumer.—

(1) Conditions for recredit.—The bank shall recredit a consumer account in accordance with paragraph (2) for the amount of a substitute check that was charged against the consumer account, if—

(A) a consumer submits a claim to the bank with respect to that substitute check that meets the requirement of subsection (b); and

(B) the bank has not—

(i) provided to the consumer—

(I) the original check; or

(II) a copy of the original check (including an image or a substitute check) that accurately represents all of the information on the front and back of the original check, as of the time at which the original check was truncated; and

(ii) demonstrated to the consumer that the substitute check was properly charged to the consumer account.

(2) Timing of recredit.—

(A) In general.—The bank shall recredit the subject consumer account for the amount described in paragraph (1) not later than the end of the business day following the business day on which the bank determines the claim of the consumer is valid.

(B) Recredit pending investigation.—If the bank has not determined that the claim of the consumer is valid before the end of the 10th business day after the business day on which the consumer submitted the claim, the bank shall recredit the subject consumer account for—

(i) the lesser of the amount of the substitute check that was charged against the consumer account, or $2,500, together with interest if the account is an interest-bearing account, not later than the end of such 10th business day; and

(ii) the remaining amount of the substitute check that was charged against the consumer account, if any, together with interest if the account is an interest-bearing account, not later than the 45th calendar day following the business day on which the consumer submits the claim.

(d) Availability of Recredit.—

(1) Next business day availability.—Except as provided in paragraph (2), a bank that provides a recredit to a consumer account under subsection (c) shall make the recredited funds available for withdrawal by the consumer by the start of the next business day after the business day on which the bank recredits the consumer account under subsection (c).

(2) Safeguard exceptions.—A bank may delay availability to a consumer of a recredit provided under subsection (c)(2)(B)(i) until the start of either the business day following the business day on which the bank determines that the claim of the consumer is valid, or the 45th calendar day following the business day on which the consumer submits a claim for such recredit in accordance with subsection (b), whichever is earlier, in any of the following circumstances:

(A) New accounts.—The claim is made during the 30-day period beginning on the business day on which the consumer account was established.

(B) Repeated overdrafts.—Without regard to the charge that is the subject of the claim for which the recredit was made—

(i) on 6 or more business days during the 6-month period ending on the date on which the consumer submits the claim, the balance in the consumer account was negative or would have become negative if checks or other charges to the account had been paid; or

(ii) on 2 or more business days during such 6-month period, the balance in the consumer account was negative or would have become negative in the amount of $5,000 or more if checks or other charges to the account had been paid.

(C) Prevention of fraud losses.—The bank has reasonable cause to believe that the claim is fraudulent, based on facts (other than the fact that the check in question or the consumer is of a particular class) that would cause a well-grounded belief in the mind of a reasonable person that the claim is fraudulent.

(3) Overdraft fees.—No bank that, in accordance with paragraph (2), delays the availability of a recredit under subsection (c) to any consumer account may impose any overdraft fees with respect to drafts drawn by the consumer on such recredited amount before the end of the 5-day period beginning on the date on which notice of the delay in the availability of such amount is sent by the bank to the consumer.

(e) Reversal of Recredit.—A bank may reverse a recredit to a consumer account if the bank—

(1) determines that a substitute check for which the bank recredited a consumer account under subsection (c) was in fact properly charged to the consumer account; and

(2) notifies the consumer in accordance with subsection (f)(3).

(f) Notice to Consumer.—

(1) Notice if consumer claim not valid.—If a bank determines that a substitute check subject to the claim of a consumer under this section was in fact properly charged to the consumer account, the bank shall send to the consumer, not later than the business day following the business day on which the bank makes the determination—

(A) the original check or a copy of the original check (including an image or a substitute check) that—

(i) accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated); or

(ii) is otherwise sufficient to determine whether or not the claim of the consumer is valid; and

(B) an explanation of the basis for the determination by the bank that the substitute check was properly charged, including a statement that the consumer may request copies of any information or documents on which the bank relied in making the determination.

(2) Notice of recredit.—If a bank recredits a consumer account under subsection (c), the bank shall send to the consumer, not later than the business day following the business day on which the bank makes the recredit, a notice of—

(A) the amount of the recredit; and

(B) the date on which the recredited funds will be available for withdrawal.

(3) Notice of reversal of recredit.—In addition to the notice required under paragraph (1), if a bank reverses a recredited amount under subsection (e), the bank shall send to the consumer, not later than the business day following the business day on which the bank reverses the recredit, a notice of—

(A) the amount of the reversal; and

(B) the date on which the recredit was reversed.

(4) Mode of delivery.—A notice described in this subsection shall be delivered by United States mail or by any other means through which the consumer has agreed to receive account information.

(g) Other Claims Not Affected.—Providing a recredit in accordance with this section shall not absolve the bank from liability for a claim made under any other provision of law, such as a claim for wrongful dishonor under the Uniform Commercial Code, or from liability for additional damages under section 6 or 10.

(h) Scope of Application.—This section shall only apply to customers who are consumers.

SEC. 8. EXPEDITED RECREDIT PROCEDURES FOR BANKS.

(a) Recredit Claims.—

(1) In general.—A bank may make a claim against an indemnifying bank for expedited recredit for which that bank is indemnified, if—

(A) the claimant bank (or a bank that the claimant bank has indemnified) has received a claim for expedited recredit from a consumer under section 7 with respect to a substitute check, or would have been subject to such a claim had the subject consumer account been charged;

(B) the claimant bank has suffered a resulting loss or is obligated to recredit the consumer account under section 7 with respect to such substitute check; and

(C) production of the original check or a better copy of the original check is necessary to determine the validity of the charge to the consumer account or any warranty claim connected with such substitute check.

(2) 120-DAY PERIOD.—Any claim under paragraph (1) may be submitted by the claimant bank to an indemnifying bank before the end of the 120-day period beginning on the date of the transaction that gave rise to the claim.

(b) PROCEDURES FOR CLAIMS.—

(1) IN GENERAL.—To make a claim under subsection (a) for an expedited recredit relating to a substitute check, the claimant bank shall send to the indemnifying bank—

(A) a description of—

(i) the claim, including an explanation of why the substitute check cannot be properly charged to the consumer account; or

(ii) the warranty claim;

(B) a statement that the claimant bank has suffered a loss or is obligated to recredit the subject consumer account under section 7, together with an estimate of the amount of the loss or recredit;

(C) the reason why production of the original check or a better copy of the original check is necessary to determine the validity of the charge to the consumer account or the warranty claim; and

(D) information sufficient for the indemnifying bank to identify the substitute check and to investigate the claim.

(2) REQUIREMENTS RELATING TO COPIES OF SUBSTITUTE CHECKS.—If the information submitted by a claimant bank pursuant to paragraph (1) in connection with a claim for an expedited recredit includes a copy of any substitute check for which any such claim is made, the claimant bank shall take reasonable steps to ensure that any such copy cannot be—

(A) mistaken for the legal equivalent of the check under section 4(b); or

(B) sent or handled by any bank, including the indemnifying bank, as a forward collection or returned check.

(3) CLAIM IN WRITING.—

(A) IN GENERAL.—An indemnifying bank may, in the discretion of the bank, require the claimant bank to submit the information required by paragraph (1) in writing, including a copy of the written or electronically submitted claim, if any, that the consumer provided in accordance with section 7(b).

(B) MEANS OF SUBMISSION.—An indemnifying bank that requires a submission of information under subparagraph (A) may permit the claimant bank to make the submission electronically, if the claimant bank has agreed to communicate with the indemnifying bank in that manner.

(c) RECREDIT BY INDEMNIFYING BANK.—

(1) PROMPT ACTION REQUIRED.—Not later than 10 business days after the business day on which an indemnifying bank receives a claim under subsection (a) from a claimant bank with respect to a substitute check, the indemnifying bank shall—

(A) provide, to the claimant bank, the original check (with respect to such substitute check) or a copy of the original check (including an image or a substitute check) that—

(i) accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated); or

(ii) is otherwise sufficient to determine that the claim of the bank is not valid;

(B) recredit the claimant bank for the amount of the claim up to the amount of the substitute check, plus interest if applicable; or

(C) provide information to the claimant bank as to why the indemnifying bank is not obligated to comply with subparagraph (A) or (B).

(2) RECREDIT DOES NOT ABROGATE OTHER LIABILITIES.—Providing a recredit under this subsection to a claimant bank with respect to a substitute check shall not absolve the indemnifying bank from liability for claims brought under any other law or from additional damages under section 6 or 10 with respect to such check.

(3) REFUND TO INDEMNIFYING BANK.—If a claimant bank reverses, in accordance with section 7(e), a recredit previously made to a consumer account under section 7(c), or otherwise receives a credit or recredit with regard to such substitute check, the claimant bank shall promptly refund to any indemnifying bank any amount previously advanced by the indemnifying bank in connection with such substitute check.

(d) PRODUCTION OF ORIGINAL CHECK OR A SUFFICIENT COPY GOVERNED BY SECTION 6(d).—If the indemnifying bank provides the claimant bank with the original check or a copy of the original check (including an image or a substitute check) under subsection (c)(1)(A) of this section, section 6(d) shall govern any right of the indemnifying bank to any repayment of any funds that the indemnifying bank has recredited to the claimant bank pursuant to subsection (c).

SEC. 9. DELAYS IN AN EMERGENCY.

Delay by a bank beyond the time limits prescribed or permitted by this Act is excused if the delay is caused by interruption of communication or computer facilities, suspension of payments by another bank, war, emergency conditions, failure of equipment, or other circumstances beyond the control of a bank, and if the bank uses such diligence as the circumstances require.

SEC. 10. MEASURE OF DAMAGES.

(a) LIABILITY.—

(1) IN GENERAL.—Except as provided in section 6, any person who, in connection with a substitute check, breaches any warranty under this Act or fails to comply with any requirement imposed by or regulation prescribed pursuant to this Act with respect to any other person shall be liable to such person in an amount equal to the sum of—

(A) the lesser of—

(i) the amount of the loss suffered by the other person as a result of the breach or failure; or

(ii) the amount of the substitute check; and

(B) interest and expenses (including costs and reasonable attorney fees and other expenses of representation) related to the substitute check.

(2) OFFSET OF RECREDITS.—The amount of damages that any person receives under paragraph (1), if any, shall be reduced by the amount that the claimant receives and retains as a recredit under section 7 or 8, if any.

(b) COMPARATIVE NEGLIGENCE.—

(1) IN GENERAL.—If a person incurs damages that resulted in whole or in part from the negligence or failure of that person to act in good faith, then the amount of any liability due to that person under subsection (a) shall be reduced in proportion to the amount of negligence or bad faith attributable to that person.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection reduces the rights of a consumer or any other person under the Uniform Commercial Code or other applicable provision of Federal or State law.

SEC. 11. STATUTE OF LIMITATIONS AND NOTICE OF CLAIM.

(a) ACTIONS UNDER THIS ACT.—

(1) IN GENERAL.—An action to enforce a claim under this Act may be brought in any United States district court, or in any other court of competent jurisdiction, before the end of the 1-year period beginning on the date on which the cause of action accrues.

(2) ACCRUAL.—For purposes of paragraph (1), a cause of action accrues as of the date on which the injured party first learns, or by which such person reasonably should have learned, of the facts and circumstances giving rise to the cause of action.

(b) NOTICE OF CLAIMS REQUIRED.—Unless a person gives notice of a claim to the indemnifying or warranting bank, not later than 30 days after the person has reason to know of the claim and the identity of the indemnifying or warranting bank, the indemnifying or warranting bank is discharged from liability in an action to enforce a claim under this Act, to the extent of any loss caused by the delay in giving notice of the claim.

(c) NOTICE OF CLAIM BY CONSUMER.—A timely claim by a consumer under section 7 for expedited recredit constitutes timely notice of a claim by the consumer for purposes of subsection (b).

SEC. 12. CONSUMER AWARENESS.

(a) IN GENERAL.—During the 3-year period beginning on the effective date of this Act, each bank shall provide to each consumer that is a customer of the bank, in accordance with subsection (b), a brief notice about substitute checks that describes—

(1) how a substitute check is the legal equivalent of an original check for all purposes, including any provision of any Federal or State law, and for all persons, if the substitute check—

(A) accurately represents all of the information on the front and back of the original check as of the time at which the original check was truncated; and

(B) bears the legend: "This is a legal copy of your check. You can use it in the same way you would use the original check."; and

(2) the consumer recredit rights established under section 7 when a consumer believes in good faith that a substitute check was not properly charged to the account of the consumer.

(b) DISTRIBUTION.—

(1) IN GENERAL.—The notice required by subsection (a) shall be provided—

(A) to each consumer that is a customer of the bank as of the effective date of this Act, and that receives original checks or substitute checks along with periodic account statements, not later than together with the first regularly scheduled communication with the customer after the effective date of this Act;

(B) at the time at which a customer relationship is initiated, if such relationship is initiated on or after the effective date of this Act and such customer will receive original checks or substitute checks along with periodic account statements; and

(C) to each customer of the bank that requests a copy of a check and receives a substitute check, at the time of the request.

(2) MODE OF DELIVERY.—A bank may provide the notices required by this subsection by United States mail, or by any other means through which the consumer has agreed to receive account information.

(c) MODEL LANGUAGE.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Board shall publish model forms and clauses that a depository institution may use to describe each of the elements required by subsection (a).

(2) SAFE HARBOR.—A bank shall be treated as being in compliance with the requirements of subsection (a) if the substitute check notice of the bank uses a model form or clause published by the Board, and such model form or clause accurately describes the policies and practices of

the bank. A bank may delete any information in the model form or clause that is not required by this Act, or rearrange the format of such form.

(3) Use of Model Language Not Required.—This section shall not be construed as requiring any bank to use a model form or clause that the Board prepares under this subsection.

SEC. 13. EFFECT ON OTHER LAW.

This Act shall supersede any provision of Federal or State law, including the Uniform Commercial Code, that is inconsistent with this Act, but only to the extent of the inconsistency.

SEC. 14. REGULATIONS.

The Board may prescribe such regulations as it deems necessary to implement, prevent circumvention or evasion of, or facilitate compliance with the provisions of this Act.

SEC. 15. STUDY AND REPORT ON FUNDS AVAILABILITY.

(a) Study.—In order to evaluate the implementation and the impact of this Act, the Board shall conduct a study of—

(1) the percentage of total checks cleared in which the paper check is not returned to the paying bank;

(2) the extent to which financial institutions make funds available to consumers for local and nonlocal checks prior to the expiration of maximum hold periods;

(3) the length of time within which depositary banks learn of the nonpayment of local and nonlocal checks;

(4) the increase or decrease in check-related losses over the study period; and

(5) the appropriateness of the time periods and amount limits applicable under sections 603 and 604 of the Expedited Funds Availability Act, as in effect on the date of enactment of this Act.

(b) Report to Congress.—Not later than 30 months after the effective date of this Act, the Board shall submit a report to Congress concerning the results of the study conducted under this section, together with any recommendations for legislative action.

SEC. 16. EVALUATION AND REPORT BY THE COMPTROLLER GENERAL.

(a) Study.—Not later than 5 years after the date of enactment of this Act, the Comptroller General of the United States shall evaluate the implementation and administration of this Act, including—

(1) an estimate of the gains in economic efficiency made possible from check truncation;

(2) an evaluation of the benefits accruing to consumers and financial institutions from reduced transportation costs, longer hours for accepting deposits for credit within 1 business day, the impact of fraud losses, and an estimate of consumers' share of the total benefits derived from this Act; and

(3) an assessment of consumer acceptance of the check truncation process resulting from this Act, as well as any new costs incurred by consumers who had their original checks returned with their regular monthly statements prior to the date of enactment of this Act.

(b) Report to Congress.—Not later than 5 years after the date of enactment of this Act, the Comptroller General shall submit a report to Congress concerning the findings and conclusions of the Comptroller General in connection with the evaluation conducted pursuant to subsection (a), together with such recommendations for legislative and administrative action as the Comptroller General may determine to be appropriate.

SEC. 17. VARIATION BY AGREEMENT.

(a) Section 8.—Any provision of section 8 may be varied by agreement of the banks involved.

(b) No Other Provisions May Be Varied.—Except as provided in subsection (a), no provision of this Act may be varied by agreement of any person or persons.

SEC. 18. EFFECTIVE DATE.

Except as otherwise specifically provided in this Act, this Act shall become effective 12 months after the date of enactment of this Act.

COMMENDING AUGUST HIEBERT

EXPRESSING SENSE OF THE SENATE REGARDING THE CENTENARY OF THE RHODES SCHOLARSHIPS IN THE UNITED STATES

HONORING MAYNARD HOLBROOK JACKSON, JR.

COMMENDING GENERAL ERIC SHINSEKI

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of the following Senate resolutions, en bloc: S. Res. 186, S. Res. 187, S. Res. 188, and S. Res. 190.

The PRESIDING OFFICER. The clerk will report the resolutions by title.

The legislative clerk read as follows:

A resolution (S. Res. 186) commending August Hiebert for his Service to the Alaska Communications Industry.

A resolution (S. Res. 187) expressing the sense of the Senate regarding the centenary of the Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation.

A resolution (S. Res. 188) honoring Maynard Holbrooke Jackson, Jr., former Mayor of the City of Atlanta, and extending condolences of the Senate on his death.

A resolution (S. Res. 190) commending General Eric Shinseki of the United States Army for his outstanding service and commitment to excellence.

There being no objection, the Senate proceeded to consider the resolutions, en bloc.

Mr. FRIST. Mr. President, I ask unanimous consent that the resolutions be agreed to, en bloc; that the preambles be agreed to, en bloc; that the motions to reconsider be laid upon the table; and that any statements relating to these resolutions be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 186) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 186

Whereas Augie Hiebert came to Alaska in 1939 and built the first successful commercial radio station;

Whereas on Dec. 7, 1941, Augie Hiebert picked up the first report of the raid on Pearl Harbor from his radio station in Fairbanks, Alaska giving military leaders the first word of the attack that began World War II;

Whereas in 1953, Augie Hiebert founded Alaska's first television station;

Whereas Augie Hiebert established Alaska's first FM radio station and was named president of the Alaska Broadcasting System, overseeing the affiliation of nine stations that serve all major Alaska communities;

Whereas Augie Hiebert helped establish Alaska's first satellite earth station activated in 1970;

Whereas Augie Hiebert led in the development of the Territory and State of Alaska, working for over a half century to pioneer modern radio and television on behalf of the broadcast industry;

Whereas Augie Hiebert has been a pillar of the Alaska community as president of the Anchorage Chamber of Commerce and the Association of the U.S. Army in Alaska, and as director of the Alaska Educational Broadcasting Committee, the CBS Television Network Affiliates Association, the Civil Air Patrol, and the Pioneers of Alaska: Now, therefore, be it

Resolved, That it is the sense of the Senate that Augie Hiebert is commended for his service to the communications industry in Alaska and the world and for bringing the best that broadcasting has to offer to the people of Alaska.

The resolution (S. Res. 187) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 187

Whereas the Rhodes Scholarships, the oldest international fellowships, were initiated after the death of Cecil Rhodes in 1902, and now bring outstanding students from the United States, Australia, Bangladesh, Bermuda, Canada, the Commonwealth Caribbean, Germany, Hong Kong, India, Jamaica, Kenya, Malaysia, New Zealand, Pakistan, Singapore, South Africa, Uganda, Zambia, and Zimbabwe to the University of Oxford;

Whereas the first American Rhodes Scholars were elected in 1904, and since that time distinguished American Rhodes alumni have included over 20 members of Congress, a President of the United States, 3 Supreme Court Justices, cabinet members, military leaders, 80 heads of colleges or universities, and prominent artists, scientists, and business people;

Whereas the Mandela Rhodes Foundation, a partnership between the Rhodes Trust and the Nelson Mandela Foundation, was established in February, 2002;

Whereas after a lifetime of struggle against apartheid and the momentous challenge of governing the new South Africa as its first democratically elected President, Nobel Peace Prize Laureate Nelson Rolihlahla Mandela continues to be devoted to building a society characterized by justice and opportunity in the Republic of South Africa;

Whereas President Mandela's efforts have manifested themselves in the work of the Nelson Mandela Children's Fund, established in the wake of President Mandela's pledge to devote ⅓ of his Presidential salary to projects aimed at improving the quality of life of South Africa's disadvantaged children; and

Whereas in Cape Town in February, 2002, President Mandela noted that the partnership between the Rhodes Trust and the new Mandela Foundation signals "the closing of the circle and the coming together of 2 strands in our history": Now, therefore, be it

Resolved, That the Senate—

(1) celebrates the centenary of the Rhodes Scholarships in the United States;

(2) welcomes the establishment of the Mandela Rhodes Foundation, which embodies the spirit of reconciliation and shared commitment that is one of South Africa's greatest assets;

(3) shares the Foundation's commitment to support initiatives aimed at increasing educational opportunities, fostering leadership, and promoting human resource development throughout Africa; and

(4) affirms the support of the United States for these worthy goals throughout the sub-Saharan region, and asserts that the pursuit of these goals is in the shared interest of the American and African people.

The resolution (S. Res. 188) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 188

Whereas the Honorable Maynard Holbrook Jackson, Jr. was born on March 23, 1938, in Dallas, Texas, and at the age of 14 entered Morehouse College as a Ford Foundation Early Admission Scholar;

Whereas the Honorable Maynard Holbrook Jackson, Jr. graduated *cum laude* from North Carolina Central University School of Law;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became the first African-American Vice Mayor of the City of Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. proved to be a gifted and brilliant political leader, and he later became the first African-American Mayor of the City of Atlanta;

Whereas, during his years in office, the Honorable Maynard Holbrook Jackson, Jr. was the catalyst for the design of a $400 million terminal at Atlanta's Hartsfield International Airport;

Whereas the Honorable Maynard Holbrook Jackson, Jr. helped to secure Atlanta's selection as the site of the 1996 Summer Olympics;

Whereas the Honorable Maynard Holbrook Jackson, Jr. served as president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became Chair of the National Voting Rights Institute of the Democratic National Committee;

Whereas the Honorable Maynard Holbrook Jackson, Jr. established the American Voters League, a nonpartisan organization committed to increasing voter turnout;

Whereas upon being elected Mayor of Atlanta, the Honorable Maynard Holbrook Jackson, Jr. began encouraging and fostering interracial understanding in Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a strong supporter of affirmative action, civil rights, and the expansion of social and economic gains for minorities;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a great champion for diversity, inclusion, and fairness—not just in government and business, but also in all areas of life;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a wonderful human being who never wavered from the principles that guided his life and career;

Whereas the efforts of the Honorable Maynard Holbrook Jackson, Jr. on behalf on the City of Atlanta and all Americans earned him the esteem and high regard of his colleagues; and

Whereas the untimely death of the Honorable Maynard Holbrook Jackson, Jr. has deprived his community, the City of Atlanta, the state of Georgia, and the entire Nation of an outstanding leader: Now, therefore, be it

Resolved: That the Senate—

(1) honors the life and accomplishments of the Honorable Maynard Holbrook Jackson Jr.;

(2) recognizes the legendary compassion exhibited by the Honorable Maynard Holbrook Jackson, Jr. as a civil rights leader; and

(3) extends its condolences to the Jackson family and the City of Atlanta on the death of a remarkable man.

The resolution (S. Res. 190) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 190

Whereas General Eric Shinseki, the Army's 34th Chief of Staff, retired in June 2003, from active military duty after 37 distinguished years of service;

Whereas General Shinseki, a native of Hawaii, graduated from the United States Military Academy, West Point, in 1965 and served in a variety of assignments, including 2 combat tours in Vietnam, and was wounded twice in combat while serving his country;

Whereas General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with oak leaf clusters), Bronze Star Medal with "V" Device (with 2 oak leaf clusters), Purple Heart (with oak leaf cluster), Meritorious Service Medal (with 2 oak leaf clusters), Air Medal, Army Commendation Medal (with oak leaf cluster), Army Achievement Medal, Parachutist Badge, Ranger Tab, Office of the Secretary of Defense Identification Badge, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge;

Whereas General Shinseki has spent the last 4 years of his career in the highest position attainable in the Army and has proven himself a tremendous leader who has demonstrated unselfish devotion to this Nation and the soldiers he leads;

Whereas General Shinseki focused the Army on improved readiness in preparation for war and transformed the Army into the lean, agile, lethal fighting force that achieved victories during Operations Enduring Freedom and Iraqi Freedom;

Whereas General Shinseki provided the vision to set the Army on a path of transformation that will provide the Nation with an Army that is more lethal, agile, deployable, and flexible; capable of fighting and winning this Nation's wars in all future threat environments.

Whereas General Shinseki exemplifies the trademark characteristics exhibited by all great leaders and is a remarkable man of integrity, courage, and honor;

Whereas General Shinseki is an American hero who has been selfless in his service to his country through war, peace, and personal trial, and epitomizes the spirit of aloha; and

Whereas John F. Kennedy, the 35th President of the United States once said, "When at some future date the high court of history sits in judgment of each one of us—recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to 4 questions—were we truly men of courage . . . were we truly men of judgment . . . were we truly men of integrity . . . were we truly men of dedication?" and whereas when history looks back at the Army's 34th Chief of Staff, it will be clear that this was truly a man of courage, judgment, integrity, and dedication: Now, therefore, be it

Resolved,

SECTION 1. COMMENDATION.

The Senate—

(1) thanks General Eric Shinseki of the United States Army on behalf of a grateful Nation; and

(2) commends General Eric Shinseki for his extraordinary dedication to service to this great country and for his lifetime of commitment to excellence.

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to General Eric Shinseki.

MEASURE READ THE FIRST TIME—S. 11

Mr. FRIST. Mr. President, I understand that S. 11 is at the desk, and I ask for its first reading.

The PRESIDING OFFICER. The clerk will read the bill by title for the first time.

The legislative clerk read as follows:

A bill (S. 11) to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

Mr. FRIST. I now ask for its second reading and object to further proceedings on this matter.

The PRESIDING OFFICER. Objection is heard. The bill will remain at the desk.

UNANIMOUS-CONSENT AGREEMENT—ADJOURNMENT RESOLUTION

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate receives the adjournment resolution, it be agreed to and the motion to reconsider be laid upon the table, provided the text is identical to the resolution that is at the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR FRIDAY, JUNE 27, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 10:15 a.m., Friday, June 27. I further ask that following the prayer and the pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day and the Senate then begin a period for morning business with Members permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Tomorrow, the Senate will be in a period for morning business. Members will be able to pay tribute to our departed friend and colleague Strom Thurmond. We will give Members an opportunity to submit statements for the RECORD so they can be compiled for a printed tribute to Senator Thurmond. There will be no rollcall votes tomorrow.

Again, I thank my colleagues for their hard work over the past several weeks. We will have more to say about recent accomplishments of the Senate tomorrow and the events which culminated in tonight's passage—or this morning's passage—of the historic prescription drug benefits bill.

ADJOURNMENT UNTIL 10:15 A.M. TOMORROW

Mr. FRIST. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment as a mark of further respect for the late Senator Strom Thurmond.

There being no objection, the Senate, at 1:15 a.m., adjourned until Friday, June 27, 2003, at 10:15 a.m.

NOMINATIONS

Executive nominations received by the Senate June 26, 2003:

DEPARTMENT OF ENERGY

RICK A. DEARBORN, OF OKLAHOMA, TO BE AN ASSISTANT SECRETARY OF ENERGY (CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS), VICE DAN R. BROUILLETTE, RESIGNED.

OFFICE OF SPECIAL COUNSEL

SCOTT J. BLOCH, OF KANSAS, TO BE SPECIAL COUNSEL, OFFICE OF SPECIAL COUNSEL, FOR THE TERM OF FIVE YEARS, VICE ELAINE D. KAPLAN, RESIGNED.

DEPARTMENT OF HOMELAND SECURITY

PENROSE C. ALBRIGHT, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF HOMELAND SECURITY. (NEW POSITION)

DEPARTMENT OF JUSTICE

RENE ACOSTA, OF VIRGINIA, TO BE AN ASSISTANT ATTORNEY GENERAL, VICE RALPH F. BOYD, JR.

IN THE ARMY

THE FOLLOWING NAMED OFFICER TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

REGINA M. CURTIS, 8093

THE FOLLOWING NAMED OFFICER TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

NANCY M. PRICKETT, 6928

THE FOLLOWING NAMED OFFICERS TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

STEPHEN J. DEMSKI, 2648
JOSEPH F. MARANTO, 4896

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY IN THE JUDGE ADVOCATE GENERAL'S CORPS AND FOR REGULAR APPOINTMENT UNDER TITLE 10, U.S.C., SECTIONS 624, 531, AND 3064:

To be major

ANDREW S. KANTNER, 7763
DANIEL A. TANABE, 5125

CONFIRMATION

Executive nomination confirmed by the Senate June 26, 2003:

EXECUTIVE OFFICE OF THE PRESIDENT

JOSHUA B. BOLTEN, OF THE DISTRICT OF COLUMBIA, TO BE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET.

THE ABOVE NOMINATION WAS APPROVED SUBJECT TO THE NOMINEE'S COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

EXTENSIONS OF REMARKS

TAX INCENTIVES FOR TELECOMMUNICATIONS BUSINESSES

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. RANGEL. Mr. Speaker, today I am introducing legislation to provide tax incentives to encourage greater diversity of ownership in telecommunications businesses. My bill is a response to the increasing ownership of television and radio properties by large media companies.

I strongly believe that promoting a diversity of views on the airwaves is an important public policy goal. The only way to accomplish that goal is to broaden the ownership of broadcast stations. The television and radio spectrum is a limited resource. The trend in recent years has been a greater concentration of ownership of that resource by the large media companies. We need to reverse that trend.

Mr. Speaker, small businesses that wish to enter telecommunications businesses face significant barriers. To enter a broadcast business, a small business must purchase an existing property. Owners of those properties find it much easier to sell to large businesses than to small businesses. Therefore, small businesses quite often do not have a seat at the table when there are negotiations over the sale of broadcast properties.

My bill would attempt to reduce those barriers by providing limited deferral of capital gain taxation when a telecommunications property is sold to a small business. It would provide the sellers of those properties a positive incentive to consider a small business purchaser.

Large segments of our society historically have been underrepresented in the ownership of radio and television properties. I believe that it is vital that those groups have access to the television and radio spectrum so that their views may be represented on our airwaves. Therefore, my bill would provide a larger deferral of capital gain taxation when the sale is to a small business owned and controlled by individuals from these historically underrepresented groups.

Mr. Speaker, I understand that some may attack my bill as being the re-enactment of a flawed prior program. The provisions in my bill are quite similar to the tax certificate program that was repealed by the Congress in 1995. I do not quarrel with those who assert that there were abuses in that program. However, it is unfortunate that the Congress chose repeal and not reform because that program had been effective in accomplishing its goal of expanding ownership of radio and television businesses. In 1978, before the implementation of that program, only .05 percent of all broadcast stations in this country were owned by minority groups. By 1994, the year before the program was repealed, the program had succeeded in increasing minority ownership sixty-fold to 3 percent. Since that program was repealed, the number of minority-owned broadcast properties has declined.

The bill that I am introducing today contains provisions specifically designed to address the abuses in the prior program. It is limited to small business purchasers, it contains restrictions on the number of purchases that can be made by any one business, it contains recapture provisions to prevent the use of the small business as a front for another party, and it contains provisions designed to prevent avoidance of the ownership requirements through options or other sophisticated transactions.

I am hopeful that we can avoid the emotionally charged rhetoric that occurred in 1995 when this issue was last considered. All small businesses, regardless of their ownership, would be eligible for the benefits of my bill. It is true that the bill provides a slightly larger incentive when the small business purchaser is owned and controlled by individuals who are from segments in our society historically underrepresented in ownership of broadcast businesses. I believe this incentive is appropriate so that the views of those groups are heard on our Nation's airwaves. The bill simply attempts to ensure that small businesses, including minority owned small businesses, have a seat at the table when a broadcast property is being sold.

Mr. Speaker, I am hopeful that we will be able to deal with this issue on a bipartisan basis. We should all support the goal of expanding diversity in ownership of broadcast properties. I am pleased that in the past Senator MCCAIN introduced a similar proposal in the Senate. I am hopeful that we can find bipartisan support in the House. Following is a brief description of the provisions of the bill.

DEATH TAX REPEAL PERMANENCY ACT OF 2003

SPEECH OF

HON. DENNIS MOORE

OF KANSAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 18, 2003

Mr. MOORE. Mr. Speaker, I rise in opposition to H.R. 8, Permanent Death Tax Repeal Act and in support of the Democratic substitute.

I have long been a supporter of providing estate tax relief to American families, small business owners, and farmers who have worked their entire lives to transfer a portion of their estates upon their death. I have also been an advocate, however, for ensuring that we transfer to our children and grandchildren a healthy economy and a government that maintains its commitment to Social Security and Medicare.

In the last Congress, I voted to repeal the estate tax and later voted to override President Clinton's veto of that legislation. Again, in the 107th Congress, I voted to repeal the estate tax as a stand-alone measure and later voted for President Bush's $1.35 trillion tax cut, which contained a provision to phase out and ultimately repeal the estate tax.

When I voted for the President's tax bill last year, I did so with his assurance that we would have the money to pay for it without dipping into the Social Security surplus. Unfortunately, due to the recession and the war on terrorism, the budget surpluses projected last year did not materialize and we are now borrowing money from Social Security Trust Funds to pay for even our most basic needs including the war on terrorism.

While I agree that we should fix provisions of last year's tax cut to increase certainty in the tax code that will help people plan for their financial future, we should also make sure that we are not borrowing money—particularly from the Social Security Trust Funds—to pay for these cuts while we are simultaneously trying to enhance our national security needs. We should also ensure that we aren't raising other taxes to pay for provisions that are, quite frankly, political in nature and have nothing to do with ensuring that the estate tax burden is reduced on our small businesses and farms.

For example, Mr. Speaker, the underlying bill contains a hidden tax on all decedents. By fully repealing the estate tax, this bill would have the effect of repealing a provision in the code, referred to as the "step up in basis," that protects heirs from paying capital gains on estates.

Anyone who has ever sold a "capital" asset, such as real estate, stocks, bonds, mutual funds, knows that cost basis is what the gain or loss on the sales price is measured against. Generally speaking, cost basis is the purchase price of property subject to certain adjustments upward or downward. For example, if property was purchased in 1950 at a cost of $10,000 and sold in 2001 at $100,000, an individual would have a taxable capital gain of $90,000. The step-up basis interacts with estates such that when this property passes by reason of death, the heir inherits the asset with a new cost basis equivalent to the market value of the asset on the date of the benefactor's death. Taking the example above, if the property were transferred in 2001 at a value of $100,000 and the heir sold the property in 2006 for $120,000, the heir would only have a taxable capital gain of $20,000 instead of $110,000.

Should this bill become law, an owner of farmland, stocks, mutual funds, or even a personal residence would have lost the opportunity to pass the asset to the next generation without passing along the owner's cost basis, thus reducing the future capital gains bill that will have to be paid when the heirs sell the asset. In short, this amounts to a tax increase

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

on all estates due simply to the increased cost basis of the estate.

I believe there is a more responsible way to provide estate tax relief to our small business owners and farmers. The substitute will provide substantial and immediate relief by increasing a family's exclusion from $1 million to $6 million. It would also preserve the step-up basis provisions in current law so heirs to an estate do not receive a large capital gains bill as they would if Congress repealed the estate tax entirely. All of these changes would take place immediately. The Treasury Department estimates that increasing the estate credit to $6 million would exempt approximately 99 percent of all estates without the dramatic loss in revenues.

Mr. Speaker, the substitute is also paid for. In this environment when our budget is in crisis, it is critically important that we do not continue to drown ourselves in red ink. The majority's bill would cost over $60 billion a year, at a time when we are running a $400 billion annual deficit. We simply cannot afford to borrow even more money to provide additional tax cuts.

Again, I have supported previous efforts to provide estate tax relief because, in the past, we have been able to afford it. I am concerned, however, that the total costs of these bills will continue to drive our nation into debt, and reduce our ability to deal with the long-term challenges facing Social Security and Medicare. Until we deal with the long term financial problems facing Social Security, we need to be very careful about any tax or spending bills that would place a greater burden on the budget in the next decade, effectively transferring these costs and burdens to our children and grandchildren.

A SPECIAL TRIBUTE TO ESPERANZA ON THE OCCASION OF THE 20TH ANNIVERSARY CELEBRATION

HON. PAUL E. GILLMOR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. GILLMOR. Mr. Speaker, it is with great pride that I rise today to pay special tribute to an outstanding organization in Ohio. Esperanza, Ohio's only non-profit association dedicated to the promotion and advancement of education for Hispanics, has been serving the Hispanic community in Northeastern Ohio since 1983.

Over the duration of the last twenty years, Esperanza has become a vital asset to the Hispanic population in Ohio, aiding thousands of Hispanic youth with educational programming, tutoring, mentoring, college and career guidance, and scholarship opportunities for students pursuing higher educational opportunities.

Esperanza conducts programs for Cleveland youth in elementary, middle and high school. Furthermore, Esperanza offers a complimentary, instructional computer program to neighborhood residents. The fully equipped Community Technology Center provides individualized training sessions in keyboarding, data entry, Microsoft Office, Windows, and the Internet to Hispanics of all ages.

Esperanza's competitive scholarship program offers an annual process that is available to all Hispanic students residing in Northeastern Ohio. In 2002, with the aid of various corporations, educational institutions and individual donors, Esperanza was able to reward forty-seven Hispanic students with scholarships at the annual Fiesta of Hope Scholarship Luncheon.

NASA Glenn Research Center and Dr. Michael Schwartz, President of Cleveland State University, will co-chair this year's Fiesta of Hope Scholarship Luncheon.

Mr. Speaker, I ask my colleagues to join me in paying special tribute to Esperanza on occasion of the 20th anniversary celebration. Our communities are served well by having such honorable and philanthropic organizations, like Esperanza, who genuinely care about the well-being of Northeastern Ohio's Hispanic community.

REMEMBERING THE CONTRIBUTION AND LIFE OF GEORGE THOMAS "MICKEY" LELAND

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. RANGEL. Mr. Speaker, today, as we consider a resolution recognizing the work of our late colleague in the alleviation of hunger, I would like to honor George Thomas "Mickey" Leland for his contributions to this country and the world. He may have been the greatest advocate for the hungry that the House of Representatives has ever known. Mickey was born on November 27, 1944, in Lubbock, Texas. From 1972, when he was first elected into public office, until his death in 1989, Mickey Leland fought on behalf of the hungry, poor and less fortunate around the world. Neither partisanship nor race nor political boundaries prevented Mickey from reaching those who needed him. Republicans and Democrats alike respected Mickey for his determination and moral rectitude. I urge my friends and colleagues in this chamber to honor Mickey's memory by rededicating ourselves to eradicating world hunger and the poverty which is its cause.

In 1984, Leland co-authored legislation creating the House Select Committee on Hunger. It was the Committee's responsibility to focus solely on the widespread problems of hunger and malnutrition. Mickey chaired the Committee from its inception until his death. The Committee's efficacy stemmed from his unwavering moral leadership. He legislated on infant mortality, fresh food for at-risk women and children, and comprehensive services for the homeless. Mickey Leland refused to narrow the scope of his energy and dedication to his own country. Following reports of famine in sub-Saharan Africa, Speaker "Tip" O'Neil appointed Leland to lead a bipartisan Congressional delegation created to assess the magnitude of Africa's needs. The findings of that delegation resulted in $800 million in humanitarian relief.

In his pursuit to help the needy, Mickey traveled around the world. He met with Fidel Castro to reunite Cuban families and traveled to Moscow as part of joint U.S.-Soviet food initiative to Mozambique following the Cold War. He met privately with Pope John Paul II in 1987 and 1989 to garner support for his efforts in Africa. Mickey did everything he could. Those of us who were privileged to serve with him in this Congress were always inspired and challenged by Mickey to do more to alleviate the suffering of the people whom Jesus called "the least of these."

Mickey died just as he lived, trying to help. He never passed leadership to others when he could infuse a project with his warmth and energy. Mickey was leading a mission to a refugee camp in Ethiopia when his plane crashed, killing him and 15 others. Mickey died on August 7, 1989, near Gambela, Ethiopia.

DEATH TAX REPEAL PERMANENCY ACT OF 2003

SPEECH OF

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 18, 2003

Ms. SCHAKOWSKY. Mr. Speaker, I rise in strong opposition to H.R. 8 and in support of the Pomeroy substitute. The House Republican leadership and President Bush are once again putting the interests of the Bush class ahead of the needs of working families and our future well being. They are once again demonstrating that they have the wrong priorities.

Providing tax relief for low wage hard working families remains a low priority for House Republicans and the Bush Administration. Instead, they want to once again provide even more tax breaks for people who need it the least by eliminating that inheritance tax. Republicans are denying immediate assistance to 12 million children who come from families that earn between $10,500 to $26 a year, and where one million of the children have parents that currently serve or have served in the military. Nearly 674,000 children or one in four children back in my home state of Illinois would have qualified for this aid. This is an outrage. Talk about having your priorities backwards!

Proponents of this legislation make baseless claims that it will help small businesses, farmers and working families. The claim that the estate tax puts small family farms out of business. The National Farmers Union disputes this assertion, "There is no evidence that the estate tax has forced the liquidation of any farms, and existing estate tax already exempt 98 percent of all farms and ranches." The fact is that the estate tax currently affects only the richest 2 percent of estates, and the number dramatically shrinks as the exemption rises to $3.5 million in 2009. H.R. 8 eliminates the tax on the wealthiest 2 percent of all Americans—people like Bill Gates and Ken Lay. In my home state of Illinois less than 2500 families would benefit from the repeal of the estate tax. The rest of the public would not benefit from it at all. In fact, it will hurt their future and further damage our struggling Bush economy, where 2.7 million private sector jobs have been lost.

H.R. 8 will hurt our economic future because it would add at least an additional trillion dollars to the federal deficit over the next twenty years. The vast majority of Americans will have to make sacrifices to pay for this tax cut for millionaires. If this bill is enacted into law there will be less money available for Social Security, Medicare, and prescription drugs for seniors, not to mention homeland security and education. Mr. Speaker, how can it be that we do not have money to fund the Leave No Child Behind Act but we do have money to give more tax cuts for the super rich? How can this be?

Let me be clear. I am a strong supporter of small businesses and family farms and I am not against reforming the estate tax. I believe that families with modest assets should be exempt from the estate tax. That is why I support the Pomeroy substitute which exempts estates worth less than $3 million for an individual and $6 million for families from the estate taxes. The substitute would exempt 99.65 percent of all estates.

The Bush Administration and their Republican colleagues have a one track mind. They are once again attempting to lower taxes for the richest 1%. Just last month the Bush Administration and leaders in Congress passed tax cuts for millionaires and tax dodging corporations. President Bush made it a top priority and Vice President CHENEY personally negotiated the final bill language with the Republican Congressional leadership. The tax bill passed last month will provide a $604,000 tax break for Vice President CHENEY and $332,000 to Treasury Secretary John Snow. In total, it could provide up to $3.2 million in total tax savings for President Bush, Vice President CHENEY, and the Cabinet. I wonder how much the families of President Bush, Vice President CHENEY, and the Cabinet would benefit from repeal of the estate tax?

H.R. 8 undermines our basic sense of fairness. The legislation undermines progressive aspects of our tax code. It replaces it with a regressive tax code that puts more of a burden on middle and low wage families. A regressive tax code restricts opportunities for those who are not born into wealthy families. William Gates Sr., a supporter of the estate tax recently said, "What makes America great is the broad ownership of property and enterprise. We all succeed to the extent that children are born without vast disparities in access to education, health care, and opportunity. We are weakened when our policy makers are more concerned with preserving existing wealth and power than creating avenues for new asset creation and opportunity." I couldn't agree with him more.

Finally, the estate tax gives wealthy individuals an incentive to contribute to charity. Charitable organizations are very concerned about efforts to repeal the estate tax. According to the Joint Economic Committee Democrats, eliminating the estate tax could reduce contributions by 6 to 12 percent. This would reduce revenues for soup kitchens, AIDS prevention programs, and other vital community organizations that rely on charitable contributions to stay afloat.

Support America's families. Oppose the underlying bill and support the Pomeroy substitute.

TRIBUTE UPON RETIREMENT OF PAUL POGORZELSKI

HON. JAMES P. MORAN

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. MORAN of Virginia. Mr. Speaker, I rise to pay tribute to Paul Pogorzelski of Falls Church who is being honored by the United States Navy tomorrow for his 42 years of Federal service. But his abiding love of country and honor of service actually began at the young age of 12 when Paul joined the Civil Defense as a messenger with the 72nd Precinct in Brooklyn, New York.

In 1956, Paul enlisted in the Coast Guard. Upon promotion, he was assigned to the Marshall Island loran station, and was responsible for the operation, maintenance and communication of loran equipment. After his return to the United States, he was an instructor of electronics in Connecticut. In 1960, he was honorably discharged with a good conduct medal.

He first came to Washington in the early 1960s representing Raytheon and General Electric on the TARTAR radar missile program. Paul then received a political appointment from Undersecretary Vance to the Naval Ordnance Command, working on patrol gunboat missile systems, Antelope and Ready; the Hydrofoil program; R&D and introduction of the frigate program; guided projectile program between NAVSEA and the Army at the Picatinny Arsenal in New Jersey; the readiness of all Navy ships improving their readiness through the CASREP program. He also traveled to Holland to purchase the forerunner of the MK–92 fire control system.

As an intelligence liaison officer at NAVSEA, Paul handled special projects including nuclear powered submarines. He provided survivability assessments for SEA–05, SEA–08, and the PEOs. As facilities manager he engineered and built sensitive, compartmented information facilities both in Crystal City and the Washington Navy Yard, and established interconnectivity with the intelligence community.

Paul has received numerous awards and citations for his efforts in providing the Command with accurate and timely intelligence information regarding the survivability and vulnerability of our ships that were hit by foreign weapons, such as the USS *Stark*, USS *Samuel B. Roberts*, USS *Bridgetown*, USS *Princeton*, and USS *Cole*.

Our Nation is privileged to have had such a dedicated civil servant for these many years. I ask that my colleagues join me in honoring him today for his lifetime commitment of outstanding service to this Nation.

HONORING TED CONNORS

HON. JEB BRADLEY

OF NEW HAMPSHIRE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. BRADLEY of New Hampshire. Mr. Speaker, I rise today to honor Ted Connors upon his retirement from the position of Executive Director of the Portsmouth Housing Authority after 35 years of service.

The son of the city's first night-shift police officer, Ted Connors grew up in Portsmouth, New Hampshire, known as "the City of the Open Door". Ted witnessed Portsmouth change over the years from a rough-and-tumble military town into the tourist and business center it is today. This native brought a valuable hometown boy's point of view to his position.

Ted displayed an inspirational devotion to improving the quality of life for residents in his hometown. His top priority was to expand work-force housing in the region in support of the growing number of local employees being driven out of the city due to increasing housing costs. His commendable efforts led to a significant increase in the number of subsidized apartments, from 200 to 1,200.

In addition to subsidized housing, Ted instigated numerous other services for the city of Portsmouth. He developed a transportation system that supplies 120,000 rides a year for elderly persons needing to travel to medical appointments, various shopping complexes, or centers for meals. Ted also oversaw the development and completion of a new Senior Citizen's Center in October 2000, which offers various programs such as basic health care, transportation, daily lunches and social activities.

Without Ted's commitment to improving the quality of life for its residents, Portsmouth would not be the city it is today. His efforts to make New Hampshire a better place have made a lasting impact on the people that know him and know of him. Even Ted's successor has admitted that no one can truly fill the retiring director's shoes. Portsmouth and the state of New Hampshire are fortunate to have dedicated individuals like Ted working to make this city and this state a great place to live.

IN MEMORY OF THE HONORABLE BOB STUMP

HON. SILVESTRE REYES

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. REYES. Mr. Speaker, it is with a heavy heart that I reflect today on the passing of my dear friend Congressman Bob Stump. Bob was a great man and I am deeply saddened by his passing. He was a great American, a respected legislator, and a good friend.

He served with great distinction in Congress for twenty-six years, two years as Chairman of the House Armed Services Committee and six years as Chairman of the Veterans Affairs Committee.

I had the honor and privilege to serve on both of these committees with Bob as my Chairman. Although we did not always see eye to eye, I always had a great deal of respect for Bob's patriotism and leadership. Bob was a true supporter of men and women in uniform. Under his leadership, we made huge strides to improve the quality of life for our troops and veterans, increasing pay, housing, and healthcare allowances, increasing assistance to disabled veterans and their survivors, and strengthening the Montgomery GI Bill to help millions of veterans fulfill their educational and career goals.

Bob was a modest and decent man who, in dedicating the majority of his life to public service, was a dedicated patriot and a true American Hero. Bob's enthusiasm and spirit touched the lives of all who had the pleasure of meeting him. Although his presence is greatly missed in the halls of the House, I know that Bob is and will be well remembered.

My thoughts and prayers are with the Stump family and with everyone else who loved and admired him.

Thank you, Mr. Speaker.

CBC SPECIAL ORDER ON AFFIRMATIVE ACTION

HON. BARBARA LEE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Ms. LEE. Mr. Speaker, I want to thank our CBC Chairman, ELIJAH CUMMINGS, for holding this special order. I wish to contribute this evening by inserting into the RECORD the following speech which I delivered on Monday June 23, 2003 at the Rainbow Push Coalition and the Citizen Education Fund's Women's Luncheon in Chicago.

Thank you very much for that kind introduction and thank you for inviting me here today. I want to acknowledge and thank Reverend Jesse Jackson for staying the course, for continuing to speak truth to power and for your friendship and support throughout the years. I want to thank you for the Act of Courage Award presented to me last year in Los Angeles. Believe me, the inspiration and encouragement that I have received from you during very difficult and challenging times has given me strength.

Reverend Barrons, your guidance, spirit and commitment has touched my life. To Mrs. Jacqueline Jackson, thank you for your leadership and for being an exemplary role model for women. You are our first lady and we are so proud.

To the entire Rainbow PUSH family, your commitment to work for justice and peace has shown the world "a better way." You continue to fight to make the American dream a reality, not just for the select few but for "all God's children."

I also want to acknowledge the many elected officials, members of the clergy, and community leaders, and phenomenal women here today and to acknowledge everyone who is part of the struggle to compel our nation to live up to its own promises of liberty and justice for all. And in the memory of our fallen hero Mayor Maynard Jackson, let us rededicate ourselves to our work for political, social and economic justice.

Today, the Supreme Court issued a decision on a monumental affirmative action case. This morning the Supreme Court rejected the Bush Administration's efforts to eliminate affirmative action as we know it.

I say monumental because this judgment will echo far beyond the boundaries of the University of Michigan and far beyond the realm of higher education.

We are still studying the Court's ruling to understand its ramifications; however, the Supreme Court did uphold affirmative action and that is a clear defeat for the Bush Administration. This decision is a testament to the broad mobilization to defend civil rights, it validates the "power of the people" and the legality of affirmative action and requires us to be vigilant as we move forward.

Many of you, including myself, are proud products of affirmative action. We are duty-bound to protect it.

This is one of the most important civil rights cases in the last quarter century. Affirmative action is still necessary, not just in the interests of people of color, but in the interests of women and the country as a whole.

What was at stake here is the University of Michigan's attempts to create a classroom that reflects the diversity of this country as well as its persistent economic inequalities.

What is also on trial here is the principle of affirmative action, and in this case the Bush Administration weighed in on the side of reversing progress rather than pursuing justice.

Along with Reverend Jackson, and many others, I was at the Supreme Court the day when this case was heard. I was very proud to speak to the thousands and thousands of young people led by the Michigan students and BAM who had come to Washington from all over the country to protest the effort to eliminate affirmative action.

Believe me, I see a new sense of energy and involvement by our young people, and as adults we must support their organization efforts. Thank God, they are preparing themselves to take over the world. This victory speaks volumes to their efforts.

I was sitting in the audience when Solicitor General Ted Olson, the Administration's attorney, passionately argued against affirmative action, declaring that the University of Michigan—and by implication all other universities and institutions—should use race-neutral means for its admissions.

I thought how sad it was to witness our own government arguing against the interests of so many of its own people.

I would suggest race-neutral admissions would be fine—just as soon as this becomes a race-neutral country. And not a day sooner.

In upholding the University of Michigan law school's affirmative action program, race will continue to be a critical component in achieving parity and equal opportunity for all. We must be the active watchdogs over this decision and how it is implemented.

I was there when Justice Scalia told the University of Michigan that it had a choice: it could either be an elite, first-rate school or it could lower its standards and pursue racial diversity.

How sinister—and wrong—can you get?

Justice Scalia was, in fact, offering a false dichotomy: in reality, you cannot be a top-flight university without diversity.

While that fact eludes the Bush Administration, it does not escape corporate America, the military, or many members of Congress, all of whom voiced their support for the University of Michigan and the principle of affirmative action.

Sixty-five major businesses, all Fortune 500 companies, submitted a brief as a friend to the court on this case.

These global businesses have annual revenues of over a trillion dollars.

As employers, they are deeply interested in this case because they recognize, and I quote here from their brief, "the existence of racial and ethnic diversity in institutions of higher education is vital to [our] efforts to hire and maintain a diverse workforce, and to employ individuals who have been educated and trained in a diverse environment."

Affirmative action, these corporate giants explained, does not only benefit minorities or the economically disadvantaged: affirmative action benefits everyone by offering cross-cultural experience and understanding.

Without that interaction, they argued, we all suffer, and without such a workforce, these companies will be hard-pressed to compete in the global business environment.

Those same views were echoed by many of the highest ranking retired military officers in this country, including former Chiefs of Staff, former Secretaries of Defense, General Norman Schwarzkopf, and other decorated veterans representing all four service branches.

They wrote the court, "Based on decades of experience, [we] have concluded that a highly qualified, racially diverse officer corps" is "essential to the military's ability to fulfill its principal mission to provide national security."

"Limited race-conscious recruiting and admissions policies" at universities such as Michigan, they continued, is critical to both meeting the security needs of this country and to following through on Harry Truman's fifty-year old executive directive to end segregation in the military.

Again, these retired military officers, like their business counterparts, stressed that affirmative action is essential to the success of their mission.

Diversity is a critical component of our democracy as well. That is why I joined my congressional colleagues, led by Michigan Congressman John Conyers, ranking member of the Judiciary Committee and long a warrior in the fight for civil rights, in submitting our own amicus brief to the Court.

We asked the Court to recognize the educational and political benefits of diversity; to uphold the use of race as one factor among others that can be considered in government decision-making; and to reaffirm that the role of race in this decision making is not limited to remedying specific instances of identified discrimination.

The fact is we don't have a level playing field in this country.

People of color and women earn less money, own fewer assets, and enjoy less access to the nation's elite institutions. African American unemployment is twice as high as that of whites.

Affirmative action is still necessary, not just in the interests of minorities but in the interests of the country as a whole.

This decision upholds justice, access, and fair play. Let me tell you what has happened in my home state of California.

In California, we have seen the devastating effects of the assault on affirmative action. When I was in the state legislature, I fought tooth and nail against efforts to end affirmative action.

Reverend Jackson and the Rainbow Coalition not only stood with us, they actively opposed Prop 209 by marching, engaging in peaceful protests, and organizing.

All the "street heat" that could be brought to bear, Reverend Jackson helped bring it.

During those years, I was chair of the California Legislature Black Caucus, and we defeated each and every anti-affirmative action legislative measure that then-Governor Pete Wilson wanted to sign into law.

But a member of the University of California Board of Regents, and African American, yes, a brother, well, I should say, a black man, Ward Connely, led the ballot initiative to end affirmative action.

These efforts resulted in a state constitutional amendment and action by the Board of Regents to end affirmative action on all campuses.

So, while we won in the legislature, misinformation and prejudice helped carry the day at the polls when California voters passed Proposition 209 in 1996.

That initiative eliminated affirmative action programs for women and people of color run by state or local governments in the areas of public employment, contracting, and education.

California and some other states have tried to create alternatives to affirmative action, but these alternatives depend on and reinforce residential segregation and fall short in other ways. They just don't work. Now, very few minority and women owned businesses have state contracts, and very few are employed in key positions.

Alumni legacies—such as those President Bush undoubtedly benefited from when he was admitted to Yale with an exceedingly mediocre academic record, to say the least—combined with emphasis on test scores that favor both white applicants and the economically advantaged are creating campuses that are increasingly segregated.

In California, we are undergoing the re-segregation of our colleges and universities. At many of the top schools in the state, minority enrollment has been cut in half since Prop 209 passed. Thank God for our historically Black Colleges. Our African American students are now going south benefiting from their excellent education. But what we have learned is that 70 percent of these students do not return to California. What a brain drain we have in California.

Shame on California.

One observer described the process of eliminating affirmative action, at Boalt Hall, the University of California's premiere law school, as "watching justice die."

In looking at the Administration's position on affirmative action, we have to place that particular choice within the larger context of the Bush Administration's class war on America's working families and their policies of rewarding the rich.

This Administration and its allies in Congress are rolling back advances in racial equality, economic opportunity, and gender equity.

First Trent Lott lamented the defeat of Strom Thurmond's white supremacist Dixiecrat Party in 1948.

The Administration may have rushed to disown itself from those remarks, but its policies are taking us back to those days nonetheless.

The Administration is creating massive tax cuts for the rich, but twelve million children of America's working families were left off their master plan for the child tax credit. They did this deliberately. It was not a mistake.

So were single mothers who apparently don't deserve tax credits in the world of George Bush. They also left out over 200,000 military families. What a disgrace.

We have an Administration that preaches leave no child behind, but then wants to gut Head Start and leaves tens of thousands of children on waiting lists instead of in preschool. They want to block grant Head Start, remove it from the Department of Health and Human Services, put it in the Department of Education and require four-year-olds to take a literacy test. Their proposal would end Head Start as we know it.

We have an Administration that would like to privatize both Social Security and Medicare, leaving our parents and grandparents with neither financial security nor real prescription drug coverage.

We have an Administration that is trying to block grant Section 8 housing programs, dismantling Section 8 as we know it.

And we have an Administration that is stripping away our civil liberties, one by one. We must stop Patriot Act II from getting through Congress.

It's an Administration that is wiping out decades of progress on Clean Air and Clean Water, even though asthma, childhood cancer rates, and scores of other health problems associated with pollution are on the rise, especially among people of color. It's an administration that puts our tax dollars into a $400 billion dollar defense budget to build more missiles, yet cuts after school programs and won't fully fund education.

This is an administration that is launching a similar assault on women's rights.

Look at its attack on Title IX, for example, a program that is featured in this conference. Title IX has opened up opportunities for girls and women on the sports field that have also opened up opportunities in life.

Our beloved, recently deceased Congresswoman Patsy Mink of Hawaii sponsored Title IX. In honor of her memory and legacy, we must not let this Administration turn back the clock.

Title IX is about banning sex discrimination, pure and simple. And the Bush Administration is trying to wipe out those protections, just like it's trying to wipe out affirmative action and the Clean Air Act.

This is an administration that wages war abroad while also waging war at home, on the nation's poor, on people of color, on women, on the environment, on seniors, and on working families.

What can we do in the face of these assaults? Fight back! Believe me, we must be vigilant to stop any legislation—illegal legislation that the Republican House and Senate will put forward.

We must take back the House, take back the Senate, and take back the White House in 2004.

To do that, we must educate, organize, mobilize, and vote!

We must register our folks to vote, we must vote and we must demand that our votes be counted. No more stealing elections. Democracy is at a crossroads. We must make democracy real.

Rainbow PUSH represents the very diversity that is under attack. And diversity is a tremendous strength. Use it!

If people tell you their vote doesn't matter, remind them about Florida.

Each and every vote the Supreme Court chooses to count matters. We must demand that they all be counted!

This is a critical moment in history and you have to make it our moment.

I am reminded of the Book of Esther and the conversation between Mordecai and Esther when she faced her moment of truth.

Mordecai turned to Esther as she paused in the face of what looked to be an insurmountable obstacle, and he said to her, "Who knows whether you have not come to the kingdom for such a time as this?"

Let me pose a similar question to you here, today. Who knows whether or not you have come for such a time as this?

Queen Esther and her forces were victorious. This too is a battle we can win. We, too, will be victorious. And, again, women will help lead the way.

Thank you for all that you do. Let us take from this moment the determination to follow in the footsteps of our heroes—Dr. King, Justice Marshall, Mrs. Parks and Mrs. Till, Ida B. Wells, Sojourner Truth, Maynard Jackson, and Reverend Jesse Jackson—and, like Esther, seize our moment.

I say again, Rainbow PUSH, you have come for a time such as this.

Thank you and God bless you.

TAXPAYER PROTECTION AND IRS ACCOUNTABILITY ACT OF 2003

SPEECH OF

HON. EARL POMEROY

OF NORTH DAKOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. POMEROY. Mr. Speaker, I rise today to say that I cannot support this bill. I do support nearly everything in the underlying bill. It is mostly the product of a bipartisan effort to address taxpayer rights issues and those provisions should be enacted. Unfortunately, the addition of "poison pill" language into this bill prevents me from supporting this legislation today.

This bill has many good components, including provisions I worked on personally with Mr. HOUGHTON. There are several excellent provisions from members of both sides of the aisle, in addition to a number of important recommendations made by the Taxpayer Advocate at the Internal Revenue Service (IRS) to improve services of the agency and protect consumer rights. Most of these provisions are broadly, if not unanimously, supported.

However, what started as a good bipartisan bill has been tarnished by the addition of an anti-consumer provision that is troublesome enough that I cannot vote for it. Language was added to this bill to strip essential consumer protections for those purchasing health insurance using tax credits granted under the Trade Assistance Act (TAA). These existing, carefully negotiated consumer protections are in place to ensure adequate coverage for those using the tax credit. They are enjoyed by every member of this Congress, and they are critical to providing meaningful health coverage.

Proponents of removing these consumer protections call it "consumer choice." But as a former insurance regulator, I can tell you that families facing unemployment and possible loss of health insurance due to U.S. trade policy need health insurance that is both affordable and provides adequate coverage. They should not be forced to "choose" one over the other.

Under current law, insurance companies who agree to offer coverage to displaced workers under this program are substantially limited in their ability to turn down applicants, charge excessive premiums or otherwise seek to cover only the healthiest individuals. Without these requirements, the promise of help for most of these people and their families would be meaningless. Understand, however, these are not special protections. These are standard protections and they are being stripped in this bill.

Making coverage cheaper by restricting it to the healthy undermines its purpose—health security for those who need it most. It's like making automobile air bags out of tissue paper—a tactic sure to make cars cheaper for all and hurt only those few who are in accidents—those whose goal it is to protect in the first place.

Only healthy people can afford to "waive" the protections. If the waiver is available, the insurance industry would likely gladly enter into arrangements to cover only the young and healthy displaced workers and walk away from those who need help most. This would make a mockery out of the agreement the members of this House voted for in passing the TAA.

Or worse yet, perhaps those most in need of coverage would indeed be issued policies, using this credit, but only coverage that exempts any pre-existing conditions. In other words, this credit could be used to underinsure individuals or families, leaving them vulnerable without the protection they need most. Is it really helpful to displaced workers to provide a tax credit to purchase coverage that doesn't cover what they need most? Of course it isn't, and that's why we included standard consumer protections in the first place.

Mr. Speaker, aside from this anti-consumer provision related to health care tax credits, I strongly support the underlying bill. The majority of this bill is good for taxpayers and would serve to improve the operations of the IRS and the services they provide to our constituents. However, as long as this poison pill provision remains in this bill, I will oppose it.

TRIBUTE TO RAO ANUMOLU

HON. CAROLYN McCARTHY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mrs. McCARTHY of New York. Mr. Speaker, I rise before you today to express my deep appreciation and recognition of Mr. Rao S. Anumolu of Hauppauge, NY for his tireless efforts in support of our nations defense. As President and CEO of ASR International Corporation, Mr. Anumolu has assisted the Department of Defense in its fight to protect our homeland since the attack on our country on September 11th and particularly during the Iraqi war. Since its conception in 1986, ASR International has developed cost effective technology and systems to protect our nations airports, waterways, railroads and highways. Most recently, ASR International has developed the "SAFETY/SECURITY ASSURANCE SYSTEM" in order to further support our efforts at Homeland Security in a comprehensive and cost effective manner.

In addition to Mr. Anumolu's arduous work with ASR International, he has made quite a name for himself outside their doors. Earning a MS in Industrial Engineering and a MBA in Management, Mr. Anumolu furthered his education in the field of Defense by enrolling in numerous courses at Defense Systems Management College as well as Harvard University and other esteemed institutions. With this stellar academic background, Mr. Anumolu entered the work force, holding such prestigious positions as Senior Engineer, Program Manager and Director of Prime Defense contractors before founding ASR International in 1986.

This is not the first time Mr. Anumolu has been recognized for his efforts. In 1993, Mr. Anumolu received the Business Excellence Award from the U.S. Small Business Administration for his work in the field of Defense. Now, it is my turn to say "Thanks."

Mr. Speaker, I ask my colleagues to join with me in expressing our gratitude to Mr. Anumolu for his exemplary work and dedication to the safety and protection of all Americans. His many accomplishments have helped make the United States a safe place for all.

HONORING FATHER WALTER L. DOLAN

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor and recognition of Father Walter L. Dolan, O.F.M., upon the occasion of his retirement from active ministry.

Father Dolan has served as President of Padua Franciscan High School in Parma for the past nine years. Under his leadership, the high school has flourished in many ways. Enrollment has steadily increased at Padua, and today the high school is the largest Catholic co-educational secondary school in northern Ohio. Additionally, it was because of Father Dolan that Padua Franciscan High School is now officially designated as a College Preparatory High School—making it only one of fourteen with this status in the entire State of Ohio.

Not only has Father Dolan significantly raised the bar on academic standards and excellence at Padua, he also focused on the improvement of the school's athletic facilities. These significant exterior developments created new baseball and softball fields, new track fields and facilities, parking and roadway improvements, and a new football stadium. Father Dolan ensured that appropriate landscaping graced the boundaries of every new development.

Moreover, Father Dolan's goal for Padua included financial stability for the school, and aid for eligible students. During his tenure, Father Dolan secured a major funding effort to build a strong endowment, entitled "The Campaign For Tomorrow." This significant endeavor exists to increase the amount of financial aid to students in need. This endowment is also designed to maintain the school's technological level, and also provides teachers with cutting-edge educational training.

Mr. Speaker and Colleagues, please join me in honor and recognition of Father Walter L. Dolan as he retires as President of Padua Franciscan High School, and as he retires from active ministry. Father Dolan's contributions throughout his ministry are significant and immeasurable, and his work and service will be greatly missed. His leadership, expertise, guidance and concern for others have served to uplift the entire Padua community, and the entire Cleveland community, and his gift of faith and compassion will forever light our community.

IN HONOR OF ROY BOHNER

HON. MARTIN FROST

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FROST. Mr. Speaker, I rise today in honor of Mr. Roy Orthmor Bohner, who recently celebrated his 51st anniversary working with Lockheed Martin Missiles and Fire Control in Dallas, TX.

Roy Bohner has been a dedicated employee of MFC since he began working there many years ago as an Engineering Trainee and a junior hydraulics design engineer. Some of his notable accomplishments include a design of an autopilot for a radio controlled drone aircraft, a successful R&D program to do flight control analysis, and design studies for a "fly-by-wire" control system named Electro-RAM. In addition to his service in Dallas, Roy spent some time at the General Dynamics plant, now Lockheed Martin Aeronautics in Fort Worth, as part of the Industry Assist program.

Prior to joining MFC, Roy served our country in World War II as a member in the 11th Army Division, and he continues to contribute to this Nation through his loyalty and dedication to his projects at Lockheed Martin. A man of ardor and great humor, Roy's objective is to be the oldest living employee at Missiles and Fire Control in Dallas.

Roy is an exemplary model of the American worker who is dedicated to continue serving this great Nation.

Mr. Speaker, Roy Bohner deserves special recognition for his tremendous achievement and dedication. He serves as a role model to the rest of us, and I wish him success in his future endeavors.

TRIBUTE TO MARIE DAVIS OF NORTH ADAMS, MI

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SMITH of Michigan. Mr. Speaker, I rise today to honor Marie Davis of North Adams, Michigan.

A lifelong resident of North Adams, Marie has enriched the lives of others through her outstanding participation in civic and volunteer activities, and her many accounts of life in North Adams.

Marie was born on August 14, 1909 and is a lifelong resident of North Adams. She attended school there and graduated from North Adams High School, and has been a member of the North Adams United Methodist Church. Marie has also represented North Adams as a member of the Women's Congress at the Hillsdale County fair for many years.

Mrs. Davis is best known for her historical accounts of life in North Adams and has kept diaries of all major events that have occurred there. She has written and published five books about local history, including: "This is North Adams," "100 Years of Sports in North Adams", "The History of North Adams Schools," and "1886–2002: The History of the North Adams Fire Department."

Marie Davis will celebrate her 94th birthday on August 14, 2003, and is still considered North Adams' official historian, continuing to chronicle the lives and events of that community.

North Adams is a small midwestern town with tree-lined streets, friendly neighbors, and thanks to Mrs. Davis, a preserved heritage. I am pleased to recognize the efforts of Marie Davis in preserving the memories, stories and values of the past for present and future generations.

GENERAL ERIC K. SHINSEKI

HON. CURT WELDON

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WELDON of Pennsylvania. Mr. Speaker, I rise today to celebrate the outstanding service of one of America's true heroes, General Eric K. Shinseki.

General Shinseki retires from the Army after a career that spanned the globe and 38 years of service in peace and war. Let me be very clear, what General Shinseki has accomplished as chief is tied directly to the welfare of soldiers and their ability to remain the world's greatest warfighters and we owe him a debt of gratitude.

General Shinseki was just a young cadet at West Point, when General of the Army Douglas MacArthur, gave his distinguished Farewell Speech on the banks of the Hudson to the Corps of Cadets. General MacArthur's words embodied the creed of military service:

> "Duty," "honor," "country"—Those three hallowed words reverently dictate what you want to be, what you can be. They are your rallying points to build courage when courage seems to fail, to regain faith when there seems to be little cause for faith, to create hope when hope becomes forlorn.—General Douglas MacArthur's Farewell Speech, May 12, 1962.

These ideals—of duty, honor and country so eloquently expressed by General MacArthur that day have been personified in General Shinseki's distinguished career. General Shinseki graduated from the United States Military Academy in 1965 and later received a Master of Arts Degree in English Literature from Duke University.

As a young officer, General Shinseki served two combat tours in Vietnam. He was twice wounded, and earned two Purple Hearts as well as four Bronze Star Medals. He then went on to serve for more than ten years throughout Europe in positions of increasing authority and responsibility. In 1996, General Shinseki was promoted to lieutenant general and returned to the Pentagon as Deputy Chief of Staff for Operations and Planning.

General Shinseki's duties culminated with his promotion and assignment as Chief of Staff of the Army in 1999. Already, as Vice Chief of Staff, he had developed an innovative plan to prepare the Army to face the unique challenges of the 21st century. Soon after becoming Chief of Staff of the Army, General Shinseki embarked on a bold plan to transform the Army to a lighter, more lethal, more flexible and transportable force that would be fully capable of meeting the full range of threats that face today's Army. He was a visionary who began transformation long before the term became popular.

Perhaps most poignantly, General Shinseki should be remembered as the gladiator President Roosevelt spoke of so long ago:

> It is not the critic who counts, not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena; whose face is marred by dust and sweat and blood; who strives valiantly; who errs, and comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows the great enthusiasms, the great devotions; who spends himself in a worthy cause; who at best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat.—Address at the Sorbonne, Paris, France, April 23, 1910.

Throughout his thirty-eight years of service General Shinseki's first and primary focus has always been the men and women of the United States Army. Among his many accomplishments, General Shinseki revolutionized recruitment, training and education. Just one example of General Shinseki's innovative approach is eCybermission, a program that encourages young men and women to pursue education and careers in engineering and science, which he sees as fundamental to the future of the Army and the nation.

General Shinseki attributes much of his success to the support of his wife Patty, who has also contributed greatly to aid the wives and families of our service men and women. Together, they have raised two wonderful children, Lori and Ken.

This nation, the Congress, the Department of Defense, and the men and women of the Army, owe a debt of gratitude to General Shinseki and his wife Patty for their selfless service. They have given meaning to the timeless values that continue to reverberate across the plain at West Point—"Duty, Honor, Country."

THE CASE FOR LABOR STANDARDS IN TRADE AGREEMENTS

HON. BARNEY FRANK

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FRANK of Massachusetts. Mr. Speaker, I ask that excerpts of a recent speech by Mr. LEVIN of Michigan be printed.

> In recent years the major industrial growth in El Salvador, Nicaragua and Guatemala has been in the maquilas, assembling apparel in free trade zones.
>
> 100,000 to 150,000 people work in the garment maquilas of each nation.
>
> 75–85 percent of the workers on average are women, with an average age of 18–25.
>
> A majority are the sole source of income for themselves and their children.
>
> By law, the work week is supposed to be 44 hours, with overtime on a voluntary basis.
>
> The typical worker receives about 65 to 75 cents per hour. If paid by piece the average could be around $1 per hour.
>
> Almost every nation in the world has agreed through the International Labor Organization (ILO) to respect five core labor standards: prohibitions on child labor and forced labor, non-discrimination, and the rights to associate and to bargain collectively. In the garment maquilas, the most salient are the rights to associate and organize and to bargain collectively.
>
> In Central America today, the basic labor-management dynamic is like the United States at the turn of the last century.
>
> In Nicaragua and El Salvador, an employer can fire any employee whom it believes is sympathetic to an organizing effort simply by paying severance.
>
> In one plant I visited in Nicaragua workers had quite recently been working 70- to-80 hours (apparently for the same $100 a month); in some cases they were working 24 hour shifts. Protests finally forced new management, but the new management acknowledged that they were still working people longer than permitted in the law.
>
> In Guatemala, we talked with a worker who had personally witnessed other employees who had been trying to organize being beaten with bats at work.
>
> In Nicaragua and Guatemala, we heard numerous reports of employers using the criminal process in order to break up unions in maquilas and other sectors.
>
> In El Salvador, we visited a free trade zone in which a plant was shut down to avoid its workers being able to organize. We heard highly credible evidence that the leaders of the organizing effort were subsequently blacklisted as they sought other employment.
>
> In Guatemala, it is not legally possible for a union to attempt to organize within an entire industry, like the garment industry, without having in advance 50 percent plus one of the workers signed up and registering with the government.
>
> Nicaraguan and Guatemalan employees cannot strike without government approval.

The State Department Human Rights Report, and numerous other reports from groups like Human Rights Watch, confirm that the facts and incidents are the constant reality.

In El Salvador, Beatrice Alamanni de Carillo, a veteran judge and professor, serves as Prosecutor for the Defense of Human Rights. She was appointed by the National Assembly, with a majority from the conservative Arena Party. Her comments:

"In the private sector an anti-union culture persists in great measure and for many years, employers have generated a climate that does not contribute to the promotion of worker organization in their workplace. . . . The Ministry of Labor and Social Welfare has not demonstrated a real will to guarantee in practice the rights of workers, either individually or collectively. There is a very loud clamor that the authorities of that Ministry do not make their best efforts to adequately check working conditions in businesses, and, in addition, they tolerate and promote an anti-union culture in the country."

In each country, the rights to associate and organize and to bargain collectively are not realities. The laws themselves are inadequate.

Even where there are laws on the books, they are not well enforced and are often used against workers trying to organize.

As far as I could determine, there is not a single effective collective bargaining agreement in any of the garment maquilas of the three countries, though there are almost 400,000 workers.

In Guatemala, a leader of the union connected with the Christian Democrats put it this way: the problem is that employers have "impunity;" "they make up their own laws."

You may jump to the conclusion that I came back discouraged. That is not accurate.

If the issue of core labor standards is addressed in CAFTA by including a fully enforceable obligation to adopt these standards, it will have an important impact on socio-economic dynamics in these countries by helping develop a middle class.

In the last decade the apparel/textile maquilas have been the major source of economic growth and new employment in each of the three nations I visited, and in Honduras.

The realities within the maquilas today are built on a total imbalance in relationships between employer and employee. The vast majority of workers, young women, are particularly vulnerable, with overriding fear that for them losing a job means an end to their income.

It is essential in order to provide opportunities to the CAFTA countries to expand trade and strengthen commercial ties with the region. It is equally essential that the rules of trade and investment be shaped in a way that maximizes the benefits to those countries and the U.S.

For workers to be able to break the cycle of poverty, they need to have the ability to join together, to participate, to improve their economic status. This is an antecedent to helping those workers use the potential of globalization to create, join, or expand the middle class.

Hernando de Soto recently authored The Mystery Of Capital: Why Capitalism Succeeds In The West And Fails Everywhere Else, which posits that economies develop where property rights are formalized, are clearly and efficiently defined, are enforceable, and may be exercised by all; in this way all property can become capital. Labor market standards help workers maximize a key property right—property in one's own labor.

A key reason to seek a minimum floor of respect for the five core, internationally-recognized labor standards is to ensure that the CAFTA countries will not compete in a race to the bottom in their efforts to promote trade and attract investment. Some argue that the race to the bottom is a myth, that income levels will rise when trade and investment flows increase, and all domestic standards will rise as income levels increase. These arguments ignore the fact that, as with all other economic factors, investment dollars are scarce and there is fierce competition to attract those dollars. When the competition is over labor-intensive industries, one of the key points of competition is the labor market pool.

A New York Times article from about two years ago quoted the President of El Salvador regarding intra-regional competition, who stated, "The difficulty in this region is that there is labor that is more competitively priced than El Salvador."

Another article from about one year ago in the Washington Post described the interesting changes in patterns in banana trade, with Ecuador attracting an increasing share. The explanation, according to one major fruit company executive, is that "the costs in Ecuador are so much lower. There are no unions, no labor standards, and the pay is as low as two dollars a day."

If the promise of expanded trade—increased incomes and lower levels of income inequality—is to be realized, it is important that the CAFTA countries not compete with each other based upon abuse of core labor standards. The best way to do that is to establish over a reasonable period of time a floor—adopting the five core labor standards as rules of competition in this critical economic area in the FTA itself—just as we establish floors through rules of competition in other areas like intellectual property, investor rights, and tariff levels.

The Central American nations do not need to suppress their workers in order to compete. There is an opportunity to build an economic structure based on implementation of core labor standards so that garments from those nations could bear a label reading "made under internationally recognized labor standards," which many competing goods will not possess.

The alternative is an increasing effort by consumer groups in the U.S. to boycott companies that make garments under conditions that violate these standards.

Efforts by American retailer-purchasers to promulgate and implement private business codes will not make up for a lack of a basic governmental and societal structure. In the New York Times article quoted above, an official from a major American retailer said "We can't be the whole solution. The solution has to be labor laws that are adequate, respected, and enforced."

By addressing core internationally recognized labor standards in the CAFTA negotiations, it is more likely that the domestic coalition necessary to tackle the tough market access issues with the United States can be assembled.

Total two-way trade between the United States and the CAFTA countries is about $20 billion. Combined, the CAFTA countries constitute the 18th largest export market for the U.S. and about half of all foreign direct investment in these countries comes from the U.S.

Beyond the current relationship, the United States is seeking better market access for goods and service providers, protection for investors, and improved intellectual property protection from the CAFTA countries. These countries are seeking more investment and more U.S. market access, primarily in the textiles and apparel and agriculture sectors. Otherwise, CAFTA will provide no significant benefits to Central America beyond those provided by the Caribbean Basin Initiative (CBI).

I joined with several others in helping to shape the enhanced market access in textiles and apparel when we expanded the CBI a few years ago. The result has been a move toward a more integrated Caribbean-area textile and apparel market. I believe that further integration is necessary. If not, once quotas are removed in 2005 much more of this market will be lost to goods from other areas.

One of the keys to increased market access will be squarely facing up to the core labor standards issue. When we considered the expansion of CBI, the core labor standards issue was directly addressed by heightening the labor standards criterion in the CBI program. Under that criterion, the United States may unilaterally judge whether a nation is implementing the core labor standards. With the negotiation of CAFTA, and the consequent elimination of the CBI labor standards criteria, including a fully enforceable obligation to enforce the five core labor standards, is even more important.

The further integration in apparel and textile, as well as agriculture, means some further displacement in the United States. Comparative advantage is sound economics, but the distortion of the labor market by suppression of workers to create this advantage is unsound as an economic and policy matter, is unnecessary, and will only deepen opposition from competing workers and businesses in the United States.

Facing the issues surrounding core labor standards is not a vehicle for "protectionism." Indeed, it is an opportunity for expanded trade.

Only a coalition that is far broader and solidly bipartisan, much more so than the narrow votes in the U.S. House achieved by last minute concessions, can be the basis for working out decisions on the tough issues of apparel and textiles and agriculture in CAFTA, and beyond.

More broadly, CAFTA can and should be a building block towards effective negotiation of an FTAA.

The CAFTA negotiations present the opportunity for the United States to negotiate fully enforceable core labor standards, combined with a phased-in compliance period, a significant and ongoing commitment of U.S. technical assistance to the countries to help them achieve compliance before and in the initial years of the agreement, and positive market access incentives for countries that improve their laws and enforcement record (for instance, by accelerating implementation of market access phase-ins or by providing improved access than required by the terms of the FTA). The goal of those of us who seek to establish rules in this area is to expand trade, not shut it off.

There are many similarities between Central American nations and those in the rest of Latin America. Where there are, what is negotiated in CAFTA will matter. That will be true, for example in investment, intellectual property, customs obligations, and labor standards.

Where there are differences, it is a serious mistake to use an agreement for one country as a model for another, turning a building block into a stumbling block.

This is what seems to be evolving as to use of the Chile and Singapore agreements for negotiations in CAFTA. Last week USTR tabled in the CAFTA negotiations a proposal on core labor standards using the Chile and Singapore provisions as a model. Use of a standard of enforcing one's own laws is viable where a nation's laws embody the five ILO core labor standards and there is a record of enforcement of those laws. The laws of Chile and

Singapore do embody the five core labor standards and these are enforced in practice. The opposite is true in the Central American nations I visited; the standard of "enforce your own laws" would be a backward step in the CAFTA and benefit those with the worst laws.

This sparked the letter last week to Ambassador Zoellick from the Democratic leadership of the House and Mr. Rangel, Mr. Matsui and myself. We said "We write as supporters of negotiations for a U.S.-Central American free trade agreement . . . That said, we are not supportive of the proposed U.S. draft text for the FTA's labor chapter . . . The current version of this text does not adequately address the economic and individual impact of the egregious conditions for workers in the region, and should not be the starting point for consideration of these issues."

Inclusion of a core labor standards provision in the CAFTA, and in future trade agreements, will help answer arguments of those who complain that globalization is harmful to the poor and anti- the "little guy."

I came home from my trip with a positive view of the opportunities that can be achieved, but only if we address the significant challenges. A key challenge is to place core labor standards in a broader perspective, and to understand that it is vital to the future of each Central American nation, the Central American region, the integration of the hemispheric market and the future of U.S. trade policy.

INTRODUCTION OF THE "WINNING THE PEACE ACT OF 2003"

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FARR. Mr. Speaker, I rise today to introduce a new piece of legislation—the "Winning the Peace Act of 2003". I am pleased to be joined by colleagues from both sides of the aisle—Representative WOLF of Virginia, Representative HOEFFEL of Pennsylvania, Representative LEACH of Iowa, and Representative WEXLER of Florida—as original cosponsors of the bill.

The "Winning the Peace Act of 2003" creates a much-needed institutional framework to deal with post-conflict situations, such as those the U.S. currently faces in Afghanistan and Iraq. The principle components of the bill are as follows:

Creation of Director of Reconstruction Positions to provide a point person in the U.S. government to coordinate operations in post-conflict scenarios.

Creation of a FEMA-like office within USAID to manage a database and serve as a clearinghouse for post-conflict reconstruction experts, and to provide support for post-conflict operations.

Creation of a NATO unit to respond to post-conflict scenarios, and authorization of the President to make a U.S. contribution of personnel to the unit.

Establishment of a U.S. post-conflict training center, building on existing training programs in the country.

Creation of a Civilian Police Reserve to train and deploy American police officers interested in serving overseas in post-conflict environments.

Creation of a "Security Development Fund"—$300 million in a drawdown account to provide resources to cover immediate and unforeseen costs in declared post-conflict situations, and potential U.S. contributions to multilateral operations.

The "Winning the Peace Act of 2003" is designed to fill a vacuum in U.S. foreign policy. It creates institutional mechanisms where only adhoc arrangements exist. It establishes a permanent source of funding instead of relying on the Congressional appropriations calendar, or emergency supplemental bills. Equally important, the bill lays the groundwork, through training and education, for a new cadre of post-conflict experts, both civilians and military, in the governmental and non-governmental sectors.

The United States has faced post-conflict situations in the past—in the 1940s in Germany and Japan, and more recently in Somalia, Haiti, Bosnia and Kosovo, to name a few. We, along with our allies—countries and multilateral institutions—have observed and learned much in recent history. While it is true that no two situations are identical, it can be said there are always common challenges. The "Winning the Peace Act of 2003" addresses those challenges and will strengthen the capacity of the United States to pursue its foreign policy objectives in the future.

INTRODUCTION OF THE KILAUEA POINT NATIONAL WILDLIFE REFUGE EXPANSION ACT OF 2003

HON. ED CASE

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CASE. Mr. Speaker, I rise today to introduce a bill to authorize expansion of the Kilauea Point National Wildlife Refuge on the Island of Kaua'i. This bill is a vital component of one of my principal goals in Congress: to ensure that federal and/or state or private protection is extended to as many of Hawai'i's threatened and irreplaceable areas as possible, both to ensure the survival and recovery of Hawai'i's unique endangered and threatened species and to preserve the remaining unspoiled natural treasures of our beautiful islands for future generations.

The Kilauea National Wildlife Refuge, located at the northernmost tip of Kaua'i, was established in 1985. The initial acreage of 31 acres was increased to 203 acres through additional acquisitions in 1993 and 1994. The refuge provides invaluable habitat for many native seabirds, including the Laysan Albatross, the Red-footed Booby, and the Wedge-tailed Shearwater, as well as for the endangered nene (Hawaiian Goose). Native plants have also been reintroduced to the area. The Refuge and its historic lighthouse have become one of Hawai'i's world-class tourist destinations, visited by some 400,000 visitors each year.

The proposed expansion area consists of three indispensable land parcels that are currently available for purchase and could be added to the eastern boundary of the Refuge. The Kilauea River runs through the land, which also includes an extensive lo'i (irrigated terrace for traditional cultivation of taro, the staple crop of Native Hawaiians) which could be restored to support endangered Hawaiian water birds, including the Koloa duck, Hawaiian coot, Hawaiian stilt, and Hawaiian moorhen. There is also a high quality estuarine ecosystem at the lower reaches of the river, which includes habitat for endangered birds as well as native stream life, such as the hihiwai (an endemic snail) and o'opu (native goby). The proposed addition also provides an excellent habitat for the nene, Hawai'i's state bird, which was only recently saved from extinction. The beach is also sometimes used by endangered Hawaiian monk seals, and endangered sea turtles nest in the area.

These three parcels are available for sale and each of the owners has expressed a desire to see the land protected from development. But given rampant urbanization on Kaua'i (and elsewhere in Hawai'i) and the high demand for waterfront property, we could very well lose this remarkable opportunity to add high quality wildlife habitat to our national refuge system.

The Kilauea community strongly supports protecting the land from development. In fact, the Kilauea Point National Wildlife Refuge is a model for management of other federal refuges nationwide. The operations of the Refuge are supported by community volunteers, who give daily tours of the Refuge and help in the preservation of native plant species. The principal volunteer group, Kilauea Point Natural History Association, even has a small store in the Visitor Center, the proceeds of which go to the Refuge and for environmental education throughout Hawaii.

I urge my colleagues to join me in supporting this bill, and invite you to come to the Island of Kaua'i to visit the Refuge. I know that if you did so, you would be convinced as I am of the importance of protecting these lands.

A PROCLAMATION CONGRATULATING JACKSON CITY SCHOOL DISTRICT AND THEIR ENERGY PROJECT JEEP III FOR 2003

HON. ROBERT W. NEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. NEY. Mr. Speaker,

Whereas, JEEP III (Jackson's Energy Education Project) showcases their dedication to Energy awareness and education throughout the school district and community; and

Whereas, these young people have demonstrated exceptional talent, ingenuity, and creativeness in finding ways to expand our understanding of energy issues; and

Whereas, Jackson City Schools' "JEEP III" received First Place honors for the State of Ohio; and

Whereas, Jackson City Schools will be recognized in Washington, DC at the National Youth Awards Program for Energy Achievement sponsored by the National Energy Education Development (NEED) Project;

Therefore, I join with the residents of the entire 18th Congressional District of Ohio in congratulating Jackson City Schools for their outstanding pursuit of excellence.

IN HONOR OF SAINT BONIFACE PARISH

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor of the parish community of Saint Boniface Parish, as they celebrate 100 years of faith and hope in Cleveland's Westside neighborhood. Throughout the past century, Saint Boniface Parish has served as a spiritual refuge—radiating hope, encouragement, education and faith.

Father Casimir Reichlin began the ministry of Saint Boniface in February of 1903. His visionary focus aimed at educating children within the framework of the neighborhood parish has remained as significant and impactful today as it was 100 years ago. As Saint Boniface Parish was born, so was Saint Boniface School. In 1904, Reverend A. M. Seeholzer was named Pastor of Saint Boniface Parish. Under the guidance of Father Reichlin, Pastor Seeholzer oversaw the construction of a four-room frame building that would serve parishioners and students for the next 12 years.

In March of 1923, parishioners and spiritual leaders of Saint Boniface Parish celebrated the grand opening of the new Saint Boniface School. The sturdy, two-story brick structure contained 16 classrooms, accommodating more than 700 students, in grades kindergarten through high school. Today, Saint Boniface School provides preschool, kindergarten and first grade instruction.

Mr. Speaker and colleagues, please join me in honor and recognition of every member of Saint Boniface Parish, as they celebrate 100 years of fostering faith, hope, enlightenment and love within our Cleveland community. Saint Boniface Parish continues its dedication to providing educational and spiritual growth, elevating the lives of countless children, adults and families within our community.

A RESOLUTION HONORING JOSIE COLE, LEGRAND SMITH SCHOLARSHIP WINNER OF PARMA, MI

SPEECH OF

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 13, 2003

Mr. SMITH of Michigan. Mr. Speaker, let it be known that it is with great respect for the outstanding record of excellence she has compiled in academics, leadership and community service, that I am proud to salute Josie Cole, winner of the 2003 LeGrand Smith Scholarship. This award is made to young adults who have demonstrated that they are truly committed to playing important roles in our Nation's future.

As a winner of the LeGrand Smith Scholarship, Josie is being honored for demonstrating that same generosity of spirit, intelligence, responsible citizenship, and capacity for human service that distinguished the late LeGrand Smith of Somerset, Michigan.

Josie is an exceptional student at Springport High School, and possesses an outstanding record of achievement in high school. Josie has received numerous awards for her excellence in academics and athletics, as well as her volunteer activities with the Eaton Rapids Women's Club and Vacation Bible School. Josie is also proficient in sign language and has signed the National Anthem at athletic events at Springport High School.

Therefore, I am proud to join with her many admirers in extending my highest praise and congratulations to Josie Cole for her selection as winner of a LeGrand Smith Scholarship. This honor is a testament to the parents, teachers, and others whose personal interest, strong support and active participation contributed to her success. To this remarkable young woman, I extend my most heartfelt good wishes for all her future endeavors.

SAINT ANTHONY OF PADUA PARISH CELEBRATES 75TH ANNIVERSARY

SPEECH OF

HON. PAUL E. KANJORSKI

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 15, 2003

Mr. KANJORSKI. Mr. Speaker, today I call the attention of the House of Representatives to the 75th anniversary of Saint Anthony of Padua Parish of Exeter, Pennsylvania. The parish will celebrate this milestone with a Mass and dinner on May 18, 2003, with the dinner chaired by Attorney Charles J. Bufalino.

At the start of the 20th century, thousands of Italian immigrants came to America in search of a better life for themselves and their families. Many of them came to work in the coal mines of Northeastern Pennsylvania, with quite a few settling in the Exeter area. In addition to their common heritage and language, they shared a common faith, so they founded a parish where they could come together as a community.

The first church serving Saint Anthony of Padua Parish was built in 1928 and 1929, to be followed by a new church in 1963. Father Alphonse Manley, a diocesan priest, staffed the parish until the arrival of Father Emilio Boccalatte, O.S.J., an Oblate of Saint Joseph, in 1930. The Oblates of Saint Joseph have staffed the parish ever since. The present pastor is the Rev. Daniel Schwebs.

I am told it is quite common to find parishioners, young and old alike, in the church offering prayers throughout the day, and this is an example of the faith that abides at Saint Anthony's.

Mr. Speaker, I am pleased to call to the attention of the House the 75th anniversary of Saint Anthony of Padua Parish, and I extend my congratulations to all who are associated with the parish.

TRIBUTE TO ADRIAN SPOTTEN HOOPER, A LEGACY OF MARITIME ACHIEVEMENTS

HON. CURT WELDON

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WELDON of Pennsylvania. Mr. Speaker, I rise today to honor the memory of Adrian Spotten Hooper, one of Pennsylvania's most distinguished business, maritime and community leaders. Mr. Hooper was Chairman of Penn's Landing Corporation, in Philadelphia, PA, during the area's initial development and head of the Independence Seaport Museum when it was moved to the waterfront. In fact, there would be no Independence Seaport Museum without Adrian's leadership.

Mr. Hooper, born and raised in West Philadelphia, had been fascinated by the sea since his youth. He ran away from home at the age of 15 and tried to join the Merchant Marine, but was forced to return after his father intervened and arranged for him to sail on a Norwegian vessel in the North Atlantic for a few months. Mr. Hooper got sailing out of his system for a while, and graduated from Lower Merion High School in 1941. But to the sea he soon returned. As soon as World War II broke out, Adrian joined the Navy. He wanted to be at sea and fight in the war so badly that he memorized the eye chart, because he was blind in one eye. He went on to serve our country as a torpedoman on a destroyer in the Atlantic and the Pacific until 1945.

After the war, Mr. Hooper earned a bachelor's in business from the University of Pennsylvania's Wharton School in 1950. That year, he married Elizabeth Wharton Shober, and they moved to Devon, PA. He also began his professional career as a dispatcher for Interstate Oil Transport Company in Philadelphia.

Mr. Hooper's career was interrupted in 1951 when he joined the Army during the Korean War. He served stateside until 1953.

After the war, Mr. Hooper returned to the Interstate Oil Transport Company and served as chief executive officer until the company was sold in 1981 to Southern Natural Resources.

Mr. Hooper's public service began in the early 1970s, when former Mayor Frank L. Rizzo appointed him chairman of Penn's Landing Corporation. At the time, the 22.5-acre area along the Delaware River from Market to Lombard Streets, commemorating where Philadelphia began more than 300 years ago, was fallow. Under Mr. Hooper's direction and able leadership, Penn's Landing became an entertainment center.

Mr. Hooper dedicated his life to maritime issues. He served as chairman of the American Institute of Merchant Shipping in the mid-1970s. While president of the Independence Seaport Museum, then called the Philadelphia Maritime Museum, Mr. Hooper led a $15 million fund drive that enabled the museum to move from Chestnut Street to Penn's Landing in 1995.

Mr. Hooper had many other exciting ventures outside of Philadelphia.

In 1966, Mr. Hooper and the late Charles P. "Pete" Conrad, Apollo 12 commander, founded Universal Space Net, a satellite tracking firm in California. The firm has done work for NASA, the Air Force, and aerospace firms.

Mr. Hooper's first wife died in 1996, and he married Susan M. Borresen Hooper in 1999. In addition to his wife, Mr. Hooper is survived by daughters Suzanne, Elizabeth, and Dana; a son, Adrian Jr.; stepchildren Karen and Devon Walsh; and four grandchildren.

Mr. Hooper's legacy will endure not only in the principles he stood for and the improvements he brought to Pennsylvania, but also his wonderful family, his wife and children. Mr. Hooper's legacy is sure to include his keen understanding that the most important elements of our maritime infrastructure are people—shipyard workers, commercial seafarers, merchant fleet operators, and many others who make America the maritime nation that it is today.

Mr. Speaker, our region has lost an exceptional leader, and I have lost a good friend. I wish the family of Adrian Hooper my heartfelt condolences and may they find comfort in knowing that the many people he impacted deeply value his dedication and generosity and the example of his life and work. Adrian Hooper exemplified the spirit of service that has made this country great. It is proper to remember and honor a man of such worth and character with great respect for what he accomplished and stood for.

THE REALITY PRINCIPLE

HON. BARNEY FRANK

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FRANK of Massachusets. Mr. Speaker, President Bush's serious personal involvement in the effort to bring about Middle East peace deserves both praise and, more important, strong support from all Americans. As a strong supporter of the State of Israel and its right to exist as a democratic, Jewish state in a secure environment, I firmly believe that what President Bush is doing is very much in furtherance of the achievement of that goal, and I am pleased that he is taking the risks that are inherent when any president seeks genuinely to push for peace in the Middle East. As Thomas Friedman noted in a recent column in the New York Times, President Bush's involvement is essential if we are to reach peace.

As Mr. Friedman also notes, and those of us who seek peace must be prepared to acknowledge this, "it may be that the Palestinians are capable only of self-destructive revenge, rather than constructive restraint and reconciliation." That is, no one can be sure that peace is attainable on grounds that will allow Israel to live securely and without the constant threat of terrorist attacks on its citizens. But as Mr. Friedman adds, "surely Israel has more to gain in the long term by giving Mr. Abbas every chance to prove otherwise, and to empower him to do so . . ."

There are two very tough decisions now facing the government of Israel, and I believe that those of us who have been and are consistent defenders of Israel's right to exist, in the face of the overwhelming hostility of so many neighboring countries, should be explicit in urging the Israeli government to take the necessary action to test the Palestinians willingness to embrace genuinely a two-state solution. One of those decisions is to be willing to withdraw settlements from much of the West Bank and all of Gaza. The other, even harder given the understandable emotion that the murder of innocent civilians triggers, is to show the restraint that the Bush Administration has asked Israel to show with regard to retaliation against the leaders of Hamas and other terrorist groups. I do not deny Israel's right to act in its own defense, but I do urge the government to consider seriously the wisdom of Mr. Friedman's argument for restraint as a very important step towards testing the prospects for peace.

I have been struck, in conversations with Israeli government officials, by the confidence they have expressed in the good intentions of the new Palestinian Prime Minister, Mahmoud Abbas. But it is also clear that he faces great difficulties, including, sadly, the hostility of Yasir Arafat, whose unwillingness seriously to make peace has been a major factor contributing to the turmoil in the region. Refraining from actions which will unnecessarily undercut Prime Minister Abbas, is clearly in the interest of Israel, certainly until it becomes clearer as to whether or not he will be able to achieve the peace that Israel believes he seeks.

Thomas Friedman's article in the New York Times for Saturday, June 21, spells out this complex set of considerations very well, and I ask that this important article be reprinted here.

THE REALITY PRINCIPLE

(By Thomas L. Friedman)

Have you noticed how often Israel kills a Hamas activist and the victim is described by Israelis as "a senior Hamas official" or a "key operative"? This has led me to wonder: How many senior Hamas officials could there be? We're not talking about I.B.M. here. We're talking about a ragtag terrorist group. By now Israel should have killed off the entire Hamas leadership twice. Unless what is happening is something else, something I call Palestinian math: Israel kills one Hamas operative and three others volunteer to take his place, in which case what Israel is doing is actually self-destructive.

Self-destructive is, in fact, a useful term to describe Israelis and Palestinians today. "Both sides," notes the Israeli political theorist Yaron Ezrahi, "have crossed the line where self-defense has turned into self-destruction. When self-defense becomes self-destruction, only an external force can bring people back to their senses. And that force is President Bush. I think he is the only reality principle left that either side might listen to, and I hope he understands that."

You know that both sides are in self-destruction mode when you can look at their military actions and say that even if they succeeded they would be worse off. The question is not whether Israel has a right to kill senior Hamas officials. They are bad guys. The question is whether it's smart for Israelis to do it now.

The fact is, the only time Israelis have enjoyed extended periods of peace in the last decade has been when Palestinian security services disciplined their own people, in the heyday of Oslo. Unfortunately, Yasir Arafat proved unwilling to do that consistently. The whole idea of the Bush peace process is to move Mr. Arafat aside and replace him with a Palestinian prime minister, Mahmoud Abbas, who is ready to rebuild the Palestinian security services, and, in the context of an interim peace settlement, corral Hamas.

Hamas knows this. So its tactic is to goad Israel into attacks that will unravel the whole process. The smart thing for Israel to do—and it's not easy when your civilians are being murdered—is not to play into Hamas's hands. The smart thing is to say to Mr. Abbas: "How can we help you crack down on Hamas? We don't want Israel to own Hamas's demise. Palestinians have to root out this cancer within their own society. If Israelis try to do it, it will only metastasize."

Israel's supporters argue that if America can go after Osama bin Laden, Israel can go after Hamas. Of course Israel is entitled to pursue its mortal enemies, just as America does, but it cannot do it with reckless abandon, notes Mr. Ezrahi, for one reason: America will never have to live with Mr. bin Laden's children. They are far away and always will be. Israel will have to live with the Palestinians, after the war. They are right next door and always will be.

The fact is, Ariel Sharon's two years of using the Israeli Army alone to fight terrorism have not made Israelis more secure. He needs a Palestinian partner, and he has to operate and negotiate in a way that will nurture one. And the people who get that the best are Israelis. In a Yediot Ahronot poll released Friday, two-thirds of Israelis were critical of Mr. Sharon's tactic of targeted assassinations of Hamas officials and said they wanted Mr. Abbas to be given a chance to establish his authority.

It may be that Mr. Abbas can't step up to this. It may be that the Palestinians are capable only of self-destructive revenge, rather than constructive restraint and reconciliation. But surely Israel has more to gain in the long term by giving Mr. Abbas every change to prove otherwise, and to empower him to do so, rather than killing one more Hamas "senior official," who will only be replaced by three others.

Because if the two sides cannot emerge from this dead end, then you can forget about a two-state solution, which is what both Hamas's followers and the extremist Jewish settlers want. They each want a one-state solution, in which their side will control all of Israel, the West Bank and Gaza. The one-state solution would mean the end of the Zionist enterprise, because Israel can rule such an entity, in which there would soon be more Arabs than Jews, only by apartheid or ethnic cleansing. It would also mean the end of Palestinian nationalism, because the Israelis will crush the Palestinians rather than be evicted. That is the outcome we are heading toward, though, unless the only reality principle left, the United States of America, really intervenes—with its influence, its wisdom and, if necessary, its troops.

HONORING CLINICA MARIPOSA

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FARR. Mr. Speaker, I rise today to honor Clinica Mariposa, Planned Parenthood of Watsonville, CA. During a time when healthcare services are continually becoming more expensive, and information on reproductive health is becoming more restricted, Planned Parenthood provides invaluable services and resources to the Watsonville community. For nearly thirty years, Clinica Mariposa has offered education, outreach, and medical services to an ever-growing population that depends on these affordable services.

Since the establishment of Planned Parenthood services in Watsonville in 1974, there has been a demonstrated commitment to affordability, cultural sensitivity, confidentiality, and high medical standards. All of these things contribute to the achievement of Planned Parenthood's goal of "every child, a wanted child, every family a healthy family."

It is frightening that in a country based on opportunity and equality, there are so many people who are without healthcare. Planned Parenthood has become a crucial part of the local healthcare network that provides a broad range of affordable services. Over the years, the growing health needs of the Watsonville community have been answered by Planned Parenthood and their ever-expanding services and facilities. By utilizing community-based satellites at farm labor camps and community agencies in addition to the Penny Lane location, Planned Parenthood fills a special role serving low-income residents regardless of their insurance status.

In an atmosphere where the constitutionally established right to reproductive choice is being threatened, and access to comprehensive sex education is being limited, the presence and services of Planned Parenthood are critical now more than ever. The presence of Planned Parenthood in Watsonville has ensured that residents have the full spectrum of choices and opportunities regarding their health. In addition, through school based education programs, Planned Parenthood has worked to reduce unintended teen pregnancies by giving young people the information and skills they need to make healthy choices.

The exceptional services that Planned Parenthood offers would be impossible without the dedication of the staff, the generosity of their many supporters, and the support of community leaders. I applaud the hard work of all those who have devoted their time and energy to the cause of affordable, high quality healthcare at the Watsonville Planned Parenthood.

INTRODUCING THE "SMALL BUSINESS FEDERAL SAFEGUARD ACT"

HON. ED CASE

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CASE. Mr. Speaker, small businesses are the lifeblood of our economy and generate nearly half of our nation's GDP, yet the federal government is shutting small businesses out of the federal contracting process by bundling small contracts together into large megacontracts.

In my State of Hawai'i for example, the federal government has created large megacontracts for military housing projects. This allows huge corporations to swoop in and win the contracts, even though Hawai'i's small businesses could do the work. Bundling has put these projects, and many other government contracts, out of the reach of small businesses and forces them to become subcontractors. I have heard from countless small business owners who said subcontracting for a large prime contractor is detrimental to their financial health and unfairly forces them to abide by the large corporations' work rules.

Today I introduce a companion bill to S. 633. This bill will strengthen the definition of a bundled contract and prevent federal agencies from circumventing statutory safeguards intended to prevent contract bundling.

This is a fair and temperate solution, and I ask for my colleagues' support.

A PROCLAMATION HONORING MR. AND MRS. THOMPSON ON THEIR 70TH WEDDING ANNIVERSARY

HON. ROBERT W. NEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. NEY. Mr. Speaker,

Whereas, Victor and Ruth Thompson were united in marriage June 26, 1933, and are celebrating their 70th anniversary this year; and

Whereas, Victor and Ruth have demonstrated love and a firm commitment to each other; and

Whereas, Victor and Ruth have proven, by their example, to be a model for all married couples; and

Whereas, Victor and Ruth must be commended for their incredible devotion to each other;

Therefore, I join with the residents of the entire 18th Congressional District of Ohio in congratulating Victor and Ruth Thompson as they celebrate their 70th Wedding Anniversary.

IN HONOR AND REMEMBRANCE OF SAMUEL LADERMAN

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor and remembrance of Samuel Laderman—beloved family man, respected attorney and CPA, and friend and mentor to countless.

Mr. Laderman began his career in the late 1940s first as an accountant. A few years later, he earned a law degree from Cleveland Marshall Law School, which singled him out as one of the few attorneys who also held a CPA license. Mr. Laderman built his career in law and accounting based on expertise, integrity, and a strong work ethic. He forged lifelong professional relationships based on trust, fairness, good will and his ever-present vivacious personality and quick wit.

Aside from his great professional success, Mr. Laderman possessed a kind heart, great sense of humor, and his main priority, focus and greatest love was his family. He was happily married to his college sweetheart, Cecile "Cece" Perry for 58 years. Together they lovingly raised two daughters, Flora and June, and a son, Gerald. Their closeness as a family and deep faith carried them through the tragic loss of their daughter June, who lost her battle with leukemia as a teenager. In her honor and memory, Mr. and Mrs. Laderman worked to help others through their creation of the June Beverly Laderman Memorial Fund with University Hospitals of Cleveland. Mr. Laderman volunteered his time and talents within our community on a regular basis. He was a member of the Cuyahoga County Bar Association, and was first president of the Hillel Alumni Association of Cleveland. In addition, Mr. Laderman was past president of the Cleveland Heights Chapter of B'nai B'rith, and served on the board of B'nai Jeshurun Synagogue.

Mr. Speaker and Colleagues, please join me in honor and remembrance of Samuel Laderman—beloved family man, respected attorney, CPA, and friend and mentor to countless. I offer my deepest condolences to his beloved wife Cecile; beloved children, Flora and Gerald; to his three adoring grandchildren, extended family, and to his many colleagues and friends. Mr. Laderman's life has left a luminous mark upon our community, and his spirited work and personal and professional legacy will be remembered always.

IN HONOR OF DUANE SCHAEZLER

HON. MARTIN FROST

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FROST. Mr. Speaker, I rise today to recognize the outstanding service of Arthur Duane Schaezler, a gentleman who has recently celebrated his 51st anniversary with Lockheed Martin Missiles and Fire Control in my district.

Duane Schaezler served this country as an Air Force navigator for three years before he obtained his BS in Aeronautical Engineering from the University of Texas in 1949. Duane joined what was then-Chance Vought Aircraft in 1951 and has since applied his vast experience and expert technical knowledge in the areas of guidance, navigation, flight dynamics and control systems.

Duane is an excellent example of a dependable and deliberate American whose positive work ethic and loyalty are so important in today's society.

Today, I ask my colleagues to join me in congratulating Duane Schaezler on his incredible accomplishment of fifty-one years with Lockheed Martin and wish him continued success in the future.

TRIBUTE HONORING 2003 LEGRAND SMITH SCHOLARSHIP FINALISTS THOMAS CLEVENGER OF JACKSON, MICHIGAN, AND JEREMY WAGNER-KAISER OF BATTLE CREEK, MICHIGAN

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SMITH of Michigan. Mr. Speaker, It is with a sincere pleasure to recognize the finalists of the 2003 LeGrand Smith Congressional Scholarship Program. This special honor is an appropriate tribute to the academic accomplishment, demonstration of leadership and responsibility, and commitment to social involvement, demonstration of leadership and responsibility, and commitment to social involvement displayed by these remarkable young adults. We all have reason to celebrate their success, for it is in their promising and capable hands that our future rests.

The finalists of the LeGrand Smith Congressional Scholarship Program are being honored for showing that same generosity of spirit, depth of intelligence, and capacity for human service that distinguished the late LeGrand Smith of Somerset, Michigan. They are young men and women of character, ambition, and initiative, who have already learned well the value of hard work, discipline and commitment.

These exceptional students have consistently displayed their dedication, intelligence and concern throughout their high school experience. They stand out among their peers due to their many achievements and the disciplined manner in which they meet challengers. While they have already accomplished a great deal, these young people possess unlimited potential, for they have learned the keys to success in any endeavor.

As a Member of Congress of the United States of America, I am proud to join their many admirers in extending our highest praise and congratulations to the finalist of the 2003 LeGrand Smith Congressional Scholarship program.

HONORING RALPH AND ELEANOR LOCHER ON THE OCCASION OF THEIR 64TH WEDDING ANNIVERSARY

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor and recognition of Mayor Ralph and Eleanor Locher, as they celebrate the sixty-fourth year of their marriage. Their committed partnership to each other also reflects their deep commitment and service to our entire Cleveland community.

Mayor and Mrs. Locher met in their rural hometown of Bluffton, Ohio. As a young boy, Mayor Locher and his family emigrated from Romania and settled in Bluffton. Mrs. Locher was born and raised in Bluffton. Their dedication for each other and their passion for politics originated during their teen years in high school, as they were avid members of the high school debate team—and they've been inseparable ever since.

Mayor and Mrs. Locher attended Dayton University together. After they graduated, they moved to Cleveland and were married in June of 1939. Mr. Locher went on to attend law school at Western Reserve University, while Mrs. Locher worked as a teacher. Soon after, daughter Virginia was born. Mrs. Locher became the steel frame of the Locher family, evolving into the role of mother, supportive wife and civic activist. Throughout Mayor Locher's impressive career as attorney, mayor and judge, Mrs. Locher was a constant and committed advocate, organizer and friend. Their unbreakable alliance has served to encourage, uplift, and bring out the best in one another.

Mr. Speaker and colleagues, please join me in honor and recognition of Mayor Ralph Locher and Eleanor Locher as they celebrate sixty four years of marriage. The longevity of their union underscores a deep and abiding love and commitment for each other—and reflects their deep respect, admiration and solid friendship that continues to grow stronger throughout their journey. Family has always been central to their life together—daughter Virginia Wells; grandson Andrew and his wife Heather; and great-granddaughter Caroline. We stand in celebration of the wedding anniversary of Ralph and Eleanor Locher—the spirit of love within their union is cause for celebration and is an inspiration to us all.

"Love is the river of life in the world"—Henry Ward Beecher.

HONORING GUY REDMOND

HON. MARTIN FROST

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FROST. Mr. Speaker, it is my privilege today to recognize an outstanding engineer from my district. Mr. William Guy Redmond, Jr., recently celebrated the remarkable accomplishment of over 50 years of service to Lockheed Martin Missiles and Fire Control in Dallas, Texas.

Guy Redmond came to what was then-Chance Vought Aircraft Company as a young man after serving in the U.S. Navy and receiving degrees from SMU and MIT. Over the years, Guy has amassed over 20 patents. He is highly respected by all for his integrity and technical expertise and unwavering dedication to his organization.

In 1983, Guy was recognized through a nomination for the coveted IEEE Pioneer award for his contributions to the company and the community.

Mr. Speaker, I would like to recognize Guy Redmond again today for his enormous accomplishments at Lockheed Martin and offer my heartiest congratulations on his 51st anniversary. I'm sure the members of this body will agree with me that 50 years of constancy and dedication is a feat not accomplished by many, and I wish him great success in his future endeavors.

CONDEMNING TERRORISM INFLICTED ON ISRAEL SINCE AQABA SUMMIT AND EXPRESSING SOLIDARITY WITH THE ISRAELI PEOPLE

SPEECH OF

HON. HENRY A. WAXMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. WAXMAN. Mr. Speaker, I rise in strong support of this resolution and join my colleagues in condemning the ongoing Palestinian terrorist attacks that threaten to derail the renewed effort to bring Israelis and Palestinians back to the peace process.

Since the Aqaba summit, 22 Israeli civilians have been murdered in terrorist attacks even as the Israeli Government has taken measures to release Palestinian prisoners, dismantle settlement outposts, allow Palestinian workers back into Israel and transfer revenue funds to the Palestinian treasury.

This is not a cycle of violence. This is a cycle of terrorism where Hamas and Islamic Jihad bargain for a "ceasefire" so they can buy time to regroup and rearm.

I was shocked, therefore, to hear President Bush condemn Israel's attack on Hamas leader Abdel Aziz Rantisi and Secretary of State Powell speak out against Israel's attempt to arrest other Hamas operatives.

Although the Israelis are willing to take risks for peace, they have every right as a sovereign state to defend their vital interests. The United States, as a nation engaged in the global war on terrorist groups, should stand firmly with Israel on this issue. The same coffers that fund Al Qaeda funnel money and weapons to Hamas and Islamic Jihad, and the same state sponsors of terrorism that arm Hezbollah and smuggle mortars, explosives, and weapons into Gaza.

I stand with the President in support of a two state solution that will bring security and stability to the region. The reality is, however, that the future of the Road Map depends on the direction of the Palestinian leadership. Although newly appointed Palestinian Prime Minister Mahmood Abbas faces challenges, he has the ability to move in the direction of peace by shutting off the constant stream of anti-Israel hatred and incitement on Palestinian television and newspapers.

Likewise, it the responsibility of the Arab states, the European Union, Russia, and the United Nations to support Prime Minister Abbas by joining the United States in isolating Arafat and shutting down the financing of terrorist networks that seek to undermine Palestinian reform.

The Road Map for peace requires all parties involved to maintain a commitment to these principles and to understand that the cessation of terrorism is the first step toward that vision.

JAMES AND ANN McENTEE HONORED FOR YEARS OF SERVICE TO THE PEOPLE OF SANTA CLARA COUNTY

HON. ZOE LOFGREN

OF CALIFORNIA

HON. MICHAEL M. HONDA

OF CALIFORNIA

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. LOFGREN. Mr. Speaker, today Mr. HONDA, Ms. ESHOO, and I rise to recognize the achievements of Jim and Ann McEntee for their contributions to Santa Clara County. Jim McEntee is retiring as the Director of the Office of Human Relations after 27 years of dedicated service to the people of Santa Clara County and Ann is retiring after 40 years in teaching.

Jim and Ann have been happily married for 30 years during which time they have served the community as a team. He and his wife Ann, a teacher, have raised a large multi-cultural family.

Jim's first career was as a Roman Catholic priest, during which he served as an Associate Pastor in the Roman Catholic Archdiocese of San Francisco for 16 years before working for Santa Clara County.

Jim has a long history of building bridges between communities, bringing programs and services to the people in Santa Clara County. He is a founding member of the Confederation de la Raza Unida, founding chairperson of the Second Harvest Food Bank of Santa Clara County, a founding member of the Emergency Housing Consortium and the Help House the Homeless Coalition. Jim has also worked very closely with the United Farm Workers of America since 1965.

Jim and Ann worked together to help organize and actively promote many community activities that serve to promote an appreciation of local ethnic cultures, e.g. The Martin Luther King Celebration, Cinco de Mayo Celebration, and the Tet Festival. They also take a leadership role in promoting social justice in the community through a church-based organization called "Just Faith."

Ann has dedicated her career to teaching, and for the past 11 years she has taught Special Education at Lee Mathson Middle School where she reaches out to students and families by making regular home visits. Ann also developed a school dispute resolution program at Lee Mathson to help students develop the skills to resolve their problems constructively and peacefully.

We wish to thank Jim and Ann McEntee for their tireless service to the County and wish them the best in their future endeavors. Furthermore, they have our personal thanks for our years of friendship. Though we will miss their compassion, expertise and commitment, their dedication has left its mark on Santa Clara County.

CONDEMNING TERRORISM INFLICTED ON ISRAEL SINCE AQABA SUMMIT AND EXPRESSING SOLIDARITY WITH THE ISRAELI PEOPLE

SPEECH OF

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. CANTOR. Mr. Speaker, I rise today to support H. Res. 294, and I thank Mr. DELAY for scheduling this important resolution this week.

On June 4, 2003, President Bush, Prime Minister Sharon, and Prime Minister Abbas came together to pledge their commitment to the "Road Map" to Peace. At this summit, Mr. Abbas promised to reign in the terror groups that have plagued Israel with 3 years of relentless terror. Since this summit, 29 Israelis have been murdered and over 120 have been wounded in terrorist attacks by Palestinian organizations such as Hamas, Islamic Jihad, and Yasser Arafat's own Fatah. In all, the Israeli defense forces have counted 319 separate attacks on soldiers and civilians.

Mr. Speaker, the United States sustained a horrifying terrorist attack on September 11, 2001, and responded rightfully by pursuing and attacking those responsible for the cowardly murder of innocent civilians on American soil. Israel has lived with a perpetual September 11 since its inception and must be allowed to pursue those who wish to murder innocent Israeli civilians. The terrorist actions of the last few weeks demonstrate that these organizations are not interested in peace, but rather the complete eradication of the State of Israel. We must condemn those who use terror against civilians as a means to destroy freedom and peace.

Israel, like the United States, was founded on the common values of democracy, freedom, and peace. Today, I reiterate that we must stand by Israel, our strongest ally in the Middle East, in its fight against the terrorist organizations that seek to destroy the peace. We must maintain our commitment to Israel's security and the safety of its citizens.

Peace must come with security, not in spite of it. Israel has always made a sincere commitment to peace in the region. Many times its commitment to peace has come at the expense of innocent life. Before the process can move forward, we must compel the Palestinian authority to take immediate and effective steps to dismantle the terrorist infrastructure on the West Bank and Gaza Strip. Only then can we come to a peaceful solution of this conflict in which Israel, the Jewish State, can live side by side with a democratic Palestinian State in peace and security.

TRIBUTE TO MAYOR PAUL BAUMUNK

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CRANE. Mr. Speaker, I rise today to recognize the mayor of Lindenhurst, Illinois, Paul Baumunk, whose outstanding leadership and commitment to community service has significantly benefited the people of Lindenhurst.

A longtime resident of Lindenhurst, Mayor Paul Baumunk served as a teacher in Lake County for 31 years, both with the Lake Forest High School and the College of Lake County Vocational Center. He also served as a member of the Lindenhurst Plan Commission and the Lindenhurst Lakes Commission. In addition, Paul somehow found the time to participate in the Chamber of Commerce, the Lindenhurst Men's Club, the Lyons Club and in VFW Post #4894.

Although he has always been a devoted public servant, Paul has always held his family as a top priority. He and Joy, his wife of 32 years, originally settled in the community of Lindenhurst in 1977 to raise their son Philip and daughter Amy. Paul's retirement will allow him to spend more time with his family, something he will greatly cherish.

Mr. Speaker, I ask that you and my other distinguished colleagues join me in congratulating Mayor Paul Baumunk on his retirement after 12 years of diligent service to the Village of Lindenhurst, Illinois. Paul has been a valuable member of the community for which he cares so deeply, and his service will be greatly missed. I wish him the best of luck in future endeavors, and I know he will enjoy his retirement for many years to come.

PERSONAL EXPLANATION

HON. ERNIE FLETCHER

OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FLETCHER. Mr. Speaker, on Wednesday, June 25, 2003, had I been present for rollcall vote Nos. 312, 313, 314, 315, 316, and 317, I would have voted the following way: rollcall vote No. 312, S. 858—"yea;" rollcall vote No. 313, H.R. 2474—"yea;" rollcall vote No. 314, H.J. Res. 49—"yea;" rollcall vote No. 315, H. Con. Res. 49—"yea;" rollcall vote No. 316, H. Res. 199—"yea;" rollcall vote No. 317, H. Res. 294—"yea."

THE U.S. SUPREME COURT DECISION ON AFFIRMATIVE ACTION IN HIGHER EDUCATION

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. SOLIS. Mr. Speaker, I rise to applaud the Supreme Court's decision to uphold affirmative action. The Court's ruling this week was a tremendous victory for all those who believe that diversity is one of our nation's greatest strengths.

The historical significance of this important ruling cannot be underestimated. For millions of minority students—Latino, African-American, Native American—it means the opportunity at a better education, higher wages, and a promising future.

The Court's ruling is especially important to Latinos, our nation's fastest growing and now largest minority group. Fewer than 10 percent of college-age Latinos pursues higher education. Only 16 percent of Latinos between the ages of 25–29 have bachelor's degrees. Clearly, many challenges remain to increase Latino enrollment at colleges and universities across the country. Affirmative action is key to breaking down the barriers to higher education for Latinos.

Affirmative action is not only beneficial to minority students, but also to non-minority students. Greater diversity on our college campuses ultimately produces students who are better equipped to thrive in an economy and society that is increasingly multicultural. As Justice O'Connor noted in the Court's decision, the future of our nation relies on leaders who are comfortable with "diverse people, cultures, ideas and viewpoints." O'Connor was most likely influenced in her opinion by an unlikely coalition of business, military, civil rights, and education groups that urged the Court to uphold affirmative action because its produces leaders who are prepared for today's increasingly global economy.

The country's highest court has ruled that race may be a factor in college admissions because the nation has a compelling need for racial and ethnic diversity on our college campuses. The ruling calls into question race-neutral affirmative action plans used in several states, including my own state of California where there has been a 39 percent increase in the rejection of Latino freshman applicants to California public universities since the state's race-neutral plan was implemented. Given the Supreme Court's decision, I hope California will review and revise its affirmative action policies so that public universities in my state truly reflect the state's very diverse population. The Court has spoken about the importance of diversity. Now should California.

Throughout the United States, there are millions of Latinos and Latinas who want to succeed. They want equal educational and economic opportunities. The Court's ruling provides great hope for these young people. Again, I applaud the Court for this landmark decision.

CONDEMNING TERRORISM INFLICTED ON ISRAEL SINCE AQABA SUMMIT AND EXPRESSING SOLIDARITY WITH THE ISRAELI PEOPLE

SPEECH OF

HON. RON KIND

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. KIND. Mr. Speaker, I rise today to express my concern over the recent terrorism conducted by Palestinian extremists against the citizens of the state of Israel. This comes just weeks after a groundbreaking summit where both Palestinians and Israelis came together and agreed to the Road Map to Peace. It is most unfortunate that one small sect of extremists shake the relationship between the two.

My colleagues and I mourn the loss of 22 innocent Israeli citizens who have fallen victim to this terror since the summit. In addition, we morn the loss of the dozens of civilian Palestinians who have also died as a result of terrorism. These lives, I believe, should also be mentioned.

Mr. Speaker, I will vote in favor of this measure today, but I think we missed a great opportunity to send a clear message that this Congress is fully committed, along with the President, in support of the Roadmap for Peace. The Roadmap recognizes the importance of including both Israelis and Palestinians in establishing much desired peace in the region. While the Roadmap may have its flaws, I believe it is the only way to get both parties back on the track to peace.

The people of the United States stand firm in our commitment to the security and health of a democratic Israel. We must continue to do all we can to promote negotiations to advance the peace process in the Middle East. Together we can root out the terrorism that plagues the region and move forward with one goal in mind, peace.

TRIBUTE TO FRAN AND MARIE BONNER

HON. PAUL E. KANJORSKI

OF PENNSLYVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. KANJORSKI. Mr. Speaker, I rise today to recognize two very exceptional people I am proud to call my constituents as they reach a milestone that has become more and more rare in today's world. Fran and Marie Bonner recently celebrated their 40th wedding anniversary. Even more uncommon is their steadfast dedication to public service, giving back to their community and fellow citizens. I am honored to highlight the achievements of two people who have contributed so much to Northeastern Pennsylvania.

Francis Peter Bonner and Marie Ann Clatch were engaged on Christmas day in 1961. They met in 1959 at The Madison Restaurant in Hazleton when Fran was registering Marie to vote. His first words to her were "Are you registered to vote?" When she said no he promptly registered her as a Democrat, and she has been both his girl and a Democrat ever since.

Marie, daughter of Fred Clatch and Jenny Corra was married to Francis, son of Miles Bonner and Mary Hannigan, on June 23, 1963 by Father Thomas Hannigan, at Our Lady of Grace Church in Hazleton. They have been Pennsylvania residents all of their married lives. First in Secane, then in Berwyn, then in Harrisburg and now in Hazleton. They have a daughter, Mary Patricia, who currently resides in Washington, DC, with her husband Roy Eichler.

Marie and Fran have led remarkable lives in the arena of public service. Marie has been a homemaker all her life and very active in her daughter's school and after school programs. She has done a considerable amount of volunteer work for both the Harrisburg School system and St. Margaret Mary's Church. She remains a terrific role model for the many children she has encountered throughout her volunteering career.

Fran has been extremely active in local and state government, serving in a senior position in Governor Milton Schapp's Administration and later on the Unemployment Compensation Board during the Governor Robert Casey's Administration. He has been extremely active in the Hazleton Community serving as the Chairman of St. Joseph's Hospital Board, and as a Trustee for the Anthracite Health and Welfare Fund for 15 years. It is no surprise he was bestowed the honor of "Hazletonian of the Year."

Fran also served on the White House adhoc Anthracite committee in 1980 and was a Member of the Marketing Panel for the Governor's Coal Conference that same year. In 1977 he was a member of the United States Department of Energy Anthracite Task Force and throughout the 1970s he served on both the Governor's Energy Council and the Pennsylvania Industrial Development Authority. He has been active in the Philadelphia Fellowship Commission and the Hazleton City Planning and Zoning board. He was also the Deputy State Chairman of the Democratic State Committee and the Assistant Director of the Urban Studies Program at the University of Villanova.

The Pennsylvania House of Representatives recognized Fran for directing the recovery efforts of the Kocher mine disaster in 1976. He has testified on the advancement of anthracite coal before both the U.S. Congress and Pennsylvania Legislature.

Mr. Speaker, I am proud to showcase the achievements of these two special residents of Pennsylvania's 11th Congressional District and ask my colleagues to join me both in celebrating their 40 years of marriage and in wishing them many more happy years together.

RECOGNIZING CHIEF WARRANT OFFICER DAVID WILLIAMS, U.S. ARMY APACHE HELICOPTER PILOT AND PRISONER OF WAR, ON HIS VALIANT BRAVERY OVERSEAS

HON. J. RANDY FORBES

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FORBES. Mr. Speaker, I rise today in recognition of Chief Warrant Officer David Williams, U.S. Army Apache helicopter pilot who was a Prisoner of War during Operation Iraqi Freedom. Iraqi forces detained him for 21 days as a POW after his helicopter was grounded near Karbala, Iraq. Williams valiantly fought and survived imprisonment after being captured.

Chief Warrant Officer Williams moved to Hampton Roads in 1981 with his family and grew up in Chesapeake, Virginia. From early childhood, David was always enthralled with planes and the magic of air flight. After graduating from Great Bridge High School in Chesapeake, Williams enrolled in community college and joined the Army as a full time reservist. After spending two years as a crew chief on a med-evac Huey helicopter, Williams searched for a bigger challenge. He was assigned to the Army's 106th Special Operations Aviation Regiment and also went through Survival, Evasion, Resistance and Escape school while traveling the world doing preparatory combat missions.

Next week, we will welcome back David Williams to his hometown of Chesapeake, Virginia with a host of events and celebrations for his heroic return. We are pleased to salute him for protecting our flag and our freedom. The Independence Day holiday is a perfect time to show our deep appreciation to this brave citizen and soldier who spent his childhood in the Fourth District of Virginia.

Williams showed tremendous bravery and commitment to his country while held by his Iraqi captors. Today we recognize him for his unwavering patriotism and dedication to both his job and the American people.

Mr. Speaker, please join me in honoring Chief Warrant Officer David Williams for his bravery and dedication abroad, his service to Chesapeake, the Commonwealth of Virginia, and the American people.

PERSONAL EXPLANATION

HON. JIM SAXTON

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SAXTON. Mr. Speaker, yesterday, June 25, 2003, I was unable to cast my vote for rollcall numbers 312, 313, 314, 315, 316, and 317 due to the fact that I was attending a funeral for my dear friend from Arizona, Representative Bob Stump.

Had I been presented, I would have voted "aye" for all 6 votes.

LEGISLATION ADDRESSES SHOCKING PROBLEM OF PRISON RAPE

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WOLF. Mr. Speaker, I recently shared with our colleagues several personal accounts related by survivors of the brutal and inhumane act of sexual assault in our nation's prisons.

H.R. 1707, the Prison Rape Reduction Act of 2003, focuses attention on the growing problem of prison rape. I was pleased to coauthor this legislation with my Virginia colleague, Rep. Bobby Scott. The bill is pending mark-up in the House Judiciary Committee and we are hopeful that it will be on the House floor soon. I believe in being tough on crime. But this has nothing to do with being tough on crime. It has everything to do with human dignity and ending deliberate indifference toward sexual assaults in prisons, maintaining order in prisons, and reducing social and economic costs to a society left to deal with physically and psychologically damaged former inmates.

Today I want to share additional stories from those whose lives have been forever changed by the sexual assaults happening every day in the prisons in our country.

Imagine knowing that someone you love is being repeatedly raped, abused, and degraded and that there is little to nothing that you can do about it.

For the last two and a half years, my family and I have been paralyzed by this knowledge and our inability to stop the rape and abuse.

My name is Vivian Edwards and I am here to tell you about my nephew, Roderick Johnson. In my family, he goes by Keith.

Keith is a Navy veteran and was imprisoned in Marshall, Texas in January of 2000 for a non-violent crime. He wrote a $300 check even though he knew that he did not have the funds to cover this amount, violating the terms of his parole for a burglary that he committed over 10 years ago.

From the beginning, my nephew knew that being a gay man put him at risk, so he informed prison officials that he was gay in hopes that he would be offered protection. My nephew was offered no protection. While at Allred, he was placed in the general population.

He might as well have been put in a lions' den. He was immediately given the name "CoCo" by the other inmates which made it clear to all inmates that he was available for sexual exploitation. The prison officials also began to call Keith by this nickname and would refer to him as "she" or "her."

Keith was raped by a member of the gang called "Gangster Disciples" in early October 2000. My nephew informed prison officials about what had happened and that he feared for his life. He asked for medical attention. He was denied help and denied medical assistance. They told him that medical care was only available for an emergency. My nephew was raped! How can someone say that is not an emergency?

Soon after the rape, things just got worse for my nephew. Hernandez began "sharing" Keith with other inmates, and Keith literally became a sex slave.

Keith wrote to several of his family members from prison. He was afraid to tell most of us that he was being severely sexually abused. But the letters started to change, and he eventually told us what was happening. I can still remember reading the words: "they make me do things I don't want to do" and just crying. He told us that he feared for his life.

We called the prison to find out what was going on. Staff at the prison said they would check into Keith's complaints. They said Keith's complaints didn't warrant an investigation but they would move him to another prison wing. He wasn't safe there either. Other family members and I continued to write and call on Keith's behalf, but nothing ever changed—he was never safe.

During a period of 18 months, Keith appeared before the classification committee of Allred seven times. Each time he asked to be put in protective custody, but his requests were denied each time.

Each time they denied Keith the protection that he so badly needed, he was sent back to the general population and raped and forced to perform sexual acts against his will. He was traded between various gangs in prison—the Bloods, the Crips, the Tangos, the Mandingo Warriors—and sold out for $5 and $10 for sex acts.

By December of 2001, Keith feared for his life so much that he purposely incurred a serious disciplinary violation. He was given the maximum punishment and received 15 days in solitary confinement. Ironically, this was the first and only protection that he ever received while at Allred. Sadly, though, this punishment also included extending his sentence for more than two more years past the date that he would have been eligible for release.

After Keith's seventh life endangerment claim, he began writing the ACLU and other outside organizations for assistance. The ACLU National Prison Project came to his rescue. They filed a federal lawsuit on behalf of my nephew against several Texas prison officials that ignored his pleas for protection against gangs who forced him into sexual slavery.

Keith had asked us to pray for him, and we did. Our prayers were finally answered. He was moved to a safety protection unit soon after the ACLU National Prison Project filed the lawsuit.

Keith has tested negative for HIV, but still lives in constant fear that he might have contracted other diseases from countless forced sex incidents. Prison rape is a serious crime that not only affects the victim, but also the family. As I said before, my entire family has been horrified and devastated for the past two and a half years because of what has happened to Keith. Today we are praying for Keith, but we are also fighting for him and for every other prisoner that has been a victim of rape while in prison as well.

I have tried to write this story many times, only to find myself in tears at the thought of recounting the events. But now, years later, I am finding the courage, little by little, to speak out. I pray that this courage will be with me today.

My name is Hope. In July 1997 I was incarcerated following an arrest for a drug related offense. I had been sent to a rehab facility in Virginia, but because of my extreme withdrawal symptoms from heroin and cocaine, they pulled me out of this facility and sent me, instead, to jail.

I was sent to the DC jail on no particular charges, but simply because I needed medical attention and was pending indictment. From the DC jail, I was transferred to a medical unit at CCA (a privately contracted jail adjacent to DC jail). This was where anyone with medical concerns, pregnancy, injury, extreme illness, or other debilitating circumstances was sent.

The unit consisted of male and female inmates. When I got there, I was surprised to realize that male guards were on staff guarding the mixed population. Male guards were allowed to watch us changing, showering, and using the toilet.

Also to my surprise, male and female inmates were allowed recreational time together on this unit. I met a woman pregnant with her third child all of which were conceived in jail.

I was denied a shower for more than 2 weeks. When I finally was permitted to have one, the guard came to get me at 3 a.m. He took me to a private, hospital-type room. He proposed I smoke a cigarette with him (smoking was not permitted in this facility). I smoked with him, and this he thought allowed him access to rape me. He attacked me while I was showering.

I was terrified, and I didn't know what to do. I was in terrible physical condition because of my withdrawal, and I didn't know who would believe me.

Then, it happened again on a subsequent night. I was doped up on the psych meds that had been prescribed to aid with my withdrawal symptoms. Again, he took me to the shower, and raped me. I was defenseless, and mentally and physically weakened by the drugs. The nurses were asleep in their station 20 feet up the hall, and the relieving guard was on break.

Afterwards, he gave me back my paper jumpsuit. I was putting it on when another guard entered the room and became extremely suspicious. You'd think this eye-witness would have been enough to prosecute him. But it wasn't. An "inconclusive" rape test conducted after my shower meant there was no follow-up.

Since then, my hands have been tied. I have not been able to prosecute the rapist. I have had no avenue for seeking justice.

Since my release, I have tried to move on with my life. I am married, I have three children, and I am in school studying to be a Social Worker with a specialty in addictions rehabilitation. But the pain of this experience comes back to me often. I am still struggling to put it behind me.

To my rapist, I say God will be your judge. I practice daily forgiveness when the mind numbing thoughts won't go away. I pray and I pray to help me get through this. I keep praying because it's my life.

I will never forget that night in March of 2000.

That was the night I was raped by a federal prison guard.

My name is Marilyn Shirley and I am here today as living proof that prisoner rape does happen.

I was convicted of a drug charge and placed in the Federal Medical Center at Carswell in Fort Worth, Texas from January 12, 1998 until September 10, 2000.

While in prison, I took all of the required Bureau of Prisons courses—from substance abuse prevention classes to classes that taught me job skills. I never once had an incident report written against me. In fact, I was rewarded with time credited for good behavior. Upon my release, I walked away with a $250 check from the Bureau of Prisons and a permanently devastated emotional and mental state as a result of my rape.

On that night in March 2000, I was woken up at approximately 3:30 a.m. by prison guard Michael Miller, a Senior Officer of the Bureau of Prisons. He told me, in the presence of my roommates, that I was wanted at the officer's station.

I was scared to death that they'd called me because something had happened to my husband who had heart problems and diabetes, or to my twins.

I could not have been more wrong. I should have feared for my own safety. After entering the officer's station, Miller made a phone call stating that if a Lieutenant heads for the Camp to give him the "signal."

After hanging up the phone, Miller started forcing himself on me, kissing me and groping my breasts. I was pushed into a storeroom where supplies were kept for the inmates. He continued to assault me; the more that I begged and pleaded for him to stop, the more violent he became. He tried to force me to perform oral sex on him. He then threw me against the wall and violently raped me.

I can still remember him whispering in my ear during the rape: "Do you think you're the only one? Don't even think of telling, because it's your word against mine, and you will lose." Miller also said to me "who do you think they will believe, an inmate or a fine upstanding officer like me?"

The ordeal was finally over after Miller received the abrupt signal of someone clearing their throat over his radio, signaling that someone was coming. I later learned there are no security cameras in the officer's station.

After returning to my room, I took off my sweatpants and put them in plastic and hid them in my locker.

Soon after, I confided in an Officer of the Bureau of Prisons, who was my welding boss, that Officer Miller had raped me. I asked her not to tell anyone because I didn't want anything to interfere with my release date, as I was afraid of what Miller would do to me if I reported it. I also told one of my roommates, and I swore her to secrecy, too.

I stayed silent for months. Having nowhere to hide, I went to sleep every night not knowing if he was going to come for me again. Following the rape, Officer Miller harassed, intimidated and threatened me in many direct and indirect ways.

I lived in fear, until I was released from prison in September 2000. That day, I brought my sweatpants to the Carswell camp administrator and told her about the rape. I gave statements and answered questions. The semen stained sweatpants were taken as evidence to the FBI Crime Lab. I was then given a lie detector test, which I passed.

Just recently, about three years after my release, a federal jury found Officer Miller guilty of rape finding that my civil rights were indeed violated. Meanwhile, Michael Miller is still under criminal investigation. I owe a lot to my attorneys who believed in me and my family who supported me.

Miller has continued to work as a corrections officer with the Federal Bureau of Prisons. Even after I reported the rape, he was only transferred to a men's prison. I cannot believe that this rapist is getting paid with people's tax dollars; it's not right.

Back in 1998, preparing to enter prison was one of the hardest things that I ever had to do. But, now that I am out, I am left with paralyzing panic attacks, awful nightmares, and a terrible state of depression all of the time.

Rape should not have been part of my punishment. Though I am still struggling with the emotional damage I have suffered from this rape, it is important for me to speak out. With God's help, I get strength from knowing that if I refuse to remain silent, maybe others won't have to suffer this way. Thank you for listening, and, please, let's work together to end this injustice.

TRIBUTE TO DR. ISRAEL "IKE" TRIBBLE, JR.

HON. JIM DAVIS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. DAVIS of Florida. Mr. Speaker, I rise in honor of Dr. Israel "Ike" Tribble, Jr., a remarkable man who dedicated his whole life to equipping African-American young people in our community, our state and our country with the educational tools they need to succeed in their personal and professional lives.

Ike had an amazing ability to see the good in everyone, and he knew that education was the key to fully unlocking everyone's God-given potential. After earning a masters in school administration and a doctorate in administration and policy analysis, Ike began a career focused on promoting higher education opportunities for all people.

Ike first blessed Floridians with his talents in 1982 when he moved to Tallahassee to serve as associate vice chancellor for academic programs for the Florida Board of Regents. From there he was recruited to start the Florida Education Fund, a program designed to help African-Americans earn doctorates and law degrees. During his 17 years leading the Fund to new heights, Ike helped thousands of young people on their path to higher education.

When Ike was not working long hours at the Fund, he was devoting his energies to a host of other civic boards and committees. He served on the Advisory Committee on the Education of Blacks in Florida and as Chairman of the Board of Commissioners of the Tampa Housing Authority. As the first African-American chairman of the Greater Tampa Chamber of Commerce, Ike was responsible for making the board more representative of our diverse business community and focusing business and community leaders on the virtues of educating our young people.

In 1999, Ike was diagnosed with acute leukemia. Ike faced his illness with the same courage and positive attitude that he applied to all other facets of his life. Through chemotherapy and multiple transplants, Ike fought to the end, and he never stopped giving back to his community.

I consider it the highest honor, privilege and joy to have called Ike Tribble my dear friend and a mentor. Ike's passion and commitment to improving the lives of those around him was unsurpassed. Like so many touched by Ike, I will forever be inspired by Ike's compelling example, his wisdom and his zest for life.

On behalf of the Tampa Bay community, which so greatly benefitted from Ike's life work, I would like to extend my deepest sympathies to the Tribble family.

THE HISPANIC RESOURCE CENTER IN THE CITY OF KENNER, LOUISIANA

HON. DAVID VITTER

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. VITTER. Mr. Speaker, today the City of Kenner crowns its celebration of June as Hispanic Heritage Month with the grand opening of its Hispanic Resource Center, the first of its kind in Louisiana. I am honored to recognize this landmark event in my district.

The Hispanic Resource Center will provide valuable services ranging from citizenship courses and homebuyers' training to computer tutorials and classes in English as a Second Language. In addition to offering specific programs that address real needs, the Center will serve as a facilitator to put Hispanic residents in touch with local agencies and organizations that can help with legal advice, health care, and other concerns.

I would like to congratulate Mayor Louis Congemi and the members of the Kenner City Council for their role in creating this important institution. Mayor Congemi is to be commended for his leadership in guiding the development of the Resource Center from initial idea to grand opening.

The Hispanic Resource Center proclaims and symbolizes the vitality of the Hispanic community in Kenner. I am confident that the Center will make a meaningful difference in the lives of many who hope in America's promise and pursue the American dream. I am pleased to extend my best wishes to all of those involved in the work of the Hispanic Resource Center upon this happy occasion.

HONORING SUSAN BOOTH FOR HER OUTSTANDING COMMITMENT TO PUBLIC SERVICE

HON. ROSA L. DeLAURO

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. DELAURO. Mr. Speaker, it is with great pleasure that I rise today to join the many gathered to pay tribute to an outstanding member of our community, Susan Booth, as she is honored by the Devon Rotary and named a Paul Harris Fellow. The Paul Harris Fellow recognition was created in memory of Paul Harris, the founder of Rotary as a way to show appreciation for contributions to the Foundation's charitable and educational program. Every Paul Harris Fellow receives a pin, medallion and a certificate when he or she becomes a Fellow, identifying the recipient as an advocate of the Foundation's goals of world peace and international understanding. The commitment and dedication that Susan has demonstrated is indeed a reflection of all that the Rotary stands for. It is wonderful to see her work so proudly recognized by her community.

Founder of the Archway Foundation, Susan has spent nearly fifteen years collecting donations to feed and clothe homeless children in Romania. Inspired by a television program about Romanian orphans abandoned when communism collapsed, Susan, a railroad conductor on a commuter train between Connecticut and New York's Grand Central Station, switched to night shifts so that she could earn a master's degree in Social Work. Upon completing her degree, Susan went to Bucharest on a week's vacation in search of these Romanian orphans who were living in sewers and abandoned buildings. With only a short list of contacts, Susan was fortunate to find an individual who knew where to look. "In that sewer, I found my life's work," she has said. Indeed, she has dedicated countless hours to her mission.

Operating out of her own home and a post office box, Susan collects clothing and donations and has been awarded hundreds of thousands in charitable grants. Through her hard work and the generosity of her contributors, Archway has been able to purchase two small homes in Romania as well as employ several Romanians. One of the homes is used as a soup kitchen from which volunteers take food out to hundreds of homeless children every week and provides groceries to squatter families who take refuge in abandoned buildings.

It is not often that you find an individual with such dedication and commitment. Susan's good work has touched the lives of thousands of needy children. More importantly, she has inspired countless numbers of people to donate their time and energy to provide one of life's most precious gifts—hope.

I am proud to stand today to join the Devon Rotary and the many family and friends who have gathered this evening in extending my sincere thanks and heart-felt congratulations to Susan Booth as she is named a Paul Harris Fellow. Yours is a legacy that is sure to continue to inspire generations to come.

PERSONAL EXPLANATION

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. MENENDEZ. Mr. Speaker, I rise to offer a personal explanation. On June 23, 2003, I was absent from the Chamber as I attended my son's high school graduation. During that time, I was not present to vote on rollcall votes 297, 298, 299, and 300. Had I been present, I would have voted "yea" on rollcall votes 297–300.

HONORING THE CAREER OF CHARLOTTE LESSER

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. HARMAN. Speaker, in the course of my career as a public official I have been privileged to work with some truly remarkable people—often unsung heroes who contribute every day, unselfishly and unswervingly, to the health and well-being of our communities. One such person is my friend and constituent Charlotte Lesser, and I rise today on the occasion of her retirement as Director of Health Education at the Beach Cities Health District (BCHD) to commend her for her many achievements and contributions.

For 10 years, Charlotte Lesser has successfully spearheaded BCHD efforts to provide critical assistance to South Bay citizens in need. Under her leadership, BCHD has developed organizations and services that promote health education activities and fitness awareness for the residents of Manhattan Beach, Redondo Beach and Hermosa Beach.

And as is the case with so many local leaders, Ms. Lesser volunteered her time to strengthen South Bay communities through her involvement with the South Bay Family Healthcare Center, the South Bay Youth Project, the Wellness Community, and the South Bay Coalition for Alcohol and Drug-Free Youth.

In addition to her work as a champion of local health care services, Charlotte Lesser chaired the Redondo Beach Chamber of Commerce and founded and directed the Manhattan Beach Neighborhood Watch.

In recognition of her unwavering commitment to the community, in 1999, Charlotte Lesser was named Los Angeles County Woman of the Year. But Charlotte is also my trusted friend and has been a wonderful resource to my staff and me.

Mr. President, I join the community in thanking Charlotte Lesser for her years of service and accomplishment, for they are evidence of her dedication and boundless energy. Although she is retiring from BCHD, her achievements will not end there. I look forward to her upcoming appointment to the Los Angeles County Commission for Women. I know she will continue to be an active leader and community advocate.

INTRODUCING THE REBUILD AMERICA ACT OF 2003

HON. JAMES L. OBERSTAR

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. OBERSTAR. Mr. Speaker, today Cong. JERRY COSTELLO, LINCOLN DAVIS, other Members of the Committee on Transportation and Infrastructure, and I have introduced the "Rebuild America Act of 2003".

In the 107th Congress, the Democrats on Transportation and Infrastructure Committee introduced similar legislation to invest in the safety and security of the Nation's infrastructure. At that time, we were alarmed by the negative effects that the policies of the Bush Administration were having on our Nation's economy. Now, almost two years later, our concerns have been proven correct.

Figures released earlier this month show that the national unemployment rate has increased from 4.2 percent in January 2001 to 6.1 percent, the highest level since July 1994. Further since January 2001, the number of people unemployed has increased from 5.95 million to 9 million—an increase of more than 3 million, or more than 50 percent.

Moreover, workers who have lost their jobs are having more trouble finding new jobs. The average length of unemployment is now almost 20 weeks, the longest it has been in nearly two decades. In the past two years, the number of workers who have been unemployed for longer than six months has increased by 1.3 million to nearly 1.9 million—an increase of more than 216 percent. One-half of the unemployed are out of work for more than 10 weeks and one in five have been out of work for more than six months.

The response of the Bush Administration has been tax breaks for the wealthy. And once those are enacted into law, pass more tax breaks for the wealthy. The Administration could have developed a bipartisan plan to use the surplus it inherited to invest in our Nation's infrastructure, shore up the Social Security Trust Fund, and pay down the national debt, however, it has squandered each of those opportunities. Instead, the Administration continues to pursue policies that favor only a small portion of the population (the ultra-wealthy) and push our economy further and further into debt and recession. As the economy continues to founder, the need for legislation that will create jobs has become even more apparent.

Unlike the Republican "trickle down" approach to the economy, the Rebuild America

Act of 2003 stimulates the economy by creating jobs—especially jobs in nonresidential construction—and rebuilding our Nation's infrastructure. This bill provides $50 billion to enhance the safety, security, and efficiency of our Nation's infrastructure, including improvements to rail, highway, transit, aviation, maritime, water resources, environmental, and public building infrastructure. By leveraging Federal infrastructure investments, the 10-year cost to the Federal Treasury would be less than $34 billion.

Moreover, the bill fully offsets this $34 billion cost to the Treasury by cracking down on abusive corporate tax shelters (e.g., Enron), preventing American corporations from avoiding paying U.S. taxes by moving to a foreign country, and extending customs user fees.

According to the U.S. Department of Transportation, each $1 billion in new infrastructure investment creates 47,500 jobs and $6.2 billion in economic activity. The bill will create more than two million jobs—virtually eliminating the job losses that have occurred since the Bush Administration came into office—and restore more than $310 billion to our economy. Moreover, in the wake of the September 11, 2001 terrorist attacks, the bill gives priority to infrastructure investments that focus on enhanced security for our Nation's transportation and environmental infrastructure systems.

By ensuring that the funds are invested in ready-to-go projects, the bill will provide a much-needed jumpstart to our economy. The bill provides funds for each of the critical areas of our Nation's transportation and environmental infrastructure, including: $8 billion for highways and transit; $3 billion for airports; $21.5 billion for rail including high-speed rail, freight rail, and Amtrak; $13 billion for environmental infrastructure including wastewater, drinking water, wet weather, and Corps of Engineers projects; $2.5 billion for port security; and $2 billion for economic development and public buildings.

In addition, this infrastructure investment will increase business productivity by reducing the costs of producing goods in virtually all industrial sectors of the economy. Increased productivity results in increased demand for labor, capital, and raw materials and generally leads to lower product prices and increased sales. Also, the bill takes into account the fiscal crises that the states are currently facing and allows recipients of the funds an extended period of time to meet their state and local match requirements.

Simply put, this bill will strengthen the fabric of our Nation's infrastructure while creating jobs for the millions of people who have lost their jobs under the Bush Administration. This investment will specifically help unemployed construction workers. The number of unemployed private construction workers is 715,000—an 80 percent increase over the comparable period in the last year of the Clinton Administration. The unemployment rate for construction workers is now 8.4 percent, more than 68 percent higher than the rate in May 2000. A recent national survey found that transportation construction contractors hire employees within three weeks of obtaining a project contract. These employees begin receiving paychecks within two weeks of hiring. By giving priority to those projects that can award bids within 90 days of enactment, the bill ensures that this money is readily dispersed to needed projects that will get people working again.

This investment will also help address the disproportionate effect that the increase in unemployment has had on people of color. The rate of unemployment for African Americans is 10.8 percent—twice the rate for whites. The unemployment rate for Hispanic Americans is 8.2 percent—more than 50 percent higher than the rate for whites. Under the existing highway, transit, and aviation laws, as a general rule, states, cities, and transportation authorities are required to provide at least 10 percent of the amounts made available to Disadvantaged Business Enterprises, including minority- and women-owned businesses.

There are thousands of projects that are ready to begin construction in all sectors of our transportation and infrastructure systems. For example, a survey of the state Departments of Transportation by the American Association of State Highway and Transportation Officials found that, as of April 2003, the states have 2,710 projects, totaling $17.1 billion, that are ready to go to construction within 90 days if additional funding is made available.

Accordingly, the bill provides $5 billion in additional authority for Federal-aid highway capital investments and gives states the authority to obligate $5 billion of existing budget authority (contract authority) in state highway accounts. This proposal would create more than 237,500 jobs and $31 billion of economic activity.

Similarly, a survey of transit authorities by the American Public Transportation Association found that public transportation authorities have $12 billion in projects that are ready to go to construction within 90 days if additional funding is made available. Accordingly, the bill provides $3 billion in transit and operating grants and would create more than 142,500 jobs and $18.6 billion of economic activity.

In aviation, an Airport Council International survey of airport authorities estimates that $5 billion is needed to install explosive detection systems at U.S. airports. In addition, the Federal Aviation Administration has deferred millions of dollars for airport capacity and safety projects because of the diversion of airport improvement program (AIP) funds to security projects. To address these issues, the bill provides $3 billion for airport development projects, including $2 billion for AIP grants to enhance airport safety, efficiency, and capacity, and $1 billion for airport security grants to reconfigure airports to accommodate explosive detection systems. This proposal would create more than 142,500 jobs and $18.6 billion of economic activity.

In the area of high-speed rail, there are currently several corridors that are completing environmental analyses of high-speed rail projects and are ready to go to construction. The bill provides funding for these projects through the issuance of $14 billion in tax credit bonds for construction of infrastructure and the acquisition of rolling stock for two high-speed rail corridors. This proposal would create more than 665,000 jobs and $86 billion of economic activity.

For passenger rail, Amtrak has identified approximately $8 billion of capital needs for the reconstruction and rehabilitation of the Northeast Corridor and other station upgrades and for the acquisition and rehabilitation of rolling stock. With regard to the infrastructure needs of short line and regional railroads, a recent study concluded that it will take approximately $7 billion of capital investment to rehabilitate the track, bridges, and other elements of their infrastructure to enable them to carry the 286,000–pound railcar that is becoming the industry standard.

In order to address these needs, the bill provides $7.5 billion for capital investment for passenger and freight rail, including: $2.5 billion for capital investment for Amtrak; $500 million for direct grants to short-line and regional railroads to improve their infrastructure; and $250 million for grants to provide the credit risk premium for at least $5 billion in loans and loan guarantees for freight railroad infrastructure projects under the Railroad Rehabilitation and Improvement Financing (RRIF) program. This proposal would create more than 356,000 jobs and $46.5 billion of economic activity.

Our Nation's environmental and infrastructure also has a backlog of important projects in need of funding. The Congressional Budget Office estimates that there is an annual investment need of between $11.6 billion and $20.1 billion to ensure a safe, clean supply of drinking water, and an additional need of an annual investment of between $13 billion and $20.9 billion in wastewater treatment. Further, a survey conducted by the Association of Metropolitan Sewerage Agencies found that, in just 58 communities, wastewater treatment facilities have more than $4 billion of wastewater treatment projects that are ready to go to construction if funding is made available.

This bill provides a total of $11.5 billion for wastewater and drinking water infrastructure investment, including: $10 billion to construct, rehabilitate, and restore the Nation's wastewater and drinking water infrastructure through the existing State Revolving Fund (SRF) programs ($8.5 billion for the Clean Water SRF and $1.5 billion for the Safe Drinking Water SRF), and $1.5 billion for wet weather overflow grants for planning, design, and construction of treatment works to address combined sewer and sanitary sewer overflows. This proposal would create more than 546,000 jobs and $71 billion of economic activity.

In the area of marine transportation, the Coast Guard estimates that it will cost approximately $6 billion over the next 10 years for ports and vessel owners to comply with security standards that the Coast Guard will prescribe under the Maritime Transportation Security Act. To date, only $370 million has been appropriated to fund port security grants. In 2002, ports and marine facility operators submitted 712 proposals, totaling more than $600 million, which were denied funding because of the lack of available resources. The requests for port security funding were seven times greater than the available funding.

This bill begins to address this funding shortfall by providing $2.5 billion for port security grants to ports and marine facility operators for their costs to implement facility and port security plans pursuant to the Maritime Transportation Security Act of 2002. This proposal would create more than 118,000 jobs and $15.5 billion of economic activity.

The Nation's water resources are also in need of investment to both protect and improve the quality water related infrastructure services, such as hydropower facilities, ports, dams, and water supply facilities. The Corps of Engineers has identified a need to assess and improve security at 372 critical infrastructure projects, and those efforts have not yet been completed. The Corps also has an unfunded operation and maintenance backlog of more than $1 billion.

To address these needs, the bill provides $1.5 billion to fund investment in currently authorized water resources infrastructure projects. This proposal would create more than 71,000 jobs and $9.3 billion of economic activity.

There is also considerable unmet need in the area of economic development. Certain communities and regions of the country suffer from chronic economic distress. These communities and regions often have unemployment, poverty, and outmigration rates that are more than 150 percent of the national average. These economically distressed communities and regions rely on Federal investments to complete basic transportation and public infrastructure projects. The Economic Development Administration and existing regional commissions have no shortage of requests for assistance, but are woefully underfunded, and face drastic budget cuts under the Administration's FY2004 budget proposal.

This bill addresses this severe underfunding by providing $1.5 billion in grants to economically distressed communities for economic development infrastructure projects. Grants are administered through the Economic Development Administration ($1 billion), the Appalachian Regional Commission ($150 million), the Delta Regional Authority ($150 million), and the Northern Great Plains Regional Commission ($150 million). This proposal would create more than 71,000 jobs and $9.3 billion of economic activity.

Further, the General Services Administration (GSA)-controlled inventory of 1,860 existing Federal buildings is aging and requires extensive repair and renovation to ensure that Federal employees are housed in safe, modern facilities. GSA estimates that it needs $5 billion over the next five years to fund the necessary repair, alterations, and rehabilitation of Federal buildings and it currently has approximately 5,500 work items pending for repair and alteration. The bill provides $500 million for repair and alteration of Federal buildings and would create more than 23,000 jobs and $3.1 billion of economic activity.

This package of infrastructure, transportation, and environmental investment and security enhancement makes sound economic sense. It provides funds where they are needed most and will get America working again. Our Nation needs an economic stimulus program that creates jobs in hard hit sectors of our economy, rehabilitates our basic infrastructure to allow us to remain competitive in world markets, addresses the infrastructure security needs of our transportation and environmental systems, and helps to revive our stagnant economy. Let us start by passing this bill.

CONCERNING THE SAFETY, SECURITY, AND FREEDOM OF THE PEOPLE OF TAIWAN

HON. ROBERT E. ANDREWS

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. ANDREWS. Mr. Speaker, 54 years ago, on June 27, 1949, President Harry Truman deployed the U.S. Navy's 7th Fleet to the Taiwan Strait to protect Taiwan against the possibility of an invasion by the People's Republic of China, PRC. Since then, we have committed ourselves to defending Taiwan, as enshrined in the Taiwan Relations Act of 1979. President Bush himself declared in 2001 that America would do whatever it takes to defend Taiwan. In light of the threat posed by the PRC's military buildup in Fukien, we must unequivocally stand by our promises to support Taiwan. America cannot afford to lose a democracy in such a volatile region—and the people of Taiwan cannot afford to lose their safety, security, and freedom.

I rise today to call attention to an important resolution that I introduced today concerning the safety and security of Taiwan, and the right of Taiwan's 23 million people to determine their own future. In the past 2 decades, Taiwan has undergone a remarkable transformation from a one party, martial law dictatorship to a full-fledged democracy that respects human rights and human freedoms. Time and again, Taiwan has proven herself one of America's staunchest allies, recently pledging her support for continued humanitarian aid to both Afghanistan and Iraq. At the same time, however, Taiwan's democracy faces a serious military threat from the People's Republic of China. The PRC continues to regard Taiwan as a renegade province, despite the fact that it has never exercised control over the island. The PRC continues to openly entertain the use of force against Taiwan, thereby jeopardizing the stability of the entire Asian Pacific region.

A Washington Post report of June 11, 2003, reveals the PRC's plans to build up its military for the purpose of "unification with Taiwan." Already, the PRC has set up 400 short-range ballistic missiles in the province of Fukien, directly targeted at Taiwan, in addition to purchasing advanced weaponry systems, such as fighting aircrafts, submarines, and destroyers. The Washington Post reports that the PRC is accelerating its military acquisitions and notes that this buildup is "intended to create a force capable of bullying Taiwan and thwarting U.S. intervention in any conflict between China and Taiwan." In other words, the PRC is preparing to use force and coercion to take over a territory it has no legal right to, and to impose its totalitarian ideology on a people who have fought long and hard for their freedom, and who have no wish to live under Communist rule.

The resolution I introduced today is a step towards protecting a fellow democracy from the threat of Chinese aggression. The resolution calls on the Bush administration to seek from the leaders of the PRC a public and immediate renunciation of any threat or use of force against Taiwan. This includes the dismantling of the Fukien missiles and other military apparatus designed to intimidate Taiwan. The administration must let the PRC government know that America will no longer tolerate the constant harassment targeted towards the people of Taiwan. If the PRC government refuses to dismantle the missiles, the administration should then authorize the release of the Aegis system to Taiwan, enabling Taiwan to defend itself against any Chinese attack.

Mr. Speaker, these PRC missiles in Fukien province are not conducive to a peaceful resolution of current Taiwanese-Chinese relations. We can not expect the people of Taiwan to live their daily lives under such threatening and uncertain conditions. In the name of democracy, we must ensure that the future of Taiwan is determined peacefully, and with the expressed consent of the Taiwanese people. Also, I urge both my colleagues and the administration to support Taiwanese efforts to hold a referendum vote on the issue of admittance into the World Health Organization, WHO. The people of Taiwan deserve to have their voices heard in this ongoing debate, the outcome of which will have a monumental effect on their health and well-being. As the foremost promoter of freedom and democracy around the world, we can not in good faith deter the people of Taiwan from holding their referendum. There can be no double standard when it comes to exercising democracy.

Mr. Speaker, no group but the citizenry of Taiwan has the right to determine the future of Taiwan. I ask that my colleagues join me in supporting democracy for the Taiwanese people, and ensuring their safety and security. Let us ensure that it will never be necessary to send the 7th Fleet to the Taiwan Strait again.

SENATE—*Friday, June 27, 2003*

The Senate met at 10:15 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, the Reverend Daniel P. Coughlin, Chaplain of the United States House of Representatives.

PRAYER

The guest Chaplain offered the following prayer:

Before the Congress of the United States leaves to celebrate Independence Day, we pause to pray to You, Lord God, for the repose of the soul of Senator Strom Thurmond. Lord, reward this most senior statesman for his many years of pledged service to this country.

As the Source of life and justice that will last forever. You have inspired the Founders of this Nation, individuals such as Senator Thurmond and citizens across this land, to continually seek what is right: to pursue lasting values for themselves and for all their brothers and sisters: and to pray always that they may grow in virtue and so strengthen this democracy.

Our national celebration this year is an occasion for us to thank and praise You for this form of government, for its leaders and for the natural and human resources with which You continue to endow this great Nation.

May we also take this moment to pray for the new Chaplain of the U.S. Senate, Chaplain Barry Black. Guide him by Your holy inspiration to ably respond to the needs of the Senators and this community. Gift him with the spirit of wisdom and prayer. And may he always find joy in serving You by serving in this august chamber. You, Lord God are America's boast now and forever! Amen.

PLEDGE OF ALLEGIANCE

The President pro tempore led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

The PRESIDENT pro tempore. In my capacity as Senator from Alaska, I note there is no quorum. I suggest the absence of a quorum.

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. SESSIONS. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

MORNING BUSINESS

The PRESIDENT pro tempore. Under the previous order, the Senate will begin a period of morning business with Senators permitted to speak therein for up to 10 minutes.

IN REMEMBRANCE OF STROM THURMOND

Mr. SESSIONS. Mr. President, I wish to take a few minutes at this time to express my sympathy to the family of Senator Strom Thurmond, one of America's most dynamic leaders in this past century, a man who lived through extraordinary change in his life, a man whose commitment to his country was unwavering.

I had the opportunity in 1997 to travel with him to China. He was 94, I believe, at that time. His vigor and his strength were extraordinarily impressive to me and all of us who traveled with him. He wanted to see The Wall. He wanted to meet the people of China. He would tell them: America and China are friends. We want to be better friends. He made very perceptive and appropriate remarks.

Then we met Jiang Zemin at his resort in the month of their vacation time and Strom made an extraordinary speech that reflected so well America and had so comprehensive an understanding of the relationships of our countries. That just struck me particularly.

We went out to a Chinese army base. He trooped the line of a group of Chinese troops. I remember saying to him afterwards that I never thought I would be in Communist China, seeing Strom Thurmond, the great cold warrior, troop the line of a group of Chinese troops. But he was extraordinary in that way.

I had come up to this Senate in the mid-1980s as a nominee and it wasn't a very pleasant experience. I will never forget and will always appreciate his courtesy and support for me at that time and enjoyed responding a little bit to that when I was able to come back to this Senate and he was leader on the Senate Judiciary Committee, chairman of the Armed Services Committee. It was just a pleasure to work with him.

He lived through a complete change in the South. He reflected the change that went on in our region of the country. I think he did it in a positive and especially important way. His leadership in moving from the days of segregation to a new era of relations between the races was very important and positive throughout the South.

He served his country in an almost unprecedented way. He was 40 years old when World War II began. He was an elected judge in his home State and he was an army reservist. He insisted that he be allowed to be on active duty and they allowed him to do so. I understand at first it wasn't going to happen.

He ended up in England when they were planning for the Normandy invasion. A number of people were called upon to fly gliders in during that invasion at the time. He volunteered to fly on a glider, one of the most dangerous missions there could be. The planes would pull up these gliders and get them going and just let them go and they would have to find a place to land down behind enemy lines—extraordinarily high risk. Many were killed on landing. Many were killed in combat, many were separated, many were injured. That is the kind of man Strom Thurmond was.

I asked him one time: Strom, did you stay in until Germany surrendered?

He said: Oh, yes, we stayed until Germany surrendered and we were on a train coming back when they declared the war on Japan was over. We were being sent to the East.

He was prepared to go there. As long as this country was in combat he wanted to be there, committing his life, his every effort to the defense of this Republic. He did so in the Senate and he did so in uniform and as a leader in South Carolina.

He was beloved in his State, respected to an awesome degree. He won his Senate race on a write-in vote with a substantial majority, the only Member, I believe, in the history of this Senate ever to be elected on a write-in vote. That shows the power and the energy and the vigor and the leadership of this man. I have appreciated his friendship.

I know his family is hurting at this time and my sympathies are extended to them. I know the great members of his staff, Duke Short and the whole team that worked with him for so many years, are hurting today and our sympathies go out to them as well as to the family.

Mr. President, I know you served with Senator Thurmond so many years. The two of you together have

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

conducted a remarkable effort to maintain our military strength and leadership in the world. He was certainly committed to that.

There are many other things I could say. I will not at this time. I just express my sympathy to his family, his friends, the people of South Carolina, and those around this great country who will mourn his passing.

I thank the President and yield the floor.

The PRESIDENT pro tempore. May the Chair request the Senator to occupy the Chair so this Senator may speak about Senator Thurmond?

Mr. SESSIONS. I will be honored to.

Mr. STEVENS addressed the Chair.

The PRESIDING OFFICER (Mr. SESSIONS). The Senator from Alaska.

Mr. STEVENS. Mr. President, next Tuesday it will be my honor to be part of the funeral delegation to South Carolina to attend the funeral of our departed President pro tempore. When I first came to the Senate, I was in the Gallery up there watching the debate on the Alaska statehood bill. A filibuster was being led against that bill by the Senator from South Carolina. As a matter of fact, he held up the bill for a considerable period of time.

Because of his opposition, we developed a strategy of trying to get the bill passed by the Senate without amendment—passed by the Senate as it had come to us from the House, without amendment. It was, I think, the only statehood bill in history that ever passed both Houses in identical form without amendment by the Senate. We did that because we knew if the bill went to conference and came back, Strom Thurmond would have another shot at the bill and another filibuster.

I remember that today because I remember how, when I did finally arrive here in 1968 as a Member of the Senate, Strom came up to me and said: I remember you, boy.

And he remembered I had been part of the group from the Eisenhower delegation that worked on our bill. We formed a friendship that day that I never expected to have.

Strom was, as I have said, a distinguished member of the U.S. armed services. He was the oldest officer to land in Normandy. As we all know, he landed in a glider. The pilot was killed. I talked about that with Strom because I had been trained to fly gliders. Even though I was a pilot, some of us were trained to fly gliders in case they needed glider pilots and I had anticipated I might have gone to Normandy. Instead, I was sent to China. When I returned and was a Member of the Senate here, we often discussed our wartime service. Of course, he was considerably older than I was and his experience was entirely different. But over the years I grew, really, to have great fondness for Senator Thurmond, despite our original, really, antagonism. Believe me, as an advocate for statehood for my State, anyone who was going to filibuster that bill was not exactly a friend at that time. But as we grew together and grew older together here in the Senate, Strom became a person who did give me a lot of guidance. At one time he was chairman of the Armed Services Committee and I was chairman of the Defense Subcommittee for Appropriations, and we did a lot of work together.

But my memory of Strom really goes back to the time after 1981 when we had a dinner for the new President pro tempore as we had taken the majority in the Senate. Strom became President pro tempore. I was the assistant leader. Senator Baker was the leader. We had a dinner at one of the local hotels. Senator Baker and his wife Joy and I and my wife Catherine were at the head table. When it became Strom's time to thank the people there for honoring him, he started talking with the people at the head table, and he came to me. I had just been remarried. Catherine and I were married in December of 1980. Just before that dinner, she had informed me we were going to have a child.

Strom stood up and was introducing people. He came to me and made some kind remarks about me. And he turned and said: Here is his lovely lady who has now joined our family. She is a beautiful woman, and isn't it nice that she is with child?

I thought Catherine was going to break my arm and bust my head. I grabbed Strom and asked him to come over and tell Catherine I had not told him that. She did listen to him for a moment or two. And he smiled, and said: Child, he never told me. He never told me anything about that. He said: I just looked at you. I can tell when a woman is in flower.

Mr. President, being from Alabama, you can understand the way he pronounced that.

It is something I will never forget.

When our child came, he became Uncle Strom to Lily Stevens. Every day he sat here in that chair, he would ask me about Lily. Lily, as a matter of fact, last evening had a tear in her voice as she called to tell me she had heard about Strom.

Strom was really a member of this Senate family. He got to know every one of us in a way that I think no one else did because no one else was near 100 years old. He was like a 1,000-pound gorilla around here; he did what he wanted to do, but he did it in a way which really reflected his southern heritage. He was a southern gentleman to the core.

I have to tell the Senate that there are many things Senator Strom Thurmond did in his life with which I didn't agree. There were many votes he cast here on the floor that I opposed. But I can't think of a person who more epitomized being a Senator and what it meant to be a Senator. He lived up to his principles, and he lived up to the idea of what this democracy is about. He was, I believe, one of the finest Senators who will ever serve in this body.

I am honored, following him as President pro tempore, to go back and participate in the services and to once again remind his people who sent him to the Senate that he was a person who became a very distinguished Senator whom history will always admire.

Thank you very much.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. WARNER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CHAFEE). Without objection, it is so ordered.

Mr. WARNER. Mr. President, I am deeply moved this morning, as are Senators all over America today—not only those who are present in the Senate, but so many who have gone on from the Senate to other careers—about the loss of our distinguished colleague Senator Thurmond. I think it is coincidental, and indeed most fitting, that the Presiding Officer in the Chamber this morning is the son of the distinguished Senator from Rhode Island, Senator John Chafee.

I first met Senator Thurmond when I joined then the Secretary of the Navy, John Chafee, as his principal deputy and in later years to succeed him. Really, our first call was to come to the Senate to meet with Richard Russell, John Stennis, Strom Thurmond, John Tower, and Barry Goldwater. I remember our calls as the brand-new team of the Secretary of the Navy during the height of the war in Vietnam—at least one of the periods of great intensity—was in 1969. Senator Thurmond greeted us in his office in the same way that he greeted me throughout my 25 years in the Senate. Each of those years—except since his retirement in January that I shared with him, as did John Chafee and others—it was a learning experience every day you were with him.

I stop to think of the men and women of the Armed Forces today all across the world, engaged in fighting in Afghanistan and Iraq, and guarding the outposts of freedom. They have not lost Strom Thurmond because they have the wealth of the memories of him. I don't know of any class of individual—perhaps other than his immediate family—for whom Senator Thurmond had a deeper or more abiding love and devotion than those in uniform.

This record last night covered briefly his distinguished military career, and I don't doubt others will address that.

But we always remember that he was a judge in the State of South Carolina. By virtue of his age at that time—I think right on the brink of 40, give or take a year—he would not have been subjected to the draft. He would not, by virtue of his judicial position, have had to leave that position and go into the Armed Forces—other than by his own free will. He resigned his judicial post to go into the ranks of the U.S. Army, where he served with great distinction, going in on D-Day with the airborne assault divisions, landing, helping those who were wounded—that was his first call—and then marshaling the forces to mount the offensive against the German army, and going through those matters until victory in May of 1945.

When we walked into his office, two things always struck me. One was the portrait that was obviously painted in the period when he was Governor—straight, tall, and erect, eyes that were penetrating, eyes that reflected a tremendous inner confidence and conviction, but eyes that had a soft side, because he did have a soft side. He loved humor. He was very often the object of a lot of humor, including respectfully from this humble Senator. But what a tower of strength. I served with him these many years on the committee as really an aide-de-camp—yes, a fellow Senator, but I was happy to be "general" Strom Thurmond's aide-de-camp on many missions—missions that took me abroad on occasions when he was chairman, and missions from which I learned so much at the hand of the great master on the subject of national events. He was unwavering in his steadfast support of Presidents, be they Democrat or Republican, and unwavering in his resolve for the care of the men and women in uniform on active duty, their families, the retirees. And, oh, Mr. President, did he love the National Guard. There wasn't a bill that went through the Armed Services Committee and conference when he wouldn't tug on my shoulder and say let's beef up a little bit for the Guard and Reserve here. Remember, in times of crisis, they are among the first to respond.

That bit of wisdom has proven ever so true. Going back to the Balkans campaign, the Guard was actively engaged at all levels of that campaign. The Air Guard, for example, flew so many of the missions carrying food, medicine, and other supplies to the ravaged civilians and others in Sarajevo. I remember I joined one time in one of those missions. I remember it so well because the plane behind ours was shot down and lost—just to point up the risks that those Air Guard took on those missions.

Now, today, in Operation Iraqi freedom, worldwide against terrorism, once again the Guard and Reserve are in the forefront—a Guard and Reserve that have benefited through the many years of Strom Thurmond being a Senator and receiving a fair allocation of equipment and money, often in competition with the regular forces.

But Strom Thurmond was there with his watchful eye on the Armed Services Committee to ensure that degree of fairness for the Guard and Reserve. He rose to the rank of major general. I mentioned his portrait as you walked in. Then, in a very discreet way, there was a large frame that contained all of his many decorations. He rarely talked about them. As a matter of fact, only after one tried to elicit facts from him would he share facts about the combat of war and what he received in World War II, and the other recognitions by our Government and other governments for his contribution to freedom worldwide.

So I say to my dear friend—really a big brother—I thank him for all he has done for the world, for the Nation, for this humble Senator and, I daresay, many others of my comtemporaries, as we came along in this institution on the learning curve that was often at the hands of Strom Thurmond.

My final thoughts are with his family, his wife and children, all of whom I have known throughout these years, and with whom I have had the privilege so often to be photographed, from little sizes all the way up, as we do through the years with our colleagues. But I know the Presiding Officer's father, were he here today, would join in the most fervent and heartfelt expressions with regard to our comrad, our colleague, our dear friend, Strom Thurmond.

ONGOING MILITARY OPERATIONS

Mr. WARNER. Mr. President, this morning we had another meeting organized by the majority leader, in consultation with the Democratic leader, with Secretary of Defense Rumsfeld and the Vice Chairman of the Joint Chiefs Staff, General Pace, together with representatives from the intelligence agencies.

This is the third time Secretary Rumsfeld has been to the Senate this week. He has been in close consultation with the Senate during these perilous days for our Armed Forces around the world, and most particularly in Iraq. Our discussions, by necessity, were largely related to classified matters and were behind closed doors.

I do share with my colleagues two thoughts. I sensed by those colleagues—quite a number—who joined us this morning a heartfelt concern for the men and women of the Armed Forces who, around the clock, 7 days, 7 nights, are in harm's way in Iraq and Afghanistan, most particularly, and we share in the bereavement of their families for those who are lost from time to time.

Steadfast this Nation must remain in its resolve to bring to a conclusion the hostilities in Iraq and Afghanistan, such that the peoples of those two countries can themselves create a government free of oppression and persecution to enable them to have a very large measure of freedoms, freedoms we enjoy in the form of democracy, beginning with speech, privacy, and a sense of security in their homes, in their workplaces, and in the nation.

This is a long and courageous struggle worldwide, headed by, if I may say most respectfully, a very strong and courageous President of the United States, George Bush, and those principal deputies and many others right down to the privates, sailors, airmen, and marines who are making possible this freedom throughout the world.

We will stay the course. We will meet every challenge. We shall not waver in the mission of this country. I just pray and hope the American people have a complete and full understanding of the risks they are taking and the absolutely essential requirement that this Nation continue its leadership and succeed.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. WARNER. Mr. President, I ask unanimous consent that the Senate proceed to executive session to consider the following nominations on today's Executive Calendar: Calendar No. 248, the nomination of LTG John P. Abizaid to be General; and Calendar Nos. 254 through 277, and all nominations on the Secretary's desk in the Air Force, the Army, and the Navy.

I further ask unanimous consent that the nominations be confirmed, en bloc; that the motions to reconsider be laid upon the table; that the President be immediately notified of the Senate's action; and that the Senate then return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

The nominations were considered and confirmed, en bloc, as follows:

IN THE ARMY

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be general

Lt. Gen. John P. Abizaid, 6229

The following Army National Guard of the United States officers for appointment in the Reserve of the Army to the grades indicated under title 10, U.S.C., section 12203:

To be major general

Brigadier General George A. Alexander, 7321
Brigadier General Edmund T. Beckette, 5971
Brigadier General Wesley E. Craig, Jr., 6586
Brigadier General James R. Mason, 7632
Brigadier General Gerald P. Minetti, 5388

Brigadier General Richard C. Nash, 9717
Brigadier General Gary A. Pappas, 3580
Brigadier General Clyde A. Vaughn, 8410
Brigadier General Dean A. Youngman, 4722

To be brigadier general

Colonel William E. Aldridge, 6293
Colonel Louis J. Antonetti, 5832
Colonel Michael W. Beaman, 0589
Colonel Robert T. Bray, 7857
Colonel Nelson J. Cannon, 2178
Colonel Robert P. Daniels, 0451
Colonel David M. Davison, 7296
Colonel David M. DeArmond, 0169
Colonel Myles M. Deering, 1556
Colonel James B. Gaston, Jr., 0282
Colonel Alan C. Gayhart, Sr., 1480
Colonel David K. Germain, 4847
Colonel Frank J. Grass, 4493
Colonel Gary L. Jones, 7353
Colonel James E. Kelly, 1864
Colonel Kevin R. McBride, 7136
Colonel James I. Pylant, 3241
Colonel Steven R. Seiter, 6859
Colonel Thomas L. Sinclair, 7981
Colonel Frank T. Speed, Jr., 2477
Colonel Deborah C. Wheeling, 9217
Colonel Matthew J. Whittington, 0327

IN THE AIR FORCE

The following named officer for appointment in the United States Air Force to the grade indicated under title 10, U.S.C., section 624:

To be brigadier general

Col. William J. Germann, 0850

IN THE ARMY

The following named officer for appointment in the United States Army to the grade indicated under title 10, U.S.C., section 624:

To be brigadier general

Col. William M. Jacobs, 6398

IN THE MARINE CORPS

The following named officers for appointment in the United States Marine Corps Reserve to the grade indicated under title 10, U.S.C., section 12203:

To be major general

Brig. Gen. John W. Bergman, 6022
Brig. Gen. John J. McCarthy, Jr., 8507

IN THE AIR FORCE

The following officer for appointment in the United States Air Force to the grade indicated under title 10, U.S.C., section 624:

To be brigadier general

Col. Thomas F. Deppe, 3181

IN THE NAVY

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be admiral

Adm. William J. Fallon, 0304

IN THE AIR FORCE

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Michael M. Dunn, 3491

IN THE ARMY

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Keith B. Alexander, 9763

IN THE MARINE CORPS

The following named officer for appointment in the United States Marine Corps to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Lt. Gen. Wallace C. Gregson, Jr., 5925

IN THE NAVY

The following named officer for appointment in the United States Navy to the grade indicated under title 10, U.S.C., section 624:

To be rear admiral (lower half)

Capt. Terry L. McCreary, 1209

The following named officers for appointment in the United States Navy to the grade indicated under title 10, U.S.C., section 624:

To be rear admiral (lower half)

Capt. Martin J. Brown, 4202
Capt. William A. Kowba, 6939
Capt. Michael J. Lyden, 0018

The following named officers for appointment in the United States Navy to the grade indicated under title 10, U.S.C., section 624:

To be rear admiral (lower half)

Captain John M. Bird, 4297
Captain John T. Blake, 9104
Captain Fred Byus, 2722
Captain Frank M. Drennan, 9259
Captain Mark E. Ferguson, III, 0136
Captain John W. Goodwin, 7120
Captain Richard W. Hunt, 0833
Captain Arthur J. Johnson, Jr., 1340
Captain Mark W. Kenny, 5645
Captain Joseph F. Kilkenny, 3925
Captain William E. Landay, 9427
Captain Michael A. LeFever, 2036
Captain Gerard M. Mauer, Jr., 9770
Captain Douglas L. McClain, 4212
Captain William H. McRaven, 3730
Captain Richard O'Hanlon, 7322
Captain Kevin M. Quinn, 3457
Captain Raymond A. Spicer, 7586
Captain Peter J. Williams, 1065

IN THE AIR FORCE

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be general

Gen. Robert H. Foglesong, 8617

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Daniel P. Leaf, 9223

The following named officer for appointment in the United States Air Force to the grade indicated under title 10, U.S.C., section 624:

To be major general

Brig. Gen. Joseph E. Kelley, 2386

The following Air National Guard of the United States officer for appointment in the Reserve of the Air Force to the grade indicated under title 10, U.S.C., section 12203:

To be major general

Brig. Gen. Douglas Burnett, 0970

The following named officer for appointment in the Reserve of the Air Force to the grade indicated under title 10, U.S.C., section 12203:

To be brigadier general

Col. Craig S. Ferguson, 1196

IN THE NAVY

The following named officer for appointment as Vice Chief of Naval Operations, United States Navy and appointment to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., sections 601 and 5035:

To be admiral

Vice Adm. Michael G. Mullen, 9509

IN THE AIR FORCE

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Lt. Gen. William T. Hobbins, 8417

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Randall M. Schmidt, 1246

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Walter E.L. Buchanan III, 7387

IN THE ARMY

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Lt. Gen. Dan K. McNeill, 4203

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. William G. Boykin, 5846

IN THE MARINE CORPS

The following named officer for appointment in the United States Marine Corps to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Robert R. Blackman, Jr., 0141

NOMINATIONS PLACED ON THE SECRETARY'S DESK

IN THE AIR FORCE

PN457 Air Force nominations (436) beginning REBECCA G. ABRAHAM, and ending JEFFREY YUEN, which nominations were received by the Senate and appeared in the Congressional Record of March 26, 2003

PN458 Air Force nominations (18) beginning BRIAN J. ACKER, and ending ANGELA D. WASHINGTON, which nominations were received by the Senate and appeared in the Congressional Record of March 26, 2003

PN459 Air Force nominations (16) beginning PAUL M. BARZLER, and ending CHARLES W. WILLIAMSON, III, which nominations were received by the Senate and appeared in the Congressional Record of March 26, 2003

PN691 Air Force nomination of James R. Burkhart, which was received by the Senate and appeared in the Congressional Record of June 5, 2003

PN692 Air Force nominations (6) beginning CHARLES M. BELISLE, and ending BRETT

A. WYRICK, which nominations were received by the Senate and appeared in the Congressional Record of June 5, 2003

PN693 Air Force nominations (85) beginning GLENN D. ADDISON, and ending DANIEL J. ZACKMAN, which nominations were received by the Senate and appeared in the Congressional Record of March 26, 2003

PN694 Air Force nomination of Thomas K. Hunter, Jr., which was received by the Senate and appeared in the Congressional Record of June 5, 2003

PN695 Air Force nomination of Jeffrey J. King, which was received by the Senate and appeared in the Congressional Record of June 5, 2003

PN716 Air Force nominations (3) beginning JEAN B. DORVAL, and ending GARY M. WALKER, which nominations were received by the Senate and appeared in the Congressional Record of June 12, 2003

PN717 Air Force nomination of Richard J. Delorenzo, Jr., which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN718 Air Force nomination of Gerald M. Schneider, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN719 Air Force nomination of Jane B. Taylor, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN720 Air Force nominations (5) beginning DARRELL A. JESSE, and ending NORBERT S. WALKER, which nominations were received by the Senate and appeared in the Congressional Record of June 12, 2003

PN721 Air Force nominations (4) beginning THOMAS C. BARNETT, and ending JEAN A. VARGO, which nominations were received by the Senate and appeared in the Congressional Record of June 12, 2003

PN722 Air Force nomination of Edward C. Callaway, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN723 Air Force nomination of H. Michael Tennerman, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN724 Air Force nomination of Steven E. Ritter, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN725 Air Force nomination of Bryan A Keeling, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN726 Air Force nomination of Robert L. Zabel, Jr., which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN727 Air Force nominations (3) beginning DARRYL G. ELROD, JR., and ending KEVIN R. VANVALKENBURG, which nominations were received by the Senate and appeared in the Congressional Record of June 12, 2003

PN728 Air Force nomination of Drew Y. Johnson, Jr., which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN729 Air Force nomination of Rachel L. Beck, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN740 Air Force nomination of Larry J. Mastin, which was received by the Senate and appeared in the Congressional Record of June 16, 2003

PN741 Air Force nominations (5) beginning ROBERT L. DAUGHERTY,JR., and ending CHARLES V. RATH, JR., which nominations were received by the Senate and appeared in the Congressional Record of June 16, 2003

IN THE ARMY

PN666 Army nomination (102) beginning CRAIG M. ANDERSON, and ending DIANE M. ZIERHOFFER, which nominations were received by the Senate and appeared in the Congressional Record of May 20, 2003

PN667 Army nominations (12) beginning ANULI L. ANYACHEBELU, and ending DONALD G. ZUGNER, which nominations were received by the Senate and appeared in the Congressional Record of May 20, 2003

PN668 Army nominations (72) beginning DOREEN M. AGIN, and ending BONNITA D. WILSON, which nominations were received by the Senate and appeared in the Congressional Record of nulldate

PM669 Army nominations (10) beginning KEVIN R. ARMSTRONG, and ending NANCY A. VINCENTJOHNSON, which nominations were received by the Senate and appeared in the Congressional Record of May 20, 2003

PN696 Army nomination of James A. Decamp, which was received by the Senate and appeared in the Congressional Record of June 5, 2003

PN697 Army nomination of Timothy H. Sughrue, which was received by the Senate and appeared in the Congressional Record of June 5, 2003

PN698 Army nominations (2) beginning LESLIE J. MITKOS, JR., and ending BERRIS D. SAMPLES, which nominations were received by the Senate and appeared in the Congressional Record of June 5, 2003

PN699 Army nominations (2) beginning PATRICIA J. MCDANIEL, and ending NICHOLAS K. STRAVELAKIS, which nominations were received by the Senate and appeared in the Congressional Record of June 5, 2003

PN700 Army nomination of Scott D. Kothenbeutel, which was received by the Senate and appeared in the Congressional Record of June 5, 2003

PN701 Army nomination of Glenn T. Bessinger, which was received by the Senate and appeared in the Congressional Record of June 5, 2003

PN730 Army nominations (5) beginning JANE M. ANDERHOLT, and ending JAY A. WHITAKER, which nominations were received by the Senate and appeared in the Congressional Record of June 12, 2003

PN731 Army nominations (7) beginning RODNEY A. ARMON, and ending MARK W. THACKSTON, which nominations were received by the Senate and appeared in the Congressional Record of June 12, 2003

PN732 Army nomination of Anthony Sullivan, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN733 Army nomination of Bryan C. Sleigh, which was received by the Senate and appeared in the Congressional Record of June 12, 2003

PN742 Army nomination of Kenneth S. Azarow, which was received by the Senate and appeared in the Congressional Record of June 16, 2003

PN743 Army nomination of Michael F. McDonough, which was received by the Senate and appeared in the Congressional Record of June 16, 2003

IN THE NAVY

PN562 Navy nomination of Michael U. Rump, which was received by the Senate and appeared in the Congressional Record of April 30, 2003

PN563 Navy nominations (2) beginning WILLIAM A. DAVIES, and ending GARY S. TOLLERENE, which nominations were received by the Senate and appeared in the Congressional Record of April 30, 2003

PN564 Navy nominations (2) beginning DOUGLAS W. FENSKE, and ending MICHAEL J. KAUTZ, which nominations were received by the Senate and appeared in the Congressional Record of April 30, 2003

PN565 Navy nominations (3) beginning BRIAN H. MILLER, and ending PERRY T. TUEY, which nominations were received by the Senate and appeared in the Congressional Record of April 30, 2003

PN566 Navy nominations (3) beginning GERALD W. CLUSEN, and ending MARK A. WILSON, which nominations were received by the Senate and appeared in the Congressional Record of April 30, 2003

PN567 Navy nominations (7) beginning KENNETH J. BRAITHWAITE, and ending ANDREW H. WILSON, which nominations were received by the Senate and appeared in the Congressional Record of April 30, 2003

PN568 Navy nominations (7) beginning CHRISTOPHER M. BALLISTER, and ending CARL M. M. LEE, which nominations were received by the Senate and appeared in the Congressional Record of April 30, 2003

PN569 Navy nominations (8) beginning JEFFREY D. ADAMSON, and ending MARCUS K. NEESON, which nominations were received by the Senate and appeared in the Congressional Record of April 30, 2003

PN589 Navy nominations (236) beginning DANFORD S. K. AFONG, and ending THEODORE A. WYKA, which nominations were received by the Senate and appeared in the Congressional Record of May 1, 2003

PN590 Navy nominations (23) beginning SCOTT F. BOHNENKAMP, and ending CHRISTOPHER L. WALL, which nominations were received by the Senate and appeared in the Congressional Record of May 1, 2003

PN591 Navy nominations (15) beginning CHARLES L. COLLINS, and ending CYNTHIA R. SUGIMOTO, which nominations were received by the Senate and appeared in the Congressional Record of May 1, 2003

PN592 Navy nominations (29) beginning GREGORY S. ADAMS, and ending PETER A. WITHERS, which nominations were received by the Senate and appeared in the Congressional Record of May 1, 2003

PN604 Navy nominations (10) beginning BRADFORD E. ABLESON, and ending OLRIC R. WILKINS, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN605 Navy nominations (10) beginning CHRISTOPHER A. BARNES, and ending SCOTT M. STANLEY, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN606 Navy nominations (32) beginning THOMAS M. BALESTRIERI, and ending ROBERT S. WRIGHT, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN607 Navy nominations (30) beginning LISA L. ARNOLD, and ending PEGGY W. WILLIAMS, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN608 Navy nominations (22) beginning SCOTT W. BAILEY, and ending KEVIN R. WHEELOCK, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN609 Navy nominations (15) beginning MATTHEW R. BEEBE, and ending STEVEN M. WIRSCHING, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN610 Navy nominations (35) beginning EVAN A. APPLEQUIST, and ending RICHARD D. WRIGHT, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN611 Navy nominations (86) beginning WILIAM B. ADAMS, and ending DANIEL J. ZINDER, which nominations were received by the Senate and appeared in the Congressional Record of May 8, 2003

PN638 Navy nominations (3) beginning REBECCA E. BRENTON, and ending WARREN C. GRAHAM, III, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN639 Navy nominations (6) beginning KATHY A. BARAN, and ending MARGARET A. TAYLOR, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN640 Navy nominations (5) beginning MICHAEL D. DISANO, and ending VINCENT M. SCOTT, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN641 Navy nominations (6) beginning NANCY R. DILLARD, and ending CHRISTOPHER L. VANCE, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN642 Navy nominations (7) beginning JEAN E. BENFER, and ending CYNTHIA L. WIDICK, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN643 Navy nominations (7) beginning DAVID L. BAILEY, and ending RUSSELL L. SHAFFER, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN644 Navy nominations (7) beginning ROBERT W. ARCHER, and ending JIM O. ROMANO, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN645 Navy nominations (8) beginning CHRISTOPHER L. ABBOTT, and ending WILLIAM A. WRIGHT, III, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN646 Navy nominations (13) beginning CHARLES S. ANDERSON, and ending PHILIP A. YATES, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN647 Navy nominations (19) beginning BRIAN K. ANTONIO, and ending THOMAS L. VANPETTEN, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN648 Navy nominations (239) beginning EUGENE M. ABLER, and ending MICHAEL E. ZAMESNIK, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN649 Navy nomination of Judy L. Miller, which was received by the Senate and appeared in the Congressional Record of May 14, 2003

PN650 Navy nominations (7) beginning THOMAS W. HARRINGTON, and ending ROBERT L. YOUNG, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN651 Navy nominations (11) beginning MATTHEW O. FOLEY, III, and ending FRANK G. USSEGLIO, II, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN652 Navy nominations (13) beginning CRAIG E. BUNDY, and ending CLIFF P. WATKINS, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN653 Navy nominations (13) beginning WILLIAM M. ARBAUGH, and ending RICHARD E. WOLFE, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN654 Navy nominations (14) beginning DANIEL M. BLESKEY, and ending WILLIAM E. VAUGHAN, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN655 Navy nominations (22) beginning BARTLEY G. CILENTO, JR., and ending JAMES L. WHITE, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN656 Navy nominations (31) beginning NANCY J. BATES, and ending LLOYD G. WINGFIELD, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN657 Navy nominations (52) beginning ANNEMARIE ADAMOWICZ, and ending MARY A. WHITE, which nominations were received by the Senate and appeared in the Congressional Record of May 14, 2003

PN734 Navy nominations (7) beginning SHERRY L. BRELAND, and ending JULIA D. WORCESTER, which nominations were received by the Senate and appeared in the Congressional Record of June 12, 2003

PN745 Navy nominations (46) beginning RAUL D. BANTOG, and ending DONNA M. WILLOUGHBY, which nominations were received by the Senate and appeared in the Congressional Record of June 16, 2003

PN758 Navy nominations (6) beginning LINSLY G. M. BROWN, and ending JOSEPH S. NAVRATIL, which nominations were received by the Senate and appeared in the Congressional Record of June 18, 2003

PN686 Public Health Service nominations (173) beginning THOMAS D. MATTE, and ending RONALD R. PINHEIRO, which nominations were received by the Senate and appeared in the Congressional Record of June 3, 2003

NOMINATION OF GENERAL ABIZAID

Mr. WARNER. Mr. President, just a day or so ago the Armed Services Committee, as is its responsibility, held a nearly 4-hour hearing on the nomination of General Abizaid, U.S. Army, for appointment to the grade of full general. Within days, a change of command will take place such that he will succeed General Franks as the Commander of the U.S. Central Command. I think General Franks has performed his duties with extraordinary professionalism, courage, and conviction, and his strength of mind and knowledge were an inspiration to all members of the Armed Forces who served in his command throughout the ongoing operations in Afghanistan and the ongoing operations in Iraq.

I have come to know General Franks quite well. He is a lovely individual—he has his soft side—a marvelous husband, and he has a wife who has given him enormous support throughout his long and distinguished career in the Army.

We are fortunate now to have an individual whom General Franks encouraged the President and the Secretary of Defense to have succeed him, and that is General Abizaid.

General Abizaid will have as his responsibility the Central Command which extends from Africa right up to the European sector where it abuts with General Jones's role as the Chief of U.S. Forces in that area. He served as General Franks's principal deputy in the planning and execution of Operation Iraqi Freedom.

The committee, in the course of the hearings, was very complimentary of both General Franks and General Abizaid and their staff and particularly the men and women in the Armed Forces who executed their plans, especially in the historic, stunning, 17-day advance to Baghdad that led to the overthrow of the Saddam Hussein regime.

We all recognized throughout that hearing, as we did this morning in our briefings with Secretary of Defense Rumsfeld and GEN Peter Pace, that this operation is continuing in terms of the risks to the men and women in the Armed Forces every hour of the day. They are courageously facing those risks, and we must stay the course in this situation.

General Abizaid, throughout his hearing, repeatedly said he is prepared to pick up the responsibilities of General Franks and stay that course and bring, from the military perspective, the fastest possible conclusion to the hostilities, such that Ambassador Bremer, working in parallel with CENTCOM, can reestablish a form of government under the control of the Iraqi people, and to bring to the Iraqi people the basic necessities of life, be it electricity, sewage, or otherwise.

Now, the most challenging phase of the military operation, as we said in the course of the hearings, really once the major combat was secured, was finally bringing the situation under control to provide a sense of security throughout Iraq, and that is being done. We are making progress.

He assured us that progress is being made and that he has the experience to carry it forward with his long distinguished career in the Army. He has been a part of the Central Command officer corps on four occasions in his career. So he does have extraordinary background, a unique background, to take on this responsible post.

He was joined by his lovely wife Kathleen in the course of the confirmation proceedings. He was so respectful to his wife, which the record reflects. They have three children, all of whom are of adult age now, who are actively working one way or another in the cause of freedom in various parts of the world.

He also brings experience with regard to joint duty, joint responsibilities. That means the combined efforts of the Army, the Navy, the Air Force, the Marine Corps, and such other areas of military participation.

I want to pay tribute to the civilians in the Department of Defense. They, too, are present throughout Iraq and accepting a very high level of risk in supporting the troops in their missions.

His prior assignments were as Director of the Joint Staff, Director for Strategic Plans and Policy, J–5, on the Joint Staff, and a participant in joint operations in Kosovo and Bosnia, and in northern Iraq following Operation Desert Storm. He was integral in that situation. All of this eminently qualifies him for the challenges of commanding general of the U.S. Central Command.

He brings a unique perspective to this post. He is truly an expert and a student in this region. He is currently serving his fifth tour of duty in the Middle East. He is fluent in Arabic and has a proud—and I underline this, a proud—family heritage closely tied to the cultures of this region of the world.

He is the son of a man who served this Nation as an enlisted man in the U.S. Navy in World War II. So he comes from a family with longstanding service to this Nation.

I had the joy of talking with his wife, and we reminisced about how her father was a medical doctor, serving in the combat zones of France in World War I, as did my father serve as a doctor in the Fifth Division in the trenches in France in World War I.

That concludes my remarks with regard to General Abizaid. I am pleased this morning that the Senate has confirmed him and we will shortly notify the President.

NOMINATION OF MARK E. FERGUSON III

Mr. WARNER. Mr. President, I acknowledge that, as a body, we have just promoted Captain of the U.S. Navy Mark Ferguson to the rank of admiral. He will receive that promotion in due course. I hope to be present.

Many Senators know Mark Ferguson. Perhaps their first recollection of him as a young officer is he was an aide-de-camp to the NATO Supreme Allied Commander. In that capacity, he made many visits to the offices of Senators, and on the occasions when General Clark was hosting congressional delegations in the NATO command area, this wonderful naval officer was integral in making the arrangements. He is a marvelous family man, what we call a black-shoe naval officer, which means he is proud of the shoes he has worn on the decks of all types of surface vessels throughout his career. He is a sailor's sailor and brings to this new post a marvelous background of achievement. We wish him and his family well in his new post as a young frocked admiral, which will take place during the course of this summer.

UNANIMOUS CONSENT AGREEMENTS—EXECUTIVE CALENDAR

Mr. WARNER. Mr. President, I ask unanimous consent that on Tuesday, July 8, the time determined by the majority leader, after consultation with the Democratic leader, the Senate proceed to executive session for the consideration of Calendar No. 227, the nomination of David Campbell to be U.S. District Judge for the District of Arizona, provided that the Senate then proceed to a vote on the confirmation of the nomination with no intervening action or debate. I further ask consent that following the vote, the President be immediately notified of the Senate's action and the Senate then resume legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WARNER. Mr. President, I ask unanimous consent that at a time determined by the majority leader, after consultation with the Democratic leader, the Senate proceed to executive session for the consideration of Calendar No. 88, the nomination of Victor Wolski to be a judge of the U.S. Court of Federal Claims. Further, I ask that the same order apply to Calendar No. 132, the nomination of Bruce Kasold to be a judge of the U.S. Court of Appeals for Veterans Claims.

The PRESIDING OFFICER. Without objection, it is so ordered.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will now return to legislative session.

MEASURE PLACED ON THE CALENDAR—S. 11

Mr. WARNER. Mr. President, I understand that S. 11 is at the desk and is due for its second reading.

The PRESIDING OFFICER. The Senator is correct. The clerk will read the bill by title.

The bill clerk read as follows:

A bill (S. 11) to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

Mr. WARNER. On behalf of the majority leader, I object to further proceedings on the measure.

The PRESIDING OFFICER. The objection is heard. The bill will be placed on the calendar.

Mr. WARNER. That would be under rule 14?

The PRESIDING OFFICER. That is correct.

PROVIDING FOR THE CONDITIONAL ADJOURNMENT OR RECESS OF BOTH HOUSES OF CONGRESS

The PRESIDING OFFICER. Under the previous order, the Senate having received from the House H. Con. Res. 231 in the form contemplated in the agreement, the resolution is agreed to and the motion to reconsider is laid upon the table.

The concurrent resolution (H. Con. Res. 231) was agreed to, as follows:

H. CON. RES. 231

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on the legislative day of Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Monday, July 7, 2003, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Monday, July 7, 2003, or at such other time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate whenever, in their opinion, the public interest shall warrant it.

MORNING BUSINESS

Mr. WARNER. Now, I ask unanimous consent that the Senate be in a period for morning business to be determined by the leadership. It is hoped during that period of time that Senators can make themselves available to speak with respect on our late colleague Senator Strom Thurmond.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WARNER. I yield the floor.

Mr. DORGAN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. DORGAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

IN REMEMBRANCE OF STROM THURMOND

Mr. DORGAN. Mr. President, let me add my voice to those of my colleagues who last evening and this morning have expressed sympathy to the families of Senator Strom Thurmond. I was privileged to serve in this Chamber for many years while Senator Strom Thurmond was a Senator. He was quite a remarkable American. He was a hero in many ways. His life was controversial in some ways.

I talked to Strom Thurmond one day about the Second World War. Americans should know, when he was in his 40s, this man volunteered for service in the Second World War, volunteered to get in a glider to fly at night and crash-land behind enemy lines, behind German lines. All of the rest in that glider were young kids, 18, 19, 20-year-old GIs. This 40-plus-year-old lawyer and judge who volunteered for service in the Second World War was in that glider that crash-landed behind enemy lines.

He was quite a remarkable American and had a remarkable political career. In his later years as he suffered health challenges and difficulties, but he never complained, ever. He showed up for all of the votes in the Senate even at times when it appeared to us it was difficult for him to do so.

The American people, I know, will thank Senator Strom Thurmond for the service he gave to his country. I wanted to add my voice to the many others in this Chamber who wish to remember the memory of this remarkable American.

CONGRESSIONAL CEMETERY

Mr. DORGAN. Mr. President, I call to the attention of the Senate and the country something that is important. Some while ago I went to what is called the Congressional Cemetery here in Washington, DC. I want to state why I did that.

I went to visit a gravesite of a man named Scarlet Crow, an American Indian. He came to Washington, DC, in 1867 with some other American Indians from my part of the country, a member of the Wahpeton-Sisseton Sioux Tribe. He came here to negotiate a treaty. He was found under the Occoquan bridge one morning, dead. The death certificate said Scarlet Crow committed suicide. I actually got a record of the investigation of Scarlet Crow's death—remember, now, this is 1867—and discovered the police reports in Alexandria, VA, and the investigator who investigated Scarlet Crow's death seem to suggest that Scarlet Crow was murdered. He did not commit suicide, in fact, he was murdered. He was found lying under a bridge with a blanket neatly folded over him. They say he hanged himself. The police investigators said the branch from which they allege Scarlet Crow hanged himself could not have held a 6-year-old child.

That was a different time. American Indians came to this town to negotiate treaties. This man, Scarlet Crow, never returned to the Dakotas because he died under the Occoquan bridge under mysterious and strange circumstances. It appears his death was not fully investigated or resolved. The death certificate simply says he committed suicide.

Because I was interested in this and because he came from a part of the country where I reside, I went to the cemetery one day to find Scarlet Crow's gravesite. Here is Scarlet Crow's tombstone. It is at a place called the Congressional Cemetery. The Congressional Cemetery is a place I had not previously visited. It is here in Washington, DC. It holds the bodies of many Congressmen and Senators and others. It was founded in 1807 by a group of citizens residing in the eastern section of the new Federal city of Washington. Immediately, it became the sole burial place in Washington for Members of Congress. For over 60 years, Members of Congress and other Government officials were interred at what was known as Congressional Cemetery. The Government appropriated money to help construct some buildings, roads, and walls and to make other site improvements.

Other than relatively small and very infrequent Federal dollars, Government support ended many decades ago and the cemetery has fallen into disrepair. It is a rather forlorn place, as a matter of fact. I will show some pictures. This is the entrance to Congressional Cemetery. You can see the beat-up roads. Let me show an example of the roads inside the Congressional Cemetery. This, one would think, would be a place of honor, a place that is repaired and made to look presentable. Instead, here is what the Congressional Cemetery appears like to those who visit it. Roads in desperate disrepair. This does not look like a cemetery that has been maintained at all. It has not been.

Here is another picture of what the cemetery looks like inside. Roads in disrepair, grass growing out of the middle of those roads.

One wonders why, with a Congressional Cemetery, which was the burial place for so many Members of Congress, and many others over so many years, why the Federal Government and Congress would not restore it to its place of honor.

I am pleased that some of my colleagues, at my request, included some small amount of money in the Legislative Branch appropriations bill in FY2002, and a bit earlier, as well.

As we begin the appropriations process this year, I think in the honor of those who are laid to rest in that Congressional Cemetery, we really do need to do what is necessary to make that cemetery a place of honor.

Let me discuss a couple of the people who are buried at this cemetery. Vice President Elbridge Gerry is buried at the cemetery. I have a picture showing his tombstone. This is a tombstone of former Vice President of the United States Elbridge Gerry. He is buried in the cemetery.

There is a term, "gerrymandering," in politics that many will recognize. Gerrymandering comes from Elbridge Gerry.

His marker describes he was born in 1744, died in 1814. It quotes on his words on his grave marker:

> It is the duty of every man, though he may have but one day to live, to devote that day to the good of his country.

These words describe how Gerry lived. In fact, the day that Gerry died he had to get to the temporary Senate Chambers in the Patent Office building so he could preside over the Senate. British troops burned the Capitol in the War of 1812 and the Senate was functioning from a temporary location in 1814. In those days, the Vice President presided over the Senate almost daily because the President pro tempore did not have a continuous office. On November 23, 1814, determined to preside over the Senate, Gerry suffered a fatal stroke.

At that time, Members of the Senate gathered in their chairs at the customary hour. Upon hearing the reports that Vice President Gerry had died, the body voted to send two Senators to the Vice President's home to "ascertain the fact." When they returned with confirmation, the Senate appointed a joint committee to "consider and report measures most proper to manifest the public respect for the memory of the deceased," and then the Senate adjourned. On the following day, the Senate ordered that the President's chair "be shrouded with black during the present session; and as a further testimony of respect for the deceased, the members of the Senate will go into mourning, and wear black crape around the left arm for thirty days."

Gerry is the only signer of the Declaration of Independence buried in Washington, DC. On the Fourth of July, there is annually an event at his tomb in the Congressional Cemetery with the Sons and Daughters of the American Revolution.

There is another person buried at the cemetery who is an interesting person. His name is Issac Bassett. He was the second page who served in the U.S. Senate. He came to work in the Senate at age 9 in 1831. He never left. He worked there until 1895. He came to work at age 9 as a page in the U.S. Senate, and he worked here for 64 years. One wonders whether any of the current pages will work continuously for the next 64 years. I don't expect so. He was here even longer than the longest serving U.S. Senator, the late Strom Thurmond. He is buried at the cemetery. Right next to him is a larger marker for Alexander Bache, the founder of the U.S. Coastal Survey and a charter member of the National Academies of Science and its first president.

In addition to the nearly 80 Members of the House and Senate buried in the Congressional Cemetery, there are also 128 cenotaphs erected to honor former Members.

Here is what they look like.

The latest cenotaphs were for Speaker Tip O'Neill, Hale Boggs, and Nicholas Begich. It is something that has been done for quite some while. There is currently some interest in placing a cenotaph for our recently departed colleague, Daniel Patrick Moynihan.

These cenotaphs were designed by the distinguished Capitol Architect, Benjamin Henry Latrobe.

As transportation improved, it became custom to remove remains to a congressman's home state for burial, but a cenotaph was placed in the Congressional Cemetery in their memory. The practice ceased in 1877.

It is my hope that this Congress will take a look at this cemetery and understand that the Congressional Cemetery is the final resting place of nearly 80 Members of the House and the Senate, a signer of the Declaration of Independence and two Vice Presidents. It is where you will find the grave of John Phillip Sousa. You will see the gravestone of J. Edgar Hoover. It is quite a remarkable cemetery.

Let me again show a photograph that shows the entrance and the roads in this cemetery. It is in desperate, desperate disrepair. The Congressional Cemetery ought to be a place of honor. It is the final resting place for many who served this country with great distinction for so many years.

As this Congress considers what our responsibilities are and what we can and should do, it is my hope that we will invest the small amount of resources necessary to once again provide the honor and majesty that should accompany this monument of ourselves called the Congressional Cemetery.

Cemeteries have a way of casting personalities. Everywhere you go at the Congressional Cemetery, you can't help but notice strong personalities who served this country over its more than two centuries.

I indicated when I started that this cemetery doesn't belong to the U.S. Government. It is run by a nonprofit organization. But when the cemetery was started in 1807, it received financial support from the federal government. It was created by a group of citizens who wanted it to become the sole burial place in Washington, DC, for Members of Congress. And over nearly two centuries—Senators, Congressmen, and public officials who served this country in a remarkable way have found their way to this final resting place in the Congressional Cemetery. It is a shame, in my judgment, for it to have fallen into such desperate disrepair.

My hope is that in the coming couple of weeks in the appropriations process, we may once again continue to make some progress to address it. I have spoken with Mr. BYRD, the Senator from West Virginia, at some length about this and with other colleagues. I think all recognize that this is something to which we should pay some attention. I know there are many other very big issues we deal with here in the Senate. But this is something that I think is important to the memory of who we are, who served our country, how we treat them in death, and how we respect their memories. We can and should do better to bring a sense of repair and majesty to the Congressional Cemetery.

It is not too far from this building. I encourage all of my colleagues to go to the Congressional Cemetery and drive down those roads full of potholes in great disrepair and ask yourself if we don't have an obligation to do something about it. I hope so.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware.

IN REMEMBRANCE OF STROM THURMOND

Mr. BIDEN. Mr. President, I would like to proceed in morning business to briefly discuss two totally different subjects, if I may.

I rise initially to acknowledge the passing of a good friend of mine. People may find it strange to hear the Senator from Delaware say that, because they are used to so much hyperbole from all of us in the Senate, in Congress, and many in public office. They find it difficult to believe that people with disparately different views, as Strom Thurmond and I had, were good friends.

I received a call not too many weeks ago from Nancy, Strom Thurmond's wife, telling me she had just spoken to the Senator. To use Nancy's phrase, she said that Strom "was now on God's time, Joe." I wondered for a moment about exactly what she meant. She went on to say that he doesn't have much time left, his body is shutting down.

She said he made a request which both flattered me greatly and saddened me significantly. She said he asked her to ask me whether or not I would deliver a eulogy for him at his burial, which is going to take place on Tuesday next—this coming Tuesday.

It might come as a surprise to a lot of people that on Tuesday, somewhere approaching 4 or 5 o'clock, people—including representatives from Strom's family—will stand up to speak of him and that I will be among them. I am a guy who as a kid was energized, angered, emboldened, and outraged all at the same time by the treatment of African Americans in my State—a border State—and throughout the South. When I was not much older than the young pages who are now sitting down there I literally ran for public office and got involved in public office and politics because I thought I would have the ability to play a little tiny part in ending the awful treatment of African Americans. I will stand up to speak about Strom Thurmond.

In the 1950s I was a child in grade school, and in the late 1950s and into the 1960s I was in high school. As hard as it is to believe now, that was an era where, when you turned on your television, you were as likely to see "Bull" Conner and his German Shepherd dogs attacking black women marching after church on Sunday to protest their circumstance, or George Wallace standing in a doorway of a university, or Orville Faubus.

This all started to seep into my consciousness when I was in grade school, as it did, I suspect, for everyone in my generation. It animated my interest, as I said, and my anger. I was not merely intellectually repelled by what was going on in the South particularly at the time, I was, as is probably a legitimate criticism of me, angry about it and outraged about it.

The idea that I would come to the Senate at age 29—to be precise, I got elected at age 29; by the time I got sworn in, I turned 30—and 2 years later to be serving on a committee with J. Strom Thurmond, him the most senior Republican and me the most junior not only Democrat but junior member of the committee. Over the next 28 years he and I would become friends. He and I would, in some instances, have an intimate relationship.

The idea that my daughter, who is now a 22-year-old grown woman, would, to this day, in her bedroom, have one picture sitting on her dresser of all the pictures she has since she was a child. From the moment she was born—her father was a Senator and her entire life I have been a Senator—she has had the privilege of being able to meet Senators and Presidents and kings and queens. She has one picture sitting on her bureau. It startled me when I realized it the other night. She does not live at home. She, like all young people, is on her own. It is a picture of her and Strom Thurmond, taken when she was 9 years old, sitting on her desk.

If you had told me—first off, if you had told me when I was 20 years old I was going to have a child, that would have been hard to believe. But if you told me when I was 29 years old—when I did have two children—that one of my children, as I approached the Senate roughly 30 years later, would have a childhood picture of her or him in Strom Thurmond's office, standing next to his desk with his arm around her, and it was kept on her bureau, I would have said: You have insulted me. Don't do that.

The only point I want to make today, as I do not intend at this moment to attempt to eulogize Strom, is that I think one of the incredible aspects of our democracy—even more precisely, our Government, our governmental system—that is lost today on so many is it has built into it the mechanisms that allow you not only to see the worst in what you abhor and fight it but see the best in people with whom you have very profound philosophic disagreement.

There is an old expression: Politics makes strange bedfellows. That is read today by most young people, or anyone who hears it, as meaning what it maybe initially meant: that they are strange bedfellows because people need things from each other, and they compromise. So you end up being aligned with someone with whom you disagree, out of self-interest.

But the majesty of this place in which I stand—this Senate, the floor of this place, the floor of the Senate at this moment—is it has another impact on people I do not think many historians have written very well about, and I think it is almost hard to understand, even harder to articulate; and that is, it produces relationships that are a consequence of you looking at the best in your opponent, the best in the people with whom you serve, the best about their nature.

I remember, as a young Senator—I guess I was 31—wandering on the floor one day. New Senators will not like what I am about to say, but when you are a newer Senator, you have less hectic Senate responsibilities than you do when you are a more senior Senator. You are no less important. But being chairman of a committee gives you the honor of turning your lights on and turning them off, meaning you are the first and last there. When you are not a senior Member, you are not required to do that as much.

So I was wandering literally onto the floor, like my friend from Montana just has, and there was a debate going on.

(Mr. BURNS assumed the chair.)

Mr. BIDEN. One of my colleagues, who also became a friend, was railing against something I felt very strongly about. And at the time, because of the circumstance in which I got here, I was meeting regularly, once a week, with one of the finest men I ever knew, the then-majority leader Senator Mike Mansfield.

When I got here, between the date I got elected and the date I arrived, my wife and daughter were killed in an automobile accident and I was not crazy about being here. Senator Mansfield, being the great man he was, took on the role of sort of a Dutch uncle. He would tell me what my responsibility was and why I should stay in the Senate.

And then, without my knowing it, really, at the time—looking back, it is crystal clear—he would ask me to come and meet with him in his office once a week and talk about what I was doing. But he acted sort of like he was the principal and I was the young teacher, and I was coming to tell him how my classes were going. But, really, it was just to take my pulse and see how I was doing.

Anyway, I walked on the floor one day, and a particular friend of mine, Jesse Helms—he has become a close friend, God love him. He is in North Carolina now in retirement—he was going on about something I had a very serious disagreement with.

I walked into Senator Mansfield's office—which was out that door—and I sat down with him. He said: How is it going? And I began to rail about how could this Senator say such and such a thing? It had to do with the Americans with Disabilities Act or what was being discussed then. And Senator Mansfield, in his way, just let me go on, and then he said: Joe—I will not bore you with the whole story. This relates to Strom—he said: Joe, you should understand one thing. And he told me the story about Harry Truman.

When Harry Truman first got to the Senate—I will paraphrase this—he wrote back to his wife Bess and said: I can't believe I am here. I can't believe how I got here with all these great men.

Apparently, not long thereafter, he wrote back to Bess and said he couldn't understand how all these other guys got here.

Well, he told me that story. And he said: Let me tell you, every single solitary man and woman with whom you will serve in the Senate has something very special that their constituency sees in them. And your job is to look for that.

I can't imagine anybody saying that today, can you? I can't imagine, in this raw political environment we are in, somebody having the insight Mike Mansfield had and telling a novitiate, if you will, a new, young Senator, that part of my job was to look for that thing in my colleague, a colleague with whom I have a bitter disagreement, to look for that thing in him that his constituency recognized which was special and sent him here.

Maybe subconsciously, because of that, I became one of Strom Thurmond's close friends and, as his AA will tell you, one of his protectors, especially as he got older. Mike Mansfield was right. I never called Mike Mansfield "Mike." I am standing here as a senior Senator saying Mike Mansfield. I never called him Mike until the day he died. I called him Mr. Leader. And Strom Thurmond had a very special piece of him that his constituents saw that had nothing to do with the most celebrated aspects of his career.

The most celebrated aspects of his career were the ones I abhor the most: The filibuster to fight civil rights and to keep black Americans in the shadow of white Americans or signing the Southern Manifesto.

It is funny—I say to my friend from Montana—I actually got tied up with a lot of Southerners.

Senator John Stennis became my friend. I had his office. I have the table he presented to me in the conference room that had been Richard Russell's, upon which—I am told—the Southern Manifesto was signed. I might note parenthetically, if you all know John Stennis, he talked at you like this all the time. He would hold his hand like this. When I was looking through his office, when he was leaving, to see whether I could take his office because of my seniority, he reminded me of the first time I came by his office as a young Senator to pay my respects, which was a tradition then. And I sat down at that conference table which he used as his office desk.

He patted the leather chair next to me. He said: Sit down. He said: What made you run for the Senate? After congratulating me.

And like a darn fool I told him the exact truth. I said: Civil rights, sir.

As soon as I said it, I could feel the beads of sweat pop out on my head, my underarms get damp. Why am I telling this old segregationist that the reason was civil rights? That is not a very auspicious way to start off a relationship.

He looked at me and said: Good. Good. Good.

That was the end of the conversation.

Over the intervening years, we served 18 years. We shared a hospital room in Walter Reed for 3 months. He was in there, and I was. He became supportive of me in my effort to run for President back in the 1980s. We became good friends. But 18 years later, when I came back to look at his office to see whether or not I would take his office because it was a more commodious space, I walked into the office. It was during that interregnum period after the Presidential election. President Bush was about to take office. There had been this transition.

Anyway, I said to his secretary of many years—I am embarrassed, I can't remember her first name. I think it may have been Mildred. He was in the Senate 42 years, maybe 43—is the chairman in?

She said: Senator, you can go right into his office.

I walked in. He was sitting in the same spot he was 18 years earlier. Only this time in a wheelchair with an amputated leg was John Stennis. I said: Mr. Chairman, I apologize.

He said: Come in, sit down. Sit down. He patted the chair. I sat down. He startled me. He said: You all remember the first time you came to see me, JOE?

I had not. And he reminded me. I looked at him and he recited the story. And I said: I was a pretty smart fellow, wasn't I, Mr. Chairman?

And he said: I wanted to tell you something then and I am going to tell you now. He said: You are going to take my office, aren't you?

I said: Yes, sir, Mr. Chairman.

He caressed that table—it was a big mahogany table about half the size of the table in the cabinet room—as if it was an animate object. He said: Do you see this table, JOE?

I said: Yes, Mr. Chairman.

He said: This table was the flagship of the Confederacy from 1954 to 1968. He said: Senator Russell would have us every Monday, Tuesday, Wednesday—I forget what day—and we would have lunch here. He said: Everybody had a drawer. And he opened one of the drawers. He said: We planned the demise of the civil rights movement at this table. He said: It is time now that this table go from the table of a man against civil rights to the table owned by a man for civil rights. I give you my word on that.

I was moved by that. I looked at him, and he said: One more thing, JOE, before you leave. He said: The civil rights movement did more to free the white man than it did the black man.

And I said: How is that, Mr. Chairman?

None of you here are old enough to remember him, but again the way he talked, he went like this, he said: It freed my soul. It freed my soul.

The point I want to make that I am grappling with here is the men and women who serve here, and Strom Thurmond in particular, actually change. They actually grow. They actually, because of the diverse views that are here and the different geography represented, if you are here long enough, it rubs against you. It sort of polishes you. Not in the way of polish meaning smooth, but polishes you in the sense of taking off the edges and understanding the other man's perspective.

I believe Strom Thurmond was a captive of his era, his age, and his geography.

I do not believe Strom Thurmond at his core was racist. But even if he had been, I believe that he changed, and the news media says he changed, they think, out of pure opportunism. I believe he changed because the times changed, life changed. He worked with, he saw, he had relationships with people who educated him, as well as I have been educated.

Hubert Humphrey wrote a book—and I had the great honor of serving with him—called "The Education of a Public Man." I watched Strom Thurmond as the percentage of his staff increased in terms of black representation. He and I were chairmen, or cochairmen, of the Judiciary Committee for almost two decades—16 years I believe. I watched him. He would lean over to me in the middle of a hearing because we had a genuine trust and say: Joe, what did they mean by that?

I will never forget we were holding a hearing on a Supreme Court Justice, and at the end the last group of witnesses we had—we had six witnesses—included a young man representing the gay and lesbian task force. He was chairing and I was the only one with him because the hearing was already finished and these were people coming to register opposition or support. They ranged from all kinds of groups that were before us—extremely conservative ones and liberal ones—to give everybody their say. Everybody on the committee knew it was basically over. Because of being the ranking Democrat or ranking Republican or the chairman, you have to be there.

I will never forget sitting next to him and he leaned over and said: What is he saying? This young man was explaining the point of view of why, in fact, to be gay was not to be in any way maladjusted. But Strom came from an era and a time that was different, so he looked at the young man and he said: Have you received psychiatric help, son?

Now, everybody in that room who was under the age of 40 laughed and thought he was being a wise guy. He was serious.

He leaned over to me and he said: Joe, why do they call it "gay"?

He wasn't being snide. He literally, at 91 years old, didn't understand that. I guess it must not have been Rehnquist. It must have been someone later. He did not understand. Remember, this man was over 100 years old. He came from the Deep South. People from the far North don't understand either. But he came from an environment that was so different. But in this place, over time, he had the ability, without even knowing it, to apply Mike Mansfield's standard, which was to look at the other guy or woman and try to figure out what is the good thing about them that caused their people to send them here, with all their warts, foibles and faults.

I deem it a privilege to have become his friend. We were equals in the sense that our vote counted the same. Our influence on some issues was the same. But I am 60 and he was 100. There was always a 40-year chasm between us. I could say things to Strom and be irreverent with him. I could grab him by the arm and say: Strom, don't—which I would not have been able to do if there had been a 10-year difference. I was like the kid. It is strange—I find it strange even talking about it—how this relationship that started in stark adversarial confrontation ended up being as close as it was, causing Strom Thurmond to ask his wife whether I would deliver a eulogy for him. I don't fully understand it, but I do know it is something about this place, these walls, this Chamber, and something good about America, something good about our system, and it is something that is sorely needed—to look in the eyes of your adversary within our system and look for the good in him, and not just the part that you find disagreeable or, in some cases, abhorrent.

I will end on a more humorous note. I had the privilege of being asked to be one of the four people to speak at his 90th birthday party. The other people were George Mitchell, then majority leader, a fine man; Bob Dole; and Richard Milhouse Nixon. It was before a crowd of a thousand or more people, black tie, here in Washington. It was quite an event. It kind of shocked everybody that I was asked to be one of the speakers. It shocked me to be seen with Richard Milhouse Nixon, even though he was President when I arrived here.

I did some research about Strom to find out about his background before I did this tribute on his 90th birthday—a combination tribute and roast. You know what I found? I found a lead editorial—I don't have it now—from the year 1947 or 1948 from the New York Times, and the title, if memory serves me correct, is something like "The Hope of the South." It was about Strom Thurmond. The New York Times, the liberal New York Times, in the late forties—it must have been 1947—wrote about this guy, Strom Thurmond, a public official in South Carolina, who got himself in trouble and lost a primary because he was too empathetic to African-Americans because when he was a presiding judge, he started an effort statewide in South Carolina that tried to get better textbooks and materials into black schools, and he tutored young blacks and set up an organization to tutor and teach young blacks how to read. Strom Thurmond. Strom Thurmond. I think it was in 1946 or 1947. The essence of the editorial was that this is "the hope of the South." In the meantime, he got beat by a sitting Senator for being "weak on race."

I think Strom Thurmond learned the wrong political lesson from that and decided no one would ever get to the right of him on this issue again. But I also was sitting next to him when he voted for the extension of the Voting Rights Act.

The only point I want to make is, people change, people grow, and people react to crises in different ways. I choose to remember Strom Thurmond in his last 15 years as Senator rather than choose to remember him when he started his career.

I do not choose that just as a matter of convenience. I choose that because I believe men and women can grow. I believe John Stennis meant it when he said the civil rights movement saved his soul. I believe Strom Thurmond meant it when he hired so many African Americans, signed on to the extension of the Voting Rights Act, and voted for the Martin Luther King holiday.

I choose to believe that he meant it because I find it hard to believe that in the so many decent, generous, and personal acts that he did for me that it did not come from a man who is basically a decent, good man, and the latter part of his career reflects that.

I choose it not just because I am an optimist. I choose it not just because I want to believe it. I choose it not just because I believe there is a chemistry that happens in this body. I choose it because I believe basically in the goodness of human nature and it will win out, and I think it did in Strom.

I will have more to say—or less to say but hopefully more succinctly and in a more articulate way—at his funeral.

I close by saying to Nancy, Strom, Jr., and all of his children, how much I cared about their father, how much, in a strange way, he taught me, and how much I hope he learned from those of us who disagreed so much with his policy on race. The human side of this can never be lost. They lost the blood of their blood, bone of their bone. It was a tough time. But I am flattered that he asked me, and I just hope that I and others are worthy of his memory when we speak of him on Tuesday.

WAR IN IRAQ

Mr. BIDEN. Mr. President, I planned yesterday to be here today to speak about a totally different subject, and then we learned last evening what happened to Strom Thurmond. With the permission of my colleagues, I wish to move for a few minutes to a totally different subject, and that is the war in Iraq. I say "the war in Iraq" because there is still a war in Iraq.

I returned from Baghdad on Tuesday with two of my distinguished Republican colleagues—Senators LUGAR and HAGEL. I came away with several impressions that I want to pass on to my colleagues in the hope that it will give some additional information or insight. My impressions, although not stated in the same way by my two colleagues, Senators HAGEL and LUGAR, I am confident are the same ones they had because we did a number of press conferences and we talked at length. It was a 14-hour flight back. We are good friends, and we all agree on the essence of what I am about to say, although we have different emphasis on different points. Let me say what those primary impressions are and why I think there is such an urgency.

First, there is still a war going on. It is more like a guerrilla war but there is a war. Meeting with our military troops, meeting with our generals, one told us: Every time I send a young man out on patrol on the streets of Baghdad in a humvee, I tell them: Treat it as if you are in battle.

He told us how they know now that our young men and women are being targeted not by some random group of Islamists who are angry but by professionals, the leftover fedayeen, the Republican Guard. Where did all these folks go? They went back into their communities.

One colonel told us they know that people who are engaged in going after Americans are instructed in the following way: All our young men and women wear helmets and flack jackets. They are instructed when there is a disturbance to come out of the crowd. If they are going to try to kill one of our young men and women, there is a 4-inch opening to do it; that is, space between the back of the helmet and the top of the bulletproof vest is where they aim to kill our soldiers. That is not the work of just random and irrational people who are angry we are in their country. How well coordinated and how well organized it is they do not know, and I do not know, but there is still a war going on.

The second impression I came back with is, what a remarkable group of people we have working in the toughest of conditions against the longest of odds to put Iraq back on its feet and back into the hands of the Iraqi people. I am not merely talking about our military, which has been celebrated with good reason and everybody knows; I am talking about our civilians. I am talking about Ambassador Bremer. I am talking about Ambassador Crocker. I am talking about Secretary Slocum. I am talking about the most talented group of people we have assembled, the people who have had incredible experience in Bosnia, in Kosovo, and in Afghanistan in trying to stand up a police department.

We spent an hour or more at the police training academy with men I know are the best in the world. I know because I spent so much time in the Balkans and so much time dealing with the subject. I know they are the single best in the world. In fact, coincidentally, one of them happens to be a former chief of police of the Newark Police Department in the town in which I attended college, the University of Delaware. These are incredibly talented people working under incredibly difficult conditions, made more difficult, I am sad to say, by the incredible miscalculations this administration is making about how to proceed in Iraq.

Many of us on this floor—I am not unique—have pointed out that winning the war is only half the problem, the smaller half. Winning the peace is an astronomically difficult subject. As I say to my colleagues and anyone who asks, if the Lord Almighty came down and sat in this chair and agreed to give the President and those on the ground in Iraq the right answers to the next 20 decisions they had to make, the next 50 decisions they had to make, consequential decisions, we still only have, in my view, a 65-percent chance of getting it right.

That is how complicated Iraq is. That is how difficult this problem is. But it has been made much more difficult, frankly, by the wrong assumptions that were made by the administration. This is not second-guessing. These are things that, for a year before, many of us argued with them about.

I supported us taking out that tyrant, but there seems to be a tone deafness right now, and that is that the administration thought building the peace would be built upon three assumptions they had, for which, in the hearings we held I never found any basis. One is, they expected to find a fully functioning bureaucracy when they got to Iraq, a literate country that would have in place for each of their departments—think of it in terms of the United States—their department of education, their department of public works, their department of highways, their department of security. We were told, with absolute certainty by the administration, that all we had to do was go in and decapitate the Baathists, that is the neo-Nazis who ran that country, and we would have this infrastructure ready to take over the running of their country. But it melted away. It is not there.

The second assumption was we were told they expected to find an army intact. Again, we decapitate the bad guys but there would be a standing army we could work with. That melted away. It does not exist, and to the extent it exists, it is engaged in guerrilla activity.

The third assumption was we were going to find a police force in the country that once we took the bad apples out of—like we did, by the way, in Colombia, helping them vet their national police—that we would have tens of thousands of police officers we could work with who were trained. There are none, and there never were any.

The result has been massive problems in terms of getting basic services back and restoring security. We have seen looting and political sabotage against power, oil, and water plants, some organized resistance, which seems to be getting more organized. All of this is compounded by years of neglect by Saddam Hussein's regime. Neither this administration nor any of us could have reasonably anticipated how badly he treated the infrastructure of his own country. It is not merely that he did not repair the infrastructure during the period when the embargo was on them, when they were operating under sanctions, but for 30 years.

In fairness to the administration, no one knew how badly he had raped and pillaged his own country and infrastructure. We knew what he did to his people but we did not know this.

Ultimately, Iraqis need to do all these jobs: Administrate, be the army, be the police force, restore security, maintain security, but it is going to take a long time to do that. Meanwhile, the international community should be filling the gaps, not we the United States alone.

What is worse is we should have known better. We had extensive experience in the Balkans. We had considerable experience in Afghanistan, which is a failure, in my view. We had considerable bipartisan testimony from experts on the left, right, and center, going back to July, that these problems would be protracted and they would be deep. I will never forget two leading generals, the former head of CENTCOM and former NATO director, testifying before our committee, and I remember the parallel they used.

They said we have this incredible military juggernaut which we have planned incredibly well and executed it incredibly well, but we should in tandem be planning for the occupation of Iraq. There was virtually no planning, but that is water over the dam.

That is not just me. Ask my Republican colleagues who deal with this. There was no planning. The question now, and my purpose today, is not to say, aha, look at the mistake you made, you did not listen. It is to say, let's get over this. Now that we realize and the whole world understands these infrastructures do not exist, it is time to internationalize the effort.

First, we need a significant infusion of military and civilian police to fill the gap of the Iraqi police. On another date, I will spend more time on this, but there are 79,000 Iraqi police spots we have to fill. Our experts on the ground in Iraq say there is a need immediately for 5,800 European crack police, the gens de guerre, to be brought in to maintain the peace and security of the citizens, stop the looting, make the traffic lights work, investigate the murders and the rapes, while we are training 80,000 new police officers.

There is a gigantic vacuum, and our own people on the ground say we need help now. So I implore the President to get over his feelings about the Europeans, the French and the Germans in particular, and seek their assistance because I believe they are ready to assist. They need to be asked.

As I said, we are starting from scratch to build an Iraqi police force of 73,000 people with 18,000 cars. Now we have about 30,000 Iraqi police, all ill trained, with about 200 cars. How long will it take to get to 73,000, which is a very thin blue line? The estimate of many is about 5 years. So what do we do in the meantime if we do not seek to internationalize this?

Second, we need to sustain and probably increase our military forces in Iraq, and it need not be more Americans. We should be reaching out to NATO. When I have spoken to Lord Robertson, when I have spoken to the head of NATO, and spoken to the country specific, I am told they are prepared to send hard, tough, fighting troops into Iraq, but they want to be asked. To the best of my knowledge, the President and Secretary of Defense and the Vice President have decided not to ask. If that is true, that is foolhardy.

We need between 30,000 and 60,000 forces there, and they should be NATO forces. Meanwhile, the notion that has been floated out of the Pentagon by Mr. Rumsfeld, as he suggested 6 weeks ago that we could get down to 30,000 troops by the end of the year, is pure fantasy. Who are we kidding? Get down to 30,000 troops within 6 months? Unless he has a plan no one has ever heard of internationalizing this to the extent that they are backfilled with European and other forces.

We need to get more troops in. They need to be effective, and the best place to look is NATO. As I said, I met with Secretary General Robertson last weekend. NATO is willing to help, but the administration has to ask. So please ask, Mr. President.

Third, we are going to need significant resources to get all of this done. Just a couple of weeks ago my committee, headed by Senator LUGAR, had testimony from leading members of the administration saying do not worry; basically, the oil revenues are going to take care of all of this. What a joke. We have a leading oil man appointed by the administration in Baghdad with whom we sat and met, my two colleagues and I. He said we will get to 1 million barrels a day maybe by the end of the summer; maybe by the end of 2004, an average of 2.4 million a day.

Let me explain that. It means there may be the ability to generate $5 billion worth of revenue this year and $14 billion next year; and it costs us $3 billion a month just to maintain our troops there.

It is time we start leveling with the American people. Maybe the most important impression was our folks on the ground are doing an incredible job. I am not being solicitous. I am not just saying we are doing a great job. They are doing an incredible job. The most positive thing I came away with: I went over despondent about a lack of a political game plan of transferring government to the Iraqis. I am truly impressed with Ambassador Bremer and his team. They have that process underway, after we finally discarded what I assume was the Cheney-Rumsfeld idea of putting Mr. Garner in there and finding Mr. Chalabi—I may be wrong about that; if I am, I apologize for sounding harsh.

But the President was wise enough to recognize the model they originally came up with on the political transition—General Garner is a fine man, and the expatriates being the basis upon which the government would be stood up quickly—was not realistic, and he made a swift change. I implore the President to make a similar change in thinking about police and the military.

Nobody back home understands. The American people have not been given the facts, in my view, to be able to fully understand how monumental the task is we are undertaking, how long it will take and how much it will cost, how many troops. The President needs to go to the American people and tell them.

I will end where I began 10 months ago in this Chamber after my hearings in July—almost a year ago, when I chaired the Foreign Relations Committee. I said then and I repeat it: The one thing all who come out of the Vietnam era generation can agree on is, regardless of what our view was on the war at the time, no foreign policy, no matter how well fashioned, can be sustained without the informed consent of the American people.

As I have said repeatedly, folks in my State and around the country thought when we went in that Johnny and Jane would come marching home as they did after gulf I, immediately after the war. There is a bit of shock and dismay on the part of the families of the National Guard and the reservists when they find out their dads and moms are not coming home; they are being extended.

We knew ahead of time they would have to be extended. You knew it, I knew it. We did not tell. We told them, the President didn't. Mr. President, please go on television, tell the American people what is expected of them now. They will respond. We are a mature people. They don't like the fact that 161,000 Americans have to stay there for an extended period of time. But we have to tell them, and tell them why it is so important it be done. It is in the naked self-interests of the United States that we get this right—that we stand up with a government at the end of the day that is at least more democratic, is not a breeding ground for terror, and is a stabilizing influence in the region because it will save the lives of our children and our grandchildren if we do it right. We have an opportunity to do it right. This is doable. But not on the cheap, and not without leveling with the American people.

Nearly 2 months ago, on May 1, President Bush landed on the USS *Abraham Lincoln* to address our troops and the Nation. Behind them was a large banner that read "Mission accomplished." Our troops did accomplish their first mission, a remarkable mission in Iraq, of ridding its people of the tyrannical regime of Saddam Hussein. But the larger and more difficult mission is building the peace in Iraq and is far from accomplished. In fact, it has only just begun.

I respectfully suggest it is time for the President to explain that to the American people, to talk to us straight about the hundreds of thousands of troops who will be needed immediately and the tens of thousands of troops who will be needed for a long time, and the tens of billions of dollars that will be needed, and how we will have to energize the international community as donor nations to come up with that money so we do not hold the bag for it all. It will take many years.

When Senator LUGAR and I held our hearings, everybody kept saying, the day after the war, and we said, no, it is not the day after, it is the decade after Saddam Hussein is down—the decade after. I have not found one reasonable person who suggests that the United States will not be heavily involved, even after there is a transition to an Iraqi Government, for at least the next 3 to 5 years. If anybody thinks it is less than that, they are kidding themselves. If it is less than that, it will mean we will lose the peace.

I know it is dangerous, and I can see my colleague looking at me; it is dangerous to prognosticate in this business because everybody remembers exactly what you said. But I am saying the same thing I said last July. It was a worthy goal to take down Saddam Hussein. He was a danger to his people. The one thing the whole world has seen is what a madman he was. He has killed 300,000 of his own people at least. Mass graves abound. We did a worthy and noble thing. But we must internationalize this effort now. Now. Now. We must level with the American people.

I conclude by saying what the troops told us. You have been on these missions. These young men and women we have dinner with, these young troops we go out and ride around with, the people we spend our time with in the country, they want to know in Baghdad, are we going to support them? They know how tough this is. They know how many more of them are going to die. They know their life is at risk. They know this is an incredibly difficult undertaking, and they are wondering why, when they pick up the papers back home, it is not being stated that way. It is being treated as if this is over. The American people deserve to be leveled with.

Everyone here knows, whether we say another year or 10, whether it is 75,000 troops or 160,000, whether it is $1 billion or $20 billion or $40 billion, we all know it is a lot more than any of us are telling the American people.

It is time, as one of my Republican colleagues said, to tell the truth. I am not suggesting the President is lying. He is not. I am suggesting the American people do not have any idea what we have signed them on to. We had better tell them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

SENATOR STROM THURMOND

Ms. STABENOW. Mr. President, I take a moment to send my thoughts and prayers to the family of Senator Strom Thurmond of South Carolina, a man of a remarkable career who made his mark in the permanent history books of the Senate and the country. I know he will be remembered at the funeral next week that many colleagues will be attending. We send our thoughts and prayers to his family at what I am sure is a difficult time as they face this loss.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT

Ms. STABENOW. Mr. President, last night's vote on the Medicare prescription drug bill is one of the toughest votes I have cast since becoming Senator in 2001.

As the people of Michigan know, I made the issue of adding a prescription drug benefit to Medicare one of the centerpieces of my 2000 campaign. I told Michiganians that if they sent me to the Senate, I would fight to add a meaningful prescription drug benefit to Medicare. I also said I would do everything within my power to lower prescription drug prices for everyone.

For years, I have criss-crossed Michigan and listened to seniors who desperately need help with paying for their medicines. I have heard from middle class, retired people who have had to cut pills in half because they could not afford to pay for their full prescriptions. I have gone with seniors to Canada where they could actually afford to buy American-made prescription drugs because they cost so much less north of the border.

Since 2001, I have sponsored and cosponsored bills that would provide a comprehensive prescription drug benefit in Medicare and lower prices for all Americans. These are the goals that I have fought for and have spoken out for on this Senate floor time and time again.

Specifically, I have cosponsored S. 7, a bill that would provide a meaningful Medicare prescription benefit. And I have co-sponsored bills to open the border to Canada to allow families to purchase low-cost, F.D.A.-approved drugs made in the U.S. that have been sold in Canada for half the price or less.

I have co-sponsored legislation creating more competition to lower prices by allowing more generics, or unadvertised brands on the market and helping States set up bulk purchasing programs to lower prices for those without health insurance to help pay for their prescription drugs.

I have particularly focused on lowering prices for all Americans because the soaring cost of prescription drugs is hurting all of us.

When a brand-name prescription drug goes up in price three times the rate of inflation, everyone is affected by that. It hurts our seniors, many of whom must pay for prescriptions directly out of their pockets. It harms our businesses by dramatically increasing their health care costs. The average small business has seen their health care premiums double in the last 5 years. This affects our ability to grow and to provide new jobs.

The bill that the Senate passed last night only accomplishes some of my goals. It has its strengths and weaknesses. It is a step in the right direction, but only a beginning step.

On a positive note, this bill establishes an outpatient prescription drug benefit for all seniors for the first time since the entire program was created in 1965.

Currently, Medicare only covers prescription drugs for those who are in the hospital. As we all know, this has been a seniors challenge for our seniors.

Unfortunately, the benefit is confusing and will vary depending upon decisions made by insurance companies, but at least this bill establishes for the first time that there should be a benefit.

The bill provides a benefit for low income seniors who make less than 160 percent of poverty. Married couples earning less than $19,392 per year will receive a comprehensive prescription drug plan. This will help approximately 350,000 seniors in Michigan. Again, this is a step in the right direction.

This bill also provides a catastrophic benefit for seniors who have extraordinary prescription drug bills each year. For some seniors, it is not uncommon for them to have monthly prescription drug bills of over $1,000 per month or $12,000 per year. This bill has a catastrophic cap at $5,800 per year. After $5,800, seniors would only have to pay 10 percent of additional out-of-pocket costs in one year. This is a positive step.

This bill also includes several improvements in payments for Medicare providers. Since 1997, many Medicare providers have been underpaid and have been forced to make difficult decisions regarding serving new Medicare patients. Specifically, this bill provides increased payments for rural providers such as hospitals, ambulance services, and home health agencies. This is important to the people of Michigan.

The bill also makes great strides in helping to lower prescription drug prices for all Americans. For the first time, we have closed loopholes in our drug laws that have allowed brand name drug makers to keep lower cost generic drugs off the market. This bill will mean that there will be more competition between similar drugs and thus lower prices for families, for businesses, and for everyone using prescriptions drugs. This is a positive aspect that I have been fighting for, for the last 2½ years.

It also includes a provision that I have long championed that will allow pharmacies and families to purchase lower priced prescription drugs from Canada. In some cases, the same drugs that are sold in Canada can cost up to 50, 60, or 70 percent less than they cost here in the U.S. That makes absolutely no sense.

Regrettably, opponents of this type of free market competition attached a provision that allows the Secretary of Health and Human Services to stop its implementation. I hope that HHS Secretary Tommy Thompson will not block it and allow U.S. citizens to get lower priced, FDA approved, American made prescription drugs from Canada.

Unfortunately, this bill has serious drawbacks as well which is why it has been such a difficult situation for me. The Republican Congress, along with the President, has not been willing to allocate enough funding to provide a comprehensive benefit to most of our middle class seniors.

They arbitrarily picked a figure of $400 billion in total spending for 10 years even though we know that it would take twice that amount to provide American seniors with the same kind of prescription drug coverage that we in the Congress enjoy. Why was that decision made? I have always said this is a question of values and priorities.

Which is more important, or more effective, putting money in people's pockets and improving the quality of life for Americans, another trillion dollar tax cut for the privileged few, or meaningful prescription drug benefit that will help our seniors and their families afford live saving medicine and put money back in people's pockets through lower prescription drug prices.

The answer to that question, I believe, is very clear. Unfortunately, misplaced priorities have resulted in a prescription drug plan that is much less than American families need and deserve.

There are many short-comings in this plan that I will continue to do everything in my power to correct.

For example, the drudge benefit stops when a senior's drug expenditures are between $4,500 and $5,800. During that period, after seniors have spent $4,500 on their prescription drug costs, and before they reach $5,800, seniors would pay 100 percent of that $1,300 in prescription drug bills. This is a major gap in coverage.

Secondly, the copayments, the deductibles, the premiums are too high and too unpredictable. The $35 premium often quoted is not even guaranteed in the bill. Seniors will be left to the mercy of insurance companies that will decide the premiums and the benefits that will be provided. This is not in the bill. It is up to the insurance companies.

Another very important issue relates to those who already have prescription drug coverage. There is currently not enough incentive in this plan to make sure employers do not drop existing prescription drug coverage for their retirees. This is a very important issue for the retirees in Michigan.

I will continue to fight for changes in this legislation to protect those who currently have coverage, who have worked hard their whole lives, who have retired and have been fortunate enough to have good benefits and are very concerned that they not lose them, as we work to help others who do not have coverage. It makes no sense to set up a system that might actually take away benefits currently being provided to retirees through private insurance.

Furthermore, one of the most negative parts of this bill is the fact that it does not allow seniors to get their prescription drugs through the traditional Medicare system as their first choice. Under the bill passed by the Senate, seniors must pick a private prescription drug plan or enroll in a private PPO or HMO if one is available to them.

Traditional Medicare, that seniors know and depend on, is only available if private plans are not available. Does this make sense? Only if you are a pharmaceutical company or an insurance company. I believe seniors should have many choices, including the choice to stay in the Medicare Program they know and trust.

As I have said so many times before on this Senate floor, when given a choice between traditional Medicare and a Medicare HMO, 89 percent of our American seniors and persons with disabilities have chosen traditional Medicare—89 percent.

This choice is not available to them under this bill. I believe this is a major flaw that I will continue to do everything I can to correct.

During debate on this bill, I sponsored and cosponsored and supported amendments that would have corrected all of these problems. These amendments would have stopped the benefit shutdown, reduced out-of-pocket costs, protected current retiree coverage, and provided a real comprehensive Medicare prescription drug benefit. Regrettably, none of these important amendments received the necessary support from my Republican colleagues to pass.

When deciding how I would cast my vote on this bill, I looked at all of these things: the positive and the negative. I evaluated whether or not this was a step forward for Michigan families, for Michigan workers, for Michigan businesses and, most importantly, for our seniors who have waited too long for help to pay for their medicine.

After many hours of thoughtful review and discussions with those affected by this legislation, I voted in favor of this bill last night, not because it was the best we can do but because it is a first step in the right direction. This direction—the direction in which we need to move—is for a real, meaningful prescription drug benefit for our seniors who have waited too long for their Government to act.

We were successful in improving this bill in some ways during this debate, but much more needs to be done. There will be other opportunities to do so, and I will take them.

This bill does not take effect until 2006. So between now and then I will be fighting hard to provide seniors with the real prescription drug benefit they need and deserve, and I will continue to help lead the fight to lower prescription drug prices for everyone.

As we know, this legislation is not finished. It must now go to a conference committee, a joint committee between the Senate and the House of Representatives, where differences between the Senate and House bills will be addressed. There are critical differences between the two bills.

The House of Representatives passed, by only one vote, a bill that truly begins to unravel Medicare. The House started down the road of privatizing the health care system of senior citizens and the disabled in our country. They voted to begin the process of turning back the clock to the days when too many seniors and families could not find or afford private insurance.

If I had been in the House of Representatives last evening, where I served for 4 years, I would have voted no. If the House bill comes before the Senate as it is currently written, I will vote no. Unlike the Senate, where we worked in a bipartisan way to develop a plan that the majority of Senators could support, the House process was very partisan and polarizing, and it resulted in an extreme plan that could not be supported by my Democratic colleagues who care deeply about strengthening and preserving Medicare for the future.

Our seniors expect and deserve the best plan we can offer. I will continue to work with my colleagues to achieve that goal. And I hope and pray that we will be successful.

Madam President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mrs. DOLE). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. FRIST. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE HONORABLE J. STROM THURMOND, FORMER U.S. SENATOR AND PRESIDENT PRO TEMPORE EMERITUS FROM THE STATE OF SOUTH CAROLINA

Mr. FRIST. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 191, which is at the desk, and I ask that the resolution be read.

The PRESIDING OFFICER. The clerk will report the resolution.

The assistant legislative clerk read as follows:

A resolution (S. Res. 191) relative to the death of the Honorable J. Strom Thurmond, former United States Senator and President Pro Tempore Emeritus from the State of South Carolina.

S. RES. 191

Whereas the Honorable J. Strom Thurmond conducted his life in an exemplary manner, an example to all of his fellow citizens;

Whereas the Honorable J. Strom Thurmond was a devoted husband, father, and most recently, grandfather;

Whereas the Honorable J. Strom Thurmond gave a great measure of his life to public service;

Whereas, having abandoned the safety of high position, the Honorable J. Strom Thurmond served his country during World War II, fighting the greatest threat the world had thus far seen;

Whereas the Honorable J. Strom Thurmond served South Carolina in the United States Senate with devotion and distinction;

Whereas his service on behalf of South Carolina and all Americans earned him the esteem and high regard of his colleagues; and

Whereas his death has deprived his State and Nation of a most outstanding Senator: Now, therefore, be it

Resolved, That the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable J. Strom Thurmond, former Senator and President Pro Tempore Emeritus from the State of South Carolina.

Resolved, That the Secretary of the Senate communicate these resolutions to the House of Representatives and transmit an enrolled copy thereof to the family of the deceased.

Resolved, That when the Senate adjourns today, it stand adjourned as a further mark of respect to the memory of the Honorable J. Strom Thurmond.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. Madam President, this resolution has been submitted by myself and on behalf of Senator DASCHLE, Senator GRAHAM, and Senator HOLLINGS in honor of the honorable and great J. Strom Thurmond.

Last night shortly after 9:45, we were notified of the death of Strom Thurmond. At that time, I pointed out that it was a century ago—a long time ago—when Mark Twain was alive and Teddy Roosevelt was still President, J. Strom Thurmond was born in Edgefield, SC, and, thus, began a life of public service unmatched—unmatched—in the modern history of America.

Strom Thurmond served as United States Senator from December 1954, 2 years after I was born, until January of this year, nearly a half century of service in this body—this body we have the honor of participating in on a daily basis.

Though his period of service is a remarkable accomplishment in and of itself, Strom led a remarkable life even before coming to the Senate. Late last night and over the course of the morning, if one turned on a television set, they would hear anecdotes, stories about this great man, and those pre-Senate years when he was a teacher, an athletic coach, and a superintendent of education.

He studied law under his father, Judge J. William Thurmond, and became a city attorney, a county attorney, a State senator, and eventually a circuit court judge. He resigned his position as a circuit judge to volunteer to fight in World War II. This he did at the age of 39, 18 years after serving as an Army reservist and having earned a commission as a second lieutenant.

Indeed, as we all know, age never was an obstacle for Strom Thurmond. As a member of the 82nd Airborne, Strom landed a glider at Normandy on D-Day and helped secure the foothold for the Allies to liberate the European continent.

For his distinguished service, Strom was awarded five battle stars and 18 other decorations, including the Legion of Merit with oak leaf cluster, the Purple Heart, the Bronze Star for Valor, the Belgian Order of the Crown, and the French Cross of War. No wonder when a speech writer once used the word "afraid," Strom Thurmond handed the text back with the retort:

> I've never been afraid of anything.

After the war, Strom returned home to South Carolina. He was elected Governor in 1946, and then ran for President of the United States as the States Rights Democratic candidate. Strom won four States and 39 electoral votes, and that tally stands as the third largest independent electoral vote in U.S. history.

Though he did not win the Presidency, Strom was determined to serve in Washington. He ran for the Senate in 1954, became the only candidate elected to Congress by a write-in vote in American history, and he was reelected eight more times.

In the most recent years, it became increasingly difficult for Strom to go back and forth to South Carolina, but that did not stop the people of South Carolina from coming to him, and it should not have. For decades, Strom attended every county fair, handled every constituent request, and sent a congratulatory note to every high school graduate, many of whom came to intern in his office. It has been said that almost 70 percent of South Carolinians have met Strom Thurmond face to face. Over the course of his long and distinguished career, Strom Thurmond was a witness to history.

As a young man, he knew people who stood in the presence of Andrew Jackson. He campaigned for the votes of men who fought in the Civil War. He and Herbert Hoover won their first elective office in the same year, 1928.

Strom more than saw history, he wrote it. He was the first major southern Democrat to switch to the Republican Party. He served for more than 17 years as President pro tempore of the Senate. As chairman of the Armed Services Committee, he ensured that our men and women of the Armed Forces had the best training, the best equipment, and the best leadership in the world.

As we all know, Strom did set the record for the oldest and longest serving Senator. He served with about one-fifth of the nearly 2,000 men and women who have been Members of the Senate since 1789. He was nearly one-half the age of the U.S. Constitution. Strom certainly faced his trials. As the Dixiecrat candidate for President in 1948, he campaigned on a platform of States rights, but in doing so he also opposed civil rights, as he did for many years as a Senator.

History will reflect that part of Strom's life. We will let history also reflect that when Strom saw that America had changed, and changed for the better, he changed, too.

A longtime friend of Senator Thurmond's, Hortense Woodson, once said of him:

> Everything he's done has been done to the full. There's no halfway doings about Strom.

Indeed, Strom Thurmond will forever be a symbol of what one person can accomplish when they live life to the fullest. God bless our friend and our colleague from South Carolina, Senator Strom Thurmond.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. GRAHAM of South Carolina. Madam President, I compliment our majority leader for his statement. It was very eloquent and it means a lot to Senator Thurmond's family.

I know personally that Senator Thurmond had a great fondness for Senator FRIST. He told me he is a very smart man and he is a good doctor, too. If you ever need him, look him up.

I rise today in support of this resolution on behalf of myself and Senator HOLLINGS. I appreciate the majority leader and Senator DASCHLE allowing this to occur. It is offered in the spirit of Strom Thurmond's life. Something can be said about Strom Thurmond in the Senate very easily. He loved the Senate and the Senate loved him. His colleagues who have served with him so long all have personal stories of fun, good times, tough fights. He was a valuable ally and a worthy opponent, and the Senate has lost its longest serving Member. Many of us have lost a very dear friend. That goes for the Senate family, the people who help us with the doors, the clerks, and the reporters of debates. Everyone enjoyed and appreciated Senator Thurmond.

It is important to comment on Senator Thurmond, the man. His children have lost their father. Whether one is 100 or 200, it is always difficult, no matter how long one lives, to give up their father and mother.

I have talked to two of his three children today, and I have expressed my condolences. They are doing very well but they are sad because they have lost their daddy. I have talked with his wife. We reminisced about their life together, the raising of their children, and the experiences they have had. So my prayers, along with the prayers of everyone in the Senate, go to the family. He was a good family man. If a script was written in Hollywood about his life, it would not have ended any better in this regard.

He became a first-time grandfather at the age of 100 last week. He has three children under 30. He had his first child when he was 68. He was just a phenomenal person. He has done things that most of us could not dream of doing in many ways.

I am convinced that two things drove him in his final years: That he wanted to finish out his term because he is not a quitter, and when he was elected to serve his last 6-year term he meant to serve it out. He helped me to become his successor, and I will be forever grateful. He also wanted to see his grandchild born, and God allowed him to do that. He was presented his grandson last week. They tell me it was a very magic and touching moment. A week later, he passed on.

He has suffered personal tragedy, lost a daughter in an accident. He has experienced much good and bad in his life. He has touched so many people. It is a loss to the Senate. It is a loss to his family. It is a loss to his staff.

Duke Short, who served with Senator Thurmond in Washington for so many years, was a very loyal and capable staff director. I know that Duke and his family feel the loss.

Dr. Abernathy in South Carolina has been with Strom Thurmond since the 1940s when he worked with him as Governor. Dr. Abernathy is a legend in his own right.

There are so many people who have worked for Senator Thurmond throughout the years, and I know they feel this loss. Senator Thurmond has had enough interns to probably fill up a football stadium. His first group of interns are now on Social Security.

He was elected in 1954. I was born in 1955. All I have known in my life is Senator Thurmond, and for 36 years Senator Thurmond and Senator HOLLINGS served together. Both of them are distinctive gentlemen, bigger than life. A lot of us who have associated with Senator Thurmond feel his loss.

South Carolina has lost her favorite son. Much has been said and will be said of Senator Thurmond's legacy. The majority leader, Senator FRIST, went over his life very well, and it is just an amazing story to tell: Being a superintendent of education in the 1920s; getting elected for the first time in 1928; being a judge in South Carolina at the start of World War II, deciding to give up that job which would have exempted him from service, being in his early forties; joined the 82nd Airborne, landing in a glider. The pilot of the glider was killed when it landed. His men were wounded. He led them out and secured the objective.

When the war in Europe was over, he volunteered to go to Japan and he fought until they quit. He was just an unbelievable person who embraced life.

People ask me: How did he make it so long? He just had a passion. He had a passion for everything he did—his family, his constituents. His legacy in South Carolina is quite simple for every South Carolinian—black, white, rich, poor, no matter whether you are from upstate, middle, low State—I am sure every State has different regions and different dialects but the one thing we had in common: If we had a problem, we knew who to call. We knew to pick up the phone and call Senator Thurmond because if he could help you, he would.

The average, everyday South Carolinian, from the company owner to the janitor, believed that Senator Thurmond was on their side. And when they called, they received a call back. When they wrote a letter, they received a letter back. The reason I know that is people tell me everywhere I go.

One guy told me Senator Thurmond used to cut his grass. These stories abound. Some of them have been embellished, I am sure, but the only way that he could have lasted this long in politics, doing as many things as he has done, taking on the issues that he has taken on, is that at the end of the day people saw that he had a servant's heart.

Part of his legacy is the 1948 campaign, and it needs to be mentioned. Senator FRIST mentioned it. That was a tough time in our country. He ran as a States rights candidate with a lot of passion for the limited role of the Federal Government. He won on the platform that divided the races. That was a dark time in South Carolina. That was a dark time in our Nation.

Senator Thurmond made a choice later in life. He could have done almost anything he wanted. But as the 1950s came to a close and the 1960s came about and people started insisting their Government treat them better, Senator Thurmond made a choice. Instead of hanging on to the rhetoric of the past and the politics of the past, he embraced the future.

Here is what he does not get much credit for. Instead of going with the flow, which some people want to ascribe to him, he in a subtle way led a change. He could have been a barrier to change, but he made it easy for people in South Carolina, politicians on the Democratic and Republican sides, to embrace change because when Strom came out for something, it made it easier for you to come out for something because it gave you cover. When Strom Thurmond appointed the first African-American judge in the history of South Carolina to the Federal bench, it made it easier for the people in the statehouse to give appointments to African Americans. That is what we do not need to lose.

When he embraced traditional Black colleges and started giving them the same recognition and funding as every other university in South Carolina, it made it easier for the legislature to improve the quality of life for everybody. At the end of his life, in 2001, he was awarded lifetime recognition from the Urban League in South Carolina, that is designed to build racial harmony, for his lifetime of service to traditionally African-American colleges.

That needs to be mentioned as much as the 1948 campaign. He will be held accountable in history for that part of his life. History should know that in many subtle ways, in many bold ways, he allowed my State to move forward, and everybody in my State is better off for it.

From a personal point, when I was in the House, I was the first Republican to be elected from my Third Congressional District in 120 years. One reason I was able to win when everybody behind me was beaten for 120 years was, Senator Thurmond, for the first time in his political career, embraced a campaign very directly—because he had been smart enough not to get involved in political races and try to represent everybody. He took to me, and I am the beneficiary of that. He said: I will come and campaign for you, Lindsey. I said: Great. And I turned to my staff and said: What do you do with a 92-year-old man? I was worried we would wear him out and we could not utilize his services. I was worried about him at age 92. Three days he campaigned for me. When he left, I said: Thank God he is gone. He wore me out.

He had a passion I had never seen. I picked him up at the airport on day 1, in an airplane flown by his personal pilot who was 75 years old, a single-engine plane. We went to a parade in September. It is hot in South Carolina in September. We went from one end of town to the other shaking hands. We went to the funeral home because he remembered the guy who owned the funeral home always gave him apples. He walked in unannounced because the Senator wanted apples, and he got the apples. He campaigned all day. We had a fundraiser that night. We went to a football game that night. He made a speech at half time. We went to a rodeo that started at 9 o'clock at night, and he got up in the middle of the ring on a barrel and gave a speech. He wanted to see the third shift change at the textile plant. I said: I am too tired, and I went home. That went on for 3 days.

When he left, I asked him to sign a fundraising letter for me. We were all worn out. He looked at the letter and he said you misspelled your own name and you are in the Third District, not the Second District.

At 92 years of age, he had a passion and he helped me. I stand appreciative. When I ran for the Senate, he endorsed me in a primary. I can tell you, I would not be his successor if he had not come out and said: LINDSEY GRAHAM is the right guy to follow me. That will stick with me forever.

What have I learned from Senator Thurmond? If you are willing to change, you can serve your State and Nation well. If you care about people, they will take care of you. Let it be said that God gave to this Nation, my State, South Carolina, a public servant, a man of great character and heart, and that we miss him, but we thank God that he gave us J. Strom Thurmond.

I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Madam President, I enjoyed hearing my colleague from South Carolina tell his stories about Strom Thurmond. I rise to join the tribute to the memory of Strom Thurmond that is, very appropriately, the day after his death.

Most of the time when someone dies, we gather in great sorrow and we mourn his passing and we think about what might have been. In Strom's case, there is no reason to think about what might have been. He did it all. There was nothing left undone. There was nothing left to accomplish.

This should not be a time of mourning or sorrow but a time of celebration. So I rise to celebrate the life of Strom Thurmond. The best way to do that, I think, is to tell Strom Thurmond stories. All of us are full of Strom Thurmond stories.

I remember D-Day, when the big celebration occurred on the anniversary of D-Day and Strom Thurmond was not there. ARLEN SPECTER, who was there, greeted him in the Senate and said: Strom, it was a marvelous, marvelous celebration, and you should have been there. And his response was: I was there when it counted. It put us in our place.

My father had the experience of working with Strom Thurmond. My father was elected in 1950, and, as has been noted, Strom Thurmond was elected in 1954. They became instant friends, not just political friends. There were occasions when they disagreed politically, but they became personal friends.

When Strom married, my mother—old enough to be Strom's wife's mother—kind of took Nancy under her wing and they became friends. The Thurmonds and the Bennetts remained close for a long, long time, to the point when my children started getting married, my parents said: You have to send Strom Thurmond an announcement. And we did and thought we had taken care of our social obligation. Then we get a phone call from Strom Thurmond's office: We got this announcement, and we don't mean to be prying, but who are you? Well, we are the children of Wallace Bennett. There was a pause. Then the person on the end of the line said: And who's Wallace Bennett?

But Strom knew who Wallace Bennett was, and when I came to the Senate, Strom greeted me very warmly and called me Wallace. It took a little while for him to figure out that I was not my father. And that was a compliment to me because I was very proud of my father and the service he performed in the Senate, and I took the opportunity to touch base with Strom.

From that, I thought: This man in his nineties is not all that sharp. He confuses me. He does not have all of this as straight as he might. Then I had a couple of experiences that set me straight. We had an issue with the State of Utah that was all wrapped up in the Armed Services Committee. It was quite a complicated issue. Someone said to me: Explain that to JOHN WARNER because JOHN WARNER is second ranking to Strom and is handling all of the detailed kind of things. You go talk to JOHN WARNER. He said: You will be talking to somebody who I know can handle the problem.

So I went to Senator WARNER and I started outlining the details of this situation to him. He cut me off. He said: You are going to have to talk to the chairman.

I, having had this image of this old man, thought, I don't really want to have to talk to the chairman. And, as delicately as I could, I said to JOHN: Can't we work this through and kind of handle it? He said no. He said: That is a serious enough issue, I don't dare handle that. You are going to have to talk to the chairman.

Just then, Senator Thurmond walked through the doors. So, gathering up my courage as a freshman Senator, I walked over to him and said: Senator Thurmond, I would like to visit with you about—and I no sooner got the title of the issue out of my mouth, than he said: It's all taken care of. And he kept walking. I followed him along, sure that he had not understood what I was talking about. This was a complicated kind of issue, and he had oversimplified it and assumed that it had been taken care of.

So I started to intrude again with some of the details. He was very respectful and wasn't patronizing. But he said: I know; I understand; all taken care of.

Well, thus dismissed, I went back to my staff and said: I think we have a problem here. Senator WARNER won't handle it, and he insists that Senator Thurmond has to handle it, and Senator Thurmond just said it has all been taken care of.

We contacted the Armed Services Committee staff, and they said: Oh, yes, that has all been dealt with. Senator Thurmond stepped in, he understood the issue, he made his decisions, he took care of it, and it is all taken care of.

So I decided, well, I had better not underestimate this man, in spite of his age.

Then I had the experience while I was on the campaign plane with Senator Dole in the 1996 election when we were flying around the eastern States on the day of the South Carolina primaries. The word came in that Senator Dole was winning the South Carolina primary. We had some exit polls that looked pretty good. We decided to change our itinerary and fly to South Carolina so that Senator Dole could be there to receive the plaudits and applause and the excitement of winning the South Carolina primary. So we did. Of course, this had been a long day. We didn't leave South Carolina to come back to Washington on the campaign plane until after the returns were in and all of the celebrations had been held.

Senator Dole, very appropriately, went up into the front part of the plane to take a nap as we were flying back. Senator Thurmond had hitched a ride back to Washington on the campaign plane. That left Senator Thurmond and me and one or two others sitting around the table just behind the front part of the plane chatting.

It was now midnight, way past my bedtime, and here we were having political discussions on a campaign plane in the middle of the Presidential campaign—the kind of thing that political junkies like me love to do. It was a great discussion. But the interesting thing about it was that Strom Thurmond not only understood the discussion and participated in the discussion, but he led the discussion. He was instructing us about political lore. He was telling tales out of his past, which is what old people often do. But he was also analyzing things for the future and had a firm hand on everything. I thought I was talking to a man at least 20 and maybe 30 years younger than his chronological age. I understood: OK, this man still has all of his faculties, mental as well as physical.

We landed at Dulles Airport well after 1 o'clock in the morning. Everybody was dragging except Strom, who strode off to his car in fine style. I remember what he said on that occasion about how you live a long time. He said you eat right, you exercise regularly, and you keep a positive outlook. He did all of those things, although I am not quite sure about the eating right part because there were times when I caught Strom eating some things that I am not sure a dietician would recommend.

The time came for him to run for reelection. I couldn't believe at 94 he was going to run for reelection. Ninety-four is the time you retire. Being a skeptic, I had a hard time believing the people of South Carolina would vote for a 94-year-old man. So I sidled up to one of his top staffers as we were getting ready for that campaign. I said: Can Strom Thurmond really win one more time in South Carolina? Is this going to be close? He said: No, it is not going to be close at all. Strom is going to win going away.

By the way, I remembered when the Republicans had taken control of the Senate in 1994 and we were having our discussions about platforms. One of the issues that was raised by one of the freshman Senators newly elected was term limits and how we needed to be for term limits. We were debating back and forth. Strom was sitting there not talking. Suddenly, he spoke up, and he said: I am for term limits. We all kind of giggled a little. He said: But if they are not enacted, I am going to run again.

Here he was running again—94 years old. And I was being told by his staff that Strom would win overwhelmingly. I said: Look, we all love him. We all love the history. But 94 years old? He said: Let me tell you a story.

This is my favorite Strom Thurmond story.

He said: I was Strom's AA, and I got a phone call from a woman in South Carolina who said to me: I need the Senator's help. Here is the situation. My fiance and I got married just before he shipped out in the Navy for a 6-month cruise in the Mediterranean. We knew we would not like the separation, but we decided, for a variety of reasons, that we should get married now rather than wait until after he got back. He has just called me and said he has been given leave. He has 2 weeks of leave right now in the middle of this 6-month tour, except that he cannot leave the theater in case something should arise that would require him to be back on the ship within 24 hours. He has to stay in or around the Mediterranean area where his ship is. So he said catch an airplane, come over here, we can have a 2-week honeymoon in the Mediterranean and I can still be available for the military situation, if it should arise.

She said: I went down to get my passport and I was told it takes 2 weeks to get a passport. By the time I get a passport to fly over to be with my husband, his leave will be up and he will have to get back on the ship. Can the Senator help me get a passport any faster than 2 weeks?

Well, said the staffer, I will find out. He called the woman in South Carolina who was handling passports and introduced himself and said: I am calling on behalf of Senator Thurmond to see what we can do about getting this woman's passport a little faster. The passport lady said: It takes 2 weeks. Well, Senator Thurmond would really be grateful. She said: I don't care what Senator Thurmond wants. It takes 2 weeks. I don't care who you are, and I don't care who he is. Passports take 2 weeks.

Well, he said, I have to tell you that under these circumstances, I am now going to have to call Senator Thurmond. When there is a situation I can't handle myself, I have to involve him. Those are my instructions. She said: Call him. Tell him anything you want. He can call me. I don't care. Passports take 2 weeks.

So he said: Well, I am not threatening you. I am just telling you. I have to call Senator Thurmond.

So he hung up talking to the passport lady, and he picked up the phone and called Senator Thurmond. Now, it seems Senator Thurmond was in Germany, and it was in the middle of the night in Germany, but his instructions were that he was to call Senator Thurmond in any such situation. So he woke Senator Thurmond up, in the middle of the night in Germany, and started to explain this situation.

He did not get half way through the explanation I have given here when Senator Thurmond said: What is her name?

He said: Well, her name is—and he started to describe the wife of the marine who was sent out with the Navy.

Senator Thurmond said: No, no, not her name, the passport lady's name.

So he gave Senator Thurmond the passport lady's name.

Senator Thurmond said: Thank you very much—and hung up.

Ten minutes later the staffer said: I got a phone call from the passport lady. She exploded over the phone and said: He called George Shultz. The Secretary of State now knows my name.

Senator Thurmond called George Shultz and he said: George, you've been a marine. This is their honeymoon. Can't you get this lady to give the woman a passport?

She got her passport. She got to the Mediterranean. She had her honeymoon.

The staffer said to me: Senator, South Carolina is full of stories like that. South Carolina is full of people like that. Strom Thurmond will win, big time. No matter how old he is, no matter what his situation, that is the kind of service Strom Thurmond has rendered as a Senator.

One of our colleagues was in the Senate doctor's office, as we go in there from time to time, and he noticed Strom coming out of the doctor's office with a very worried look on his face. We were all very concerned about Strom and his health in his later years. So the colleague said to the doctor: What's the matter with Strom?

The doctor said, appropriately: I cannot discuss the medical condition of one patient with another patient, so I can't say anything to you. He said: However, I don't think it would be violating medical ethics to tell you that Strom is a little worried about the fact that he can no longer do one-arm pushups.

This was a man of legend. Eat right, exercise, keep a positive attitude, always be available for your constituents, even when it is the middle of the night in Germany, and never worry about who you may call or upset as long as you are working on behalf of a constituent. This was Strom Thurmond.

We have all kinds of stories. These are my favorite ones. I offer them as part of the celebration of an extraordinary life, a life fully lived, of someone about whom we need not say: Well, we worry about what might have been. In his case, there was nothing left over that might have been because he did it all.

I yield the floor.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from South Carolina.

Mr. GRAHAM of South Carolina. Mr. President, I thank Senator BENNETT from Utah for that remembrance. It was just exactly what needed to be said. I say to the Senator, I know he loved you and your father dearly. On behalf of the people of South Carolina, I thank you very much for what you just said.

Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 191) was agreed to.

The preamble was agreed to.

Mr. GRAHAM of South Carolina. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

LEGISLATIVE ACHIEVEMENTS

Mr. FRIST. Mr. President, most of our colleagues are departing, and we will shortly, in just a bit, for a recess which, as all of us know, is a time for visiting with our constituents, visiting around the country with people who give us the opportunity to serve in the Senate and interact with them in a way that we can ask questions. How are we doing? You elected us to fulfill a vision that you have had and which we are doing our best to lead with. So it gives us an opportunity to really sit back and assess how we are doing as public servants, as Senators representing our own States.

As I look back over the last week, it has truly been an exciting week for America. After years of discussion, after years of debate, we passed a bill this morning, in the middle of the night, late last night after midnight, that we know, once we work through conference, and once it is signed by the President of the United States, will strengthen Medicare, will improve Medicare, will modernize Medicare in a way that we simply never have since the origin of Medicare in the mid-1960s.

We know from this legislation that we developed in a bipartisan way, that for the first time in this program and, indeed, in the history of the country, seniors, through the Medicare Program, will have access to prescription drugs. They will have for the first time the option to choose health care coverage that best suits their individual needs. It is all voluntary. They don't have to take advantage of any of these new options that they will have. Their health care coverage will be responsive not only to them, the way this program is designed, but to the constant advances in health care delivery and new medicines and new technology that we know characterize health care today but will even more so characterize health care in the years to come. It will be able to capture those lifesaving innovations of modern medicine.

Best of all—I keep mentioning it—I am very pleased with the way this bill came to the Senate floor, was debated, and in committee prior to that because it really was a bipartisan effort. Many times, especially when the American people look at the way we operate here, they say: That extreme partisanship and that rhetoric going back and forth; how in the world does any business get done?

This particular legislation, probably as complicated as any legislation that would be on this floor—and clearly it is big; this is the largest single expansion of an entitlement program in the last 30 years—was carried out in a way that debate took place in a civil fashion and people came together, not always agreeing, as we saw last night and early this morning, on every single issue, but we tackled the issues head on, something our seniors deserve, something the American people expect. And we delivered a bill that reflects the needs and priorities of both sides of the aisle.

Not everybody is perfectly happy with it. We know it is not perfect. But it is as good as can be generated from this body at this point in time.

That is sort of the last week, the last couple weeks. Over the last 6 months, as leadership in the Senate, we have tried to lead this body in a way that is very much mission focused, that is very much building on relationships, centered on different relationships on both sides of the aisle in a way that values are important—the values of civility and trust, and with a real action orientation, looking for solutions to problems, not just talking about them, not just legislating for legislation's sake but actually delivering where problems are identified.

So if you look at being mission focused and relationship centered and values based and action oriented, that is what you set out to do. Then it provides a good opportunity, now as we go into this recess about 6 months into the year, to see what sort of job we are delivering for the American people.

Again, I mentioned the bill last night because I think it fits all four of those criteria and shows us with that common mission of moving America forward and doing it in a very respectful and civil way.

Over the past 60 days, the Senate has acted, responded, and provided solutions to many of the jobs problems and the challenges brought to us. Every Senator can leave for this Fourth of July recess today proud of what they have accomplished on behalf of our fellow citizens. We passed the third largest tax cut in history. The Jobs and Growth Act is providing immediate relief to millions of Americans, American citizens, their families, to States, to businesses. Of the $350 billion stimulus and growth package that we passed, nearly $200 billion, a full 60 percent, is provided this year and next, not way off in the future. Indeed, many of those checks will start flowing in the next 4 weeks.

This injection of money, this injection of resources will grow the economy, and by growing the economy will create jobs, will increase investment, will provide States with resources to maintain essential government services, and will reduce unemployment.

On this chart, I do list, in this whole jobs and growth dimension, the fact that we did do a budget, the second earliest in the history of this body in terms of generating a budget on April 11. And we did pass the jobs and growth package on May 23. If you look, just since this jobs and growth package was signed into law, stocks have surged about $619 billion in value. We should not read too much into short-term fluctuations in stock prices, but indeed, recent trends in the stock market suggest that overall conditions are set for a resumption of strong overall economic growth.

As I mentioned, because of passage of this jobs and growth package, American workers will have more money in their paychecks. A family of four making $40,000 will see their taxes reduced by $1,133 in 2003. Those checks for $400 will be sent to nearly 25 million taxpayers starting in about 4 weeks.

We also voted in these last several weeks to expand the child tax credit to include low-income families. Because of the jobs and growth act, working Americans will have more money in their pockets to spend, to save, to invest how they wish next month.

Last month, we also passed—I have this listed under health—the global HIV/AIDS bill on May 15. As a physician, as one who has been trying to fight this virus for the last 20 years—really since about 1983 when this virus first appeared—23 million people have been killed. It has infected another 40 million people alive today and will, in the best of all worlds, kill another 60 million people. This bill, in a bipartisan way, working with the President of the United States, who led, and with the House and with the Senate, will have the impact of helping prevent another 7 million infected people.

It will help care for 10 million HIV-infected individuals and AIDS orphans and probably, most importantly, does bring back hope to millions of people in this country but indeed all over the world who recognize that ultimately that virus can and will be destroyed.

It links prevention, care, and treatment in a comprehensive way, led by the United States of America, where we can leverage our leadership so that countries all over the world will step up and join us arm in arm in fighting this deadly virus.

Our work in passing this global HIV/AIDS legislation demonstrates that we as a society place a high value on life. History will judge us on how we respond to such challenges and, indeed, we can now say very proudly that we are responding, that we in this body made the right choice. We are taking the necessary steps to put an end to one of the most deadly scourges of human life in recorded history. It is a moral challenge, a medical challenge, a humanitarian challenge. But we are responding, and we are leading.

Alongside these legislative accomplishments, we also passed a number of other measures. In the last 2 months we passed the Department of Defense authorization, the Federal Aviation Administration, FAA, authorization, and the extension of unemployment benefits.

We also allotted significant resources to upgrade technology at America's historically black colleges and universities.

I am particularly very excited about this legislation because, again, firsthand, I have had the opportunity to visit and speak at historically black medical schools. In fact, I was at Morehouse School of Medicine a few weeks ago. On my visit there, I had the opportunity of looking at their technology and innovation center, where they are actually using technology to best teach young physicians-in-training so they will be able to extend the great power they have as physicians in making others' lives better.

We took a historic step in bringing a National Museum of African American History and Culture to our Nation's Capital. There have been 80 years of petitions on bringing an African American museum to the family of museums we have here in Washington, but only in this Senate are we finally, by passing that legislation, close to having a museum of African American history in Washington on the Mall. I want to take the opportunity to thank all of my colleagues, but in particular Senator BROWNBACK, and in the House, Congressman JOHN LEWIS, for their leadership on this initiative.

We passed expedited hiring authority for the Security and Exchange Commission under the leadership of Senator SHELBY. This legislation will allow the SEC to hire the accountants and the economists they need to enforce corporate accountability and maintain that investor confidence we know and trust, and that we know must be the undergirding foundation of our investor economy today.

Our colleague from Maine, Senator SUSAN COLLINS, led the campaign to increase public access to cardiac or heart defibrillation. We passed a trauma care systems planning piece of legislation that is potentially important to everybody listening to me. If you happen to be in a motor vehicle accident driving home from work today, where are you going to go? How quickly are people going to respond? Are you going to have a tertiary trauma center nearby? We, in effect, will double our national efforts through this legislation as we focus on trauma care systems planning. I had the opportunity to introduce that, and passage was on June 23.

My colleague from Tennessee, Senator ALEXANDER—through his leadership, we passed the American History and Civics Education Act. Because of this act, and through this act, America's students will be able to learn our Nation's great history and civic traditions.

That reminds me of Senator GREGG, the Senator from New Hampshire, and his tremendous work on the initiative called Keeping Children and Families Safe Act, which was signed by President Bush just this week, focusing on our children and their safety and their security.

Earlier this year, in March, we passed the ban on partial-birth abortion, a procedure that is unnecessary and offends the sensibilities of the American people.

The following month we passed the President's faith-based initiative—not the whole initiative, but an important aspect of it, through a bill called the CARE Act.

The same month we passed AMBER Alert. Some are listed here on the chart, including partial-birth abortion ban, faith-based initiative, AMBER Alert, which we have all seen on television and heard on radio where the names actually come forth, where we have a national alert in the event some tragedy has occurred.

Last week the child care conference report was passed. Millions of lives of Americans and future citizens will be protected by each of these initiatives passed. They all passed on the floor of the Senate, demonstrating our deep commitment and compassion for our most vulnerable citizens.

Internationally—and I have some of these under security—again, I will not go through each one. While all of this has been going on, we have funded Operation Iraqi Freedom. Who will ever forget that morning watching the Iraqi people pull down that statue of Saddam Hussein? The United States, this body, will continue to aggressively support the war on terror. We will continue that financial commitment, whatever it takes, and that moral commitment to the war until America's enemies are defeated.

Internationally, also globally, we passed the Moscow Treaty, the NATO expansion. When you look at Bulgaria and Estonia, Latvia, Lithuania, Slovakia, and Slovenia, we see democracy in action, where 15 or 20 years ago people would have said "impossible." So the very freedoms we are fighting for, whether it is in Iraq or this ongoing war of terror, they are embodied in what we have voted on in this Senate—expansion of NATO to include these new democracies.

We also passed the Microenterprise Assistance Program, which will help impoverished citizens build and grow small businesses, so people who may not have access to capital are given some assistance, which, combined with their own entrepreneurial spirit, can grow and they can have that opportunity to take part in a growing economy. This economic tool is especially powerful for impoverished women in developing countries all over the world. I spend some time every year going to Africa and in a few months I will be going with a Senate delegation to South Africa, Botswana and Namibia. Last January, I was in Uganda, Tanzania, Kenya, and the Sudan. You see the importance of these what are called microenterprise grants, giving people that opportunity to grow economically, help their family return to dignity and opportunity that they simply don't otherwise have.

I listed here a series called values. I mentioned most of these. But the Burmese Freedom Act is an issue that is ongoing in a part of the world where we see the civil liberties we take for granted being stripped away. When you say freedom in this country, you think of freedom of speech, freedom of expression, and freedom of the press. But the Burmese Freedom Act is necessary because in that part of the world—particularly right now—those freedoms don't exist. Again, this was an important response on behalf of the Senator from Kentucky and others to bring attention to the human rights abuses that are being put forth and committed by the Burmese government against its citizens.

So the Senate, by working together, has accomplished a lot, with a lot of hard work and cooperation. I once again thank my colleagues for their efforts. We are doing all this, and I put "action" up here on the chart, and the goals that we have met because day to day we are focusing on each of these and we rarely have the opportunity to go back. The importance is on "action." This is occurring now in this first 6 months, but it occurred compared to the last Congress, when we never passed a budget.

In the last Congress, we didn't pass 11 out of 13 appropriations bills. In the last Congress, we did not pass Medicare. So it is the action, and the solution is fulfilling the agenda that we put forth. That is what the American people expect. We have made the legislative process work.

The one area that I believe continues to undermine the effectiveness of the Senate is the obstructionism towards the President's circuit court nominees, the judicial nominees. This is unprecedented in our 200-year history, the tactics to endlessly delay the process and prevent the Senate from performing its constitutional responsibility to vote on the President's judicial nominees. That is inconsistent with the Constitution.

Our responsibility is to advise and consent. Yet we are being denied a simple up-or-down vote, allowing people to vote how they wish, but allowing them to express advice and consent by voting which is, in the end, the only way we can express that advice and consent. The Senate has few constitutional responsibilities as important as exercising that advice and consent on the President's judicial nominees. I am determined to press forward in the next weeks to carry out a fair and orderly Senate process and return to the norms of the last 200 years, where Senators are given that opportunity for an up-or-down vote.

Looking ahead, July will be a busy month. I do want my colleagues to know—and we had some discussion with the Senator from West Virginia last night in terms of making sure we have good productive Fridays—I can assure my colleagues that in July, in large part because we will be addressing the appropriations bills very aggressively during that month, we will be working 5 days a week, and it is likely that votes will continue late in the day on Fridays, at least later than usual on Fridays.

During July, in addition to the appropriations bills, we will complete action on the Energy bill, which we all know is critical to generating an affordable, reliable energy supply.

I know we will be aggressive in passing these appropriations bills for the Cabinet agencies. Early on, I expect to see the Department of Defense, the Department of Homeland Security, Labor and Health and Human Services, and, at the same time, I want to address one other issue in July—and this is an ambitious schedule—but I do believe strongly, and I say this in part as a physician, yes—that we have an obligation to diminish—I would like to say eliminate—the frivolous medical liability lawsuits that are being applied today.

That needs to be the goal: to get rid of the frivolous lawsuits because they unnecessarily drive up the cost of health care, and if you unnecessarily drive up the cost of health care, you end up driving people to the ranks of the uninsured.

We will address that issue during the month of July, as well as issues surrounding genetic discrimination, an issue that has already been addressed in committee and is ready to come to the floor.

This is an impressive list, I think. It is one I am confident we will be able to handle in a systematic and productive way, always keeping in mind that goal of moving America forward and that we are working for the American people. They send us here to get results, not unnecessary legislation, but get results to the problems and challenges they face.

If we look at the list, I think we are on the right track. We have accomplished a lot. We have had a number of successes. We have seen results. We are delivering to the American people in strong, effective legislation, and I have every expectation that we will continue building on this record of success in the weeks and months to come.

To my colleagues, I do wish them all a happy Fourth of July. I hope they will travel safely. I extend my best wishes to them and their families.

Mr. President, in a few minutes I will be back with another statement, and then we will have some closing business over the course of the day.

For now, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DOMENICI. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DOMENICI. Parliamentary inquiry: What is pending before the Senate?

The PRESIDING OFFICER. The Senate is in morning business.

Mr. DOMENICI. The Senator from New Mexico desires to proceed as in morning business.

The PRESIDING OFFICER. The Senator has that right.

THE HOPE-FILLED SENATOR FROM NEW MEXICO

Mr. DOMENICI. Mr. President, I was in my office and I regret that I was unable to be in the Chamber when the distinguished majority leader, Dr. BILL FRIST, gave a rather elaborate, detailed, and enlightened discussion regarding illnesses, ailments, cures, and the evolution of diseases in this country and in the world.

I commend him for that. Had I been in the Chamber at that time, I would have taken the opportunity to present him with the first document that the Senator from New Mexico is having printed. It will be something that I choose to call "The Hope-filled Senator." The hope-filled Senator is the story of America's future in terms of diseases, prescriptions, and cures. It is my own story of what I believe is going to happen to prescription drugs, to the medical profession, and to the delivery of health care over the next 30 to 40 years.

I am hoping that this very brief summary of the hope-filled Senator's thoughts will be of some help to Senators and people who are so worried about the costs of prescription drugs. Will it really work; will we really have enough money to do it or not?

Today, I will not repeat the contents of this hope-filled statement that I delivered as the Senator from New Mexico, calling myself a hope-filled Senator.

Suffice it to say that when one discusses a program of the magnitude of this prescription drug program, that it is absolutely imperative that it is looked at from more than one vantage point. One vantage point is to look at it as Senators did on the Senate floor, in the back rooms and in caucuses. We talked about the specifics of who is going to get the drugs, how much is it going to cost, will we have enough money, and are we going to be able to pay for it? We asked will America go bankrupt? Will Medicare really survive and will it be competitive? Are we really building into the system? We examined the ingredients that are so well known for bringing prices down. We examined competition for delivery and competition for business. All of that is one way to look at it.

One must look at it that way, but another way to look at it is to try to think of what is going to happen to health delivery and medical care during the ensuing 10, 20, 30, or 40 years. The hope-filled Senator is talking about those things as he looks at the next four decades.

By way of recapitulation of what was in my statement of a hope-filled Senator, there are three or four big things. We finished mapping the chromosomes of the human anatomy. We call that the genome system. That means that after years of mankind researching to try to find where in the chromosome of the human body was the aberration that caused multiple sclerosis, and years of research at various institutions to locate the gene, or the number of genes that caused, perhaps, schizophrenia—what we finally did in a record period was to take them all, map them and index them. We can say we know where they all are. We do not have to go looking for them anymore.

I do not mean to make this a big thing, because people sometimes think they do not have to worry about it. But this is a big thing. For years, even in our lifetime, we can remember reading a story that would leave the medical journals and be big enough to hit the newspapers. The story would say, "Michigan State group of researchers discover the location on the genome system of a multiple sclerosis gene." Remember that? Boy, that was big time.

Soon, I am going to hand to the majority leader the first copy of a document called "The Hope-filled Senator." I am going to have it encapsulated with gold print. It is the hope-filled Senator's other side of the story. It is the story of the delivery system of health care during the next 40 or 50 years as it most assuredly will impact on this prescription drug system.

I did not go bother a bunch of scientists in putting this document together. So, they may find this document lacking. But what I did, and I repeat it now because our leader is in the Chamber, I used four or five big things that are going to change. I started with the genome mapping, indicating that we have now located the aberrations on the chromosome system of the anatomy of every known disease from which mankind suffers.

Why is that important in the hope-filled Senator's dissertation regarding prescription drugs? Because there is no question during the delivery system that we tried so valiantly to find out how much it is going to cost. During that time many diseases for which we are spending huge amounts of money in prescriptions are going to be cured. Researchers will know where the illnesses are and they will be able to research how to fix them. And, they are going to fix many of them.

What does that mean? That means many of the expected costs that the Congressional Budget Office plugged into their estimates are going to be different. Indeed, there are going to be prescription drug breakthroughs that come from this genome mapping that are going to clearly indicate that there are different ways to do what we are doing today. We can achieve better results. So, as I said this will dramatically change the delivery system of health care.

I was foolish enough, as a hope-filled Senator, to predict that before the turn of 40 years the hospitals in America will not be the hospitals of today. I predicted that we would have hospitals that are going to be more concerned with genetics than with the individual curing of an ailment.

I did not dream that up. When I first started working on genomes, I had a magnificent, wonderful doctor who egged me on, and he was the inventor of Tylenol. He used to sit in my office and talk with me. He used to draw what he thought a hospital might look like in 30 or 40 years. I used to laugh and throw the drawings away. He drew a center where you would check your gene system and they would tell you, as you left, what was wrong with you and how they would fix you. Or if you got sick, that is what they would plug in. That would be the hospital.

He is still alive; he is currently practicing as a very old doctor. He joined up with doctors who are down in the South delivering health care to poor people free. He does this just because he wants to keep on being a doctor. He was so thrilled that he hooked me on this concept that we never lost contact.

In this hope-filled sermon, we start with that.

Then I said, the American economy is going to change so rapidly in terms of its productivity and, at the same time, produce new things because of nanoscience. I defined nanoscience as the newest science that is so unique, and so way out, that today's scientists are saying we will not recognize the products that humanity will be using because of nanoscience. They are practicing a science of changing the molecules that make up a substance. Imagine, compare that with making zinc by adding a couple of compounds. That science is today's industry. They will be changing the molecular makeup so things change and become something different.

It is predicted with the five centers that exist in America today on nanoscience, and many more to come, that the breakthroughs, once they start, will occur with such rapidity that the productivity in America and in the world will change. That means those who make medicine and cures will be part of picking up that change and those breakthroughs also.

The third that I am aware of, and there are probably some I am missing, is a most incredible science. For lack of better terminology it is called microengineering or the production of microengines.

I visited the Sandia National Laboratory in New Mexico. They wanted to show me microengines. I thought, you have to be kidding; what kind of engines could there be that are so small they have now reached this level? They showed me. Microengines are so small. Now we have in the computer business a chip, and on the surface of the chip we can put these different things, and that is how we get these millions of megabytes. Now it is trillions and numbers we did not even used to use. They actually create engines that are so small they put them on a chip, but they can be synchronized and organized as engines on that little chip.

The engines look to me something like an oil patch when you see the drilling wells with the pumps. They are so small you could never see them unless you used an extremely powerful microscope.

What will happen with these engines? We do not know. But, they have a hypothesis. It is entirely possible that one of the first things we will do with these engines is organize them so well that we will be able to inject them in the human body. They will be directed to do some work, and they will do it like they are told. And, believe it or not, they possibly will go in and eat what you want them to eat. They will be able to go into the heart system to open up areas we worry are clogged. These little microengines will dissolve those clogs for you.

Those are engineers that can do that work. We will not even have to send patients over to Vanderbilt University to a bunch of scientists or heart specialists.

There will be huge numbers of breakthroughs if we add those three things to a vibrant American economy. We must not mess up by causing the American economic system to go to sleep. We must keep the economy vibrant, by doing the right things in terms of taxing the right things and not the wrong things. If we continue to fund the right research instead of the wrong things, and we keep on funding NIH but maybe we reach the point where 10 percent a year might be enough and maybe we move over and fund some physical science like the Energy Department and a few other institutions of our Government that are doing basic science so physical science can catch up with the biological sciences. There will be huge numbers of breakthroughs.

My hope-filled delivery dissertation says: Don't be so worried about whether we will be able to deliver on what we promise. We may be able to deliver even more than we think we are going to deliver. And let's just watch out that in putting the system together—and I know the majority leader has been worried about this—that we don't just put bureaucracy in place where it inhibits the injection of these new things into the delivery system.

That is why HCFA, which this Senator personally as a young Senator found was such a terrible inhibitor to delivering appropriate care had to be changed. The management tool had grown so big that all we heard as Senators when we went home to our hospitals, to our doctors, to our clinics, to those centers that were taking care of people in shelters, all we heard was HCFA is messed up so badly that we are doing worse with their rules than if we did not have any rules. It was so bad once that I thought I would come back here and introduce a bill that recommended we experiment with 100 places where we will treat seniors with no regulations. We would look at them once every 6 months. And take a chance and see if they are not better run and the people taken care of better and cheaper than those who have to have someone checking off every time an apple was delivered to a senior that happened to have been decayed, if it was brown and faulty. At one time, you had to note that you delivered a bad apple, literally, to a senior.

Now, frankly, I know a lot about fiscal policy.

I know a lot of experts on this bill who are worried about whether we are going to have enough money to deliver under this system. But I chose to go over it and spend a little bit of time on it. Once I decided we were going to try this and to talk about this, I say to my friend, the majority leader—yesterday afternoon while he was still burdened, I sat down and wrote on a piece of paper what the score would be at whatever hour we voted last night. What I wrote down was the vote would be 78 yes, and 22 no. The vote turned out to be 76–21. I think I know what happened to one of them who would have made it 77, the Senator from Pennsylvania. But I think it became pretty clear to people like me that the Senate was ready. I had a hope they were ready, because even if they weren't, I had a hunch they had some hope we could get this done.

Mr. FRIST. Mr. President, will the Senator yield?

Mr. DOMENICI. I am pleased to yield.

Mr. FRIST. Mr. President, just about 30 minutes ago I sat down and wanted to review a little bit about the last 6 months. As I did that and came to the floor and cited some of the legislation we have done, I so much appreciate the comments of the Senator from New Mexico because they fit with the hope which I translate into maybe additional dreams and hopes, but reality.

I have been blessed to be in this body for the last 8 years, but prior to that, 20 years in the scientific field and spending hours and nights in laboratories thinking and trying to hypothesize about what would occur 6 months later; or why a capillary muscle relaxed in a way based on the metabolic environment and doing my best to figure it out and doing the experiments; but then 6 months later because of the work of other people in maybe unrelated fields, having that hypothesis changed and productivity to increase to the point that my idea was solved—not the way I wanted to, but because of investment with science. I would run over from the laboratory to the clinical arena and work in a health care system that was beautiful, which was delivering the very best quality of care but looking at it through really a Medicare system at the time that was so rigid and inflexible because of the 130,000 pages of regulations from HCFA—the Health Care Financing Administration—which had evolved over a period of 30 years with good intentions but which so micromanaged and so straitjacketed the physicians, the scientists, the researchers, the patients, governing the doctor-patient interaction—130,000 pages of governing which meant you could not capture whether it is the nanotechnology or the 3 billion bits of information out of the human genome project today, with the micromanaging that the Senator was talking about—that can't be assimilated into the system of health care delivery at a rate which the American people deserve.

I mention that because as I was going through this legislation, I was thinking of AIDS/HIV, a huge problem with 23 million people dead and 40 million people infected, and there is no cure. Another 60 million people will die. Thus, we need to encourage that innovation, invent that vaccine, engage in that science. Right now we don't know what the hypothesis is. But it is there, and we are going to see it in our lifetime, because in part, just as the Senator from New Mexico led the support in the human genome at the time, at the time nobody really knew what was going to happen, he was out here 15 years ago leading on the human genome project, for a shorter period of time we had that phone book of 3 billion bits of information which is there. It is the phone book, as he said. Now it can be applied.

I mention that because 12 hours ago on this floor we passed a piece of legislation that delivers prescription drugs in an unprecedented way for the first time in the history of the Medicare program. We are helping seniors with prescription drugs. But at the same time it modernizes Medicare to get rid of the unnecessary bureaucracy, the red tape, the straitjacket, the micromanagement, building in the flexibility where those new ideas, the dynamism from the marketplace, the innovation in the marketplace can be assimilated and speed up the process where we can address this huge unfunded liability which we know occurs in Medicare today because of what our seniors deserve. But we have a doubling of the number of seniors.

At the same time we offer the prescription drug package, we modernize Medicare in such a way that it is flexible. These new ideas will be incorporated in a rapid fashion.

Heart transplantation. At the time I first started heart transplants, it was very rare. Lung transplants had never been done successfully. I am not that old. But I had the opportunity to be involved in heart transplants. It took about 5 years after I was doing them routinely in the private sector for Medicare to allow any reimbursement for our seniors—5 years because of bureaucrats. It is the way Government works. It takes a long time. That is just one procedure.

The optimism which the Senator talked about, I think so realistically and eloquently, is there. There is no question.

When we talk about 14 years out trying to predict essentially a static system moving ahead, and it is not going to happen—the advances in technology are just like that. The half-life of science has gone from 10 to 7 to probably 4 years now, and it is going to be down to 2 years. It is the same way with the health care delivery systems, and the old fee-for-service.

My dad practiced medicine for 55 years. As the Senator was talking about the genetic testing that is going to be available, the appropriate response and how we are going to be able to develop cures, I was sitting there thinking of my dad with his black bag in the 1940s, 1950s, and 1960s. He didn't have any medicines. He had none. He had antibiotics after 1945, but none before that.

But the revolution I have seen when I was doing heart transplants and lifting people's hearts out and putting them in was made possible because of one drug—cyclosporine. If the pharmaceutical companies had not invested to get that drug, we would not have been able to do heart and lung transplants.

The advances we went through in that 20 or 25 years—and now I see because of the work like the human genome projects and nanotechnology—that combination—once we allow that to marry with our health care and government-sponsored programs, the sky is the limit. Productivity will increase. The advances can be assimilated. We will be able to think more in terms of, yes, longevity, but also quality of life.

It does come down to hope. I very much appreciate the Senator articulating the big vision, because every day we are here, in the back of my mind I am thinking the same thing. Prescription drugs are important, but at the same time to develop a system that can capture that technology and at the same time look at HIV/AIDS and make sure there is a vaccine bill, and that we keep trying. We are all trying to get it through.

But right now, because of the medical liability issues which we are going to address in July, when you have predatory trial lawyers—not all are predatory—who are really going to come in and say that vaccine has certain side effects, there is going to be a lawsuit, and there will be a lot of frivolous lawsuits that drive up the cost of health care and drive people to the ranks of the uninsured.

One last issue which I didn't mention earlier but which we addressed on the floor goes into this—medical safety in the hospital.

The Institute of Medicine report said there are 100,000 people who die every year because of medical errors in the hospital. Most of that is cross-reaction from drugs and the like. The best way to approach that is to have information voluntarily shared by physicians and by nurses to learn in an ongoing, continuous quality management program and to have that information available, which is correct, and which is self-correcting. But if you have predatory trial lawyers all the way around, and you have incentives not to share that information, we are never going to make this system better.

So it all fits together: the science, the technology, the framework which the Senator explained so well. What we are doing in Medicare, the access to prescription drugs, global HIV/AIDS—you put all that together. If we keep moving things, as we have in the last, I would say, 6 months, I am absolutely—absolutely—convinced we are going to be able to capture those hopes.

In many ways, people say: You're dreaming. You describe them as hopes. Having seen science and technology in my own life, they may have started as dreams, and they may be hopes now, but in our lifetimes they are going to be reality.

Mr. DOMENICI. Thank you so much for your comments. I was very pleased to yield.

I just want to say, without hopes and dreams in these fields, there is no question we are overwhelmed. It is hopes and hope-filled ideas that keep us energized. But it does not mean we do not have a big job because, as a matter of fact, the hopes can truly be deenergized by systems that do not let it work. That is what we have to worry about.

In my opinion, the breakthroughs are going to be so rapid that the bureaucracy that manages the change is going to have to be looked at all the time by people who really know. The breakthroughs will occur, and it will make your 5-year example—of how long it took for the heart to go from being done to being accepted—it will make that example pale as compared to the breakthroughs that are going to be over and over and around here and over there. We think the new bureaucracy—which the Senator and others helped put together—will make that work better.

I do want to hold the floor. I thank the Senator.

The PRESIDING OFFICER (Mr. BENNETT). The Senator from New Mexico.

IN REMEMBRANCE OF STROM THURMOND

Mr. DOMENICI. Mr. President, I rise to speak about my friend, Senator Strom Thurmond. I do not have any prepared remarks but I want to speak for a few moments about Senator Strom Thurmond.

Senator Strom Thurmond spent many, many years sitting in the seat, for those observing the Senate Chamber, right next to the seat where the distinguished majority leader is sitting right now.

I have eight children. Senator Thurmond, as everyone knows, lived a very long life with his first wife without children. I don't know if that had anything to do with his huge interest in asking people such as me how my children were, and I am not one who is very loathe to tell people about my children's successes.

So he used to say to me, and to anyone around, he would point at me, and say: "There is the Senator with all the smart kids." Of course, I was embarrassed, and I would bend down and say: "Senator, there are lots of Senators with smart children."

Then he would say: "Well, you told me about one" . . . and he would explain what I told him. He would ask, "how is that one doing?"

Well, obviously, those days are gone now. I was privileged, with my wife Nancy, to go to the wedding of his daughter here in this town not too many years ago. It was a beautiful wedding, a big wedding. It was a beautiful daughter and a beaming father, Strom Thurmond.

He was already past 90, for certain, and how thrilled he was to walk down the aisle and to be part of the normal wedding activities.

I note that with all the blessings he has received in his life, and all the legacy that he leaves, he got one blessing that he deserved; that is, that wedding and that marriage yielded his first grandchild. And I just wonder because he had already left the Senate; he was no longer here; he was in a hospital, but I just wonder, how happy that day must have been for him. He had a grandchild at that very old age.

There are Senators, such as from his home State, who have known him through campaigns and actions and activities that I hear of. I have read of these activities, but I did not participate in them, so they will do better than I in talking about him. But I am 71. I am very lucky, I feel, in that I have spent 31 years in the Senate. The only thing I did prior to that is, 6½ years before I came here, I accepted a dare from a group of friends to run for an office. I ran and got elected. And that office was for city council, which put me in a mayorship of sorts in our biggest city.

So you know, if you write down, at 71, what I have done: I ran for a nonpartisan office, got elected, served 4 years, waited 2 years, got elected to the Senate, and came here. But we all know, if we are going to put down what Strom Thurmond has done as a public servant, all of which clearly is one's legacy, it would take me quite a while to discuss it all. Just his military career would be a rather good speech and a rather good talk on the Senate floor.

The other thing that, to me, is of such rare, rare importance is that when you consider 100 years, and that 80 or 79 of those years he was an adult, you just think of all the things that have changed during his adulthood. Governance, governmental changes, cultural changes, philosophical leanings and tendencies of our great country changing. You have to conclude that this man, who represented a State that also changed and had become a great industrial State, and a great educational State, with fantastic educational institutions, that this great man also learned how to change. He changed with time, not changing in the sense of giving up but rather of gaining more for himself and becoming more rather than becoming less.

Now, I have known a lot of great Senators, more than most, because there are only five or six Senators who have been here longer than I, as of today, maybe five. So I have known a lot of them. I think it is only fair to say, for his family, for Nancy, for his children, there really have never been any Senators like him that I have been privileged to know.

He was indeed unique. He was so different that you cannot forget him. First, he was so personal to everyone. He was never forgetting. He was always considerate. He spent more time and effort at little things.

I know nothing about his constituent work. Let those who know speak. I speak of little things here in the Senate. The Chair and I both watched during a week at the end of a day's work, we watched Strom Thurmond while he was still around and healthy and walking. We watched what he did. He went with his staff from one event to another, perhaps three, four, five events an evening, because he had been invited and because it was somebody who said: "Would you come to my party?" "Would you come to my fundraiser?" "Would you come to my birthday?" "Would you come and join me; we have visitors from my State." What it was that made him that kind of person, who knows? I don't know. You don't know. The Senate doesn't know. I am not sure his family knows. But the truth is, we know he did that.

All of these would appear, what I have said so far, to be things that one might say are not very important. Well, I stated them because I think they are very important. They are of utmost importance. I think they are the essence of who he is and what he is and what he was.

But don't let anyone think he didn't do his work. When you look at the committees he chaired, the events that happened during those chair-filled years, be it on the Judiciary, on Armed Services, or whatever, you have to know he had a great capacity for work and he did his work and got it done.

Can you just imagine not having a chance to know him when he was a judge? What a great judge he would have been. Can you imagine, not having a chance to know him, what a good school superintendent he must have been? Can you imagine not getting to know him, what a good commissioner he must have been at the local level where he governed? For I believe he is what he was. And it is probable that he took care to do everything right and he took care to be concerned and worried about people, as he did his job, and that he never forgot the people who were good to him and meant something to his success.

I, for one, am very sorry we will be going to a funeral. But, I guess it is really only fair to say that he has been very blessed. After all, we won't, any of us, ever go to a funeral for a fellow Senator who has lived 100 years—none of us. This will be the only one. Because he has been very, very blessed. The Lord has been kind and decent to him. Those around him should be very proud. Obviously, his kinfolk are sad.

I remember at that wedding, while we were celebrating youth, his daughter was a young lady. I remember meeting his sister, two sisters I believe. They were alive and there. I don't mean to cast any aspersions about the fact they were alive. They were lively, I assure you. They knew a lot. They were talking. They were carrying on conversations. Strom Thurmond was talking with them about us and my wife Nancy.

They were quick to ask us to sit down, and you could hardly believe that a man almost 100 was there with sisters at a wedding for a very young daughter of his, who has just since then had his first grandchild. What a beautiful, beautiful tribute all of this is to Strom Thurmond's family, to their heritage, and to those around them and those who love them.

My wife Nancy and I extend our heartfelt condolences to Nancy and all of the other kinfolk, to his relatives, and clearly to his daughter and son-in-law who have that young grandchild of whom he must be so proud.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mrs. DOLE. Mr. President, last evening we received the news of the passing of a dear friend and leader in this Chamber, Strom Thurmond. Strom Thurmond retired this year at the age of 100 after more than half a century serving the people of South Carolina and our Nation as a Senator, as Governor of South Carolina, and as a State legislator.

Remarkably, his career in the Senate spanned the administrations of 10 Presidents, from Dwight Eisenhower to George W. Bush. His passing last night certainly will be felt by so many Members of this Chamber who had grown accustomed to the courtly gentleman from South Carolina. But his life leaves a lesson for us all in compassion, respect, civility, dedication, and hard work.

Before he was elected to the Senate in 1954, as the only write-in candidate in history to win a seat in Congress. Strom Thurmond was elected county school superintendent, State Senator, and circuit judge. He resigned his judgeship to enlist in the Army in World War II. He landed in Normandy as part of the 82nd Airborne assault on D-Day and, the story goes, flew into France on a glider, crash-landing in an apple orchard. He went on to help liberate Paris, and he received a Purple Heart, five Battle Stars, and numerous other awards for his World War II service.

My husband Bob and I were honored to have known Strom Thurmond for so many years and to count him among our very special friends. He and Bob shared a great deal of common history, dating from their World War II days. And his southern gallantry always had a way of making this North Carolinian feel right at home.

I first worked with Strom Thurmond when I served as Deputy Special Assistant to the President at the White House. Even then he was an impressive Senator. President Reagan praised his expert handling as chairman of the Senate Judiciary Committee of nominees to the U.S. Supreme Court.

In fact, it was Strom Thurmond's skill as chairman that helped to shepherd through the nomination of Sandra Day O'Connor as the Nation's first female on the U.S. Supreme Court. I had always admired Strom Thurmond for his constant dedication to the people of South Carolina and to the industries of that State.

Bob Dole has joked that someone once asked if Strom had been around since the Ten Commandments. Bob said that couldn't have been true: If Strom Thurmond had been around, the 11th commandment would have been: Thou shalt support the textile industry.

And that industry still needs a lot of help. In fact, when President Reagan called Strom to wish him a happy 79th birthday back in 1981, Strom Thurmond, with his constant attention to South Carolina interests, used the opportunity to talk to the President about the textile industry.

Indeed, South Carolina is full of stories of how the senior Senator from South Carolina managed to cut through redtape to make sure that his residents got the things they needed. And whenever South Carolinians called, or anyone else for that matter, Strom Thurmond could always be counted on to show up—at a Fourth of July parade, a county festival, or a State fair, armed with his trademark Strom Thurmond key chains.

North Carolinians developed a fondness for Strom Thurmond. He often flew in to Charlotte before driving to his Edgeville, SC, home. He became so familiar in the airport that many of the workers there knew him, and he knew them all for stopping to share a kind word or a funny story.

I was so honored that just before Strom went home for good to South Carolina, he came in his wheelchair, with Nancy's help, to my little basement office to welcome me to the Senate.

Bob and I send our heartfelt condolences to Strom's family, our dear friend, Nancy, and the children, including daughter Julie, who worked with me at the American Red Cross. He was a loving husband, a proud father, and new grandfather, and, of course, the people of South Carolina, for whom he worked tirelessly throughout his career in public service and to whom he chose to return when his work was done in the Senate.

Today as I remember him, his life, and his legacy, I think of the Bible in the 25th chapter of Matthew when the Lord said:

> Well done, thou good and faithful servant. . . . enter thou into the joy of thy Lord.

May God bless him and his family.

I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

(Mrs. DOLE assumed the Chair.)

FILIBUSTER REFORM

Mr. FRIST. Madam President, last Tuesday, the Committee on Rules and Administration favorably reported S. Res. 138, a proposal to amend the Senate's cloture rule. The committee's action represents an important milestone on the road to filibuster reform. It brings the Senate one key step closer to ending filibusters on nominations. On May 9 of this year, I introduced S. Res. 138, along with a bipartisan group of 11 cosponsors. Our purpose was to respond to a disturbing change in the way the Senate considers nominations.

Lengthy and apparently implacable filibusters have erupted on two judicial nominations. Although it has long been clear that a majority of Senators stand ready to confirm Miguel Estrada and Priscilla Owen, it is increasingly obvious that a minority of Senators never intends to permit these nominations to come to a vote.

Beyond these filibusters are the expressed threats to filibuster additional nominees, threats that may well materialize after the Senate reconvenes in July.

Given the record already established this year, we have every reason to take these threats seriously and to imagine they will be executed. Killing judicial nominations by filibuster is not simply business as usual in the Senate. Up until now, no judicial nomination has ever been rejected in that fashion.

Even the failed Supreme Court nomination of Abe Fortas 35 years ago is not truly an exception to this rule. In the Fortas case, one cloture vote was taken with 45 Senators supporting cloture and 43 opposed. At least five additional Senators who missed that vote expressed opposition to cloture. Yet another who supported cloture expressed opposition to the nomination.

It was far from plain, even to the nominee, that a majority was ready to confirm the nomination, much less a supermajority was available to invoke cloture.

After a single cloture vote taken four session days after the nomination was brought to the floor, the nominee asked that his name be withdrawn.

These facts differ dramatically from those pertinent to filibusters underway in this Congress and from the rest of Senate cloture history on judicial nominations.

Thus far, we have had six cloture votes on Mr. Estrada and two cloture votes on Justice Owen, with more than a majority of Senators but less than a supermajority, favoring cloture. So the filibusters endure with no end in sight.

Prior to this year, the record number of cloture motions filed on any single judicial nomination was 2, and 17 such motions were filed overall. In a majority of those cases, cloture was invoked and confirmation followed. Even when cloture failed, confirmation followed. In all cases, the nominations were brought to a vote, the full Senate worked its will, and the nominees were confirmed.

The Estrada and Owen filibusters and their threatened progeny are anything but customary. They represent a disturbing change in Senate norms, a change that has been defended on untenable grounds.

Proponents of the filibusters claim they have no choice. With the Senate and its committees controlled by the party of the President, they have no choice but to filibuster, or so they say. Their logic is facile but faulty, and it runs contrary to many years of Senate tradition.

For 70 percent of the 20th century, one party controlled the White House and the Senate. This was the case for 6 years of President Wilson's term and the entire terms of Presidents Harding, Coolidge, and Hoover. It was the case through 12 years of President Franklin Roosevelt and 6 years of President Harry Truman. It was the case for all of the Kennedy-Johnson years, all of President Carter's years, 6 of President Reagan's years, and 2 years under President Clinton. In some of those eras, the Senate minority was Republican; in others Democratic. But at no time did those minorities resort to partisan filibusters of judicial nominees. At no time did those minorities deny the Senate the right to vote on confirmation.

What is happening now is aberrant. It breaks with Senate traditions. If the trend begun with the Estrada and Owen filibusters is not arrested, a disturbing new practice will take root.

Partisan filibusters to kill nominations will lead inevitably to more of the same in retribution. Left to fester, things can only get worse. The outcome cannot be good for current or future Senates, for current or future Presidents, for current or future nominees.

Those of us concerned about these consequences have two fundamental choices: We can either acquiesce to this partisan change in Senate norms, or propose a reform to Senate rules. Unwilling to accept a change in Senate traditions that will damage and weaken this institution, we offer a targeted and limited amendment to the rules.

Our remedy is narrow, aimed not against the filibuster generally, but against filibusters on nominations. If adopted, our proposal would have declining cloture requirements of 60, 57, 54, 51, and then a simple majority on successive cloture votes. The first cloture motion cannot be filed until a nomination has been pending for 12 hours. Successive cloture motions cannot be filed until the prior cloture motion has been resolved. As under current rules, each cloture motion will take 2 days to ripen. Our proposal is true to Senate traditions. It will permit robust debate and time for reflection, but also allow the Senate to reach a definite resolution on confirmations.

As I have said on this floor and before the committee, the filibuster is not sacrosanct. When it has been abused, it has been reformed. The very cloture rule itself represented just such a response to filibuster abuse. It has been amended five times since it was first adopted in 1917. Moreover, the very modest debate limitations we propose are significantly less restrictive than more than 25 provisions now in statute law that expedite Senate debate on measures ranging from budget reconciliation to the execution of war powers.

Madam President, some on the other side of the aisle have said our proposal is too extreme in that it would undermine their capacity to use existing rules to reshape Senate norms. Others from the same side have said our reform is too narrow because it does not attack filibusters in all circumstances.

My response is this: We must fix what is damaged, but we do not require radical surgery. We shall reform our rules to repair what is broken and restore traditions. Beyond that, we shall leave our rules alone.

Our opponents contend that our narrow reform will inevitably lead to the wholesale destruction of the filibuster in the Senate and that it will convert the Senate into a smaller copy of the House. I know of few, if any, Senators who would support that outcome, and I regard such predictions as fanciful. This proposal does not attack the use of filibuster on legislation. Instead, it builds on an existing tradition of distinctive procedures for the consideration of executive business.

One of those traditions is a 1980 precedent urged by Majority Leader BYRD which obviates debate on a motion to proceed to a nomination. Using the logic of our opponents, one could theorize that a next consistent step would be to mimic this precedent and kill debate on a motion to proceed to legislation. But 23 years have passed and that next step has not been taken. In its wisdom, the Senate has known how far it must go to resolve particular problems and when it must stop.

Our opponents argue that filibuster reform will undermine the balance of power between the President and the Senate. They claim if we adopt this proposal, the Senate will diminish itself and become the President's handmaiden. I do not desire that result, and I strongly disagree with that conclusion.

What their position amounts to is that Senate power to check a President can only be vindicated if a minority prevails against a majority ready to confirm.

Once again, for 70 of the last 100 years in this century, one party controlled both the Senate and the White House. Yet filibustering nominations was unheard of most all of that time. Was the Senate the President's handmaiden then and only now has awakened to its constitutional purpose?

Over two centuries, a number of judicial nominations failed on the Senate floor. Filibusters were unnecessary to defeat Clement Haynsworth, Harold Carswell, or Robert Bork, much less many earlier nominees, starting with President Washington's nominee, John Rutledge.

The full Senate, no President's handmaiden, asserted constitutional checks and balances. If we can only affirm Senate power by the filibuster, then we have come to a new and very unfortunate place. Thus, we propose to reform Senate rules in order to restore Senate traditions.

Filibuster reform is imperative. It will enable all Senators to meet their constitutional responsibility to advise and consent. With Senators so empowered, the voice of all Americans will again be heard on these matters.

EXECUTIVE SESSION

NOMINATION OF VICTOR J. WOLSKI, OF VIRGINIA, TO BE JUDGE OF UNITED STATES COURT OF FEDERAL CLAIMS

Mr. FRIST. Madam President, I ask unanimous consent that the Senate proceed to executive session for the consideration of Executive Calendar No. 88.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The assistant legislative clerk read the nomination of Victor J. Wolski, of Virginia, to be a Judge of the United States Court of Federal Claims.

CLOTURE MOTION

Mr. FRIST. This nomination has been pending on the calendar since March 27. This is one of four nominations on the calendar to the U.S. Court of Federal Claims that we have been hoping to clear for Senate action. I now send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on Executive Calendar No. 88:

Bill Frist, Orrin Hatch, Larry E. Craig, Craig Thomas, Michael B. Enzi, Chuck Grassley, Arlen Specter, M. Crapo, John E. Sununu, Elizabeth Dole, James Talent, John Ensign, Susan Collins, Judd Gregg, John McCain, R.F. Bennett, and Gordon Smith.

Mr. FRIST. I ask unanimous consent that the live quorum under rule XXII be waived, and that the vote occur on Tuesday, July 8, immediately following the vote on the Campbell nomination.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. I also announce if cloture is invoked and the nomination is subsequently confirmed, I will be prepared to ask unanimous consent that the remaining three nominations to the Court of Federal Claims be immediately confirmed so that all four nominations would be cleared at the same time.

EXECUTIVE CALENDAR

Mr. FRIST. I ask unanimous consent that the Senate proceed to the consideration of the following nominations: Calendar Nos. 202, 246, 247, 251, 253, 278, 279, 280, 281, 282, 283, 284, 286, and all remaining nominations on the Secretary's desk.

I further ask unanimous consent that the nominations be confirmed, the motions to reconsider be laid upon the table, any statements relating to the nominations be printed in the RECORD, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

The nominations considered and confirmed are as follows:

DEPARTMENT OF JUSTICE

Robert D. McCallum, Jr., of Georgia, to be Associate Attorney General.

LEGAL SERVICES CORPORATION

David Hall, of Massachusetts, to be a Member of the Board of Directors of the Legal Services Corporation for a term expiring July 13, 2005.

Lillian R. BeVier, of Virginia, to be a Member of the Board of Directors of the Legal Services Corporation for a term expiring July 13, 2004, vice Hulett Hall Askew, term expired, to which position she was appointed during the last recess of the Senate.

THE JUDICIARY

Fern Flanagan Saddler, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

Judith Nan Macaluso, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

DEPARTMENT OF STATE

Marsha E. Barnes, of Maryland, a Career Member of the Senior Foreign Service, Class Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Suriname.

Robert W. Fitts, of New Hampshire, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Papua New Guinea, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to the Solomon Islands and Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Vanuatu.

John E. Herbst, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Ukraine.

William B. Wood, of New York, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Colombia.

Tracey Ann Jacobson, of the District of Columbia, a Foreign Service Officer of Class One, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Turkmenistan.

George A. Krol, of New Jersey, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Belarus.

Greta N. Morris, of California, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of the Marshall Islands.

John F. Maisto, of Pennsylvania, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador.

FOREIGN SERVICE

PN678 Foreign Service nominations (193) beginning Ali Abdi, and ending Lawrence C. Mandel, which nominations were received by the Senate and appeared in the CONGRESSIONAL RECORD of May 22, 2003.

PN685-1 Foreign Service nominations (148) beginning Beth A. Salamanca, and ending Peter H. Chase, which nominations were received by the Senate and appeared in the CONGRESSIONAL RECORD of June 3, 2003.

BARRY C. BLACK, SENATE CHAPLAIN

Mr. FRIST. I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 189, which is at the desk.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 189) electing Doctor Barry C. Black, of Baltimore, Maryland, as Chaplain of the United States Senate.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. Madam President, this unanimous consent was with regard to our new Chaplain, ADM Barry Black, who will be joining us shortly as the 62nd Chaplain of the Senate. I have had the wonderful opportunity of initially meeting Admiral Black over the last several months and wish to point out his distinguished record of public service, his compelling life, his 27-year career in the Navy where he has delivered ministry to over 600,000 Navy, Marine Corps, and Coast Guard service members.

Since the year 2000 he has provided moral counsel, spiritual counsel to the Navy's top officers as the 22nd Chief of Navy Chaplains. He was the first person of color to hold that particular office in naval history. He has provided spiritual guidance to soldiers and their families during Operation Desert Shield and Desert Storm.

His calm manner, his soothing manner is a beautiful fit, I believe, for what this body both has come to depend on with our past Chaplains and has come to expect in our Chaplain, one of whom, Dr. Lloyd Ogilvie, I had the opportunity to know for the last 8 years.

Admiral Black has had an inspiring life, and I look forward to all of our colleagues and their spouses, their families, and the extended Senate family to come to know him in the way that I have.

I ask unanimous consent that the resolution be agreed to and that the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 189) was agreed to, as follows:

S. RES. 189

Resolved, That Doctor Barry C. Black, of Baltimore, Maryland, be, and he is hereby, elected Chaplain of the Senate, effective Monday, July 7, 2003.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will now return to legislative session.

WELFARE REFORM EXTENSION ACT OF 2003

Mr. FRIST. Madam President, I ask unanimous consent that the Senate immediately proceed to H.R. 2350 which is being held at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (H.R. 2350) to reauthorize the Temporary Assistance for Needy Families block grant program through fiscal year 2003, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill appear at this point in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 2350) was read the third time and passed.

BILL EMERSON AND MICKEY LELAND HUNGER FELLOWSHIPS

Mr. FRIST. I ask unanimous consent that the Senate immediately proceed to H.R. 2474 which is at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (H.R. 2474) to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal years 2003 and 2004.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 2474) was read the third time and passed.

PROVIDING SECRETARY OF HOMELAND SECURITY TO BE INCLUDED IN THE LINE OF PRESIDENTIAL SUCCESSION

Mr. FRIST. I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 179, S. 148.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (S. 148) to provide the Secretary of Homeland Security to be included in the line of Presidential succession.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill appear in the RECORD at this point.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 148) was read the third time and passed, as follows:

S. 148

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SECRETARY OF HOMELAND SECURITY IN PRESIDENTIAL LINE OF SUCCESSION.

Section 19(d)(1) of title 3, United States Code, is amended by inserting "Secretary of Homeland Security," after "Attorney General,".

PROHIBITION OF REMOVAL OF ART AND HISTORIC OBJECTS FROM SENATE WING OF CAPITOL AND SENATE OFFICE BUILDINGS

Mr. FRIST. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 181, S. Res. 178.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 178) to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate Wing of the Capitol and Senate office buildings for personal use.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. Madam President, I ask unanimous consent that the resolution be agreed to, the motion to reconsider be laid upon the table, and that any statements relating thereto be printed in the RECORD without any intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 178) was agreed to.

The resolution reads as follows:

S. RES. 178

Resolved, That (a) a Member of the Senate or any other person may not remove a work of art, historical object, or an exhibit from the Senate wing of the Capitol or any Senate office building for personal use.

(b) For purposes of this resolution, the term "work of art, historical object, or an exhibit" means an item, including furniture, identified on the list (and any supplement to the list) required by section 4 of Senate Resolution 382, 90th Congress, as enacted into law by section 901(a) of Public Law 100-696 (2 U.S.C. 2104).

(c) For purposes of this resolution, the Senate Commission on Art shall update the list required by section 4 of Senate Resolution 382, 90th Congress (2 U.S.C. 2104) every 6 months after the date of adoption of this resolution and shall provide a copy of the updated list to the Committee on Rules and Administration.

THE CALENDAR

Mr. FRIST. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 170, S. Res. 174, and Calendar No. 171, S. Res. 175, en bloc.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Madam President, I ask unanimous consent that the resolutions be agreed to, the preambles be agreed to, the motions to reconsider be laid upon the table en bloc with no intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

DESIGNATING THURSDAY, NOVEMBER 20, 2003, AS "FEED AMERICA THURSDAY"

The resolution (S. Res. 174) designating Thursday, November 20, 2003, as "Feed America Thursday" was considered and agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 174

Whereas Thanksgiving Day celebrates the spirit of selfless giving and an appreciation for family and friends;

Whereas the spirit of Thanksgiving Day is a virtue upon which our Nation was founded;

Whereas 33,000,000 Americans, including 13,000,000 children, continue to live in households that do not have an adequate supply of food;

Whereas almost 3,000,000 of those children experience hunger; and

Whereas selfless sacrifice breeds a genuine spirit of Thanksgiving, both affirming and restoring fundamental principles in our society: Now, therefore, be it

Resolved, That the Senate—

(1) designates Thursday, November 20, 2003, as "Feed America Thursday"; and

(2) requests that the President issue a proclamation calling upon the people of the United States to sacrifice 2 meals on Thursday, November 20, 2003, and to donate the money that they would have spent on food to a religious or charitable organization of their choice for the purpose of feeding the hungry.

DESIGNATING THE MONTH OF OCTOBER 2003 AS "FAMILY HISTORY MONTH"

The Resolution (S. Res. 175) designating the month of October as "Family History Month" was considered and agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 175

Whereas it is the family, striving for a future of opportunity and hope, that reflects our Nation's belief in community, stability, and love;

Whereas the family remains an institution of promise, reliance, and encouragement;

Whereas we look to the family as an unwavering symbol of constancy that will help us discover a future of prosperity, promise, and potential;

Whereas within our Nation's libraries and archives lie the treasured records that detail the history of our Nation, our States, our communities, and our citizens;

Whereas individuals from across our Nation and across the world have embarked on a genealogical journey by discovering who their ancestors were and how various forces shaped their past;

Whereas an ever-growing number in our Nation and in other nations are collecting, preserving, and sharing genealogies, personal documents, and memorabilia that detail the life and times of families around the world;

Whereas 54,000,000 individuals belong to a family where someone in the family has used the Internet to research their family history;

Whereas individuals from across our Nation and across the world continue to research their family heritage and its impact upon the history of our Nation and the world;

Whereas approximately 60 percent of Americans have expressed an interest in tracing their family history;

Whereas the study of family history gives individuals a sense of their heritage and a sense of responsibility in carrying out a legacy that their ancestors began;

Whereas as individuals learn about their ancestors who worked so hard and sacrificed so much, their commitment to honor their ancestors' memory by doing good is increased;

Whereas interest in our personal family history transcends all cultural and religious affiliations;

Whereas to encourage family history research, education, and the sharing of knowledge is to renew the commitment to the concept of home and family; and

Whereas the involvement of National, State, and local officials in promoting genealogy and in facilitating access to family history records in archives and libraries are important factors in the successful perception of nationwide camaraderie, support, and participation: Now, therefore, be it

Resolved, That the Senate—

(1) designates the month of October 2003, as "Family History Month"; and

(2) requests that the President issue a proclamation calling upon the people of the United States to observe the month with appropriate ceremonies and activities.

THE CALENDAR

Mr. FRIST. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of the following measures en bloc: Calendar No. 173, S. Res. 62; Calendar No. 174, S. Res. 149; Calendar No. 187, S. Res. 90.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Madam President, I ask unanimous consent that the resolutions be agreed to, the amendments to the preambles, where applicable, be agreed to, and the preambles, as amended, if amended, be agreed to, and the motions to reconsider be laid upon the table en bloc, with no intervening action or debate, and that any statements regarding these matters be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

REGARDING THE HUMAN RIGHTS SITUATION IN CUBA

The resolution (S. Res. 62) calling upon the Organization of American

States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba, was considered and agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 62

Whereas the democracies of the Western Hemisphere have approved an Inter-American Democratic Charter that sets a regional standard regarding respect for human rights and fundamental freedoms;

Whereas the government of the Republic of Cuba approved and is bound to respect the Charter of the Organization of American States (OAS) and the American Declaration of the Rights and Duties of Man;

Whereas in 2001, 2000, 1999, 1998, and previous years, the government of the Republic of Cuba declined to reply to the OAS Inter-American Commission on Human Rights when it sought the government's views on human rights violations in the Republic of Cuba;

Whereas all countries have an obligation to promote and protect human rights and fundamental freedoms as stated in the Charter of the United Nations and the Universal Declaration of Human Rights;

Whereas the United Nations Commission on Human Rights considered and passed a resolution in 2002 regarding the situation of human rights in the Republic of Cuba and called for the United Nations High Commissioner for Human Rights to send a personal representative to the Republic of Cuba;

Whereas the United States and other countries remain concerned about violations of human rights and fundamental freedoms in the Republic of Cuba, including the freedoms of expression, association, and assembly, and the rights associated with the administration of justice;

Whereas, according to the Department of State, Cuban authorities use exile as a means of repression and continue to harass, threaten, arbitrarily arrest, detain, imprison, and defame human rights advocates and members of independent professional associations, including journalists, economists, doctors, and lawyers with the goal of coercing them into leaving the country;

Whereas Cuban citizens are routinely jailed solely because their views do not coincide with those of the government;

Whereas Amnesty International in its 2002 report noted an increase in human rights violations in the Republic of Cuba, including short-term arbitrary arrests, threats, summonses, evictions, interrogations, losses of employment, restrictions on travel, house arrests, and other forms of harassment directed by the government against political dissidents, independent journalists, and other activists in an effort to limit their ability to exercise fundamental freedoms;

Whereas Amnesty International also noted with concern the beginning of a trend toward the increased use of violence by Cuban authorities in order to repress dissent;

Whereas Cuban political prisoners are deliberately exposed to harm and poor conditions as a means of punishment, including beatings, denial of medical treatment, forced labor against medical advice, unsanitary eating conditions, and coexistence with inmates carrying highly infectious diseases;

Whereas peaceful dissidents in the Republic of Cuba, such as Oscar Elias Biscet, who upon finishing more than 3 years in jail for "instigation to commit a crime" is again in police custody and facing a possible year-long sentence, are subjected to ongoing harassment and imprisonment;

Whereas many Cubans, such as journalist Bernardo Arevalo Padron, who is currently in jail serving a 6 year sentence, are routinely jailed under the charge of "disrespect" for making negative statements about the government of the Republic of Cuba;

Whereas many Cubans, such as Carlos Oquendo Rodriguez, who is serving 2 years in prison, are routinely jailed under the charge of "public disorder" for criticizing the Castro regime;

Whereas many Cubans, such as Francisco Chaviano Gonzalez, the longest serving current Amnesty International prisoner of conscience in the Republic of Cuba, are imprisoned on charges of "revealing state security secrets" and "falsifying public documents" for promoting democratic practices and human rights;

Whereas many Cubans, such as Juan Carlos Gonzalez Leiva, a blind lawyer and president of the Cuban Foundation for Human Rights, are imprisoned on charges of "disobedience" and tortured while incarcerated for peacefully protesting the Republic of Cuba's brutal treatment of dissidents;

Whereas many Cubans, such as Leonardo Miguel Bruzon Avila, president of the 24th of February Movement (named for both a turning point in the Spanish-American War and the day in 1996 when 2 civilian aircraft carrying 4 members of the Cuban American Brothers to the Rescue movement were shot down over international waters by Cuban fighter jets), are charged with "public disorder" and held without trial for planning peaceful public ceremonies;

Whereas many Cubans, such as Nestor Rodriguez Lobaina, who is president of the Cuban Youth for Democracy Movement and currently serving a 6 year prison sentence, are charged with "damages" for denouncing violations of human rights by the Cuban government and communicating the brutality of the Cuban regime to Cuban citizens and the world;

Whereas many Cubans, such as Jorge Luis García Pérez, who is a founder of the Pedro Luis Boitel Political Prisoners Movement and serving a 15 year prison sentence, are charged with "enemy propaganda" and suffer systematic abuse and a lack of medical assistance while in prison, for criticizing communism;

Whereas Amnesty International reports that participants in Oswaldo Paya's Varela Project collecting the required 10,000 signatures on a petition for peaceful change to the legal system of the Republic of Cuba have been harassed, detained, subjected to confiscation of signed petitions, and "kicked, punched, and threatened" by Cuban state security officials; and

Whereas the European Parliament rightfully recognized Oswaldo Paya for his work on the Varela Project with the 2002 Sakharov Prize for his human rights work in the Republic of Cuba: Now, therefore, be it

Resolved, That the Senate calls upon—

(1) the Organization of American States Inter-American Commission on Human Rights to continue its reporting on the human rights situation in the Republic of Cuba and to request a visit to the Republic of Cuba for the purposes of reviewing and reporting to the international community on the human rights situation there;

(2) the United Nations High Commissioner for Human Rights and his newly appointed personal representative to vigorously pursue the implementation of the 2002 Resolution regarding the situation of human rights in the Republic of Cuba;

(3) the European Union, to build upon the European Parliament's recognition of Cuban dissidents and, through the appropriate bodies and mechanisms, request to visit the Republic of Cuba for the purpose of reviewing the human rights situation there and issue a report to the international community on its findings; and

(4) human rights organizations throughout the world to issue statements of solidarity with the Cuban human rights activists, political dissidents, prisoners of conscience, independent journalists, and other Cubans seeking to secure their internationally recognized human rights and fundamental freedoms.

EXPRESSING THE SENSE OF THE SENATE THAT THE INTERNATIONAL RESPONSE TO THE CURRENT NEED FOR FOOD IN THE HORN OF AFRICA REMAINS INADEQUATE

The Senate proceeded to consider the resolution (S. Res. 149) expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate, which had been reported from the Committee on Foreign Relations with an amendment to the preamble.

(Strike the part in black brackets.)

S. RES. 149

Whereas, according to the United Nations World Food Program, there are nearly 40,000,000 people at risk of starvation in Africa this year due to drought and widespread crop failure;

Whereas more than 14,000,000 of those people live in Ethiopia and Eritrea;

[Whereas the World Food Program has raised only 25 percent of the $100,000,000 it needs to assist 900,000 people in Eritrea;**]**

Whereas increased food and transportation costs have reduced the purchasing power of aid organizations;

Whereas the United States has contributed more than any other donor country in responding to the food crisis;

Whereas food aid is only part of the solution to the complex problems associated with famine, and non-food aid is also critical to lowering fatality rates;

Whereas the number of people at risk of food shortages in the Horn of Africa could exceed the levels of the famine of 1984;

Whereas urban areas in the region lack effective food security and vulnerability monitoring and sufficient assessment capacity;

Whereas countries in Africa have the highest HIV/AIDS infection rates in the world;

Whereas malnutrition lowers the ability of people to resist infection by the HIV/AIDS virus and hastens the onset of AIDS;

Whereas a person infected with HIV/AIDS needs to consume a higher number of calories per day than the average person does in order to survive; and

Whereas there is not enough food in the assistance pipeline to satisfy the dire food needs of the people in drought-affected countries of the Horn of Africa: Now, therefore, be it

Resolved, That it is the sense of the Senate that the President should—

(1) review our food assistance programs to ensure that we are as committed to, and successful at, meeting food needs in Africa as we are to meeting food needs in other parts of the world;

(2) take all appropriate measures to shift available United States food assistance resources to meet food needs in the Horn of Africa, including drawdowns of the remainder of the reserve stocks in the Emerson Humanitarian Trust;

(3) encourage other donors to commit increased food assistance resources through bilateral and multilateral means; and

(4) direct the Secretary of State, the Secretary of Agriculture, and the Administrator of USAID to work with international organizations, other donor countries, and governments in Africa to develop a long-term, comprehensive strategy for sustainable recovery in regions affected by food crisis that—

(A) integrates agricultural development, clean water access, inoculations, HIV/AIDS awareness and action, natural disaster management, urban vulnerability measures, and other appropriate interventions in a coordinated approach;

(B) estimates costs and resource requirements; and

(C) establishes a plan for mobilizing resources, a timetable for achieving results, and indicators for measuring performance.

The resolution (S. Res. 149) was agreed to.

The amendment to the preamble was agreed to.

The preamble, as amended, was agreed to.

The resolution, with its preamble, as amended, reads as follows:

(The resolution will be printed in a future edition of the RECORD.)

EXPRESSING THE SENSE OF THE SENATE THAT THE SENATE STRONGLY SUPPORTS THE NONPROLIFERATION PROGRAMS OF THE UNITED STATES

The Senate proceeded to consider the resolution (S. Res. 90) expressing the sense of the Senate that the Senate strongly supports the nonproliferation programs of the United States, which had been reported from the Committee on Foreign Relations with an amendment to the preamble.

(Strike the part shown in black brackets and insert the part shown in italic.)

S. RES. 90

Whereas on March 6, 2003, the Senate gave its advice and consent to the Treaty Between the United States of America and the Russian Federation on Strategic Offensive Reductions, done at Moscow on May 24, 2002 (the Moscow Treaty), which treaty will result in the [draw down] *withdrawal from operational deployment* of thousands of strategic nuclear weapons by December 31, 2012;

Whereas the lack of strict and effective control over and security of all weapons of mass destruction by the governments having jurisdiction over such weapons continues to be of grave concern to all nations that are threatened by terrorism, especially after the catastrophic terrorist attacks of September 11, 2001; and

Whereas despite some recent improvements in cooperation at the highest levels of the Russian Federation, various officials and agencies of the Russian Federation have been counter-productive in barring access and information to the United States with respect to nonproliferation programs and activities, thereby needlessly hindering the progress of such programs and activities: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) the Senate strongly supports the nonproliferation programs of the Department of Defense, the Department of Energy, and the Department of State, which programs are intended to reduce the worldwide threat posed by nuclear, chemical, and biological weapons that remain unsecured in the Russian Federation and elsewhere;

(2) the Russian Federation should continue to improve the access of the United States to key facilities, and the sharing of information with the United States, so as to bring a successful and timely conclusion to various nonproliferation programs and activities; and

(3) the United States should redouble its efforts to achieve full implementation of the nonproliferation programs of the Department of Defense, the Department of Energy, and the Department of State under effective management, and make full use of all funds that Congress appropriates or otherwise makes available for such programs.

The resolution (S. Res. 90) was agreed to.

The amendment to the preamble was agreed to.

The preamble, as amended, was agreed to.

The resolution, with its preamble, as amended, reads as follows:

(The resolution will be printed in a future edition of the RECORD.)

Mr. BYRD. Madam President, on March 6, 2003, the Senate gave its advice and consent to ratification of the Moscow Treaty on strategic nuclear arms reductions. The 97 to 0 vote belied significant weaknesses in the treaty: it contains no verification procedures, it does not require the destruction of any warheads or missiles, and it expires on the same day that it goes into effect.

Those weaknesses should not be ignored. I joined with my colleagues in voting to approve a formal treaty on U.S. and Russian arms reductions in order to send a message that more work is needed to reduce, control, and secure the most dangerous weapons that mankind has created. The Moscow Treaty is a modest step away from the Cold War threat of nuclear holocaust, but more steps need to be taken.

The resolution that I offer represents the Senate's next step in pushing for more action in the control of nuclear, chemical, and biological weapons. I am grateful to the chairman of the Foreign Relations Committee, Senator LUGAR, for his support of the resolution as its principal cosponsor. The Byrd-Lugar resolution urges the administration and the Russian Federation to do more to implement nonproliferation programs.

The United States has a good record in working with the countries of the former Soviet Union on nonproliferation programs. The Cooperative Threat Reduction program, conceived by former Senator Sam Nunn and of Senator RICHARD LUGAR, has an astounding record of success. That program has destroyed more than 6,000 Soviet-era nuclear weapons and more than 800 ballistic missiles. The program helped to remove all nuclear warheads from Belarus, Ukraine, and Kazakstan. It has made significant progress in securing nuclear materials, chemical weapons, and biological weapons.

The Byrd-Lugar resolution states the sense of the Senate on three important issues relating to U.S. non-proliferation programs.

First, the resolution states clearly the strong support of the Senate for non-proliferation programs that "are intended to reduce the threat posed by nuclear, chemical, and biological weapons that remain unsecured in the Russian Federation and elsewhere."

Second, the resolution urges the Russian Federation to increase access to key weapons facilities and to share more information about its weapons programs. According to General Accounting Office testimony delivered to the House Armed Services Committee on March 5:

> Russia will not allow DOD [Department of Defense] and DOE [Department of Energy] the level of access they require to design security improvements [at weapons storage sites], verify their installation, and ensure their proper operation. As a result, agencies have been unable to help protect substantial portions of Russia's nuclear weapons. . . In addition, many Russian biological sites that store dangerous biological pathogens remain off-limits. (GAO testimony, 3/5/03, GAO-03-526T)

Third, the resolution urges our country to redouble efforts to achieve full implementation of nonproliferation programs, under effective management, and with full use of the funds that Congress may appropriate for nonproliferation activities.

Critics have been active in pointing out that poor management of some nonproliferation projects has resulted in wasted money and lost time. Most recently, some have leveled criticism at two projects that were intended to eliminate Russian rocket fuel. The United States spent $200 million to build two facilities to eliminate fuel that was left over from destroyed Russian missiles, only to find that the fuel was diverted into the Russian civil space program. As a result, these facilities are left with no rocket fuel to destroy.

It is a very serious issue when such a great amount of money is devoted to an unsuccessful program. There is no excuse for poor planning and management. We should not lose sight of the importance of nonproliferation programs, and to ensure their success we must not ignore such examples of mismanagement. That is why the Byrd-

Lugar resolution makes a point about the need for effective management in our nonproliferation programs.

But just as management improvements are needed, the Executive Branch has been slow to implement nonproliferation programs. There has been delay after delay in spending funds that Congress appropriates for these projects.

According to the administration's fiscal year 2004 budget, $543 million in DOD nonproliferation funds will remain unexpended this year. To put that figure in perspective, the White House has requested $439 million for these programs in its fiscal year 2004 budget. I support that request, but that money—like the half a billion dollars that remains in our coffers—will do nothing to improve our security unless it is spent by the administration. Whatever funds that Congress appropriates to nonproliferation programs should be used in a timely manner that recognizes the serious nature of the threat posed by loose nuclear weapons in Russia.

The Byrd-Lugar resolution underscores the important nonproliferation tasks ahead of us by spotlighting problems that need to be addressed by the United States and Russia. Just as this resolution follows up on the Moscow Treaty, there is much more work to do after this resolution. These are matters on which the Armed Services Committee, of which I am a member, and the Foreign Relations Committee, of which Senator LUGAR is chairman, should continue to work together.

One issue that is particularly deserving of increased attention is expansion of non-proliferation programs to countries outside of the former Soviet Union. The supplemental appropriations bill passed by the Senate on April 3, 2003, included temporary authority for the President to spend up to $50 million in nonproliferation funds outside of the former Soviet Union during this fiscal year. Unfortunately, this provision was not included in the final version of that bill that was signed into law by the President on April 16, 2003.

The Director of the Central Intelligence Agency warned the Armed Services Committee on February 11 of a new nuclear arms race among smaller countries. Let us look beyond the borders of the former Soviet Union to address the heart of the growing menace of nuclear proliferation, and start thinking about how to leverage the success in Russia of the Nunn-Lugar programs into results in other countries.

The Nunn-Lugar programs have greatly reduced the chance that a poorly secured Russian military facility may serve as a one-stop shop for terrorists seeking a nuclear, chemical, or biological weapon. I count myself as a consistent and strong supporter of these programs.

But there is much more work to do. The Moscow Treaty, which requires that thousands of nuclear warheads be removed from deployment, but not necessarily destroyed, renews the need for a cooperative program to keep these weapons out of the hands of terrorists. The Byrd-Lugar resolution sends a message to the White House and to the Kremlin that we need to fix the problems that have surfaced in the nonproliferation programs between our countries and accelerate our work to secure and destroy unneeded and unwanted weapons of mass destruction.

MEASURE INDEFINITELY POSTPONED—S. CON. RES. 23

Mr. FRIST. Madam President, I ask unanimous consent that Calendar No. 34, S. Con. Res. 23, be indefinitely postponed.

The PRESIDING OFFICER. Without objection, it is so ordered.

AUTHORITY FOR COMMITTEES TO REPORT LEGISLATIVE AND EXECUTIVE MATTERS

Mr. FRIST. Madam President, I ask unanimous consent that notwithstanding the recess or adjournment of the Senate, committees be authorized to report legislative and executive matters on Wednesday, July 2, from 10 a.m. to 12 noon.

The PRESIDING OFFICER. Without objection, it is so ordered.

AUTHORIZING THE CHAIR TO MAKE APPOINTMENTS

Mr. FRIST. Madam President, notwithstanding the Senate's adjournment or recess for the Fourth of July recess, I ask unanimous consent that the Chair be authorized to make chair appointments.

The PRESIDING OFFICER. Without objection, it is so ordered.

AUTHORIZATION TO SIGN DULY ENROLLED BILLS OR JOINT RESOLUTIONS

Mr. FRIST. Madam President, I ask unanimous consent that during this adjournment of the Senate, the majority leader or the assistant majority leader or Senator ALLEN be authorized to sign duly enrolled bills or joint resolutions.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

A SMALL TOWN WITH A BIG HEART

Mr. DASCHLE. Madam President, Independence Day marks a time for Americans to celebrate our country's creation through an epic struggle for freedom and liberty. Families come together to commemorate the qualities displayed by the early patriots: a commitment to democratic expression, a yearning to be free from tyranny, and a sober willingness to sacrifice life itself on behalf of these aims.

This Fourth of July, thousands of men and women in our military will be in Iraq, dedicating themselves to the reconstruction of this country that has lived so long in the shackles of Saddam Hussein's reign of terror. Our objective is much the same as in 1776: creating conditions in which the people are protected from oppression and in which free expression and democratic government can flourish. We know this is not an easy task—indeed, our forces continue to suffer casualties but its success or failure will be very important, not only to Iraq, but also to the future of this country and the entire Middle East.

I am so proud of the service members who have stepped forward, making tremendous sacrifices, to fight for the liberty of a foreign people in a foreign land. These men and women have been unflinching in their resolve and have already accomplished much.

I am particularly proud of the roughly 2,000 South Dakotans who have been involved in the Iraq campaign. Many of them are South Dakota National Guard members, who participated in a mobilization with few precedents in our State's history. It was, by far, the largest mobilization since World War II. At the time the fighting began, units from more than 20 communities had been called up, from Elk Point in the south to Lemmon in the north, from Watertown in the east to Custer in the west. Indeed, our State's mobilization rate ranked among the highest of all the States on a percapita basis. Also, hundreds of personnel from Ellsworth Air Force Base were deployed overseas at the height of the campaign.

But no community in South Dakota, or perhaps even the country, is more remarkable in its contribution to this effort than the small town of Frederick.

Frederick lies roughly 30 miles from my hometown of Aberdeen. It is a small, close-knit community with a population of fewer than 300 people. But twenty-six of Frederick's sons and daughters answered the call to duty—nearly ten percent of its population! Frederick's military personnel are serving in nearly every branch of the armed forces, including the Army, Navy, Air Force, Marines, Army National Guard, Air National Guard, and Army Reserve. To put this tremendous display of patriotism in perspective, the boroughs of New York City would need to send roughly 750,000 people to match Frederick's effort.

On July Fourth, Frederick is commemorating the patriotism of its service members with a community parade and celebration that will feature a flyover by a B–1 bomber out of Ellsworth Air Force Base. They will honor their friends, neighbors and loved ones serving in the U.S. military, and I want to join them by recognizing them here today. They are:

Air Force: A1C Justin Wallace, SSgt. Jason Strand, Senior MSgt LeRoy Fiekens, SSgt. Tara Meyers,

A1C Paul Sumption, and TSgt. Reiff Mikkonen.

Air Force National Guard: SSgt. Brian Achen.

Army: LTC Ronald Claeys, PFC Gary Kurtzhals, and PFC Mikael Schmit.

Army National Guard: SPC Stephen Achen, Sgt. Ryan Henningsen, Sgt. Robert Heider, PFC Jeff Pierce, Cpl. Mike Bunke, Col. Gordon Niva, SSgt. Eric Kinslow, Sgt. Dave Gunther, SPC Ben Deuter and Sgt. Ryan Bakeburg.

Army Reserve: Maj. Susan Lahr and PFC Glenn Gunther.

Navy: Petty Officer Josh Larsen and Petty Officer Randy Jensen.

Marine Corps: Sgt. Eric Thompson and MSgt. Scott McCullough.

Let me also take a moment to recognize another young patriot from Frederick, 10-year-old Peyton Healy. Though she does not know any of the 26 deployed soldiers personally, Peyton took the initiative to develop a way for the people of Frederick to support troops serving abroad, creating the "Project Patriotic Penny Fund." Working with the local American Legion post, she placed donation cans in area businesses to raise money for postage on care packages to the troops. She hoped to raise roughly $100—enough to pay for one package to every Frederick service member. The people of Frederick placed $195 in these cans—19,500 pennies. They also donated supplies for the packages, such as crossword puzzles, pens and paper, batteries, hygiene products, and candy.

Most importantly, Peyton helped us see the defining characteristic of the people of Frederick. She helped us see that the people of this tiny town have enormous hearts. I call upon my colleagues and the people of this Nation to join with me in commending the people of Frederick, and in celebrating alongside them on Independence Day the democracy and liberty they so proudly defend and promote.

BURMA

Mr. McCONNELL. Madam President, on June 11, 1995 my colleagues joined Senator FEINSTEIN and myself in passing the Burma Freedom and Democracy Act. This legislation prohibits the importation of all products from Burma, freezes the assets of Burma's ruling thugs and their political arm, bans travel to the United States for the junta's political and military leadership, and provides assistance for democracy activists inside the country. At this time, our House colleagues are working to pass their version of this legislation and I urge them to do so quickly.

Today we have news reports from Tokyo that the Japanese Foreign Ministry will be suspending new development assistance pending the release of Daw Aung San Suu Kyi. This is a positive first step, but this is not enough.

I urge our Japanese allies to reflect upon the junta's continual efforts to smother democracy in Burma and review their overall engagement policy towards the junta. The junta put the final nail into the coffin of constructive engagement when it signaled its hostility to political dialogue and national reconciliation on May 30 by arresting Suu Kyi and murdering Burmese democrats. It is painfully clear now that the junta's support for engagement was nothing more than a farce used to bankroll its corrupt and vicious rule.

Constructive engagement for Japan and Association of Southeast Asian Nations, ASEAN, has done nothing to improve the political, economic, or social situation in Burma. The ASEAN policy of noninterference will not stand. Burma's military government is a festering sore infecting the region with narcotics, HIV/AIDS, and instability. In fact, without question, Burma is worse off now than at any point in its history. The path now is clear: isolate the vile thugs who rule this country. We must encourage Burma's neighbors to use their considerable influence to make clear to the military regime that they, too, find the political situation intolerable; it must change.

When the Prime Minister of Thailand visits the United States and his meetings with American officials are dominated by the issue of Burmese atrocities, it displaces Thai national security and economic issues from the discussion. When the Association of South East Asian Nations convened in Phnom Penh, Cambodia, this month and the discussions centered not on fighting HIV/AIDS or improving regional economic development but on the arrest of Suu Kyi and the murder of National League for Democracy political activists, it distracts ASEAN from other important issues.

The regime in Burma is pulling down the region, and it is time that its neighbors owned up to their responsibility in fixing this problem once and for all. This is not a problem that can be pushed under the rug; ASEAN and Burma's neighbors must confront this problem. Until the region confronts the junta and demonstrates backbone in the face of corrupt despotism, they will find the United States a less willing negotiating partner.

Clearly, the transfer of power 1990 elected government will provide peace, stability, and the opportunity for enhanced regional economic growth. It is this goal, not merely the release and continued harassment of Suu Kyi, that should drive the foreign policies of Burma's regional neighbors.

I welcome the statements coming from Japan demanding Aung San Suu Kyi's release from the notorious Insein Prison—a jail Burmese political prisoners call "The Hell of Asia." However, her release from prison alone will solve none of Burma's problems. There is much more that needs to be done here in Congress, and at the White House, by Japan, ASEAN, the European Union, and by Secretary General Kofi Annan and the United Nations Security Council to ensure that the thugs now ruling Burma are one day soon consigned to the ash heap of history.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT

Mr. AKAKA. Madam President, I rise today to speak on S. 1, the Prescription Drug and Medicare Improvement Act of 2003.

For far too long Medicare has lacked a prescription drug benefit. The lack of this benefit has been the gaping hole in the Medicare safety net. Prescription drugs are the largest out-of-pocket health care cost for seniors. Many who cannot afford drug coverage often break the drugs in half, skip doses, or do not fill their prescriptions.

The legislation the Senate passed last night will finally establish a benefit. I supported this bill because it is an important step forward in meeting the prescription drug needs of seniors. However, I am particularly concerned that the bill provides insufficient prescription drug coverage for seniors and depends excessively on private plans.

Medicare beneficiaries will experience a gap in their prescription drug coverage after their drug expenditures reach $4,500. They will not receive any benefits until their total drug expenditures reach at least $5,813 unless they qualify for the additional low-income support. This gap in coverage will occur while they are still paying premiums. It is unfortunate that amendments designed to fill in the gap were defeated. This issue must be revisited in the future. Also, the eligibility requirements for the additional low-income support are too restrictive and will deny many seniors in need the extra help that they need.

The dependence on private insurers to administer this benefit presents additional challenges to providing seniors with access to prescription drugs. Prescription drug-only insurance policies are currently not offered and they will need to be developed. The utilization of private plans creates a system in which insurers have incentives to limit access to needed drugs. In addition, the premiums that seniors pay for coverage are likely to vary depending on what region people live in. It is not equitable for a Federal benefit to have different prices across the country. Seniors should have the option of choosing a Medicare-administered plan instead of one that is run by a private insurer.

It is unfortunate that amendments to strengthen the prescription drug coverage and to provide seniors with an option to enroll in a Medicare administered plan were defeated. I look forward to continue working with my colleagues to address these important issues to improve the Medicare prescription drug benefit.

Again, I supported this bill because it is an important step towards providing much needed prescription drug coverage for seniors. Also, I am pleased that my amendment to restore a Medicaid disproportionate share hospital, DSH, allotment for Hawaii was adopted. This amendment is vital to Hawaii's hospitals which are struggling to meet the elevated demands placed upon them by the increasing number of uninsured patients. DSH payments will help Hawaii hospitals meet the rising health care needs of our communities. I hope that this provision is retained in conference.

S. 1. THE MEDICARE PRESCRIPTION DRUG BENEFIT ACT

Mr. ROCKEFELLER. Madam President, as the Medicare prescription drug debate draws to a close, I would like to take a few moments to give my colleagues my honest assessment of this legislation.

I join many of my colleagues in recognizing how difficult it has been for the managers of this bill to hold to a proposal that fits within a $400 billion budget constraint. In that respect, they are to be commended for their discipline. But for my part, I believe that constraint, combined with the fervent intent by some to move Medicare to a private insurance model, has produced a bill that is fatally flawed. Seniors will not get the affordable, meaningful prescription drug coverage they expect because the majority of Members seem to have concluded that we cannot break the $400 billion barrier. I think it is a false choice.

The actual prescription drug benefit in this bill is inadequate to meet the needs of more than 40 million Medicare beneficiaries and eventually America's seniors are going to figure that out. The fact of the matter is that $400 billion is simply not enough to buy an adequate benefit. But we already knew that—our debates last year made that abundantly clear.

I believe that insisting on the capped amount of $400 billion for a Medicare drug benefit as a precondition of moving a new benefit through the legislative process serves as a convenient excuse. It means this drug benefit is sure to fail to meet seniors' real drug coverage needs. It also means that we will only cover 20–25 percent of seniors' drug costs.

What is worse, the complicated structure of this bill will cause seniors to be angry and confused by the benefit—and they will be entitled to be. This is not the straightforward guaranteed Medicare prescription drug benefit seniors have been repeatedly promised. There is no standard premium and there is no uniform benefit. For the first time under Medicare there is no universal coverage for all Medicare beneficiaries. This bill falls fall short of what seniors expect and need.

Let's take a few minutes to look at how the shortcomings of this bill will become apparent to a Medicare beneficiary—a senior or disabled person who enrolls in this benefit. For illustrative purposes, let's take an 80-year-old West Virginia widow living at 250 percent of the poverty level.

Assume this widow spent her entire career working for the same employer. Since her retirement, her employer has provided her with a fairly generous drug benefit—$150 deductible, $10 copays, and catastrophic coverage. However, once the Senate's proposed drug benefit is enacted, she becomes one of the 37 percent of Medicare beneficiaries who currently receive good employer-sponsored coverage who lose that coverage. That is because the way this bill works her former employers' contribution to her drug costs are meaningless because they do not count toward her catastrophic limit.

I want to note here that, during the health care reform debates of more than a decade ago, one of the few things that we seemed to agree on was that we should not disrupt the health care coverage that Americans already rely on. My friends on the other side of the aisle, in particular, were quite adamant about that point. Well, this bill would not just disrupt the drug coverage for millions of seniors, it would completely strip the drug coverage from 4.5 million seniors who have employer-sponsored coverage today.

It will strip their employer-sponsored coverage and leave them with an inferior drug benefit which is either less generous or more expensive. I offered an amendment to correct this problem, but it failed just 2 days ago.

To return to my example, as a result of having lost her employer-sponsored coverage, this 80-year-old senior decides she has to enroll in the new drug benefit next year—in 2004—only to find out that it will not be implemented until 2006. There is a discount drug card, but it is not substantially better than the discounts she gets today—and it is far worse than the drug benefit she used to receive from her former employer.

This widow spends the next 2 years trying to figure out whether it is to her benefit to enroll in this new Medicare prescription drug benefit. But she can't really make an informed decision because she has no idea what the premium will be or what the benefit will actually look like. She decides to enroll in the voluntary benefit having been told that if she waits to enroll she will have to pay a very harsh late enrollment penalty.

This particular 80-year-old senior lives in West Virginia, so let's assume that no private insurers enter the area to provide a drug benefit. That has been my State's experience with the Medicare+Choice Program and I have no reason to believe that this proposal will produce a different outcome.

My illustrative senior citizen enrolls in the fallback. Her sister, however, lives in northwestern Ohio and has enrolled in a Medicare Advantage Plan. For the first time under Medicare, the West Virginia widow and her sister in Ohio have a different Medicare benefit and are paying a different premium for that benefit. In addition, her sister is being offered additional benefits like a catastrophic limit on her medical expenditures and disease management. These additional benefits are not even being offered to the West Virginia senior because she remains in traditional Medicare.

Now, fast forward 1 year and assume that private insurers decide to enter West Virginia. The fallback plan she received through traditional Medicare disappears and she is required to enroll in a private insurance plan. She cannot see the doctor she was seeing because he is not in the private insurer's network. She cannot go to the pharmacy she usually visits—the one that is right down the street—because it is also outside the network. She can't have the drug she was taking because it is not on the insurers' formulary.

Again, fast forward, this time it is 2 years later. Let's assume that the private insurers did not make enough profit to continue to provide a drug benefit in West Virginia—then what happens? The now 83-year-old widow will have to start the process all over again.

What is worse is that each senior will face a different calculation in determining how this bill will or won't help them. Senior citizens with incomes of 135 percent of the poverty level should theoretically pay no deductible, 5 percent cost sharing up to $4,500 in total spending, 10 percent cost sharing between $4,500–$5,800 and 2.5 percent cost sharing above $5,800.

But this bill has an asset test that will prevent millions of seniors from getting the low-income subsidies in this bill. If a senior owns a burial plot worth $1,000, a $3,000 Treasury bill, and a vehicle worth $6,000—indeed, if a senior owns anything that adds up to over $10,000 in assets, not including his or her home, the cost sharing they have to pay will double.

Our Nation's neediest seniors, those with incomes 74 percent of Federal poverty, will not be permitted to enroll in the new Medicare prescription drug benefit at all. Even though these low-income seniors are Medicare beneficiaries, they will not be eligible for this particular Medicare benefit because they are now eligible for Medicaid. They will be discriminated against for the very first time under this new Medicare benefit.

Seniors who are forced to remain in Medicaid may well end up seeing their drug coverage dramatically cut back. With our Nation's economy still fairly stagnant, State budget situations remain dire. In some States, dual-eligible Medicare beneficiaries may only have coverage for three prescriptions per year, regardless of their medical needs.

Put simply, the Medicare drug benefit the Senate is about to vote on has fatal flaws. The following is a list of 10 fatal flaws that, combined, persuade me this bill should not get my vote.

1. The drug benefit has no national premium. CBO estimates that $35 will be the national average premium. That number appears nowhere in the legislative language. It is a projection, a best guess—and it certainly could be higher.

2. Under this prescription drug plan, the premium will vary in every region of the country, perhaps State by State, and there is no limit on how high it can be. We defeated an amendment that would have limited the variation to no more than 10 percent above the national average, but it failed.

3. Private insurers will actually decide what the premium will be. And, this premium will grow each year by the rate of increase in drug costs—that is roughly 10–12 percent increases every year. That means seniors in 2008 could well be paying $50 a month for their drug premium alone—and that is on top of the cost of their deductible and copayments.

4. There is no requirement for private plans to offer a standard benefit—private plans are only required to offer an actuarially equivalent benefit. That means West Virginians and other rural beneficiaries may not have access to the same drug benefit that other seniors will have—again, for the very first time under Medicare seniors in some States won't get the same benefits as seniors in other States. I am not very confident that West Virginia seniors will end up with the better benefit—we never do.

5. The bill currently has a completely unstable fallback. Under this proposal, the only time a beneficiary will have the option of receiving coverage through Medicare is if there are not at least two bids from private insurers to serve a region. There is no guaranteed Medicare prescription drug benefit of the kind I believe seniors fully expect. Moreover, if private insurers do not enter an area, the fallback moves into place for 1 year. The next year, a new bidding process begins, and if two plans show up, the Medicare fallback disappears. Private insurers can then change or terminate coverage every 2 years. This means that seniors, especially seniors in rural areas where preferred provider organizations or PPOs and private plans are not likely to come to the table, may end up bouncing between a fallback, then a private plan, and then back to a fallback. Back and forth, back and forth. All the while, this senior will be forced to change doctors and pharmacists, their cost sharing will be changing, as may their premiums. The Senate prescription drug plan we are considering leaves the big HMOs and insurance companies in charge.

6. There is a significant gap in coverage. That gap is $1,300—seniors pay their monthly premiums but get no drug benefit in that gap. Two amendments to address this problem did not achieve sufficient votes for passage. One was an amendment to eliminate this gap. Another one would have said that seniors would not have to pay premiums when they were not receiving any benefit. The failure of these two strengthening amendments means that under this legislation, if a Medicare beneficiary has $5,900 in drug spending per year, by October 7 of that year, their benefit will run out. That beneficiary will continue to need the drugs each day for the rest of the year but her benefit will run out on October 7. Fifteen million Medicare beneficiaries will fall into the gap.

7. Low-income seniors who are eligible to receive a drug benefit under Medicaid will not be eligible for the Medicare prescription drug benefit, as I illustrated in my earlier example. This means that 43,000 West Virginians will not be eligible for this Medicare prescription drug benefit. Millions more across America won't be eligible for this Medicare benefit even though they paid their whole lives into the Medicare program rightfully expecting that it would cover their health care costs.

8. Again, under this legislation, CBO estimates that 37 percent of Medicare beneficiaries who currently receive a drug benefit from their employer will lose that coverage because of the way this legislation defines out-of-pocket costs.

9. This proposal requires private insurers to provide beneficiaries with a catastrophic limit on expenditures for medical benefits, disease management, chronic care services and preventive benefit. But, such benefits are not made available to beneficiaries remaining in traditional Medicare. Everyone keeps arguing that these private plans will provide better, more comprehensive, preventive care. But, the fact is that this bill precludes the traditional Medicare from providing better, more coordinated care. There is no reason that traditional Medicare cannot provide the same level of care as a private plan—at a significantly lower administrative cost, I might add—but not if we preclude it from doing so.

10. And if those reasons weren't enough, consider what is headed our way in conference: today, the House will include in its prescription drug bill new tax shelters for health care, that disproportionately help the rich and undermine employer-based health insurance coverage . . . the very system that the vast majority of Americans depend on for their health care and a voucher system for Medicare beneficiaries beginning in the year 2010.

Under this system, seniors would receive a defined contribution payment rather than a defined benefit. In other words, rather than defined benefits beginning in 2010, seniors would receive a set premium payment—like a voucher—from the Government.

We need to think about what we are doing here. In my judgment, every Member of Congress should think about this benefit from the perspective of their beneficiaries. This proposal is a great opportunity for seniors to shop for new coverage every few years. If you have the utmost faith in private insurers to provide good health coverage to elderly Americans and the disabled, then this is the plan for you. This plan puts private insurers in the driver's seat by giving them flexibility to vary premiums and change or terminate coverage every 2 years. But, as far as providing long-term security, this proposal fails.

Finally, several Members have come to the floor and claimed that this proposal is just a downpayment—that we will be able to revisit the benefit over the years and make it more generous. That is simply untrue. We have an administration that is intent on large tax cuts, that is focused on the minimization of Government and that is committed to the privatization of the Medicare Program. Most every amendment offered during this debate to improve this benefit has lost. I don't know why any senior would believe that we will be able to revisit this program and make it better. We should take the time to get it right.

Mr. LIEBERMAN. Madam President, I want to state my support for the Medicare Prescription Drug Bill, S. 1, and my reasons for doing so.

I believe that by passing this legislation, we begin to answer the prayers of many seniors who are struggling to cover the rising costs of the prescription drugs they need to live longer and healthier lives. I commend the bipartisan Congressional effort to beat back the worst pieces of the President's initial proposal—which would have forced seniors out of Medicare en masse and paved the road to privatizing the system—and forged this more sensible compromise.

But my support is not an enthusiastic endorsement. We cannot ignore the substantial weaknesses in this proposal. For one, the bill does not take effect until 2006—seniors have waited long enough. More specifically, this bill has an enormous gap in coverage—the so-called "doughnut hole"—that leaves millions of seniors without the assistance they need. Premiums may vary from plan to plan. Some seniors may be forced to go round and round in a revolving door, changing plans as private plans come and go. And seniors covered under employer-based retiree plans would not get the catastrophic benefit they need. Unfortunately, Republicans defeated Democratic amendments to remedy these shortcomings.

Nevertheless, the bill represents a dramatic improvement in prescription drug coverage for our nation's seniors. It would provide comprehensive prescription drug coverage for our lowest income elderly with no or minimal premiums. It also guarantees that a drug benefit is available to all Medicare beneficiaries by giving them a "fallback" traditional government plan when there is a lack of private plans in their area. Even with the existing gap, 80 percent of Medicare beneficiaries will get back more in benefits than they pay in premiums.

Both problems and advantages to the bill are summarized in more detail below.

All in all, this is a foundation upon which to build in the months and years ahead. Senator KENNEDY is right. Seniors deserve the basic coverage this plan will provide—and an end to the political stalemate that has blocked action for the last several years. Thanks to the persistent, principled, and passionate advocacy of him and other Democrats—and the strength of Republicans who resisted President Bush's divisive prescription—that's precisely what they're getting.

But I do think we can and should do more to improve this plan, and there are several specific areas we should focus on as we go forward. First, we must fill the doughnut hole I described above. This gap in coverage will hurt our seniors at their time of greatest need—financially and physically. The gap occurs because after a senior's drug spending reaches a certain amount, the benefit ends. The benefit doesn't start again until there is a significant out of pocket payment, at which time catastrophic coverage kicks in. Many of the beneficiaries who fall into that gap are likely to be seriously ill and financially strapped, and therefore faced with the same awful choice between medicines and necessities that too many seniors face today.

That's not the only problem with this bill. Another is that the drug benefits paid by employer-based retiree plans would not count toward the catastrophic benefit promised to seniors. Therefore, seniors covered under these plans would not gain from this new benefit. In fact, these seniors may get less Medicare coverage than other beneficiaries. Also, CBO estimates that as many as 37 percent of employers may drop their retiree drug coverage, which is the last thing we want to happen as a result of this bill.

In addition, there is no set premium for seniors under this plan. Many seniors will enroll in private drug-only plans because that will be their only option. The premiums for these plans may vary significantly and may be quite high in certain parts of the country. This is clearly unfair and will hurt those seniors in locations where premiums are high.

Moreover, the drug coverage approach in the bill relies on uncertain and historically unstable private health insurance plans. In fact, there will not be a guaranteed "fallback" option for coverage in a traditional Medicare plan. This fallback will only occur when there are less than two private plans in any region. Seniors may be pushed from plan to plan as the private plans come and go.

But on balance, this bill has more strengths than weaknesses, starting with the fact that it commits $400 billion to help reduce the costs of prescription drugs for America's senior citizens. This is a historic breakthrough, and we should not minimize that.

One of the most encouraging parts of this bill is that it provides comprehensive coverage for low income seniors up to 160 percent of poverty with no or minimal premiums and cost sharing—40 percent of all Medicare beneficiaries. There is no "doughnut hole" for this group. Although I wish that there were better coverage for the remaining 60 percent of beneficiaries, there is at least strong, reliable coverage for the lowest income group.

Another positive aspect of the current bill is that all Medicare beneficiaries are provided a "fallback" traditional government plan when there are not two private plans in their area. This means that all Medicare beneficiaries are guaranteed that a drug benefit is available. I co-sponsored Senator STABENOW's amendment to guarantee this fallback without regard to the presence or absence of private plans to increase the stability of coverage and decrease the risk of needing to move from plan to plan. That amendment failed.

There were other important amendments that I did not have the opportunity to vote on. I would like to note my position on them for the record.

Stabenow Amendment No. 931 to Bill S. 1: I was a co-sponsor of this amendment that would have ensured the availability of the traditional Medicare plan in all areas. Bill S. 1 guarantees a "fallback" plan only when there are not two private plans in any region. This amendment would have guaranteed the availability of a Medicare-administered drug benefit for all Medicare beneficiaries in all regions and this "fallback" would not be dependent on the presence or absence of private insurers. This would have avoided the revolving door of drug insurance we may face with the enactment of the underlying bill. As discussed, seniors could be forced to change insurers and drug formularies from year to year. This amendment would have provided stability, by allowing seniors access to the federal fallback plan at all times. It is important that seniors don't just have drug coverage, but have coverage they can trust. For this reason, I was a co-sponsor of this amendment and would have voted for it.

Daschle Amendment No. 939 to Bill S. 1: This amendment would have ensured that an affordable plan would have been available to all Medicare beneficiaries by limiting the variations in the amount beneficiaries have to pay in premiums to only 10 percent above the national average, no matter where they live. Currently, premiums for Medicare HMO plans with drug coverage vary from $99/month in Connecticut to $16/month in Florida. Similarly, the premiums in Medicare PPO plans vary from $166/month in New York to $39/month in Alabama. This amendment would have limited these types of inequities. For this reason, I would have voted for this amendment.

Gregg Amendment No. 945 to Bill S. 1: This bipartisan amendment attempts to help ensure that Americans have access to generic drugs in a timely fashion. This amendment speeds the market entry of generic drugs by eliminating some patent extension practices used by brand name manufacturers. I voted for similar generic drug legislation in the last Congress, which passed the Senate. I would have voted for this amendment.

Dayton Amendment No. 957 to Bill S. 1: This amendment would require that Members of Congress receive prescription reimbursements at the same level as Medicare beneficiaries. I believe that it is appropriate and fair for us to be subject to the same problems to which our constituents will be subject. For these reasons, I would have voted for this amendment.

Dodd Amendment No. 969 to Bill S. 1: This amendment would have allowed an ongoing open enrollment period for two years so that beneficiaries could enroll and disenroll in Medicare Prescription Drug Plans and Medicare Advantage plans during 2006 and 2007. Medicare beneficiaries would have been able to choose which plan they wanted as they gathered more information about each plan during the first two years of this benefit. For this reason, I was a co-sponsor of this amendment and would have voted in favor.

Dodd Amendment No. 970 to Bill S. 1: This amendment would have provided 50 percent cost sharing through the "donut hole" for seniors between 160 percent and 250 percent of poverty. Beneficiaries who have an income of only $15,000/year (or $20,000/year for a couple) are just over the 160 percent cut-off. This amendment would have helped these beneficiaries who have reached the initial coverage gap and before these beneficiaries have reached the annual out-of pocket limit. I am greatly concerned that the bill voted out of the Finance Committee will hurt these beneficiaries. For these reasons, I would have voted for this amendment.

Harkin Amendment No. 991 to Bill S. 1: I was a co-sponsor of this amendment to have a demonstration project through the Medicaid program to encourage community-based services for individuals with disabilities. I believe that it is important that we treat disabled and challenged individuals in their communities to try and decrease the institutionalization of this population. We need demonstration projects to establish cost effectiveness and quality. For these reasons, I co-sponsored this amendment and would have voted for it.

Dodd Amendment No. 998 to Bill S. 1: This amendment would have increased the amount of the direct subsidy to employers who provide retiree prescription coverage. It would have encouraged retiree benefit plans to continue to exist as an alternative to Medicare. I am deeply concerned that the bill voted out of the Finance Committee will hurt seniors who currently have employer prescription drug coverage. Seniors who have worked hard all of their lives and earned drug insurance from their former employers should not lose this coverage and this bill could, according to CBO estimates, eliminate over a third of these benefits. For these reasons, I would have voted for this amendment. This provision needs to be corrected.

Clinton Amendment No. 1000 to Bill S. 1: I was proud to cosponsor Senator CLINTON's amendment to ensure that seniors get the information that they need to make informed choices about which medication they should take for a given medical condition. Often, there is more than one medication that is available for treatment. This measure would have supported research to determine which of these drugs is most effective and would have ensured that this information would be made available to patients and their physicians. I believe that it is important to support these studies as a means of improving the quality of prescribing practices and make certain that patients get the best possible care. For these reasons, I cosponsored this amendment and would have voted for it.

Boxer Amendment No. 1001 to Bill S. 1: This amendment would have filled the coverage gap or "doughnut" for beneficiaries who are ill and who have drug expenditures that exceed $4500. Bill S. 1 contains a provision that after Medicare beneficiaries' drug expenditures reach $4500, there is no more coverage until the total drug expenditures reach at least $5813 (unless beneficiaries qualify for low-income protections). No other private or public health insurance policy has this kind of coverage gap. In addition, S. 1 requires that during this coverage gap, Medicare beneficiaries would be required to pay their monthly premium. This is unfair. This amendment would have ensured that Medicare beneficiaries continue to receive the same drug coverage even after drug costs reach $4500 and before they reach $5800. They are paying their premiums and should continue to receive benefits. For these reasons, I would have voted in favor of this amendment.

Sessions Amendment No. 1011 to Bill S. 1: I support the Senate's vote to defeat Senator SESSIONS' amendment. The Senate Finance committee included provisions in S. 1 to extend Medicaid and S-CHIP coverage to legal immigrants. These benefits would aid taxpaying residents who have come to this country for a better future. It is only right that hard working newcomers who play by the rules receive our help when needed. Senator SESSIONS' amendment would have eliminated these provisions. For these reasons, I would have voted to oppose the Sessions amendment.

I attempted to cast as many votes as possible during the Senate Medicare debate. I did not miss any votes for which my vote would have changed the outcome, including the vote for Senator HARKIN's amendment. Although I missed this vote and the count was 50–48 in favor of a motion to table the amendment, even if both I and another Senate absentee had cast our votes, Vice President CHENEY would have cast the deciding vote. Most of the amendments passed or failed by wide margins, as did the final bill.

In conclusion, Mr. President, I want to reiterate that on balance I view this bill as real progress, despite its flaws. But I also want to make clear that I will oppose any effort to tip that balance against senior citizens in conference. I am troubled by provisions in the House bill that would undermine traditional Medicare and force seniors into private plans. And I will not support any effort to include these provisions or ones like them into the conference report and make the bill weaker instead of stronger.

Mr. CORZINE. Madam President, I rise today to discuss the Grassley-Baucus Medicare prescription drug legislation approved by the Senate late last night.

I supported this legislation, though I did so reluctantly. On balance, I believe the proposal represents a modest step forward toward the goal of a guaranteed prescription drug benefit under Medicare. It is a first step.

From a New Jersey perspective, I am particularly pleased that the managers agreed to my request to include a provision that will protect the ability of nearly 250,000 New Jersey seniors to continue to receive benefits through our State's 27-year-old pharmaceutical benefit program, known as the PAAD program. This program, which enjoys bipartisan support, is uniformly believed to have served our State exceedingly well. Similar long standing programs exist in other States, as well.

Unfortunately, the bill adopted by the Senate also has many shortcomings. I am hopeful that many of those problems will be addressed before the final version of the legislation is sent to the President. The Senate bill is the minimum first step I can support, however. And I will oppose the final conference report if it drops my provision protecting the ability of States to administer long standing prescription drug programs.

As I have traveled New Jersey I've heard from my constituents about their struggle to deal with rising drug prices. Many New Jerseyans fear that the cost of prescription drugs will bankrupt them in their last years. They worry about the burden those costs can impose on their families. And around our country, too many seniors are forced to choose between paying rent and buying their prescription drugs. That's a choice that no American should have to face.

I believe strongly that seniors who have worked hard all their lives, paid taxes and contributed to Medicare should have access to the medicines they need to maintain independent, productive lives. Modern medicine largely is based on pharmaceutical treatment. Providing a prescription drug benefit is the right thing to do for our seniors and their families. But it also serves broader public goals.

After all, we all pay the price if we fail to provide a guaranteed prescription drug benefit. That failure increases the number of hospital admissions and surgical procedures. It also increases costly institutionalization in nursing homes, and deprives seniors of the ability to live independently in their communities.

My own State of New Jersey recognized the value of a prescription drug benefit in 1975 when it created the PAAD program, which serves low- and middle-income seniors. New Jersey's PAAD program is considered the Nation's most generous State administered prescription drug program for the elderly. Together, PAAD and Senior Gold, a more recent program with broader eligibility added under a Republican governor, provide comprehensive prescription drug coverage to nearly 250,000 low-income seniors and disabled people in New Jersey, without deductibles or premiums.

It is absolutely essential that seniors who currently receive higher quality benefits under state drug programs than they would under the Medicare drug benefit continue to receive the state benefits. Their position should not be diminished by Federal edict. For example, seniors in the New Jersey PAAD program pay only $5 for their prescriptions. They do not pay premiums or deductibles. By contrast, seniors who enroll in this Medicare benefit would pay a substantial premium averaging $35 per month, along with a $275 deductible, and a 50 percent copay. It is unthinkable that we would force these seniors to disenroll in their more generous state program to receive less coverage under Medicare—particularly those seniors with low and moderate incomes.

I have been making this point to my colleagues on the Finance Committee for a long time, and I am very pleased that a provision to protect my State's seniors has now been included in the bill. I want to thank Senators GRASSLEY and BAUCUS for their tremendous assistance in addressing this issue. The bill before us not only allows New Jersey to continue to administer the PAAD program, but it contains language I sought to ensure that state payments on behalf of a beneficiary count toward the beneficiary's out of pocket costs, helping that beneficiary reach catastrophic coverage sooner. This will save the state of New Jersey an estimated $105 million annually.

I particularly want to thank Liz Fowler and Andrea Cohen of Senator BAUCUS's staff for all of their efforts on these issues. They have devoted many hours to these issues and done great work, and I want them to know that I appreciate their assistance.

I would note that giving states the money we would otherwise give private plans to administer benefits would allow states to expand their programs. Rough estimates indicate that the Medicare subsidy for those seniors currently enrolled in New Jersey's PAAD program is at least $300 million. With this new Federal money, the State of New Jersey could expand this successful program to higher income seniors, eliminating gaps and strengthening the program in many ways. This is a win-win for everybody. And, I want to note that the provision is budget neutral: it won't cost the taxpayers one penny. I will work hard with my colleagues in the New Jersey delegation to ensure that this provision will be retained in conference.

In addition to preserving state pharmaceutical assistance programs, we must also work to make this drug benefit better for all Americans. While I plan to support the underlying bill in order to push the legislative process forward, let me be clear: this is not the Medicare prescription drug proposal I would have preferred and it is not the proposal I have advocated with my constituents for the last few years.

The bill before us would require seniors to pay hefty premiums—premiums that will vary by region, and are likely to be especially burdensome in my State of New Jersey. The bill also won't pay a penny in benefits until seniors pay $275, on top of those premiums. And, even after paying that $275 deductible, the program still will pay only 50 percent of the cost of drugs.

I'm also concerned that the proposal contains what is called a "doughnut hole"—a gap in coverage that will leave seniors with high drug costs paying premiums but not getting coverage for some time. While the Federal Government would pay 50 percent of a beneficiary's drug costs up to $4,500, a beneficiary with drug costs that exceed that level would have to pay all of their drug costs between $4,500 and $5,800. Those Medicare beneficiaries who require drugs that exceed $4,500 are usually the sickest and most vulnerable seniors. And it is wrong to force them to bear these costs on their own, especially considering that they will be paying premiums at the same time. Some have called this the sickness tax.

In addition, the bill fails to provide equal benefits for low-income Medicare beneficiaries who also qualify for Medicaid, the so-called "dual eligibles." These seniors will not be guaranteed the same benefit, and the burden on states will be increased.

When you add up all the limitations and all the costs that will be imposed on seniors, you end up with a benefit that's a far cry from the comprehensive coverage provided under the traditional Medicare program. In fact, most seniors actually will pay into this program more than they receive. That's not what most seniors were expecting. It's not what many of us have been promising. And, as more older Americans appreciate what this bill is really about, more are getting angry about it, and understandably so.

Compounding matters, even the limited benefit provided in this bill will not go into effect until 2006. There is no good excuse for that. I was pleased to cosponsor an amendment offered by my distinguished colleague from New Jersey, Senator LAUTENBERG, to make the benefit effective in July of next year. That would have given the Administration as long as it took to get the entire Medicare program underway back in the 1960's. Unfortunately, the amendment was defeated.

Another concern of mine is that the bill before us could serve to weaken private insurance coverage, and actually might encourage employers to eliminate prescription drug coverage to their retirees. The Congressional Budget Office has estimated that the Grassley-Baucus bill could lead to a 37 percent reduction in employer-sponsored retiree drug benefits. This is largely because under the Grassley-Baucus plan, retirees with employer sponsored prescription drug coverage would not qualify for catastrophic coverage if their employer plan paid for their drug costs.

This is a major disincentive for employers to offer their retirees prescription drug benefits. Today, approximately 12 million seniors have some form of prescription drug coverage through their former employers. By and large, these employer-based drug benefits are more generous than those provided for in this bill. And it is imperative that the final version of this legislation ensure that all prescription drug costs paid by an employer help the beneficiary achieve catastrophic coverage. Without this critical provision, seniors enrolled in retiree health plans may never trigger their Medicare catastrophic drug coverage.

Today I have noted several problems with the substance of this bill, and many of them are quite serious. There are many others. At the same time, it is important to remember that, for all its problems, the bill provides $400 billion to create a critical new public program for our Nation's seniors. It's a start. And for many seniors, especially those with very low incomes, it will be of tremendous help.

Given that, I hope my colleagues will join me in approving the legislation before us and sending it to conference. And then I hope the conferees will listen more closely to the concerns of America's seniors and improve it. If those concerns are heard, and the conferees respond, we could soon witness an historic achievement that makes a huge difference in the lives of millions of America's seniors.

Mrs. CLINTON. Madam President, I have long championed a prescription drug benefit that would provide real prescription drug coverage for seniors and individuals with disabilities. Last year and again during this debate, I voted for proposals that provided a comprehensive, reliable benefit without gaps in coverage that force seniors to pay premiums even while they get no benefits in return.

S. 1, the Grassley-Baucus bill that passed, however, contains serious shortcomings, including these large benefit gaps. So I must reluctantly oppose this legislation unless it is improved.

I am particularly concerned that it poses a strong danger to significant numbers of New Yorkers. It leaves 37 percent of seniors who rely on their retiree drug coverage at risk of losing their employer coverage because of incentives in the bill for employers to drop coverage. It also leaves out 300,000 of New York's nursing home residents who rely on Medicaid and another 230,000 low-income New Yorkers who also rely on Medicaid because Medicare beneficiaries who are also eligible for Medicaid are excluded from receiving the prescription drug benefit that passed last night. These New Yorkers could actually find themselves worse off than they are today if their employers or Medicaid programs drop or reduce coverage.

The provisions excluding those beneficiaries who are dually eligible for Medicare and Medicaid also harms New York State's finances. New York State has effectively been subsidizing the Federal Government for years in the absence of a Federal provision for prescription drug benefits, by paying for the drug costs of these Medicare beneficiaries. But by failing to include dually eligible Medicare beneficiaries in the Medicare prescription drug benefit, this bill continues to leave New York, which is in a precarious State budget situation, to subsidize the Federal Government's lack of adequate investment.

Finally, the bill includes a Grassley-Baucus amendment that starting in 2009 will allow for government subsidization of private plans at levels much higher than the government funding for beneficiaries in traditional Medicare, and would then allow the private plans to offer benefits not available to the 90 percent of seniors in traditional Medicare, which I believe begins to subordinate the goal of health care for seniors to the goal of privatizing Medicare.

While I am pleased that New York's State drug program, EPIC, will still be available under a provision that Senators CORZINE, LAUTENBERG, SCHUMER and I worked hard to include, the other measures I supported to make sure seniors with other sources of coverage were not harmed by this proposal were unfortunately left out of the bill.

For their sake, for the sake of New York's fiscal situation, as well as for the sake of other New York seniors who will be confronted with an unnecessarily complex maze of bureaucracy to navigate in order to access benefits, I felt obliged to oppose the bill. There were some important provisions in the bill, including Senator SCHUMER's amendment that provides greater market competition for generic drugs so that seniors will have a cheaper alternative and don't have to rely on higher priced name-brand drugs.

These positive provisions were not enough, however, for me to vote for the bill unless it is substantially improved. While I believe New York deserves a better bipartisan alternative than the one that passed the Senate yesterday, I hope that those in conference will fight against changes that make the bill even worse for New York, and I will continue fighting this year, as well as in years to come, to correct these deficiencies and actually to deliver on the long-awaited promise of a simple, affordable, comprehensive prescription drug benefit for all seniors.

I request that this statement and a separate document, Governor Pataki's letter dated June 12, 2003, be submitted for the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATE OF NEW YORK,
June 12, 2003.

DEAR NEW YORK CONGRESSIONAL DELEGATION MEMBERS: Prescription drug costs continue to strain the budgets of the nation's senior citizens. I applaud your efforts this year to address this important issue. As you begin consideration of legislation to provide prescription drug coverage to all senior citizens, please consider two issues vitally important to New York State.

First, New York taxpayers continue to support a significant cost for prescription drug coverage for its dual eligible population. The dual eligibles are elderly and disabled individuals who qualify for both the Medicare and Medicaid programs. Medicaid is required to provide medical services not covered by Medicare—including prescription drugs.

More than 600,000 New Yorkers are considered dual eligibles and each year New York's Medicaid program spends nearly $1.5 billion on prescription drugs for the dual eligible population alone. We have always believed that these costs should be borne by the federal government and strongly support efforts to federalize prescription drug costs for the dual eligible population.

In addition, New York administers the nation's largest prescription program for seniors, EPIC. Today, more than 300,000 seniors are enjoying the significant benefits EPIC offers and savings thousands of dollars each on vitally important medicines. Costs for this program exceed $600 million annually in State only dollars. Currently eighteen states have programs similar to New York's to provide prescription drug benefits to senior citizens.

Any federal program created this year to provide prescription drug coverage should recognize state efforts and allow seniors to choose their benefit plan (in New York, that choice would be between EPIC and the federal plan) while providing a direct Medicare subsidy to the state program for individuals that choose that option.

The Federal government has accepted responsibility of providing health care to senior citizens and I strongly urge an expansion to include prescription drug coverage. I applaud President Bush for his leadership on this issue and our Congressional delegation for its commitment to our seniors.

Your efforts on this important legislation could dramatically improve the health of a segment of our population that has given so much to New York's and America's safety and prosperity. We urge you to work with us to ensure that our seniors get the prescription drug coverage they deserve, and that the federal government assumes its rightful role in supporting services for our dual-eligible population.

Very truly yours,
GEORGE E. PATAKI,
Governor.

MEDICARE REIMBURSEMENT OF MAMMOGRAPHY

Ms. MIKULSKI. Madam President, I rise to state for the record my strong support of Senator HARKIN'S amendment to the Medicare prescription drug bill (S. 1) to increase Medicare reimbursement for mammorgrams. I am a proud cosponsor of this amendment. I am pleased that Senator GRASSLEY and Senator BAUCUS agreed to include it in the Medicare prescription drug legislation that passed the Senate earlier today. Americans must have access to mammography because it is an important tool to screen and detect breast cancer.

It is vital for Medicare beneficiaries to have access to mammography. A woman's risk of having breast cancer increases with age. A woman's chance of getting breast cancer is 1 out of 2,212 by age 30. This increases to 1 out of 23 by age 60 and 1 out of 10 by age 80. More than 85 percent of breast cancers occur in women over the age of 50. There will be 70 million Americans aged 65 and over in 2030. At the same time about 700 mammography facilities have closed nationwide over the last 2 years. Adequate reimbursement is essential to help ensure that women have access to this important screening tool. This amendment will increase Medicare reimbursement for mammograms. This amendment is also an important step to help radiologists enter and remain in the field of mammography by providing more adequate reimbursement. Mammography is not perfect, but it is the best tool we have now.

I have long fought to ensure that Medicare beneficiaries have access to mammography. I cosponsored the Assure Access to Mammography Act, S. 869, that would increase Medicare reimbursement for mammograms. It would also increase the number of radiologists by increasing Medicare graduate medical education, GME, to provide three additional radiologists in each teaching hospital. In 1990, I introduced the Medicare Screening Mammography Amendments of 1990 to provide Medicare coverage of annual screening mammography. My legislation was included in the Omnibus Budget Reconciliation Act of 1990. Before that, Medicare did not cover routine annual screening mammograms. Additional legislation since then has expanded access to mammography for Medicare beneficiaries. I will continue to fight to ensure that women have access to quality mammography, and I urge that the final version of the Medicare prescription drug bill include provisions to increase Medicare reimbursement for mammograms.

EDUCATION FUNDING

Mr. KENNEDY. Madam President, there is troubling news on the education front. Yesterday, the Republican majorities on the House and Senate Appropriations Committees approved education budgets filled with harsh cuts that will hurt families, students, schools, and teachers throughout the country.

Unfortunately, the pattern is all too clear. Our Republican colleagues promise strong support for education and quietly break the promise. The bills unveiled yesterday contain a litany of broken promises on education.

Obviously, money is not the answer to all the problems of our schools. But the way we allocate resources in the Federal budget is a clear expression of our Nation's priorities. And the priorities on education reflected in this Republican Appropriations bill are profoundly wrong.

In January 2002, President Bush promised that "America's schools will be on a new path of reform . . . our schools will have greater resources to meet those goals." But yesterday, on a strict party-line vote, our Republican colleagues voted to cut funding for the No Child Left Behind Act by $200 million. We have raised standards and raised expectations on schoolchildren. We intend to hold schools accountable for better performance. Yet now the Republican majority wants to cut funding for school reform.

President Bush promised that we would "leave no child behind," and that became the title of the landmark school reform bill he signed into law a year and a half ago. But yesterday, behind closed doors, our Republican colleagues approved a budget that leaves 6 million children behind. It underfunds the title I program for needy children by over $6 billion. Under the Republican education budget, needy children will not get smaller classes, will not get supplemental services, and will not get special attention in reading and mathematics.

In March last year, President Bush promised to support teachers, making sure they "get the training they need to raise educational standards." But yesterday, Republicans on the Appropriations Committees proposed to cut 20,000 teachers from professional development programs. They proposed to eliminate training for teachers in technology.

We need to upgrade teacher quality, not downgrade teacher training. The No Child Left Behind Act requires schools to give every classroom a high quality teacher. They need more resources, not fewer resources, to reach that goal.

President Bush promised that his administration "will promote policies that expand educational opportunities for Americans from all racial, ethnic, and economic backgrounds." But yesterday, our Republican colleagues approved a budget that cuts 32,000 children from education programs in English as a Second Language. They want to eliminate the Thurgood Marshall Scholarship program. They want a zero increase in Pell grants, a zero increase in campus-based financial aid, and a zero increase in College Work Study.

President Bush promised to increase AmeriCorps by 25,000 volunteers. Two weeks ago, the Administration told us that AmeriCorps programs would be cut by 25,000 volunteers.

Clearly, Federal resources are being limited unfairly because of the massive tax breaks already enacted that benefit the wealthy. If we freeze future tax breaks for the wealthy, we can obtain the resources we need for education.

In the Senate and the House, Senator BYRD and Congressman OBEY have shown impressive leadership on this issue. Instead of providing millionaires with an average tax cut of $88,000 each as the President proposes, they would use the savings to fund the No Child Left Behind Act, invest in teachers, and help students pay for college.

But the Republican majority rejected those amendments. The Republican majority voted to give $88,000 to each millionaire and to cut funds for education. These are the wrong priorities for America, and we are going to oppose them on the Senate floor.

Next week on the Fourth of July, we will all celebrate our Nation's founding values, values whose preservation depends heavily on the quality of education of each generation. As Senators go home to their States for the recess, they should ask constituents whether they give higher priority to tax breaks for millionaires or to education. They should ask their constituents if they value investing in school reform and improvement. They should ask teachers what they think of a cut in the No Child Left Behind budget.

If we intend to hold schools and students accountable, Congress has to be accountable, too.

On this Fourth of July, let's reflect on our history, on the need to keep our promises, and on the importance of building a better future.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Madam President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in New York, NY. On September 12, 2001, a 66-year-old Sikh was savagely attacked by three white teenagers. The man was shot with a pellet gun and chased down by the teens who battered him with a baseball bat. The victim was hospitalized with head, back and wrist injuries.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

HILARY B. ROSEN, PRESIDENT AND CEO OF THE RECORDING INDUSTRY ASSOCIATION OF AMERICA

Mr. LEAHY. Madam President, I come to the floor today to offer congratulations and heartfelt appreciation for the exceptional work of Hilary Rosen, Chair and CEO of the Recording Industry Association of America. Hilary will step down at the end of this year, after 17 years with the RIAA. She leaves a legacy of remarkable efforts to ensure that innovations are protected while finding legitimate new venues in the Digital Age. She has accomplished a great deal while at the same time ushering the organization, and the music industry, through extremely trying years.

After matriculating at George Washington University and earning a Bachelor of Arts in International Business, Hilary devoted her energies to working for a former Governor of New Jersey in addition to two senatorial transition teams, those of my distinguished colleague and former colleague, DIANNE FEINSTEIN and Bill Bradley. She was an accomplished advocate and began her own consulting firm in 1987. Hilary's hard work and talent were rewarded in 1998 when she assumed the position of Chair and CEO at the RIAA.

She has represented the music industry with both tenacity and good humor. While the Internet has ushered in a new era of information and communication capabilities, we are now well aware of the dangers posed by this innovation. These dangers take many forms: the security issues that result when we have achieved so much interconnectedness, the proliferation of child pornography that seeks to exploit society's most vulnerable, and of course the threat posed to copyright holders by those who distribute, for free, the work products of artists. Hilary has made genuine headway, sometimes single-handedly, in harnessing the power of the Internet to further the goals of the music industry while helping in the fight against the worst abuses of technology.

But her political activities extend well beyond the boundaries of the organization she leads. She was a founding member of Rock the Vote, a group which has successfully sought to reach out to younger Americans, imbuing those coming of age with the belief that they can have a positive impact on our political processes. And she sits on numerous not-for-profit boards including the Human Rights Campaign

Foundation, Y.E.S. to Jobs, and the National Cancer Foundation. Looking at the list of groups she is involved with, the variety of causes she champions rivals the diversity of artists and labels she represents.

We know that her partner, Elizabeth Birch, and their twins, Jacob and Anna, will enjoy having more time with Hilary. If past experience is a predictor of future performance, she will shine in whatever endeavor she next chooses.

SUPREME COURT NOMINATIONS

Mr. KENNEDY. Madam President, in considering potential nominees for a possible vacancy on the Supreme Court, I hope President Bush will consider the example of earlier Presidents who followed both the letter and the spirit of the Constitution, and fully respected the role the Framers gave the Senate to share with the President.

The Framers originally rejected a proposal that the President alone appoint judges, and they seriously considered allowing the Senate to exercise that responsibility alone. In the end, they decided to make that responsibility a shared function of the President and the Senate, through the "advice and consent" mechanism.

There is nothing "novel" or extra-constitutional about Presidents consulting in advance with the Senate before nominating a person to a lifetime position on the Supreme Court. George Washington wanted the Senate to be his own "privy council" and refused to do so, but for the past century many Presidents have taken the opposite course. They have decided not only that such consultation was fully consistent with the Framers' system of checks and balances, but also that their concern for achieving a consensus in the selection of strong and independent Justices could be best achieved by consulting in advance with the Senate.

Presidents who did so often achieved broad Senate and national support for their nominees, avoided divisive and unnecessary battles, and prevented embarrassing rejections of their selections.

President Theodore Roosevelt frequently consulted with Senators before making Supreme Court nominations, including the 1902 nomination of Oliver Wendell Holmes, Jr., who was confirmed the day he was nominated.

In 1932, President Herbert Hoover presented his list of possible nominees to Senator William Borah, a fellow Republican. Benjamin Cardozo, a Democrat, was at the bottom of the President's list, but Senator Borah persuaded the President to nominate Cardozo, who was confirmed nine days after his nomination was sent to the Senate.

President Franklin Roosevelt also shred his list of potential nominees with Senator Borah in advance. Senator Borah expressed his enthusiastic support for William O. Douglas, who was quickly confirmed by a vote of 62–4.

In 1975 President Gerald Ford shared his list of 11 prospective nominees with both the Senate and the American Bar Association. Although there was support for others on the list, his choice, John Paul Stevens, was confirmed in three weeks by a vote of 98–0.

President Bill Clinton consulted with Senators from both parties on each of his two Supreme Court nominees. Senator Dole, Senator HATCH, and others advised him that his favored candidate would be controversial, and supported the nomination of Ruth Bader Ginsburg. Later, Senators from both parties, including Senator HATCH, recommended Stephen Breyer. Both Ginsburg and Breyer were quickly and overwhelmingly confirmed.

Nominations which generated the most controversy were those which had little or no consultation with the Senate, or where the President ignored advice of the Senate.

President Richard Nixon sought little or no direct advice from Senators who were not friends and supporters of his prospective nominees. He suffered two consecutive defeats, and the opponents included members and party leaders of the President's own party.

President Ronald Reagan's Chief of Staff, former Senator Howard Baker, consulted with leading Senate Democrats, and received strong advice that Robert Bork would have substantial opposition. Bork was nominated nevertheless, and was defeated by a vote of 58–42.

There is no down-side to serious consultation with the Senate. If a well-known prospective nominee has significant bipartisan support, the President will know in advance that he is likely to achieve prompt confirmation of the nominee, without a divisive debate in the Senate that would also be divisive for the country. The selection of a Supreme Court Justice with broad national support would help bring the country together at a time when we are facing many difficult challenges, and I hope very much that the Members of the Senate can work closely with the President and with one another to achieve that goal.

IN REMEMBRANCE OF STROM THURMOND

Mr. HOLLINGS. Madam President, last night with the passing of our revered colleague, Senator Strom Thurmond, I indicated I would have a longer recount of his work. The Nation has lost one of its most distinguished and longest-serving public servants, my State has lost its greatest living legend, and I would like to add to my comments.

By any measure, Senator Thurmond ranks as a giant of modern American politics. Few people in recent memory have had greater influence on the shape and substance of American politics, and few elected officials have shown themselves more devoted to serving the people of their State and nation. There was no more hard-working politician in America than Senator Thurmond. Right up to the day he retired from the Senate, he remained devoted to his constituents.

Of course, any discussion of Senator Thurmond's political and legislative legacy ultimately turns to a discussion of Senator Thurmond the man. He was one of the most amazing men anyone in this Chamber ever has met. He was what we attorneys call "sui generis." When God made Strom, He broke the mold for sure. Merely listing all of Senator Thurmond's "firsts" conveys the prodigious energies and talents of the man.

In 1929, he began his political career by becoming the youngest person ever elected Superintendent of Education in Edgefield County, South Carolina. He entered state-wide politics in 1933, when he was elected to the State Senate. As a South Carolina Senator, he was known for his devotion to improving public education and promoting opportunities for the people of my State. His concern for the common man motivated many of his legislative efforts, such as writing the act that raised workers' compensation benefits and sponsoring South Carolina's first Rural Electrification Act. Although these efforts may seem far removed from our concerns today, they were crucial to my State at the time.

He left the Senate in 1938 to become Judge Thurmond. Continuing his lifelong love affair with politics and public service, he served as a South Carolina Circuit Judge until the United States entered the Second World War in 1941. Then Judge Thurmond took off his robe and volunteered for active duty. He enlisted despite the fact that, as a 39-year-old Circuit Judge, he was exempt from military service.

He fought in five battles in 4 years, and on D-Day, he rode a glider into Normandy with the 82nd Airborne. For his wartime service, Senator Thurmond was awarded 18 decorations, including the Purple Heart, Bronze Star for Valor, and Legion of Merit with Oak Leaf Cluster. He remained in the Army Reserves after the War and was made Major General in 1959.

After the war, he came home and ran for Governor. He was elected in 1947, and his administration was known for its progressive policies on education and infrastructure. During his tenure, 60,000 new jobs were created in the private sector, teacher pay was boosted to unprecedented levels, and the State Farmers' Market was begun. These initiatives helped start South Carolina on the road to a dynamic, modern economy.

In 1948, Governor Thurmond ran for President on the States' Rights ticket. In 1954, he became the first person ever elected to the Senate as a write-in candidate. That election established him as a force in national politics and a giant in South Carolina.

He was reelected to the Senate eight times, more than any Senator. When he left in January, he was the oldest and longest-serving Senator in U.S. history. He served as chairman of two powerful committees: Judiciary and Armed Services. In those capacities, he played an important role in keeping our national defense strong and ensuring the quality of our Federal judiciary.

He took controversial stands on civil rights and other divisive issues, but over time he changed and ended up garnering the support of many of those whom he opposed. He will go down in history for his devotion to his constituents.

Senator Thurmond also changed the course of politics in the South. His conversion to the Republican party in 1964 heralded a new age in party affiliation in the South and led the way for the region's transformation from a one-party, Democratic stronghold.

Senator Thurmond is gone, but his legacy will live on for many lifetimes. The people of South Carolina loved him as they have loved no other politician. Today his loss is mourned across my state, by Democrats and Republicans alike. Those of us who have the privilege of serving in the Senate lament the loss of an admired colleague whose influence on this institution will stand for generations.

Mr. HATCH. Madam President, I want to take a minute to say a few words in honor of Strom Thurmond, our friend and former colleague, who has passed away.

From the moment Strom Thurmond set foot in this Chamber in 1954, he has been setting records. He was the only person ever elected to the U.S. Senate on a write-in-vote. He set the record for the longest speech on the Senate floor, clocked at an astounding 24 hours and 18 minutes. He was the longest-serving Senator in the history of the U.S. Senate. He was also the oldest serving Senator. Many of my colleagues will recall the momentous occasion in September of 1998 when he cast his 15,000th vote in the Senate. With these and so many other accomplishments over the years, he has appropriately been referred to as "an institution within an institution."

In 1902, the year Strom Thurmond was born, life expectancy was 51 years—and today it is 77 years. Strom continued to prove that, by any measure, he was anything but average.

He was so much in his life. To provide some context, let me point out that during his lifetime, Oklahoma, New Mexico, Arizona, Alaska and Hawaii gained Statehood, and 11 amendments were added to the Constitution. The technological advancements he witnessed, from the automobile to the airplane to the Internet, literally spanned a century of progress. Conveniences we have come to take for granted today were not always part of Strom Thurmond's world. Perhaps this explains why, during Judiciary Committee hearings, he was often heard asking witnesses who were too far away from the microphone to "please speak into the machine."

The story of his remarkable political career truly could fill several volumes. It began with a win in 1928 for the Edgefield County Superintendent of Schools. Eighteen years later, he was Governor of South Carolina. Strom was even a Presidential candidate in 1948, running on the "Dixiecrat" ticket against Democrat Harry Truman.

I must admit that he came a long way in his political career, given that he originally came to the Senate as a Democrat. I was happy to say that wisdom came within a few short years when Strom saw the light and joined the Republican Party.

When I first arrived in the Senate in January of 1977, he was my mentor. As my senior on the Judiciary Committee, it was Strom Thurmond who helped me find my way and learn how the committee functioned. He was not only a respected colleague, but a personal friend.

During his tenure as chairman of the Judiciary Committee, Strom Thurmond left an indelible mark on the committee and the laws that came through it. He became known and respected for many fine qualifies and positions—his devotion to the Constitution, his toughness on crime, his sense of fairness.

He was famous for his incredible grip. Many of us in this Chamber had the experience of Strom Thurmond holding our arm tightly as he explained a viewpoint and asked for our support. I might add that this proved to be a very effective approach.

Strom was also known to have a kind word or greeting for everyone who came his way, and for being extremely good to his staff. Despite his power and influence, he never forgot the importance of small acts of kindness. For example, whenever he ate in the Senate Dining Room, he grabbed two fistfuls of candy. When he returned to the floor of the Senate, he handed the candy out to the Senate Pages. Unfortunately, it was usually melted into a kaleidoscope of sugar by then! I have a feeling that the Pages preferred it when Strom took them out for ice cream.

Strom Thurmond was truly a legend—someone to whom the people of South Carolina owe an enormous debt of gratitude for all his years of service. Clearly, the people of South Carolina recognize the sacrifices he made and are grateful for all he did for them. In fact, you cannot mention the name Strom Thurmond in South Carolina without the audience bursting into spontaneous applause. He truly was an American political icon.

Abraham Lincoln once said that "The better part of one's life consists of friendships." With a friend like Strom Thurmond, this sentiment couldn't be more true. I am a great admirer of Strom Thurmond, and I am proud to have called him my friend.

One final note about Strom Thurmond: He was a great patriot. A decorated veteran of World War II who fought at Normandy on D-Day, Strom Thurmond loved this country. Let me close by saying that this country loved him, too.

Mr. LEVIN. Madam President, this is a sad day for the family of our late and beloved colleague, Strom Thurmond. I want to begin my remarks by extending my and Barbara's heartfelt condolences to all of them for their great loss. It is also, though, a day for all Americans, and most especially those of us in the Senate community, to remember a man who spent a lifetime—in fact more than the average lifetime—in dedicated public service to this nation.

When I joined the Armed Services Committee in 1979, Senator Thurmond had already served on the committee for 20 years. I knew of him as a passionate and effective advocate for a strong national defense even before I joined the committee. In the 24 years that we served on the committee together, I came to appreciate even more his commitment to the welfare of the men and women who serve and who have served in our nation's military, as well as their families.

One of the reasons Senator Thurmond was such an effective leader on national security issues is that he spoke from his heart and from personal experience. He served his country in uniform for 36 years. He was commissioned in the Army Reserve even before he began his remarkable career in politics. He retired as a Major General in the Army Reserves.

In June 1944, Lt. Col. Strom Thurmond landed behind German lines in a glider with the rest of the 82d Airborne Division as part of the D-Day invasion. He truly was a member of what Tom Brokaw called "the greatest generation."

During Senator Thurmond's long tenure on the Armed Services Committee, our Armed Forces faced challenge after challenge in Western Europe, Vietnam, the Middle East, the Persian Gulf, the Balkans, and Afghanistan. Through it all, Senator Thurmond was unwavering in his support for our men and women in uniform. His steadfast commitment to our national defense was a rock upon which they and we could all depend. He never stopped working to ensure that our military is always ready to answer the call whenever and wherever needed.

Senator Thurmond served as chairman of the Senate Armed Services Committee in the 104th and 105th Congresses. I had the honor and pleasure to serve as his ranking member in 1997 and 1998. I know from personal experience how seriously Senator Thurmond treated his duties as chairman and how hard he worked to be fair and evenhanded with every member of the committee. Our former colleague and chairman, Senator Sam Nunn, was right when he said that there was not a single national security issue facing this country that has been or could be solved by one political party. That legacy of bipartisanship on the Armed Services Committee was continued under the chairmanship of Strom Thurmond. I am sure that I speak for all of our colleagues in saying just how much we appreciate not only the commitment that Senator Thurmond brought to his duties as chairman, but also his lifelong dedication to the defense of our Nation and to the welfare of those who defend us.

In my 24 years of service with Strom Thurmond, I never knew him to be anything other than unfailingly optimistic, always courteous, and everthoughtful of his Senate colleagues and their families. I cannot say how many times he gave me and all my colleagues advice on exercise, on diet, and on taking care of ourselves and our families in general. I wish I had followed his advice more often because it was always given out of his true concern as a friend. Strom himself was a marvelous specimen of physical fitness. One need only receive a handshake or a shoulder slap from Strom Thurmond to fully appreciate his strength and stamina.

Sadly Strom Thurmond has left this Earth and we will always miss him. I hope his family takes comfort in knowing, though, that he leaves an example of dedicated public service that will stand as a inspiration for generations to come.

Mr. COCHRAN. Madam President, we are deeply saddened by the death of our former colleague, Strom Thurmond. He was a beloved friend, always gracious, and affectionate.

His service in the Senate was distinctive not only because he served so many years but because of his love for his job and his dedication to serving the interests of the people of South Carolina.

He was determined to make his influence felt in the committees and on the floor. He took an active part in the debates even on the most controversial issues.

His 24 hour speech on the Civil Rights Act was a record-setting event. He also was a fervent and effective supporter of our military forces and the veterans who had risked their lives in military service to our Nation.

I will always count it as one of my richest blessings that I got to know Strom Thurmond and the members of his family. My hope is that Nancy and their children will be comforted by the warmth and sincerity of the esteem and affection in which the Thurmond family will always be held by their many close friends in the Senate family.

Mr. DODD. Mr. President, I rise to pay tribute to my colleague and dear friend, Senator Strom Thurmond, who passed away last night at the age of 100.

A few months ago, as he was about to retire from the United States Senate, I said on this floor that I could not even begin to imagine the Senate without Senator Thurmond. And since he left this Chamber, I can't tell you how many times, during a vote, when the clerk would reach the lower half of the alphabet, I've looked up from wherever I was on the floor—expecting to see the man who was, for so long, South Carolina's senior Senator.

He was truly an institution within this Chamber—a ranking Member, a committee chairman, a President pro tempore, and the first ever President pro tempore emeritus. He cast over 15,000 votes. His service spanned the terms of 10 U.S. Presidents. And he was directly involved in the confirmation hearings of all nine current Supreme Court Justices.

Strom Thurmond's life was one devoted to public service. He was a teacher, a school superintendent, a State Senator, a judge, a war hero, Governor, and, of course, a Senator for nearly 50 years.

At each step in his life, Strom Thurmond was searching for ways to serve his country. As a circuit judge in South Carolina, he took a leave of absence to volunteer to parachute behind enemy lines during the D-Day invasion at Normandy. For his valor in World War II, he received the Purple Heart, five Battle Stars for Bravery and numerous other decorations. And shortly after the war ended, he was elected Governor of South Carolina, an office he held for 4 years.

But there is no doubt that when his constituents remember Strom Thurmond, their thoughts will immediately turn to his years as their Senator. He served them in this body for over one-fifth of our Nation's history. For many South Carolinians, when he retired earlier this year, he was the only senior Senator they had ever known.

Strom Thurmond did not merely serve in the Senate; he did so, even during his final years, with unparalleled vigor. His commitment to the people of South Carolina was legendary—whether it was helping an elderly constituent get a Social Security check, or ensuring that the widow of a law enforcement officer could keep her husband's badge, Strom Thurmond never forgot the people who sent him to Washington.

And the dozens of schools, buildings, parks, and streets in South Carolina that bear his name today show that they never forgot him either.

I served with Strom Thurmond for 22 years in the Senate, and my father served with him for 12—that's 34 years in which a Dodd served in this body with Senator Thurmond. Both of us certainly had our share of disagreements with him. But those disagreements always came in the spirit of respect, thoughtfulness, and collegiality that are hallmarks of the Senate. And Strom Thurmond truly embodied those qualities.

To the Dodd family, though, Strom Thurmond was more than just a colleague—he was a true and loyal friend. We will never forget the loyalty and friendship he showed us even during some trying and difficult times.

It is impossible to look back at the years of Strom Thurmond's life without being amazed. He lived through the invention of the Model T Ford and the creation of the Internet. As a child, he read newspaper accounts of battles that were fought with bayonets in the trenches of Europe. And in his later years, he watched satellite television reports of conflicts won with smart bombs and laser technology. He experienced the Great Depression of the 1930s and the technology bubble of the 1990s.

And as America matured and changed during his lifetime, Strom Thurmond grew, as well.

Senator Thurmond didn't just live through a century of history. He was intimately involved in it. In each step that America took, Strom Thurmond was there. In that respect, and in so many others, Strom Thurmond was a truly unique and rare individual.

I offer my condolences to the entire family of Strom Thurmond. We will miss him very much.

Mr. CRAIG. Madam President, a constant of the universe has changed. Strom Thurmond is no longer with us. We mourn because this world is poorer for his passing, but we also know he smiles down upon us from a better, happier place.

True to the creed taught him by his father, Strom always gave of himself, to his family, his beloved state of South Carolina, and to his country. He understood that the essence of leading is serving.

Strom changed his times and changed with his times. Born during the administration of Theodore Roosevelt, he retired a thoroughly modern Senator.

He wanted to be history's first 100-year-old Senator. Through faith and force of will, he made it. Even more happily, he wanted to see the birth of his first grandchild, and he did, just recently.

Like many great persons, Strom combined changeless values with an amazing ability to adapt in a changing world. In turns, he was a liberal and a conservative; a Democrat, Independent, and Republican; a famous bachelor, widower, husband, father, and now grandfather. He came to the Senate from what they call the "Old South," but when I came to Congress, I saw in Strom a Senator committed to equal opportunity and inclusiveness. He was young at heart, had a sense of fun and adventure, and was always open to new ideas. This is the way Strom should be remembered, as an example of how the human spirit can grow and mature gracefully.

Yet, for all the changes, Strom's constituents were reassured by a sense of his being changeless. What never changed was a foundation of timeless values. He was devoted to faith, family, patriotism, integrity, public service, hard work, and compassion for everyday people.

Only in recent years, did Strom and I discover from a genealogy website that we were distant cousins. After that, we enjoyed greeting each other with, "Hi, Cousin!"

Today, I say, "Farewell for now, Cousin. Your life has honored and inspired your family, friends, and Nation."

ADDITIONAL STATEMENTS

ON THE 100TH ANNIVERSARY OF SAN PEDRO HIGH SCHOOL

• Mrs. BOXER. Mr. President, I rise to reflect on the proud history of San Pedro High School, which is celebrating its centennial this year. The school has grown considerably since 1904, when the San Pedro community honored its first graduating class at a ceremony at the town hall building. Maude Wayne was the only member of that class, and also served as student body president for the school's other 22 students.

When San Pedro High School first opened, students were taught in a single room on the second floor of 16th Street Elementary School. Today's campus has existed since 1937, educating athletes Garry Maddox and Alan Ashby, and astronaut Anna Fisher.

San Pedro High School is a fixture in the community, filled with many fond memories. Many alumni have lived in the San Pedro community all their lives, and take pride in the school that educated them, their children and their children's children. San Pedro Pirates young and old have attended many anniversary celebrations and have enjoyed exchanging stories about their high school years. San Pedro High truly plays a significant role in the community.

I would like to extend my congratulations to principal Stephen Walters and all the past principals, as well as current and past teachers, administrators, and students. They have all been a part of the school's success over the years. This is a proud moment for them and for the entire community, and I thank them all for making San Pedro High the best it could be.•

TRIBUTE TO DOCTOR A. MICHAEL ANDREWS II

• Mr. INHOFE. Mr. President, I rise to pay tribute today to an outstanding American for his significant, lasting contributions to the soldiers of the United States Army.

On June 23, 2003, Dr. A. Michael Andrews II, the Deputy Assistant Secretary of the Army for Research and Technology/Chief Scientist, returned to the private sector after over six and a half years of selfless service to the Army and the Nation. Mike hails from the great state of Oklahoma, and received his B.S. and M.S. in Electrical Engineering from the University of Oklahoma. In 1971, he received his Ph.D. in Electrical Engineering from the University of Illinois.

Following a stellar 25-year career as a senior engineer and senior executive at Rockwell International Corporation, Mike came to the Pentagon in January 1997 as the Director for Technology in the Office of the Assistant Secretary of the Army for Research, Development and Acquisition.

His exemplary performance as Director of Technology led to Mike's appointment as the Deputy Assistant Secretary of the Army for Research and Technology/Chief Scientist, DAS, R&T, in November 1998. As DAS, R&T, Mike was responsible for the Army's entire Research and Technology program, spanning 21 Laboratories and Research, Development and Engineering Centers, with approximately 10,000 scientists and engineers and a budget that, under his leadership, grew over 30 percent to reach $1.8 billion in Fiscal Year 2004.

In October 1999, the Army Secretary and the Chief of Staff of the Army announced their Vision for transforming the Army to an Objective Force—a force that is rapidly deployable and can operate in both large-scale wars and urban peacekeeping operations. It was clear that the Army's Science and Technology, S&T, program was the cornerstone to achieving their vision of a full spectrum force within this decade. Mike took bold steps to shift the focus of the Army's technology by judiciously refocusing and redirecting the Army's $10 billion plus S&T investments over 2000–2007 towards developing and demonstrating Objective Force technologies.

Understanding the importance of Congressional support for the Army S&T program, Mike consistently worked to develop better communications with Members of Congress and Congressional Staff. These efforts resulted in Congress providing over 98 percent of the requested Army S&T program funding over the last five Fiscal Years and 100 percent, thus far, for Fiscal Year 2004.

In addition to his pursuit of achieving a lighter, more lethal Army, Mike also initiated a unique partnership with the private sector to link the Army and the entertainment industry to establish unique training environments for our soldiers. By leveraging significant entertainment industry investments and capabilities in modeling and simulations, e.g., electronic games, theme parks and digital movies, and existing Army efforts, Mike established a university-based center called the Institute for Creative Technologies. The Institute provides an environment for shared investment and joint projects to enhance Army training. The Institute has expanded beyond Hollywood to the Army's Field Artillery Center and School at Fort Sill, OK, where its significant simulation and modeling capabilities can be brought directly to soldiers undergoing basic and advanced Field Artillery training.

Finally, Mike was also the driving force in launching the Cybermission program, a personal initiative of Chief of Staff of the Army CSA, General Eric K. Shinseki. This program raised the visibility of the Army's commitment in the education of America's youth in science, math and technology among 7th-8th grade students across America. ECybermission introduces young Americans and potentially future soldiers to the Army and the theme of Service to Our Nation while supporting the President's commitment to education.

Mike was honored with the Presidential Rank Award in 2001, elected as a Fellow of the Institute of Electrical and Electronic Engineering in 2001, and presented the National Defense Industry Association Firepower Award in 2000.

In this short space, it is difficult to fully document the many significant, positive ways that Mike has shaped the future of the Army. Through his tireless attention to detail and personal involvement, Mike has shepherded the FCS program through the past five years and has brought attention and credit to the Army's S&T community for the outstanding achievements that they have made. Mike Andrews' effective work with senior Army and DoD staff principals, scientists and engineers, and industry significantly enhanced the Army's efforts toward the development of the Future Combat Systems, Objective Force, and Transformation. He demonstrated visionary leadership, planning and organizational skills throughout his tenure. As we honor him, we note that this institution and our country is better off for the major contributions he has made. We wish him all the best in his future endeavors.●

MESSAGE FROM THE HOUSE

At 10:18 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2417. An act to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 231. Concurrent resolution providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate.

ENROLLED BILLS SIGNED

The message further announced that the Speaker has signed the following enrolled bills:

H.R. 1596. An act to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the "Timothy Michael Gaffney Post Office Building".

S. 858. An act to extend the Abraham Lincoln Bicentennial Commission, and for other purposes.

H.R. 2030. An act to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building".

H.R. 1740. An act to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the "Dr. Caesar A.W. Clark, Sr. Post Office Building".

H.R. 925. An act to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the "Caesar Chavez Post Office".

H.R. 917. An act to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the "Floyd Spence Post Office Building".

H.R. 825. An act to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the "Michael J. Healy Post Office Building".

H.R. 1609. An act to redesignate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the "Admiral Donald Davis Post Office Building".

H.R. 981. An act to designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the "James R. Merry Post Office".

H.R. 985. An act to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the "Delbert L. Latta Post Office Building".

H.R. 1055. An act to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the "Dr. Roswell N. Beck Post Office Building".

H.R. 1368. An act to designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the "Normal D. Shumway Post Office Building".

H.R. 1465. An act to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the "General Charles Gabriel Post Office".

The enrolled bills were subsequently signed by the President pro tempore (Mr. Stevens).

MEASURES PLACED ON THE CALENDAR

The following bill was read the second time, and placed on the calendar:

S. 11. A bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

The following bill was read the first and second times by unanimous consent, and placed on the calendar:

H.R. 2417. An act to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. CAMPBELL, from the Committee on Indian Affairs, with an amendment in the nature of a substitute:

S. 344. A bill expressing the policy of the United States regarding the United States relationship with Native Hawaiians and to provide a process for the recognition by the United States of the Native Hawaiian governing entity, and for other purposes (Rept. No. 108–85).

By Mr. LUGAR, from the Committee on Foreign Relations, without amendment and with an amended preamble:

S. Res. 90. A resolution expressing the sense of the Senate that the Senate strongly supports the nonproliferation programs of the United States.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. LEVIN (for himself, Mr. Warner, Mr. Biden, Mr. Hollings, Mr. Bingaman, Ms. Stabenow, Mr. Kennedy, Mr. Lautenberg, Mr. Pryor, Ms. Landrieu, Mrs. Clinton, Ms. Mikulski, Mr. Durbin, Mr. Dodd, Mr. Lieberman, Mr. Corzine, Mr. Miller, Mr. Kerry, and Mr. Jeffords):

S. 1368. A bill to authorize the President to award a gold metal on behalf of the Congress to Reverend Doctor Martin Luther King, Jr. (posthumously) and his widow Coretta Scott King in recognition of their contributions to the Nation on behalf of the civil rights movement; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. AKAKA (for himself, Mr. Warner, Mr. Allen, Mr. Sarbanes, and Ms. Mikulski):

S. 1369. A bill to ensure that prescription drug benefits offered to medicare eligible enrollees in the Federal Employees Health Benefits Program are at least equal to the actuarial value of the prescription drug benefits offered to enrollees under the plan generally; to the Committee on Governmental Affairs.

By Mr. BROWNBACK (for himself and Mr. Kyl):

S.J. Res. 14. A joint resolution expressing support for freedom in Hong Kong; to the Committee on Foreign Relations.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. FRIST (for himself, Mr. Daschle, Mr. Graham of South Carolina, Mr. Hollings, Mr. Stevens, Mr. Byrd, Mr. McConnell, Mr. Reid, Mr. Akaka, Mr. Alexander, Mr. Allard, Mr. Allen, Mr. Baucus, Mr. Bayh, Mr. Bennett, Mr. Biden, Mr. Bingaman, Mr. Bond, Mrs. Boxer, Mr. Breaux, Mr. Brownback, Mr. Bunning, Mr. Burns, Mr. Campbell, Ms. Cantwell, Mr. Carper, Mr. Chafee, Mr. Chambliss, Mrs. Clinton, Mr. Cochran, Mr. Coleman, Ms. Collins, Mr. Conrad, Mr. Cornyn, Mr. Corzine, Mr. Craig, Mr. Crapo, Mr. Dayton, Mr. DeWine, Mr. Dodd, Mrs. Dole, Mr. Domenici, Mr. Dorgan, Mr. Durbin, Mr. Edwards, Mr. Ensign, Mr. Enzi, Mr. Feingold, Mrs. Feinstein, Mr. Fitzgerald, Mr. Graham of Florida, Mr. Grassley, Mr. Gregg, Mr. Hagel, Mr. Harkin, Mr. Hatch, Mrs. Hutchison, Mr. Inhofe, Mr. Inouye, Mr. Jeffords, Mr. Johnson, Mr. Kennedy, Mr. Kerry, Mr. Kohl, Mr. Kyl, Ms. Landrieu, Mr. Lautenberg, Mr. Leahy, Mr. Levin, Mr. Lieberman, Mrs. Lincoln, Mr. Lott, Mr. Lugar, Mr. McCain, Ms. Mikulski, Mr. Miller, Ms. Murkowski, Mrs. Murray, Mr. Nelson of Florida, Mr. Nelson of Nebraska, Mr. Nickles, Mr. Pryor, Mr. Reed, Mr. Roberts, Mr. Rockefeller, Mr. Santorum, Mr. Sarbanes, Mr. Schumer, Mr. Sessions, Mr. Shelby, Mr. Smith, Ms. Snowe, Mr. Specter, Ms. Stabenow, Mr. Sununu, Mr. Talent, Mr. Thomas, Mr. Voinovich, Mr. Warner, and Mr. Wyden):

S. Res. 191. A resolution relative to the death of the Honorable J. Strom Thurmond, former United States Senator and President Pro Tempore Emeritus from the State of South Carolina; considered and agreed to.

ADDITIONAL COSPONSORS

S. 271

At the request of Mr. Smith, the name of the Senator from Massachusetts (Mr. Kerry) was added as a cosponsor of S. 271, a bill to amend the

Internal Revenue Code of 1986 to allow an additional advance refunding of bonds originally issued to finance governmental facilities used for essential governmental functions.

S. 377

At the request of Ms. LANDRIEU, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 377, a bill to require the Secretary of the Treasury to mint coins in commemoration of the contributions of Dr. Martin Luther King, Jr., to the United States.

S. 464

At the request of Mr. REID, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 464, a bill to amend the Internal Revenue Code of 1986 to modify and expand the credit for electricity produced from renewable resources and waste products, and for other purposes.

S. 595

At the request of Mr. HATCH, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 595, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financings to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 623

At the request of Mr. WARNER, the name of the Senator from Arizona (Mr. MCCAIN) was added as a cosponsor of S. 623, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 678

At the request of Mr. AKAKA, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 678, a bill to amend chapter 10 of title 39, United States Code, to include postmasters and postmasters organizations in the process for the development and planning of certain policies, schedules, and programs, and for other purposes.

S. 724

At the request of Mr. ENZI, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 724, a bill to amend title 18, United States Code, to exempt certain rocket propellants from prohibitions under that title on explosive materials.

S. 894

At the request of Mr. WARNER, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 894, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 230th Anniversary of the United States Marine Corps, and to support construction of the Marine Corps Heritage Center.

S. 976

At the request of Mr. WARNER, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 976, a bill to provide for the issuance of a coin to commemorate the 400th anniversary of the Jamestown settlement.

S. 982

At the request of Mr. SANTORUM, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 1011

At the request of Mr. KERRY, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 1011, a bill to amend title II of the Social Security Act to restrict the application of the windfall elimination provision to individuals whose combined monthly income from benefits under such title and other monthly periodic payments exceeds $2,000 and to provide for a graduated implementation of such provision on amounts above such $2,000 amount.

S. 1015

At the request of Mr. GREGG, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1015, a bill to authorize grants through the Centers for Disease Control and Prevention for mosquito control programs to prevent mosquito-borne diseases, and for other purposes.

S. 1046

At the request of Mr. DASCHLE, his name was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1064

At the request of Mr. BREAUX, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1064, a bill to establish a commission to commemorate the sesquicentennial of the American Civil War, and for other purposes.

S. 1082

At the request of Mr. BROWNBACK, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 1082, a bill to provide support for democracy in Iran.

S. 1172

At the request of Mr. FRIST, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 1172, a bill to establish grants to provide health services for improved nutrition, increased physical activity, obesity prevention, and for other purposes.

S. 1316

At the request of Mr. BROWNBACK, the names of the Senator from Indiana (Mr. LUGAR) and the Senator from Missouri (Mr. TALENT) were added as cosponsors of S. 1316, a bill to treat payments under the Conservation Reserve Program as rentals from real estate.

S. RES. 169

At the request of Mrs. CLINTON, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. Res. 169, a resolution expressing the sense of the Senate that the United States Postal Service should issue a postage stamp commemorating Anne Frank.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LEVIN (for himself, Mr. WARNER, Mr. BIDEN, Mr. HOLLINGS, Mr. BINGAMAN, Ms. STABENOW, Mr. KENNEDY, Mr. LAUTENBERG, Mr. PRYOR, Ms. LANDRIEU, Mrs. CLINTON, Ms. MIKULSKI, Mr. DURBIN, Mr. DODD, Mr. LIEBERMAN, Mr. CORZINE, Mr. MILLER, Mr. KERRY, and Mr. JEFFORDS):

S. 1368. A bill to authorize the President to award a gold medal on behalf of the Congress to Reverend Doctor Martin Luther King, Jr. (posthumously) and his widow Coretta Scott King in recognition of their contributions to the Nation on behalf of the civil rights movement; to the Committee on Banking, Housing, and Urban Affairs.

Mr. LEVIN. Madam President, joined by a number of my colleagues in the Senate, I am today introducing legislation, S. 1368, that will authorize the President to award a Congressional Gold Medal to Reverend Doctor Martin Luther King, Jr., posthumously, and his widow, Coretta Scott King, in recognition of their countless contributions to the Nation as leaders of the civil rights movement. A companion bill is being introduced in the House by Congressman JOHN LEWIS of Georgia. This medal is one small way for Congress to recognize and honor this couple's distinguished record of public service, sacrifice, and commitment to protect the dignity of a people and awaken the conscience of a country.

Dr. King embraced all Americans in his quest to make a living reality of equality of opportunity and economic and social justice for all humankind, those fundamental principles in our Constitution. The vision of equality which guided his life and contributed to his death is indelibly woven into the fabric and history of our Nation. This medal will pay tribute to Dr. King's many great accomplishments: from his courageous application of the doctrine of nonviolent civil disobedience to combat segregation to his leadership in the Montgomery bus boycott, from his efforts on behalf of 1964 Civil Rights Act and 1965 Voting Rights Act to his soaring speeches that inspired a nation to action. For these and for all his other contributions, Dr. King deserves our highest honor.

Mrs. Coretta Scott King joined her husband in his lifework and has continued his legacy to this day. Like Dr. King, Mrs. King was a leader in our country's civil rights movement, striving through nonviolent means to promote social change and attain full civil rights for African-Americans and other discriminated people. Mrs. King worked to preserve Dr. King's memory and ideals by, among other things, developing and building the Martin Luther King, Jr. Center for Nonviolent Social Change in Atlanta, establishing the "Freedom Concerts" organization to increase awareness of the Southern Christian Leadership Conference, and leading a campaign to recognize Dr. King's birthday as a national holiday. Mrs. King's continuing contributions to our nation also merit her receipt of this award.

Here in America we have come a long way towards achieving Dr. King's dream of liberty, justice and equality for all. But we still have work to do. Let us rededicate ourselves to continuing the struggle that he died for and that Mrs. King continues to work for. The Congressional Gold Medal is a fitting tribute to these two heroes who tirelessly fought to create a united America.

I hope that my colleagues will join Senators WARNER, BIDEN, HOLLINGS, BINGAMAN, STABENOW, KENNEDY, LAUTENBERG, PRYOR, LANDRIEU, CLINTON, MILKULSKI, DURBIN, DODD, LIEBERMAN, CORZINE and me in commemorating the efforts of the late Reverend Doctor Martin Luther King, Jr. and his widow, Coretta Scott King, by supporting this legislation.

By Mr. BROWNBACK (for himself and Mr. KYL):

S.J. Res. 14. A joint resolution expressing support for freedom in Hong Kong; to the Committee on Foreign Relations.

Mr. BROWNBACK. Mr. President, I rise to introduce a joint resolution for myself and Senator KYL regarding the United States' commitment to preserving freedom in Hong Kong. It is not simply the responsibility of the United States, but also of the Administration of Tung Chee Hwa, Hong Kong's chief executive and the People's Republic of China.

This resolution emphasizes an isolated event taking place on July 9 of this year—the passage of draconian laws on sedition, subversion, and theft of state secrets. This law evokes something out of one of the novels of George Orwell. Just as the resolution states, the law, as now drafted, is vague and overly broad in its definitions of subversion, sedition, and official secrets.

The Secretary of Security, an appointee of the Government of the People's Republic of China, would have very broad authority to ban organizations not approved by his Beijing masters. Nothing less than the survival of the Catholic Church in China and the Falun Gong, a quasi-religious practice that emphasizes breathing and meditation, are at stake with this law. Beijing has clearly targeted these and many other groups promoting democracy and human rights.

In addition, the Secretary of Security would have the authority to waive the right to notice and the right to be heard—something that person could execute on a whim. This horrendous bill would allow the Hong Kong Government to prosecute members of the news media for publishing information that would arbitrarily be deemed a "state secret."

These "state secrets" might include Hong Kong-Mainland cooperation on the Severe Acute Respiratory Syndrome or SARS. If China handled a new outbreak of some contagion the same way it handled SARS, I would think the people of Hong Kong should know that their lives might be in danger because of the Government's negligence.

This is the extreme case; however, it must be made clear to my colleagues, and to the world, that the legislation to be voted on July 9, in Hong Kong, would create a severe chilling effect on the press to freely report information. The Hong Kong Journalists Association, the Overseas Press Club, and the Committee to Protect Journalists all oppose this bill.

In addition, the legislation would strip other provisions contained in a current Hong Kong law, the Societies Ordinance, of due process protections. On top of that, the Hong Kong police would have new powers to search without having a warrant. Those two provisions are the bedrock of a free society. How does the Hong Kong government think it can get away with this?

It assumes that it can ride out the cries of outrage from inside Hong Kong and throughout the world. I hope that Chief Executive Tung's administration understands that this resolution only represents the beginning. Sir, if you read these comments, please understand you are on the losing side of history.

Hong Kong has been remarkably free in the last six years. That is a true statement. The fact that Mr. Tung and his colleagues fail to understand is that without these freedoms, Hong Kong will surely fail.

Unfortunately, the People's Republic of China has increasingly interfered in Hong Kong's independent judiciary, intimidated the media to induce self-censorship, and excluded visitors who disagree with the Chinese Communist Party's policies.

The Hong Kong SAR Government, encouraged by the Government of the People's Republic of China, has eroded Hong Kong's political independence, international prestige, and its appeal as a business and financial hub of Asia. Recently, the American Chamber of Commerce in Hong Kong reversed its position regarding the bill saying that it would be a disaster for business in Hong Kong.

The South China Morning Post reported: "In a letter to all legislators, chamber chairman James Thompson said the bill contained worrying provisions, such as that seeking to ban organisations. These would jeopardise Hong Kong's distinctive features, in particular its transparent legal system and free flow of information."

Similarly, the International Chamber of Commerce in Hong Kong in its submission to the Hong Kong Government opposing the bill stated "We regret that the Administration has chosen to ignore our request, and that of many others in Hong Kong for a second round of public consultation before bringing the matter to the Legislative Council, and rigidly following its own timetable.

They continued saying, "The Consultation Document is complicated enough, and has taken us much time to prepare a response. The Bill is even more difficult to study as it relates to a number of existing ordinances, if nothing else. Yet we have to rush to forward our comments to meet a deadline. This timetable also puts undue pressure on the Legislative Council to finish scrutiny in a hurry. For a matter of such great significance, it is to be regretted that it should have to be rushed through at the risk of sacrificing quality."

The lifeblood of Hong Kong's existence, its business community, opposes the bill and the Hong Kong Government pressured by Beijing fails to understand why there is all this outrage. The business community in this fascinating center for finance, shipping and media is well known for its cozy relationship with Mr. Tung, his cabinet and other officials, and even for being close with Beijing to get the favorable treatment it receives in China.

Yet, this community, arguably the most influential in Hong Kong's affairs, is outright opposed to the effort to suppress freedom in Hong Kong. It is not such a large leap to understand that Hong Kong's vibrancy results from its freedom.

I underline these concerns for my colleagues today in the hope that it will give pause to legislators in Hong Kong, and deter this and any future assaults on freedom in this important territory.

I ask unanimous consent that the text of the joint resolution be printed in the RECORD.

There being no objection, the joint resolution was ordered to be printed in the RECORD, as follows:

S.J. RES. 14

Whereas Hong Kong has long been the freest economy in the world, renowned for its rule of law and its zealous protection of civil rights and civil liberties;

Whereas the Agreement between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the People's Republic of China on the Question of Hong Kong, done at Beijing December 19, 1984 (the Sino-British Joint Declaration of 1984) explicitly guarantees that all of Hong Kong's freedoms, including freedom of the press, religious freedom, and freedom of association, will continue for at least 50 years after the transfer of Hong Kong's sovereignty from the United Kingdom to the People's Republic of China on July 1, 1997;

Whereas in the 6 years since the transfer of the territory, the citizens of Hong Kong have enjoyed a certain degree of individual liberty, religious freedom, freedom of the press and freedom of speech, which keep it both politically vibrant and stable;

Whereas the People's Republic of China has increasingly interfered in Hong Kong's independent judiciary, intimidated the media to induce self-censorship, and excluded visitors who disagree with the policies of the Chinese Communist Party;

Whereas the Government of the Hong Kong Special Administrative Region (SAR), encouraged by the Government of the People's Republic of China, has eroded Hong Kong's political independence, international prestige, and appeal as a business and financial hub of Asia;

Whereas the freedoms cherished by the people of Hong Kong serve as a constant reminder to the world and to the Government of the People's Republic of China that such freedoms could, but do not, prevail on mainland China;

Whereas the traditional liberties of Hong Kong's 7,000,000 people are now immediately threatened by a new national security bill proposed by the SAR Government that would revise Hong Kong's laws regarding sedition, treason, subversion, and theft of state secrets;

Whereas the national security bill, as now drafted, is vague and overly broad in its definitions of subversion, sedition, and official secrets, weakens existing due process protections in the Societies Ordinance, and gives dangerous new powers to the police to make searches without warrant;

Whereas the proposed legislation would give the Hong Kong SAR Secretary for Security, an appointee of the Government of the People's Republic of China, broad authority to ban organizations not approved by Beijing, thereby threatening religious organizations such as the Falun Gong and the Roman Catholic Church;

Whereas, under the proposed legislation, such basic and fundamental procedural rights as notice and opportunity to be heard could be waived by the Secretary for Security if honoring these rights "would not be practicable";

Whereas the proposed legislation provides for the imprisonment of individuals accused of "unauthorized disclosure of protected information," making it possible for the Hong Kong SAR Government to prosecute members of the news media for publishing any information relevant to relations between the People's Republic of China and Hong Kong;

Whereas similar subversion laws in the People's Republic of China are regularly used to convict and imprison journalists, labor activists, Internet entrepreneurs, and academics;

Whereas the members of Hong Kong's Legislative Council who have been elected by universal suffrage oppose the proposed legislation, but are powerless as a minority to block the votes controlled directly and indirectly by the Government of the People's Republic of China;

Whereas the clear majority of people in Hong Kong have expressed strong concerns about, and opposition to, the proposed legislation;

Whereas the scheduled consideration of these proposals to restrict Hong Kong's freedoms in the Legislative Council on July 9, 2003, makes the threat to the people of Hong Kong clear and imminent; and

Whereas the United States has consistently supported the desire of the people of Hong Kong to be free, and, as Congress declared in the United States-Hong Kong Policy Act of 1992 (22 U.S.C. 5701 et seq.): "The human rights of the people of Hong Kong are of great importance to the United States and are directly relevant to United States interests in Hong Kong. Human rights also serve as a basis for Hong Kong's continued economic prosperity": Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That Congress—

(1) declares that restrictions on freedom of thought, expression, and association in Hong Kong are limits on the fundamental rights of the people of Hong Kong;

(2) declares that the national security bill would undermine freedom of the press and access to information, both of which are fundamentally important to the economic and commercial success of Hong Kong;

(3) calls upon the SAR Government to—

(A) avoid implementing any law that restricts the basic human freedoms of thought and expression, including the proposed implementation of Article 23 of the Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China (the Basic Law); and

(B) immediately schedule and conduct elections for the Legislative Council of the Hong Kong SAR according to rules approved by the people of Hong Kong through an election law convention, by referendum, or both; and

(4) calls upon the President of the United States to—

(A) urge the Government of Hong Kong, including Hong Kong Chief Executive Tung Chee Hwa and the Legislative Council, not to implement any law, including any law established pursuant to the proposed implementation of Article 23 of the Basic Law, that restricts the basic human right to freedom of thought and expression;

(B) call upon the People's Republic of China, the National People's Congress, and any groups appointed by the Government of the People's Republic of China to leave all revisions of Hong Kong law to a democratically-elected legislature;

(C) call upon the Government of the People's Republic of China to fully respect the autonomy and independence of the Independent Commission Against Corruption and the chief executive, civil service, judiciary, and police of Hong Kong;

(D) declare that the continued lack of an elected legislature in Hong Kong constitutes a violation of the Sino-British Joint Declaration of 1984; and

(E) call upon the Government of the People's Republic of China to honor its treaty obligations under the Sino-British Joint Declaration of 1984.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 191—RELATIVE TO THE DEATH OF THE HONORABLE J. STROM THURMOND, FORMER UNITED STATES SENATOR AND PRESIDENT PRO TEMPORE EMERITUS FROM THE STATE OF SOUTH CAROLINA

Mr. FRIST (for himself, Mr. DASCHLE, Mr. GRAHAM of South Carolina, Mr. HOLLINGS, Mr. STEVENS, Mr. BYRD, Mr. MCCONNELL, Mr. REID, Mr. AKAKA, Mr. ALEXANDER, Mr. ALLARD, Mr. ALLEN, Mr. BAUCUS, Mr. BAYH, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BREAUX, Mr. BROWNBACK, Mr. BUNNING, Mr. BURNS, Mr. CAMPBELL, Ms. CANTWELL, Mr. CARPER, Mr. CHAFEE, Mr. CHAMBLISS, Mrs. CLINTON, Mr. COCHRAN, Mr. COLEMAN, Ms. COLLINS, Mr. CONRAD, Mr. CORNYN, Mr. CORZINE, Mr. CRAIG, Mr. CRAPO, Mr. DAYTON, Mr. DEWINE, Mr. DODD, Mrs. DOLE, Mr. DOMENICI, Mr. DORGAN, Mr. DURBIN, Mr. EDWARDS, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mrs. FEINSTEIN, MR. FITZGERALD, Mr. GRAHAM of Florida, Mr. GRASSLEY, Mr. GREGG, Mr. HAGEL, Mr. HARKIN, Mr. HATCH, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUYE, Mr. JEFFORDS, Mr. JOHNSON, Mr. KENNEDY, Mr. KERRY, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LOTT, Mr. LUGAR, Mr. MCCAIN, Ms. MIKULSKI, Mr. MILLER, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Florida, Mr. NELSON of Nebraska, Mr. NICKLES, Mr. PRYOR, Mr. REED, Mr. ROBERTS, Mr. ROCKEFELLER, Mr. SANTORUM, Mr. SARBANES, Mr. Schumer, Mr. SESSIONS, Mr. SHELBY, Mr. SMITH, Ms. SNOWE, Mr. SPECTER, Ms. STABENOW, Mr. SUNUNU, Mr. TALENT, Mr. THOMAS, Mr. VOINOVICH, Mr. WARNER, and Mr. WYDEN) submitted the following resolution; which was considered and agreed to:

S. RES. 191

Whereas the Honorable J. Strom Thurmond conducted his life in an exemplary manner, an example to all of his fellow citizens;

Whereas the Honorable J. Strom Thurmond was a devoted husband, father, and most recently, grandfather;

Whereas the Honorable J. Strom Thurmond gave a great measure of his life to public service;

Whereas, having abandoned the safety of high position, the Honorable J. Strom Thurmond served his country during World War II, fighting the greatest threat the world had thus far seen;

Whereas the Honorable J. Strom Thurmond served South Carolina in the United States Senate with devotion and distinction;

Whereas his service on behalf of South Carolina and all Americans earned him the esteem and high regard of his colleagues; and

Whereas his death has deprived his State and Nation of a most outstanding Senator: Now, therefore, be it

Resolved, That the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable J. Strom Thurmond, former Senator and President Pro Tempore Emeritus from the State of South Carolina.

Resolved, That the Secretary of the Senate communicate these resolutions to the House of Representatives and transmit an enrolled copy thereof to the family of the deceased.

Resolved, That when the Senate adjourns today, it stand adjourned as a further mark of respect to the memory of the Honorable J. Strom Thurmond.

NOTICES OF HEARINGS/MEETINGS

SUBCOMMITTEE ON NATIONAL PARKS

Mr. THOMAS. Mr. President, I would like to announce for the information of the Senate and the public that the following hearing has been scheduled before the Subcommittee on National Parks of the Committee on Energy and Natural Resources:

The hearing will be held on Tuesday, July 8, 2003, at 10 a.m., in room SD-366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of the hearing is to conduct oversight of the maintenance backlog, land acquisition backlog, and deficit in personnel within the National Park System, including the impact of new park unit designations on resolving each of these concerns.

Because of the limited time available for the hearings, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Committee on Energy and Natural Resources, United States Senate, SD-364 Dirksen Senate Office Building, Washington, DC 20510–6150.

For further information, please contact Tom Lillie at (202) 224-5161 or Pete Lucero at (202) 224-6293.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DOMENICI. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Committee on Energy and Natural Resources.

The hearing will be held on Thursday, July 10 at 10 a.m., in Room SH-216 of the Hart Senate Office Building.

The purpose of the hearing is to discuss the reasons behind the high price of natural gas, its affect on the economy and to consider potential solutions.

Because of the limited time available for the hearings, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Committee on Energy and Natural Resources, United States Senate, Washington, DC, 20510–6150.

For further information, please contact Scott O'Malia at 202–224–2039.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DOMENICI. Mr. President, I would like to announce for the information of the Senate and the public that the Committee on Energy and Natural Resources will hold a hearing on July 22, 2003, at 10 a.m., on issues related to forest health problems in our Nation's forests.

The Committee will examine impacts of insects, disease, weather-related damage, and fires on public and private forest lands. Processes for implementing forest health and hazardous fuels reduction projects on public and private lands will also be examined. Witnesses will be requested to suggest changes needed to improve the timeliness and effectiveness of projects to reduce hazardous fuels and to combat the spread of insects and disease infestations. The Committee will also consider S. 1314, the Collaborative Forest Health Act: H.R. 1904—the Healthy Forest Restoration Act, as well as other related legislation that addresses these issues.

Because of the limited time available for the hearings, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Committee on Energy and Natural Resources, United States Senate, SD–364, Washington, DC 20510–6150 prior to the hearing date.

For further information, please contact Frank Gladics (202–224–2878) or Meghan Beal (202–224–7556).

ORDERS FOR MONDAY, JULY 7, 2003

Mr. FRIST. Madam President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 2 p.m., Monday, July 7. I further ask consent that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then begin a period of morning business, with Members permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. I would further ask that on Tuesday, July 8, the Senate vote on the confirmation of the nomination of Executive Calendar No. 227, at 11:45 a.m.

SCHEDULE

Mr. FRIST. On Monday, July 7, the Senate will be in a period of morning business. This will provide an opportunity for Members, who have not yet had the opportunity, to deliver statements honoring our friend and colleague, Strom Thurmond. As I mentioned last night, we will have the tributes to Senator Thurmond printed as a Senate document for distribution.

Also, on Monday, it was my hope that the Senate would be able to begin consideration of S. 11, the medical malpractice legislation. We will continue to work towards a consent for consideration of this important measure, and it may be necessary to proceed to that bill on Monday if an agreement is not reached.

As I announced, there will be no rollcall votes during Monday's session. The next scheduled votes will occur on Tuesday, July 8, at 11:45 a.m. The first vote will be on Executive Calendar No. 227, the nomination of David Campbell, to be a U.S. District Judge for the District of Arizona, to be followed by a vote on invoking cloture on the nomination of Victor Wolski, to be a Judge of the U.S. Court of Federal Claims.

Again, I thank my colleagues for their hard work over the past few weeks, and I wish everyone a safe and restful recess.

ADJOURNMENT UNTIL MONDAY, JULY 7, 2003, AT 2 P.M.

Mr. FRIST. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the provisions of H. Con. Res. 231; further, that the Senate adjourn as an additional mark of respect for Senator Strom Thurmond.

There being no objection, the Senate, at 4:14 p.m., adjourned until Monday, July 7, 2003, at 2 p.m.

CONFIRMATIONS

Executive Nominations Confirmed by the Senate June 27, 2003:

LEGAL SERVICES CORPORATION

DAVID HALL, OF MASSACHUSETTS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE LEGAL SERVICES CORPORATION FOR A TERM EXPIRING JULY 13, 2005.

LILLIAN R. BEVIER, OF VIRGINIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE LEGAL SERVICES CORPORATION FOR A TERM EXPIRING JULY 13, 2004.

DEPARTMENT OF STATE

MARSHA E. BARNES, OF MARYLAND, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF SURINAME.

ROBERT W. FITTS, OF NEW HAMPSHIRE, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO PAPUA NEW GUINEA, AND TO SERVE CONCURRENTLY AND WITHOUT ADDITIONAL COMPENSATION AS AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE SOLOMON ISLANDS AND AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF VANUATU.

JOHN E. HERBST, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO UKRAINE.

WILLIAM B. WOOD, OF NEW YORK, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF COLOMBIA.

TRACEY ANN JACOBSON. OF THE DISTRICT OF COLUMBIA. A FOREIGN SERVICE OFFICER OF CLASS ONE. TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO TURKMENISTAN.

GEORGE A. KROL. OF NEW JERSEY. A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE. CLASS OF COUNSELOR. TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF BELARUS.

GRETA N. MORRIS. OF CALIFORNIA. A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE. CLASS OF MINISTER-COUNSELOR. TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF THE MARSHALL ISLANDS.

JOHN F. MAISTO. OF PENNSYLVANIA. TO BE PERMANENT REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE ORGANIZATION OF AMERICAN STATES. WITH THE RANK OF AMBASSADOR.

THE ABOVE NOMINATIONS WERE APPROVED SUBJECT TO THE NOMINEES' COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

DEPARTMENT OF JUSTICE

ROBERT D. MCCALLUM. JR.. OF GEORGIA. TO BE ASSOCIATE ATTORNEY GENERAL.

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601.

To be general

LT. GEN. JOHN P. ABIZAID

THE JUDICIARY

FERN FLANAGAN SADDLER. OF THE DISTRICT OF COLUMBIA. TO BE AN ASSOCIATE JUDGE OF THE SUPERIOR COURT OF THE DISTRICT OF COLUMBIA FOR THE TERM OF FIFTEEN YEARS.

JUDITH NAN MACALUSO. OF THE DISTRICT OF COLUMBIA. TO BE AN ASSOCIATE JUDGE OF THE SUPERIOR COURT OF THE DISTRICT OF COLUMBIA FOR THE TERM OF FIFTEEN YEARS.

IN THE ARMY

THE FOLLOWING ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS, FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADES INDICATED UNDER TITLE 10. U.S.C.. SECTION 12203:

To be major general

BRIGADIER GENERAL GEORGE A. ALEXANDER
BRIGADIER GENERAL EDMUND T. BECKETTE
BRIGADIER GENERAL WESLEY E. CRAIG. JR.
BRIGADIER GENERAL JAMES R. MASON
BRIGADIER GENERAL GERALD P. MINETTI
BRIGADIER GENERAL RICHARD C. NASH
BRIGADIER GENERAL GARY A. PAPPAS
BRIGADIER GENERAL CLYDE A. VAUGHN
BRIGADIER GENERAL DEAN A. YOUNGMAN

To be brigadier general

COLONEL WILLIAM E. ALDRIDGE
COLONEL LOUIS J. ANTONETTI
COLONEL MICHAEL W. BEAMAN
COLONEL ROBERT T. BRAY
COLONEL NELSON J. CANNON
COLONEL ROBERT P. DANIELS
COLONEL DAVID M. DAVISON
COLONEL DAVID M. DEARMOND
COLONEL MYLES M. DEERING
COLONEL JAMES B. GASTON. JR.
COLONEL ALAN C. GAYHART. SR.
COLONEL DAVID K. GERMAIN
COLONEL FRANK J. GRASS
COLONEL GARY L. JONES
COLONEL JAMES E. KELLY
COLONEL KEVIN R. MCBRIDE
COLONEL JAMES I. PYLANT
COLONEL STEVEN R. SEITER
COLONEL THOMAS L. SINCLAIR
COLONEL FRANK T. SPEED. JR.
COLONEL DEBORAH C. WHEELING
COLONEL MATTHEW J. WHITTINGTON

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 624:

To be brigadier general

COL. WILLIAM J. GERMANN

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 624:

To be brigadier general

COL. WILLIAM M. JACOBS

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES MARINE CORPS RESERVE TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 12203:

To be major general

BRIG. GEN. JOHN W. BERGMAN
BRIG. GEN. JOHN J. MCCARTHY. JR.

IN THE AIR FORCE

THE FOLLOWING OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 624:

To be brigadier general

COL. THOMAS F. DEPPE

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601.

To be admiral

ADM. WILLIAM J. FALLON

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

MAJ. GEN. MICHAEL M. DUNN

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

MAJ. GEN. KEITH B. ALEXANDER

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES MARINE CORPS TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

LT. GEN. WALLACE C. GREGSON. JR.

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 624:

To be rear admiral (lower half)

CAPT. TERRY L. MCCREARY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 624:

To be rear admiral (lower half)

CAPT. MARTIN J. BROWN
CAPT. WILLIAM A. KOWBA
CAPT. MICHAEL J. LYDEN

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 624:

To be rear admiral (lower half)

CAPTAIN JOHN M. BIRD
CAPTAIN JOHN T. BLAKE
CAPTAIN FRED BYUS
CAPTAIN FRANK M. DRENNAN
CAPTAIN MARK E. FERGUSON III
CAPTAIN JOHN W. GOODWIN
CAPTAIN RICHARD W. HUNT
CAPTAIN ARTHUR J. JOHNSON. JR.
CAPTAIN MARK W. KENNY
CAPTAIN JOSEPH F. KILKENNY
CAPTAIN WILLIAM E. LANDAY
CAPTAIN MICHAEL A. LEFEVER
CAPTAIN GERARD M. MAUER. JR.
CAPTAIN DOUGLAS L. MCCLAIN
CAPTAIN WILLIAM H. MCRAVEN
CAPTAIN RICHARD O'HANLON
CAPTAIN KEVIN M. QUINN
CAPTAIN RAYMOND A. SPICER
CAPTAIN PETER J. WILLIAMS

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be general

GEN. ROBERT H. FOGLESONG

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

MAJ. GEN. DANIEL P. LEAF

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 624:

To be major general

BRIG. GEN. JOSEPH E. KELLEY

THE FOLLOWING AIR NATIONAL GUARD OF THE UNITED STATES OFFICER FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 12203:

To be major general

BRIG. GEN. DOUGLAS BURNETT

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10. U.S.C.. SECTION 12203:

To be brigadier general

COL. CRAIG S. FERGUSON

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT AS VICE CHIEF OF NAVAL OPERATIONS. UNITED STATES NAVY AND APPOINTMENT TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTIONS 601 AND 5035:

To be admiral

VICE ADM. MICHAEL G. MULLEN

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

LT. GEN. WILLIAM T. HOBBINS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

MAJ. GEN. RANDALL M. SCHMIDT

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

MAJ. GEN. WALTER E. L. BUCHANAN III

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

LT. GEN. DAN K. MCNEILL

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

MAJ. GEN. WILLIAM G. BOYKIN

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES MARINE CORPS TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10. U.S.C.. SECTION 601:

To be lieutenant general

MAJ. GEN. ROBERT R. BLACKMAN. JR.

AIR FORCE NOMINATIONS BEGINNING REBECCA G. ABRAHAM AND ENDING JEFFREY YUEN. WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MARCH 26. 2003.

AIR FORCE NOMINATIONS BEGINNING BRIAN J. ACKER AND ENDING ANGELA D. WASHINGTON. WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MARCH 26. 2003.

AIR FORCE NOMINATIONS BEGINNING PAUL M. BARZLER AND ENDING CHARLES W. WILLIAMSON III. WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MARCH 26. 2003.

AIR FORCE NOMINATION OF JAMES R. BURKHART.

AIR FORCE NOMINATIONS BEGINNING CHARLES M. BELISLE AND ENDING BRETT A. WYRICK. WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 5. 2003.

AIR FORCE NOMINATIONS BEGINNING GLENN D. ADDISON AND ENDING DANIEL J. ZACHMAN. WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 5. 2003.

AIR FORCE NOMINATION OF THOMAS K. HUNTER, JR.

AIR FORCE NOMINATION OF JEFFREY J. KING.

AIR FORCE NOMINATIONS BEGINNING JEAN B. DORVAL AND ENDING GARY M. WALKER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 12, 2003.

AIR FORCE NOMINATION OF RICHARD J. DELORENZO, JR.

AIR FORCE NOMINATION OF GERALD M SCHNEIDER.

AIR FORCE NOMINATION OF JANE B. TAYLOR.

AIR FORCE NOMINATIONS BEGINNING DARRELL A. JESSE AND ENDING NORBERT S. WALKER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 12, 2003.

AIR FORCE NOMINATIONS BEGINNING THOMAS C. BARNETT AND ENDING JEAN A VARGO, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 12, 2003.

AIR FORCE NOMINATION OF EDWARD C. CALLAWAY.

AIR FORCE NOMINATION OF H. MICHAEL TENNERMAN.

AIR FORCE NOMINATION OF STEVEN E. RITTER.

AIR FORCE NOMINATION OF BRYAN A. KEELING.

AIR FORCE NOMINATION OF ROBERT L. ZABEL, JR.

AIR FORCE NOMINATIONS BEGINNING DARRYL G. ELROD, JR. AND ENDING KEVIN R. VANVALKENBURG, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 12, 2003.

AIR FORCE NOMINATION OF DREW Y. JOHNSTON, JR.

AIR FORCE NOMINATION OF RACHEL L. BECK.

AIR FORCE NOMINATION OF LARRY J. MASTIN.

AIR FORCE NOMINATIONS BEGINNING ROBERT L. DAUGHERTY, JR. AND ENDING CHARLES V. RATH, JR., WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 16, 2003.

ARMY NOMINATIONS BEGINNING CRAIG M ANDERSON AND ENDING DIANE M ZIERHOFFER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 20, 2003.

ARMY NOMINATIONS BEGINNING ANULI L ANYACHEBELU AND ENDING DONALD G ZUGNER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 20, 2003.

ARMY NOMINATIONS BEGINNING DOREEN M AGIN AND ENDING BONNITA D WILSON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JANUARY 1, 1.

ARMY NOMINATIONS BEGINNING KEVIN R ARMSTRONG AND ENDING NANCY A VINCENTJOHNSON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 20, 2003.

ARMY NOMINATION OF JAMES A. DECAMP.

ARMY NOMINATION OF TIMOTHY H. SUGHRUE.

ARMY NOMINATIONS BEGINNING LESLIE J. MITKOS, JR. AND ENDING BERRIS D. SAMPLES, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 5, 2003.

ARMY NOMINATIONS BEGINNING PATRICIA J. MCDANIEL AND ENDING NICHOLAS K. STRAVELAKIS, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 5, 2003.

ARMY NOMINATION OF SCOTT D. KOTHENBEUTEL.

ARMY NOMINATION OF GLENN T. BESSINGER.

ARMY NOMINATIONS BEGINNING JANE M. ANDERHOLT AND ENDING JAY A. WHITAKER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 12, 2003.

ARMY NOMINATIONS BEGINNING RODNEY A. ARMON AND ENDING MARK W. THACKSTON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 12, 2003.

ARMY NOMINATION OF ANTHONY SULLIVAN.

ARMY NOMINATION OF BRYAN C. SLEIGH.

ARMY NOMINATION OF KENNETH S. AZAROW.

ARMY NOMINATION OF MICHAEL F. MCDONOUGH.

FOREIGN SERVICE NOMINATIONS BEGINNING ALI ABDI AND ENDING LAWRENCE C. MANDEL, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 22, 2003.

FOREIGN SERVICE NOMINATIONS BEGINNING BETH A. SALAMANCA AND ENDING PETER H. CHASE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 3, 2003.

NAVY NOMINATION OF MICHAEL U. RUMP.

NAVY NOMINATIONS BEGINNING WILLIAM A. DAVIES AND ENDING GARY S. TOLLERENE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON APRIL 30, 2003.

NAVY NOMINATIONS BEGINNING DOUGLAS W. FENSKE AND ENDING MICHAEL J. KAUTZ, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON APRIL 30, 2003.

NAVY NOMINATIONS BEGINNING BRIAN H. MILLER AND ENDING PERRY T. TUEY, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON APRIL 30, 2003.

NAVY NOMINATIONS BEGINNING GERALD W. CLUSEN AND ENDING MARK A. WILSON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON APRIL 30, 2003.

NAVY NOMINATIONS BEGINNING KENNETH J. BRAITHWAITE AND ENDING ANDREW H. WILSON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON APRIL 30, 2003.

NAVY NOMINATIONS BEGINNING CHRISTOPHER M. BALLISTER AND ENDING CARL M. M. LEE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON APRIL 30, 2003.

NAVY NOMINATIONS BEGINNING JEFFREY D. ADAMSON AND ENDING MARCUS K. NEESON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON APRIL 30, 2003.

NAVY NOMINATIONS BEGINNING DANFORD S. K. AFONG AND ENDING THEODORE A. WYKA, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 1, 2003.

NAVY NOMINATIONS BEGINNING SCOTT F. BOHNENKAMP AND ENDING CHRISTOPHER L. WALL, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 1, 2003.

NAVY NOMINATIONS BEGINNING CHARLES L. COLLINS AND ENDING CYNTHIA R. SUGIMOTO, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 1, 2003.

NAVY NOMINATIONS BEGINNING GREGORY S. ADAMS AND ENDING PETER A. WITHERS, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 1, 2003.

NAVY NOMINATIONS BEGINNING BRADFORD E. ABLESON AND ENDING OLRIC R. WILKINS, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING CHRISTOPHER A. BARNES AND ENDING SCOTT M. STANLEY, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING THOMAS M. BALESTRIERI AND ENDING ROBERT S. WRIGHT, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING LISA L. ARNOLD AND ENDING PEGGY W. WILLIAMS, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING SCOTT W. BAILEY AND ENDING KEVIN R. WHEELOCK, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING MATTHEW R. BEEBE AND ENDING STEVEN M. WIRSCHING, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING EVAN A. APPLEQUIST AND ENDING RICHARD D. WRIGHT, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING WILLIAM B. ADAMS AND ENDING DANIEL J. ZINDER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 8, 2003.

NAVY NOMINATIONS BEGINNING REBECCA E. BRENTON AND ENDING WARREN C. GRAHAM III, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING KATHY A. BARAN AND ENDING MARGARET A. TAYLOR, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING MICHAEL D. DISANO AND ENDING VINCENT M. SCOTT, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING NANCY R. DILLARD AND ENDING CHRISTOPHER L. VANCE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING JEAN E. BENFER AND ENDING CYNTHIA L. WIDICK, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING DAVID L. BAILEY AND ENDING RUSSELL L. SHAFFER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING ROBERT W. ARCHER AND ENDING JIM O. ROMANO, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING CHRISTOPHER L. ABBOTT AND ENDING WILLIAM A., WRIGHT III, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING CHARLES S. ANDERSON AND ENDING PHILIP A. YATES, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING BRIAN K. ANTONIO AND ENDING THOMAS L. VANPETTEN, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING EUGENE M. ABLER AND ENDING MICHAEL E. ZAMESNIK, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATION OF JUDY L. MILLER.

NAVY NOMINATIONS BEGINNING THOMAS W. HARRINGTON AND ENDING ROBERT L. YOUNG, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING MATTHEW O. FOLEY III AND ENDING FRANK G. USSEGLIO II, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING CRAIG E. BUNDY AND ENDING CLIFF P. WATKINS, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING WILLIAM M. ARBAUGH AND ENDING RICHARD E. WOLFE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING DANIEL M. BLESKEY AND ENDING WILLIAM E. VAUGHAN, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING BARTLEY G. CILENTO, JR. AND ENDING JAMES L. WHITE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING NANCY J. BATES AND ENDING LLOYD G. WINGFIELD, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING ANNEMARIE ADAMOWICZ AND ENDING MARY A. WHITE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON MAY 14, 2003.

NAVY NOMINATIONS BEGINNING SHERRY L. BRELAND AND ENDING JULIA D. WORCESTER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 12, 2003.

NAVY NOMINATIONS BEGINNING RAUL D. BANTOG AND ENDING DONNA M. WILLOUGHBY, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 16, 2003.

NAVY NOMINATIONS BEGINNING LINSLY G. M. BROWN AND ENDING DENISE M. SHOREY, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 18, 2003.

PUBLIC HEALTH SERVICE NOMINATIONS BEGINNING THOMAS D. MATTE AND ENDING RONALD R. PINHEIRO, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON JUNE 3, 2003.

EXTENSIONS OF REMARKS

THE INTRODUCTION OF THE "EQUAL TREATMENT OF PENSIONS AND BANKRUPTCY ACT OF 2003"

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CONYERS. Mr. Speaker, today, I am introducing the "Equal Treatment of Pensions and Bankruptcy Act of 2003" to eliminate an unfair and abusive practice that has allowed corporate insiders to protect their exorbitant pensions even as their employees jobs and retirement savings are obliterated in bankruptcy.

Recently, some in top corporate management have attempted to insulate their pension benefits by placing them in a trust that would be beyond the reach of the bankruptcy court. As a result, while employees lose their jobs, pensions, and other benefits, these insiders are able to walk away from the bankrupt company with a substantial windfall. This immoral tactic does not benefit the rehabilitation of the business. To the contrary, it loots the company of assets that could be used to pay creditors, employees, and help the company successfully emerge from bankruptcy. It is bad for business, it is bad for unpaid creditors, it is bad for the families who are shattered by the failure of a company.

This is an ongoing problem. In April, American Airlines enraged employees by threatening to shut down the company if they didn't accept billions in steep pay and benefit cuts, while secretly setting aside millions in pension guarantees for top executives. Although CEO Donald Carty resigned in April, American has kept its executive pension plan.

The legislation provides that if the company places any supplemental retirement benefits or deferred compensation in a trust for the benefit of management or another insider, the court will have the authority to reclaim those funds for the benefit of the creditors, including the employees. It also clarifies that a party with an interest in the case or a committee of creditors may bring a motion to reclaim these funds if the trustee or the debtor in possession consents for fails to bring such a motion. While these parties are now permitted to bring such motions, as recently reaffirmed by the U.S. Court of Appeals for the Third Circuit in the Cybergenics case, this bill reaffirms that right under the Code.

This is pattern of abuse is becoming ever more widespread. We must protect the livelihood of the average American worker and their families and ensure that top executives are not allowed to pillage a firm and enjoy protection in bankruptcy that would be denied to the people who are least to blame for the bankruptcy.

A TRIBUTE TO TSCL'S LEADERSHIP

HON. WALTER B. JONES

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. JONES of North Carolina. Mr. Speaker, it is a pleasure for me to introduce to you the TREA Senior Citizens League and its new leadership.

The TREA Senior Citizens League (TSCL) is a national group of politically active seniors concerned about the protection of their earned Social Security, Medicare, military, and other retirement benefits. TSCL originated as a group of retired enlisted servicemen and women. TSCL is among the largest seniors groups with over 1.2 million active members. It is a non-partisan, non-profit educational and advocacy organization.

Key issues for TSCL include Social Security COLA fairness; using a separate CPI–E consumer price index for the elderly to calculate COLA for seniors; Notch reform; and a fair medicare and prescription drug coverage. One of the main issues continues to center on Notch reform and providing either a lump sum benefit over four years or an improved benefit calculation for those individuals born in the years 1917–1926. It is also important to ensure that future generations do not receive lower benefits because of the year in which they were born or because of government miscalculations in the Social Security system.

Since 2001 TSCL has been under the leadership of Board of Trustees Chairman George Smith with board members Ms. Dottie Holmes, Mr. Fred Athans, Mr. Richard Brogan, and more recently Mr. Ralph McCutchen. The elected TSCL Board of Trustees is a volunteer board governing the organization. Retirees and near-retirees make up the board and volunteer their services with the goal of improving the lives of fellow seniors. It was a pleasure for me to meet with their fine Board of Trustees Members List October at their offices in Alexandria, Virginia.

Under the forward-looking leadership of George Smith, the organization is determined to gain greater credibility and respectability both in Congress and in the country as a whole. In this regard Chairman Smith is to be commended for enlisting my good friend and former colleague in Congress Former Ambassador David Funderburk as TSCL's Legislative Consultant.

The legislative program for the organization for the 108th Congress includes plans for personal meetings with over half of the Members of Congress to try to gain support for issues of interest to seniors and TSCL members. TSCL efforts in these tasks have been boosted by the recent scholarly study of noted economist Dr. John Haldi that verifies the viability of the Notch. The organization has an active website, newsletter and direct mail communication with its members.

Just in the first half of 2003, TSCL has hosted a press conference in the Capitol, and worked with Members of Congress and the White House on the prescription drug issue. A Dear Colleague letter from six Members of Congress has introduced the organization and its issues to the whole Congress. Several Members of the House and Senate have recently contributed articles on seniors issues to the TSCL newsletter: The Social Security & Medicare Advisor. And I am pleased to say that TSCL strongly supports my bill: The Social Security Guarantee Act.

Since Mr. Smith took over leadership of the TSCL Board of Trustees he has brought a seriousness of purpose and a determination to build credibility and respect for the organization. He insisted that the group's educational efforts through direct mail be well researched and documented. As Chairman Smith says, TSCL does not sell anything. Rather it strives to educate the public about issues important to senior citizens. Since so many of them have served their country in the military and in so many other ways, they are especially deserving of fair treatment.

When Mr. Smith one day completes his voluntary stint as Chairman of the TSCL Board of Trustees he should be able to say that he has left the organization much better off than he found it. He is to be commended for his vision and his desire to help some of the most worthy and needy of all of our citizens: our senior citizens including many who served the military and fought for their country. I am happy to pay tribute to the organization and its leadership.

SHED LIGHT ON HIDDEN FEES

HON. LUIS V. GUTIERREZ

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. GUTIERREZ. Mr. Speaker, today I am introducing the "Wire Transfer Fairness and Disclosure Act of 2003," a bill to require additional disclosures relating to exchange rates in transfers involving international transactions.

Immigrants throughout the United States work hard, save money and send billions of dollars to relatives living in foreign countries. The money sent home helps finance basic needs ranging from food and medicine to education to new homes. Unfortunately, customers wiring money to Mexico are often losing millions of dollars to undisclosed "currency conversion fees" charged by giant firms such as Western Union and MoneyGram.

Wire Transfer companies aggressively target audiences in immigrant communities with

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

ads promising low rates for international transfers. However, such promises are grossly misleading particularly for those with ties to Mexico or other Latin American countries, since companies do not always clearly disclose extra fees charges for converting dollars into Mexican pesos. While large wire service companies typically obtain pesos at bulk bargain rates, they charge a significant currency conversion fee to their U.S. customers. The exchange rate charged to customers sending U.S. dollars to Mexico routinely varies from the benchmark rates by as much as 15 percent. The profits from these hidden currency conversion fees are staggering, allowing companies to reap millions of dollars more than they make from service fees.

To address these problems, this Act requires full disclosure of all fees involved in all money-wiring transactions. More specifically, the bill requires that any financial institution or money transmitting business which initiates an international money transfer on behalf of a consumer (whether or not the consumer maintains an account at such institution or business) shall provide the following disclosures:

The exchange rate used by the financial institution or money transmitting business in connection with such transaction.

The exchange rate prevailing at a major financial center of the foreign country whose currency is involved in the transaction, as of the close of business on the business day immediately preceding the date of the transaction (or the official exchange rate, if any, of the government or central bank of such foreign country).

All commissions and fees charged by the financial institution or money transmitting business in connection with such transaction.

The exact amount of foreign currency to be received by the recipient in the foreign country, which shall be disclosed to the consumer before the transaction is consummated and printed on the receipt given to the consumer.

Mr. Speaker, I urge my colleagues to support this pro-consumer legislation.

HONORING AMERICAN ASSOCIATES, INC.

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. KILDEE. Mr. Speaker, I am happy to rise before you today on behalf of a group of men and women who constantly help others live the American dream. On July 2, civic and community leaders will gather with the friends and families of American Associates, Inc. Real Estate Company, to celebrate the company's 20th anniversary.

For two decades, American Associates, located at 1453 N. Elms Road in my hometown of Flint, Michigan, has helped thousands of families achieve the dream of home ownership. Founded by Randy and Carol Haney, they, along with a staff of 40 agents, have specialized in finding new, used, and luxury homes for their customers. With the help of a computerized nationwide relocation service, the company has also been able to identify multi-family, industrial, and commercial properties, and even vacant lands.

Randy and Carol have also sought to place a strong influence on America as well. For the last 16 years, they, along with 250 volunteers from area youth, civic, school, and church groups, have distributed American flags throughout neighborhoods in Genesee County during the July 4th weekend. This year, American Associates plan to pass out 40,000 flags, and to date have distributed approximately 350,000. This selfless and patriotic gesture of goodwill serves to remind us all to celebrate the freedom we have as Americans, and to strengthen our pride in the ideals on which our flag stands for.

Also this year, in memory of local resident Private First Class Jason Meyer, who heroically gave his life in service to his country in Iraq, American Associates has supplied a tree to be planted in a local park as a special tribute to the fallen soldier.

Mr. Speaker, as a Member of Congress, I consider it my duty and my privilege to protect and defend human dignity and the quality of life for our citizens. I am extremely grateful that people like Randy and Carol Haney, and the staff of American Associates, make my task easier. I ask my colleagues in the 108th Congress to please join me in commending them for going above and beyond to promote our great Nation.

CORPUS CHRISTI, AN ALL AMERICAN CITY

HON. SOLOMON P. ORTIZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. ORTIZ. Mr. Speaker, I rise today to commend the City of Corpus Christi for the recent accomplishment of being recognized by the National Civic League as an All-America City. As a resident of Corpus Christi, I can wholeheartedly endorse the concept that Corpus Christi represents all the best in an American city.

Corpus Christi is a place where the pace is easy and the people are the best there is. It is peaceful and beautiful with beaches, military bases, high rises and a vibrant business community.

Corpus Christi's presentation included our Juvenile Assessment Center (an organization that helps decrease juvenile crime), Forward Corpus Christi (an economic development organization), the Air Quality Group (Corpus Christi is the only major city in Texas to meet state and federal air quality standards), and a local Junior ROTC team.

One of the central components of our community is our military complex. We often say South Texas is "Navy Country." Four separate bases are incorporated in the Corpus Christi area: an army base and three naval bases. The military presence in the area contributes 20% to our local economy.

Corpus Christi conveyed this pride in our military, and demonstrated the importance of our military community, by incorporating the nationally recognized efforts of the Flour Bluff Navy Jr. ROTC into the presentation.

It was the solemn and excellent presentation of the Jr. ROTC, which has won seven national titles for excellence, and which led the way for the city to win the recognition by the National Civic League as an All-America City.

Corpus Christi is the only city in Texas to receive this distinct honor this year.

I thank my friend, Robin Hayes of North Carolina, for introducing the resolution to officially commend the winners of this competition in the House of Representatives.

Mr. Speaker, I ask my colleagues to join me and the other co-sponsors of this resolution, all of whom are proud to live in an All-America City, in commending Corpus Christi and the other nine cities honored by the National Civic League.

THE PARK PROFESSIONALS PROTECTION ACT

HON. NICK J. RAHALL II

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. RAHALL. Mr. Speaker today I am introducing legislation to protect the park professionals who "dedicate their careers to preserving our system of National Parks from the Bush Administration's privatization plan.

According to the Bush Administration, the rush to replace National Park Service employees with private-sector subcontractors is a harmless experiment to see if the services provided by thousands of dedicated public servants could be had more cheaply. The Administration claims it is considering only a small number of positions and asserts that taxpayers will see cost savings from this plan.

Unfortunately, this is just not the case. The Administration's privatization scheme is so vast, so unwarranted and so clumsy that it threatens to undermine both the National Park Service and the resources it was created to protect. To avoid this, I am introducing legislation to stop the Bush plan.

The Administration proposes to privatize approximately 1,700 full-time National Park Service employees by the end of next year. While this number alone is troubling, it is only the beginning. According to The Washington Post, the Administration has identified approximately 70% of the current NPS workforce it feels should be eligible for replacement by private workers.

And who are the people the Administration is seeking to replace? According to the Director of the National Park Service, nearly 90% of the men and women potentially eligible for privatization in the Washington, D.C. area are minorities and the numbers in areas such as Santa Fe and San Francisco are similarly lopsided.

Making matters worse, the alleged cost savings created by replacing these workers is unproven and unlikely. Despite paying private consultants more than $5 million, or about three thousand dollars per position being considered, not a single study has been produced demonstrating even a nickel in savings. Meanwhile, that $5 million came from funds intended to pay for the operation and maintenance of our National Parks.

Of course, the reason no savings can be demonstrated is that there are no savings to be had. This entire scheme is based on the premise that you can build a workforce of dedicated professionals, with the experience, institutional memory and expertise of the National Park Service, for less money. You can't.

The description on paper of an NPS employee's job doesn't begin to include all of the services that employee performs on the ground. Visitors don't direct their questions about plants and animals only to NPS biologists nor do they wait to ask questions regarding historic preservation until an NPS historian is available. Wildfires and heart attacks don't happen only when full-time fire fighters or EMTs are on duty.

The National Park Service challenges all of its employees, regardless of their actual job titles, to respond to all kinds of visitor needs, and the employees work hard to meet this challenge. This kind of all-out commitment and willingness to pitch in comes from a passionate commitment to your job, a commitment which cannot be bought from the lowest bidder or adequately described in a want ad.

What's more, each unit of our National Park System is unique, both in the resources it offers and the challenges it faces. Such richness and diversity defy a "one-cheapest-size-fits-all" approach. The best scientific mind to further stabilize the Anasazi ruins at Mesa Verde is not the best person to protect endangered species in the Dry Tortugas. A private corporation, offering the lowest possible salaries, probably can't provide either of these people, much less both of them.

The fact is, NPS employees' salaries are scandalously low, their housing is dilapidated and they are frequently asked to pack up their families and move to a park thousands of miles away. These men and women work in the National Park Service because they love National Parks, and the people who visit them, and there is no excess to be wrung from their paychecks. While it is appropriate to seek the lowest bidder for the uniforms they wear or the equipment they use, allowing the lowest bidder to replace their expertise and experience will only cheapen our National Parks.

The mission of the National Park Service is resource protection and visitor enjoyment, not profit. To accomplish that mission, the National Park Service needs employees motivated by a love of people and of parks, not of money. The natural, cultural and historic resources contained within our National Parks are too valuable to allow the job of protecting them to be traded on the open market.

My legislation will stop this privatization scheme in its tracks and I urge my colleagues to support it.

IN HONOR OF THE TVB BENEFIT VARIETY SHOW 2003

HON. JERROLD NADLER

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. NADLER. Mr. Speaker, I rise today to praise the extraordinary efforts of NYU Downtown Hospital and its Chinese Community Partnership for Health program, for all of their work in health education, outreach and case management throughout lower Manhattan. I salute them on the occasion of the fourth annual Hong Kong Television Broadcast Limited Benefit Variety Show, which raises funds for this worthy cause.

Lower Manhattan is a diverse community that welcomes thousands of new immigrants every year, especially to the dynamic neighborhood of Chinatown. NYU Downtown Hospital is the only health care facility in the area and works to guarantee that these immigrants have access to quality health care.

The hospital has numerous successful outreach programs including the Chinese Community Partnership for Health (CCPH) program. The CCPH works to promote health care to all the residents of New York's Chinese community, including the tens of thousands of new residents each year. For ten years, the CCPH has served more than 80,000 garment and restaurant workers, elderly Chinese residents and school children in the Hospital's service area.

The centerpiece of the Partnership program is its health screening activities conducted by specially trained outreach teams that include bilingual nurses with both Eastern and Western healthcare concepts and practices. CCPH helps these immigrants overcome language and cultural barriers which prevent them from receiving the medical assistance they need and deserve.

To help raise funds for this worthy cause, CCPH and NYU Downtown Hospital will host a three-day extravaganza featuring a celebrity gala dinner and culminating in the Benefit Variety Show. Produced by the Hong Kong Television Broadcasts Limited (TVB), the Benefit Variety Show is an annual event in its fourth year that will be held in New York on July 10th. The festivities are broadcast worldwide, which helps to display New York's tremendous diversity.

Mr. Speaker, in closing, I ask my colleagues to join me in recognizing the many individuals who work tirelessly to make this event an annual success, including Sir Run Run Shaw, Executive Chairman of TVB; George C.K. Liu, Chairman of the Physician Committee; Mr. Tim Cheng of the East Buffet and Restaurant; Pulchee Ngan, General Manager, Raymond Miu Productions, Inc.; and Hong Kong Superstars Jerry Lamb, Yumiko Cheng, Maggie Cheung, Denise Ho, Aaron Kwok, Alan Lam, Samantha Lam, Edmond Leung, Gigi Leung, Edwin Siu, Tommy Yuen, and Tim Yuk. I would also like to recognize the Chinese Consolidated Benevolent Association, who are the grand benefactors of this event and do so much throughout Chinatown to serve and protect the interests of the Chinese community in New York City.

I appreciate all the good work that CCPH does to promote quality health care and I wish them great success with this year's variety show.

COMMEMORATING THE 10TH ANNIVERSARY OF THE UCSD CANCER CENTER LUAU & LONG BOARD INVITATIONAL

HON. SUSAN A. DAVIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mrs. DAVIS of California. Mr. Speaker, I rise today to honor the University of California—San Diego (UCSD) Cancer Center Luau and Long Board Invitational annual event for their continuous exemplary work in furthering the efforts of cancer treatment and research at the Rebecca and John Moores UCSD Cancer Center.

This year marks the 10th Anniversary of the Luau and Long Board Invitational, which each year brings together varying groups, from world-renowned surfing legends to corporate executives, to unify around the same cause. The many activities of the day include a ceremony honoring the recipient of the Queen of Makaha Award, recognizing an individual for his or her efforts to fight cancer and dedication to helping others in ways that embody the true "aloha" spirit.

This year's 10th Anniversary event serves as a milestone of success and a measure of the many contributions of supporters both in and out of the San Diego community toward the struggle against cancer. Through a good deal of time and effort, the Luau has earned a worldwide reputation as one of the finest and most soulful surfing-themed philanthropic events to be found anywhere. The challenge of organizing the Luau year after year is successfully accomplished by a passionate grassroots network of local volunteers, many of whom are cancer survivors. Additionally, the Luau is generously supported by a diverse collection of prominent, community-minded companies, organizations and individuals.

Since its founding in 1994, the Luau has raised more than $1 million to finance promising cancer research projects at the Rebecca and John Moores UCSD Cancer Center. In 2002 alone, over $170,000 was raised. Today, scientists and doctors are making great strides in the battle to fight cancer, but the disease continues to be one of the most widespread diseases in the United States. We must do our part to keep up the fight, and this Luau serves as a perfect means for all San Diegans to get involved.

I applaud the UCSD Cancer Center Luau and Long Board Invitational for their continuous efforts in the fight against Cancer. To all those who have spent countless hours on this important event year after year: Mahalo!

I yield back the balance of my time.

IN RECOGNITION OF MR. SHARAD SHAH AND SHARE AND CARE FOUNDATION

HON. FRANK PALLONE, JR.

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. PALLONE. Mr. Speaker, I rise today to laud the accomplishments of Mr. Sharad

Shah, and the organization he helped create, The Share and Care Foundation. Share and Care is a unique organization that provides medical equipment, food, basic health care, crisis and disaster relief, youth vocational training, internship programs, scholarships and more to those desperately in need. This forum has been the starting ground for many people, and has provided a much-needed service to lift up underprivileged children and women faced with seemingly insurmountable obstacles, and set them on the road to a productive life.

Share and Care, the brainchild of a small group of Indian-Americans, was born in 1982 in New Jersey. More than 50 active volunteers are involved in multifaceted projects and services. The volunteers see themselves as catalysts, promoting low cost, high return programs at grass root levels. Their 100% volunteer organization maximizes the utilization of funds for a deserving cause. In the last twenty years this organization has grown over a hundred fold.

Share and Care has offered its services since the Bhopal tragedy in 1984 to the recent Gujarat earthquake in 2001. Share and Care aided in building schools, hospitals, training centers, health camps and blood banks, and sponsored thousands of students seeking an education. This Foundation has directed more than $5 million in cash and kind donations to the victims of the January 2001 earthquake. About 2,500 individuals throughout the United States donated more than $1 million for the effort. Additionally, about 50 corporations and groups collected donations and chose Share and Care to distribute the money in order to deliver relief to the people of Gujarat.

This Foundation is a recognized name that people trust with their donations and can rely on for help in the most tragic times. Their numerous community and rehabilitation initiatives have totaled more than $30 million. Mr. Speaker, on this day I rise up to acknowledge a truly remarkable individual and I ask that my colleagues join me in honoring Mr. Shah and his organization for the fine and important work they have done over the past twenty years.

HONORING MAYNARD HOLBROOK JACKSON, JR.

HON. MAX BURNS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. BURNS. Mr. Speaker, I rise today to honor the life of Maynard Holbrook Jackson, Jr., and to extend condolences to the family, friends, and business associates of the untimely death of an extraordinary man who changed the way the world sees the City of Atlanta.

Mr. Jackson loved Atlanta, the State of Georgia, and its people. He worked endlessly to create a city that many refer to as the "Mecca of the South." Because of his tireless devotion, Atlanta's growth and development has gained national prominence.

A savvy politician and businessman, Mr. Jackson was the first African-American to be elected mayor of a major southern city. A great champion for diversity, inclusion, and fairness, he built bridges between racial, economic, and social lines that brought a sense of togetherness to the City of Atlanta and its citizens.

Mr. Jackson's dynamic leadership was the driving force in the design, development and expansion of one of the nation's busiest airports, Atlanta's Hartsfield International. In addition, his legacy includes programs that empowered neighborhoods and a department that oversees cultural affairs. He worked tirelessly as an advocate of affirmative action and laid the foundation that brought the 1996 Summer Olympics to Atlanta.

Mr. Jackson was a successful politician and businessman who had a passion for public service. The death of this remarkable man creates a great void for the City of Atlanta, the State of Georgia, and the entire Nation.

PERSONAL EXPLANATION

HON. JOHN SULLIVAN

OF OKLAHOMA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SULLIVAN. Mr. Speaker, due to events beyond my control I was unable to be present for the following rollcall votes. Had I been able to submit my votes, they would have been as follows:

Rollcall vote No. 297 on agreeing to the passage of H. Res. 264—"yes".

Rollcall vote No. 298 on agreeing to the passage of H. Res. 177—"yes".

Rollcall vote No. 299 on agreeing to the passage of H. Con. Res. 209—"yes".

Rollcall vote No. 300 on agreeing to the passage of H.R. 2465—"yes".

MAKE RESEARCH FUNDED BY THE PUBLIC AVAILABLE TO THE PUBLIC

HON. MARTIN OLAV SABO

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SABO. Mr. Speaker, today I will introduce the Public Access to Science Act, PASA, of 2003, legislation to make federally funded research available to the public.

It is wrong when a breast cancer patient cannot access federally funded research paid for by her hard-earned taxes. It is wrong when a family whose child has a rare disease must pay again for access to research their tax dollars already paid for. Common sense dictates we provide the most cutting-edge research to all who may benefit from it, especially when they have already paid for it with their tax dollars.

The United States Government funds basic research with the intention and the belief that the new ideas and discoveries that result will improve the lives and welfare of the people of the United States and around the world. Our government spends $45 billion a year to support scientific and medical research whose product is new knowledge for the public benefit. We must remember that government funded research belongs to, and should be readily available to, every person in the United States. Lifting restrictions that prevent the widespread sharing of federally funded research can only speed scientific advancement.

I urge you to join me by cosponsoring this legislation to require research substantially funded by the Federal Government to be ineligible for copyright protection, and thus available in the public domain.

PERSONAL EXPLANATION

HON. SUE WILKINS MYRICK

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mrs. MYRICK. Mr. Speaker, I was unable to participate in the following votes. If I had been present, I would have voted as follows:

June 24, 2003, Rollcall vote 307, on agreeing to the Filner amendment, I would have voted "no".

PERSONAL EXPLANATION

HON. JIM KOLBE

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. KOLBE. Mr. Speaker, yesterday, I attended the funeral of the Honorable Bob Stump in Phoenix, Arizona and missed votes on the following measures:

1. S. 858—To extend the Abraham Lincoln Bicentennial Commission, and for other purposes (#312). Had I been present, I would have voted "aye."
2. H.R. 2474—To require that funds made available for fiscal years 2003 and 2004 for the Bill Emerson and Mickey Leland Hunger Fellowships be administered through the Congressional Hunger Center (#313). Had I been present, I would have voted "aye."
3. H.J. Res. 49—recognizing the important service to the Nation provided by the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary (#314). Had I been present, I would have voted "aye."
4. H. Con. Res. 49—expressing the sense of the Congress that the sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences (#315). Had I been present, I would have voted "aye."
5. H. Res. 199—calling on the Government of the People's Republic of China immediately and unconditionally to release Dr. Yang Jianli, calling on the President of the United States to continue working on behalf of Dr. Yang Jianli for his release, and for other purposes (#316). Had I been present, I would have voted "aye."
6. H. Res. 294—condemning the terrorism inflicted on Israel since the Aqaba Summit and expressing solidarity with the Israeli people in their fight against terrorism (#317). Had I been present, I would have voted "aye."

RECOGNIZING UCSD CANCER CENTER

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to honor The UCSD Cancer Center Luau and Longboard Invitational. This event brings together surfing legends from around the world, celebrities, and corporate executives to benefit cancer treatment and research at the Rebecca and John Moores UCSD Cancer Center. It features a friendly surfing competition between sponsored teams, a Polynesian-themed party featuring food, entertainment, live and silent auctions of surf memorabilia, and a brief ceremony to honor the winner of the Rell Sunn—Queen of Makaha Award. This award recognizes an individual for his or her efforts to fight cancer and dedication to helping others in ways that embody the true "aloha" spirit.

Since its founding in 1994, the Luau has raised more than $1 million for the center. Much of these funds have been used as "seed money" that finances the initial stages of promising cancer research projects and helps them qualify for additional funding from federal or other sources.

The Luau also has earned a worldwide reputation as one of the finest and most soulful surfing-themed philanthropic events anywhere. It is organized by a passionate grassroots network of local volunteers (many of whom are cancer survivors), and is generously supported by a diverse collection of prominent, community-minded companies, organizations and individuals. This year's event promises to be extra special, as it is the 10th anniversary of the UCSD Cancer Center Luau.

This event is especially meaningful to me because in the summer of 1998, I am one of thousands of men who was diagnosed with prostate cancer following a simple prostate-specific antigen (PSA) test. During my annual examination in the summer of 1998, my doctor noted a slight elevation in my PSA test. He followed up with a sonogram and an MRI, neither of which revealed the disease. It was only after a prostate biopsy that it was determined that I had cancer. Following the diagnosis, in consultation with my family, I decided to pursue surgery as my treatment option. I am fortunate—early detection saved my life. My doctor was familiar with PSA results, and I had healthcare coverage for my treatments. As a cancer survivor, I personally understand the hope that the groundbreaking research provides to individuals who are suffering, or who have a loved one who is battling a disease. I understand the importance of finding better ways to diagnose and treat this disease which affects so many people in our nation.

I am proud to support the UCSD Cancer Center, and I urge my colleagues to join me in recognizing the Luau and Longboard Invitational. This event will help to ensure that the Cancer Center is able to continue to provide quality services to those facing cancer, and to develop new lifesaving treatments.

TRIBUTE TO THE VILLAGE OF SOUTH RANGE, MICHIGAN ON THE CENTENNIAL OF ITS FOUNDING

HON. BART STUPAK

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. STUPAK. Mr. Speaker, I rise today to congratulate the Village of South Range, Michigan on 100 years of vibrant community life as the Village celebrates the centennial of its founding.

In 1903, Theodore Roosevelt was President, the Wright brothers made their historic first flight on the hills outside Kitty Hawk, and Henry Ford started the Ford Motor Company with the introduction of the Model A Ford roadster.

Another memorable event of 1903 was the founding of the Town of South Range by the Whealkate Mining Company, at the south end of the copper range on the Keweenaw Peninsula in Michigan's Upper Peninsula.

At the time the Town of South Range was founded, most of the land within its boundaries was owned by various copper mining companies who had flocked to the area with the discovery of rich copper deposits in the 19th century. This period in the Keweenaw's history, and the economic and cultural fabric created by the mines, the miners, their families and the communities that grew up around them is the story commemorated by the Keweenaw National Historical Park.

Once the Town of South Range was platted, it became possible for hardworking miners and local people to buy the lots and begin to build a community separate from the mining companies that most of them worked for. As the town grew, businesses, churches and social clubs were created to serve its inhabitants.

In 1906 the residents petitioned the Houghton County Commissioners to incorporate the Village of South Range, which it remains today. The Village may have fewer than one thousand residents and winter weather that averages fifteen feet of snow, but its people also have warm hearts and a true civic spirit.

Led by Village President Michael Rompf, they have planned a two week centennial celebration during which South Range will choose a centennial queen and highlight its history with photo exhibits, mine tours, visits to historic sites and a living history re-enactment.

South Range residents have not forgotten music and dancing, just like the socials that provided respite from the backbreaking work in the mines for their forebears. They plan dancing to swing and polka music, and teen dances for the younger crowd. A pasty supper, community flag raising on the Fourth of July, a parade, craft and dog shows, slow pitch softball and of course, fireworks will all bring community residents and visitors closer together.

On a serious note, a ceremony will re-dedicate South Range's memorial to war veterans, the "Honor Roll," at the Community Center on July 5th. This will mark completion of the restoration of the memorial and honor those who served in action from South Range. An observance of the 50th anniversary of the Korean War will follow this ceremony, hosted by South Range's VFW Post.

Mr. Speaker, I ask that you and my fellow Members of Congress join me in extending warm congratulations to the Village of South Range as we celebrate not only the birth of our great nation, but also the contributions and hard work that made possible South Range's 100 years of continued vitality as a community. South Range and thousands of communities like it are truly the bedrock Of our national strength.

REGARDING THE CAMBODIAN NATIONAL ASSEMBLY ELECTIONS

HON. JAMES A. LEACH

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. LEACH. Mr. Speaker, I rise to note that Cambodia is scheduled to hold its National Assembly elections on July 27, 2003, and to express our hopes and concerns that the electoral process be free and fair. The United States is strongly committed, not to a particular outcome in those elections, but to a credible process that is fair in its administration and execution, and free of the violence, intimidation, and alleged fraud that sadly have marred other elections since the 1997 coup in that country.

On June 10, 2003, the Subcommittee on Asia and the Pacific held a hearing on "Recent Developments in Southeast Asia" that focused in part on the upcoming Cambodian elections. While there have been improvements in recent years, such as an updated Electoral Law and a new National Election Committee, certain credible concerns persist. Experts at our hearing and other observers have questioned the independence of the Election Committee, complained of opposition politicians' lack of access to Cambodian mass media, and raised concerns about continuing political violence. In February, Om Radsady, an outspoken critic of Prime Minister Hun Sen, was assassinated. That same month, at least two other dissidents were detained on frail allegations that they were responsible for inciting the January 29, 2003 anti-Thai riots in Phnom Penh, during which the Thai Embassy was attacked and damaged. These incidents underscore the need for further vigilance.

For these reasons, I join the U.S. Department of State in calling on the Government of Cambodia to prevent all forms of election coercion and to prosecute perpetrators of violence. I also share the Department's hope that the Cambodian National Election Committee will demonstrate its neutrality and independence, fulfill its promise of equal media access, and act rapidly to deal with allegations of irregularities during the 30-day election campaign period, on polling day, and during the ballot counting process.

The people of the United States share the aspirations of the people of Cambodia to free expression, self-determination, and the development of an election administration that commands confidence across Cambodian society. We sincerely hope that the July 27 elections will be an important step in that process.

IDENTITY THEFT PROTECTION AND INFORMATION BLACKOUT ACT OF 2003

HON. RAHM EMANUEL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. EMANUEL. Mr. Speaker, I rise today to introduce the "Identity Theft Protection and Information Blackout Act of 2003." I am proud to offer this legislation on behalf of eighteen of my Republican and Democratic colleagues in the House.

As Congress debates reauthorization of the Fair Credit Reporting Act's preemption provisions, ordinary Americans are more concerned than ever about the privacy of their financial and health information. Moreover, the identity theft epidemic continues to disrupt lives and cost families and businesses millions of dollars. Americans want, need, and expect the Federal government to take action to address these issues.

In response to this urgent problem, my legislation establishes methods for preventing identity theft and amends the FCRA to protect consumers' sensitive, private health-related information by safeguarding it from indiscriminate use by credit bureaus, financial institutions, and affiliates.

This legislation also protects Social Security numbers from identity thieves. An individual's Social Security number has been called the "the golden key" to financial identity theft. To protect this vital key to personal information, my legislation institutes national standards governing the collection, use, display, sale and security of social security numbers by government and by private sector entities.

Mr. Speaker, I encourage my colleagues to join me in cosponsoring the Identify Theft Protection and Information Blackout Act, and I strongly urge the House to consider this important measure as we move closer to reauthorizing the Fair Credit Reporting Act and similar legislation to keep personal financial and related information private and protected from fraud and abuse.

CONGRATULATIONS HONORARY DEGREE RECIPIENTS

HON. MARCY KAPTUR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. KAPTUR. Mr. Speaker, it is with the greatest pleasure that I congratulate the 2003 Honorary Degree recipients from John Carroll University, Monsignor William Linder, who received a Doctor of Laws, and the recipients of a Doctorate in Humane Letters, Sonya Rendon Blacio and Mary Patricia McTeague. America is fortunate to be blessed with citizens of their high calibre and profound dedication.

Monsignor William Linder has spent his life saving cities and souls. During the Newark riots of 1967, the New Jersey native, a parish priest at the time, stepped forward to bring people together and build trust. He moved through the battle zone, delivering food and transporting the injured to hospitals. After the smoke cleared, the priest called together a group of residents to set about rebuilding the city they loved. In Newark's Central Ward, they formed the New Community Corporation (NCC) and charged it with the mission of creating housing and the products and services that would bring jobs. The NCC has become the largest and most successful community development organization in the United States. It has brought new life to the old city of Newark, providing housing and jobs for thousands, and creating a community development model that is now being studied and emulated throughout the world. Monsignor Linder has won the McArthur Foundation "Genius" fellowship, and he has received countless honors in the course of his remarkable ministry to the people of northern New Jersey. He has said, "I have never really thought of myself as a pastor to only Catholics. I am a pastor of people."

In honor of Monsignor Linder, Professor George Bilgere penned the following poem:

You walked into the battle zone
Of Newark in the sixties
A young, audacious, rabble-rousing priest,
Hoping to rebuild the city from its core,
To heal its broken heart, to do
What no one believed you could do.

The broken-hearted cities,
The neighborhoods called Hough
And Watts and Spanish Harlem,
Are not the parts of America
We think of saving
When the bombs are falling,
Or when the flag is waving
Over baseball games in spring.

Probably there aren't many flags
Waving over East St. Louis or Cabrini Green
Or Roxbury or Eight mile,
But it's hard to know for sure
Because no one travels there
Who doesn't have to.
Only those who have no choice
Live in the broken heart
Of America.

But now, thirty-five years later,
A gray-haired, audacious, rabble-rousing priest,
You watch the Central Ward prosper
While the country watches you,
Taking hope from the strength and courage,
The hard work of one stubborn man,
One man of vision who understands
That America will not be whole or free
Until the cities,
The broken-hearted cities, are healed.

Sonya Rendon Blacio and Mary Patricia McTeague have had dramatic success in creating a new world in Guayaquil, Ecuador. Rendon, an Ecuadorian education, and McTeague, an American and a former nun, have built a school that is a model of both educational excellence and egalitarianism. At Escuela Nuevo Mondo, which the two women began in 1979, the school's 200 faculty members instruct 1400 tuition-paying students, the children of affluent Ecuador, in the morning. In the afternoon, 900 children of poverty receive the same education for free from the Fundacion Nuevo Mondo. Rendon and McTeague state that Nuevo Mondo is in truth "a social revolution aimed at changing attitudes between social classes and opening doors to offer options to some of the 80 percent of Ecuadorians who otherwise would not have the opportunity for quality education, medical and social assistance." Today, Nuevo Mondo operates elementary and high schools, a commercial bakery, two day care centers, two medical centers and vocational training projects. The people of Ecuador continue to struggle, but Nuevo Mondo has been a beacon pointing the way to a new world.

In honor of Sonya Rendon Blacio and Mary Patricia McTeague, Professor George Bilgere penned the following poem:

On the coast of Ecuador,
Out of poverty and despair,
A new world is rising,
One classroom at a time
A Nuevo Mundo, where once
Was only a jungle and a dream.

At first your idea was simple;
Build a school for their children
So in the afternoon
There would, at last, be a classroom
For the children of the poor.

But you learned over time
That the rich, too, are poor,
As long as they can't define
The word hunger, or explain
What it means to have no shoes,
Or to be unable
To read the Bible, or a novel,
Or your name.

Real change, you found,
Comes only when the rich man suffers
To learn from the beggar
That they are brothers
Who can help each other
Ease the pain of the world;

Only then will come the day
When the old world passed
Through hard work and love
And the Gospel of Jesus Christ,
Into the new world you dream of
And are building from the jungle
One classroom at a time,
That Nuevo Mundo, where all
Are brothers and sisters,
Equal in every way.

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2003

SPEECH OF

HON. DENNIS MOORE

OF KANSAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Mr. MOORE. Mr. Speaker, I rise in opposition to H.R. 660. It is being promoted by some in Congress as the silver bullet that will help small businesses get health insurance, but I believe that this legislation puts consumers at risk without helping small business owners get health insurance.

Many of my concerns about AHPs mirror those of Sandy Praeger, the Kansas Insurance Commissioner. I will quote extensively from her remarks about AHPs made before the Senate Small Business and Entrepreneurship Committee on February 5, 2003.

AHPs will not reduce the cost of health insurance for small businesses. In fact, the Congressional Budget Office (CBO) estimates that H.R. 660 would actually drive up the cost of coverage for 20 million individuals—80 percent of small employers and their families who are now covered under employer-based health insurance plans. The results of this legislation could actually make coverage less affordable for the vast majority of small business workers who now have coverage. A recent study released by National Small Business United (NSBU) found that AHPs would result in more than 1 million more uninsured and cause premiums to skyrocket for the sickest workers.

Additionally, H.R. 660 will hurt those who most need health coverage, and those who employ them. H.R. 660 could actually hurt those who most need health coverage by allowing AHPs to "cherry pick" only the healthiest, cheapest-to-insure individuals to participate in their plans. Most States prohibit this kind of health insurance discrimination, but H.R. 660 would preempt these anti-discrimination measures in most States, allowing AHPs to discriminate against those who most need coverage. Commissioner Praeger's remarks illustrate how H.R. 660 would undermine State reforms in this regard and leave sicker and higher risk employees out in the cold.

In order to keep costs low, AHPs would have an incentive to target the people who are the least costly to insure—healthy, young people who rarely access health services. By giving AHPs the power to charge higher premiums for less healthy groups and the discretion to offer narrower benefits, these bills will allow AHPs to deter less healthy groups from enrolling. Small businesses that employ older, disabled or chronically ill individuals would be forced to pay more out-of-pocket or left behind altogether. As noted above, 80 percent of small employers will be left out and will likely see their premiums increase as the State-regulated health insurance market loses its healthy individuals to AHPs, leaving sicker and older individuals in the State market.

State consumer protections, such as external appeals of disputed claims, would be ignored as well as other guaranteed benefits such as maternity care, mammograms, mental health treatment, or diabetes. For many years, I have supported efforts to enact a strong patients' bill of rights that would extend consumer protections to all Americans. This legislation, however, would expose millions of workers—in both small and large businesses—who now enjoy the advantages of State consumer protections into plans that are completely exempt from those protections.

Fundamentally, AHPs would completely destroy the State insurance market. As Commissioner Praeger stated:

> The AHP legislation in Congress would undermine state reforms and once again fragment the market. Each association would create its own risk pool that, due to the benefits provided, types of business in the association, or area serviced, could have significantly lower risk than the general market. While the bill does make some effort to reduce "cherry picking" the NAIC believes the provisions would be inadequate.

Commissioner Praeger goes on to say:

> This self-selection is extremely disruptive to the marketplace and will create a very unstable situation in an already fragile small group market, likely reducing the number of insurers willing to offer coverage in the general market. Insurance is of little use unless the costs of caring for the relatively few can be distributed among the many who are healthy.

AHPs would exempt health insurers from State rules that are needed to effectively govern health insurance companies. AHPs would also be exempt from State solvency laws and oversight and subject to inadequate standards. The American Academy of Actuaries has said that the solvency standards for AHPs contained in H.R. 660 are inadequate, and Commissioner Praeger's testimony underscores these concerns. Her testimony states that the solvency standards under the bill are "woefully inadequate" and goes on to predict "If a nationwide AHP were offered to a large association, a capital surplus of only $2 million would result in disaster." Supporters of H.R. 660 claim that the Department of Labor has sufficient resources to oversee the new plans and prevent insolvencies and fraud. Commissioner Praeger believes that this is not the case. She notes that "The Department of Labor has neither the resources nor the expertise to regulate insurance products."

More than 500 organizations—including many of the major consumer and health care provider organizations—have voice their opposition to this legislation. The legislation is also strongly opposed by the Nation's Republican and Democratic governors, attorneys general and insurance commissioners. Additionally, many in the small business community oppose H.R. 660, including the National Small Business United (NSBU), which has voiced its opposition to this legislation because it would hurt, not help, many small employers. They cite a recent study by Mercer found that AHPs would result in more than 1 million more uninsured and cause premiums to skyrocket for the sickest workers.

I do understand that small employers are clamoring for relief from the high cost of health care, and I support efforts to improve individuals' and small businesses' ability to obtain quality health insurance. I have introduced H.R. 1937, the Small Business Health Insurance Availability Act. This bill would do several things to help uninsured Americans who work for small businesses get adequate health care. My legislation would establish a tax credit toward the purchase of health insurance for all small employers who choose to offer it. The credit will reimburse 20 percent of health insurance costs, up to $400 per year for individuals and $1000 for family coverage. Businesses can get an additional 10 percent tax credit (up to 30 percent total) if they join in a Health Benefit Purchasing Coalition, which provides small employers a way to pool resources, negotiate collectively with insurers, and administer health plans for small employer groups. In order to foster innovation on the State level, the bill creates State grant programs for initiatives that expand health insurance to the uninsured through market innovations.

I believe that we must help uninsured Americans to obtain health insurance while not putting individual insurance markets or consumers at risk. My legislation, in contrast to the very controversial AHP proposals, could be enacted into law immediately without disrupting health insurance markets or regulatory structures. It would also preserve the rights and protections of consumers in States and ensure that the business of health insurance remain regulated on the State level. It would also give small business owners, like their big business competitors, the opportunity to band together and bargain for better insurance rates and terms.

INTRODUCTION OF H.R. 2620 TRAFFICKING VICTIMS PROTECTION REAUTHORIZATION ACT OF 2003

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. LANTOS. Mr. Speaker, today I proudly joined my good friend from New Jersey, the Chairman of the Veterans Committee and the Vice-Chairman of the Committee on International Relations, in introducing H.R. 2620, the Trafficking Victims Protection Reauthorization Act of 2003.

Mr. Speaker, in the 106th Congress, Mr. Smith and our former colleague, Sam Gejdenson of Connecticut, spent enormous energy to pass the Trafficking Victims Protection Act of 2000. I was proud to be an original co-sponsor of that landmark legislation. It is wise to recall where we were just a few short years ago with respect to trafficking of persons. The CIA estimated that 50,000 people were being trafficked into the United States each year and being held in conditions that amounted to modern day slavery. They were being forced to labor in our fields, to work endless hours in sweatshops, and to serve in sexual slavery in cities across our land. U.S. prosecution of traffickers faltered because attorneys in our Department of Justice did not have the right tools to pursue the new forms of trafficking, which often relied on threats, not chains, and on document fraud, not bills of sale. Overseas, millions of people were being used as chattel, and the brothels of Bombay and Bangkok were overflowing with prostitutes, many young girls, who were forced to provide sex. Governments were barely aware of what was happening to their own people, and where they were, they usually blamed the victims and forgot about them. And the international community was just starting to fashion an international agreement to address the horrors of trafficking.

Today the picture is visibly brighter. Because of the enactment of the Smith-Gejdenson Act, the Attorney General is prosecuting cases from American Samoa to New Jersey and has recently achieved the first conviction under the new tools provided by that Act right here in the DC metropolitan area. Victims are coming forward because of the federal benefits we are offering to them, treating them like the refugees that they are. The naming of countries that are not making significant efforts to combat trafficking and the threat of sanctions against them are forcing measurable changes in the way that governments around the world are facing this modern day form of slavery. A new international criminal protocol is gaining wide acceptance, and is being studied by the Administration. Modern day slavery is under assault from all directions.

But Mr. Speaker, we need to do more. In the two-and-a-half years since the enactment of the Smith-Gejdenson Act, we have learned much more about the phenomena of trafficking and how to combat it. It is time to do a thorough review of our trafficking statutes and ensure that we are doing everything we can to prevent trafficking, protect victims and prosecute traffickers.

And that is exactly what the Trafficking Victims Reauthorization Act of 2003 accomplishes. Drawing from the conference earlier this year held by the Department of State, this bill authorizes new strategies for prevention, including using trafficking victims to identify traffickers at the borders and deterring sex tourism, which is part of the fuel of sex slavery around the world. It increases protection by making measured expansions of the visa category for trafficking victims and related provisions to better enable cooperation, particularly with respect to state and local trafficking prosecutions, which are increasingly the front line of law enforcement in this area. And it enhances prosecution of traffickers by, for example, ensuring that trafficking is treated like the organized crime that it is. Perhaps most critically, it demonstrates Congressional commitment to fighting this scourge by authorizing additional funds for U.S. agencies to combat this human rights crisis around the world.

Mr. Speaker, I salute Congressman SMITH, Congressman PITTS and Congresswoman SLAUGHTER for the vision they are showing today by joining me in this fight against trafficking in human beings. Just as we made a real difference two-and-a-half years ago, we can accelerate our fight against modern-day slavery. I urge all my colleagues to join in this fight.

BILL TO MAKE PERMANENT THE EXPANDED EXPENSING BENEFITS PROVIDED TO SMALL BUSINESSES UNDER THE JOBS AND GROWTH TAX RELIEF RECONCILIATION ACT OF 2003

HON. WALLY HERGER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. HERGER. Mr. Speaker, last year Congress, working together with President Bush, enacted into law the Jobs and Growth Tax Relief Reconciliation Act of 2003. Among other provisions, this new law strengthens and expands the expensing provisions afforded to small businesses under section 179 of the Internal Revenue Code. As such, the law encourages small businesses to make new capital investments, thus spurring our economy and creating jobs. I believe Congress should make this provision permanent and today I am introducing the "Small Business Expensing Permanency Act of 2003" to do just that.

Specifically, the Jobs and Growth Act increases from $25,000 to $100,000 the amount of new investment a business can expense—or deduct from income—in a given year. The new law also increases—from $200,000 to $400,000—the amount of total investment a business can make in a year and still qualify for expensing under section 179. Unfortunately, under the new law, these provisions are set to expire after 2005.

My legislation will repeal the 2005 sunset. If the higher expensing limits are good for our nation's small businesses over the next two years, they should be good for small businesses indefinitely.

Small businesses truly are the backbone of our economy, representing more than half of all jobs and economic output. We should not take small business vitality for granted, however. Rather, our tax laws should support small businesses in their role as the engines of innovation, growth, and job creation.

Mr. Speaker, in difficult economic times, we must do all we can to encourage new investment and job creation by creating certainty and predictability for America's small business owners. The "Small Business Expensing Permanency Act of 2003" will help accomplish this worthy goal. I applaud the administration for its consistent leadership on this issue, and I look forward to working with my colleagues to enact this much-needed legislation.

H.R. 2620: TRAFFICKING VICTIMS PROTECTION REAUTHORIZATION ACT

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SMITH of New Jersey. Mr. Speaker, today I am introducing the Trafficking Victims Protection Reauthorization Act of 2003, which is intended to improve the United States efforts in combating the scourge of human trafficking. I am very pleased to have Congressmen LANTOS, ranking member of the International Relations Committee, Congressman PITTS and Congresswoman SLAUGHTER, join me as original cosponsors.

According to a recently released U.S. Government estimate, 800,000 to 900,000 women, children, and men fall victim to international trafficking each year and end up prisoners of slavery like practices in the commercial sex industry, domestic servitude, sweatshops, and agricultural farms, among other destinations.

In October 2000, we adopted the Trafficking Victims Protection Act (TVPA), P.L. 106–386. As a result of that law, the U.S. Government allocated $68.2 million last year to combat trafficking in human beings. In the past two years, federal prosecutors initiated prosecutions of 79 traffickers—three times as many as in the two previous years. Nearly 400 survivors of trafficking in the United States have received assistance, facilitated by the Department of Health and Human Services, to begin recovering from their trauma and to rebuild their shattered lives. Thanks to the efforts of the State Department, USAID, and the spotlight put on the issue through the annual Trafficking in Persons Report, governments worldwide have also begun taking significant actions against human trafficking.

Despite these substantive inroads, people continue to be bought and sold in modern day slavery. Victims continue to face obstacles in the process of securing needed assistance. We are not yet addressing trafficking in persons as an organized crime activity. We have not yet aggressively targeted sex tourism as a factor contributing to the demand for trafficked persons in prostitution, and more specialized research is needed.

The Trafficking Victims Protection Reauthorization Act (TVPRA) would address these and other areas of concern, would authorize funding to continue our government's efforts against trafficking, and would build upon the experience of implementing the TVPA to refine U.S. laws and practices to better fulfill the intent of that law. Specifically, the TVPRA would enhance the prevention of human trafficking by:

Requiring that U.S. Government contracts relating to international affairs contain clauses authorizing termination by the United States if the contractor engages in human trafficking or procures commercial sexual services while the contract is in force;

Promoting innovative trafficking prevention initiatives, such as border interdiction programs; and

Requiring airlines to inform passengers about U.S. laws against sex tourism.

The TVPRA would enhance protections for trafficking victims by:

Allowing Federal, State, or local law enforcement authorities to certify, for the purpose of receiving benefits, that a victim of trafficking has cooperated in the investigation or prosecution of trafficking crimes;

Allowing trafficking victims to sue their traffickers in U.S. courts;

Eliminating the requirement that a victim of trafficking between the ages of 15 and 18 must cooperate with the investigation and prosecution of his or her trafficker in order to be eligible for a T-visa;

Allowing benefits and services available to victims of trafficking to be available for their family members legally entitled to join them in United States; and

Providing for the confidentiality of T-visa applications.

The TVPRA would enhance prosecution of trafficking-related crimes by:

Permitting federal anti-trafficking statutes to be used to prosecute acts of trafficking involving foreign commerce or occurring in the special maritime or territorial jurisdiction of the United States;

Making human trafficking crimes predicate offenses for RICO charges; and

Encouraging the use of International Law Enforcement Academies to train foreign law enforcement authorities, prosecutors and members of the judiciary regarding human trafficking.

The TVPRA would improve the U.S. Government's response to trafficking by:

Encouraging critical research initiatives;

Mandating a report on Federal agencies' implementation of the TVPA;

Designating that the Director of the State Department Office to Monitor and Combat Trafficking shall have the rank of Ambassador-at-Large; and

Prohibiting the use of funds to promote, support, or advocate the legalization or practice of prostitution.

The TVPRA would reauthorize appropriations for each of FY 2004 and 2005:

$4 million to the Interagency Task Force to Monitor and Combat Trafficking;

$15 million to the Department of Health and Human Services;

To the Secretary of State, $15 million for assistance for victims in other countries; $15 million for programs to improve law enforcement and prosecution; and $15 million for trafficking prevention initiatives;

$300,000 to the Organization for Security and Cooperation in Europe for trafficking prevention and legal reform programs;

$15 million to the Department of Justice for assistance to victims in the United States and $250,000 for anti-trafficking training activities at the International Law Enforcement Academies (ILEAs);

$15 million to the President for foreign victim assistance (prevention activities); $15 million for assistance to foreign countries to meet the minimum standards to combat trafficking; $300,000 for research; and $250,000 for anti-trafficking training activities at the ILEAs; and

$10 million to the Department of Labor.

Mr. Speaker, the Trafficking Victims Protection Act of 2000 enjoyed broad, bipartisan support in both Houses of Congress. We are making progress in our battle against modern day slavery, but clearly there is still much work to be done by government authorities, by civil society, by our faith communities, and by all men and women of good will. As lawmakers, we have the opportunity to make our contribution to this endeavor. I strongly urge my colleagues to support this commonsense reauthorization bill to support and enhance the good work which has been undertaken.

RECOGNIZING MARY ELLEN DESANTOS

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. SOLIS. Mr. Speaker, I rise today to pay tribute to an individual who has dedicated over twenty-five years of her life to public education, Mary Ellen DeSantos, on the occasion of her retirement.

DeSantos' remarkable contributions as an educator with the Los Angeles County Office of Education are well known. Her leadership has proven invaluable in implementing innovative approaches to improve the quality of education for language minority students in the Los Angeles County area utilizing the Title I and Title VII program.

DeSantos has taken on many roles in the private and public education sector in Arizona and California. Over the course of twenty-five years she has been a primary and secondary education teacher, director of state categorical programs, bilingual coordinator, and a vocational teacher trainer.

Mary Ellen DeSantos' hard work has enriched the lives of over eight thousand students. Her numerous contributions will not be forgotten.

TRIBUTE TO FABIUS-POMPEY BOYS BASEBALL TEAM

HON. JAMES T. WALSH

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WALSH. Mr. Speaker, I rise today in recognition of the stellar Varsity Boys Baseball Team of Fabius-Pompey High School, winners of the Class C New York State Championship.

This year the Boys Baseball Team earned their 6th consecutive Section 3 title, as well as their second State Champion title. These awards are only fitting, since at the end of their Spring 2003 season they were on a 55–game winning streak in their own Patriot Division. Coach Shawn May certainly has much in which to be proud.

On behalf of the entire 25th District of New York State, I would like to congratulate the following champions: Christopher Blanck, Erik Dodge, John DeMetro, Mathew Morse, Mitchell Morse, Seth Woodford, Brett Farewell, Keith Fields, Andrew Ford, James Spicer, Joshua Truax, Joseph Wilcox, Brendan Blanck, Coach Shawn May, and Assistant Coaches Josh Virgil, Kevin Carroll, and Rich Kuty.

CERTIFICATION OF ASSISTANCE TO SERBIA

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SMITH of New Jersey. Mr. Speaker, the U.S. Department of State last week made its determination to certify compliance by the Government of Serbia and Montenegro with the terms of section 578 of the Consolidated Appropriations Resolution (P.L. 108–7). This section conditions certain bilateral assistance to Serbia on progress in three areas, although by far the most critical being cooperation with the International Criminal Tribunal for the former Yugoslavia.

I agree with the Department's assessment that progress has been made, especially since March. In particular, I welcomed action earlier this month by the Serbian authorities to apprehend Veselin Svjilancanin, indicted by the Tribunal for the 1991 massacre near Vukovar in Croatia. Although there was resistance, this action was a success and signaled what is perhaps a new determination by Belgrade to transfer all remaining indictees. Having been in Vukovar, along with my good friend and colleague Mr. WOLF, just before the city fell to Serb forces, I am glad to see all three indicted by the Tribunal for this crime will be tried in The Hague.

Nevertheless, Mr. Speaker, I am concerned that the Department's determination was the wrong one to make. While progress has been made, it remains insufficient. Still at large and believed to have been in Serbia are several other persons, including Ratko Mladic and others—Ljubisa Beara, Vujadin Popovic, Ljubomir Borovcanin, Vinko Pandurevic and Drago Nikolic—indicted by the Tribunal for their connection to the 1995 Srebrenica massacre in which thousands of innocent people were executed.

I am concerned, deeply concerned, that these individuals will continue to evade justice while officials in Belgrade may get the impression they have done enough. Clearly, they have not. Mr. Speaker, I would urge Serbian authorities to take the action necessary to remove "cooperation with the Tribunal" as an outstanding issue in our bilateral relationship. In doing so, they will also continue to help Serbia emerge from Slobodan Milosevic's legacy of nationalist hatred.

In the meantime, Mr. Speaker, I also urge the State Department to use remaining levers to encourage not just better, but full, cooperation with the Tribunal, which Secretary Powell had assured Mr. CARDIN and myself in correspondence was a position we all shared. The crimes which occurred were too severe and too horrendous to allow those responsible to escape justice.

RECOGNIZING ANTONIO R. VILLARAIGOSA

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. SOLIS. Mr. Speaker, I rise today to recognize an outstanding individual who has made significant contributions to improve the quality of life of the constituents of California's 32nd Congressional District, Antonio Villaraigosa.

Antonio Villaraigosa is a visionary, caring and progressive public servant. Throughout his professional career, Antonio Villaraigosa has held various leadership positions in the public sector and the labor movement. He served on the boards of the Southern California Rapid Transit District and the Metropolitan Transportation Authority. In 1994, he was elected to the California State Assembly representing the 45th District of Los Angeles, and four years after was elected Speaker of the Assembly. As Speaker of the Assembly he was credited with fostering an unprecedented era of bipartisanship.

As a true coalition-builder, Antonio Villaraigosa spearheaded a $9.1 billion initiative to rebuild and modernize California schools, a $2.1 billion initiative to provide parks and open space throughout the state, and a state health insurance program, "Healthy Families."

On June 28, 2003, Antonio Villaraigosa will be sworn in as Los Angeles City Councilmember representing the 14th District. Some of his priorities include community safety, economic development, environmental issues and constituent services. His outstanding accomplishments and efforts to improve his community are inspiring and worth honoring.

TRIBUTE TO WEST GENESEE VARSITY BOYS AND GIRLS LACROSSE TEAMS

HON. JAMES T. WALSH

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WALSH. Mr. Speaker, I rise today in recognition of the high achievements of the boys and girls lacrosse teams from West Genesee High School. For the second year in a row, both teams battled their way to the New York State Class A Lacrosse State Championships, and brought home the title.

Having won the title for the third year in a row, the girls team also earned the honor of being the first Division I team ever to take home three successive state championships. Led by Coach Bob Elmer, the Lady Wildcats completed their season by adding number 67 to their ongoing winning streak.

The boys' team acquired the 12th state title in West Genesee boys lacrosse history. Coached for the last 28 years by Mike Messere, this team has a lot to be proud of, having beaten the No. 1 ranked team in the state.

On behalf of the people of the entire 25th District of New York State, I would like to congratulate the following champions on their incredible victories:

Girls: Eileen Gagnon, Samantha Falcone, Kelsey Campbell, Shannon Burke, Meghan Burgoon, Katie Donovan, Lyndsay Moore, Jacquie Griffin, Kendall Tupper, Betsy Bubnack, Kelly Nelson, Coileen O'Hara, Ashley Didio, Kathryn Keneally, Julie Fabrizio, Eireann Byrne, Lauren Delprato, Beth Elmer, Lindsay Hamann, Jamie Boulton, Kelly Duffy, Lisa McCarthy, Keelin Hollenbeck, Lori Pietraszek, Head Coach Bob Elmer and Assistant Coach Dan Hallinan;

Boys: Mike Malfitano, David Osier, Joel Derrigo, Brian Cast, Jake Moulton, Jed Bebee, Josh Begley, Kevin Hennigan, Brian Stanton, Andrew Hanover, Alex Bily, Cheney Raymond, Dan Bolestra, Pat McCormack, Jeff Murphy, Drew Dabrowski, Tom Donahue, Kiel Moore, Michael Paul Solomon, Marc Cizenski, Andrew Sugar, Bill Gleason, Casey Rotella, Chris Bulawa, Brian Cummings, Chris Duffy, Sean Leahy, Brian Calabrese, Bob Toms, Michael Malone, Mark Keida, Matt Cassalia, Tom Geiss, Head Coach Mike Messere, and Assistant Coach Bob Deegan.

FISHING QUOTA STANDARDS ACT OF 2003

HON. THOMAS H. ALLEN

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. ALLEN. Mr. Speaker, I join my colleagues Mr. ROBERT SIMMONS, Mr. WILLIAM DELAHUNT, Mrs. LOIS CAPPS, Mr. MICHAEL CAPUANO, Mr. SAM FARR, Mr. EDWARD MARKEY, Mr. GEORGE MILLER, and Ms. LYNN WOOLSEY in introducing the "Fishing Quota Standards Act of 2003."

From 1996 until 2002, Congress placed a moratorium on new quota programs, programs which place limits on the amount of the total allowable catch that a fisherman may harvest within a particular fishery. The purpose of the moratorium was to protect fishermen, coastal communities, and the marine environment from the negative effects of unregulated quota systems by giving Congress an opportunity to develop national standards. When left unchecked, quota systems can give unfair advantages to the highest bidder—leaving the family fishermen out in the cold. Quota programs can also create over-consolidation of the industry, negative impacts on local communities and individual fishermen, and over-harvesting of the resource. When the moratorium expired last September, no national standards had been put in place, leaving regional fishery management councils free to develop new quota programs.

That is why we are introducing the "Fishing Quota Standards Act of 2003." This Act allows for the establishment of fishing quota systems if they allocate quota fairly among fishermen, prevent excessive consolidation, and include management measures designed to ensure the sustainability of the fishery. Both quota systems and share holders must come under periodic review to ensure adherence to the goals of the program. Standards legislation must be passed as soon as possible to avoid any future negative results from quota systems developed without any standards at all.

This Act allows for the establishment of fishing quota systems within a fishery management plan or plan amendment if such systems:

Are voted on and approved by fishermen who hold a permit to fish in the fishery and crew who derive seventy-five percent of their income from the fishery subject to the proposed fishing quota system.

Include management measures designed to ensure the sustainability of the fishery and provide additional and substantial conservation benefits to the fishery.

Allocate quota to distribute the public resource fairly.

Not allow anyone to hold an excessive share of quota.

Reserve an allocation to new entrants into the fishery.

Minimize, to the maximum extent practicable, negative social and economic impacts of the system on local communities.

Ensure adequate enforcement, management, and data collection of the system.

Be effective for a set period, 7 years. A system can be altered or renewed to respond to fishery management issues and to ensure the sustainability of fish stocks.

NATIONAL RIVER MUSEUM AND AQUARIUM GRAND OPENING

HON. JIM NUSSLE

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. NUSSLE. Mr. Speaker, I rise today to offer my deepest congratulations to a community I have had the honor of representing since I took office in January of 1991. Tomorrow Dubuque, Iowa will pass a milestone in its history with the official opening of its National Mississippi River Museum and Aquarium.

The Mississippi River has already drawn more than 1 million visitors to the City of Dubuque. This community chose to make its story of the river a cornerstone of urban renewal by investing millions of dollars to revitalize the river front. The June 28 opening represents the community's dedication to growing its tourism industry. For more than 12 years Dubuque has worked to create a world-class center to educate residents and tourists alike about the Mississippi River, its science and cultural history.

This project enjoys rare, unified and vigorous support from local government, the business community, and residents. During difficult economic times in the 1980s, the people of Dubuque came to understand all too well that being subject to a single economic sector's peaks and valleys hinders a city's self-sufficiency. The years of planning for the museum have been a catalyst for change by redirecting the economy toward tourism and making Dubuque a more viable community. Significant changes are happening in the area adjacent to the museum known as the Port of Dubuque. These changes include The Grand Harbor Resort and Waterpark, a new riverwalk, a community amphitheater, and a conference center.

Enthusiasm for this project has been infectious. It has spread to Main Street where activities are beginning to flourish with the opening of new businesses, including several new restaurants. The entire business community in Dubuque and the surrounding area is already seeing a positive economic impact due to this project. Dubuque's spirit of partnership, community pride and determination have helped the city to grow. They have found a way to tie together Iowa's best strengths—our people and our rich natural resources—to serve as an example to other cities of what can be accomplished.

Mr. Speaker, I wish to personally commend Mayor Terry Duggan and other local elected officials for their leadership in Dubuque's revitalization. Additionally, this project would not be possible without the very diligent work of Jerry Enzler and Teri Goodmann. Thanks in large part to Jerry's work, the museum is now an affiliate of the Smithsonian Institution and last year was named by the U.S. Department of Transportation to be the official interpretive center for the Mississippi's Great River Road. Dubuque has been well served by Mayor Duggan, the city council, Jerry, Teri, and the countless others who have been undaunted in their efforts to obtain financial assistance for the museum from individuals, private industries and government officials.

I am proud to have played a part in making this project a reality and look forward to attending the Grand Opening. I believe Dubuque serves as a great example of what a community can do when it identifies goals and pursues them. At one time the phrase often used in the city was, "will the last person out please shut off the lights?" What a difference less than 20 years have made! The city now calls itself, "Masterpiece on the Mississippi." It is truly a masterpiece of natural beauty, historical value, and residents bursting with pride and enthusiasm. Dubuque, your lights are on for the whole world to see and experience.

SUPREME COURT RULING ON AFFIRMATIVE ACTION IS A JUST, FAIR DECISION IN SOCIETY WHERE RACIAL DISPARITY IS STILL THE ROOT OF MANY PROBLEMS

HON. WM. LACY CLAY

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CLAY. Mr. Speaker, I rise to express my joy over the 5–4 ruling by the United States

Supreme Court that favors affirmative action based on race. It is the right decision at the right time. The Supreme Court ruling on affirmative action is a just, fair decision in a society where racial disparity continues to feed problems rooted in racial injustice. It is the right decision at the right time.

On Monday, the Supreme Court announced its ruling in a case where white applicants sued the University of Michigan law school, alleging the use of race was an illegal quota system. The case, Grutter v. Michigan, has been called the most important civil rights case in 25 years because it challenged the use of racial preferences in school admissions.

While we lost on points, or a point system used to help minorities compete for slots, the decision by the high court affirms the United States Constitution on the side of balancing the scales of fairness, not on the side of continuing the unfairness built into a system that allows the racially privileged to continue their reign.

The white ruling class in America was built in large part on slavery and its aftermath—slave wages, and as long as America depends on the beneficence of gatekeepers who are insensitive to the history of this nation and the long-term effects of American apartheid, then the problem of racial disparity will continue.

Affirmative action is one tool that can help make-up for years of deprivation by helping people of color hurdle racial pitfalls in less time than would normally take many more generations to remove," he said. To wait for the goodness of human nature to rise to the top and result in racial fairness, is not judicious governance. It took the courts to help undo segregation and it will take the courts to help maintain justice. Sometimes only laws compel people to do the right thing. Without compulsion, many people of all races will submit to whatever decisions that favors them, even decisions made at the expense of weaker, less fortunate, powerless people.

Good law creates balance and for these times, affirmative action is good law. It addresses the needs of a disparaged group that has been historically discriminated against based on race. To overlook that reality is to impose a new form of segregation. According to Pete Williams, NBC news correspondent for MSNBC News, the 5–4 ruling that favored the university's law school, noted that "race can be one of many factors that colleges consider when selecting their students, while, at the same time, knocking down a similar lawsuit over the university's undergraduate program."

An Associated Press summary said the two split decisions means "minority applicants may be given an edge when applying for admissions to universities, but limited how much a factor race can play in the selection of students. The high court struck down a point system used by the University of Michigan, but did not go as far as opponents of affirmative action had wanted. The court approved a separate program used at the University of Michigan law school that gives race less prominence in the admissions decision-making process."

In April, I noted that affirmative action today really means affirmative access for minorities, a group of Americans that was systemically denied access to education and society in general, for hundreds of years.

What I don't think some people realize is that affirmative action is not new. While affirmative action seems like something out of the ordinary, historically, it is not new.

Segregation was affirmative action for whites. And when it comes to getting into college, there is affirmative action (even quotas) for athletes, intellectuals, artists and the children of the rich, just to name a few categories. Only when minorities were added to the list of beneficiaries has affirmative action become a problem."

Former U.S. Education Secretary Richard W. Riley noted in mid–2002 that a study published by the Educational Testing Service, entitled "Crossing the Great Divide," stated that by the year 2015 the nation's college campuses will be missing 250,000 African Americans and 550,000 Hispanic undergraduates, "because we did not prepare them to do college-level work. (If) the economy continues to demand ever-higher skills for good jobs, minorities will have to run faster just to stay in place."

Mr. Speaker, we know we cannot easily legislate away racism in the heart and minds of people. However, you can legislate and interpret in the courts, a road map that bypasses individual racism and institutionalizes opportunity and affirmative access, for all. Racism in America does not exist in isolation. It's systemic existence calls for affirmative action regarding race if we are to keep the doors open for those who were once summarily denied entrance to a chance to live better lives.

REGARDING LEGISLATION TO ESTABLISH THE INDEPENDENT COMMISSION ON INTELLIGENCE ABOUT IRAQ

HON. HENRY A. WAXMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WAXMAN. Mr. Speaker, today I am introducing legislation to establish the Independent Commission on Intelligence about Iraq. This Commission is necessary to restore the confidence of the American public and the international community regarding the Bush Administration's use of intelligence information about Iraq.

I am joined in introducing this bill by Representative MARTIN FROST, Representative RON KIND, and 20 other members who supported President Bush when he asked for congressional authorization to use force in Iraq. We were allies of the President when he wanted authority to go to war. And we are allies of the President today in the ongoing fight against terrorism.

For us, this issue is not about whether we were right to go to war in Iraq. We voted for the war resolution. And it is not about whether biological or chemical weapons will ultimately be found in Iraq. Instead, we are introducing this bill because it is now clear we had an inexcusable breakdown in our intelligence system prior to the Iraq war. We need to know how and why this happened, so that we can make sure it never happens again.

We need to know whether the breakdown was caused by problems within our intelligence agencies, and whether they failed to do their jobs competently and responsibly. If, as some in the Administration have hinted, essential information was withheld from the President, we need to discover who did that and hold them accountable.

If we find that the intelligence community did their job well, then we need to know whether Bush Administration officials either ignored or misused the intelligence information. At the end of the day, regardless of the consequences, we need to know what went wrong.

We can't avoid the responsibility. President Bush is leading us in a new doctrine of preemptive warfare. While there is obviously disagreement over the merits of this approach, there is unanimity that preemptive warfare's essential ingredient is accurate intelligence. It can't be founded on theory or suspicion—it needs fact. Without that, the world will be unable to distinguish preemptive warfare from ordinary aggression.

The House and Senate Intelligence Committees have already begun the process of assessing the intelligence community's performance, and the Independent Commission we would create here would supplement that valuable effort.

It appears, however, that the Intelligence Committees will not be assessing how the Bush Administration used the intelligence information it received. Representative PORTER GOSS, the Chairman of the House Intelligence Committee, said, "I'm not going into what the customer did with the intelligence." I disagree with that approach, and that review will also be an important part of the Independent Commission's responsibilities.

It is profoundly important that the President, the Vice President, and other senior Administration officials accurately portray intelligence information. There is no question more grave than whether our Nation should go to war. When the topic is whether to commit our armed forces to battle, Congress and the American public need to be able to rely unquestioningly on the accuracy and veracity of the information from the President and other Administration officials.

Unfortunately, serious concerns have already been raised regarding how the Bush Administration handled intelligence information on threats posed by Iraq in the months leading up to the conflict. One of the main questions that has emerged is whether White House officials manipulated or deliberately ignored key intelligence on Iraq. The Administration's responses to date have been incomplete and inconsistent, and have raised a host of new questions.

For months, I have been asking a simple question: Why did the President cite 'forged evidence about Iraq's efforts to obtain nuclear materials from Africa in his State of the Union address?

Yet I have been unable to get an answer to this basic question. Instead, the Administration has provided only murky and conflicting explanations regarding the use of forged evidence by the President and other top Administration officials.

The first Administration explanation, as described in the Washington Post on March 8, 2003, was "we fell for it."

But we now know that wasn't true. Multiple press accounts have reported that CIA analysts doubted the validity of the evidence long before the President's State of the Union address and had communicated those doubts to the White House. Other press accounts have reported that State Department analysts also concluded in 2002 that the evidence was bogus.

National Security Advisor Condoleezza Rice then asserted that "maybe someone knew down in the bowels of the agency, but no one in our circles knew that there were doubts and suspicions that this might be a forgery."

But this also doesn't appear accurate. According to a June 30, 2003, New Republic article entitled "The Selling of the Iraq War: The First Casualty," Vice President CHENEY's office had received the forged evidence from the British in 2002 and had provided it to the CIA; the CIA in turn had dispatched a former ambassador to Africa to check its validity; the ambassador determined the evidence was unreliable; and the CIA communicated this report to the Vice President's office.

Other accounts, such as those by Nicholas Kristof in the New York Times, reach the same conclusion. According to a June 13, 2003, Knight Ridder News Service report by Jonathan Landay: "Three senior administration officials said Vice President DICK CHENEY and some officials on the National Security Council staff and at the Pentagon ignored the CIA's warning and argued that Bush and others should include the allegation in their case against Hussein."

The White House has asserted that the President's State of the Union address was closely vetted by intelligence officials. But if this is so, what did these officials communicate to the President and his White House advisors and how did the White House respond? NPR has reported that early drafts of the President's State of the Union address that contained the forged evidence were reviewed by senior intelligence officials, who objected to the inclusion of the evidence. According to NPR, the White House ignored their objections. Instead, the White House response was to keep the forged evidence in the speech, but to change the wording so that the evidence was attributed to British sources.

Another question raised by the official White House account is why the White House hasn't taken disciplinary action against the CIA Director and other intelligence officials. If the White House was kept in the dark about something as fundamental as forged nuclear evidence—as Condoleezza Rice maintains—this would be an extraordinarily serious failure by the intelligence community. Shouldn't those responsible face equally serious consequences?

Other significant questions regarding the forged documents remain unanswered. For example, in some statements, the Administration has asserted that "additional evidence" supported the claim about Iraq's attempts to purchase uranium in Africa. Yet the only evidence the Administration provided to the IAEA to support its claims was the forged documents. And despite my repeated requests for this other evidence, the Administration has yet to provide it. What is the other evidence? And why didn't the President and other Administration officials cite to it instead of to the forgeries?

And then there is the question of the December 19 fact sheet by the State Department. This fact sheet—which received front-page coverage in the media—repeated the fake evidence that Iraq sought to import uranium from Africa. When I wrote the President about this, the State Department responded as follows: "The December 19 fact sheet was a product developed jointly by the CIA and the State Department."

But according to a senior intelligence official quoted in the Washington Post, the CIA objected to the inclusion of the fake evidence in the State Department fact sheet but the objection "'came too late' to prevent its publication."

Both of these accounts can't be right.

A broad, independent investigation is necessary to answer questions like these. That is why we are proposing a nonpartisan Commission on Intelligence about Iraq. This Commission would examine the collection, evaluation, and use by the Administration of Intelligence on threats posed by Iraq, and make recommendations to Congress and the President regarding steps to enhance the accuracy of intelligence and representations regarding intelligence. The Commission would have the ability to recommend that its findings be made public.

Unlike with congressional committees examining intelligence on Iraq, no political party would have an advantage on the Iraq Commission. Based on the model of the 9/11 Commission which was thoroughly vetted by Congress, the Commission on Intelligence about Iraq would be composed of five members appointed by Republicans and five appointed by Democrats.

Some have tried to deflect efforts to explore questions about the handling of intelligence on Iraq as "revisionist history" or equated such efforts with questioning the war in Iraq. This is misdirected criticism. The purpose of the Commission is simple: to understand the truth.

The Commission's effort should proceed regardless of whether one agrees or disagrees with the ultimate decision to wage war in Iraq, and regardless of whether biological or chemical weapons ultimately are found there. The credibility of our government will remain in jeopardy if we do not resolve doubts regarding the handling of classified information on Iraq.

COMMENDING THE SAN MATEO POLICE DEPARTMENT

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. LANTOS. Mr. Speaker, I rise today to applaud the San Mateo Police Department, whose creative and effective policing strategies over the past decade merit recognition and praise by this body.

Law enforcement is one of the principal functions of responsible government, and the duties of a police department are as vital as they are numerous. I would like to take this opportunity to recognize the enormous strains police departments nationwide are currently experiencing, with their budgets shrinking even as their responsibilities multiply. New antiterrorism duties have been met in many cases not, Mr. Speaker, by additional funds, but by service and pay cuts, as the present Administration and Congressional leadership undermine our nation's Finest with their irresponsible theology of tax cuts.

Mr. Speaker, I ask that my colleagues join me in thanking the police departments of America for their selfless and courageous service in this most trying time for our nation, and in offering our sympathy as they work hard to make America safe.

The San Mateo Police Department stands out among police departments nationally as a paragon of public service and public sensitivity, and has worked creatively to forge partnerships with the community.

Mr. Speaker, the SMPD has made tremendous strides in recent years. During the period from 1997 to 2002, the overall crime rate in San Mateo plummeted 8 percent and there was not a single murder in the city of nearly 100,000 people. The SMPD's hard work has clearly paid off, and in addition to lower crime rates, it has yielded dividends that cannot be quantified.

Ten years ago, Mr. Speaker, the SMPD launched a Community Oriented Policing program, with the ambitious goal of improving the quality of life for every single person who lives and works in the City of San Mateo. The Department sought to accomplish this task by engaging the individuals, businesses, and local service organizations of San Mateo, as well as appropriate outside governmental agencies, and their approach has been enormously successful.

Indeed, Mr. Speaker, the San Mateo Police Department has been incredibly innovative in its efforts to reach out to the community. Among the more creative initiatives launched by the SMPD in recent years is the Citizen-Police Ride-Along Program, in which San Mateo residents accompany an officer in a police cruiser in order to get a sense of what a police patrol is like. In addition, Mr. Speaker, the SMPD has teamed up with San Mateo Parks & Recreation to form the Police Activities League (PAL), an organization with support from the State of California that helps promote trust and understanding between cops and kids. Six years into the program, the verdict is in and it is unambiguous: PAL has been an unqualified success and has contributed to a marked improvement in relations between youth and law enforcement.

Mr. Speaker, I would like to single out San Mateo Chief of Police Susan E. Manheimer for her leadership and her commitment to the principles of equality, professionalism, justice, and the highest standards of ethics. I have the utmost confidence that her commitment to a focused approach of Problem Oriented Policing will further reduce crime in the City of San Mateo and contribute generally to a better quality of life in the area, and I congratulate her on the Department's accomplishments under her stewardship.

And finally, Mr. Speaker, I would like to offer my sincerest and most heartfelt congratulations to police officers Bob Szelenyi and Fred

Haney on their promotion to the rank of Sergeant in the San Mateo Police Department. I have known Bob personally since his infancy, and consider him a man of great character, industry, and integrity. In his decade and a half on the force, Mr. Speaker, Bob has established himself as a leader in mediation and negotiation, and is held in the highest regard for his involvement with San Mateo youth.

Officer Szelenyi has been awarded multiple public service awards for his work with kids, Mr. Speaker, and has earned the respect of his colleagues and many others in my district and the entire Bay Area for his successful negotiation of a gang truce several years ago. That truce prevented countless acts of violence and untold suffering, and we are all eternally indebted to him for his hard work on behalf of the lives and safety of the people of San Mateo.

While I did not have the privilege of watching Mr. Haney take his first steps, Mr. Speaker, I am familiar with his work because his remarkable contributions to the community of San Mateo are so well-known. I am proud that he is one of the top officers defending my community, and I believe his work in preventing gang violence, both as an individual officer and as a member of a special gang task force, contributed to the drop in crime my community has enjoyed over the past five years. Furthermore, Mr. Speaker, I would like to commend Mr. Haney on his work at the frontier of digital evidence and high-tech crimes. He is a model public servant, and I salute him.

Mr. Speaker, I offer my warmest congratulations to the San Mateo Police Department, Police Chief Manheimer, and Sergeants Szelenyi and Haney, and my unending thanks to them for their service to the people of San Mateo. I wish them Godspeed.

DEPARTMENT OF HOMELAND SECURITY APPROPRIATIONS ACT, 2004

SPEECH OF

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 24, 2003

The House in Committee of the Whole House on the state of the Union had under consideration the bill (H.R. 2555) making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes:

Mr. HASTINGS of Florida. Mr. Chairman, I rise today in support of the Department of Homeland Security Appropriations bill. This is the first appropriations bill for the new Department and there are few legislative issues that will have as great an impact on our nation.

As many of my colleagues are aware, I have continually expressed concern over inadequate funding available for first responders. I introduced legislation in both this, and the 107th Congress to remedy this funding shortfall. So, when I first reviewed this legislation, I was pleased to note that it provides $888 million more to first responders than the President requested. However, the CBO estimates that with price increases in the current fiscal year, this legislation, in real dollar terms, is about $150 million below current levels. The proposed legislation is clearly inadequate to provide the homeland security we need.

This is especially alarming given the fact that the states are suffering their worst fiscal crisis since World War II. The National Governors' Association reports that 46 states have significant revenue shortfalls, and that several have shortfalls in excess of $1 billion. Homeland Security is one of our most critical national priorities, and yet this Administration is determined to offer $350 billion in new tax breaks.

A number of critical security shortfalls are not addressed in this legislation. For instance, the U.S. Coast Guard estimates that to adequately secure our ports with cameras and other security measures will cost approximately $4.4 billion, yet this bill provides only $100 million for this initiative. In addition, there are no funds in this bill to improve methods of inspecting people and cargo entering this country through our ports. Nor are their any funds to increase the number of containers inspected. According to nearly every expert in the field of security, these areas have been severely neglected since 9/11.

With the budget deficit projected at more than $400 billion this year, a few billion more for homeland security won't matter very much. I urge my colleagues to carefully consider what a "yes" vote will mean for a number of Amendments that will be introduced later today. True, they will increase the cost of this legislation, but more importantly, they will increase our national security, which is what this bill is fundamentally supposed to accomplish.

H.R. 2035, THE IDENTITY THEFT AND FINANCIAL PRIVACY ACT

HON. MAX SANDLIN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SANDLIN. Mr. Speaker, I am pleased to add my name as a cosponsor of H.R. 2035, the Identity Theft and Financial Privacy Act.

As Congress begins the process of reauthorizing various provisions of the Fair Credit Reporting Act FCRA, I hope that my colleagues will join me in supporting measures that help protect people from the growing problem of identity theft. Consumers' private financial information should be carefully guarded, and Congress must act promptly to ensure that credit bureaus provide individuals with updated, accurate information about their credit reports.

H.R. 2035 is an important first step in Congress's efforts to prevent identity theft. By requiring consumer reporting agencies to provide free credit reports annually upon the request of a consumer, this legislation will allow individuals to detect identity theft at an early stage, before their credit reports are permanently damaged. Such reports can be the determining factor behind financial institutions' decisions to extend credit for the purchase of homes and durable goods such as cars and home appliances. Credit reports damaged by stolen identity and fraud can prevent hard working individuals and families from building better lives and attaining the desirable goals of home ownership and financial security.

To that end, I am pleased that H.R. 2035 includes a provision that would require credit card issuers to confirm change of address requests if such a request is received within 30 days of a request for an additional card, and would amend the FCRA to require consumer reporting agencies to notify requesters of potential fraud when the request includes an address for the consumer that is substantially different from the most recent address on file with the consumer reporting agency.

Finally, by requiring the truncation of credit card numbers on printed receipts, H.R. 2035 will curtail a common method by which identity theft so often occurs. In many instances, criminals have easy access to individuals' credit card numbers simply by viewing those numbers on printed receipts. In 2001, 73 percent of American households had at least one credit card, making a large segment of the country vulnerable to having their financial information stolen. This legislation will thwart a significant number of would-be identity thieves by blocking most of the numbers in a person's credit card account, thereby preserving and protecting sensitive, private financial information for the vast majority of the public.

Congress has a responsibility to help the American people, and our national economy, prosper. Strengthening financial privacy laws and preventing identity theft will help to achieve these goals, and I encourage my colleagues to join me in supporting the Identity Theft and Financial Privacy Act.

RECENT RUSSIAN PURCHASE OF AMERICAN MINE REPRESENTS FREE MARKET SUCCESS BENEFITING BOTH COUNTRIES

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. LANTOS. Mr. Speaker, after the fall of the infamous Berlin Wall and break up of the Soviet Union, I advocated a Marshall Plan for Russia and the former Soviet Republics to demonstrate that democracy and a market economy is the better way for our former adversary.

It is one thing to win the Cold War but quite another to vastly improve the lives of ordinary citizens who have never known freedom. Regrettably, our government did not seize the opportunity then and instead opted for smaller and fragmented programs to encourage private sector investment.

Although we could and should have done more, a new generation of Russian entrepreneurs is boldly moving that country to a vibrant market economy, contributing to Russia's unlikely status as the world's leading growth economy of 2003.

One of the most impressive examples is the Russian oil company, YUKOS, which under the able leadership of Mikhail Khodorkovsky, has become one of the largest and best operated energy companies in the world. This is good news for Americans, in that future oil imports from Russia will significantly reduce our energy dependence on the volatile Middle East.

Mr. Speaker, another striking example of positive change in Russia today can be found in corporate governance. Business leaders, such as Mr. Khodorkovsky and Mr. Vladimir Potanin, head of INTERROS, Russia's largest private investment company, are pressing the issue of corporate responsibility and working to set standards to insure reform and good governance to help pave the way for Russia's membership in the WTO.

The clearest sign of Russia's emergence as a player in the world economy is the recent acquisition by the Russian mining giant, Norilsk Nickel, of the Stillwater Mining Company in Montana, the largest acquisition by a Russian company in the United States.

Norilsk Nickel brings experience and a first-rate management team to complement the Montana plant's operation and competitive position. This new synergy will bring benefits to both companies, the Stillwater shareholders and workers, and the consumers—the U.S. auto industry, who depend on both plants for the palladium it uses in catalytic converters.

The transaction passed muster with two Federal agencies. The Administration's interagency group that looks at security-related issues on all foreign acquisitions in the U.S., and the Federal Trade Commission that scrutinizes impact of such transactions on consumers. The Stillwater shareholders also voted overwhelmingly in favor of the purchase.

Only a few years ago, it would have been all but impossible to imagine the U.S. government approving the sale of an American mining company that holds claims on the only significant sources of platinum and palladium outside of South Africa and Russia. These two precious metals are the key ingredients in the automotive catalytic converters used to scrub pollution from exhaust emissions. They also are vital components in a wide-range of electronics and, of course, in fine jewelry as well.

Commercial transactions, such as the Norilsk Nickel-Stillwater acquisition are important to Russia. Operating on a global scale and in tune with accepted rules of Commerce and good corporate governance and also demonstrates that major East-West investments is opening the doors to opportunity for both sides.

Mr. Speaker, we need to encourage this kind of economic collaboration and rally the forces of a free market that make it possible. We should applaud the vision and dynamic leadership of Russia's new entrepreneurs and the implicit support accorded by our respective governments to encourage these bold initiatives.

TRIBUTE TO JOHNSON COUNTY, KANSAS, CHRISTMAS BUREAU

HON. DENNIS MOORE

OF KANSAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. MOORE. Mr. Speaker, I rise today to thank and congratulate the Johnson County Christmas Bureau for their great work in helping the needy in our community. The Johnson County Christmas Bureau is a nonprofit organization that has been bringing Christmas joy and holiday assistance to thousands in the Kansas City area for nearly forty years.

Working out of a donated office with donated storage space, every year the Bureau puts together a "Christmas shop" for the disadvantaged, where each eligible family member can get a gift, a new item of clothing, personal items, used coats and a wide array of groceries. Each individual can choose his or her items, preserving the dignity of the family while bringing joy to those in need. The Bureau has received most of its funding through individuals, schools and church organizations—they strive to keep their overhead low so that more money may be used to provide a Merry Christmas to the needy.

I want to recognize the great contribution that the Johnson County Christmas Bureau has made to the Kansas City community and to the many lives which they have brightened. Last year, the Bureau helped over eight thousand families and this year they expect to serve many more. The many people who volunteer numerous hours from their busy lives for the Christmas Bureau, just to see the joy on the faces of others, remind us how fulfilling charity can be. It is my pleasure, Mr. Speaker, to place in the CONGRESSIONAL RECORD this tribute to the good works of the Johnson County Christmas Bureau.

IN HONOR OF VIRGINIA FRANCO

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FILNER. Mr. Speaker and colleagues, I rise today to recognize and honor Virginia Franco on her retirement after 23 years as an elementary school teacher with the San Diego Unified School District. She may be retiring from teaching, but she is definitely not retiring as a community leader.

Virginia was raised in Camarillo, CA. She was widowed while still a young woman, and came to San Diego in 1971. She began her liberal arts studies at San Diego State University, and it was there that I met her.

Virginia has managed to combine her career as a dedicated teacher of second and third grade students and mother of three children with a second career as a San Diego Educators' Association (SDEA) union activist and community leader. Over the years, she has been involved in more causes and struggles than can be mentioned here. Among them are opposition to the Pinochet dictatorship in Chile, support for victims of the death squads in El Salvador, support for affirmative action, and participation in voter registration campaigns for new citizens.

Virginia's activism continues to the present. As part of the Older Women's Project, she demonstrated against the invasion of Iraq. She is working with the San Diego labor movement to bring about a living wage ordinance for the city of San Diego. She is a leader in her labor union, the SDEA, having held the position of Human Rights Chair, an elected delegate to the NEA Representative Assembly in 2001, and is currently a member of the Political Involvement Committee.

On the occasion of her retirement, Virginia wrote a farewell letter to the parents of her students. This letter expresses as well as anyone can the reasons she tries so hard to help create a better world.

The letter reads:

DEAR PARENTS: Our last day is upon us at Clay Elementary School. We, in Room 4, have been working hard to become prepared for the challenges ahead. These few years, particularly, have been trying times in news and heavily concentrated in the area of education. For many of us, working more hours to fulfill our responsibilities for our children have become necessary. The world has entered our homes in the news, and much of it is difficult for us to understand. In our schools, we are wondering how our children will fare with the problems that concern public education due to difficult economic times in the state of California. Yet, in spite of these extraordinary times, Room 4 students have been working cooperatively to prepare for the difficult times by doing their part as better readers and citizens in order to meet those challenges.

We have learned in reading that nonfiction literature—biography, science, and social studies—help us learn about the past in order to understand the present in the hopes of preparing for a better future. We learned that reading for understanding of past and present history helps us prepare to make those decisions. We are aware that this preparation will help us work toward a time, seemingly far away, but necessary, in order to preserve better conditions of life for our families, our communities, and possibly for those whom we don't know in other parts of the world.

Our world needs fixing. By reading about the environment, we learned that many studies are possible to help us prepare for knowledge and understanding about pollution and saving our natural resources. Careers in science and math will be necessary for making changes in these areas of studies. We are beginning to understand that it is of great importance to understand the present, in the hopes of affecting the future in positive ways. Social and environmental studies will help us to fix and create that better world.

We learned about early America and the struggles to build it. It took many kinds of citizens to change it for the better. We also learned that connection with other countries remains necessary to strengthen what we share now. Citizens here in America from all over the world are helping to enrich our way of life in their sharing of their cultures. Our students know that it is their job to continue their efforts to become those good, creative, and knowledgeable students to prepare for the challenges ahead.

Thank you for your part in seeing that your child continues to prepare to become that responsible citizen that you and I hope will contribute to our community. I have been privileged, hopefully, to help chart that course. It is especially meaningful for me this year of my retirement.

I look optimistically forward to your child's educational success in the future.

Most Sincerely,

VIRGINIA FRANCO,
3rd Grade Teacher.

This letter speaks to her commitment to the children she is teaching and to the larger community. Our world would be a better place if we all were as dedicated as Virginia. As she retires, I want to acknowledge a woman of conviction, dedicated both to her love of teaching and to her belief in the importance of individuals working to make a difference in this world.

My best wishes go to my good friend, Virginia Franco.

COMMENDING LEONARD R. TOTORA

HON. STEVE ISRAEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. ISRAEL. Mr. Speaker, I rise today with great pride and admiration to commend Leonard R. Totora for his service in the United States Army.

At this time of conflict, stories like those of Mr. Totora remind us of the courage the members of our Armed Forces have always displayed and continue to display on a daily basis. They are a testament to the dedication, honor and strength of the men and women in uniform. They deserve to be praised for generations to come.

After enlisting in the army at the age of 17, Mr. Totora attended the Army School of Photography and then spent two years in Europe as a member of the Signal Corps, filming motion pictures for the military. With the outbreak of the Korean War in 1950, Mr. Totora was assigned to General MacArthur's headquarters in Japan.

In Korea, Mr. Totora served above and beyond the call of duty when he volunteered to jump 35 miles behind enemy lines with the 187th Airborne Rangers. Unfortunately, with no prior parachuting experience or training, Mr. Totora suffered severe injuries to his right leg and ankle. Knowing how important the footage he was capturing was, Mr. Totora initially refused medical treatment and remained with the 187th Airborne Rangers for many more hours.

Upon hearing the news of his heroic effort on the battlefield, UN Supreme Commander General Ridgeway awarded Mr. Totora paratrooper wings with a Battle Star. In addition to his paratrooper wings, Mr. Totora was awarded the Bronze Star for bravery against the enemy.

I commend Mr. Leonard Totora for his dedication and service to his country and for the bravery, honor and valor he displayed during his service in the Army.

MAJOR GEORGE WINTON THOMPSON

HON. NICK J. RAHALL II

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. RAHALL. Mr. Speaker, tomorrow, alumni of Woodrow Wilson High School Class of 1958 will congregate in Beckley, West Virginia. They gather to celebrate the 45 years passing after the graduation of 343 students.

My alma matter, Woodrow Wilson High School, so named in 1917, traces its roots to July 13, 1900. The school mascot is a flying bald eagle and the enrollment of the school is identified as the Flying Eagles. As the bald eagle is a majestic bird, it is also an independent creature. Eagles nest but they do not flock. It was therefore preordained that the alumni of this school separate and spread to the four corners of our great Nation and beyond.

The year 1958 represents a very different time with American citizens living under different standards. The Universal Military Training Act defined one of those standards. Under this Act, able-bodied male citizens past the age of 18 years were subject to six years of military training and duty. The United States Army, Navy, Air Force and Marine Corps thereby benefited with the coming of age by Woodrow Wilson alumni. One chapter of the military contribution made by the Class of 1958 can be found in the Vietnam War. West Virginia sacrificed more sons on a per capita basis in the Vietnam War effort than any other state in the Union. Vietnam in wartime was where some 1958 graduates celebrated their 10th year beyond graduation. By the end of the Vietnam War, these alumni had returned to their homes and families, except one. This Flying Eagle was reported as missing-in-action on May 16, 1966, when the AC–47 gun ship he was navigating failed to return from a mission. At the time of his last action, the young man who had interrupted his studies at West Virginia University to serve his country held the rank of 1st Lieutenant in the United States Air Force. When the exchange of prisoners of war took place following the Vietnam War, this airman was not among the repatriated. During the following years, the airman's mother was encouraged by our government not to relinquish hope. She mailed letters and packages for years. None of the letters or packages were either acknowledged or returned. During these same years, the airman received posthumous promotions up to the rank of major. The mystery surrounding this Class of 1958 Flying Eagle was not resolved until November 24, 1999, when his recovered remains were positively identified. His remains, along with the remains of seven additional crewmembers on the ill-fated military aircraft, were obtained from the crash site during three separate collections during 1995, 1996, and 1997. The recovered remains of all eight crewmembers were scant, as the plane had been consumed by flames upon crashing, followed by more than 30 years of deterioration in a jungle environment.

During the 34th year following his last day on Earth, this Woodrow Wilson High School alumnus was buried in Arlington National Cemetery, in common with the limited remains of his fellow crewmembers. Every Class of 1958 Woodrow Wilson High School classmate who served honorably in this Nation's Armed Forces gave something, but this one airman gave all for his country and in a greater sense, his family and his classmates. The Woodrow Wilson High School Class of 1958 alumni gathering in Beckley, West Virginia tomorrow wish to honor this classmate, Major George Winton Thompson, by having his name placed in the CONGRESSIONAL RECORD, as evidence he has yet to be forgotten. I hereby honor that request, as this is the first class reunion that the group has known the outcome of Major Thompson's story.

INTRODUCTION OF THE LEGACY ACT: LIVING EQUITABLY, GRANDPARENTS AIDING CHILDREN AND YOUTH

HON. MICHAEL E. CAPUANO

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CAPUANO. Mr. Speaker, I am pleased today to join my good friend Congressman JACK QUINN in introducing important legislation to help address an issue in our Nation that is only starting to receive national attention—grandparents raising their grandchildren.

According to recent data from the Census Bureau, the number of intergenerational families increased more than fifty percent between 1990 and 1998. It is estimated that more than 2.5 million grandparents across America are raising their grandchildren. Many of these children have parents who have passed away, are in prison, or are suffering from drug or alcohol addictions, while some have been taken out of abusive homes.

These intergenerational families or "Grandfamilies" live in rural areas, inner cities and suburbs. They come from all races and ethnicities, and live in every State in the Nation. Many of these grandparents survive on fixed incomes—social security, a small pension—and face not only the rising cost of prescription drugs, but also the cost of diapers, baby formula, toys, and school clothes.

Unfortunately, our Nation's housing policy has not kept up with the unique needs of these families. There are very few housing developments specifically designed for intergenerational families. The Grandfamilies House in Boston, Massachusetts in my Congressional District offers apartments with special features for both grandparents and children, including childproof kitchen cabinets and handicapped-accessible bathrooms. There are also activities for seniors and children, an outdoor playground and an on-site computer lab.

I am introducing the LEGACY Act in response to the growing number of communities throughout the Nation that have been working to build on the model of the Grandfamilies House in Boston. The title of the legislation was inspired by an Academy Award nominated documentary film chronicling the life of a grandmother raising her grandchildren and their struggle to move out of a Chicago housing project.

The legislation creates demonstration programs through both the Section 8 Housing Certificate Fund and the Section 202 Elderly Housing program. These demonstration projects will enable housing developers and advocacy groups additional flexibility in securing financing for this housing and providing ongoing services to intergenerational families.

In addition, the LEGACY Act clarifies that grandparents raising their grandchildren are eligible for family unification assistance, allows access to fair housing funds for education and outreach efforts about the legal issues surrounding many of these families. It also directs the Department of Housing and Urban Development to provide specialized training for their employees focused on grandparent- and other relative-headed families. Many grandparents do not have access to the services they and their grandchildren need. These training and outreach efforts will help raise the awareness of the unique issues these families face each day.

While this bill is a small step in recognizing the tremendous contributions of these grandparents, it is my hope that it will help bring this issue greater recognition. Affordable housing is only one of the many challenges these courageous grandparents face as they raise the next generation of Americans. Please join me in supporting these families by supporting the LEGACY Act.

HONORING STUART COHEN

HON. CAROLYN McCARTHY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mrs. McCARTHY of New York. Mr. Speaker, I rise in recognition of Stuart Cohen, a highly respected Emergency Transportation Specialist and Regional Emergency Planner for the Federal Aviation Administration (FAA) Eastern Region. Stuart recently announced his retirement after 33 years of public service during which he was a pioneer in the fields of emergency planning and environmental protection.

Upon his graduation from Empire State College, Stuart began 27 years of employment for the United States Postal Service where he held many positions including Superintendent of Postal Operations and Safety Specialist. After his time with the Postal Service, Stuart joined the U.S. Coast Guard to serve as an Occupational Safety and Health Specialist, making many contributions to safety, including the development of the first consolidated Coast Guard electronic safety and health manual.

After his tenure with the Coast Guard, Stuart continued to serve his country through the FAA's Eastern Region. With the FAA, Stuart held many positions including Regional Emergency Planner and Environmental Protection Specialist. Stuart's many achievements with the FAA highlight his commitment to safety and the preservation of our environment. Stuart provided emergency's support at the 1996 Olympic games in Atlanta, led a support team during the Federal Emergency Management Agency's (FEMA) 1998 Exercise, and managed Department of Transportation responses to major disasters. Stuart's commitment to the environment is just as impressive. He chaired the FAA Regional Environmental Network, authored the FAA Environmental Policy Manual, and met with airline industry official regarding environmental issues.

Stuart has received many honors and awards during his distinguished career. Most notably, Stuart's courageous and selfless response to the terrorist acts of September 11, 2001 earned him the FEMA Award for Service and the State of Virginia Award for Service.

While serving his country, Stuart has kept an active private life. He has been and continues to be involved in a number of organizations including the Nassau County Auxiliary Police, U.S. Coast Guard Auxiliary, and Volunteer Firefighters.

In his 33 years of public service, Stuart Cohen's dedication to public safety and environmental protection has helped shaped the great nation we live in today and made the country a safer, cleaner place for all. The people of the Fourth District of New York and all Americans thank him for his hard work.

PERSONAL EXPLANATION

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. ESHOO. I was absent June 4th through 12th for a family emergency. Had I been here, I would have voted "yes" on roll call votes 237–241, 246–251, 256, 259–264, 267–271, and 275 and "no" on roll call votes 236, 242–245, 252–255, 257–258, 265–266, and 272–274.

EDITORIAL BY MR. JOSEPH SZALAY ON DEFENDING FREEDOM

HON. CHRIS CHOCOLA

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CHOCOLA. Mr. Speaker, I would like to take this opportunity to enter into the RECORD an article written by Mr. Joseph Szalay, of South Bend, Indiana. A child of the political "powder keg" that was Eastern Europe in the early part of the twentieth century, Mr. Szalay has a vast amount of knowledge from which he paints a vivid picture of America's historical role in helping to liberate all those who want to be free. He tells of the many times, from World War I to the first Gulf War, when America took a stand against governments who enslave their people. A true embodiment of the American Dream, Mr. Szalay came to America from his native Hungary poor; illiterate, and alone. He built a fine tailor shop in South Bend, from which he recently retired. As a member of the greatest generation that saw this nation ascend to global prominence, we should value his perspective and revere his patriotism. I urge all of my colleagues to use this article as a reminder of the historical precedent set for the recent liberation of the Iraqi people.

[From the South Bend Tribune, April 27, 2003]

WORLD'S HISTORY SHOWS THAT U.S. POSITION IS RIGHT

(By Joseph Szalay)

As an American of European descent, I have strong reactions to this war and the anti-American sentiment I hear expressed both at home and abroad. It reminds me of a Hungarian proverb: "The dog barks but the caravan progresses."

In the former Serbia, the 1914 assassination of Crown Prince Ferdinand, son of Franz Joseph, Emperor of Austria-Hungary, ignited World War I.

In 1917, before that was over, revolutionaries took over Russia. This Communist revolution had been planned in Germany. A key piece of Communist strategy was to starve the people in order to subjugate them more easily. This plan also encompassed the starvation of 12 million (out of 40 million) Germans.

How could such a plan work? Human beings have a drive to survive. Starving people do not care what form of government they have, as long as they can put enough in their stomachs to survive.

German nationalists were aware of the Communist plan. They knew that if Germany capitulated, all of Europe could easily become Communist. They reacted by turning the Communist strategy to their own advantage. When Hitler came to power in Germany, the first thing he did was to stop starvation by feeding the people. I vividly remember that many Hungarians and people from other neighboring countries went to work in Germany. So successful was his economy that Hitler's regime developed a plan to take over the whole world, beginning with Europe—just what the Russian Communists had originally planned. Hitler's slogan was "Deutschland uber alles—Germany (taking) over the world."

What is still incomprehensible to me is the sad sequel: Hitler forced the Jews into concentration camps and gas chambers and took over countries one by one: Austria, Poland, Hungary . . . where was France? Where was the rest of the free world? Because we did not stop Hitler's conquest at the beginning, stopping him later cost the lives of 85 million people and caused unthinkable suffering not only in casualties but in the destruction of irreplaceable historical and artistic treasures.

One result of that war was to destroy the bloc of neutral states which for centuries had been able to resist the expansion of Russia and Germany alike. Masterminded by the French, the peace plan after World War I created weak artificial "nations" such as Yugoslavia; thus it paved the way for the Second World War:

World War II gave the Russian Communists the opportunity to expand their influence, giving them a free path to world conquest, their original goal.

I knew all of this through my father's experience. As a young man, he was drafted and spent four years on the front lines. When the Second World War started, he was again drafted, along with my two older brothers. As soon as I turned 18, I was also drafted, leaving my mother home alone to raise my 13-year-old sister and 7-year-old brother. With God's help, I defected from the army, living in the forest like a hermit.

Only one government was able to rescue Europe from Nazism: the United States.

After World War II, the United Nations was initiated with noble hopes by France, England, the United States and the Soviet Union. What has become of those high ideals? The U.N. has become an impotent, socialistic, bureaucratic organization full of anti-American sentiment.

Where was the United Nations when people rose up demanding their God-given right of freedom in Poland, in Hungary, in Czechoslovakia? Thousands died, thousands were imprisoned, tortured or deported to Siberia while the United Nations stood by idle.

And what of the war in Vietnam? Did the United Nations move a hair to stop it? The Communists activated their propaganda machine, trying to divide Americans. World opinion expressed at the United Nations pressured the United States to pull out of Vietnam without winning a victory over Communism. Even after the American forces departed from Vietnam, neighboring Laos and Cambodia, millions were killed to "cleanse" the country. Where was the United Nations? Where were the "peace" demonstrators? Where were the human rights advocates?

While the United Nations was clueless, the United States took leadership in eliminating Communism, whose vulnerability had been demonstrated by the freedom fighters in Poland, Hungary and Czechoslovakia. These uprisings had also shown the people's unquenchable thirst for freedom. President Reagan combined forces with the great spiritual leader and Polish hero Pope John Paul II to initiate the collapse of the "Evil Empire" of the Communist Soviet Union.

Notice that it was the United States, not the United Nations, that saved Europe yet another time.

When Saddam Hussein invaded Kuwait, it was the United States and its allies who fought and freed Kuwait. The United Nations decided that a cease-fire agreement in which Saddam promised to liquidate all his weapons of mass destruction was sufficient peace insurance. Of course, Saddam did not fulfill his obligations, but the United Nations was unable to enforce them. The United Nations did not even act when it became known that Saddam was using his arsenal of chemical weapons to eradicate his own people's fight for freedom.

Those who harbored hatred toward the United States were emboldened by the lame and indecisive attitude of the United Nations. The result? Sept. 11, 2001.

President Bush requested that the United Nations live up to its contractual obligation to defend the world against weapons of mass destruction.

There was a lengthy bureaucratic debate in which those nations whose freedom our country restored in World War II turned against the proposals of the United States. Those who had a financial interest in Saddam's rearmament blocked enforcement of the conditions imposed by the cease-fire agreement. Once again, the United States has been forced to act on its own to protect our country and the world from the danger of terrorist destruction.

On April 4, a headline in The Tribune read, "Former Soviet army generals helped Saddam with War strategy." Could this have something to do with Russia's reluctance to support any action against Saddam?

I have sketched this history to show how our country has always been willing to defend freedom, not only our own but that of the whole world. President Bush follows the example of the great presidents of the United States. He shows unwavering dedication to keeping his presidential oath. While other countries follow their economic interests, he stands tall, fulfilling his duty to God and country.

TRIBUTE TO CAPTAIN SETH MICHAUD

HON. MARTIN T. MEEHAN

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. MEEHAN. Mr. Speaker, I rise to pay tribute to United States Marine Captain Seth Michaud, who died on Sunday, June 22, 2003, in service to his country.

Seth Michaud was a resident of Hudson, Massachusetts, in my Congressional District. In 1994, he graduated from Hudson High School, where he excelled in both academics and sports. I supported Seth's application to the Naval Academy in Annapolis, MD., and was proud when he was accepted, announcing the news at a town meeting that included his family, friends, and neighbors. Seth graduated from the Pensacola Naval Flight School in 1999, and was certified as a helicopter pilot in December, 2000.

At the time of his death, Capt. Michaud was a helicopter commander, killed when a B–52 dropped nine M117 general purpose bombs during a practice mission. Seth was watching the routine training exercise from atop a ridge on the Gondoria Range in northeastern Africa, off the coast of Djibouti. He was standing outside his CH–53E helicopter when the bomb exploded. Eight other service personnel were also injured. Seth Michaud had been assigned to Marine Heavy Helicopter Squadron 461, based at New River Marine Corps in North Carolina.

Capt. Michaud and about 50 other personnel from Combined Joint Task Force—Horn of Africa were participating in training exercises that involved the coordination of aerial bombardment missions. This exercise was the fourth of its kind since the task force's arrival in December. The task force's mission is to lead the U.S. war on terrorism, by intercepting or disrupting terrorist operatives in that region of the world. Seth, like many other soldiers who have answered their nation's call to service, paid the ultimate sacrifice in defense of our freedom and liberty.

Seth is survived by his loving wife Karen Marie, and their 18-month-old son, Ian. He also leaves his parents, Francis and Karen of Hudson, a brother, Ethan, and a sister, Samantha, as well as several other relatives and friends.

Seth Michaud was a United States Marine, a loving father, husband, son, and brother, and his commitment to his Nation and his family is one for which he will be forever remembered. His family knows that Seth's dedication to his service was of great value to him. They remember him for his photographic memory, his passion for flying, and his love for his family.

Capt. Seth Michaud served his family, his hometown, and his country, proudly and faithfully.

INTRODUCTION OF NUCLEAR DISARMAMENT AND ECONOMIC CONVERSION ACT OF 2003

HON. ELEANOR HOLMES NORTON

OF THE DISTRICT OF COLUMBIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. NORTON. Mr. Speaker, today, I am introducing the Nuclear Disarmament and Economic Conversion Act of 2003 (NDECA). NDECA will require the United States to disable and dismantle its nuclear weapons when all other nations possessing nuclear weapons enact laws to do the same. NDECA further provides that when our nuclear weapons are dismantled, the resources used to support nuclear weapons programs would be diverted to our growing human and infrastructure needs, such as housing, health care, Social Security and the environment. I have introduced this bill every year following a ballot initiative in the District in 1993.

In addition to the economic cost of nuclear weapons, the weapons have increased as a destabilizing force in world affairs. North Korea, at least in part in response to stepped up aggressive talk and policies from the U.S., is expanding its nuclear capabilities. Following the Iraq War, Iran appears to be pursuing greater nuclear capability and resisting inspections. India and Pakistan have moved back from the precipice of several years ago but each remains poised with nuclear weapons.

The United States and the world community urgently need to redouble their efforts to obtain commitments to push back the new surge for nuclear proliferation. Our country would be able to better dissuade other nations who aspire to become nuclear powers if we ourselves were willing to take even greater initiative in dismantling our own nuclear weapons program. It is noteworthy that the Senate in March ratified the Moscow Treaty, which provides that by 2012 both the U.S. and Russia will reduce their long-range warheads two-thirds from approximately 6,000 warheads each to 2,200.

With 40 million people still without health care, Social Security without the benefits for the huge baby boomer generation, an economy teetering from the loss of 3 million jobs and millions more Americans pushed back out in poverty during the last three years, the time has come to begin the transfer of nuclear weapons funds to urgent domestic needs. In the 56–year period between 1940 to 1996, nuclear weapons spending exceeded the combined total Federal spending for education, training, employment, and social services; agriculture; natural resources and the environment; general science, space and technology; community and regional development (including disaster relief); law enforcement; and energy production and regulation.

HONORING THE MEMORY OF MAYNARD HOLBROOK JACKSON, JR

HON. JIM MARSHALL

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. MARSHALL. Mr. Speaker. I was elected mayor of Macon in 1995. Macon is a town of a little over 100,000 people just 80 miles or so south of Atlanta. One of the first things I did after my election was to visit with Maynard Holbrook Jackson, Jr.

Maynard Jackson was elected mayor of Atlanta in 1973 at the age of thirty-five, the first African-American mayor of a major city in Georgia as well as the southeast. He served two four-year terms and became known for promoting majority-minority partnerships to improve access for African-Americans to the world of contracting and supplying governments.

Maynard Jackson was elected again as mayor of Atlanta in 1989 and served one more term. When I went to see him as a newly elected mayor, it was to get his advice, any advice he would care to offer. I had no particular agenda, just a hope that he would impart some wisdom, given his experience in both government and business. Maynard Jackson spent hours of his time with me that day. Of course I cannot recall all that we spoke of, but I found his advice very valuable. I will always remember how cordial and engaged he was—someone who really didn't need to give me the time of day instead gave me several hours.

Maynard and I became friends who saw one another infrequently but who always responded quickly to one another's calls, e-mails or letters. The last time I spent any significant amount of time with him was just this February in Macon at the Georgia Music Hall of Fame for the opening of an exhibit honoring black classical musicians from Georgia. Maynard's aunt, Ms. Mattiwilda Dobbs, was the guest of honor for the occasion but Maynard was the star who could have easily stolen the show. Instead he remained out of the limelight, allowing his aunt to fully enjoy the attention she deserved as a world-famous artist, the first African-American soprano to perform at the Metropolitan Opera House in New York.

When I heard of Maynard's passing this Monday morning, I recalled that evening I spent with him in February at the Music Hall of Fame and I remembered one touching incident. We all were examining the memorabilia gathered for this exhibit honoring classical African-American artists of Georgia. The walls for this section of the museum were covered with photographs. Maynard grabbed my arm and pulled me toward one. It was a picture of the Morehouse College Glee Club that appeared quite old and, with great pleasure, Maynard pointed to one of the young men in the picture. It was his father, a father who had passed away when Maynard was quite young.

Now Maynard himself has passed away too young, leaving us in his prime but leaving a legacy of remarkable accomplishments for Atlanta and all of Georgia.

Mr. Speaker, it is right and just that this body honor Maynard Holbrook Jackson, Jr. with an appropriate resolution now being prepared by Representative LEWIS which I will cosponsor with other members, including I'm sure, all members of the Georgia delegation.

Maynard Jackson will be sorely missed by his family and many friends. May he rest in peace knowing that his life has been well lived.

TRIBUTE TO LEON M. URIS

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. LANTOS. Mr. Speaker, I rise to pay tribute to the life and memory of Leon Marcus Uris, the novelist and screenwriter who touched the lives of millions around the world. His unfortunate passing this week is a devastating loss to the world of literature and cinema and to thinking people and humanitarians everywhere.

The author of more than a dozen books and several screenplays, Leon Uris was best known for his Gunfight at O.K. Corral, which was universally heralded as an archetypal Hollywood Western, and his moving and humane account of the birth of the State of Israel, Exodus.

Mr. Speaker, Exodus became an international sensation immediately upon its publication in 1958, and was made into an enormously popular and critically acclaimed film two years later. Mr. Uris's Exodus is the story of the struggles and spirit of the Jewish people, a people who, persecuted and murdered in Europe, emerged from the Holocaust and fled and were expelled from hostile Islamic and Arab societies in the late 1940s and early 1950s to establish a state in their historic homeland, Israel, on land granted to them by the United Nations. I encourage all Members who have not yet read Exodus to read this eloquent and emotional account of a people's struggle for survival and freedom.

As a Jew who personally fought the Nazi occupation of Hungary and survived the Holocaust, I was deeply moved by Mr. Uris's books, many of which highlighted historical events of Jewish concern and the poignant and ongoing struggle for the survival of the State of Israel. Yet it would be unfair to pigeonhole him as a man concerned exclusively with Jewish issues. Mr. Uris was an unabashed champion of freedom and democracy, not just for Jews but for the Irish and oppressed groups worldwide whom he wrote and cared about.

Mr. Speaker, Exodus was Leon Uris's magnum opus and it was translated into dozens of languages and distributed clandestinely throughout the Soviet Union, where it became known in dissident circles simply as "The Book" and helped generate resistance against the Communist regime. The film version, directed by Otto Preminger and starring Eva Marie Saint and Paul Newman, drew attention to the plight of the State of Israel, a vibrant democracy and ally of the United States under assault from all sides. After enjoying success beyond all expectations both as a book and as a film, Exodus was reincarnated as a Broadway musical in 1971.

Many of Mr. Uris's books were sympathetic war novels, imbued with tales of courage and daring, as well as intrigue and romance. In addition to Exodus, I was especially moved by Mila 18, a heroic story he wrote in 1961 about the Warsaw ghetto uprising during World War II.

Leon Uris was an unusually creative and thorough practitioner of his craft. The New York Times noted in its obituary yesterday that in "preparing to write Exodus . . . [Mr. Uris] read nearly 300 books, underwent a physical-training program in preparation for about 12,000 miles of travel within Israel and interviewed more than 1,200 people." The child of a first-generation Russian-American mother and a Polish immigrant father, Mr. Uris's pool of talent was seemingly bottomless, and his spirit indomitable, renewed daily by his commitment to the twin causes of freedom and justice, and propelled by a quintessentially American-immigrant zeal. A successful genius who rose from "hardscrabble beginnings," the Washington Post wrote in its epitaph yesterday, Mr. Uris was a man of uncommon and extraordinary character.

Mr. Speaker, Leon Uris was one of the great novelists of the twentieth century, and has secured his place among the intellectual and literary giants of our time. It is with great sadness and deep admiration that I bid farewell to Mr. Uris, and I extend my heartfelt condolences to his family.

TRIBUTE TO HERB ZOBEL

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress and this nation today to pay tribute to an outstanding citizen from my district. Herb Zobel of Ouray, Colorado recently donated his time to aid 2,000 of his fellow biking enthusiasts as they pedaled through the Rocky Mountains for a good cause. In recognition of this dedication to community service, I would like to honor Herb here today.

Herb volunteered with "Ride the Rockies," a week-long tour of the beautiful Rocky Mountains of Colorado. Herb has participated in "Ride the Rockies" six times, an impressive athletic accomplishment, especially considering he is 74 years old. The riders pedal 35 to 100 miles daily, and although they pass through some incredible scenery, they must also pedal up some difficult mountain passes. By working as a Marshall for this year's event, Herb stood in the same spot for five to six hours every day to help direct riders through confusing parts of the route. He also dished out plenty of encouragement as the cyclists passed, since he understands how challenging the ride can be.

Mr. Speaker, it is my privilege to honor Herb Zobel here today. He exemplifies the spirit of community service that helped make this nation great. By donating his time to "Ride the Rockies," Herb selflessly helped 2,000 of his fellow riders stay fit, healthy, and happy. I congratulate Herb for his athletic achievements, commend him for his service, and wish him the very best for the future.

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2003

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, we have over 40 million people without health insurance today. Over the course of this year, another 20 million or so will find themselves without healthcare coverage for some period of time. The lack of insurance leads to decreased access to care, decreased lifespan, and increased morbidity. When people do not have health insurance, they are more likely to have uncontrolled disease, and the suffering that goes with it. They are also more likely to end up in the hospital or emergency room. A small business that cannot afford to purchase a health plan will, therefore, have workers who are more likely to call in sick, or to need long-term sick leave. And in today's economic situation, many small business owners simply do not have the funds to meet the exorbitant costs of health insurance. So they are caught between a rock and a hard place.

The lack of affordable health insurance costs our nation billions in avoidable costs each year, and has made enormous health care bills the number one cause of bankruptcy for the American people. This is a devastating and complex problem. There is no easy answer to solving it; it will require a well-thought-out bipartisan approach to enact meaningful legislation to improve access to care. The legislation before us today is not all that it could be or should be. However, it is a step in the right direction, that we cannot afford not to take.

The federal government is not the only entity grappling with the challenges of getting adequate health insurance to the American people. States have been working on this issue for decades, and have brokered extensive agreements and regulations with the insurance industry to protect consumers. This legislation will exempt AHPs from those state regulations. This is misguided and dangerous. As we go to conference with the other body, we must work to ensure that we do not undo the good work that states have done in the past. AHPs can be an important piece to the health insurance puzzle, but they should not bypass the safety mechanisms that have protected patients for decades.

If this bill is signed into law as written, people in my state of Texas will lose the right to demand independent external review of their claims. AHPs will not be required to cover emergency services, or diabetes care, or mammograms, or to charge fair premiums to the old or sick. AHPs will also have the ability to "cherry pick," that is to offer inexpensive plans to some associations—maybe groups of fitness clubs or software companies that tend to be full of younger or healthier people—while gouging associations that employ more experienced workers, or the disabled. The CBO and the Urban Institute have issued studies that predict that AHPs would do little to improve the uninsured problem, and may actually make it worse—unless we make them responsive to the demands of state legislators.

The states have been quite successful in regulating the insurance industry and protecting their consumers. Why should we undermine that? The CBO and numerous other groups have predicted that this bill will destabilize the health insurance industry in America—and actually increase the number of people without insurance while raising the costs of those with it. That is why over 500 groups have expressed formal opposition to this bill, including the National Governors Association, both the Republican and Democratic Governors Associations, the AFL–CIO, physicians groups, providers groups, insurance trade association, many chambers of commerce, and at least a hundred consumer/advocacy groups.

I am voting for this bill today, because our nation's small businesses need relief, and their employees desperately need health insurance coverage. I will follow this bill as it goes through conference. If we can find a way to harvest the good that AHPs can do, while protecting consumers from "cherry picking," or price gouging, or benefit reductions—by keeping AHPs under control of state regulations—I will proudly support the bill. If it comes back in the form it is in today, I will vote against it.

HONORING TOM RETZER, U.S. NAVY SEAL

HON. PAUL RYAN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. RYAN of Wisconsin. Mr. Speaker, tomorrow, the flags of Kenosha County in Wisconsin will fly at half-staff in honor of U.S. Navy Seal Tom Retzer who was killed in the line of duty in the Near East on June 25, 2003. His father-in-law and mother-in-law live in Kenosha, and his wife and children reside in northern Virginia.

The loss of this brave U.S. serviceman saddens us and reminds us of the dangers our military men and women face every day as they work to protect our country and stand up for freedom. Throughout our nation's history, courageous individuals like Tom Retzer have been willing to put their lives on the line to defend our land and liberty. We owe them and their families our support and our deepest gratitude. Without them, America's freedom would be fleeting. We honor the memory of Tom Retzer and offer prayers for him and his family.

TRIBUTE TO TERRY MARSDEN

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress and this nation today to recognize a great leader in the Mancos, Colorado community. After 10 years of service on the Mancos Library Board of Trustees, Terry Marsden is retiring from his position as President. In his five years in that post, Terry has been a dynamic force in the rapid evolution of the Mancos Public Library. As we recognize Terry's retirement, I commend him for his dedication and leadership within the community.

Terry Marsden's leadership has been an influential factor in the numerous enhancements made to the Mancos Public Library over the past 10 years. In his first few years on the Board of Trustees, Terry helped oversee the implementation of an automated circulation catalog system. During his time as President of the Board, Terry was also instrumental in providing for the renovation of the building, hiring additional staff and increasing the library's hours of operation, all in an attempt to make the Mancos Public Library more user friendly. He also insured the addition of six patron computers in order to allow library patrons vital internet access.

Mr. Speaker, I am honored to pay tribute to Terry Marsden before you today for his commitment to his country. Terry embodies the spirit of public service and altruism that makes our communities strong. I congratulate Terry for his positive impact upon the Mancos community and wish him all the best in his future endeavors.

TRIBUTE HONORING ATLANTA'S FIRST BLACK MAYOR, MAYNARD H. JACKSON

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, it is with great sorrow that I pay tribute to the memory of a profoundly historical gentleman from Atlanta, Mayor Maynard H. Jackson. I would like to extend my greatest sympathy to the Jackson Family by taking a moment to reflect upon his rich life.

Although Mayor Jackson was born in Dallas, Texas, he grew up in Atlanta and finished high school at 14 years of age. He graduated from Morehouse College with honors at 18, and later, successfully pursued a law degree from North Carolina Central University.

Maynard Jackson reshaped Atlanta's power structure and made history, at age 35, when he was first elected Atlanta's first black mayor from 1974 through 1982. In 1990 he was re-elected with 80 percent of the vote and took office several months before the 1990 announcement that Atlanta had been chosen as host of the Summer Olympics. He's been widely acknowledged by his statement: "It is fitting and proper that Atlanta, not perfect but the best city in America, was chosen to host the Olympic Games."

Mayor Jackson's initial eight-year tenure in City Hall will be remembered most for his impact on the black business community. He was a champion of black business, evidenced by the affirmative action programs he implemented which increased the number of city contracts awarded to blacks and other under-represented groups by more than 30 percent. After he left his 1989 mayoral term, Jackson entered the business sector by forming Jackson Securities, an investment firm which now has offices in Atlanta, Houston, Miami, Orlando, Los Angeles, San Diego, San Francisco, and Chicago.

His family was active in early voting rights efforts. His grandfather, John Wesley Dobbs, was co-chairman of the Atlanta Negro Voters League, and his father, the Rev. Maynard H. Jackson Sr., was the first black to seek public office in Dallas, the former pastor of New Hope Baptist Church, and founded the Georgia Voters league. Maynard Jackson will be missed, but never forgotten for his enthusiasm, his vision and dedication towards leaving a legacy for a world of true cohesive diversity, and contributions to the City of Atlanta, Georgia.

THE BUDGET STILL DOES NOT KEEP OUR PROMISE TO VETERANS

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FILNER. Mr. Speaker and colleagues, I rise to remind my colleagues that the proposed budget for our veterans is still woefully inadequate!

Flat-line budgeting for several years prevented the Veterans Health Administration from keeping up with inflation and increased demand. Enrollees in the VA health care system (VHA) have increased by almost 120 percent since 1996, going from 2.4 million to more than a projected 7 million in the coming fiscal year. During that same period, VHA per capita expenditures have decreased by 30 percent.

Had the level of funding kept up with the demand in inflation, the current VHA budget would be around $36 billion rather than the $25.3 billion requested by the Administration. Had adequate funding been in place, VA Secretary Anthony Principi would not have had to temporarily suspend enrollment for VA health care for many of our nation's veterans.

Veterans did not hesitate when called to service. I urge my colleagues to keep our promise to our nation's veterans when voting on the budget.

TRIBUTE TO JOE VIGIL

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I am honored to stand before this body of Congress and this nation today to pay tribute to Joe Vigil, a nationally known Cross Country/Track and Field coach. Joe helped to make Adams State College a powerhouse in track and he will soon be inducted into the Rock Mountain Athletic Conference Hall of Fame for his accomplishments. His hard work and dedication have influenced the lives of many college students and I am proud to recognize his accomplishments here today.

For 27 years, Joe led the Adams State teams to 18 National Championships and 89 individual championships. He coached 425 All-American runners, many of whom ended up competing on the national level. Recognized as one of the best coaches in the country, he is currently training some of the United States best runners for competition in the 2004 Olympic Games in Athens, Greece.

Joe's impact on student-athletes went beyond the track, however, as his runner's graduated at a rate of 96 percent. A quality college education will always be more important then any National title, a lesson Joe passed on to his teams.

Mr. Speaker, I am proud to stand today and recognize the accomplishments of Coach Joe Vigil. I am happy knowing that Joe has made an impressive impact on some of today's youth and I hope that he continues his important role in young athletes lives. Thank you, Joe, for the contributions you have made to Adams State and the surrounding community. I wish you the best of luck on your future endeavors.

OAK PARK TOWNSHIP CENTENNIAL—1903–2003 "100 YEARS OF SERVING PEOPLE"

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. DAVIS of Illinois. Mr. Speaker, Oak Parkers have always been independent thinkers. So it's not surprising that the earliest residents of Oak Park opted for an independent government that gave them a greater voice in decisions that affected their lives and their community.

In the late 19th century, Oak Park was still a part of the Township of Cicero. However, after residents of the Austin neighborhood successfully broke away from the Cicero Township in 1899 choosing to annex to the city of Chicago, Oak Parkers began to petition once again for their own village. In 1901, citizens formally seceded from Cicero Township to establish their own municipal government. The first village elections were held in 1902 and Oak Park celebrated its new status as a united, selfcontained community.

Because the separation from Cicero Township left Oak Park in a legal limbo as regards certain delegated township functions, Oak Park citizens voted in 1903 to establish Oak Park Township. The first elected officials were supervisor, assessor, collector, clerk, two justices of the peace and two constables.

The first social service program began in 1936 with Poor Relief, a Great Depression program to aid financially struggling residents. This was the start of the General Assistance program, which has provided financial assistance to thousands of Oak Park citizens over the years.

The growing population of youth and elderly in the 1960's and 1970's ushered in Youth Services and Senior Services. Guided by volunteer citizen committees, the services are key components in Oak Park's quality of life.

In 1971, the Senior Citizens Committee was formed and the Meals-at-Home program was established. In 1973, the Township established by popular vote the volunteer Community Mental Health Board to assess need and help fund mental health programs. In that same year, the Advisory Committee on Childcare was formed. Also in the 70's came a transportation program for seniors and people with disabilities, as well as the Senior Citizen Information and Referral Service, the Energy Assistance program and the Income Tax Assistance program.

Within the last ten years, Oak Park Township has continued to meet the growing needs of its constituency. A youth Advocacy Council was established to give a voice to the teenage population. Additionally, the Townships of Oak Park and River Forest initiated a collaborative youth services program. In 1993, the Township's Youth and Senior Services programs won three state awards and one year later the Community Mental Health Board became the only one in the state to be Medicaid certified for its case management services.

The Township's assessor and collector functions, in accordance with the Township's overall vision of service and accessibility, has changed dramatically over the years. Since the 1930's, the assessor has been a service office, not assessing property, but helping residents, businesses and public agencies better understand property matters, taxation and assisting with appeals.

Since 1996, to improve operational efficiencies while providing broader services, the Township has entered into partnerships with other governments and private agencies to coordinate and expand its youth, senior and mental health programs. Intergovernmental agreements exist between the Township and all the other 10 governmental units in Oak Park and River Forest—villages; parks; libraries; schools and the River Forest Township.

From its humble beginnings serving Oak Park's population of 3,000 residents in 1903, one hundred years later Oak Park Township has evolved into a full service unit of local government serving Oak Park's 53,000 residents in 2003. I congratulate Oak Park Township on their 100th birthday and know that they will continue to identify and address unmet needs in their community.

BILL TO FACILITATE ACQUISITION OF MINERAL RIGHTS AT ROCKY FLATS

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. UDALL of Colorado. Mr. Speaker, I am today introducing a bill to facilitate the acquisition by the Federal Government of mineral rights or other non-Federal interests in lands that are located within the boundaries of the Rocky Flats site in Colorado.

In the 1950's, the Federal Government bought land at Rocky Flats for the use as a production facility for nuclear-weapon components. However, the purchase did not include all the mineral rights, some of which remained in private ownership.

Production at Rocky Flats ended more than a decade ago. Since then, the Department of Energy, through its contractors, has been working to have the site cleaned up and closed.

In 2001, Congress passed legislation I sponsored with Senator WAYNE ALLARD to guide the future of Rocky Flats. Under that legislation—the Rocky Flats National Wildlife Refuge Act of 2001—once the cleanup and closure are accomplished, most of the land at Rocky Flats will be transferred from the Department of Energy to the Department of the Interior and will be managed as a unit of the National Wildlife Refuge System.

The refuge act includes some provisions related to the non-Federal minerals—primarily sand and gravel—at Rocky Flats. It says "nothing in this [law] limits any valid, existing . . . mineral right" except for "such reasonable conditions on access . . . as are appropriate for the cleanup and closure of Rocky

Flats and for the management of the refuge." And it says that a Memorandum of Understanding (MOU) between DOE and Interior is to "address the impacts" mineral rights "may have on the management of the refuge, and provide strategies for resolving or mitigating these impacts."

These provisions were included in the refuge act in order to make clear that while these mineral rights are to be respected as private property, future development of the minerals could have adverse effects on the land, wildlife habitat, and other values of the future wildlife refuge. That is why Congress directed the agencies to consider these potential future effects and work to find ways to mitigate those impacts.

So far, however, the Energy and Interior Departments have not been able to agree on what to do about the minerals, and the MOU has not been completed.

I think the best way to handle this would be for the Federal Government to acquire the minerals. However, neither the DOE nor Interior has made this a priority, and the current budgetary situation places constraints on such acquisitions.

My bill is intended to make it more feasible for the Interior Department to acquire some or all of the minerals. It would do that by giving the Secretary of the Interior two additional methods (either instead of or in addition to purchase for cash) for completing such acquisitions—

(1) by giving "credits" that could be used instead of cash to pay for oil and gas leases on the Outer Continental Shelf; and

(2) by allowing federal lands or minerals anywhere in the country to be exchanged for the Rocky Flats minerals (under current law, such exchanges can only occur within the same state—Colorado lands/minerals for other Colorado lands/minerals).

The bill has no compulsory provisions. It does not require that any of the non-Federal interests at Rocky Flats be acquired by the government, and it does not require anyone to accept anything other than cash for any interests that the government may acquire. It would merely provide the Interior Department with new tools—in addition to those it already has—for such acquisitions.

In developing the bill, I sought and obtained technical assistance from the Interior Department. I also have given careful consideration to comments from local governments and others in Colorado, and have made revisions to earlier drafts of the legislation in response to points raised in those comments.

Mr. Speaker, this bill—the "Rocky Flats Minerals Acquisition Act"—is narrow in scope. However, I think it can assist in successful implementation of something that is very important for all Coloradans—the establishment of the Rocky Flats National Wildlife Refuge. I think it deserves the support of every Member of the House.

For the information of our colleagues, here is a short outline of the bill:

OUTLINE OF ROCKY FLATS MINERALS ACQUISITION BILL

BACKGROUND

When the ongoing cleanup of the Rocky Flats site is completed, it will be closed and most of the site will be transferred to the Interior Department for management as a National Wildlife Refuge. Within the site's boundaries there are some privately-owned mineral rights (primarily sand and gravel). Federal acquisition of at least some of these mineral rights would further sound management of the site as a wildlife refuge. However, the current budgetary situation makes it difficult to complete such acquisition.

The purpose of the bill is to provide the Interior Department with two additional tools to assist in the acquisition of minerals rights or other non-Federal property at Rocky Flats:

(1) Authority to provide "credits" (instead of or in addition to cash) that could be used for bonus bids or royalties for mineral leases on the Outer Continental Shelf; and

(2) Authority to provide eligible BLM lands (or interests) anywhere in the country in exchange for the interests acquired at Rocky Flats (waiving the current requirement that exchanges must be within the same state).

SECTION-BY-SECTION OUTLINE

Section 1—

(1) provides a short title: "Rocky Flats Minerals Acquisition Act."

(2) includes findings regarding the status of Rocky Flats and the desirability of federal acquisition of mineral interests within its boundaries

(3) states the bill's purpose as being to facilitate acquisition of non-Federal interests at Rocky Flats by authorizing the Interior Department to use credits or interests in certain public lands, instead of or in addition to cash.

Section 2—

(1) authorizes the Interior Department to use appropriated funds, credits, exchanged lands or interests therein, or any combination of these, to acquire mineral interests or other non-Federal interests at Rocky Flats;

(2) defines "credits," making clear that they can only be issued with agreement of recipient, can only be used for bonus bids or royalty payments for oil or gas leases on the Outer Continental Shelf and must be used within 10 years of their issuance;

(3) specifies that while exchanges can involve BLM lands or interests in any State, only lands or interests identified as suitable for disposal under current law can be transferred to private ownership through such an exchange;

(4) provides that interests acquired by the United States under the bill will be managed as part of the wildlife refuge and cannot be developed or transferred out of Federal ownership; and specifies that the bill adds to the Interior Department's existing authority and does not reduce any authority the Department already has.

TRIBUTE TO ELVA MARTINEZ-DRYER

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I am honored to stand before this body of Congress and this nation today to pay tribute to a phenomenal athlete from my district. Elva Martinez-Dryer, a former student-athlete from Western State College, will soon be inducted into the Rocky Mountain Athletic Conference Hall of Fame. Her exploits on the track are legendary and I would like to recognize the hard work and determination she gave the sport.

Elva helped the track team at Western State earn nation-wide recognition, personally achieving All-American status 16 times and winning five national championships. Elva became a dominant force in the sport; she did not lose a race during her final two years at school. She was awarded the "NCAA-II Track and Field Athlete of the Year Award," for her accomplishments and was inducted into the Colorado Sportswomen's Hall of Fame. Elva currently holds three records in the Rocky Mountain Athletic Conference, as well as four conference championships.

All of Elva's hard work and dedication paid off, as she earned a spot on the 2000 Olympic Team in the 5,000-meter event. In her most recent major race, Elva finished fourth in the Boulder Bolder, running the 10-kilometer race in the Elite Division.

Mr. Speaker, Elva's accomplishments are certainly deserving of praise before this body of Congress and this nation. She has accomplished more in her short career than some could hope for in an entire lifetime. Congratulations, Elva, on your induction into the Rocky Mountain Athletic Conference Hall of Fame and good luck with your future endeavors.

CONGRATULATING LOUIE WONG FOR HIS DISTINGUISHED SERVICE TO CALEXICO, CALIFORNIA

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FILNER. Mr. Speaker, I rise today to honor Louie Wong for his distinguished service to Calexico.

Louie was born in China and has made his home in Calexico since 1971. Mr. Wong and his wife own and operate YUM YUM Restaurant in Calexico where they serve, "the Best Chinese Food in Town." The YUM YUM restaurant has become a hub of activity for the Calexico community, hosting local politicos who meet to share ideas and concerns over plates of good food.

As a successful local businessman and a community activist, Louie has a long record of supporting numerous community organizations. He has just completed a term as President of the Calexico Chamber of Commerce where he has served with great distinction. He is a past recipient of the coveted Lava Lamp Award, presented annually by the Calexico Chamber of Commerce for service to the community. He was an early champion of Calexico's new cultural arts center, located in the renovated De Anza Hotel. The plan involves creating four rooms, or chambers, each dedicated to a different artistic discipline. Louie has supported this vision since its inception, by building community support for the plan and raising money, including personally paying for the architectural renderings.

Louie is a member of numerous community organizations and committees, including serving as a Trustee of the Imperial Valley College Board of Trustees, and on the Imperial Valley College Foundation Board of Directors. He has been much honored for his community service, receiving the first community service citation ever presented by the Calexico Unified School District and the Man of the Year Award from the Calexico Benevolent and Protective Order of Elks. He has served as Grand Marshall of the Calexico Christmas Parade.

Mr. Speaker, Louie Wong is a community leader, equally at home creating regional cultural arts centers as he is serving up Chinese food at high school football games to raise money for charity. He gives wholeheartedly to the organizations he supports that benefit the people of Calexico. While his service as President of the Calexico Chamber of Commerce is coming to an end, I have no doubt that he will find even more ways to improve the quality of life in his community.

TRIBUTE TO CHARLES L. STUPPARD

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. DAVIS of Illinois. Mr. Speaker, I rise to commend and congratulate Commander Charles L. Stuppard, United States Navy, who is leaving from the Joint Chiefs of Staff to be the next Commanding Officer of the U.S.S. *Arleigh Burke* (DDG51). The *Arleigh Burke* is a guided missile AEGIS Destroyer with a complement of about 325 personnel including 25 Officers. Commander Stuppard is slated to be at the helm of this powerful Navy vessel in April 2004.

Commander Stuppard joined the Naval Officer Corps in 1985. He obtained his Bachelor of Science Degree in Mechanical and Aerospace Engineering from Cornell University and his Master's degree in National Security and Strategic Studies from the Naval War College. Commander Stuppard's achievements and accomplishments are truly exemplary and I hope many young people from my district and around the country will follow in his footsteps as an Officer and a Gentleman. I congratulate Commander Stuppard for a job well done and wish him and his family fair winds and following seas.

A TRIBUTE TO GEORGETOWN, COLORADO—ONE OF AMERICA'S DOZEN DISTINCTIVE DESTINATIONS

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise today to congratulate the town of Georgetown, Colorado, for being selected by the National Trust for Historic Preservation as one of its 2003 Dozen Distinctive Destination locations. This designation acknowledges the outstanding work of the residents of Georgetown in protecting, respecting and celebrating their unique history and cultural heritage.

Anyone who has spent time in Georgetown knows of the wealth of historical structures that have been preserved and protected. This heritage provides a lasting reminder of the early years of mining and living in rugged mountainous areas of Colorado and the West.

Georgetown, the county seat of Clear Creek County, was established in 1864, when the discovery of the Belmont Lode started a stampede of prospectors and ultimately gave the town its nickname, "Silver Queen of the Rockies." The town still operates under an 1868 charter from Colorado's territorial legislature.

As the National Trust notes in its announcement of this designation: "Many vestiges of the town's heyday remain, including the Georgetown Loop Railroad, a marvel of engineering, hailed as the most complex railroad loop in the world at the turn of the century. Today, the historic railroad is still thrilling passengers as it traverses the Devil's Gate High Bridge, soaring 95 feet above Clear Creek. A year-round vacation wonderland, Georgetown's spectacular setting provides unlimited opportunities for fun. Summer months offer trout fishing, back-country hiking, biking, rafting and more—while during ski season, Georgetown is a convenient base for hitting the nearby slopes."

It was for these reasons and more that the National Trust, the country's largest private, nonprofit preservation organization, named Georgetown to its 2003 list of America's Dozen Distinctive Destinations, an annual list of unique and lovingly preserved communities in the United States.

In recognizing Georgetown, the National Trust singled out the Hamill House Museum, completed in 1879 as the home of silver baron William A. Hamill and adorned with furnishings delivered from its owner's birthplace in England. Another notable landmark is the Hotel de Paris, built in 1876. In its heyday, it was one of the finest hotels and gourmet restaurants in the state. Today the Colonial Dames operates the hotel as a museum.

Also noted by the National Trust are the town's holiday celebrations, which include a Christmas Market, Santa Lucia Processional, and horse-drawn wagon rides.

This is the fourth time the National Trust for Historic Preservation has compiled a list of A Dozen Distinctive Destinations. More than 50 destinations in 27 states were nominated by preservation organizations and local communities. Georgetown was selected because it met the National Trust's criteria of well-managed growth, a commitment to historic preservation with a protected historic core and meaningful context, interesting and attractive architecture, cultural diversity, activities for families with children, an economic base of locally-owned small businesses, and walkability for residents and visitors.

The National Trust also noted that Georgetown residents have taken forceful action to protect their town's character and sense of place and have worked hard to preserve the historic and scenic assets of their communities, with rewards that transcend town limits. In so doing, Georgetown has preserved its quality of life for its residents and tourists alike. Georgetown and towns like it in Colorado and throughout the west preserve the allure of the western lifestyle and the respect that settlers had and still have for the special places that have been established.

In announcing the places on the list of distinctive destinations, Richard Moe, the President of the National Trust for Historic Preservation, had this to say about Georgetown: "It is encouraging to see communities so committed to the preservation of their historic landmarks, the revitalization of their downtown areas, and the protection of their unique heritage. Georgetown represents a truly distinctive slice of America. That makes it an exciting alternative to the homogenization of many other vacation spots. It is my hope that more American cities and towns will follow Georgetown's lead in preserving their own spirit of place."

All I can add to that is, "amen," and my own congratulations to the people of Georgetown for this honor, so well earned through their efforts to preserve one of the places that makes Colorado such a special place to live.

HONORING SIDNY ZINK

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress and this nation today to pay tribute to a selfless community servant from my district, Sidny Zink of Durango, Colorado. An active member of the Leadership La Plata organization, Sidny was recently honored with the "Barbara Conrad Award," which recognizes a person who donates numerous hours to their community. Today I would like to join with the Durango Area Chamber of Commerce in honoring Sidny's commitment and recognizing this distinct honor.

A longtime resident of Durango, Sidny is widely known for her dedication to community service. Sidny has been active in a number of committees and organizations, such as the Big Brothers Big Sisters foundation, Community Development Corporation, the La Plata Homebuilders Society, and the Community Development Corporation. While Sidny has worked vigorously for the community, she spends much of her time with Leadership La Plata, learning how new issues could affect her community.

Mr. Speaker, in a recent ceremony in Durango, last year's recipient of the "Barbara Conrad Award" Ed Morlan passed on the award in recognition of Sidny's commitment to the community. I join with my colleagues here today in applauding Sidny's civic-mindedness and in recognizing this prestigious honor. Congratulations and thanks again, Sidny, for the many years of service you have given the Durango community.

STATEMENT RECOGNIZING DR. CHARLES CARPENTER FOR HIS ACHIEVEMENTS

HON. JAMES R. LANGEVIN

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. LANGEVIN. Mr. Speaker, I rise today to congratulate Dr. Charles C.J. Carpenter, who received the John E. Fogarty Recognition award for his lifelong achievements in global health on May 29. This prestigious honor, given by the National Institute of Health's John E. Fogarty International Center, recognizes Dr. Carpenter's career in research to combat major diseases in developing countries and his involvement in training future generations of researchers in international health. Dr. Carpenter is a Professor of Medicine at Brown University in Providence, Rhode Island, and formerly the Physician-in-Chief of Brown University's Miriam Hospital.

Born in Savannah, GA, Dr. Carpenter received a Bachelor of Arts degree from Princeton University and a medical degree from the Johns Hopkins School of Medicine. He began his medical career at Johns Hopkins, where he later served as a faculty member. He started the Johns Hopkins Cholera Research Program, which was located in Calcutta, India, and researched the treatment of cholera in children and adults. He served for 12 years as Professor and Chairman of the Department of Medicine at Case Western Reserve University before joining the medical faculty at Brown University in 1986. At Brown, he became involved with the clinical management of persons living with HIV/AIDS, and is currently the Principal Investigator of the Lifespan/Tufts/Brown Center for AIDS Research. Dr. Carpenter has also written many notable publications on his research from cholera to HIV/AIDS.

The John E. Fogarty International Center plays a vital role in the United States' response to global challenges in health. The late John Fogarty served as Representative from the 2nd District of Rhode Island and was a lifelong advocate of promoting the study of global health problems. Dr. Carpenter has consistently shown that same vision by taking on the challenge of disease prevention throughout the global community. He has shown himself to be a notable leader on seeking out ways to better the entire global community, and by doing so, has left his mark on international health.

Thank you, Mr. Speaker, and I hope our colleagues will join me in congratulating Dr. Carpenter on his lifetime of achievements.

DEPARTMENT OF HOMELAND SECURITY APPROPRIATIONS ACT, 2004

HON. GINNY BROWN-WAITE

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, with great disappointment I was unable to be present on Tuesday, June 24 to speak and vote in favor of H.R. 2555, the Homeland Security Appropriations Act for Fiscal Year 2004.

The terrorist attacks on and following September 11 highlighted our vulnerability to attack on our soil, and exposed a new enemy with a desire to harm the United States and the American people. Our swift efforts at bolstering our domestic security have resulted in the prevention of further domestic incidents. It is this absence of occurrences that confirms our success. We cannot, however, become complacent in this success and must remain committed to securing our homeland.

Our Nation continually faces new and previously unfamiliar domestic threats that are more severe than ever before. Local governments cannot be expected to bear the new financial burdens that accompany their extensive and important new detection, prevention, and emergency management responsibilities. Funding must come from the Federal Government in this matter of national security.

When I was a Florida State Senator I chaired the Senate Homeland Security Committee following September 11. Florida was the state that initiated the drive to secure federal funds for first responders. Because we had to deal with so many natural disasters, we know the many benefits of well-trained, well-equipped first responders. Local governments cannot be expected to bear the new financial burdens that accompany their extensive and important new responsibilities. Funding must come from the Federal Government in this matter of national security.

I applaud Chairman ROGERS, Chairman YOUNG, and the entire Appropriations Subcommittee on Homeland Security for their excellent work in producing the first ever Homeland Security Appropriations bill. I am so pleased that my colleagues in Congress share my concern for the priority that is Homeland Security, and that consequently, the Appropriations Act passed 425–2.

TRIBUTE TO PATTI O'ROURKE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I would like to take this opportunity to honor the life and memory of an outstanding woman from my district. Patti O'Rourke of Pueblo, Colorado made tremendous contributions during her lifetime to her community and served as leader and role model for many.

Patti graduated from law school at Fordham University in 1944 and went to work with a firm on Wall Street. She later became one of the first women to practice law in Pueblo County, Colorado, and in 1981, became the county's first female judge. Patti's reputation as a fair and caring judge, as well as her lifelong commitment to community service, was well known. She donated countless hours to a variety of causes that are too numerous to mention. In short, Patti served on many community boards, worked tirelessly to support family court reforms, and took up the cause for senior citizens. Even after leaving full-time service on the bench, Patti's interest in serving others prompted her to travel to Denver several times a week to help alleviate a large backlog of cases.

Mr. Speaker, I am honored to recognize the life and memory of Patti O'Rourke before this body of Congress and this nation today. By reaching heights no other woman had attained, Patti became a pioneer who blazed a trail other women could follow. By giving so much of herself to the community, Patti became a public servant and a beacon for everyone in Pueblo, the State of Colorado, and our nation to follow. Patti left the world a better place; she will be missed by her family, friends, and the many people whose lives she impacted for the better.

HONORING PRESTON HIGH SCHOOL GRADUATE TIFFANY BROWN

HON. JOSEPH CROWLEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. CROWLEY. Mr. Speaker, I rise to pay tribute to Miss Tiffany Brown, a constituent of mine from the Bronx, NY. Tiffany is graduating this year with honors from Preston High School in the Bronx.

Mr. Speaker, we hear so much these days about students not being interested in community service and not being interested in politics and public service, but Tiffany is the exception, not the rule. While in school at Preston, she interned with New York State Assemblyman Steve Kaufman, interned with the Eleanor Roosevelt Democratic Club, was a CCD teacher at St. Ursula's Church and co-founded a program called "R.A.M", Registering Adults and Minorities Program, which seeks to increase voting registration and participation.

Mr. Speaker, Tiffany is truly one of the best and brightest students in New York City. In high school, she was a member of Amnesty International, was a columnist for her newspaper, wrote for Preston's literary magazine, was a member of the African American club, the orchestra, a captain of the Defense Team, and a participant in the Science and Technology entry program at Fordham University. Tiffany was a well-rounded student and successful student, gaining notice as one of the Who's Who Among American High School Students.

Mr. Speaker, I applaud Tiffany's commitment to community service and her giving back so much to make the Bronx and the Co-Op City neighborhood where she lives in a better place. Mr. Speaker, academic and community success though is not achieved with the work of one person alone. It is a team effort. Tiffany comes from a strong and caring family, including her aunt who is also my Co-Op City office director Teckla Halls. Her family along with her teachers, mentors and adults in the community are all part of the success that makes Tiffany the wonderful young woman she is today.

Mr. Speaker, Tiffany is an exceptional student, one who has a bright and prosperous future ahead. I wish her and her family all the best.

HONORING BILL KILLGORE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I rise before this body of Congress and this nation today to pay tribute to a selfless community servant from my district, Bill Killgore of Grand Junction, Colorado. An active member of the Grand Junction Lions Club, Bill was recently honored as "Lion of the Year." I would like to join with his fellow Lions in honoring Bill's commitment and recognizing this distinct honor.

A longtime resident of Grand Junction, Bill is widely known for his dedication to community service. Bill has been active in a number of committees and organizations, such as the Redlands Water Board, the Avalon Theatre Restoration Committee, and serving as chairman of the Highway Cleanup Committee. While Bill has worked vigorously for the community, his heart has always been with his beloved Lions Club. Bill's work with the Lions is well known; from their commitment to community service to the many fundraising events they hold in support of local causes and organizations, Bill is always at the forefront of the club's service projects, eager to help out his community.

Mr. Speaker, in a recent ceremony in Grand Junction, former "Lion of the Year" Dan Griffin passed on that distinctive title in recognition of Bill's commitment to both the community and the club. I join with my colleagues here today in applauding Bill's civic-mindedness and in recognizing this prestigious honor. This recognition to Bill and his fellow Lions for the work that they do in my community is long overdue, and I am proud to bring it to the attention of this House today. Congratulations and thanks again, Bill, for your many years of hard work on behalf of Grand Junction and the Lions. May you have many more to come!

IN HONOR OF DR. WAYNE D. LETT, SUPERINTENDENT OF NEWPORT NEWS PUBLIC SCHOOLS

HON. ROBERT C. SCOTT

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. SCOTT of Virginia. Mr. Speaker, I rise today on behalf of Representative Jo Ann Davis and myself to recognize the outstanding service of Dr. Wayne Lett. Following 34 years of educational service, Dr. Lett will be retiring from his post as Superintendent of Newport News Public Schools on July 1, 2003.

Dr. Lett's career has been devoted to education and his efforts have been important to the lives of countless young people in Newport News. His achievements have been recognized by both local and national organizations. In 2001, Dr. Lett was named Virginia Superintendent of the Year by the Virginia Association of School Superintendents. He has provided leadership in many urban school organizations and has served as President and Vice President of the National Association of Federally Impacted Schools.

Dr. Lett's illustrious career in education began in 1969, following his graduation from East Carolina University with an A.B. in history and political science. He first served as a teacher, assistant principal, and personnel director in York County Public Schools. It was during this time that Dr. Lett earned his M.A. in history from Old Dominion University in 1972, a C.A.S. in education administration from the College of William and Mary in 1975, and an Ed.D in education administration from the same institution in 1984.

Dr. Lett's tenure in Newport News Public Schools began in 1984. After serving in a number of different administrative positions for the school district, Dr. Lett was named Superintendent in 1996.

Under Dr. Lett's leadership, Newport News Public Schools has made significant progress in the academic performance of its students. The number of fully accredited schools has risen from one to nineteen, access to rigorous coursework has been made a priority, tutoring and mentoring programs have been expanded, and the dropout rate has been reduced by more than 50 percent. During this time Newport News Public Schools has received more U.S. Department of Education "Blue Ribbon" designations than any other school division in Virginia. These are only a few of the many achievements that are the direct result of Dr. Lett's leadership.

Mr. Speaker, Representative Jo Ann Davis and I would like to congratulate Dr. Lett on his distinguished service and thank him for his great commitment to the education of our youth.

TRIBUTE TO COLORADO MOUNTAIN COLLEGE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, I am honored to stand before this body of Congress and this nation to pay tribute to an exceptional educational institution in my district. Colorado Mountain College was established in 1967 and currently provides over 25,000 students with a quality education. The school will soon be opening a new campus to better serve the Vail/Eagle Valley area. I am proud to stand here today and recognize the 36 years of service that Colorado Mountain College has given to my state and congratulate them on their expansion.

The new campus in Edwards, Colorado will provide students with state of the art facilities that will help enrich their college experience. The campus will have 16 classrooms, several labs, science and EMT facilities, and a fire science center. CMC is already the largest rural community college in the U.S. and this campus will further the services they provide to underserved areas throughout the state.

Colorado Mountain College provides students with the opportunity to take classes in one of the most beautiful landscapes in the world. Sitting high in the Rocky Mountains, CMC maintains a unique curriculum, offering classes in subject areas not found elsewhere. Students are able to study ski business and resort management, seeing first hand how some of the world's premier ski resorts are run. CMC also offers classes in forestry and fire sciences, important subjects on the Western Slope, which faces some of the worst fire danger in the country.

Mr. Speaker, Colorado Mountain College does more for its students than provide an education, it gives them the opportunity to succeed. The college is a vital part of the Colorado Community, and I am truly honored to recognize such an exceptional institution and its outstanding team of dedicated employees here today. Congratulations on the expansion, and good luck with all of your future endeavors.

IN HONOR OF BILL RUMBLE

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. BECERRA. Mr. Speaker, it is with the utmost pleasure and privilege that I rise today to recognize and pay tribute to a friend and educator, Mr. Bill Rumble, who will retire this Friday, June 27th, after 28 exceptional years of teaching in the Los Angeles Unified School District.

Born November 5, 1946 in Long Beach, California, to Everett and Marion Rumble, Bill graduated from Millikan High School in 1964 and then attended the University of California, Los Angeles, where he earned a Bachelor of Arts degree in Political Science. Following college, Bill served in the United State Navy from June 1968 to July 1970. First commissioned as an Ensign in the U.S. Naval Reserve, he was quickly called up to active duty and served as Combat Information Center Officer on the Naval destroyers USS *DuPont* and USS *Albert David*. During his two-year Naval tenure, he earned the National Defense Medal, the Republic of Vietnam Campaign Medal, the Vietnam Service Medal, and he attained the rank of Lieutenant.

Bill's service to his country did not end when he left the military, but instead evolved into a lifetime of service in the classroom. After completing his California Teaching Credential from California State University, Long Beach, in June 1974, Bill went to work for the Los Angeles Unified School District where he taught English as a Second Language, English, history, and Chicano Studies from 1974 to 1996. From 1996 to the present, he has served as the Bilingual Program Coordinator at Wilson High School, which is attended by many students who reside in my district. Though he has spent his career as a teacher, Bill somehow found the time to be a student earning his Master of Arts in Latin American Studies from California State University, Los Angeles in 1988.

Bill Rumble has never pursued but has certainly earned recognition as a dedicated public servant, committed educator, and fighter for human dignity. But what sets him apart from many others, at least for me, is his devotion to and appreciation of his role as husband and father.

Bill had the good sense to marry Carol Jacques in August of 1981. Together they have three children: Lawrence, Mateo, and Maya. In her own right, Carol is a tireless and beloved advocate in our community. Together they have mastered the art of advocacy, and together they have shared in the fruits of their progressive work. Together, they are a powerful team.

Bill's 28 years with the schools of Los Angeles have been flush with positions of leadership, including Social Studies Department Chair during 1995–96, member of the Accreditations Committee during 1996–97, member of the Professional Development Committee during 2000–03, and member of the Academic Leadership Team during 2001–03. Furthermore, Bill played an active role with our local teachers union, the United Teachers of Los Angeles, in which he assumed several positions of leadership. Ultimately, however, Bill's first priority as a teacher was his genuine concern for the education, enrichment and well being of his students.

As a tireless volunteer, Bill has supported many local community-based organizations, including Art in the Park, the Northeast branch of the Los Angeles YMCA, the Mount Washington Residents Association, and the Arroyo Seco Neighborhood Council.

Bill's retirement marks the final chapter in a distinguished teaching career. But, if I know Bill, he's just getting started. I look forward to his continued service and devotion to our community. Just as his students needed him yesterday, we who believe in social activism and a commitment to social justice need him today.

Mr. Speaker, as family, friends and colleagues gather to celebrate Bill's many accomplishments, it is with great admiration and pride that I ask my colleagues to join me today in saluting this exceptional man and brother to many. America certainly got the best end of the bargain when it opened the doors of education and public service to Bill Rumble.

TRIBUTE TO RICK LUPE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, it is with profound sadness that I rise before this body of Congress and this nation today to pay tribute to a true American hero. Rick Lupe recently passed away from injuries sustained while battling a prescribed burn on the Fort Apache Indian Reservation near Whiteriver, Arizona. I am saddened by his death and would like to take a moment to reflect on the courage and leadership of this honorable and distinguished individual.

Rick previously made headlines during another fire that took place last summer. When the Rodeo-Chediski fire scorched much of Arizona, Rick engineered a fire line at the last minute, using a back burn and bulldozers that helped save the town of Show Low. Such acts of courage are no surprise to those who knew him. In nearly two decades of service to the Fort Apache Hotshot crew, Rick developed a reputation as a strong but quiet leader, a loyal colleague, and trusted friend.

Rick possessed courage and toughness to spare. While checking on a hot spot recently, the wind picked up and blew the flames around him. When the shelter he tried to deploy blew away, Rick dropped to the ground to allow the fire to pass over him. Even though the flames and heat scorched him, leaving 3rd degree burns over 40 percent of his body, he summoned the strength to walk a half-mile to get help. Even then, Rick held on for five weeks before leaving us. He will be especially missed by his beloved wife Evelyn and his children Brent, Sean, and Daniel. I would like to extend my deepest sympathy to them during this difficult time.

Mr. Speaker, I am honored to recognize Rick Lupe today. His immediate family will remember Rick for the loving husband and father that he was. The town of Show Low, the Fort Apache Hotshots, and this nation will remember Rick as the hero that he was. Rick dedicated his life to serving his nation and his fellow citizens. We will always be grateful.

TRIBUTE TO JOEL WILLARD

HON. GREG WALDEN

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WALDEN of Oregon. Mr. Speaker, I would like to pay tribute to a member of my Washington, D.C., staff for his years of faithful service to me and to the good people of Oregon's Second Congressional District. Joel Willard has been my Executive Assistant for over 2 years, performing a myriad of responsibilities in a hectic environment with dedication and poise. It's a tough job, and he excelled at it. Joel will leave my office this week to continue his education as a law student at the University of California at Berkeley, where I have every confidence that he will demonstrate the same talents that have made him such an invaluable member of my staff.

Mr. Speaker, Joel is a lifelong Oregonian and the son of a highly respected southern Oregon family. His father, Dave, is a long-time servant of the Oregon public school system and has worked for ten years as the Superintendent of the Phoenix-Talent School District. Joel's mother, Jana, is a homemaker who has returned to graduate school after raising her children. Like Joel, his brothers Chad and Gabe are fine young Oregonians with bright, promising futures. I am proud to call them my friends.

One of Joel's defining characteristics is his dedication to the people of his native state. Since his days in the Oregon State Legislature working for State Representative Rob Patridge, Joel has pursued his passion for public policy and public service from Salem to Washington, D.C. He came to the Nation's capital on a weekend's notice and brought with him both his love of Oregon and his reverence for the American system of government. I have no doubt that he will return to the West Coast with the same idealism that first inspired him to serve his fellow citizens.

Perhaps Joel's most impressive trait is his deep religious faith and personal commitment to the teachings of Jesus Christ. Prior to his marriage, Joel lived in a home for Christian men on Capitol Hill called Jonathan House, where he enjoyed the company of young professionals who shared his moral convictions and dedication to the Christian church. Joel's unwavering devotion to his beliefs, in an age when so many young people lack a guiding moral compass, has deeply impressed me and those with whom he has worked.

Mr. Speaker, in July of last year, I had the honor of attending Joel's wedding to his lovely bride, the former Elizabeth Horton, who has been at Joel's side since their early teens. Elizabeth, also a lifelong Oregonian, has made her love of children a career as an elementary school teacher, a calling for which she is particularly well suited. Joel and Elizabeth are the sort of people that parents want their children to grow up to be, and it gives me great pleasure to know that they will share their lives together.

Mr. Speaker, it goes without saying that Joel will be difficult to replace. If you were to poll my staff, they would be unanimous in their regret at his departure, as he has been a reliable coworker and caring friend. While we are sorry to see him depart the office, we are happy to watch him enter a new phase in his life that I know will bring both great challenges and great rewards. I have no doubt that he will do as well pursuing a legal career as he has done in his work on behalf of the people of the Second District. Joel, thank you for a job well done, and know that you are leaving my office with my deepest gratitude and that of the people you have so ably helped me to represent. We're counting on you to keep in close touch.

MILITARY CONSTRUCTION

HON. CIRO D. RODRIGUEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. RODRIGUEZ. Mr. Speaker, it is an outrage that we are today considering a military construction bill that cuts funding for desperately needed facilities by $1.5 billion from last year's bill.

It is an outrage that, as young men and women in uniform are fighting and dying every day in Iraq, we are voting on a bill that will not provide needed funds for housing for their families; for dormitories or young airmen, sailors, soldiers, and marines; and for safe facilities in which to work.

The bill we are voting on today represents a sad example of a policy that the majority seems to be pursuing of paying lip-service to the men and women who risk their lives in defense of our country—while cutting funds for family housing, for needed pay raises, for health care for veterans.

The young people who are fighting for us now in Iraq and around the world have been shut out of the child tax credit, and now it seems that we are yet again going after programs that help these brave men and women and the families they have left behind.

Mr. Speaker, this is wrong, and I urge my colleagues to vote against this rule.

TRIBUTE TO RAY WAH-NYEP QUAN

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. McINNIS. Mr. Speaker, it is with a solemn heart that I stand before this body of Congress and this nation today to pay tribute to the life and passing of Ray Wah-Nyep Quan, an outstanding citizen from my district. Ray was an active member of the Grand Junction community, and he will be remembered as a respected businessman and dedicated family man. Ray passed away recently at the age of 81, leaving a legacy of leadership for his community to follow.

Ray owned and operated the Far East Restaurant in Grand Junction, providing the community with excellent food and quality service. His hard work and dedication helped make the Far East one of the most popular restaurants in town, attracting customers to its unique atmosphere, authentic decor, and quality food. The restaurant became so popular that Ray was able to expand the building twice, turning the Far East into a luxurious three-level eatery.

Ray loved his life in the United States and became an example of the American dream. Ray was a self made man whose diligence and determination aided his success. He called the United States "gold mountain" in appreciation of the opportunities he found here, and helped several Chinese immigrants move to this country to experience those same opportunities from which he has benefited. With Ray's assistance, many of these new Americans have seen their lives improve and their children go on to college.

Mr. Speaker, I am honored to pay tribute to the life of Ray Wah-Nyep Quan today. Ray loved the United States, embracing it as his own. His drive and dedication helped him become a model citizen, one who cares about the country that has helped provide him with so much. I am saddened by his passing, and my thoughts and prayers go out to his family and friends.

HOUSE OF REPRESENTATIVES—*Monday, July 7, 2003*

The House met at 2 p.m. and was called to order by the Speaker pro tempore (Mr. GILCHREST).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
July 7, 2003.

I hereby appoint the Honorable WAYNE T. GILCHREST to act as Speaker pro tempore on this day.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

PRAYER

The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

As the Nation celebrated Independence Day this year, we thank You again, Lord, and we praise You still. You have blessed this land with abundance and hold us together in our diversity.

Let freedom continue to ring out from the Nation's capital as leaders in government turn to You in prayer and seek Your guidance in the days ahead. Strengthen and protect our military troops at home and abroad, for the gift of this Nation holds promise for peoples around the world.

May the songs of equal justice and religious truths heard this weekend at the Capitol Fourth concert on the Mall and from the Mormon Tabernacle Choir at Wolf Trap continue to sound across this Nation and stir America's soul in her desire to be "the land of the free and the home of the brave," now and forever.

Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Virginia (Mr. WOLF) come forward and lead the House in the Pledge of Allegiance.

Mr. WOLF led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate agreed to the following resolution:

S. RES. 191

Whereas the Honorable J. Strom Thurmond conducted his life in an exemplary manner, an example to all of his fellow citizens;

Whereas the Honorable J. Strom Thurmond was a devoted husband, father, and most recently, grandfather;

Whereas the Honorable J. Strom Thurmond gave a great measure of his life to public service;

Whereas having abandoned the safety of high position, the Honorable J. Strom Thurmond served his country during World War II, fighting the greatest threat the world had thus far seen;

Whereas the Honorable J. Strom Thurmond served South Carolina in the United States Senate with devotion and distinction;

Whereas his service on behalf of South Carolina and all Americans earned him the esteem and high regard of his colleagues; and

Whereas his death has deprived his State and Nation of a most outstanding Senator: Now, therefore, be it

Resolved, That the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable J. Strom Thurmond, former Senator and President Pro Tempore Emeritus from the State of South Carolina.

Resolved, That the Secretary of the Senate communicate these resolutions to the House of Representatives and transmit an enrolled copy thereof to the family of the deceased.

Resolved, That when the Senate adjourns today, it stand adjourned as a further mark of respect to the memory of the Honorable J. Strom Thurmond.

The message also announced that the Senate has passed with an amendment a bill of the House of the following title:

H.R. 1474. An act to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, and for other purposes.

The message also announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 148. An act to provide for the Secretary of Homeland Security to be included in the line of Presidential succession.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 27, 2003.

Hon. J. DENNIS HASTERT,
Speaker, House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on June 27, 2003 at 12:49 p.m.

That the Senate passed without amendment H. Con. Res. 231.

With best wishes, I am

Sincerely,

MARTHA C. MORRISON,
Deputy Clerk of the House.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 27, 2003.

Hon. J. DENNIS HASTERT,
Speaker, House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on June 27, 2003 at 5:06 p.m.

That the Senate passed without amendment H.R. 2350.

That the Senate passed without amendment H.R. 2474.

With best wishes, I am

Sincerely,

DANIEL STRODEL,
Assistant to the Clerk.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 4 of rule I, Speaker pro tempore TOM DAVIS of Virginia signed the following enrolled bills on Monday, June 30, 2003:

H.R. 2350, to reauthorize the Temporary Assistance for Needy Families block grant program through fiscal year 2003, and for other purposes;

H.R. 2474, to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal years 2003 and 2004.

HOUR OF MEETING ON TOMORROW

Mr. WOLF. Mr. Speaker, I ask unanimous consent that when the House adjourns today it adjourn to meet at 10:30

☐This symbol represents the time of day during the House proceedings, e.g., ☐1407 is 2:07 p.m.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

a.m. tomorrow for morning hour debates.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

CORRECTION TO THE CONGRESSIONAL RECORD OF THURSDAY, JUNE 26, 2003, AT PAGE H6259

ADJOURNMENT

Mr. DELAY. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 148. An act to provide for the Secretary of Homeland Security to be included in the line of Presidential succession; to the Committee on the Judiciary.

ENROLLED BILLS SIGNED

Mr. Trandahl, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 2350. An act to reauthorize the Temporary Assistance for Needy Families block grant program through fiscal year 2003, and for other purposes.

H.R. 2474. An act to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal years 2003 and 2004.

BILLS PRESENTED TO THE PRESIDENT

Jeff Trandahl, Clerk of the House reports that on June 30, 2003 he presented to the President of the United States, for his approval, the following bills.

H.R. 2350. To reauthorize the Temporary Assistance for Needy Families block grant program through fiscal year 2003, and for other purposes.

Jeff Trandahl, Clerk of the House reports that on July 2, 2003 he presented to the President of the United States, for his approval, the following bills.

H.R. 825. To redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the "Michael J. Healy Post Office Building".

H.R. 917. To designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the "Floyd Spence Post Office Building".

H.R. 925. To redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the "Cesar Chavez Post Office".

H.R. 981. To designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the "James R. Merry Post Office".

H.R. 985. To designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the "Delbert L. Latta Post Office Building".

H.R. 1055. To designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the "Dr. Roswell N. Beck Post Office Building".

H.R. 2474. To authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal years 2003 and 2004.

Jeff Trandahl, Clerk of the House reports that on July 3, 2003 he presented to the President of the United States, for his approval, the following bills.

H.R. 1368. To designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the "Norman D. Shumway Post Office Building".

H.R. 1465. To designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the "General Charles Gabriel Post Office".

H.R. 1596. To designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the "Timothy Michael Gaffney Post Office Building".

H.R. 1609. To redesignate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the "Admiral Donald Davis Post Office Building".

H.R. 1704. To designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the "Dr. Caesar A.W. Clark, Sr. Post Office Building".

H.R. 2030. To designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building".

ADJOURNMENT

Mr. WOLF. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 2 o'clock and 8 minutes p.m.), under its previous order, the House adjourned until tomorrow, Tuesday, July 8, 2003, at 10:30 a.m., for morning hour debates.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2937. A letter from the transmitting a proposed emergency supplemental appropriations request totaling $32.2 mi million for fiscal year 2003 to fund non-recurring expenses associated with new Article III judgeships and to pay for higher than anticipated Criminal Justice Act representations and juror days; to the Committee on Appropriations.

2938. A letter from the Principal Deputy Under Secretary, Department of Defense, transmitting a report entitled "Interim Report to Congress on Corrosion Matters in the Department of Defense" May 2003, pursuant to 10 U.S.C. 2228 (1067) (c) Public Law 107—314; to the Committee on Armed

2939. A letter from the Deputy Secretary, Department of Defense, transmitting he Department's certification that the costs of Wedges 2 through 5, of the Pentagon Renovation will be within the specified limitation; to the Committee on Armed Services.

2940. A letter from the Assistant General Counsel for Regulations, Department of Housing and Urban Development, transmitting the Department's final rule — Open Competition and Government Neutrality Towards Government Contractors' Labor Relations on Federal and Federally Funded Construction Projects [Docket No. FR-4695-I-01] (RIN: 2501-AC98) received June 5, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2941. A letter from the Board of Governors, Federal Reserve System, transmitting the thirteenth annual report on the Profitability of Credit Card Operations of Depository Institutions, pursuant to 15 U.S.C. 1637 note, Public Law 100—583, section 8 (102 Stat. 2969); to the Committee on Financial Services.

2942. A letter from the General Counsel, National Credit Union Administration, transmitting the Administration's final rule — Rules of NCUA Board Procedure; Promulgation of NCUA Rules and Regulations; Public Observance of NCUA Board Meetings — received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2943. A letter from the General Counsel, National Credit Union Administration, transmitting the Administration's final rule — Involuntary Liquidation of Federal Credit Unions and Adjudication of Creditor Claims Involving Federally Insured Credit Unions in Liquidation — received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2944. A letter from the Director, OSHA Standards and Guidance, Department of Labor, transmitting the Department's final rule — Powered Industrial Trucks — received June 16, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and the Workforce.

2945. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's final rule — Medical Devices; Designation of Special Control for Eight Surgical Suture Devices [Docket No. 02N-0288] received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2946. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's final rule — Public Information Regulations [Docket No. 99N-2637] received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2947. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's final rule — Skin Protectant Drug Products for Over-the-Counter Human Use; Final Monograph [Docket Nos. 78N-0021 and 78N-021P] (RIN: 0910-AA01) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2948. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting the Department's report entitled, "Fleet Alternative Fuel Vehicles Program Report for Fiscal Year 2002" April 30, 2003, pursuant to Public Law 105—388; to the Committee on Energy and Commerce.

2949. A letter from the Director, Office of Congressional Affairs, Nuclear Regulatory

Commission, transmitting the Commission's final rule — Event Notification Requirements (RIN: 3150-AG90) received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2950. A communication from the President of the United States, transmitting a 6-month periodic report on the national emergency with respect to Libya that was declared in Executive Order 12543 of January 7, 1986, pursuant to 50 U.S.C. 1641(c) and 50 U.S.C. 1703(c); (H. Doc. No. 108—88); to the Committee on International Relations and ordered to be printed.

2951. A communication from the President of the United States, transmitting a 6-month periodic report on the national emergency with respect to the proliferation of weapons of mass destruction that was declared in Executive Order 12938 of November 14, 1994, pursuant to 50 U.S.C. 1703(c) and 50 U.S.C. 1641(c); (H. Doc. No. 108—92); to the Committee on International Relations and ordered to be printed.

2952. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting the Department of the Defense's proposed lease of defense articles to the Government of Singapore (Transmittal No. 03-03), pursuant to 22 U.S.C. 2796a(a); to the Committee on International Relations.

2953. A letter from the Chief Counsel, Foreign Assets Control, Department of the Treasury, transmitting the Department's final rule — Iraqi Sanctions Regulations; Authorization of Certain New Transactions — received June 23, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on International Relations.

2954. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 15-106, "Fiscal Year 2004 Budget Support Act of 2003" received July 7, 2003, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform.

2955. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 15-101, "Dedication and Designation of Commodore Joshua Barney Drive, N.E., Fort Lincoln Drive, N.E., and Lincoln Drive North, N.E., Act of 2003" received July 7, 2003, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform.

2956. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 15-100, "Lead-Based Paint Abatement and Control Temporary Amendment Act of 2003" received July 7, 2003, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform.

2957. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 15-99, "Honoraria Temporary Amendment Act of 2003" received July 7, 2003, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform.

2958. A letter from the Senior Staff Attorney, Court of Appeals For the First Circuit, transmitting the opinion from Sunday Dixon Orekoya v. James Mooney, No. 02-1306 (1st Cir. May 15, 2003); to the Committee on Government Reform.

2959. A letter from the Chief, Regulations Branch, Department of Homeland Security, transmitting the Department's final rule — Confidentiality of Commercial Information [CBP Decision 03-02] (RIN: 1515-AD29) received June 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform.

2960. A letter from the Secretary, Department of Homeland Security, transmitting the semiannual report of the Inspector General for the period October 1, 2003 through March 31, 2003, pursuant to Public Law 95—452, section 5(b) (102 Stat. 2526); to the Committee on Government Reform.

2961. A letter from the Director, Regulations Managment, Department of Veterans Affairs, transmitting the Department's final rule — Privacy Act of 1974; Implementation-Exemption of Police and Security Records (RIN: 2900-AL33) received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform.

2962. A letter from the Managing Director, Federal Home Loan Banks, transmitting the 2002 management reports of the 12 Federal Home Loan Banks (FHLBanks), Resolution Funding Corporation (REFCORP) and the Financing Corporation (FICO), pursuant to 31 U.S.C. 9106; to the Committee on Government Reform.

2963. A letter from the Chairman, Federal Maritime Commission, transmitting the Commission's semiannual report on the activities of the Office of Inspector General for the period October 31, 2002 to March 31, 2003, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 8G(h)(2); to the Committee on Government Reform.

2964. A letter from the Secretary, Federal Trade Commission, transmitting the Commission's final rule — Final notice of new Privacy Act system of records [Billing Code: 6750-01P] received June 23, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform.

2965. A letter from the Director, Office of Surface Mining, Department of the Interior, transmitting the Department's final rule — West Virginia Regulatory Program [WV-097-FOR] received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2966. A letter from the Acting Assistant Administrator, Nation Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Announcement of Funding Opportunity to submit proposals for the South Florida Ecosystem Research and Monitoring Program (SFP) FY04 [Docket No. 000202024-3109-03 I.D. 030303B] (RIN: 0648-ZA79) received June 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

2967. A letter from the Secretary, Department of Health and Human Services, transmitting the annual report on the Refugee Resettlement Program for FY 2001, pursuant to 8 U.S.C. 1523(a); to the Committee on the Judiciary.

2968. A letter from the Assistant Secretary, Department of Labor, transmitting the Department's final rule — Procedures for the Handling of Discrimination Complaints Under Section 806 of the Corporate and Criminal Fraud Accountability Act of 2002, Title VIII of the Sarbanes-Oxley Act of 2002 (RIN: 1218-AC10) received June 6, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

2969. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Licensing and Manning for Officers of Towing Vehicles [USCG 1999-6224] (RIN: 1625-AA15) received June 13, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2970. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Drawbridge Operation Regulations; Illinois Waterway, Beardstown, IL [CGD08-03-025] received June 13, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2971. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Ohio River Miles 466.8 to 470.5, Cincinnati, OH [COTP Louisville-02-011] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2972. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone: 2002 West Palm Holiday Boat Parade, Intracoastal Waterway, West Palm Beach, FL [COTP Miami 02-136] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2973. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone: Winterfest Boat Parade Fireworks, Intracoastal Waterway, Ft. Lauderdale, FL [COTP Miami 02-140] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2974. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Black Warrior River, Walker County, AL [COTP Mobile-02-023] (RIN: 2115-Aa97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2975. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Tchefuncte River, Mile Marker 1.0 to 3.0, Madisonville, Louisiana [COTP New Orleans-02-023] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2976. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; South Shore, Lake Pontchartrain, New Orleans, LA [COTP New Orleans-02-024] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2977. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Ouachita River, Miles 165.0 to 168.0, Monroe, LA [COTP New Orleans-02-026] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2978. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Red River, Miles 87.0 to 90.0, Pineville, LA [COTP New Orleans-02-027] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2979. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Ohio River, Mile Marker 934.0 to 936.0, Paducah, Kentucky [COTP Paducah, KY 02-010] (RIN:

2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2980. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Alleghany River Mile Marker 0.3 to Mile Marker 0.6, Pittsburgh, Pennsylvania [COTP Pittsburgh-02-025] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2981. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Cooper River, Port of Charleston, South Carolina [COTP Charleston-02-142] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2982. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Safety Zone; Navy Pier, Lake Michigan, Chicago Harbor, IL [CGD09-02-527] (RIN: 2115-AA97) received May 15, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2983. A letter from the Paralegal, FTA, Department of Transportation, transmitting the Department's final rule — Bus Testing [FTA Docket No. 98-B] (RIN: 2132-AA30) received June 9, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2984. A letter from the Paralegal, FTA, Department of Transportation, transmitting the Department's final rule — Buy America Requirements; Amendment to Certification Procedures [FTA Docket No. FTA-98-4454] (RIN: 2132-AA62) received June 9, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2985. A letter from the Acting Director, Department of Transportation, transmitting the Department's final rule — Procedures for Transportation Workplace Drug and Alcohol Testing Programs [Docket OST-2003-15245] (RIN: 2105-AD26) received June 9, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2986. A letter from the Deputy Assistant General Counsel, Regulations and Enforcement, Department of Transportation, transmitting the Department's final rule — Participation by Disadvantaged Business Enterprises in Department of Transportation Financial Assistance Programs [Docket OST-2000-7639 & OST-2000-7640],(RIN: 2105-AC89) received June 9, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2987. A letter from the Counsel for NIST, Department of Commerce, transmitting the Department's final rule — Procedures for Implementation of the National Construction Safety Team Act [Docket No. 021224331-2331-01] (RIN: 0693-AB52) received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Science.

2988. A letter from the Counsel for NIST, Department of Commerce, transmitting the Department's final rule — Procedures for Implementation of the National Construction Safety Team Act [Docket No. 021224331-3093-03] (RIN: 0693-AB52) received June 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Science.

2989. A letter from the Assistant Administrator for Procurement, National Aeronautics and Space Administration, transmitting the Administration's final rule — NASA Grant and Cooperative Agreement Handbook — Incremental Funding (RIN: 2700-AC53) received June 5, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Science.

2990. A letter from the Assistant Administrator for Procurement, National Aeronautics and Space Administration, transmitting the Administration's final rule — NASA Grant and Cooperative Agreement Handbook-Unsolicited Proposals — received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Science.

2991. A letter from the Deputy General Counsel, Small Business Administration, transmitting the Administration's final rule — Small Business Size Standards; Forest Fire Suppression and Fuels Management Services (RIN: 3245-AE89) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Small Business.

2992. A letter from the Director, Regulations Management, Department of Veterans Affairs, transmitting the Department's final rule — Increase in Rates Payable Under the Montgomery GI Bill--Active Duty and Survivors' and Dependents' Educational Assistance Program (RIN: 2900-AL17) received June 9, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Veterans' Affairs.

2993. A letter from the Director, Regulations Management, Department of Veterans Affairs, transmitting the Department's final rule — Veterans Education: Additional Opportunity to Participate in the Montgomery GI Bill and Other Miscellaneous Issues (RIN: 2900-AK81) received June 9, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Veterans' Affairs.

2994. A letter from the Federal Register Certifying Officer, FMS, Department of the Treasury, transmitting the Department's final rule — Federal Government Participation in the Automated Clearing House (RIN: 1510-AA89) received June 12, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform.

2995. A letter from the Regulations Coordinator, Department of Health and Human Services, transmitting the Department's final rule — Child Support Enforcement Program Federal Tax Refund Offset — received June 25, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

2996. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — Bureau of Labor Statistics, Department Store Inventory Price Indexes by Department Groups (Rev. Rul. 2003-68) received June 13, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

2997. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — Update of Rev. Proc. 96-30 (Rev. Proc. 2003-48) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

2998. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — 2003 Section 43 Inflation Adjustment (Notice 2003-43) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

2999. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — 2003 Marginal Production Rates (Notice 2003-44) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

3000. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — Assumption of Partner Liabilities [TD 9062] (RIN: 1545-BB83) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

3001. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — Guidance Regarding Election Under Section 953(d) (Rev. Proc. 2003-47) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

3002. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property (Rev. Rul. 2003-71) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

3003. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — Capital Allocation Ruling (Rev. Rul. 2003-75) received June 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

3004. A letter from the Deputy Secretary, Department of Defense, transmitting notification of a payment to the Czech Republic Government in the amount of $0.930 million to reimburse it for military support provided to U.S. military operations in connection with the global war on terrorism (GWOT); jointly to the Committees on Armed Services and Appropriations.

3005. A letter from the Director, Financial Management and Assurance, General Accounting Office, transmitting a report entitled, ``Financial Audit: Capitol Preservation Fund's Fiscal Years 2002 and 2001 Financial Statements,'' pursuant to 40 U.S.C. 188a—3; jointly to the Committees on House Administration and Government Reform.

3006. A communication from the President of the United States, transmitting notification of changes to existing law required to bring the United States into Compliance with Obligations under the United States-Chile Free Trade Agreement, pursuant to Public Law 107—210, section 2105 (a)(1)(B); (H. Doc. No. 108—90); jointly to the Committees on Ways and Means and the Judiciary, and ordered to be printed.

3007. A communication from the President of the United States, transmitting notification of changes to existing law required to bring the United States into Compliance with obligations under the United States-Singapore Free Trade Agreement, pursuant to Public Law 107—210, section 2105 (a)(1)(B); (H. Doc. No. 108—89); jointly to the Committees on Ways and Means and the Judiciary, and ordered to be printed.

3008. A communication from the President of the United States, transmitting a report on progress made toward achieving benchmarks for a sustainable peace process in Bosnia and Herzegovina; (H. Doc. No. 108—91); jointly to the Committees on International Relations, Armed Services, and Appropriations and ordered to be printed.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

[The following action occurred on June 30, 2003]

Mr. HUNTER: Committee on Armed Services. H.R. 1950. A bill to authorize appropriations for the Department of State for the fiscal years 2004 and 2005, to authorize appropriations under the Arms Export Control Act and the Foreign Assistance Act of 1961 for security assistance for fiscal years 2004 and 2005, and for other purposes; with amendments (Rept. 108-105 Pt. 3). Ordered to be printed.

Pursuant to the order of the House on June 26, 2003, the following report was filed on July 1, 2003:

Mr. KINGSTON: Committee on Appropriations. H.R. 2657. A bill making appropriations for the Legislative Branch for the fiscal year ending September 30, 2004, and for other purposes (Rept. 108-186). Referred to the Committee of the Whole House on the State of the Union.

(Pursuant to section 6 of House Resolution 299 the following report was filed on July 2, 2003)

Mr. LEWIS of California: Committee on Appropriations. H.R. 2658. A bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes (Rept. 108-187). Referred to the Committee of the Whole House on the State of the Union.

DISCHARGE OF COMMITTEE

[The following actions occurred on June 27, 2003]

Pursuant to clause 2 of rule XIII the Committee on Resources discharged from further consideration. H.R. 238 referred to the Committee of the Whole House on the State of the Union.

TIME LIMITATION OF REFERRED BILL

Pursuant to clause 2 of rule XII the following action was taken by the Speaker:

[The following actions occurred on June 27, 2003]

H.R. 1562. Referral to the Committee on Ways and Means extended for a period ending not later than July 11, 2003.

H.R. 2122. Referral to the Select Committee on Homeland Security extended for a period ending not later than July 8, 2003.

[The following action occurred on July 7, 2003]

H.R. 2330. Referral to the Committees on Ways and Means, Financial Services, and the Judiciary for a period ending not later than July 11, 2003.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII,

Mr. CRENSHAW introduced a bill (H.R. 2659) to require advance notification of Congress regarding any action proposed to be taken by the Secretary of Veterans Affairs in the implementation of the Capital Asset Realignment for Enhanced Services initiative of the Department of Veterans Affairs, and for other purposes; which was referred to the Committee on Veterans' Affairs.

MEMORIALS

Under clause 3 of rule XII, memorials were presented and referred as follows:

135. The SPEAKER presented a memorial of the Senate of the State of Louisiana, relative to Senate Resolution No. 57 memorializing the Congress of the United States that the Senate of the Legislature of Louisiana desires to clarify Senate Concurrent Resolution No. 18 of the 2003 Regular Session, enrolled on May 8, 2003, that the Louisiana Legislature only supports the testing of imported seafood by the Federal Food and Drug Administration within the boundaries of the United States; to the Committee on Agriculture.

136. Also, a memorial of the Senate of the State of Louisiana, relative to Senate Resolution No. 108 memorializing the Congress of the United States to provide funding for the Louisiana University of Medical Sciences, Inc., College of Primary Care Medicine; to the Committee on Education and the Workforce.

137. Also, a memorial of the Legislature of the State of Hawaii, relative to House Concurrent Resolution No. 26, HD1, memorializing the United States Congress to educate and sensitize members of Congress on the unfortunate circumstances of the internment of civilians during World War II; to the Committee on the Judiciary.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 122: Mr. Reyes.

H.R. 125: Mrs. Tauscher.

H.R. 169: Mr. Foley.

H.R. 241: Mr. Foley.

H.R. 676: Mr. Udall of New Mexico.

H.R. 779: Mr. Waxman.

H.R. 811: Mr. Kildee and Mrs. Christensen.

H.R. 873: Mr. Hoeffel and Ms. Eshoo.

H.R. 941: Mr. Capuano

H.R. 1068: Mr. Issa, Mrs. Myrick, and Mr. Janklow.

H.R. 1130: Mr. Marshall.

H.R. 1162: Mr. Etheridge.

H.R. 1210: Mr. Levin, Ms. Lee, Mr. Matsui, and Mr. Brown of Ohio.

H.R. 1268: Mr. Davis of Alabama.

H.R. 1442: Mr. Sandlin, Mr. Berman, and Mr. Foley.

H.R. 1533: Mr. Gonzalez, Mr. Paul, Mr. Jones of North Carolina, Mr. Frank of Massachusetts, Mr. Hayworth, and Mr. Shimkus.

H.R. 1589: Mr. Skelton.

H.R. 1633: Mr. Case, Ms. Jackson-Lee of Texas, Mrs. Christensen, Ms. Harman, Mr. Sanders, Mr. Frost, Mr. Emanuel, and Mr. Conyers.

H.R. 1865: Mr. Clay.

H.R. 1943: Mr. Norwood.

H.R. 2156: Ms. Kaptur.

H.R. 2193: Mr. George Miller of California, Mr. Acevedo-Vilá, and Ms. Eshoo.

H.R. 2198: Mr. Udall of Colorado.

H.R. 2336: Mr. Upton.

H.R. 2337: Mr. English and Mrs. Christensen.

H.R. 2409: Mr. Davis of Alabama.

H.R. 2432: Mr. Schrock.

H.R. 2475: Mr. Janklow.

H.R. 2494: Mr. Conyers and Mr. Otter.

H.R. 2524: Mr. George Miller of California and Mr. Nadler.

H.R. 2569: Mr. Boswell, Mr. Crowley, Mr. Emanuel, Mr. Abercrombie, Mr. Green of Texas, Mr. Frost, Mr. Rodriguez, Mr. Rangel, Ms. Kaptur, Mr. Hall, Mr. Baca, Mr. Allen, Mr. McIntyre, Mr. Etheridge, Mr. Carson of Oklahoma, Ms. Roybal-Allard, Mr. Payne, Mr. Costello, Mr. McGovern, Mr. Olver, and Mr. Gutierrez.

H.R. 2627: Mr. Cannon.

PETITIONS, ETC.

Under clause 3 of rule XII,

21. The SPEAKER presented a petition of Kenai Peninsula Borough, Alaska, relative to Resolution No. 2003-043 petitioning the United States Congress to establish Kenai Peninsula Borough Policy in Defense of the Bill of Rights with respect to Federal Anti-Terrorism Acts, Legislation, and Orders; to the Committee on the Judiciary.

SENATE—*Monday, July 7, 2003*

The Senate met at 2 p.m. and was called to order by the President pro tempore (Mr. STEVENS).

PRAYER

The Chaplain, Admiral Barry C. Black, offered the following prayer:

O God of new beginnings, giver of gifts and architect of opportunities, You ride the wings of the wind and even our secret thoughts are visible to Your eyes. Before we speak, You hear. And before we call, You answer.

Lord, in the stillness of this moment, we thank You for Dr. Lloyd John Ogilvie's ministry. May his legacy of faithfulness continue to bless us.

Today deliver us from insulating privilege that obscures humanity's needs. As the Senate meets, give these leaders the gift of discernment that they will know what matters most and approve what is excellent. May they remember that with many advisors, there is safety.

Lord, protect and sustain our troops in harm's way.

Accept this our prayer in the name of the One who fills our hearts with peace. Amen.

PLEDGE OF ALLEGIANCE

The President pro tempore, led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader.

SCHEDULE

Mr. FRIST. Mr. President, today the Senate returns from the Fourth of July recess, and I do hope everybody had a safe and restful period. As I announced before the recess, there will be no rollcall votes during today's session. The next scheduled rollcall votes will begin tomorrow at 11:45 a.m.

The first vote will be on the confirmation of David Campbell to be a U.S. District Judge for Arizona. The second vote will be invoking cloture on the nomination of Victor Wolski to be a judge for the U.S. Court of Federal Claims.

I would like to take a minute or two to talk about this month's schedule. We are now entering a very busy legislative session for the Senate. There is much work to be done, and we have only 4 weeks to do that. One major focus for the Senate this month will be the appropriations process. Senator STEVENS will be working hard to prepare the spending bills for floor action, and we will be scheduling these for floor action throughout the month.

In addition, this month we will complete consideration and passage of the Energy bill. Both consideration and passage will be before the August recess. I am committed, along with Chairman DOMENICI, to pass an energy bill that will enhance our country's national energy security. There are many remaining amendments, as we all know, to debate and dispose of, but I do want to be clear: We must pass a bill as soon as possible to establish a clear national energy policy which will reduce our dependence on foreign oil.

Third, we have a lot of remaining work to do on executive nominations, especially judicial nominations. I urge my colleagues again to allow the Senate to work its will on these nominations and give them an up-or-down vote. I will continue to schedule consideration of nominations as they become available with the hope that we can move forward and give the individuals their due process. Advice and consent means allowing Senators an up-or-down vote on the President's nominations.

Fourth, today we will begin to address the crisis of medical liability. Prior to the recess we attempted to reach consent to begin consideration of S. 11, the Patients First Act of 2003. We are in desperate need of medical liability reform in this country, and now is the time for us to act. Unfortunately, there was an objection prior to the recess to proceeding to this bill. Today if we are unable to reach that consent, it would be my intent to move to proceed to that bill and file cloture on the motion if that is necessary. If that is the case, the vote would occur on Wednesday of this week. Senator MCCONNELL will be here later this afternoon to discuss the medical malpractice crisis.

Also this week we will consider other authorization measures, including the State Department authorization. Chairman LUGAR has indicated the bill will be ready for the floor this week. We hope we will be able to complete action on this important bill in a day or two.

These are just a few of the issues we will be addressing during this legislative session. A lot of that will be done this week. To get our work done, it is going to take the cooperation of all Senators. We will schedule these items for consideration from Monday through Friday. Having said that, I alert Members they should prepare for full days of voting that includes Mondays and especially Fridays. That includes this Friday. Senators should arrange their schedules accordingly and plan to be here in the Senate each day of the week unless I specifically say we are not having votes.

I do want to thank my colleagues for their attention and look forward to working together with them in a collaborative way in what will be a very busy 4 weeks.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER (Mr. CORNYN). Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, the Senate will begin a period of morning business with Senators permitted to speak therein for up to 10 minutes each.

The Senator from Mississippi.

MEDICAL LIABILITY REFORM

Mr. LOTT. Mr. President, I thank the distinguished leader for the information he has just given us about the schedule for the month of July. Obviously, we do have a lot of important work to do. Having dealt with the difficulties of having to put in full days, including votes on Mondays and Fridays, I know it is not always well received. It has to be done in order to achieve these very important pieces of legislation that need to be acted on in July.

I especially thank the leader for going forward with the legislation on medical liability reform, the Patients First Act. In my own State of Mississippi, we have a health care catastrophe on our hands. Doctors are losing their coverage. They are leaving the State. And they are getting out of specialty services such as in the case of an OB/GYN. They are getting out of obstetrics. It is causing a huge problem along the Mississippi gulf coast where we have over 500,000 people. We are down to three neurosurgeons. We did have seven. We have two fully staffed trauma facilities in that area, only two. And with only three doctors now, on weekends we are really stretched very thin. If we lose one more neurosurgeon, we will not be able to keep those two trauma facilities operative.

We also have a problem in getting an adequate number of orthopedic surgeons. As Dr. FRIST knows, you have to have an orthopedic surgeon available also for trauma services. We recently attracted a doctor from St. Louis, MO who wanted to raise his family in a smaller community. He is an outstanding doctor. He was paying $70,000 a year for his medical liability insurance when he left St. Louis. He came to our State. Within 6 months his coverage went up to $150,000 a year. This is an African American doctor, highly qualified, desperately needed there in the Pascagoula-Moss Pt., MS area. I am afraid he is not going to be able to stay with that kind of problem.

This is a huge problem. Some of my friends I went to law school with are saying: Let the States handle this problem. Some States have done a pretty good job. California has done an exemplary job. I believe this legislation is pretty closely patterned after the California example.

Some States have done some good work but other States have done nothing or very little. My own State, while the legislature wrestled with it, made some progress but it has not been nearly enough. My friends in the bar say this is a States rights issue, more or less. But in this case there is no question that this is driving up health care costs across the board. Doctors will tell you that they are ordering additional procedures—defensive medicine, if you will—and it is clearly affecting how much Medicare is costing.

I have heard astronomical numbers, and I will verify them before I speak on this issue tomorrow or the next day as to exactly how much the impact of this excessive lawsuit activity against doctors and the medical professions and the hospitals is driving up the cost of Medicare. There is no question—you might say the States have a right to do this and can handle it, or tort reform, or product liability even; but in this case there is no question that it has a Federal ramification that is costing us lots of money.

We are trying to do the right thing for Medicare beneficiaries. We are trying to put prescription drugs in there but we need reform and we have to find some ways to reduce the costs that are being paid out by Medicare. This is one way to do it.

I am excited that we are going forward with this bill. I don't know if we can get enough votes to stop a filibuster but that is not the important thing. The important thing is that we have a crisis developing in America in health care delivery and the medical liability area, and so I think we should take it up and let's have the vote—and we may have to have more than one vote.

JUDICIAL NOMINATIONS

The other thing I want to do is pick up on what the leader said about judicial nominations. I continue to be concerned that we are in the process of setting a precedent, where judges can be defeated by filibuster. That has not been the rule. That has not been done—there is maybe one instance that you can point to in 200 years. In that case, I think it is a very fragile argument because the nominee, Abe Fortas, was debated for only 10 days, and there were ethical problems that developed and his name was withdrawn. We didn't do it during the Clinton years.

A lot of delays are involved when you are talking about how Senators react, and sending a blue slip to indicate their preference on judicial nominations, and there were concerns and a lot of problems. But not one time did we defeat a judge by filibuster. I had to file cloture, I think, six or seven times but in each case we either vitiated it or had a vote on cloture and then went straight to the vote. We completed action on those judges.

I don't think we should have a litmus test that involves one issue, or a few issues, because I make the case repeatedly that I voted for Justice Ruth Bader Ginsburg, even though I knew that philosophically I would not agree with her. On a lot of issues I strongly disagreed with her. But she was qualified by education, experience, temperament, and ethics. She had a right, I believe, to have an up-or-down vote. She got one and she was confirmed, and I voted for her.

On two of the other nominees, I believe for the Ninth Circuit, Berzon and Paez, I felt very strongly that they should not be on that circuit court bench. But, again, they came through the committee, we debated them on the floor, there was an attempted filibuster, which I opposed, and we voted on them. I voted against them but they got a vote. They were confirmed and they now serve on the judiciary.

I think the leader has tried very diligently to find a way to get away from these filibusters, even though we still have two. I think we have had five or six votes on cloture on Miguel Estrada, and I think we have had two on Priscilla Owen. But I hear there may be filibusters on other qualified men and women, as well as the minorities that are going to be affected by this—especially in the case of Miguel Estrada.

So we have to find a way to get away from this. There is even talk now that maybe we should have recess appointments. I don't think that is a good precedent either. I spoke against it on the floor when President Clinton did it, so how can I now say it is OK? But if we continue down this trail of filibustering judges, there will be a reaction. There will have to be additional action.

The leader has introduced a bill that has been reported out of the Rules Committee that would be very careful. After 12 days, you could file cloture, and then it would be 60 votes required; the second cloture, 57; the third cloture, 54; and finally, only 51 after basically what would take a full month. I think that is a very long, protracted, and unnecessary process but it, again, shows good faith on the part of the leader to find a way to get ourselves out of this precedent.

I think we will all rue the day if we do this. Yes, we have all ramped up the difficulty in confirming judges on both sides with a number of men and women, perhaps unfairly. But we are taking a huge leap and really undermining the process for confirming Federal judges if we allow filibusters to stand. We must find a way in the next couple of months to work through this. I call on my colleagues on both sides of the aisle, let's let cooler heads prevail and pull back from this precipice that we are standing on and find a way to give these judges an up-or-down vote. I believe we will be better as an institution and the judiciary will be better if we avoid this problem.

I have been thinking about these issues over the past week when I have been at home. I particularly was confronted everywhere I went with the problem of doctors in my State of Mississippi, and to be able to keep the doctors in practice, keep them from retiring and leaving the States, we must act in this area.

With that, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

BIPARTISAN MEDICARE REFORM BILL

Mr. FRIST. Mr. President, before we left for the Fourth of July recess, we passed historic legislation to improve Medicare, to strengthen Medicare, and to offer for the first time a prescription drug benefit through the Medicare Program for our seniors and individuals with disabilities. We worked hard in that endeavor to produce a bipartisan consensus, working together on both sides of the aisle, with this common mission, this common goal, and we succeeded.

We were successful in passing a bipartisan bill that for the first time since 1965, in the history of Medicare, offers access to this new prescription drug benefit, and at the same time reforms, modernizes, and strengthens Medicare in a very significant way. Both individuals with disabilities and seniors collectively, 40 million people, will have health care coverage that in the future will be responsive to their needs in order to achieve that goal of health care security after the age of 65 or, if you are an individual with a disability, in the near future.

It is responsive to them directly but also in a way that will allow the Medicare Program to take advantage of the great innovations in technology, in new prescription drugs that can make people's lives better, which will improve the quality of life.

I mentioned the fact that this was bipartisan legislation. I think it is important that we showed a spirit of cooperation in taking on an issue many people in the United States thought would be too partisan and too political. We addressed it in a bipartisan fashion with the leadership of Chairman GRASSLEY and Senator BAUCUS in a way that was reasoned, showed common sense, and that accomplished that goal of significant modernization while at the same time adding a new benefit. We identified the issue. We tackled it head on, and we delivered a bill that reflected the priorities of both sides of the aisle.

That demonstrated to me, and I think to the American people, that even in a very evenly, closely divided Senate, if we share a common goal we can indeed move America forward on issues that are important to the American people.

Coming back from recess, we will very shortly begin the conference where once again both sides of the aisle will work together, the Senate and the House, to fashion a final product that will be a resolution of the differences between that House and Senate bill. I am confident in that process we will have the same resolve and determination in meeting that goal, that we will be able to bridge those differences, and develop a strong bill that can be supported in a bipartisan way and signed by the President of the United States. Both Chambers are committed to accomplishing this, to doing it right, and to getting it done.

PRESIDENTIAL TRIP TO AFRICA

I do want to comment on the President's trip to Africa. I commend President Bush for his bold leadership and his personal, as well as governmental—meaning the Senate, the House, and the executive branch—commitment to the pressing needs of Africa. President Bush will be leaving this afternoon for Africa to see firsthand the opportunities, and indeed the challenges, that exist on that continent.

Approximately once a year I have had the opportunity, since being in the Senate, to go to that continent, to a range of countries, several of which he will be going to. The countries I usually go to are the Sudan, Kenya, Tanzania, and Uganda. He will visit a range of other countries.

I think it is important for members of the executive branch as well as Members of this body and the House of Representatives to go firsthand and see the ravages that occur as a product of this little virus, HIV/AIDS, to see the impact of malaria, to see the impact of resistant tuberculosis and, at the same time, to look at the issues that surround the security of those nations as well as international security.

The President's trip will highlight a positive, substantive agenda that the administration has put on the table. Part of that agenda and vision is this AIDS initiative which we addressed in the Senate a little over a month ago, a 5-year, $15 billion commitment that this body passed and was ultimately signed by the President. This global HIV/AIDS initiative is the largest international public health initiative on a single disease, a single entity, in the history of this country.

I look forward to taking a delegation of U.S. Senators to Africa sometime in August—next month—to advance our collective effort in this regard.

As I mentioned earlier in opening the Senate, we have a very challenging month ahead with medical liability, with energy, with the appropriations process, which will be well underway in a few days, with the judicial nominees, with State Department authorization. There is a lot to accomplish. I am confident we can meet the goals I set out this afternoon. I look forward to working with my colleagues to make this one of the most productive sessions thus far.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. ROBERTS). Without objection, it is so ordered.

PATIENTS FIRST ACT OF 2003—MOTION TO PROCEED

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of Calendar No. 186, S. 11, the Patients First Act of 2003.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. Mr. President, with that objection, I now move to proceed to S. 11. I understand that Members on the other side of the aisle are prepared to debate the motion itself. The majority whip, Senator MCCONNELL, is prepared to open our debate on this issue as well.

It would be my intent later today to file a cloture motion on the motion to proceed to this medical liabilities reform bill. This vote would then occur on Wednesday of this week. I look forward to the very important debate on this truly national crisis, and I encourage Members who want to speak to come to the floor today. We will be debating this legislation today as well as tomorrow. We encourage Members to come to the floor today.

I yield the floor.

The PRESIDING OFFICER. The distinguished Senator from Kentucky is recognized.

Mr. MCCONNELL. Mr. President, there is perhaps no more vexing challenge confronting this Congress than improving the quality and affordability of health care for all our citizens.

Just a few weeks ago, this Senate took historic action to strengthen and modernize Medicare by providing seniors new choices and adding a prescription drug benefit. During the past year, this Senate passed legislation to provide new resources to the scientists at the National Institutes of Health and to strengthen our Nation's defenses against the threat of bioterrorism.

While we shouldn't minimize the importance of these initiatives, the Senate has not addressed one of the most fundamental problems limiting American access to quality health care; that is, reforming our Nation's flawed medical liability system.

Our current medical liability system encourages excessive litigation, drives up costs, and is literally scaring doctors out of the medical profession. All too often, these lawsuits result in exorbitant judgments that benefit personal injury lawyers more than they compensate injured patients. I am pleased that the Senate will soon consider legislation, the Patients First Act, authored by Senator ENSIGN, to address many of these shortcomings.

As we debate this legislation over the next several days, Members will use some complex actuarial terms such as "combined loss ratios," "asset allocation," and "the McCarran-Ferguson Act" to illustrate their points. While they may be important, I believe it is more important that we recognize this is a real crisis facing real families.

Let's look first at this photo of Tony and Leanne Dyess with their family. This picture was taken prior to July 5 of last year. On that evening, Tony was critically injured in a car accident while on his way home from work in Gulfport, MS. Immediately after the crash, Tony was rushed to Garden Park Hospital, right there in Gulfport, suffering from serious brain injuries that required immediate medical attention.

Tragically, nearly all of the specialists capable of treating this type of head injury had left Gulfport because of the medical liability crisis and none was available to treat Tony Dyess.

Tony had to be airlifted to University Medical Center in Jackson, MS. Six excruciating hours passed before he received the surgery he needed to relieve the swelling in his brain. As Dr. FRIST can explain to us, every minute is critical when treating patients who have experienced serious brain trauma.

While the doctors in Jackson saved Tony's life, they were unable—unable—to prevent him from suffering permanent brain damage. As a result, Tony will require constant care and medical attention for the rest of his life.

The Senate was fortunate to hear from Leanne Dyess when she testified before a joint HELP-Judiciary Committee hearing on the medical liability crisis earlier this year. I thank her for her willingness to share her story with the American people and ask unanimous consent that her testimony be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. MCCONNELL. Mr. President, let's consider the case of Melinda Sallard. This is a picture of Melinda Sallard and her daughter. They live in Arizona.

In 2002, the administrators at Copper Queen Community Hospital in Bisbee, AZ, were forced to close their maternity ward because their doctors' insurance premiums had risen by 500 percent.

A few months later, Melinda awoke at 2 o'clock in the morning with sharp labor pains. Since her local hospital stopped delivering babies because of the medical liability crisis, Melinda and her husband were faced with a 45-mile drive to Sierra Vista in order to reach the nearest hospital with a maternity ward. As many of us who are parents know, babies do not always wait for the hospital, particularly when that hospital is almost an hour away.

Melinda gave birth to her daughter in a car on a desert highway heading to Sierra Vista. When the newborn was not breathing, her levelheaded mother cleared the child's mouth and performed CPR. After resuscitating the infant, Melinda wrapped her in a sweater, and the new family completed the journey to Sierra Vista. Thankfully, both mother and daughter survived. However, it is unacceptable that expectant mothers should be forced to drive past a perfectly good hospital and drive 45 miles through the desert to deliver a child.

Unfortunately, these are not isolated anecdotes but just a few examples of the impact runaway litigation is having on patients in every corner of our country. Patients across America—from the Pacific Northwest to the Southeast, from New England to the desert Southwest—are facing a medical liability crisis.

As many of our colleagues will recall, I offered an amendment to the generic drug legislation just last year that included some very modest medical liability reforms. During that debate, I called our colleagues' attention to this map produced by the American Medical Association. At that time, the AMA had identified 12 States, those States that are depicted on the map in red—this was a little over a year ago—as experiencing a medical liability crisis. The States shown on the map in yellow were ones at that time with significant problems which were nearing a crisis.

As I am about to illustrate, the situation has grown worse in the past year. The AMA reports there are now 19 States experiencing a medical liability crisis, with the addition of Wyoming just today.

Unfortunately, my own State of Kentucky is one of those States now facing a medical liability crisis. Knox County Hospital in Barbourville, KY, which is in the eastern part of our State, recently announced it would no longer deliver babies because its doctors could no longer handle the malpractice premiums. The hospital averaged about 200 deliveries per year. These mothers-to-be will now be forced to travel an additional one-half hour through Kentucky's mountain roads to the next closest hospital.

Not surprisingly, these expectant mothers are upset. One mother-to-be told the Lexington Herald Leader: "To have to see someone new at the last moment is just horrible. You develop a close bond with your doctor, almost like family. You don't want a stranger."

In another part of our State, Dr. Susan Coleman, up in Danville, was forced to give up delivering babies after her premiums doubled from $44,000 a year to $105,000 a year—even though she has never lost a jury verdict or paid an out-of-court settlement. More than two-thirds—84 of 120—of Kentucky's counties have either one or no obstetricians who will deliver babies.

This crisis has hit Kentucky's teaching hospitals as well. These valuable institutions not only train our future doctors, they also tackle many of the most difficult medical procedures. Earlier this year, the University of Louisville Obstetrics Department was just days away from closure because it could not find insurance for its doctors.

As I travel through Kentucky, I am approached frequently by doctors who plead for reforms we are proposing today. Some have already packed up their practices and moved across the river to Indiana, which has medical liability reforms. Many more doctors are thinking about following them.

Kentucky is now one of these States facing a medical liability crisis. So, Mr. President, Kentucky now goes from yellow to red.

Let's talk about Connecticut. This year, 28 OB/GYNs in Connecticut announced they could no longer afford to deliver babies because of rising medical liability premiums. According to the Connecticut State Medical Society, each doctor would deliver approximately 100 babies a year. This means that 2,800 Connecticut patients must now find new doctors because of the medical liability crisis.

Dr. Sally Crawford of Norwich, CT, provides a compelling example. She retired from medicine this year at age 55 because she could no longer afford her medical liability premiums. She had never been sued, but her liability insurance premiums became so expensive, they cost her $124,000 a year.

Dr. Jose Pecheco's insurer stopped offering medical liability insurance, so he shopped around for a new policy. When he learned that a new policy with "tail" coverage would cost him $150,000 a year, he did what Dr. Crawford did; he retired.

Why are insurance premiums for doctors rising? They are rising because the size of jury verdicts and settlements is rising at an alarming rate. According to the Hartford Courant, the average payment made of one of the State's major insurers to resolve claims increased from $271,000 in 1995 to $536,000 in 2001. When so many experienced physicians such as these take early retirement or curtail services, it is not surprising that the AMA has now designated Connecticut a crisis State. So Connecticut goes from yellow to red. Connecticut is now a State in crisis.

Let's take a look at North Carolina. Time magazine recently featured the story of Dr. Mary-Emma Beres, a family practitioner in Sparta, NC, who had always loved delivering babies. However, when she learned her malpractice premiums were about to triple, she was forced to give up her calling. Now Sparta is left with one obstetrician for difficult cases, and some women who need C-sections must now take a 40-minute ambulance ride to the next nearest facility.

We have heard several examples about escalating premiums that cause some doctors to retire early, but what impact is the medical liability crisis having on doctors at the beginning of their careers? The same article in Time features the story of Martin Palmeri, a medical student at East Carolina University. He had his heart set on a career in obstetrics, but after witnessing a medical liability trial in North Carolina, he decided "the risks of the specialty were greater than the rewards." He is now considering a less risky specialty.

The crisis has hit North Carolina hospitals particularly hard. According to McNeary Healthcare Services, small rural hospitals in North Carolina experienced an average increase in liability premiums of 180 percent in 2002 alone.

The crisis is impacting patient access to emergency care in Cabarrus County. The county's Level III trauma center was facing possible closure this year when its 17-member emergency medical group was faced with an 88-percent increase in premiums for reduced coverage. It is no wonder that North Carolina is facing a medical liability crisis.

and North Carolina now moves from a yellow State to a red State, a State in crisis.

Like Kentucky and North Carolina, the AMA has recently added Arkansas to its list of States facing a medical liability crisis. In Ashdown, AK, the emergency room at the Little River Memorial Hospital was in danger of closing when it could not find an insurance carrier. It was only able to stay open after obtaining new insurance coverage at a 300-percent increase in premiums. According to a recent survey by the Arkansas Medical Society, 90 percent of doctors have practiced expensive and often unnecessary defensive medicine; 80 percent of doctors are less willing to perform high-risk procedures; 71 percent of physicians surveyed in Arkansas stated they were considering early retirement; and one-third of Arkansas physicians are considering moving their practices.

Doctors in Arkansas who want to care for the State's frailest patients are in a particularly difficult bind. There are currently no insurers writing new policies for doctors who treat nursing home patients, and those doctors who have coverage report a whopping 1,000-percent increase. Let me say that again: There are currently no insurers, none, in Arkansas writing new policies for doctors who treat nursing home patients, and those doctors who have coverage report a whopping 1,000-percent increase.

Why? Jury awards and settlements are rising faster than insurers can raise their premiums to meet these increased costs. From 1992 to 2000, the amount that doctors and insurers paid out in jury verdicts and settlements tripled, but then it doubled again in 2001. In that year, for every $1 an Arkansas medical liability insurer received in premiums, it had to pay out $1.61 in jury awards and settlements. Arkansas, as you can imagine, is now confronting a medical liability crisis. So Arkansas moves from a yellow State, which indicates a State with problems, to red, indicating a State in crisis.

Next we turn north to Missouri. This April, St. Joseph Health Center in Kansas City was forced to close its trauma center when its neurosurgeons decided to leave. Last April, Overland Park Regional Medical Center in suburban Kansas City closed the only trauma center ever in suburban Johnson County, KS. This means residents of southern Kansas City and the millions of motorists who pass through on I-35 or I-70 have limited access to a trauma center in an emergency. Now critically injured patients in Kansas City must be transported to either the University of Kansas Medical Center or the Medical Center of Independence, but even that may not be for long. Because of exorbitant medical liability premiums, the two neurosurgeons who service the Independence Medical Center are packing up their practice and moving on November 1.

But this crisis isn't limited to just Missouri's major cities. In May, Dr. Julie Wood was forced to close her rural family practice in Macon because she could no longer afford her $71,000 malpractice premium while treating Medicare and Medicaid patients. Macon's other two family doctors recently stopped delivering babies in order to reduce their insurance premiums, making the nearest point of care for expectant mothers nearly an hour away.

All of that explains why Missouri unfortunately is now facing a medical liability crisis and moves from a State with problems to a State in crisis.

Let's look across the Mississippi River to Missouri's neighbor, the great State of Illinois.

Time magazine recently ran a cover story entitled "The Doctor is Out," highlighting the plight of Dr. Alexander Sosenko of Joliet, IL, and his patients.

Dr. Sosenko's insurance carrier recently dropped him and his cardiology partners, even though the practice had never lost or settled a single malpractice case. The one offer of insurance the practice received would have raised their annual premiums from $14,000 per doctor to nearly $100,000 per doctor.

Dr. Sosenko and his colleagues are trying to determine their next step, but he is clearly worried about his practice's 6,000 patients. He told Time: "We doctors can move, but our patients can't."

Dr. Sosenko's cardiology practice is not the only one in Joliet coping with a medical liability crisis. The town is quickly losing all of its neurosurgeons.

In February, two Joliet neurosurgeons gave up performing brain surgery, leaving the city's two hospitals without full-time coverage for head trauma cases. The situation may soon get worse for Joliet's patients. The town's last remaining neurosurgeon must now pay $468,000 a year for insurance and is considering leaving the State. If seriously injured patients need the trauma services of a neurosurgeon, then they will have to travel another 45 minutes to the next nearest trauma center.

These problems are not confined to Joliet. The Chicago Tribune reports that for specialties such as neurosurgery and obstetrics, medical liability rates have increased by more than 100 percent and could climb even higher later this year. So it is no wonder the AMA has now observed that Illinois is experiencing a medical liability crisis.

Mr. President, I am sorry to say that this week the AMA added a 19th State to its list of States facing a medical liability crisis. Dr. Willard Woods of Wheatland, WY, was forced to give up delivering babies earlier this year. Throughout his career, he delivered 2,500 babies, which is most of the young people within Wheatland and the surrounding communities.

Dr. Woods described his situation in the Washington Post. He said:

> I love delivering babies. I really love delivering the babies of women I delivered a couple of decades ago. And I know this community needs an obstetrician. But you can't practice without insurance. And I can't get coverage for deliveries anymore.

Since Dr. Woods stopped delivering babies, mothers with complicated pregnancies must now make the 3-hour round trip to Cheyenne. Sadly, Wyoming, too, is now facing a medical liability crisis.

So why are premiums rising so quickly that good physicians such as Dr. Coleman, Dr. Crawford, and Dr. Woods are forced to give up their practices? The primary reason is rapidly increasing jury awards.

As this chart clearly shows, the Jury Verdict Research Service reports that the median award made by a jury has more than doubled between 1996 and 2000. As you can see, between 1996 and 2000 the median jury awards have gone up dramatically, actually more than doubling. In fact, the median liability award jumped 43 percent in just 1 year—from $700,000 in 1999 to $1 million in 2000.

This chart depicts growth in liability claim payments. Not surprisingly, the increase in jury awards has led to similar increases in the dollar value of settlements reached out of court.

As this chart shows, the average claim—including both jury awards and out-of-court settlements—has risen sharply in the past 6 years, rising from $176,000 in 1995 to approximately $325,000 in 2001.

The crisis will continue to grow worse until Congress acts. If we miss yet another opportunity to pass meaningful liability reforms, I have no doubt that more of these yellow States will turn red next year as they find themselves facing a medical liability crisis.

Thankfully, President Bush has outlined several commonsense legal reforms that Congress can adopt to address this crisis. The President's proposal is based on the Medical Injury Compensation Reform Act, commonly called MICRA, which California adopted back in 1975.

As this chart shows, California MICRA reforms have kept medical liability premiums affordable for California's physicians. Since the reforms were adopted back in 1975, California's total premiums have risen 182 percent, while the rest of the Nation's have risen 573 percent—three times the California increase.

In short, while medical liability premiums across the country have taken off over the last 25 years, California's have remained relatively stable.

So what do the California MICRA reforms mean for the average doctor and his patients? Quite a bit, as this chart shows.

This chart lists the going market rate for an insurance policy with the largest insurer in each of the following cities. It should be noted that Colorado has passed meaningful liability reforms that are very similar to California's reforms. These take a look at Los Angeles, Denver, New York, Las Vegas, Chicago, and Miami. Doctors in Los Angeles and Denver, where States have enacted reforms, pay less than those in States that have not enacted comprehensive reforms.

For example, an obstetrician in Los Angeles, with the State's MICRA reforms, can expect to pay $54,000, while his colleague in Miami is looking at a bill of more than $200,000. As you can see, Florida is certainly a medical liability crisis State.

Similarly, a surgeon in Los Angeles or Denver can expect to pay about one-half as much as a colleague in Las Vegas or Chicago. These same surgeons would face an enormous liability bill—about $175,000—if they moved their practices to Miami.

Senator ENSIGN has shown a great deal of leadership on this issue dating back to his days in the House of Representatives. He has incorporated the best parts of the President's proposal and MICRA, the California law, into the legislation before the Senate, S. 11, the Patients First Act of 2003.

While I would allow the author of this legislation to explain it in detail, I will briefly describe some of the important reforms included in the Patients First Act.

First and foremost, the Patients First Act allows patients to recover 100 percent of their economic damages. This can include hospital bills, lost wages, therapy, and rehabilitation costs and a wide variety of additional expenses a victim might incur. So all of the economic losses would be recovered.

In addition to recovering every dime of economic damages, patients can receive additional sums up to $250,000 to compensate for "pain and suffering." The $250,000 is a substantial amount of money, identical to California's MICRA limit. But it still places at least some limit on unquantifiable noneconomic damages in order to prevent doctors from being driven out of business.

Let's look at punitive damages. In those rare instances where a medical professional acts in a malicious or particularly egregious manner, the Patients First Act also allows victims to recover punitive damages the greater of $250,000 or twice the economic damages. This is in addition to recovering full economic damages and up to $250,000 in noneconomic damages.

The legislation establishes a standard of "fair share" liability. What this simply means is doctors and hospitals will not be held liable for harm they did not cause. Simple justice. Doctors and hospitals won't be held liable for harm they didn't cause which is possible today and would not be possible after the passage of this act.

The Patients First Act also protects the injured by ensuring that a majority of any jury award or settlement goes to the patient who is actually hurt and not their personal injury lawyer.

Finally, this legislation preserves State flexibility on damages by including what is commonly referred to as a flexicap. Recognizing that different States have adopted different approaches to address this crisis, the Patients First Act allows States to establish their own limits on damages. Under the flexicap provision, in any State that has adopted limits on economic, noneconomic, or punitive damages, those State limits, not the Federal limits, will apply.

The flexicap also applies prospectively. If any State legislature believes the monetary limits established in this bill are too generous or not generous enough, it can simply enact a statute to change the limits within that State.

Mr. LOTT. Mr. President, will the distinguished Senator from Kentucky yield for a couple questions on these issues?

Mr. McCONNELL. I will be happy to yield.

Mr. LOTT. Mr. President, I know the Senator from Kentucky is presenting his prepared statement, and it really has been quite interesting, and I share his concern. My State is one of those first States to be in red. We have a crisis in health care delivery. We are losing doctors to retirement, leaving the State, or leaving part of their practice, like OB/GYNs getting out of the OB part of their practice. The Senator made a particular point. I think the bill is a good solution, and it is based, as Senator McCONNELL said, on the California plan that has been successful that does have some limits on punitive damages.

The Senator from Kentucky just made a point about the abilities of the States to act differently if they so choose. Will the Senator explain that? I did not understand that was in the bill. I am very interested because one of the complaints I have heard is that we are imposing our will on the States and the State legislatures cannot act, if they want to or if they will, although not many of them have. Will the Senator from Kentucky expand on that point?

Mr. McCONNELL. Mr. President, I say to my friend from Mississippi, the argument typically made for this type of legislation is that we are interfering with the rights of the States. What we have done in this measure is to give the States an opportunity to act, to, in effect, supercede what we have done to make it less generous or more generous, depending on what they may conclude. A State is given an option to address this crisis in a way that is different from the way we addressed it within certain guidelines. By doing that, we do make an effort to respect the State's right to act.

Mr. LOTT. Mr. President, if the Senator will yield further, I say to the Senator, just coming back from my State, I had occasion to meet with doctors, hospital administrators, and civilians who are having problems, like some of those the Senator pointed out earlier. I also met with some of the attorneys who raise the point that the States should be allowed to act.

My own State legislature tried to deal with this issue and made a little progress, but it is still very weak. Our crisis is getting worse, and we are losing particularly those critical services that we need in our trauma systems, for instance.

The point I wish to make or ask the Senator to further expand on is, they say: What is the Federal role in this situation? Why is it necessary for the Federal Government to become involved? My response has been, clearly, there is a Federal application for medical liability that may not exist in other areas because of the impact it is having on Medicare. The additional threat of these lawsuits, the defensive medicine, the additional costs of medical liability insurance are causing all kinds of additional costs to be added to our Medicare system. I have heard billions of dollars, and I am going to find out in the next day or so what is the approximate amount that is being added each year to the cost of Medicare.

We are trying to improve Medicare and trying to add prescription drugs, but there are other costs that are being heaped on to the system that are very destructive.

I think the answer is, more than in any other area where we tried to get some legal reform, there is a Federal application in medical liability because of the impact it is having on the Medicare system.

Does the Senator from Kentucky care to respond?

Mr. McCONNELL. Mr. President, I say to my friend from Mississippi, I do not know the exact figure—maybe my staff does—but clearly it has had an impact on the cost to the Federal Government. In addition, these doctors are moving back and forth across State lines seeking a place where they can practice their profession without basically giving away their services.

Kentucky happens to be next to Indiana which adopted standards similar to California some two decades ago. I have met a number of doctors in Louisville and Henderson who are contemplating simply moving across the river to even afford to continue to practice their profession.

At least in two ways it impacts at the Federal level, with interstate movement of doctors seeking a place to go where they can practice their profession, and the direct costs to the Federal Government under Medicare.

Mr. LOTT. A similar situation exists in my State. We are right next to Louisiana and not a State one would think would have the type of reforms they have in place. It is very easy to move from Mississippi to Louisiana. They serve different patients in a different State and medical liability costs are probably half of what they are right across the border.

What worries me more is we have doctors leaving tremendously underserved areas such as the Delta. One doctor in particular I know moved up to South Dakota and started practicing medicine. Others are retiring when they would not have retired if they believed they could make a decent living.

Even worse than that, doctors are getting out of certain practices. It has become a serious problem for health care delivery in my State. We have to act in this area, and soon, because the bleeding is growing in terms of losing doctors in these critical areas.

Mr. MCCONNELL. Mr. President, I say to my friend from Mississippi, he is absolutely right. Not only does it affect decisionmaking at the end of one's career but at the beginning. The younger doctors taking a look at which speciality to choose are shying away from obstetrics because they believe they cannot afford to go into that specialty, thus creating a shortage at that end as well as on the other end where doctors who have been in the field a number of years are no longer able to afford it. This is truly a national problem that cries out for a national solution.

One modest estimate from CBO, in response to Senator LOTT's earlier question—this is from my staff—this bill would probably save the Federal Government at least $11 billion. Our suspicion is it is higher than that.

In conclusion, as this map shows, most of America is either nearing or facing a medical liability crisis. There are not many white States on this map. The white States are the ones that are currently OK. There are six of them. The rest are either in yellow, States showing problem signs, or red, States now in crisis, to which we have added a reasonable number just since this debate last year.

During the last 8 years, the House of Representatives has recognized this brewing storm and has passed meaningful medical liability reforms on multiple occasions. Unfortunately, during this same period, the Senate has served as a graveyard for meaningful legal reforms.

However, I believe the tide has begun to turn. The American people are beginning to understand this is not a battle about doctors, personal injuries, lawyers, and insurance companies; it is about ensuring their access, the patients of America, to needed medical care. Expectant mothers are worried that their obstetricians will have to discontinue practice before their baby is born. Parents are concerned that their local trauma center might not have a neurosurgeon on staff to treat a child injured in a car accident. Seniors worry that the double whammy of rising malpractice premiums and reduced Medicare payments will drive their doctors out of business.

I believe the Patients First Act encompasses the key reforms needed to address this crisis. This legislation allows patients to be fairly compensated—fairly compensated—while placing badly needed limits on often out-of-control damage awards. I believe it is time for the Senate to address this crisis, and I urge my colleagues to support the Patients First Act.

Mr. President, I yield the floor.

EXHIBIT 1

TESTIMONY—UNITED STATES SENATE COMMITTEE ON THE JUDICIARY: PATIENT ACCESS CRISIS: THE ROLE OF MEDICAL LITIGATION—FEBRUARY 11, 2003

Ms. Leanne Dyess. Chairman Hatch, Chairman Gregg, Senators Leahy and Kennedy, distinguished members of the Senate Judiciary and HELP committees, it's an honor for me to sit before you this afternoon—to open up my life, and the life of my family, in an attempt to demonstrate how medical liability costs are hurting people all across America. While others may talk in terms of economics and policy, I want to speak from the heart.

I want to share with you the life of my two children and I are now forced to live because of a crisis in health care that I believe can be fixed. And when I leave and the lights turn off and the television cameras go away, I want you—and all America—to know one thing, and that is that this crisis is not about insurance. It's not about doctors, or hospitals, or even personal injury lawyers. It's a crisis about individuals and their access to what I believe is, otherwise, the greatest health care in the world.

Our story began on July 5th of last year, when my husband Tony was returning from work in Gulfport, Mississippi. We had started a new business. Tony was working hard, as was I. We were doing our best to build a life for our children, and their futures were filled with promise. Everything looked bright. Then, in an instant, it changed. Tony was involved in a single car accident. They suspect he may have fallen asleep, though we'll never know.

What we do know is that after removing him from the car, they rushed Tony to Garden Park hospital in Gulfport. He had head injuries and required immediate attention. Shortly thereafter, I received the telephone call that I pray no other wife will ever have to receive. I was informed of the accident and told that the injuries were serious. But I cannot describe to you the panic that gave way to hopelessness when they somberly said, "We don't have the specialist necessary to take care of him. We need to airlift him to another hospital."

I couldn't understand this. Gulfport is one of the fastest growing and most prosperous regions of Mississippi. Garden Park is a good hospital. Where, I wondered, was the specialist—the specialist who could have taken care of my husband? Almost six hours passed before Tony was airlifted to the University Medical Center—six hours for the damage to his brain to continue before they had a specialist capable of putting a shunt into his brain to drain the swelling—six unforgettable hours that changed our life.

Today Tony is permanently brain damaged. He is mentally incompetent, unable to care for himself—unable to provide for his children—unable to live the vibrant, active and loving life he was living only moments before his accident.

I could share with you the panic of a woman suddenly forced into the role of both mother and father to her teenage children—of a woman whose life is suddenly caught in limbo, unable to move forward or backward. I could tell you about a woman who now had to worry about the constant care of her husband, who had to make concessions she thought she'd never have to make to be able to pay for his therapy and care. But to describe this would be to take us away from the most important point and the value of what I learned. Senator Hatch, I learned that there was no specialist on staff that night in Gulfport because rising medical liability costs had forced physicians in that community to abandon their practices. In that area, at that time, there was only one doctor who had the expertise to care for Tony and he was forced to cover multiple hospitals—stretched thin and unable to care for everyone. Another doctor had recently quit his practice because his insurance company terminated all of the medical liability policies nationwide. That doctor could not obtain affordable coverage. He could not practice. And on that hot night in July, my husband and our family drew the short straw.

I have also learned that Mississippi is not unique, that this crisis rages in states all across America. It rages in Nevada, where young expectant mothers cannot find ob/gyns. It rages in Florida, where children cannot find pediatric neurosurgeons. And it rages in Pennsylvania, where the elderly who have come to depend on their orthopedic surgeons are being told that those trusted doctors are moving to states where practicing medicine is affordable and less risky.

The real danger of this crisis is that it is not readily seen. It's insidious, like termites in the structure of a home. They get into the woodwork, but you cannot see the damage. The walls of the house remain beautiful. You don't know what's going on just beneath the surface. At least not for a season. Then, one day you go to hang a shelf and the whole wall comes down; everything is destroyed. Before July 5th, I was like most Americans, completely unaware that just below the surface of our nation's health care delivery system, serious damage was being done by excessive and frivolous litigation—litigation that was forcing liability costs beyond the ability of doctors to pay. I had heard about some of the frivolous cases and, of course, the awards that climbed into the hundreds of millions of dollars. And like most Americans I shook my head and said, "Someone hit the lottery."

But I never asked, "At what cost?" I never asked, "Who has to pay for those incredible awards?" It is a tragedy when a medical mistake results in serious injury. But when that injury—often an accident or oversight by an otherwise skilled physician—is compounded by a lottery-like award, and that award along with others make it too expensive to

> practice medicine, there is a cost. And believe me, it's a terrible cost to pay. Like many Americans, I did not know the cost. I did not know the damage. You see, Senator Hatch, it's not until your spouse needs a specialist, or you're the expectant mother who needs an ob/gyn, or it's your child who needs a pediatric neurosurgeon, that you realize the damage beneath the surface.
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> From my perspective, sitting here today, this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we've gone through, could go a long way toward helping us heal.
>
> Senator Hatch, I know of your efforts to see America through this crisis. I know this is important to you, and that it's important to the President. I know of the priority Congress and many in the Senate are placing upon doing something . . . and doing it now. Today, I pledge to you my complete support. It is my prayer that no woman—or anyone else—anywhere will ever have to go through what I've gone through, and what I continue to go through every day with my two beautiful children and a husband I dearly love.

The PRESIDING OFFICER. The distinguished Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, let me first commend my colleague, Senator McCONNELL of Kentucky, for his presentation and his leadership on this issue. Though we disagree on some very fundamental parts of this issue, I have the highest regard and respect for his ability and I look forward to working with him.

What occurred about 45 minutes ago was that Senator FRIST, the majority leader, came to the Chamber and filed a motion to proceed, and I objected. What Senator FRIST was asking was that the Senate stop its business and move directly to S. 11 relative to the issue of medical malpractice. Because I have filed an objection, Senator FRIST indicated he would file a cloture motion. After collecting the necessary signatures from our colleagues, this will lead to a vote on cloture come Wednesday.

If Senator FRIST can gather some 60 votes, he will be in a position to then move to this bill and begin the debate and the amendment process. That is the ordinary course of the procedure.

An obvious question is why I objected. An issue clearly as important as medical malpractice should be considered by the Senate. There is no doubt in my mind. But I would object to the fact that this bill comes to the floor without any hearing before a Senate committee. Consider that. The most revolutionary and dramatic reform of tort law in America, in modern memory, will come to the floor without the normal hearings, witnesses, opportunities to amend, opportunity to work out compromises and negotiate, all part of the legislative process. So why then does a bill of this gravity and importance only come to us in this circumstance where there is no chance for us to work out ways to resolve our differences? Why, I cannot explain that to my colleagues. For a person like myself who served for some time in the House and the Senate, it seems to me that the Republican leadership in control of the committee structure would not object to taking this bill to one of their committees, having hearings, bringing in the doctors, the lawyers, the victims, the insurance companies, the pharmaceutical companies, and the companies that make medical devices. Let's hear about this problem in its entirety. But, no, they object to that. They do not want hearings. They do not want the people of this country to hear both sides of the story. They would rather come to the floor and present their side with a take-it-or-leave-it approach. I do not think that is fair. I think we can and we should do better.

Let me say at the outset that though I have objected and though most major medical associations, like the American Medical Association, support this bill, I want to make clear my high regard for the medical profession. Time and time again, in my life and the life of my family, I have turned to some of the best and most talented medical professionals in America. I have entrusted them with the most important things I have on Earth—my wife, my children, and the people whom I love.

Time and again I have found them to be selfless, extraordinarily talented, compassionate men and women who give the medical profession a good name every single day. Thank God they are there, and I want them to continue to be there. So I do not come to this Chamber as a doctor basher, as someone who thinks doctors are overpaid or frankly should be held to task for this, that, and the other. Not at all. Like most Americans, if I, my wife, or children are ever sick, I want to look up into the eyes of the best and brightest doctor in America helping a member of my family through a medical crisis. My family and I have been lucky in our lives. Many times I think we have had the best and the brightest, and I still continue to thank them as I take a position with which many of them will not agree.

I believe there is a fundamental unfairness in the current situation with medical malpractice. I have seen that unfairness in my State. Senator McCONNELL has noted it in many other States. The largest medical malpractice insurance company in Illinois, the Illinois State Mutual Insurance Company, raised its rates last week 35 percent on doctors for medical malpractice insurance. Many lines of insurance are going up in cost, health insurance and other insurance, but this is an extraordinary increase.

Two neurosurgeons in Joliet, IL, have given up the practice of brain surgery because of malpractice premium increases. They have left the city's only two hospitals without a full-time coverage for head trauma cases. Senator McCONNELL is right; Victims of automobile accidents and trauma need immediate help and immediate care.

Memorial Hospital in Belleville, IL, near the area where I grew up, has lost three OB/GYN physicians in the past 6 months due to increases in rising malpractice premiums. I met one of them. I met one during the course of the campaign last year. She came to me and said: Senator, I just cannot continue to pay these premiums and deliver babies. And I believe her.

Eduardo Barriuso of Humboldt Park, an obstetrician in my State of Illinois, pays $104,000 a year for malpractice insurance. He says he earns $175,000 a year treating mostly poor people, Medicaid patients. He pays $104,000 in malpractice, and has $175,000 in income. Like other doctors who treat patients who depend on Medicare or Medicaid or insurance through an HMO, Dr. Barriuso cannot pass on his higher insurance rates to his patients.

The Family Health Partnership Clinic in McHenry, IL, was almost forced to close after its insurer left my home State. They found new insurance at four times the cost. The clinic serves the uninsured and operates off the volunteer services of physicians. It now pays $28,000 a year for malpractice insurance, up from $7,000 last year, for a clinic serving poor people.

A Chicago area OB/GYN is studying to obtain his pharmacist license. He has decided he cannot continue as a doctor. He thinks he can make a better life as a pharmacist. He is now paying $115,000 for his liability insurance. I would readily concede the point made over and over by Senator McCONNELL that these malpractice premiums are not fair. They are unfair particularly to certain specialties—neurosurgery, trauma care physicians, OB/GYN, and several others who have been hit hard by these increases. That is just not fair.

I suggest there is another unfairness involved in this discussion, an unfairness which my colleague from Kentucky never conceded. Frankly, there is an unfairness in this bill when it comes to the victims of medical malpractice. Of all the comments made by my colleague from Kentucky, little was said about whether it is fair to cap the recovery for a victim of medical malpractice at medical bills, lost wages, and pain and suffering of no more than $250,000.

Now, I do not come as an expert on anything. Some 20 years ago, in my legal practice in Springfield, IL, I handled medical malpractice cases. For a number of years I defended doctors through their insurance company. I had about 7 years with that experience. Another 2½ years I was a plaintiffs' attorney suing some doctors and hospitals for malpractice. So I have seen it from both sides of the table in a courtroom. I do understand the dynamics of a medical malpractice case, at least as they applied 20 years ago. I do not know how many others in this Chamber have had that experience. Some have but very few.

So we come to this discussion, frankly, listening to others who are experts in the subject asking them for advice. What is the right thing to do to deal with this medical malpractice insurance crisis? I think, frankly, that this bill, which limits the compensation to be paid to an individual under a medical malpractice case to $250,000, is fundamentally unfair. It is as unfair to victims as the malpractice insurance rates are to doctors.

Is that the best the Senate can do, that we take the unfairness to doctors and then visit it on unsuspecting people who go to a doctor or to a hospital expecting professional care and come home with their lives changed or ruined?

I recall one case in Chicago. Let me give an illustration of what S. 11 would mean in this case. This woman, about 50 years old, had two moles on the side of her face. She said to her doctor: I think I would like to have those removed, doctor. He said: I will send you to one of the very best hospitals for this surgical procedure, and he did.

She went in for this surgical procedure to have two moles removed. She was given an anesthesia. They administered oxygen to her and they began to cauterize these moles. But there was a problem. Medical personnel were not supposed to use a cauterizing gun near oxygen.

As a consequence, there was an explosion and a fire on her face, burning off her nose, completely disfiguring and scarring her face. She is in her early fifties now and has gone through extensive reconstructive surgery. She is lucky to be able to breathe through what was once her nose. Her life will never, ever be the same.

She told the story herself in an article published in the newspaper in Chicago. Routine surgery went disastrously bad and her life was changed forever.

According to those who have brought the bill to the Senate, they have decided how much it is worth to live 20 or 30 years with permanent disfigurement and scarring, what it is worth to go into the hospital for routine surgery and have something happen that completely changes your life. Do you know what it is worth under this bill? It is worth $250,000 for her pain and suffering. Not a penny more, not one penny more.

The decision will be made in the Senate that in her case, and thousands of others across America, we will decide the maximum amount to which she is entitled. I don't think that is fair. I don't think it is fair to victims.

Malpractice premiums are too high and that is unfair to doctors. But a $250,000 pain and suffering cap? That is unfair in many cases of which I am aware.

Let me talk about another case from my home State of Illinois, in the city of Urbana. David was born prematurely with a lot of problems. By the time he was 6 years old many of the problems were behind him, though he still had some problems with his lungs and asthma. When he was 6 he had a respiratory infection and started running a fever. The doctor who usually cared for him was out of town so his parents took him to a clinic for nighttime care. At the clinic, he was given an antibiotic and sent home. He got worse. His parents took him to an emergency room that same night where he remained overnight with a fever. The next day, concerned about David's continuing fever, David and his parents returned. The doctor admitted him to the hospital at 5 p.m. At the hospital, they took his temperature and admitted him to a regular hospital room. They did not refer him to the ICU, nor did they place a temperature monitor on him.

His mother was dozing in the chair in his room when a nurse observed he appeared to be lapsing into a seizure condition. The nurse did an emergency code. By the time the emergency team arrived, he was in full seizure. His temperature spiked to 107.7 degrees. He remained in a state of seizure for quite some time and eventually went into cardiac arrest.

As a result of this ordeal, this 6-year-old boy was rendered a quadriplegic and lost all expressive ability. Professionals believe he has what is called receptive language. He can understand spoken language at an age-appropriate level but he is unable to communicate. He breathes through a tracheotomy stoma and is fed through a gastrointestinal tube.

That was 11 years ago. He is now 17. David can never be left alone, not for 1 minute of 1 day. His mother says she can tell he is interested in girls by the way he perks up when a girl his age enters the room. But he cannot express himself. He cannot say a word. There is no chance of recovery and, of course, in his condition he is at a heightened risk prone to infection.

The very issue that brought David to the hospital in the first place was his elevated temperature. Despite that fact, no temperature monitor was ever placed on him. In light of his history and his delicate medical condition he should have been admitted to the ICU rather than simply sent to the regular hospital room and given periodic attention. His family reached a settlement with the doctors and the hospital for the negligence in the treatment of David.

It is not likely with all of the liability protections and extreme cap on damages under this bill that defendants would have felt compelled to reach a settlement with that family if the bill before the Senate would have been the law of the land.

The tragic malpractice of which David was a victim literally took away from him all that every one of us take for granted. He will never walk again. He will never have a normal relationship with other people. Though he remains alert and is apparently not intellectually impaired, he cannot express himself and he never will be able to. He requires constant care. His mother gave up her job at a local college to care for him full time.

For all of these losses with their child, for being denied a normal life, those who bring S. 11 today say they know what it is worth. They know what the pain and suffering of David is worth for the rest of his life. It is worth $250,000. Not a penny more. Is that fair? Is that fair to David, his mother, his father? I don't think it is.

What we have here is a response to a medical insurance crisis which I don't believe gets to the root cause of a problem.

What I am about to say now is not a statement made by trial lawyers or those friendly to them. I quote from Dr. Carolyn Clancy, director for the Agency for Health Care Research and Quality at the U.S. Department of Health and Human Services. What I am stating she said, under oath, before a committee I attended several weeks ago. This is what she said:

> As we all know, medical errors and patient safety issues represent a national problem of epidemic proportion.

This is a spokesman for the Department of Health and Human Services, a medical doctor herself.

When listening to the explanation of this bill, at any point in time did you hear any reference to the fact that we are facing an epidemic of medical errors on patient safety issues in America? No. What we heard was we have lawyers who want to make too much money in court and they are taking these cases to the courtroom.

Do you know, according to Harvard, what percentage of medical malpractice actually ends up in a lawsuit being filed? Two percent. One case out of 50 ends up with a lawsuit being filed. Think of that. In the universe of medical errors and patient safety, think of it in terms of this statement by Dr. Clancy that we have a national problem of epidemic proportions.

The response of S. 11 to this epidemic of malpractice and medical negligence is to do what? It is to say that David, who is now 17, who is now a quadriplegic, unable to respond or express himself, is going to pay the price. David and children like him in the future will never, ever be able to recover more than $250,000 regardless of medical malpractice that brings them to the court.

I understand my colleague from Oregon is here and I yield to him for the purpose of a question.

Mr. WYDEN. I thank my colleague. I had a couple of questions, having listened to the statement.

First, my sense is that many physicians in our country—I am seeing this across Oregon and rural Oregon—are having a real problem out there paying their malpractice premiums. We are seeing physicians leave the profession. This has resulted in patients not having the access to care they deserve.

My understanding is that the distinguished Senator from Illinois agrees with that and that the Senator has already discussed that a bit this afternoon; is that correct?

Mr. DURBIN. That is correct. I say to my friend and colleague from Oregon, I think it is a disservice to the medical profession of America not to concede there is a medical malpractice insurance crisis affecting some specialties in some States. I do not argue that point. I have seen those doctors face to face. Maybe my colleague from Oregon has, too.

It is interesting, I might say to my friend from Oregon, as I listened carefully to the explanation on the other side as to how to deal with this crisis, I waited in vain to hear any suggestion that insurance companies should be brought in as part of this conversation. To the other side of the aisle it appears the only thing we need to do is to make sure the victims of medical malpractice have a limitation on what they can recover in court, no matter whether we are dealing with children or elderly people, no matter how serious the injuries. I do not think that is a complete and honest approach to an extremely complicated problem.

Mr. WYDEN. If my colleague will yield further, my understanding is you have already indicated you are open to working with others in the Senate, colleagues on the other side of the aisle, to try to find a bipartisan solution. I am particularly interested. Senator HATCH and I were able to do this a number of years ago for the community health centers that were being priced out of their malpractice coverage. We were able to come up with a solution that has made it possible for thousands and thousands of poor people across the country to get their care and have these clinics covered without extra cost to the taxpayers, simply by working in a bipartisan way. My sense is to get out beyond the blame game, saying it is this interest group's fault or that interest group's fault, and to try to find some common ground here between Democrats and Republicans so we can really deal with a problem that is affecting many of our physicians and affecting our vulnerable patients. My understanding is my colleague from Illinois is open to that kind of bipartisan approach and may even have some ideas he will offer this week.

I wanted to come to the floor because I think this is a real problem. I so often go to meetings and one group says it is the insurance companies' fault and the other group says it is the trial lawyers' fault. I have heard the distinguished Senator from Illinois say he wants to get beyond that and find a solution to a real problem. Perhaps he could address that in whatever time is remaining.

Mr. DURBIN. I thank the Senator. I did not have a chance to speak to Senator McCONNELL, but I did speak to Senator FRIST, who was here earlier and made that same offer. I said to him, instead of bringing this bill to the floor, take it or leave it, with no committee hearings and no effort to try to work out our differences, wouldn't it be better for us to sit down at some point and try to engage all the elements that are necessary for success if we are going to deal with this true crisis in America?

He is open. I hope, if opportunity presents itself, we have that chance. I think we need to bring to the table, not only the legal profession but also the medical profession and the insurance companies. If you do not have all three of them at the table, as I will make clear in my statement, you are not going to get to the root cause of the problem.

The answer from the other side is strictly to limit for malpractice victims the amount they can recover in court. I am going to show in charts I will present that that has not worked. Caps really do not guarantee that malpractice premiums come down, for a variety of very complicated reasons.

I hope we can do that. I hope on a bipartisan basis we can stop this high-noon standoff and reach a point where we have real conversation and dialog.

Mr. WYDEN. If my colleague will yield for one last question——

The PRESIDING OFFICER (Mr. SUNUNU). Will the Senator suspend so the Presiding Officer may remind all Senators that yielding is only for purposes of asking a question in order for the Senator from Illinois to retain his recognition on the floor.

Mr. DURBIN. I yield for the purpose of a question.

Mr. WYDEN. I ask, is there any reason why we couldn't begin such a bipartisan effort immediately? That is something I would like to do. I cited a specific example with Senator HATCH where we were able to make a real difference by working in a bipartisan way. It is making a difference in community health centers for their liability coverage. Is there any reason why efforts to come up with creative solutions that are bipartisan could not begin right now, rather than going this route that is going to polarize the Senate once again?

Mr. DURBIN. I would say through the Presiding Officer, there is no reason why it should not start this evening and I hope it will. But it will require people of good will on both sides. It will require some of the special interest groups that have not even been brought into this conversation to be brought in and to accept their share of responsibility.

I think we can work this out. We must work this out so we do not have the denial of basic medical services that are needed across the State of Oregon and Illinois and New Hampshire and Kentucky and so many other States. But we have to do it in a bipartisan, constructive way.

Mr. WYDEN. I thank my colleague.

Mr. DURBIN. I thank the Senator from Oregon for coming to the floor.

The point I wanted to make with Dr. Clancy's quote is that medical malpractice in this country is a very serious problem. It is not just a matter of how many lawsuits are filed. As I indicated, only one out of 50 malpractice cases actually ends up in court, and fewer than half of them end up going to verdict or settlement. It is a serious problem. The source of my statement is none other than the Institute of Medicine, a well respected organization here in Washington. They say this epidemic of medical malpractice has caused more American deaths this year than breast cancer, AIDS, and car accidents combined. It is an equivalent of a jumbo jet liner crashing every 24 hours for a year.

More than 70 studies in the past decade have documented serious quality problems in medical treatment. One of the most well known studies published in 1991 by a team of Harvard researchers found adverse events occur in 3.7 percent of all hospital admissions and 58 percent of those events are due to error.

The Institute of Medicine later took that study and another similar study done in Colorado and Utah and extrapolated the results to all U.S. hospital admissions. The Institute of Medicine found that there are at least 44,000 adverse events every year and as many as 98,000.

They also found that each year drugs kill 14,000 hospital patients and injure another 750,000.

The group of Harvard researchers that published the 1991 study found only 47 malpractice claims in the 31,429 cases they discovered. Of the 280 identified patients who experienced adverse events as a result of medical negligence, only eight filed malpractice lawsuits. That is only 2 percent of the people who had a justifiable reason to file a claim. Those researchers concluded that we do not now have a problem of too many claims. If anything, they said they were surprised there were so few.

A similar study published in The Lancet found that although 17.7 percent of patients experienced an adverse event that led to longer hospital stays, only 1.2 percent filed a claim. Thirty patients filed a malpractice claim out of 1,047 who could have, under this study.

There are profound problems with the current system. Doctors are not being disciplined and errors are not being reported. How can we expect fewer errors in the future if we do not address the system as a whole? Despite the alarming incidence of malpractice, only about 2,000 doctors, one-third of 1 percent of the doctors in the United States, are disciplined each year by State medical boards. Let me repeat, one-third of 1 percent of all doctors are disciplined each year by State medical boards.

I was on a trip recently and picked up a book in a book store which I recommend to people on both sides of this issue because I think it is the best and most balanced story of what we are facing and debating. It is entitled "Complications." It is by a surgical resident from Boston, Atul Gawande, a National Book Award finalist for this book. It is subtitled "A Surgeon's Notes On An Imperfect Science."

If you read this book—some people won't want to because there are some parts that may make you squeamish. I think Dr. Gawande really talks to you about the difficulty of being a medical doctor. The first chapter talks about placing a central line. It was tough for me to read this chapter, let alone what it was like for him as a surgical resident after having seen this central line implanted in a person's chest to do it for the first time himself. He had to. Trial and error was the only way he would learn. Of course, some mistakes were made. In his case they were not fatal or serious. But it was part of the learning process.

I think we have to concede that medical practice is not perfect. But we also know some serious mistakes can be made with terrible consequences on an innocent patient.

Dr. Gawande refers in one part to this whole question of what to do or how to deal with the fact that many doctors practice with other doctors who they really are worried about.

Let me give you an example of what he refers to in a chapter entitled "When Good Doctors Go Bad." He says:

> But the problem of bad doctors isn't the problem of these frightening aberrations. . . . In medicine, we all come to know such physicians: the illustrious cardiologist who has slowly gone senile and won't retire; the long-respected obstetrician with a drinking habit; the surgeon who has somehow lost his touch. On the one hand, strong evidence indicates that mistakes are not made primarily by this minority of doctors. Errors are too common and widespread to be explained so simply. On the other hand, problem doctors do exist. Even good doctors can go bad, and when they do, colleagues tend to be almost entirely unequipped to do anything about them.

He talks about situations that he has faced where doctors are taking drugs. Doctors continue to practice and make errors every day. Because of the tight-knit community of physicians, other doctors are even afraid to speak to them, let alone to governing boards. Those doctors continue to make serious mistakes.

Quoting again, he says:

> When a skilled, decent, ordinarily conscientious colleague, whom you've known and worked with for years, starts popping Percodans, or become preoccupied with personal problems and neglects the proper care of patients, you want to help, not destroy the doctor's career.

There is no easy way to help, though. In private practice, there are no sabbaticals to offer, no leaves of absence, only disciplinary proceedings of public reports and misdeeds. As a consequence, when people try to help, they do it quietly, privately. Their intentions are good; the result usually isn't.

This is a serious problem. If we are talking about malpractice claims, don't we owe it to the American people to be talking about medical errors and negligence and what we can responsibly do to make certain that the small minority of physicians who are guilty of malpractice are changed or removed from the practice?

It is estimated that 50 percent of the malpractice cases in America are filed against 5 percent of the doctors. Yet all of the doctors end up seeing their malpractice premiums increase.

When Congress set up a national practitioner database in 1986 to collect data on adverse medical practice, it was expected that at most it would report about 1,000 disciplinary actions a month. However, fewer than 1,000 a year are reported across the United States.

Let me address another issue. It is interesting, when I speak to groups of doctors, this is the focus of their attention, as it should be, because malpractice premiums have gone up so high. But 2 years ago, this wasn't what doctors were talking about. Malpractice premiums were lower. They weren't raising this issue as often.

They were raising another issue which is related. They were raising the issue of HMOs and managed care. Doctors across America told me that for years they were having difficulty being good doctors because insurance companies were telling them whether or not they could have tests performed, how long they could leave a patient in the hospital, and whether or not a surgery was indicated. They were beside themselves saying we were trained as medical professionals. We are being overruled by insurance companies.

Is it a great leap for us to take that concern of doctors over these many years and understand that perhaps one of the reasons why malpractice has increased is that HMOs and managed care companies are squeezing doctors away from the professional standards that they were taught to follow? That is part of the reality.

Another part of the reality is that not very long ago increased malpractice premiums were passed on to patients. Patients paid more in fees. Hospitals, of course, charged more for their services. Now, with HMOs and managed care and strict accounting and restrictions in compensation, the malpractice premiums can't be passed on. The doctor pays more of it personally.

That is why this has become a dominant issue. But it also relates to insurance companies.

A special interest group that is so heavily favored here in the U.S. Senate, which was hardly mentioned in the opening statement about S. 11, is the insurance companies. We just do not talk about insurance companies in polite Senate company. It is considered inappropriate to think that perhaps they have gone too far.

Do you know what this bill does? I think this is a classic. When you get to section 13 of this bill, the sense of Congress—this is like sending a note to your sister, but it is a sense of Congress, not a law—that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate.

We debated for months as to whether the HMO and managed care company would be held accountable for making the decision on what is medically necessary and appropriate. Those on the other side of the aisle stood with the insurance companies and said: No, we don't want to hold those insurance companies liable. If they say that somebody has to leave a hospital too soon or that surgery is not indicated, the best we can do in this bill on malpractice is a sense of Congress—note to your sister—that says we really think a health insurer should be liable for damages performed. No law, just that is what we think; that is what we sense.

Is that any way to address this serious problem that is part of the medical malpractice crisis facing our country? Doctors and nurses many times know who the problem doctors are, and they know the problems with insurance companies. But the culture we are creating in the medical profession and the political culture which we created on the floor of the Senate has led us to the point where we can't honestly speak to the American people about remedying this problem.

I think there is a better way to deal with this. We should enact legislation following the lead of Senator KENNEDY, who introduced a bill last year. It would establish a voluntary system to share medical error information among providers' and patients' safety organizations through the National Patients' Safety Database. Information shared in this manner would be privileged and not subject to legal discovery. But it would allow health care professionals to report accidents without fear that that information will put anyone in legal jeopardy. It would take a bad doctor out of the operating room when he should be out.

Health professionals who submit reports would also be protected from discrimination in the workplace for participating in reporting systems.

Also, consistent with the Institute of Medicine recommendation, this bill creates a new Center for Quality Improvement and Patient Safety and the Agency for Health Care Research and Quality. The center would conduct and support research on medical errors—something we need to face and face honestly.

We also have to concede another point. When the doctors from Illinois came in and said they favored this bill, I asked them: If we imposed a strict limitation of $250,000 on David and his family, a child who went to the doctor and hospital but unfortunately did not have his temperature monitored and became quadriplegic, if we said that child, no matter how long he lives, can never get more than $250,000 for pain and suffering, no matter what the circumstances, if we did that, would it bring down your malpractice premiums? The doctors said: No, not right away, but maybe in 3 or 4 years we would start to see that turn around. In 3 or 4 years?

I listened to the Senator from Kentucky come before us and talk about an immediate national crisis. If his bill passes, it doesn't respond to this immediate national crisis. There is a better way to do this.

Over the past 2½ years with the Bush administration, we have been rather liberal—I guess I could use that word—in relation to their particular subject, tax cuts. We decided to use the tax cuts to reward and help certain people in our society. I believe we should construct legislation that allows a tax credit for those medical professionals and doctors who see their malpractice premiums going through the roof. To do that gives them immediate assistance, not something that may or may not help them 3 or 4 years from now.

The same could be true for hospitals and certainly for high-risk specialties. We need to allow doctors and hospitals to claim a tax credit for the percentage of malpractice premiums they are paying or will pay in the next number of years.

I also want to talk to you about the whole question of insurers and why we are in this dilemma. This has been analyzed by many groups, including the Government Accounting Office, the Wall Street Journal, and USA Today. How did we reach this point of a malpractice insurance crisis today? Why is it so much worse today than it was?

According to the Senator from Kentucky, one of the sponsors of S. 11, it is all about lawyers filing claims. That is not the whole story.

Insurance works in this fashion. If I am going to insure you for a loss, I collect the premium from you. The only way that I make a profit is if I collect more premiums from you than I have to pay back or I take those premiums and invest them in a way where I make money, and, coupling that together with excess premiums, make my profit.

It turned out that a few years ago, with the booming stock market and during the period of economic expansion in this country, a malpractice insurance company—a leading company in St. Paul, which is now out of business—had collected so much money in reserves and was making so much money in investments that they decided to declare a $1 billion dividend. Other companies saw this and said we need to get in the malpractice business; this is lucrative. So they did. They went in and made their investments. As the stock market started to crumble, they had no choice but to cut off their malpractice insurance or raise their premiums dramatically.

Did you hear any part of that explanation in the introduction of S. 11? You didn't. It was all about lawyers filing claims.

But there is another part of the story. The insurance companies are a part of the story. We are not supposed to talk about that on the floor of the U.S. Senate. Perhaps someone is entertaining a rule to prohibit reference to insurance companies. We just don't do that around here. That is not considered polite. But it is part of the problem, and it is also part of the solution. We need to deal with making certain that insurance companies treat doctors fairly—and reinsurance companies.

Now, this gets into the complexity of insurance policy, which I may not understand as well as I should, but I do know this part: There are five reinsurance companies in the world that reinsure for medical malpractice. Only one of them, the Hartford, is regulated in the United States and subject to State regulation; the other four are not. We have no idea whether the rates they are charging are fair. So before we say to David and his family, $250,000 and not a penny more, no matter how long you live, the obvious questions is, Are the insurance companies dealing with this challenge and dealing with it fairly?

Incidentally, the insurance companies are exempt from antitrust law. They can gather information and share that information without any penalty, through the Department of Justice, for violations of antitrust.

I think we understand what we are dealing with, but let me give you an idea of actual cases in States. The Senator from Kentucky talked about various States facing a malpractice insurance crisis, with which I do not quarrel. He suggested caps on recovery was the way to bring down malpractice insurance premiums.

The Weiss Ratings analysis took a look at the percentage increase in median medical malpractice premiums in the period between 1991 and 2002. They took a look at the States with caps, with limitations on how much a victim can recover, and those without caps.

You would assume, by the opening argument, that if the State has caps on how much a victim and his family can recover, the malpractice premiums must be low. But look at these States as examples of what happened during that 10- or 11-year period of time. The States without caps on recovery for malpractice victims such as this child David: Arizona had a 3 percent increase in median premiums for medical malpractice; New York, 6 percent; Georgia, 8 percent; the State of Washington, 27 percent.

When you go to the States with caps on recovery, let's see how their premiums reacted in the same period of time: California, up 50 percent; Kansas, up 60 percent; Utah, up 82 percent; and Louisiana, up 84 percent. So there is no direct correlation, no linear relation between caps and the premiums charged to doctors—exactly the opposite of what has been argued on the floor of the Senate on the motion to proceed to the bill.

In fact, if you look at it on a national basis—this, again, from the Weiss Ratings, Incorporated—the percentage increase in median medical malpractice premiums from 1991 to 2002: States with caps, with limitations on how much victims can recover, if they are the victims of medical negligence, a 48 percent increase in that period time; States without caps, 36 percent. So it is counterintuitive to argue that we are dealing with a linear relationship, direct relationship between caps and the premiums that are charged.

I would like to also add that I think we have to be honest about how we bring the groups together to deal with this. I think we also have to look to the legal profession. I do believe that if attorneys are guilty of filing frivolous medical malpractice lawsuits, we should put into law penalties to not only penalize them for costs and attorney's fees but ultimately to prohibit them from filing this kind of lawsuit if it is done with any repetition.

I do not believe doctors should be harassed. I want them to be doctors first and not sitting around in depositions and courtrooms for lawsuits that never should have been filed. But let me add very quickly, I have been there. I, as an attorney, had people walk into my office where they had husbands who had died, children who had died, and asked me to file medical malpractice lawsuits. I had to listen to those facts and make a decision. I will tell you, I thought long and hard before I considered taking on any of those cases.

Filing a medical malpractice case is not easy. It is not cheap. It is complicated and extremely expensive. If you do not start off with an understanding that you have a good chance of recovery, then, frankly, most attorneys will turn down those cases. That is why so few cases are filed relative to the number of malpractice claims that could be filed. Attorneys know that getting involved in those lawsuits in my State, now, requires an affidavit from a doctor which says, before you can file the complaint, that you do have a legitimate claim for medical malpractice.

We know the depositions will require expert witnesses, who are extremely expensive, in preparing your case to take it to the jury. All of these things are understood. We also know, at the end of the day, most plaintiffs lose their cases filed for medical malpractice, and that is after they have cleared all these hurdles. So to suggest that attorneys are just filing these cases frivolously, believing they are going to receive money for just filing a complaint, is certainly not my experience.

Let me say before I yield the floor—I notice my colleagues are in the Chamber and would like to speak—there is an element of this bill which the Senator from Kentucky made no mention of and no reference to whatsoever. He told us very good and important stories about doctors who could not practice because of malpractice premiums. I think he should have also included the fact that this bill does not just provide a limitation on recovery for lawsuits brought against doctors; this bill provides a limitation on recovery for lawsuits brought against pharmaceutical companies and medical device manufacturers.

I did not read anywhere about a malpractice crisis involving pharmaceutical companies, but we learned 2 weeks ago, when we debated the prescription drug bill—and we have learned time and again—that hardly any major bill could go through the Senate unless it figured out a way to help drug companies. This bill is no exception. This bill has been designed to make certain there is a limitation on the amount of money that can be recovered from drug companies and medical device companies when they may be guilty of product liability, when they may have sold a product which injured someone.

I can recall a specific situation: heart catheters. I am a little bit familiar with this issue, and maybe some of those who have followed the debate are as well. These are tiny little lines which are passed through a vein of a person to their heart, and they actually film what is going on in the person's heart. It is an amazing diagnostic device.

The medical device itself had been cleared by the Food and Drug Administration, but it turned out that the manufacturer was guilty of shoddy practices in Massachusetts. This manufacturer was creating and producing catheters which, when inserted into a patient and sent up to the heart, would break, leaving portions within the heart, leading to the necessity for surgery to retrieve those pieces that were left behind.

Now, I ask you, is that truly what this debate is all about, that medical device manufacturers which negligently make a product that can endanger the lives of individuals should also be limited in terms of their liability? These are not individual doctors; these are medical device companies. The same thing can be said of pharmaceutical companies.

So I would just ask the sponsor of this legislation, the next time he comes to the floor to explain this bill—and does it in compassionate terms about doctors—why he does not tell us the rest of the story. I want to hear the rationale about drug companies and medical device companies, why they, too, need this protection when their products cause extremely excessive damage to individuals.

It is my understanding that tomorrow we are going to return to the motion to proceed to this bill, and I am sure many of my colleagues will be coming to the floor. But I will say this, as I did at the outset: It is unfair the way doctors are being treated with medical malpractice premiums. Something needs to be done in a responsible fashion, and involving doctors and lawyers as well as insurance companies. If we do it, and do it right, it will be a service to every family in America and every community in America.

But this bill, S. 11, is equally unfair to the victims of medical negligence. To put a limitation on the amount a person can recover—regardless of the permanent disfigurement, the incontinence, the blindness, the quadriplegia that these people will suffer for a lifetime—is fundamentally unfair and, as we have demonstrated, will not lead to lower premiums. There are better, more reasonable ways to approach this problem.

As I said before on the floor, and I repeat at this point, I stand ready to work with the majority and other Members of the Senate. Let's roll up our sleeves and do this the right way. Let's do it in a way that we can be proud of, and not do it in a take-it-or-leave-it fashion, as this bill has been brought to the floor.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, we are on this subject now. We are out of morning business; is that correct?

The PRESIDING OFFICER. The pending business is the motion to proceed on this bill.

Mr. THOMAS. I thank the Chairman.

I am very pleased to come to the floor this afternoon and join my colleagues to address an issue that has a crippling effect on the health care system. It has helped take out of control Medicare costs, malpractice costs. I guess specifically I am interested in it for my own State, of course, as well as everyone else's. Some providers have seen premiums jump as much as 81 percent in 2 years. Rural areas are disproportionately impacted. Often there is no other provider to fill in when a doctor is forced to close shop. That has been the case in my State.

Recent studies by HHS show that in States where they have enacted limits on noneconomic damages in lawsuits, there are about 12 percent more physicians per capita than there are where there is no such cap.

So we are beginning to not only test the costs but whether we have providers. That is a very important one. OB/GYN services have been especially impacted in my State, where 9 out of 54 recently surveyed have either stopped delivering babies or plan to do so because of rising liability costs.

I have listened to my friend from Illinois talk about this issue. Obviously it is going to be a controversial issue. There are different views, very different views, but it is not a new solution. It is one that has been in place and has proven to work in many of the States. It also is interesting that we have talked a lot—I happen to be involved with the rural health caucus. We have spent 2 weeks previous to this talking about Medicare. And we talk about, frankly, who is going to pay, but we seldom ever talk about what the costs are and what we could do about reducing some of the costs that put people out of touch with their own physician. This is one that is proven. This is one that does work. It is here to be acted upon.

As to the discussion on the other side of the aisle that maybe we are in too much of a hurry, this has been on our minds and on our floor and in our States for a very long time. This is not a new idea as a matter of fact.

I just wanted to show one little chart I think is interesting. That is to show that reforms do work as a matter of fact. This says, "2003 Premium Survey Data Selected by Specialties, $1 million to $3 million limits." Here are the specialties. Los Angeles, CA; Denver which has the limitation versus similar to what is here; New York, Nevada, Illinois, Florida do not. Then take a look here at internal medicine. Here is an $11,000 premium, $9,000 premium. Over here where there is no control—$16,000, $19,000, $26,000, $56,000. Down here is the OB/GYN. In these cases where there is some limitation, $54,000, which is obviously too much anywhere, and $30,000. But look over here where there are none, none of the controls we are talking about here, $89,000, $107,000, $102,000, $200,000. It does work. It does work. Medical Liability Monitor is the source of these numbers.

It isn't as if we are talking about something that is untested, something that we don't know about. It is not as if we are talking about a new problem of which we were not aware. The fact is, we have physicians living in Cheyenne, WY, who drive to Colorado for this reason. Can you imagine Wyoming being one of the highest places to pay. You wouldn't think that, would you? I think this is something that has a good deal of merit, something that we need to talk about.

We have cited some of the things that are peculiar to our own States. We have a doctor in Wheatland, WY, who over the last several years has delivered more than 2,000 babies in about four different counties. He has been the major provider of services there. He has quit operating. He has quit delivering babies.

Sheridan, a little larger town, has one of two OB/GYNs in the area. His medical malpractice insurance costs over $60,000 a year. So we are in the position, then, when providers drop out of communities like this, where people are forced to drive 2 to 3 hours before they can get services. We have talked a lot, and we have a lot of concerns about rural health care. And it is difficult to keep providers in those areas. When you have one or two who leave, you have none. And so it is really quite different to be in our area.

The Wyoming physician population ranks 47th out of 50 States. So every physician is very valuable to us. Forty percent of our family physicians are over the age of 50, and we are going to see more retirements. We are going to see more movement, particularly if there are disincentives to serve such as this cost of malpractice insurance. So we need to deal with this.

As I said, this idea that is being promoted has been in place. We know that it works. Is it going to solve all the problems of cost? Of course not. But we know this one will solve some of the problems of cost, and we can move forward to find some other ones.

As I said, we talk all the time about health care and who is going to pay. But as all health care costs keep going up 12 or 13, 14 percent a year, we have to begin sometime to take a look at how we can contain some of the costs so that somebody will be able to pay for it.

One of our orthopedic surgeons in Teton County, Jackson Hole, WY, has seen a 300-percent increase in liability premiums in the last 12 months. Without trauma care in Jackson, these people have to go to Salt Lake City. This is the kind of additional difficulty we have.

We all pay for medical liability costs. All patients pay the escalating costs generated by the Nation's dysfunctional medical liability system. And these increased premiums are the result. It also reduces the access to care, especially specialty care. So every taxpayer pays the price.

We think we can reduce Federal spending in Medicare, Medicaid, the Federal Employees Benefits Plan. It is suggested we can reduce this by $14 billion in 10 years. This would be a savings to everyone. Local and State governments could save over $8 billion over that period of time. So it isn't just a focus on a few people. This is the kind of thing that would save us all money and I think would make our lives much better.

What we are doing—and I think there needs to be a little explanation of it, to talk about it—doesn't limit damages to $250,000. It limits noneconomic damages to $250,000. So if someone needs care, if somebody needs various things that are economic costs, those things are not there. We want to make sure we listen carefully to what is being said here.

So what we are seeking to do, of course—it seems to me reasonable—is to set reasonable limits on noneconomic damages, provide for a quicker review of liability claims, assure claims are filed within a reasonable limit of time, and educate folks that frivolous suits only add to the overall cost of care for everyone. We spend a lot of time talking about who should pay. I have already discussed that but rarely do we talk about the costs. They are becoming increasingly important to us.

This bill is modeled after California's liability reform bill. California's law stabilized the State's medical liability insurance market, increasing patient access to care, saving more than $1 billion a year in liability premiums. As I said, specifically it allows unlimited economic damages. Past and future medical expense, loss of past and future earnings, cost of domestic services, these things are not limited. It establishes a reasonable limit on noneconomic damages which is exactly what we are seeking to do. States, however, would have the flexibility to establish or maintain their own laws on damage awards. It establishes a fair share rule that allocates damages properly and fairly in proportion to the party's degree of fault. There is a sliding scale for attorney's contingency fees; therefore, maximizing recovery for patients, which this is really all about.

It authorizes periodic payments to injured parties rather than one lump payment.

It is interesting to me, it does seem to present kind of strange politics. We argue on the other side of the aisle all the time about health care and that we ought to pay and make sure everybody has health care and so we will do it with taxes so that they are appealing to those people who need help in terms of costs. But when we come up with something that will impact the costs, suddenly the sympathy shifts over to the trial lawyers. It is sort of interesting to try to argue both sides, when there is a certain amount of conflict here.

I think this is a real opportunity for us to do some things that will be helpful to everyone, whether they are taxpayers, patients, physicians, or whatever. We have a chance to do something with that. Now is our opportunity. It is not a new problem. I think it is time we act. I am pleased to be among the sponsors. I want to work to see that this moves forward.

The PRESIDING OFFICER. The Senator from Kentucky is recognized.

Mr. McCONNELL. Mr. President, briefly, I thank the Senator from Wyoming for his contribution to this debate. We were discussing off the floor the fact that Wyoming got added to the crisis list—today, actually. Talk about a State in which the distances are great and the problems are compounded by it; Wyoming has to be at the top of the list. I thank the Senator.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

Mr. LOTT. Mr. President, I want to correct some of the perceptions that perhaps have been left about what this legislation would do, or what the situation is.

First, it is very interesting to me that it appears there is an effort to blame the medical profession, the doctors. I ask this question now of most Americans: Who do you have more confidence in, your local doctors, the drugs you have been taking, the medical devices that are keeping many alive, the type of medical care you are getting in home towns, or your local trial lawyer?

Well, that is an easy question to answer. I have had to deal with that myself on both sides of the issue. By the way, I do have a law degree and I do know a lot of lawyers on both sides of the issue for whom I have a great deal of respect. Nobody is saying you should not have an opportunity to bring a lawsuit when you have been wronged or damaged. That is clearly not the case. But the idea that we are going to say no, no, there is not a medical liability crisis, there is a medical malpractice crisis—in fact, when I go around and talk to people who have pacemakers and have drugs that make their lives somewhat acceptable, or they have had strokes but they are controlling their blood pressure, up or down, they feel pretty good about health care in America.

Health care in America is the goose that laid the golden egg. We are the most blessed people in the world when it comes to medical care. Is it perfect? No. Are mistakes made? Yes. Do we need better reporting or to keep records of this sort of thing? I will support that. The AMA may not like it that we keep closer track and deal with some of these mistakes that are made. But I am for that. I think we need to know where the problems are and we need to deal with them.

But to say the problem here is the medical profession or the insurance industry—by the way, I don't want to just dismiss their involvement either. I want to make sure we understand why these medical liability insurance rates are going through the ceiling like they are. It is a variety of issues, I believe. I don't believe it is just the lawsuits but I think that is a big contributor. I think defensive medicine is a big part of it. I think that some of their investments went south on them and that is causing some insurance companies to raise rates.

But to shift the burden over to the medical profession, when I know these men and women practicing medicine—the neurosurgeons, orthopedics, OB/GYNs—these general practitioners in the Mississippi Delta are already so terribly underserved and are just saying: We cannot continue. We are retiring or leaving and going to another State. This is the crisis. Maybe my State is worse than most but this is a huge problem, and it is all over the country now.

One of the things I want to correct is this: Senator DURBIN talked about David, referred to David's situation. The inference was that all he would get is $250,000. As a matter of fact, under this legislation, he would get all of his hospital bills paid for, all rehabilitation bills paid for, all physical therapy, all speech therapy, all occupational therapy; and if a home nurse is needed 24 hours a day, he could receive full compensation for that. He could get lost wages up to a lifetime of what he could have earned, which could be, obviously, millions of dollars. It could cover anything David's family would have to spend on his condition. Plus, the punitive damages in this legislation is not $250,000; it is the greater of $250,000 or two times economic damages. Quite often, economic damages could easily be $10 million.

Mr. DURBIN. Will the Senator yield?

Mr. LOTT. Then it would be two times that—$20 million—that a victim could receive if the economic damages are $10 million.

So let me give an example, and then I will yield. I want to make this point. Under the California situation, with the $250,000 limit, what has happened? I ask unanimous consent to have this printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From Californians Allied for Patient Protection]

SAMPLE RECENT MEDICAL MALPRACTICE AWARDS IN CALIFORNIA UNDER MICRA

December 2002; $84,250,000 total award; Alameda County.

5 year-old boy with cerebral palsy and quadriplegia because of delayed treatment of jaundice after birth.

The $750,000 award for non-economic damages was reduced to $250,000 under MICRA.

January 1999; $21,789,549 total award; Los Angeles County.

Newborn girl with cerebral palsy and mental retardation because of birth related injury.

October 1997; $25,000,000 total award; San Diego County.

Boy with severe brain damage, spastic quadriplegic and mental retardation because too much anesthesia was administered during a procedure.

November 2000; $27,573,922 total award; San Bernardino County.

25 year-old woman with quadriplegia because of a failure to diagnose a spinal injury.

July 2002; $12,558,852 total award; Los Angeles County.

30 year-old homemaker with brain damage because of a lack of oxygen during recovery from surgery.

The award included $250,000 in non-economic damages for the plaintiff's husband and $676,921 for past and future household services.

July 1999; $30,900,000 total award; Los Angeles County.

Newborn girl with cerebral palsy because of birth injuries.

October 2002; $59,317,500 total award; Contra Costa County.

3 year-old girl with cerebral palsy as a result of birth injury.

The award included $100,000 in non-economic damages for the child, $200,000 in non-economic damages for the mother and $200,000 in non-economic damages for the father.

April 1999; $6,885,000 total award; Orange County.

Premature newborn girl with permanent blindness because of delay in treatment.

February 2000; $1,384,685 total award; Riverside County.

39 year-old pregnant homemaker and mother who died because of misdiagnosis.

The $300,000 award for non-economic damages was reduced to $250,000 under MICRA.

December 1999; $50,239,557 total award; San Francisco County.

10 year-old boy with brain damage because of undiagnosed infection at birth.

The $324,000 non-economic damage verdict was reduced to $250,000 under MICRA.

Mr. LOTT. This shows that in December of 2002 there was an $84,250,000 total award in a case under the current California law; a $21 million in January of 1999; a $25 million award in October of 1997 for a boy with severe brain damage and mental retardation because of the anesthesia. It goes on. Here is one for a $59 million total award.

So the inference that all you could get under this legislation would be $250,000 is absolutely not the case. It would depend on the economic damages, the totality of the costs, and the verdict rendered. So I just wanted to make sure people are aware that there is flexibility here and that, depending on the severity and how long it would last, it could be a multimillion-dollar recovery.

I am glad to yield to Senator DURBIN for a comment or question.

Mr. DURBIN. I thank the Senator. I ask him this question: Is the Senator familiar with the provisions in this law relating to collateral sources? For example, health insurance?

Mr. LOTT. That you would get health insurance and that would be deducted, in effect, from the damage? I was not familiar with that particular provision but I understand that does happen all the time. I am not a cosponsor of the legislation but I am planning on being one. That is why I have been here listening to the debate and reading the legislation. I want to know all of the ramifications of it. There may be the collateral insurance provision that would allow the amount of money received to be reduced by that.

Mr. DURBIN. Is the Senator from Mississippi familiar with the fact that in all 50 States across the United States, including his State and mine, there is no similar provision about the deduction of collateral sources? There is only one other instance where we have passed a law where collateral sources would be credited, and that was for the victims of 9/11.

Mr. LOTT. I wasn't aware it doesn't apply to any other States. I would think the States would want to take that into consideration. I don't have a problem with that. You need to look at the totality of a situation—and you have judges and juries who will do that—to see what recovery they might be getting through their insurance, as you decide what the award may be in terms of what their economic needs are.

Mr. DURBIN. If the Senator will further yield, is he aware of the fact that in most States, if you go into a civil lawsuit and raise the issue of insurance coverage, it is an automatic mistrial?

Mr. LOTT. Absolutely. I have seen it happen. I was involved in a case one time and one of the lawyers accidentally mentioned insurance, and there was a mistrial on the spot. I always thought that was kind of ridiculous. But I also know that some juries, when they think an insurance company is involved and that actually the doctor might not himself be paying, that might affect the amount of the verdict they would give. So that is why that law is on the books.

Mr. DURBIN. If the Senator will further yield, this bill says that in any health care lawsuit any party may introduce evidence of collateral source benefits. I ask the Senator, does he consider it fair that if David's family had health insurance that paid for some or all of his medical bills, that those who were guilty of malpractice, in his case, should somehow be absolved from paying because his family had the foresight to have insurance?

Mr. LOTT. Are these lawsuits about punishment, or are they about helping the people who have been damaged? Sometimes both. By the way, there could be, I guess, under certain circumstances, a criminal act involved. While I am not an expert in this area—it has been a long time since I practiced law and defended anybody—I have always thought the admission of evidence about where the money would come from or how much should be admissible in court. I have to defer to others who have more experience and more expertise in this area than I do.

Mr. President, does Senator McCONNELL wish to comment? I yield for a question.

Mr. McCONNELL. Mr. President, I say to my friend, my understanding of the way this provision would work is the collateral rule would allow the jury to know but does not reduce the award and does not allow the insurer to subrogate. That is the way this provision is crafted in this legislation. It would allow a jury to know, but it would not reduce the award and would not allow the insurer to subrogate. That is my understanding of the way it is crafted in the underlying legislation.

Mr. DURBIN. Mr. President, I assume the Senator from Mississippi has the floor.

Mr. LOTT. I yield to Senator DURBIN for a further question or answer to the comments from Senator McCONNELL.

Mr. DURBIN. I will do it in the nature of a question. Is it not true if the jury knows that the plaintiff's family, in David's case, has health insurance which is going to pay for some of his medical costs, which are obviously going to be extensive, that this is likely to diminish the amount that will have to be paid by the party responsible for David's condition?

I ask the Senator, he suggested earlier that this should not be about punishment. Is there not a question of accountability? If the doctor in this case did not monitor his temperature leading to quadriplegia and a lifetime of pain and suffering, is there not a question of holding that doctor accountable rather than his parents for having the foresight of buying insurance?

Mr. LOTT. To answer the question, I see no problem in a jury being able to consider the totality of the situation. I do not think we should ignore the fact a doctor—first of all, they are human beings. They do make mistakes. There are lawsuits based on very good cases and recoveries of a significant nature because of the extent of the damage or the longtime life impact on that person.

When a doctor goes through this, don't you think it has an effect on his practice in that community? Do you think he is not adversely affected by it? I remember a case in my home area where a doctor left a sponge in a patient and it affected his career the rest of his life. He was punished. He was punished by the verdict, his insurance company had to pay, obviously—the patient got significant damages, both economic and punitive damages, and he suffered mightily.

The point is, I have watched this issue for pretty close to 34 years, both as a lawyer and then as a Member of Congress, and it has gotten worse and worse. It is leading to a serious problem. It is about the patients, and it is about the doctors' insurance companies. But what about the people now who are losing access to medical care, to expert doctors, to especially the trauma doctors we are about to lose in my own State, the women who have to drive literally hundreds of miles to get to an obstetrician when they are going to have a baby, what about their risks? Maybe they should be able to file a lawsuit against somebody because they do not get sufficient health care.

This is something we are going to talk about over the next 24 to 48 hours. I do think something has to be done.

I want to make this point, too, in terms of working something out: We saw last year prescription drug legislation was brought directly to the Senate floor. It did not go through the Finance Committee. Because of that, we were required to get 60 votes, and that is why we did not get prescription drug legislation last year. A couple of the alternatives that were voted on got over 50 votes, but we had to have 60. So there is nothing extraordinary about taking up a bill that comes over from the House or taking a bill directly to the floor for consideration.

I would prefer we have hearings. I think hearings would be a lot of fun. I would like to see the doctors, the nurses, and patients who are being denied care have a chance to say what this is doing to them. Maybe we could work out some of the disagreements.

I wish to make this point: That effort has been made this year. Senator FRIST has been working with Senator FEINSTEIN to come up with a bipartisan bill basically along the lines of what is in this bill with the $250,000 limit on punitive damages or two times economic damages, whichever is greater. Senator McCONNELL probably was involved in those negotiations, but it fell apart when there was pressure to raise it from $250,000 to $500,000, and they just basically quit working on it, I guess, because they could not get an agreement.

I would hope a committee would act—have hearings, report a bill, and let's make sure it is a good bill, but let's make sure it is not one written by just the plaintiffs' lawyers.

Mr. President, does Senator McCONNELL wish to comment?

Mr. McCONNELL. Mr. President, I want to make sure my friend from Mississippi is aware that, in fact, there was a joint hearing on February 11 between the Judiciary Committee and the Labor Committee on this subject. There has been a recent hearing. Of course, in previous Congresses, there have been numerous hearings on this subject for as long as the Senator from Mississippi and I have been Members of the Senate.

Mr. LOTT. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. McCONNELL. Mr. President, to make sure we all understand what the provision is in the bill we have been discussing, let's put it this way, Mr. President: This provision only allows a jury to know the victim has received benefits from a third party, such as a health insurer. It allows the jury to know that, I say to my friend from Mississippi, but the jury is free to ignore that evidence if they like. It would allow them to know there was insurance coverage, but the jury is free to ignore that evidence if they like. The provision also prevents health insurers, a third party, from recovering payments it made to the victim. That is what this bill actually does.

I think it is important just to set the record straight on what is, in fact, contained in this legislation on that point.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank my colleagues for joining us in this floor debate, and I hope others will tomorrow, and I am sure they will. It is worth noting that the State of Mississippi, faced with the circumstances described by my colleague and friend, Senator LOTT, decided to do what each State has the right to do, and that is establish its own standards of recovering for noneconomic losses.

It is my understanding they have established a schedule that starts at half a million dollars and, over a period of 10 or 15 years, goes up as high as $1 million or $1.2 million. That has been done by the State of Mississippi, as it could be done by any other State. What we are considering here is what we will do on a national basis.

I was wondering if the Senator from Kentucky would help me understand the portion of the bill relative to what he described as flexibility in terms of States rights.

Would the Senator be kind enough to yield, without me yielding the floor, to engage him in a dialog about this State flexibility? Is that permissible under the rules of the Senate? I direct that request through the Chair.

The PRESIDING OFFICER. If the Senator from Illinois will make a unanimous consent request for the purpose of engaging in a colloquy, that will be acceptable.

Mr. DURBIN. If the Senator from Kentucky is kind enough to yield to this procedure, I ask unanimous consent—I do not yield the floor—that we be allowed to engage in a dialog about some aspects of this bill so there is a clear understanding on the record of his intention.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. Mr. President, I thank the Senator from Kentucky. As I have said before, we get dangerously close to Senate debate on this floor from time to time. This just happens to be one of those moments. I am happy to be here to witness it.

I ask the Senator from Kentucky, what is the Senator's intention in the portion of the bill relative to State flexibility? I want to make certain I understand. If my State has any law relative to medical malpractice, relative to discovery or expert witnesses or, in my case, we do not have a limitation on noneconomic losses, what part of State laws would this new S. 11 preempt, and which portion would it not preempt?

Mr. MCCONNELL. Mr. President, I say to my friend from Illinois, reading from the bill, of which I hope he has a copy, section 11 says:

> **SEC. 11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.**
>
> (a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this Act preempt, subject to subsections (b) and (c)—

Which I will go through in a minute—

> State law to the extent that State law prevents the application of any provisions of law established by or under this Act. The provisions governing health care lawsuits set forth in this Act supersede chapter 171 of title 28, United States Code, to the extent that such chapter—
>
> (1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment future damages,
>
> (2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.
>
> Subsection (b) any issue that is not governed by any provision of law established by or under this Act . . . shall be governed by otherwise applicable State or Federal law.

Now, what the flexicaps are designed to do, as I understand it, is to allow a State to, in effect, opt out, consistent with the provisions that I read to my colleague from Illinois, within those parameters.

Mr. DURBIN. If I could ask my colleague from Kentucky, that paragraph (b) goes on to say:

> This Act does not preempt or supersede any law that imposes greater protections (such as a shorter statute of limitations) for health care providers and health care organizations from liability, loss, or damages than those provided by this Act.

As I read that, though, I understand that if one's State law is more generous to doctors, hospitals, drug companies, medical device providers, HMO insurance companies, then that State provision would be the applicable provision. Is that correct?

Mr. MCCONNELL. It is correct that this legislation allows states to provide greater protections to health care providers than are contained in this legislation.

Mr. DURBIN. So it is not a balanced playing field completely. We are not leaving it to the States to decide, for example, that wrongdoers of medical malpractice cases would be treated more strictly, more severely? If there is a stricter provision in the treatment of those individuals, it would be preempted by this act? Is that the way we have explained it?

Mr. MCCONNELL. Again, to ensure the availability of health care services, the states are allowed to provide greater or additional protections to health care providers than are contained in this bill.

Mr. DURBIN. Then if I might ask, the next section (c)—I am trying to get to the point of let's use an example of the State of Mississippi which has just decided on a cap of **$500,000** on noneconomic losses effective January 1 of this year. Now, the underlying bill, S. 11, says that the cap on noneconomic losses will be **$250,000**. So in that instance, is it the position of the Senator that this bill would not preempt Mississippi law; that Mississippi's number would apply even though it is larger than S. 11?

Mr. MCCONNELL. Yes. This legislation does not preempt existing or future state laws on noneconomic damages.

Mr. DURBIN. May I ask the Senator to explain subsection 2(c)(2) in terms of defenses available to a party in a health care lawsuit under any other provision of State or Federal law that does not preempt it? I do not understand that particular section. If I have caught the Senator off guard on that particular section, we can return to it at a later time, but perhaps he could explain what that particular section means.

We can come back. I do not mean to catch the Senator off guard.

Mr. MCCONNELL. Let's come back to that.

Mr. DURBIN. We can come back to that at some point. I thank the Senator for yielding and providing that additional information.

As my colleagues can tell, during the course of this exchange we are doing what usually happens in a committee hearing where sections of the bill are explained and members of the committee have a chance to ask questions such as I have asked of one of the sponsors, Senator MCCONNELL. Then perhaps members of the committee say, perhaps, we need to change that language and we offer amendments. That is the committee process.

For this bill on medical malpractice, we have not done that. We are bringing it directly to the floor. As my colleagues can see, despite the fact that my colleague, the Senator from Kentucky, is certainly an able attorney, there are some complicated elements.

It is important, if we are going to consider a bill of this gravity, that we do take the time to do it and do it right.

I also note that a case which I mentioned earlier is a clear illustration of why this bill is fundamentally unfair to victims. I mentioned this case earlier because it involves a woman who lives in the city of Chicago. As I said in my opening statement, this lady, who has written an article in a leading newspaper in our town, says that she is literally the face of tort reform.

Three years ago, she went to a prestigious hospital in Chicago for a routine surgery to have two moles removed from the side of her head. During the surgery, the oxygen which was being administered to her ignited. In her words, it set her face on fire. It ended with her face in flames.

In her words:

> My entire upper lip was burned off and much of my nose is gone. For two years, I couldn't breathe on my own, and I now wear a face mask with nasal tubes in what's left of my nose, 23 hours a day. I have endured eight surgeries, with more to follow. The doctors who are trying to reconstruct my face and teeth say the whole process could take up to seven years.

That is 10 years of surgery from that tragic accident.

> Even then, the scars and burn marks will still be visible and the emotional cost will be with me forever.

She says:

> I'm 50 years old, and the mistakes made at the hospital have damaged every part of my life—from my career to my personal life to my sense of self. . . .
>
> But today's proponents of medical malpractice reform don't want to consider each case individually. They want to put a cap on damages—regardless of how old a person was when they were injured, how serious the injury, how an individual's life has been affected by the negligence of others.

Let me interject for a moment. What is at stake in this debate is not just this important issue of medical malpractice but several other important issues. We are now talking about changing, at least in some respects, the right of States to make individual decisions about the lawsuits filed in their States.

As the Senator from Kentucky said earlier, there are some parts where the States will still have the last word but in other parts they will not. So we will preempt a State's right to establish standards for lawsuits in its State. Now that is an important issue which we consider from time to time, and depending on one's prejudice on the issue before them, they either ignore or honor States' rights. In this case, we clearly do not honor States' rights. The sponsors of S. 11 have decided that on a national basis we will preempt States' rights.

The other thing that S. 11 preempts that is critically important is the jury system. It is interesting that the men and women in the Senate who came here because of the votes of the people they represent, who trust the decision of the people they represent, would say that when 12 of them are gathered together in a jury box we cannot trust them; they are just not reasonable. They get carried away. And because they get carried away, according to those supporting S. 11, we have to restrain them. The only way to restrain them is to put limits in the law, say to them no matter how much they think this poor lady's case is worth they cannot give her more than $250,000. This bill says we just do not trust that jury.

Put the good lawyers in the room representing the doctor and the hospital, as well as those representing her, and the fear is, from those who bring S. 11 to the floor today, that they are just going to see this situation and say this is not fair, it is not right, and this poor lady deserves more than $250,000. Because of that fear that the jury may go too far, this bill says: We will stop them. We will stop them in every State in the Union.

Is it not interesting that when it comes to juries in medical malpractice cases we have so little regard for their ability to find the truth and do what is fair? And yet when it comes to so many other areas of the law, such as criminal justice and the imposition of the death penalty, the jury is sacrosanct; the jury has the final word. When it comes to deciding what this is worth for this lady, we do not trust them.

She goes on to say:

> Some claim that $250,000 compensates people who are injured.

I refer to this photograph of this poor lady and what she has been through, and she asks: "Would any healthy person allow their face to be set on fire, or worse, to receive that sum of money?"

She says:

> Not in the worst type of reality television show.
>
> Some claim that caps are necessary to protect insurance companies and HMOs. With documented medical mistakes soaring, it is astonishing that federally proposed legislation would first target the victims of medical error, before addressing the errors themselves.

Now the Senator from Mississippi earlier suggested that I went too far in suggesting we ought to look at the whole issue of medical malpractice. Well, I do not think that is an issue foreign to this debate. I think it is an issue central to this debate. If we are going to reduce exposure to lawsuits, if we are going to reduce the size of premiums, then we certainly have to look to the root cause of the problem. If we do not deal with medical malpractice and the fact that only 1 out of every 50 cases of malpractice ends up in a lawsuit being filed, then frankly no matter how much we lower the noneconomic losses per case, there is still a universe of liability, a universe of exposure, for doctors and hospitals which goes untouched.

If this is going to be an honest discussion about reducing malpractice insurance premiums and the crisis that they have created among some specialities in some States, then I think frankly, as is said by this poor lady who was a victim, what is wrong with asking how we make our hospitals safer? How do we get our doctors to reach a point where they are making better informed decisions? That is a reasonable inquiry. It is one from which we should not shy away. It is certainly one that applies directly to what we are discussing.

She goes on to say:

> Some claim that juries are the problem. I trust a jury of my peers to competently determine a fair judgment in cases like mine.
>
> The proponents of this legislation want to rein in juries in medical malpractice cases, but never question the legitimacy of the jury in cases of the death penalty or other cases of wrongdoing. It appears that their concerns focus more on satisfying specific constituencies than protecting citizens from harm.
>
> Like many people, I have been injured by poor care at a hospital. More than anything in my life, I wish I could take that day back, to make myself the way I was before the fire exploded all around me. But I can't have that day back. All I can have now is the right to be treated as an individual, to have others understand how this event has changed my life.
>
> Caps on damages seek to treat all injured people in the same way. No victim is exactly like any other. Devastating injuries affect each life differently and deserve to be treated individually.
>
> In short, my injuries are personal—though part of a national epidemic of negligence in hospitals. A recent study showed that 98,000 people were killed in hospitals, through neglect, in a single year.
>
> I'm hoping that Congress and the public will see that each victim of medical malpractice is worth considering on his own and not put arbitrary caps on the personal suffering of so many people.

That is what it comes down to, a question of individual worth. The question is whether or not we have reached such a point in our society where we have to step away from the rights of this individual who was clearly a victim—as much a victim as someone who would be shot by a gun on the street or hit by a drunk driver on the road—whether we have to say in her circumstance we cannot trust a jury of her neighbors and people in her community to decide what that injury was worth.

Have we reached that point? I hope we have not. I hope, instead, we will do something which would be a breakthrough in the Senate—that we will bring together the parties who are clearly responsible for where we are today. Those include insurance companies.

The Senator from Mississippi conceded the point. He said: I will concede that the investments of insurance companies have something to do with the premiums, of how high they are.

Well, though the Senator from Mississippi conceded the point, this bill doesn't have anything to do with it. It does not bring to task the insurance companies for the premiums they are charging or hold them accountable for premiums they will charge in the future.

We can keep noneconomic losses, limit the amount of money the victims like this can recover, find premiums still rising through the roof as they have in many States that already have these caps, and be powerless to respond. Our friends in the medical profession who are rightly asking us to do something should be enraged at that point, as well. Having been promised this so-called tort reform—though I don't believe it is real reform—that this limitation on the amount that can be recovered on individuals is going to be the answer to their prayers, it may fail. That is not fair to them.

Bringing together in one place the medical profession to deal with lessening medical malpractice, which according to the Bush administration spokesman, Dr. Clancy, has reached epidemic proportions, bringing together the insurance companies, which because of bad investments have seen their premiums skyrocket to try to make up the difference, bringing together the attorneys to make sure frivolous lawsuits are not filed, can bring a solution. If that solution is to be immediate—and it should be—it should necessarily involve some help in the Tax Code for doctors who are currently facing these problems, as well as hospitals.

I would like to know if the Senator from Kentucky would engage me, if he would explain why he has included in this medical malpractice bill, that was originally designed for doctors and hospitals, protection against lawsuits relative to medical device manufacturers and drug manufacturers. Why were these two additional groups included in S. 11 to limit their exposure to lawsuits? I don't recall any reports of a crisis when it comes to insurance for pharmaceutical companies.

I ask unanimous consent that the Senator from Kentucky be allowed to respond and I still retain the floor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. McCONNELL. I want to respond to some of the other suggestions my friend from Illinois has made, so if he completes his comments, I will be happy to respond.

Mr. DURBIN. Fair enough. I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. McCONNELL. Mr. President, with regard to medical errors, were we not debating a motion to proceed, and if we were on the bill, I am sure my friend from Illinois or other Members of the Senate would offer amendments with regard to medical errors. A medical errors bill has passed the House of Representatives.

I don't think anyone is suggesting—certainly not I—that the underlying bill which we are seeking consent to get before the Senate should not be amended or improved in a variety of different ways. However, it is pretty hard to offer an amendment when we are on a motion to proceed.

With regard to the lady who was horribly disfigured—this picture displayed by my friend from Illinois—it is important to remember that her damages would not be capped at $250,000. She would get all of her economic damages—all of them—plus $250,000 noneconomic damages, plus, in all likelihood, punitive damages on top of that equal to twice economic damages or a quarter of a million, whichever is greater.

So the notion that there is simply no other compensation, that there is a $250,000 cap, is not accurate, I say with all due respect to my friend from Illinois.

Senator LOTT read off a few moments ago a list of awards under the California system—which is the underlying bill, the one we are seeking to get before the Senate, which this bill mirrors—of multimillions of dollars for compensatory damages; and punitive damages in a case of truly egregious events could be twice the economic damages. Then there is a pain and suffering award potential of $250,000 on top of that.

The people who do not get a penny are the ones who cannot find a doctor because the doctor is no longer there. One of the examples I used in my remarks earlier, Leanne Dyess from Mississippi, did not get a penny. Nor did the women who give birth by the side of the road. They don't get any money when their doctors have been driven out of business.

So the point I make in response to my friend from Illinois: This is not nearly as draconian as he suggests. On the economic side, there are no limits at all. Under punitive damages, there could be twice what compensatory damages are, and there is a $250,000 possibility on pain and suffering already. We think that clearly the victims are not denied adequate compensation.

As we have already pointed out with several speeches, the States that have tried this kind of approach have lower malpractice insurance premiums and do not have the crisis that we have in most of America today without that kind of legislation.

Mr. DURBIN. Will the Senator yield?

Mr. McCONNELL. I will not yield at the moment.

With regard to an earlier reference to the FDA, if a product is found to be appropriate by the FDA, the companies should not have punitive damages assessed when they follow the FDA approval process. Punitive damages are for illegal conduct, and if the Federal Government blesses that conduct, it can't be illegal. However, there is no cap on economic or noneconomic damages against the drug companies in that situation.

The other part of the FDA section prevents doctors from being sued on product liability cases just because they prescribed a drug that the FDA has approved.

That is the answer to the question the Senator asked earlier.

Mr. DURBIN. Will the Senator yield?

Mr. McCONNELL. I yield the floor.

Mr. DURBIN. Let me go on to say that in this case the question I was going to ask the Senator from Kentucky is this: This poor lady was a victim in my home State of Illinois which does not allow punitive damages in medical malpractice cases. My question for him, which I will save for a time when he has a chance to answer—whether or not, under those circumstances, this victim of medical malpractice has been allowed to recover punitive damages under his bill.

The reason I ask that question is I think that the section relative to State flexibility and protection of State rights is not altogether clear. If he is saying that this lady who was a victim of this explosion in her face, which led to multiple surgeries over a projected 10-year period of time, might have recovered punitive damages under S. 11, then in my home State you cannot turn to punitive damages. Your recourse, in her case, is for noneconomic losses, which are limited.

I might also add the Senator should note his punitive damage section includes a phrase which is a very restrictive phrase. In my home State, when punitive damages were allowed they were allowed for reckless misconduct or willful and wanton misconduct, which is a higher level of negligence.

Under the specific language of S. 11, in order to recover for punitive damages, you must show a malicious intent to injure. So to have cases of gross negligence is not enough. There must be "malicious intent to injure."

Another question which I am going to ask the Senator from Kentucky to consider, and perhaps respond to at another time, is whether or not a situation where a doctor is either on drugs, addicted to drugs, or intoxicated, is a case of malicious intent as opposed to gross negligence or willful and wanton misconduct. Because if the doctor is clearly addicted or intoxicated and as a consequence someone is severely injured, the question in my mind is, Is that plaintiff, that victim, then strictly limited to $250,000? Is that a question of negligence or is that a malicious intentional act?

The reason I raise that is because though we come to the floor and have these phrases go back and forth in debate, in a courtroom it makes all the difference in the world, as in this case or similar cases where States allow punitive damages.

From my point of view, I think this bill is certainly deserving of a committee hearing where many of these questions could be asked and answered before taken up on the floor. We should have an amendment process. At the end of that process, we should decide whether or not this is the only way to deal with the malpractice insurance premium crisis, which we are facing in this country.

I will also add at this point, the Senator made reference earlier to some of the challenges facing my home State of Illinois as part of the crisis which he has referred to in his opening remarks. I might also note it was just a couple of weeks ago in his home State of Kentucky that a report that became very controversial was put together by the Program Review and Investigations Committee on the cost of medical malpractice insurance and its effect on health care. It turned out when this report was filed there were those who tried to suppress it so it would not be made public because it addressed the question of why malpractice insurance premiums were high in the State of Kentucky. They raised, I think, some important points that deserve being part of our debate, since the Senator from Kentucky has been kind enough to bring in my home State of Illinois.

This report talked about the impact of medical malpractice costs and access in Kentucky, and I quote:

> The total number of physicians in Kentucky has increased in every year for which data was available—1981 through 2000—suggesting that the cost of medical malpractice has not reduced the overall availability of physicians for the State.

It goes on to say:

> The difference of premiums in states with joint and several liability [another provision in S. 11] and other states was generally not statistically significant.

Then it went on to say:

> Premiums in states with caps on non-economic damages were not statistically different than in other states.

This is a report from the State of Kentucky written as it considered capping its own noneconomic losses. They concluded:

> Premiums in States with caps on non-economic damages were not significantly different than in other states.

It said:

> Premiums for internists and general surgeons were higher in States that capped the amount of punitive damages that may be awarded than in other states.

> . . . There was no evidence that limiting the amount that attorneys may charge for fees resulted in lower premiums.

That is from the State of Kentucky, this controversial report, which many people did not want released to the public.

I think it raises questions as to whether or not the premise of S. 11 is a sound premise. Certainly in the State of Kentucky, people who looked at it came to the opposite conclusion.

Let me say a word about attorneys' fees. There has been a lot said here about attorneys and contingency fees. The contingency fee is the way a poor person comes to court. Unless you are independently wealthy and can finance a lawsuit and pay a lawyer by the hour, your only recourse is to say to the lawyer, You recover your fee if I recover a settlement or a verdict. That is what a contingency fee is.

In this bill, S. 11, the authors go to great lengths to limit the amount of fees that can be recovered by attorneys filing medical malpractice cases.

I will tell you in my experience as a down-State Illinois attorney—I don't speak for any other part of the State or for current practitioners—it was not uncommon to say to someone coming in: I am going to charge you a 25 percent fee if we can settle this before court; a third if we have to go through a trial; and up to 40 percent if there is an appeal. You will also have to pay costs, but I will try to hold onto those in the hopes that ultimately you recover and we can take that out of the ultimate settlement.

Many people would say, What is my recourse? I can't pay for this lawsuit. I know it is expensive to hire experts, it is expensive to have attorneys prepare the case—for this lady who was a victim of malpractice and many others.

In this particular law that is before us today, we try to put, at least it is suggested that we put, limits on the amount attorneys can be paid. We take away from the individuals the right to make that decision with their own attorney.

Undoubtedly there have been abuses on attorneys' fees. I am sure that is the case, as there have been abuses on medical fees and abuses on fees charged by hospitals. But to say we are going to have a one-size-fits-all, one single approach nationwide as to the amount you can recover is in fact to work a disservice as to whether or not attorneys will be able to take these cases.

I spoke to an attorney today who took an extremely complicated case in Chicago who said before he finally reached a settlement his firm had incurred $250,000 in costs alone and there was no way that a 70-year-old plaintiff could pay them. So this attorney and his firm decided they would put the money on the table, believing the case was meritorious, hoping ultimately they could recover it if there were settlement or verdict. And there was in this case.

But in this approach here, there is an attempt to try to limit the amount attorneys can receive. I think people like the woman I showed here, this lady here, who is a victim and certainly one deserving of any compensation coming back—but she may never have her day in court, may never have an attorney, may never get a chance to submit her case to a jury of her peers if some attorney doesn't offer a contingency fee arrangement. I have serious concerns about where this will take us in terms of limiting these contingency fee contracts. That, to me, is a concern which should be I think debated and debated openly here.

I also want to raise a question—I hope if the Senator from Kentucky does not want to address the issue at this point; he will at a later point—as to his qualifications of experts in medical malpractice cases. I want to understand the limitations he is putting on the experts who come before the court.

In each trial I have been involved in, it was a decision to be made by the judge initially, and ultimately by the jury, as to the credibility of an expert witness. The difficulty which a plaintiff has in a medical malpractice lawsuit, in any city—whether it's in Illinois or Kentucky or New Hampshire—is most doctors are not anxious to testify against their colleagues. So if you are a person who has been injured in a malpractice case, you have to look hard, far, and wide to find an expert who will come to the courtroom and say the doctor did something wrong.

In this particular legislation there is a limitation on the types of doctors who can testify in medical malpractice cases. I hope tomorrow when we return to this bill the Senator from Kentucky will consider addressing that particular issue as well—what kind of limitations he puts in place. Usually it is a case for the judge to decide initially and the jury to weigh. If they take a look at the doctor who is brought in and say, This doctor doesn't even have a specialty that relates to this lawsuit, or has no experience or really no testimony, then they discount this and perhaps even reject it and maybe even use it against the party who called this doctor. But to establish standards of evidence in this law—I think at least during the course of debating this motion to proceed, we should have an opportunity to discuss the matter.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. McCONNELL. Mr. President, the Senator from Illinois mentioned the Legislative Research Service's study in Kentucky, which has been quite controversial and discredited by some. I think a more interesting study was released today by HHS here in Washington which revealed that the States' that enacted limits on noneconomic damages and medical losses have been about 12 percent more for physicians per capita than States without such a cap.

As was pointed out earlier by a number of speakers on this side of the issue, California and Colorado tend to prove the point. This legislation is modeled after the California legislation. They enjoy lower malpractice insurance premiums in California. Widely believed by everyone is that the reason for that is a sensible system of caps on noneconomic damages.

With regard to the limitation of lawyer's fees, I would remind everyone that is for the benefit of the victim because every penny the lawyer doesn't get, the victim does. The notion that somehow there would not be lawyers available to pursue worthy litigation if there were some kind of reasonable cap on lawyer's fees, it seems to me, is not substantiated by the facts. Under the Federal Tort Claims Act, there has been a 25-percent cap for many years. I never heard of any crisis created by the absence of lawyers willing to bring litigation under the Federal Tort Claims Act. Certainly there should be a reasonable limitation on fees. We want to make it possible for lawyers to be adequately compensated. But to protect the victim from his own lawyer, it seems to me that some reasonable limitation is appropriate. This bill includes what we believe to be a reasonable limitation.

The Senator from Illinois also suggested the bill only allows punitive damages in case of malicious intent. It is not just malicious intent; the bill also allows punitive damages when the doctor deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. Interpreted, that means that would apply to the situation of the drunk doctor Senator DURBIN refers to, or a doctor who was on drugs or somehow incapacitated through this kind of behavior. This would clearly mean that punitive damages would be allowed in this case.

We are making a careful list of all the questions which the Senator from Illinois asked. All of them are good questions. They deserve a response and further argument for getting past the motion to proceed and getting onto the bill. So if there are improvements that the Senator from Illinois and others think should be made to the bill, offer those amendments, debate them, vote on them. It could well be that by the time we get to the end of this bill it would be in such a form that the Senator from Illinois might applaud and want to clear the Senate. Who knows.

But at the moment, what we are left with is a cloture motion which the leader will later file on the motion to proceed in order to even get into a position to do anything beyond having an interesting back and forth conversation between the Senator from Illinois and myself and get beyond that and actually begin to offer amendments to the bill and have debate on them and see where the votes may lie.

I think that pretty well covers my observations for today. We look forward to continuing the discussion tomorrow.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from Kentucky for his invitation to improve the bill. I believe it would be a better exercise done in a committee setting with experts and witnesses and Senators having the opportunity to debate it openly and amend it and to include not just changes to the rights of malpractice victims to recover, but also the insurance industry and the medical profession. I think all of those would make for a very constructive and important and timely undertaking which, unfortunately, we are not doing here.

This is a vote to bring this bill to the floor immediately, and to literally debate it and pass it in a span of 3 or 4 weeks that we have left before the August recess.

I might also add that California is often referred to in this debate. It is true that in 1975 California passed a malpractice law which put caps on the amount that individuals could recover from malpractice lawsuits. They have not changed that $250.000 cap in the interim. The actual value has been calculated. Because there has been some 28 years since California put that in place, inflation has really taken its toll on $250.000. Its value today is about $38.877.

Mr. McCONNELL. Mr. President, will the Senator yield for a question on that point?

Mr. DURBIN. I am happy to yield.

Mr. McCONNELL. If we indexed that amount under this bill, would the Senator then support the bill?

Mr. DURBIN. I would be open to the Senator bringing that in as an option, as long as we are dealing with honest figures and fair compensation. But I would also say that in most States which have caps, there are exceptions. For instance, in the State of Mississippi, there were exceptions where judges could see extraordinary cases like the one I mentioned earlier and say that should not be subject to the caps. My problem with California is it is a blanket cap.

Mr. McCONNELL. I agree with the Senator from Illinois that some kind of inflation adjustment is an appropriate suggestion.

Mr. DURBIN. I hope the Senator also agrees with me that we ought to allow some exceptions to the cap. I don't want to put words in his mouth. But that is what I think. I think those exceptions should be allowed.

I would also say it is important to remember if there has been any containment of malpractice premiums in California, they also followed Proposition 103 which is insurance reform. It is not just the limitation on malpractice law that California has, but they passed insurance reform. After that reform, we saw some changes in the amount that was charged to physicians.

The last point I want to make is this: There has been talk that if we don't do something about malpractice insurance, some doctors are forced to leave the State in which they are practicing. I don't doubt that is a fact. I have spoken to doctors in Illinois in specialties in certain areas who are seriously considering leaving. I hope they don't have to. I hope we can do something here to avoid it.

But the fact is, in California there are indicators of significant physician dissatisfaction with medical malpractice, and they have the caps. There appears to be widespread problems recruiting physicians. Only a third of California physicians would still choose to practice in California, if they had to do it over today.

To suggest that this is all about malpractice premiums and whether you have a cap on how much victims of malpractice can recover, the California experience does not necessarily prove that.

Let me also say I would take exception—and we can debate this, I am sure—to my colleague's interpretations of the punitive damage section. It is true there are two elements here for punitive damages. They are both possibilities.

One is that the person who is being charged with malpractice has acted with "malicious intent to injure the claimant."

So that is an intentional act.

Then it goes on to say, "or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer."

I would say to my colleague from Kentucky and those who drafted this bill that is unusual wording, and wording I am not familiar with. I would have to study that. But I think to talk about the deliberate act rises to intentional conduct again. The example I used was not a deliberate act but the act of a doctor who was under the influence of alcohol or drugs who may have imbibed or taken drugs, and then in that state of mind did a careless thing which resulted in medical malpractice. Whether that is included in the phrase "deliberately failed to avoid unnecessary injury," I think is arguable. It should be clarified.

I also want to say in fairness to my friend from Kentucky, since Kentucky and Illinois have been part of this debate, that a report of Wednesday, August 9, 2000, in the Courier Journal noted that 329 physicians had been disciplined in Kentucky for alcohol or drug abuse, incompetence, and other offenses from 1990–1999 according to a report issued on questionable doctors.

I might also say, Kentucky was ranked as one of the 10 best States in 1999 in responding to this problem. I only raise that because, as painful as it is to concede by anyone, including those on the Senate floor, and certainly those in the medical profession, there are, in fact, cases where individuals have been involved in alcohol and drug abuse and then involved in malpractice.

What I am hoping we can do, if we seriously want to deal with the malpractice issue, is to go beyond limiting the amount that victims can recover and bringing this conversation to how we police the ranks, so doctors who are not doing the right thing are not going to continue to commit malpractice. That isn't fair to the patients, and it certainly isn't fair to other members of their profession who end up paying higher premiums as a result of it. I think that should be part of any legitimate discussion that deals with this malpractice crisis.

Mr. President, I know my colleague from Kentucky has yielded the floor for the evening, and I am prepared now, for my side, to close the debate on this matter and perhaps return to it tomorrow. At this point, until the Senate business is clear, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DASCHLE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DASCHLE. Mr. President, I did not come to the floor to talk specifically about this debate but I commend the distinguished Senator from Illinois for his excellent presentation today and for the work he has already committed to with our colleague, Senator GRAHAM, and others in an effort to try to resolve this matter and provide some meaningful direction and leadership.

I am disappointed we find ourselves in the position we are in, both procedurally as well as substantively—procedurally because this bill, obviously, has not had the benefit of committee consideration. The majority leader, as is his right, brought it directly to the floor.

We have a model we used last year to resolve issues of controversy of this nature, in particular the terrorism insurance bill. That bill was brought to the floor after a significant degree of consultation and cooperation and, ultimately, negotiation. As a result of that negotiation, even though the whole question of jury awards and issues involving tort reform were brought up—because there were some who argued that was the only way to resolve this issue involving terrorism and the problems of insurance related to terrorism—we passed the legislation on a bipartisan basis.

If you ask anybody today in the industry, they will tell you that insurance premiums have gone down dramatically. The terrorism insurance bill has worked. I would only hope that we could use a model such as that with this issue as well. We can find legitimate, bipartisan, constructive, substantive ways to deal with this issue.

There is no question this is a problem. There is no question that unless we address the problem successfully, it will become even more of a problem, exacerbated by the month. So clearly we have to address it. The question is how to address it.

If you look at independent analysis done over and over by studies—the most recent, the Weiss study, issued about 3 weeks ago—those studies have shown conclusively, and I would say almost unanimously, that there is no connection between caps and reduced insurance premiums, none.

So we know we have to find a way to deal with the very legitimate problem being faced today by physicians across the country. The question is how.

I give great credit to the Senator from Illinois and the Senator from South Carolina and others who have tried to find a way to address this issue in a meaningful, effective, and, ultimately, bipartisan manner. I hope we can continue to work.

There is a problem on the other side as well. We want to relieve the problem, financially, that doctors are facing but let us not forget that we had reported by Health and Human Services that there were approximately 100,000 deaths due to malpractice last year. Mr. President, 100,000 people died due to mistakes made in the operating room, in the hospital, in the clinic. I will talk more about this at a later date but there are cases in South Dakota that are troubling.

So while we ought to be concerned with one side of this ledger, let us not forget the real problem that exists, as the Senator from Illinois has said so powerfully this afternoon, on the other side of the ledger. Let's find that balance. I hope we can do that.

But the reason I oppose the motion to proceed is because we have not really allowed the same opportunity that worked with terrorism insurance to work here. If Senator DURBIN and Senator GRAHAM can work together to find some solution, you would think there could be other ways with which we could use that terrorism model and truly find a constructive, bipartisan solution to this issue.

Jamming this in the Senate, overriding the committee, and filing cloture on the motion to proceed is not the way to achieve some bipartisan consensus on a very legitimate issue. So we will vote in opposition to the motion to proceed, not because we do not want to address the issue but because there is a better model if we are ultimately going to find a solution. That is what it is we are trying to do. Let's use the model we established last year. I would hope we could do that.

But we are spinning our wheels. We have 4 weeks in July, 4 weeks in September, maybe a week or two in October—roughly 10 weeks to deal with all the appropriations bills, all of the other issues that have come before the Senate so far, a prescription drug bill, the child tax credit legislation that is still languishing here, and an education bill that falls far short of even what the President said he would commit with regard to resources.

We have a homeland security situation now, we are told by a report by Senators Rudman and Hart, that falls $98 billion short of where we need to be. One of the most stunning comments in that most recent report is that there isn't a first responder in the country that will survive today a chemical, biological, or nuclear attack to respond in the first place. That is right out of the report. So if we are serious about dealing with the Nation's issues, I hope we will not look at the ideological agenda. I hope we will look at the real agenda.

I understand the President is going to be spending some time traveling the country over the course of the next several days talking about jobs. I hope he does. When we look at all the administrations, from the very first time we started looking at whether jobs were created or lost in any administration, you cannot find one—you cannot find one—where in the first term of an administration that administration was actually responsible for the loss of jobs, not the gain of jobs. We gained them in the Eisenhower administration, the Kennedy administration, the Johnson administration, all through the 1980s and 1990s. This will be the first administration since Herbert Hoover that has actually seen a net loss of jobs—so far 3 million of those jobs in the first 2½ years.

So my point in raising these other issues is simply to say we have a lot of work to do. The more we spend time on ideological agendas and issues for which there has not been adequate committee consideration, much less an effort made by people on both sides of the aisle to address them in a substantive way rather than in a political way, we are going to lose time and lose an opportunity to address these issues.

Mr. President, I know the majority leader came to the Senate floor earlier to talk about how unprecedented it is to consider the possibility of a filibuster on a judge. I go back to our record and I will say we have broken all records with regard to the speedy confirmation of judges. The New York Times again addressed it over the weekend.

Out of 134 judges considered so far under this administration, 132 have been confirmed; 132 confirmed and 2 have not so far. But for the record I want to make sure people understand. Michael Gerhardt is one of the most respected analysts and experts with regard to the constitutionality of advice and consent. I want to read one segment of a speech he gave a few weeks ago. He talks about the historical practices of the constitutional right of advice and consent, especially as it applies to the rules of the Senate.

Obviously, we talk about rule XXII, and we are very cognizant of the importance of Senate rules in this regard. Senate historical practice, according to Mr. Gerhardt, goes back to the first recorded filibuster of a judge in 1881, to block President Hayes's nomination of Stanley Matthews to the Supreme Court. Numerous nominees before him were denied votes by delay—in other words, they didn't come to the floor—which has been a common practice for the 215 years the Senate has been meeting. But on the very first occasion of a recorded filibuster, in 1881, President Hayes's nomination was defeated; that being of Stanley Matthews.

From 1949 to the year 2002, 35 nominations were filibustered, 3 fatally, including Abe Fortas's nomination as Chief Justice. Seventeen of those thirty-five filibusters were of judicial nominations. From 1968 to 2002, Republicans filibustered against 19 Presidential nominations. So these historical practices weigh heavily in support, of course, of the constitutionality in addition to the language itself.

That really doesn't tell the whole story: Thirty-five nominations, seventeen filibustered against judicial nominations by Republicans since 1968. But the other story is the 65 nominations filibustered by 1 person in the committee, not on the floor. Sixty-five nominations failed to come out of the Judiciary Committee because of a hold respected by the majority leader at the time or by a committee chairman. Ten had hearings. Fifty-five did not. Sixty-five nominations died before they could even be considered by the Senate on the Senate floor.

You have 35 nominations which came to the floor, 17 of which were judicial, all of which were filibustered, the 17 by Republicans, but 65 didn't even have the opportunity to come to the Senate floor for even a vote on cloture.

I want to make sure the record, as the majority leader discussed the issue earlier today, is complete with regard to judicial nominations as well.

Again, I go back to my hope that we can look back on those occasions when we actually succeeded at addressing a real problem and how it was we did so.

We succeeded with terrorism insurance because people such as DICK DURBIN and MITCH MCCONNELL and others sat down and negotiated and ultimately came to a resolution that solved a problem, solved it almost, I would say today, by acclamation. Nobody would differ with that assertion that we have solved, at least for now, the issue on terrorism insurance, even though it had many of the same questions involving it that we are dealing with today regarding malpractice.

We have a lot of work to do. I hope we can address education and jobs and prescription drugs and the child tax credit and homeland security, not to mention energy and a lot of other issues that have to be addressed in the month before we leave. We can spend our time more productively. I hope that realization will be one that will be accepted by our Republican colleagues sooner rather than later.

I yield the floor.

The PRESIDING OFFICER (Mr. FITZGERALD). The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, let me make a few observations about the record of the Senate this year. This year, the Senate had to complete 11 of last year's appropriations bills. There were only 13 that were supposed to pass the basic work of the Government. This Senate had to come back and approve last year's work that was never done, 11 of the 13 appropriation bills. Last year, for the first time since the Budget Act was enacted in the early 1970s, there was no budget. The Senate never passed a budget. This year, the Senate enacted a budget.

It is important to note that this year's Senate has also enacted the President's growth package which included the third largest tax cut in American history. And just before the recently completed recess, the Senate completed a bill modernizing and preserving Medicare and adding a prescription drug benefit for our seniors, an issue that had languished over the last three or four Congresses with no action.

This has been an extraordinarily productive first part of the first session of the 108th Congress, one of which we all have a right to be proud. We are moving forward to complete the agenda for the American people.

The measure we are considering today, or hoping to consider in the course of the week, the medical liability crisis, is a major part of trying to do what we need to do to make life better for the American people.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, I rise to continue the discussion on the health care crisis that exists because of our medical liability system. It is an issue we began talking about 4 hours ago, and it is an issue that does affect every single American. I have been very pleased in listening to the debate with the wide range of issues that have been discussed. For those who have listened, I think the debate today provides a very effective beginning of a debate the American people deserve and the American people expect.

Much of the discussion today has been about procedure and the fact that we are moving to proceed with a discussion of this bill on the Senate floor. Although we can argue procedure back and forth, what we are trying to do is respond to a health care crisis that is real. The crisis affects not just doctors and providers in health care today but does, in effect, have an impact on every American, whether it is through being beneficiaries of our Government program, Medicare, Medicaid, the Federal Employees Health Benefit Plan, or through the private sector, or even for those who have no insurance today.

I will outline a little bit about how every American is affected and why it is a bill that is important to every State and every citizen in every State.

Medical malpractice premiums, as we reviewed over the course of the day, have skyrocketed in recent years. So it is a problem we have been able to identify for a period of time. A lot of people will date the debate back to the mid-1970s when MICRA, or the health care medical liability refrom that was put forth in California, was first passed and then implemented. It is an issue that in States which have not addressed the problem that is growing and is growing rapidly. We see access to doctors being threatened, especially for women, and I will come back to that particular point. Especially in rural areas, we see this access to care being threatened, and this is why it is a crisis. Access to care is being totally taken away in certain regions of the country. The AMA has a chart to be brought out, I am sure, in the next day or so that depicts those States which are in crisis. Since we last talked about some of these issues on the Senate floor, the number of States in crisis, where access to health care is threatened, has grown and grown dramatically.

Every American should participate in this debate. We hear the anecdotes. We see the trauma centers closing down. If one talks to their doctor or if my colleagues would talk to their doctors, or if the people who are listening talk to their doctors, they know it is a real problem and challenge that is increasing every day.

The situation is grave now. The crisis is there. It is getting worse and thus we bring the bill to the floor of the Senate for open debate. Once we get to the bill, it will be open for amendment where we can discuss these issues before the American people.

The horror stories are there. The headlines are there. Hospitals are closing labor wards, delivery units, obstetric units. We see the trauma centers that have either threatened to close or have actually closed. We hear the stories of the expectant mothers who are unable to find obstetricians. Doctors, especially orthopedic doctors, bone doctors, who often are in a high-risk specialty, are the ones who are involved most often in trauma centers. We see the specialties, neurosurgeons, as well as orthopedists and obstetricians, all high-risk specialities, treating the very sick in many cases, leaving their States. If they are in a high-risk State with skyrocketing premiums, they are often moving to a low-risk State. In the case of obstetricians, they are leaving the practice of specializing in the delivery of children and stopping the delivery of children totally. There are neurosurgeons who are no longer signing up to take trauma calls or work in trauma centers because of the risk of being sued. The headlines go on.

What I really want to stress as a physician, because I talk to my colleagues on a regular basis about this issue, the problem is getting worse, and getting worse by the day.

Time Magazine, June 9, the cover article—actually, I did not see Time when it came out but have gone back to look at that particular front page cover and then the articles behind it. They talk about this problem in very real terms.

I do encourage people, if they are unfamiliar with the debate, to go back and read the stories, the anecdotes, about what is happening around the country.

A year ago last July, when we talked about a particular amendment my distinguished colleague from Kentucky had offered and we debated the issue, there were 12 States that were in crisis according to criteria used by the American Medical Association. That number went from 12 States to 13, to 14, to 16, and 19. Now it is 19 States. Seven additional States have reached that threshold of being in crisis level.

Crisis level means that premiums are skyrocketing. There are increasing numbers of frivolous lawsuits, but that translates now to worse access, greater barriers to access, to everybody. All the citizens of that crisis State are harmed in the event there is a trauma accident, in the event somebody needs to see a neurosurgeon or somebody needs to see an orthopedic surgeon or somebody is going to have a baby delivered. That is really the simple reason why we need to bring this legislation to the floor now. We should not be blocking proceeding to this very important bill.

As a physician, this crisis is something I am close to because I watch what it is doing to my colleagues. These colleagues have chosen to go into this profession which is very special. I have a bias, but it is very special because they can go in and can heal, prevent disease, and people can live a better quality of life, day in, day out. That is why people go into the profession of medicine.

Yet as we talk to doctors today, many will say—and this is very different than 15 or 20 years ago—that the greatest threat to their being able to continue in this healing profession is this skyrocketing escalation of malpractice premiums. They are being forced to pay for what ends up being a lot of frivolous lawsuits. These lawsuits are engendered or occur because the current system, which needs to be reformed, gives incentives to those trial lawyers—not all trial lawyers—to go out and stir up business. I think that is what is most offensive to the American people, that a component of our liability system is unnecessarily driving up the numbers of lawsuits which in turn is diminishing access to health care. Driving up the cost of health care, which we all know, makes it more difficult for people to receive the care they deserve.

The fact that highly qualified and committed health care providers are being literally driven from the field they entered so they would have that opportunity to heal and to make others' lives better, is tragic. These individuals do not want to drop these vital services. They do not want to leave the specialities they spent years to develop, whether it is obstetrics, neurosurgery, or trauma surgery. They do not want to have to walk away from these fields. They do not want to have to leave underserved areas where this problem can be particularly bad.

Tomorrow or once we get on the bill, I will bring letters to the Senate from physicians writing if they worked in, say, the Appalachian Mountains. In underserved areas or rural areas, they are being hit particularly hard because they are having to pay these skyrocketing premiums, going from $20,000 to $40,000 to 60,000 to $80,000. They simply cannot stay in business. They cannot afford paying an $80,000 or $100,000 premium for malpractice insurance. Without the insurance, they cannot "go bare" because then if they do get sued, it destroys their livelihood and any chance of practicing medicine in the future.

The crisis is made real by the victims themselves. I hope the opponents of the underlying reform measure, or even those people who are saying, now is not the time to be addressing this in the Senate—I hope they look at those anecdotes, those individual stories now which, when accumulated in the aggregate, have reached crisis proportion. I hope they will agree that there is a crisis and now is the time to respond.

The medical liability system is the root cause of this crisis. It is the perverse incentives we need to address and that this underlying bill, when we are allowed to go to the bill, does address. The current system, with the inefficiencies, with the perverse incentives, hurts every American. In addition, it hurts the negligently injured patients it is supposed to help.

The good news is there is something to be done about the problem to make the system more fair, more just, to get rid of the waste and frivolous lawsuits. That is what the underlying bill does.

Our system encourages lawsuit abuse in lots of different ways, in part, by rewarding personal injury lawyers who file huge claims in friendly venues, looking for that big payday. These lawyers often keep up to 40 percent—I think the least is probably around 30 percent or 33 percent. They keep up to 40 percent of many of the settlements or verdicts of those injured. If there is a million-dollar verdict, for example, in some States the personal injury lawyer, the trial lawyer, pockets 40 percent, or $400,000, and the injured patient gets only $600,000.

At the same time, negligently injured patient many times don't receive any compensation at all. They are never addressed because the personal injury lawyers go after the big bucks, the big pockets, the large lawsuits. When one is negligently injured and should be appropriately compensated, the personal injury lawyers are not there to address their particular needs. Again, they are going after the big pockets, the big sum. We have a system that compensates the few all too often at the expense of the many.

The effect of these suits is staggering. Between 1996 and 2002, the average jury award in medical liability cases jumped 83 percent. Between 1997 and 2002, over that 5-year period, the percentage of medical malpractice payments of more than $1 million more than doubled. Again, this illustrates that the problem we have in this system is getting worse by the day.

The mere threat of these huge, multimillion-dollar awards forces many doctors and many insurance companies to settle cases for large amounts even if that individual physician is not guilty. The incentive is to settle, simply to avoid the exorbitant suit, even if there is no guilt involved.

We will show charts in the Senate that most of the cases filed in the U.S. courts are without merit. The most recent statistics showed that two out of three, or 67 percent, of those cases filed in U.S. courts are being dismissed or being dropped—not being settled and not actually going to trial. In addition, only 7 percent of cases actually go to trial, and a staggering 85 percent of those cases are won by the defendant.

So these numbers are clear evidence of the abuse of the current system, of the inefficiencies, of the number of lawsuits that are frivolous. It is that waste, those inefficiencies, those disincentives, those perverse incentives that this legislation addresses.

Frivolous lawsuits are unnecessarily driving up the premiums to physicians. For the most part, for the physician to stay in business with those premiums, skyrocketing premiums, increasing 10, 15, 20, 30, 40 percent a year, if that physician is to stay in business, those costs must be passed on to those patients directly.

It should be no surprise that the excessive litigation and frivolous lawsuits are forcing these malpractice premiums up. In 2002, physicians in many States did see their rates rise by 30 percent or more. In some States, and in some specialties, malpractice insurance premiums are rising by as much as 300 percent a year.

In New York and Florida, obstetricians, gynecologists, and surgeons pay more than $100,000 for every $1 million in coverage. Soon the annual premium these doctors pay could reach more than $200,000.

I mentioned earlier that the sky-high premiums uniquely affect women. This will be heard again and again in the Chamber. One of the three high-risk specialties is obstetrics. Many obstetricians are leaving the practice, leaving obstetrics, and are involved just in the practice of gynecology or family practice because they cannot afford the premiums. Right now, nearly 1 out of 11 obstetricians no longer deliver babies. Who can blame them? If you ask why, again and again it comes back to this threat of these frivolous lawsuits.

It is a tax that affects women in many ways disproportionately. If an obstetrician today pays $100,000 for premiums—and that is not unusual—say they deliver 100 babies. That is a $1,000 tax that has nothing to do with the health care that is actually delivered or the delivery itself, but it is a $1,000 tax that, in effect, is placed right on top of the delivery of that baby. Thus, if you are a woman and you have a family, you need to realize that the doctor is having to pay that $1,000 tax on each baby delivered. This cost is ultimately passed on to the patient.

This is clearly unacceptable because it reflects the waste, the perverse incentives in the system, all of which, again, can be fixed.

Again, women living in rural areas are disproportionately affected and are even more threatened by the current system.

In a June 9 front-page issue of Time magazine, there is one tragic story of an expectant mother in rural Arizona having to drive more than 2 hours on a desolate desert highway just to see a doctor. That is not the sort of story that should be happening in America, especially when we have physicians who want to stay in obstetrics, who want to practice in rural areas. However, they are being discouraged from doing so by the current system of medical liability.

If anything, the incentives should be just the opposite. We should be encouraging physicians to deliver this care to women. We ought to encourage them to go to these underserved areas which are being disproportionately affected.

It should be no surprise that the American College of Obstetrics and Gynecology is one of the strongest supporters of meaningful medical liability reform. They are uniquely positioned to understand the threat that the current system places on women. They are demanding action by Congress. I do urge my colleagues to listen to their unique concerns.

The broken liability system does more than just raise the liability premiums on individual physicians. It adds tremendous costs, both direct and indirect, throughout the health care system. We have all heard of what is called defensive medicine and the increase in defensive medicine that is, indeed, practiced because of the fear, the legitimate fear, of these outrageous and skyrocketing lawsuits. To avoid lawsuits or to make sure that they are protected as a physician if there happens to be one of these lawsuits, physicians will simply order more tests, establish more of a paper trail.

You think of the case of a simple headache. With defensive medicine, for a headache coming into the emergency room, a physician might just order, instead of a good physical exam and maybe some medicine, simple diagnostic tests. With defensive medicine we might go to the extreme of a CAT scan that might cost $800 or magnetic resonance imaging, an MRI of the head, which might cost $1,000. Why? Because people are at risk if they are in emergency rooms, treating somebody who comes to the door, even for something as simple as a headache. You do that, not just once or twice but hundreds of times, indeed thousands of times all across the United States of America—again, driven by the incentive of frivolous lawsuits being directed against you—and all of a sudden you can understand why these defensive medicine costs tens of billions every year.

Recent surveys show that 75 percent or more of doctors acknowledge practicing defensive medicine. The exact cost is hard to calculate, but we do know it is tens of billions of dollars per year. When we realize that three out of four doctors are practicing defensive medicine, those numbers seem to be very realistic.

In an authoritative study out of Stanford, two researchers there estimated that reasonable liability reform could save the country anywhere from $70 billion a year to $126 billion a year in defensive medicine expenditures; that is overall defensive medicine. If you look just at what the Federal Government could save by comprehensive medical liability reform, the Congressional Budget Office estimates about $18 billion a year could be saved over 10 years with such reform. They are looking at just the Medicare Program and the Medicaid Program and the Federal Employees Health Benefits Program.

Often in the Chamber today, a lot of people have talked about this issue of medical errors and patient safety. I think a lot of good points have been brought up in the Chamber. It is absolutely critical that we do address the issue of reporting of medical errors.

I will have to say, just listening to physicians and having been in the field of medicine myself, the current system where you know that anything you say, in terms of even a possible medical error or mistake could result in a lawsuit is unacceptable. If they are there, you need to shine a light on them, you need to elevate them, you need to talk among your peers and talk among others; that is the only way you are going to fix and reduce these medical errors.

But when above your health care system you do have some predatory lawyers who are sitting there looking for the big bucks, recognizing they are going to take home 30 percent or 40 percent of a settlement it discourages that light that we all know is critically important to allow a discussion, to allow a self-examination so you can have a system of ongoing, continuous quality improvement in health care.

In the Chamber, people have referred and will continue to refer to the report of 3 years ago by the Institute of Medicine, "To Err Is Human." A lot of these issues are talked about there. That is why I am a strong supporter of the patient safety legislation that has been developed by Senators GREGG and JEFFORDS and many others in a bipartisan way, the Patient Safety and Quality Improvement Act. That needs to be done. That needs to be addressed. But at the same time, by improving in a comprehensive way our medical liability system, we will actually improve the system itself. That will allow light to shine openly with, I believe, a lot more discussion and self-reporting by the provider system in order to have that quality improvement.

It is an inefficient system that we have today. It does waste tens of billions of dollars. It does drive underground, I believe, our ability to improve patient safety. Thus, comprehensive reform of our medical liability system is, I believe, demanded. This bill, the Patients First Act, is a commonsense measure. It does restore a balance to the system itself. It protects the right of the negligently injured patient to sue for just compensation while at the same time curtailing the abuses that we know currently exist in our system—today. It has a number of critical components. I will look forward, once we get on the bill itself, to talking about a number of those components.

I am delighted with the debate thus far. I look forward to continued participation on this important bill. We have seen at the State level that liability reform can work. This particular bill we are trying to bring to the floor is a bill based on the MICRA system, Medical Injury and Compensation Reform Act that was passed in California in the mid-1970s. We know that is a big State. It has a high cost of living. Yet the overall premiums paid by physicians there have been much more controlled than in other parts of the country. MICRA works. We have that track record. We have that to look back to. That is why I feel so good about the legislation we will hopefully bring to the floor.

There will be lots of blame passed around in terms of why the system today is not working. Some people say it is the doctors. Some people say it is hospitals. Others will say it is the insurance companies. Some people say the stock market and the bond market. We will have this crisis blamed on lots of different things as we go forward. I would argue that at the heart of the crisis is the current liability system which promotes these excessive lawsuits, and that it can be fixed. It can be fixed. That is what I look forward to doing with my colleagues on the floor of the Senate.

Passage of this measure will help on both the access issues in health care as well as the expense issues for all Americans. If we do it, and we do it right, it will improve health care for all Americans.

EXECUTIVE SESSION

NOMINATION OF BRUCE E. KASOLD, OF VIRGINIA, TO BE A JUDGE OF THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

Mr. FRIST. Pursuant to the order of June 27, I ask that the Senate proceed to executive session for the consideration of Calendar No. 132.

The PRESIDING OFFICER. The clerk will report the nomination.

The legislative clerk read the nomination of Bruce E. Kasold, of Virginia, to be judge for the United States Court of Appeals for Veterans Claims for the term prescribed by law.

RESOLUTIONS PLACED ON EXECUTIVE CALENDAR

Mr. FRIST. I now send a resolution to the desk to discharge from the Judiciary Committee the nomination of David W. McKeague, of Michigan, to be a United States Circuit Judge for the Sixth Circuit. I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, reserving the right to object, this nomination for the Sixth Circuit, and the others that will be made by the majority leader, have not had the benefit of any hearing before the Senate Judiciary Committee. I believe that hearing should take place before a lifetime appointment is given to any person to the Circuit Court. So, on behalf of Senators CARL LEVIN and DEBBIE STABENOW of Michigan, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. Mr. President, I now send a resolution to discharge from the Judiciary Committee the nomination of Susan Bieke Nielson of Michigan to be a U.S. circuit judge for the Sixth Circuit, and I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, for the same reasons, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. I now send a resolution to discharge from the Judiciary Committee the nomination of Henry W. Saad of Michigan to be a U.S. circuit judge for the Sixth Circuit, and I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, for the same reasons, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. FRIST. Mr. President, I now send a resolution to discharge from the Judiciary Committee the nomination of Richard Griffin of Michigan to be a U.S. circuit judge for the Sixth Circuit, and I ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. For the same reasons, I object.

The PRESIDING OFFICER. Objection is heard.

The foregoing resolutions will be placed on the Executive Calendar.

LEGISLATIVE SESSION

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate resume legislative session, and the motion to proceed.

The PRESIDING OFFICER. Without objection, it is so ordered.

PATIENTS FIRST ACT OF 2003—MOTION TO PROCEED—Continued

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, at the outset, I thank my colleagues and the clerical staff awaiting my arrival from the customary Monday travel day from Philadelphia to Scranton to Harrisburg to Washington. For those who may be about to venture onto the Baltimore Washington Parkway, the traffic is very heavy indeed. Although when I arrived in the Senate Chamber and I saw active debate, I am not quite sure my late arrival has caused too much inconvenience.

I support legislation which would address the serious problems faced today by doctors, hospitals and other medical professionals and at the same time provide balance to treat fairly people who are injured in the course of medical treatment.

While most of the attention has been directed to medical malpractice verdicts, the issues are much broader, involving medical errors, insurance company investments and administrative practices.

I support caps on noneconomic damages so long as they do not apply to situations like the paperwork mix-up leading to the erroneous double mastectomy of a woman or the recent death of a 17-year-old woman on a North Carolina transplant case where there was a faulty blood type match.

An appropriate standard for cases not covered could be analogous provisions in Pennsylvania law which limit actions against governmental entities or in the limited tort context which exclude death, serious impairment of bodily function, and permanent disfigurement or dismemberment.

Beyond the issue of caps, I believe there could be savings on the cost of medical malpractice insurance by eliminating frivolous cases by requiring plaintiffs to file with the court a certification by a doctor in the field that it is an appropriate case to bring to court. This proposal, which is now part of Pennsylvania State procedure, would be expanded federally, thus reducing claims and saving costs. While most malpractice cases are won by defendants, the high cost of litigation drives up malpractice premiums. The proposed certification would reduce plaintiff's joinder of peripheral defendants and cut defense costs.

Further savings could be accomplished through patient safety initiatives identified in the report of the Institute of Medicine.

On November 29, 1999, the Institute of Medicine—IOM—issued a report entitled: To Err is Human: Building a Safer Health System. The IOM Report estimated that anywhere between 44,000 and 98,000 hospitalized Americans die each year due to avoidable medical mistakes. However, only a fraction of these deaths and injuries are due to negligence; most errors are caused by system failures. The IOM issued a comprehensive set of recommendations, including the establishment of a nationwide, mandatory reporting system; incorporation of patient safety standards in regulatory and accreditation programs; and the development of a nonpunitive culture of safety in health care organizations. The report called for a 50 percent reduction in medical errors over 5 years.

The Appropriations Subcommittee on Labor, Health and Human Services and Education, which I chair, held three hearings to discuss the IOM's findings and explore ways to implement the recommendations outlined in the IOM report. The FY 2001 Labor-HHS appropriations bill contained $50 million for a patient safety initiative and directed the Agency for Healthcare Research and Quality—AHRQ—to develop guidelines on the collection of uniform error data; establish a competitive demonstration program to test best practices; and research ways to improve provider training. In Fiscal Year 2002 and Fiscal Year 2003, $55 million was included to continue these initiatives. We are awaiting a report, scheduled to be issued in September by the Department of Health and Human Services, which will detail the results of the patient safety initiative.

There is evidence that increases in insurance premiums have been caused, at least in part, by insurance company losses, the declining stock market of the past several years, and the general rate-setting practices of the industry. As a matter of insurance company calculations, premiums are collected and invested to build up an insurance reserve where there is considerable lag time between the payment of the premium and litigation which results in a verdict or settlement. When the stock market has gone down, for example, that has resulted in insufficient funding to pay claims and the attendant increase in insurance premiums. A similar result occurred in Texas on homeowners' insurance where cost and availability of insurance became an issue because companies lost money in the market and could not cover the insured losses on hurricanes.

In structuring legislation to put caps on jury verdicts, due regard should be given to the history and development of trial by jury under the common law where reliance is placed on average men and women who comprise a jury to reach a just result reflecting the values and views of the community.

Jury trials in modern tort cases descend from the common law jury in trespass, which was drawn from and intended to be representative of the average members of the community in which the alleged trespass occurred. This coincides with the incorporation of negligence standards of liability into trespass actions.

This "representative" jury right in civil actions was protected by consensus among the state drafters of the U.S. Constitution's Bill of Rights. The explicit trial by jury safeguards in the

Seventh Amendment to the Constitution were adaptations of these common law concepts harmonized with the Sixth Amendment's clause that local juries be used in criminal trials. Thus, from its inception at common law through its inclusion in the Bill of Rights and today, the jury in tort/negligence cases is meant to be representative of the judgment of average members of the community—not of elected representatives.

The right to have a jury decide one's damages has been greatly circumscribed in recent decisions of the United States Supreme Court. An example is the analysis that the Court has recently applied to limit punitive damage awards.

In recent cases, the Court has shifted its Seventh Amendment focus away from 2 centuries of precedent in deciding that Federal appellate review of punitive damage awards will be decided on a de novo basis and that a jury's determination of punitive damages is not a finding of fact for purposes of the reexamination clause of the Seventh Amendment which provides that "no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law". Then, earlier this year, the Court reasoned that any ratio of punitive damages to compensatory damages greater than 9/1 will likely be considered unreasonable and disproportionate, and thus constitute an unconstitutional deprivation of property in non-personal injury cases. Plaintiffs will inevitably face a vastly increased burden to justify a greater ratio, and appellate courts have far greater latitude to disallow or reduce such an award.

These decisions may have already, in effect, placed caps on some jury verdicts in medical malpractice cases which may involve punitive damages.

Consideration of the many complex issues on the Senate floor on the pending legislation will obviously be very difficult in the absence of a markup in committee or the submission of a committee report and a committee bill.

The pending bill is the starting point for analysis, discussion, debate, and amendment. I am prepared to proceed with the caveat that there is much work to be done before the Senate would be ready, in my opinion, for consideration of final passage.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The majority leader.

CLOTURE MOTION

Mr. FRIST. Mr. President, I now send a cloture motion to the desk on the pending motion.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the motion to proceed to the consideration of Calendar No. 186, S. 11, the Patients First Act of 2003.

Bill Frist, Mitch McConnell, John Ensign, Craig Thomas, Rick Santorum, Larry E. Craig, George V. Voinovich, John Cornyn, Trent Lott, Ted Stevens, Michael B. Enzi, James M. Inhofe, Chuck Hagel, Jon Kyl, Judd Gregg, Pat Roberts, John E. Sununu.

Mr. FRIST. Mr. President, I ask unanimous consent that the live quorum, as provided for under rule XXII, be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, this cloture vote will occur Wednesday morning. I will announce, during tomorrow's session, the precise timing of this vote for Wednesday.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

CELEBRATION OF THE 100TH ANNIVERSARY OF THE GEORGETOWN FIRE COMPANY

Mr. CARPER. Mr. President, I rise today to celebrate the 100th anniversary of the Georgetown Fire Company. Founded in 1903, the Georgetown Fire Company is only one of fifteen Delaware fire companies to achieve a century or more of service a testament of the hard work and dedication of those who have been part of this venerable organization.

Several fire companies in Delaware, particularly around rural communities, were formed in the wake of disasters. That was the case for nearby Milton, which founded its fire company in 1901. But residents and town leaders in Georgetown formed their own fire company before a major fire broke out.

On April 11, 1903, the commissioners of the Town of Georgetown advised the town's people by posting in the local newspaper, The Sussex Journal, that there would be a meeting that evening for the purpose of creating a fire company. In this posting, they stated that the formation of a fire company would decrease the cost of fire insurance within the town. There were fourteen charter members of the Georgetown Fire Company. Until that day, the community had relied solely on so-called bucket brigades and a hand-drawn ladder wagon.

Today, the fire company owns the most modern of technology and fire-fighting equipment, and what started off as a small squad of locals with minimal training has evolved into a company that today has almost 100 members, 50 of whom are active. The remaining members are life members, limited service members or honorary members, all of whom continue to help protect Georgetown. Originally located in the old fire hall building on The Circle in 1930, they moved to their new building on South Bedford Street in 1966. There, the doors are opened one evening each February for an annual fundraiser for the fire company, the legendary "Oyster Eat," which attracts people from throughout the Delmarva peninsula and beyond.

I rise today to recognize all the members of the Georgetown Fire Company, past and present, and their contributions to their beloved community. This is a historic event, especially for a nonprofit organization based solely on volunteerism. I congratulate you all and thank you for your service to the people of Georgetown and to all of Southern Delaware.

ADDITIONAL STATEMENTS

TRIBUTE TO MARGARET SEALS

● Mr. BUNNING. Mr. President, I pay tribute to one of Kentucky's finest citizens. On July 29, 2003, Margaret Seals of Winchester, will be inducted into the Kentucky Civil Rights Hall of Fame for the significant contributions she has made to the Commonwealth of Kentucky in the areas of civil and human rights.

After decades of putting the interests of others above her own, Margaret has distinguished herself as a leader. Upon attending the Lafayette Vocational School, where she developed the skills necessary to succeed, Margaret remained determined to remain a member of the workforce in order to provide for her two children. In Lexington, Margaret was the first African-American to be employed by the Social Security Administration in 1964. While she served in a number of occupational fields, some of her notable accomplishments include her service to the Winchester Board of Commissioners and the Winchester Municipal Utilities Commission.

Margaret has participated in a wide range of other public service projects including the Generations Center Board, the Urban Renewal Development Board, and the Winchester Solid Waste Committee. Her span of contributions also include the Clark County United Way Distribution Committee where she served since 1995, the same year she graduated Leadership Winchester. Margaret also remains an active member of the Elk Club. For her outstanding efforts, Reverend E. Baker, Sr., a retired pastor of the Broadway Baptist Church and an inductee into the Kentucky Civil Rights

Hall of Fame nominated Margaret to receive this distinguished honor.

Margaret's commitment to education, hard work, family, and community are an inspiration to many. Her contributions have made a difference in the lives of many and have paved a path for generations to come. Margaret's example should be emulated throughout Kentucky and across our Nation. I thank the Senate for allowing me to recognize Margaret Seals and voice her praises. She is Kentucky at its finest.●

CONGRATULATING RUTH ABBEY

● Mr. BURNS. Mr. President, I would like to congratulate Ruth Abbey of Malta, MT, on her 99th birthday. Ruth is a pillar of her community and an inspiration to many, including her children, grandchildren, great-grandchildren, and great-great-grandchildren. Ruth was a teacher for many years and subsequently served as County Superintendent of Schools.

Ruth is exemplary of our Montana way of life, and I am honored to offer my congratulations on this special occasion.●

LOCAL LAW ENFORCEMENT ACT OF 2003

● Mr. SMITH. Mr. President, I speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in West Chester, OH. On September 11, 2001, a member of the West Chester's Islamic Center was brutally attacked in the mosque's parking lot. After the beating, members of the Islamic Center received a series of physical threats and the mosque was forced to close its doors.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.●

ART STEPHENSON'S EXCEPTIONAL CONTRIBUTIONS

● Mr. SESSIONS. Mr. President, I would like to take this moment to pay tribute to Art Stephenson, former Director of NASA's Marshall Space Flight Center.

Mr. Stephenson joined Marshall in 1998, and has overseen the Center's work on critical NASA initiatives such as development of new reusable launch vehicles, Space Shuttle propulsion, advanced space transportation systems, research in microgravity, and science payload operations aboard the International Space Station, as well as the launch and continuing successful operation of the Chandra X-ray Observatory. Under his guidance the National Space Science Technology Center, a NASA partnership with local universities conducting cutting-edge propulsion research, was established and ground was broken for the critical Propulsion Research Laboratory.

For his exceptional contributions to the space program and the Nation, Art Stephenson has been recognized with the NASA Outstanding Leadership Medal, the NASA Group Achievement Award, and the NASA Exceptional Achievement Medal. In 2001, he was awarded an honorary doctorate by the University of Alabama System and was selected by the American Society for Engineering Management as the 2001 Engineering Manager of the Year. In 2002, he received the Career Achievement Award from the University of Redland, CA. Most recently, he was selected as the 2003 Martin Luther King Jr. Unity Award recipient by the Huntsville, AL, chapter of Alpha Phi Alpha Fraternity, Inc. He also received the 2003 Community Service Award from Oakwood College in Huntsville, AL.

The multiple honors and awards Art received are an indication of his devotion to our country and his dedication to NASA. Without question, Art Stephenson is a man of honor and ability, and I would like to add my thanks to those provided by so many others. His work has been given to the success of the NASA programs and he has done so without ever seeking personal gain or glory. I have been extraordinarily impressed with his integrity and commitment to service.

The State of Alabama, NASA, and the Nation are immensely proud of Art's service. He will be missed by his colleagues at Marshall Space Flight Center and those at NASA Headquarters. Our Nation owes a great deal to the Stephenson family. Art's vision pushed us all toward the ultimate goal of space exploration. His vision and that goal are both worth noting today, and I am pleased to bring them to the attention of the Senate.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE RECEIVED DURING ADJOURNMENT

Under the authority of the order of January 7, 2003, the Secretary of the Senate, on June 30, 2003, during the adjournment of the Senate, received a message from the House of Representatives announcing that the Speaker has signed the following enrolled bills and joint resolution:

H.R. 2350. An Act to reauthorize the Temporary Assistance for Needy Families block grant program through fiscal year 2003, and for other purposes.

H.R. 2474. An Act to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal years 2003 and 2004.

Under the authority of the order of January 7, 2003, as modified on June 27, 2003, the enrolled bills were signed by the Acting President pro tempore (Mr. ALLEN) on June 30, 2003.

MESSAGE FROM THE HOUSE

At 2:18 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 1. An act to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health saving accounts, to provide arrangements, and for other purposes.

MEASURES HELD OVER, UNDER THE RULE

The following resolutions were read, and held over, under the rule.

S. Res. 192. An executive resolution to discharge the David W. McKeague nomination.

S. Res. 193. An executive resolution to discharge the Susan Bieke Neilson nomination.

S. Res. 194. An executive resolution to discharge the Henry W. Saad nomination.

S. Res. 195. An executive resolution to discharge the Richard A. Griffin nomination.

ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on July 2, 2003, she had presented to the President of the United States the following enrolled bill:

S. 858. An act to extend the Abraham Lincoln Bicentennial Commission, and for other purposes.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. FRIST:

S. Res. 192. An executive resolution to discharge the David W. McKeague nomination; which was ordered to lie over, under the rule.

By Mr. FRIST:

S. Res. 193. An executive resolution to discharge the Susan Bieke Neilson nomination; which was ordered to lie over, under the rule.

By Mr. FRIST:

S. Res. 194. An executive resolution to discharge the Henry W. Saad nomination; which was ordered to lie over, under the rule.

By Mr. FRIST:

S. Res. 195. An executive resolution to discharge the Richard A. Griffin nomination; which was ordered to lie over, under the rule.

ADDITIONAL COSPONSORS

S. 11

At the request of Mr. ENSIGN, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 11, a bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

S. 98

At the request of Mr. ALLARD, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 98, a bill to amend the Bank Holding Company Act of 1956, and the Revised Statutes of the United States, to prohibit financial holding companies and national banks from engaging, directly or indirectly, in real estate brokerage or real estate management activities, and for other purposes.

S. 227

At the request of Mrs. FEINSTEIN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 227, a bill to amend the Higher Education Act of 1965 to extend loan forgiveness for certain loans to certified or licensed teachers, to provide for grants that promote teacher certification and licensing, and for other purposes.

S. 247

At the request of Ms. SNOWE, the names of the Senator from Michigan (Mr. LEVIN), the Senator from Ohio (Mr. DEWINE) and the Senator from Ohio (Mr. VOINOVICH) were added as cosponsors of S. 247, a bill to reauthorize the Harmful Algal Bloom and Hypoxia Research and Control Act of 1998, and for other purposes.

S. 537

At the request of Mr. CRAPO, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 537, a bill to ensure the availability of spectrum to amateur radio operators.

S. 557

At the request of Ms. COLLINS, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 557, a bill to amend the Internal Revenue Code of 1986 to exclude from gross income amounts received on account of claims based on certain unlawful discrimination and to allow income averaging for backpay and frontpay awards received on account of such claims, and for other purposes.

S. 623

At the request of Mr. WARNER, the names of the Senator from Georgia (Mr. CHAMBLISS), the Senator from New Mexico (Mr. DOMENICI) and the Senator from Nebraska (Mr. NELSON) were added as cosponsors of S. 623, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 639

At the request of Mr. DURBIN, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 639, a bill to designate certain Federal land in the State of Utah as wilderness, and for other purposes.

S. 875

At the request of Mr. KERRY, the name of the Senator from North Dakota (Mr. CONRAD) was added as a cosponsor of S. 875, a bill to amend the Internal Revenue Code of 1986 to allow an income tax credit for the provision of homeownership and community development, and for other purposes.

S. 894

At the request of Mr. WARNER, the names of the Senator from California (Mrs. FEINSTEIN), the Senator from Louisiana (Mr. BREAUX) and the Senator from New Mexico (Mr. BINGAMAN) were added as cosponsors of S. 894, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 230th Anniversary of the United States Marine Corps, and to support construction of the Marine Corps Heritage Center.

S. 939

At the request of Mr. HAGEL, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 939, a bill to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding of such part, to provide an exception to the local maintenance of effort requirements, and for other purposes.

S. 950

At the request of Mr. ENZI, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. 950, a bill to allow travel between the United States and Cuba.

S. 976

At the request of Mr. WARNER, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 976, a bill to provide for the issuance of a coin to commemorate the 400th anniversary of the Jamestown settlement.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 1010

At the request of Mr. HARKIN, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 1010, a bill to enhance and further research into paralysis and to improve rehabilitation and the quality of life for persons living with paralysis and other physical disabilities.

S. 1023

At the request of Mr. HATCH, the name of the Senator from Mississippi (Mr. LOTT) was withdrawn as a cosponsor of S. 1023, a bill to increase the annual salaries of justices and judges of the United States.

S. 1034

At the request of Mrs. FEINSTEIN, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 1034, a bill to repeal the sunset date on the assault weapons ban, to ban the importation of large capacity ammunition feeding devices, and for other purposes.

S. 1082

At the request of Mr. BROWNBACK, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 1082, a bill to provide support for democracy in Iran.

S. 1091

At the request of Mr. DURBIN, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 1091, a bill to provide funding for student loan repayment for public attorneys.

S. 1108

At the request of Mrs. CLINTON, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1108, a bill to establish within the National Park Service the 225th Anniversary of the American Revolution Commemorative Program, and for other purposes.

S. 1245

At the request of Ms. COLLINS, the name of the Senator from Rhode Island (Mr. CHAFEE) was added as a cosponsor of S. 1245, a bill to provide for homeland security grant coordination and simplification, and for other purposes.

S. 1252

At the request of Mr. DAYTON, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 1252, a bill to provide benefits to domestic partners of Federal employees.

S. 1297

At the request of Mr. TALENT, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 1297, a bill to amend title 28, United States Code, with respect to the jurisdiction of Federal courts inferior to the Supreme Court over certain cases and controversies involving the Pledge of Allegiance to the Flag.

S. 1303

At the request of Mr. BROWNBACK, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 1303, a bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration services, and chemotherapy support services.

S. 1333

At the request of Mr. GRASSLEY, the names of the Senator from Georgia (Mr. CHAMBLISS) and the Senator from Ohio (Mr. DEWINE) were added as cosponsors of S. 1333, a bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain expenses of rural letter carriers.

S. 1368

At the request of Mr. LEVIN, the names of the Senator from Utah (Mr. HATCH), the Senator from South Dakota (Mr. DASCHLE), the Senator from Nevada (Mr. REID), the Senator from North Carolina (Mr. EDWARDS) and the Senator from Ohio (Mr. VOINOVICH) were added as cosponsors of S. 1368, a bill to authorize the President to award a gold medal on behalf of the Congress to Reverend Doctor Martin Luther King, Jr. (posthumously) and his widow Coretta Scott King in recognition of their contributions to the Nation on behalf of the civil rights movement.

S. CON. RES. 21

At the request of Mr. BUNNING, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. Con. Res. 21, a concurrent resolution expressing the sense of the Congress that community inclusion and enhanced lives for individuals with mental retardation or other developmental disabilities is at serious risk because of the crisis in recruiting and retaining direct support professionals, which impedes the availability of a stable, quality direct support workforce.

S. CON. RES. 25

At the request of Mr. VOINOVICH, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. Con. Res. 25, a concurrent resolution recognizing and honoring America's Jewish community on the occasion of its 350th anniversary, supporting the designation of an "American Jewish History Month", and for other purposes.

S. CON. RES. 33

At the request of Mr. CRAIG, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. Con. Res. 33, a concurrent resolution expressing the sense of the Congress regarding scleroderma.

S. CON. RES. 40

At the request of Mrs. CLINTON, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as "National Purple Heart Recognition Day".

S. CON. RES. 45

At the request of Ms. LANDRIEU, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. Con. Res. 45, a concurrent resolution expressing appreciation to the Government of Kuwait for the medical assistance it provided to Ali Ismaeel Abbas and other children of Iraq and for the additional humanitarian aid provided by the Government and people of Kuwait, and for other purposes.

S. RES. 109

At the request of Mr. FEINGOLD, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S . Res. 109, a resolution expressing the sense of the Senate with respect to polio.

S. RES. 140

At the request of Mr. CAMPBELL, the names of the Senator from Connecticut (Mr. DODD), the Senator from New Mexico (Mr. BINGAMAN), the Senator from Maine (Ms. COLLINS) and the Senator from Oregon (Mr. WYDEN) were added as cosponsors of S. Res. 140, a resolution designating the week of August 10, 2003, as "National Health Center Week".

S. RES. 151

At the request of Mr. GRASSLEY, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. Res. 151, a resolution eliminating secret Senate holds.

S. RES. 167

At the request of Mr. BUNNING, his name was added as a cosponsor of S. Res. 167, a resolution recognizing the 100th anniversary of the founding of the Harley-Davidson Motor Company, which has been a significant part of the social, economic, and cultural heritage of the United States and many other nations and a leading force for product and manufacturing innovation throughout the 20th century.

S. RES. 169

At the request of Mrs. CLINTON, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. Res. 169, a resolution expressing the sense of the Senate that the United States Postal Service should issue a postage stamp commemorating Anne Frank.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 192—TO DISCHARGE THE DAVID W. MCKEAGUE NOMINATION

Mr. FRIST submitted the following resolution; which was ordered to lie over, under the rule:

S. RES. 192

Resolved, That the Committee on the Judiciary is discharged from the further consideration of the nomination of David W. McKeague, of Michigan, to be a United States Circuit Judge for the Sixth Circuit.

SENATE RESOLUTION 193—TO DISCHARGE THE SUSAN BIEKE NEILSON NOMINATION

Mr. FRIST submitted the following resolution: which was ordered to lie over, under the rule:

S. RES. 193

Resolved, That the Committee on the Judiciary is discharged from the further consideration of the nomination of Susan Bieke Neilson, of Michigan, to be a United States Circuit Judge for the Sixth Circuit.

SENATE RESOLUTION 194—TO DISCHARGE THE HENRY W. SAAD NOMINATION

Mr. FRIST submitted the following resolution; which was ordered to lie over, under the rule:

S. RES. 194

Resolved, That the Committee on the Judiciary is discharged from the further consideration of the nomination of Henry W. Saad, of Michigan, to be a United States Circuit Judge for the Sixth Circuit.

SENATE RESOLUTION 195—TO DISCHARGE THE RICHARD A. GRIFFIN NOMINATION

Mr. FRIST submitted the following resolution; which was ordered to lie over, under the rule:

S. RES. 195

Resolved, That the Committee on the Judiciary is discharged from the further consideration of the nomination of Richard A. Griffin, of Michigan, to be a United States Circuit Judge for the Sixth Circuit.

AMENDMENTS SUBMITTED & PROPOSED

SA 1134. Mr. FRIST proposed an amendment to the bill H.R. 1, to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

TEXT OF AMENDMENTS

SA 1134. Mr. FRIST proposed an amendment to the bill H.R. 1, to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes; as follows:

Amend the title so as to read: "An act to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes.".

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Wednesday, July 9, 2003, at 10 a.m. in Room 106 of the Dirksen Senate Office Building to conduct an Oversight Hearing on the Indian Gaming Regulatory Act.

Those wishing additional information may contact the Indian Affairs Committee at 224–2251.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. LOTT. Mr. President, I wish to announce that the Committee on Rules and Administration will meet at 9:30 a.m., Wednesday, July 9, 2003, in Room 301 Russell Senate Office Building to conduct a hearing on Senate Resolution 173 proposing changes in Rule XVI of the Standing Rules of the Senate as they relate to unauthorized appropriations.

For further information concerning this meeting, please contact Susan Wells at 202–224–6352.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DOMENICI. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Committee on Energy and Natural Resources.

The hearing will take place on Wednesday, July 16, at 2:30 p.m. in Room 366 Dirksen Senate Office Building in Washington, DC.

The purpose of this hearing is to consider the nomination of Suedeen G. Kelly to be a Member at the Federal Energy Regulatory Commission.

For further information, please contact Judy Pensabene of the Committee staff at 202–224–1327.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Mr. FRIST. Mr. President, I understand that the House companion bill to S. 1 is at the desk, and before the Chair appoints conferees pursuant to the order of June 26, I ask unanimous consent that the title amendment, which is at the desk, be agreed to.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 1134) was agreed to, as follows:

AMENDMENT NO. 1134

Amend the title so as to read: "An act to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes.".

The PRESIDING OFFICER. Under the previous order, H.R. 1 having been received from the House, the Senate shall proceed to its consideration, all after the enacting clause shall be stricken and the text of S. 1 as passed inserted in lieu thereof, the bill shall be read a third time and passed, with the motion to reconsider laid on the table; further, the Senate insists on its amendments and requests a conference with the House, and the Chair is authorized to appoint conferees with a ratio of 5 to 4.

The Presiding Officer appointed Mr. GRASSLEY, Mr. HATCH, Mr. NICKLES, Mr. FRIST, Mr. KYL, Mr. BAUCUS, Mr. ROCKEFELLER, Mr. DASCHLE, and Mr. BREAUX conferees on the part of the Senate.

The bill (H.R. 1), as amended, was read the third time and passed, as follows:

Resolved, That the bill from the House of Representatives (H.R. 1) entitled "An Act to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.", do pass with the following amendments:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Prescription Drug and Medicare Improvement Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

Sec. 101. Medicare voluntary prescription drug delivery program.

"PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

"Sec. 1860D. Definitions; treatment of references to provisions in MedicareAdvantage program.

"Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

"Sec. 1860D–1. Establishment of voluntary prescription drug delivery program.
"Sec. 1860D–2. Enrollment under program.
"Sec. 1860D–3. Election of a Medicare Prescription Drug plan.
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TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

"PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

"DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICAREADVANTAGE PROGRAM

"SEC. 1860D. (a) DEFINITIONS.—In this part:

"(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Center for Medicare Choices as established under section 1808.

"(2) COVERED DRUG.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

"(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section; or

"(iii) insulin described in subparagraph (C) of such section (including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator);

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—

"(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B, but shall be so considered if such payment is not available under part A or B or because benefits under such parts have been exhausted.

"(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully resolved under subsection (d) or (e)(2) of section 1860D–5.

"(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A Medicare Prescription Drug plan or a MedicareAdvantage plan may exclude from qualified prescription drug coverage any covered drug—

"(i) for which payment would not be made if section 1862(a) applied to part D; or

"(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–5(e).

"(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A and enrolled under part B (other than a dual eligible individual, as defined in section 1860D–19(a)(4)(E)).

"(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Administrator determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Drug plan, including—

"(A) a pharmaceutical benefit management company;

"(B) a wholesale or retail pharmacist delivery system;

"(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

"(D) any other risk-bearing entity; or

"(E) any combination of the entities described in subparagraphs (A) through (D).

"(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 1860D–6(c)(3), or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

"(6) MEDICAREADVANTAGE ORGANIZATION; MEDICAREADVANTAGE PLAN.—The terms 'MedicareAdvantage organization' and 'MedicareAdvantage plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to MedicareAdvantage organizations).

"(7) MEDICARE PRESCRIPTION DRUG PLAN.—The term 'Medicare Prescription Drug plan' means prescription drug coverage that is offered under a policy, contract, or plan—

"(A) that has been approved under section 1860D–13; and

"(B) by an eligible entity pursuant to, and in accordance with, a contract between the Administrator and the entity under section 1860D–7(b).

"(8) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860D–25) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

"(9) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' means the coverage described in section 1860D–6(a)(1).

"(10) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' means the coverage described in section 1860D–6(c).

"(b) APPLICATION OF MEDICAREADVANTAGE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a Medicare Prescription Drug plan and an eligible entity, unless otherwise provided in this part such provisions shall be applied as if—

"(1) any reference to a MedicareAdvantage plan included a reference to a Medicare Prescription Drug plan;

"(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

"(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

"(4) any reference to part C included a reference to this part.

"Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

"ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

"SEC. 1860D–1. (a) PROVISION OF BENEFIT.—

"(1) IN GENERAL.—The Administrator shall provide for and administer a voluntary prescription drug delivery program under which each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

"(A) MEDICAREADVANTAGE ENROLLEES RECEIVE COVERAGE THROUGH MEDICAREADVANTAGE PLAN.—

"(i) IN GENERAL.—Except as provided in clause (ii), an eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization shall receive coverage of benefits under this part through such plan.

"(ii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE MSA PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in an MSA plan under part C shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'MSA plan' has the meaning given such term in section 1859(b)(3).

"(iii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in a private fee-for-service plan under part C shall—

"(i) receive benefits under this part through such plan if the plan provides qualified prescription drug coverage; and

"(ii) if the plan does not provide qualified prescription drug coverage, receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'private fee-for-service plan' has the meaning given such term in section 1859(b)(2).

"(B) FEE-FOR-SERVICE ENROLLEES RECEIVE COVERAGE THROUGH A MEDICARE PRESCRIPTION DRUG PLAN.—An eligible beneficiary who is enrolled under this part but is not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

"(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

"(3) SCOPE OF BENEFITS.—Pursuant to section 1860D-6(b)(3)(C), the program established under this part shall provide for coverage of all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes).

"(4) PROGRAM TO BEGIN IN 2006.—The Administrator shall establish the program under this part in a manner so that benefits are first provided beginning on January 1, 2006.

"(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(1)(F)), such beneficiary—

"(1) may continue to receive such coverage and not enroll under this part; and

"(2) pursuant to section 1860D–2(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

"(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

"ENROLLMENT UNDER PROGRAM

"SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

"(1) PROCESS SIMILAR TO PART B ENROLLMENT.—The Administrator shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

"(2) CONDITION OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive access to qualified prescription drug coverage.

"(b) SPECIAL ENROLLMENT PROCEDURES.—

"(1) LATE ENROLLMENT PENALTY.—

"(A) INCREASE IN MONTHLY BENEFICIARY OBLIGATION.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1860D–17 applicable to such beneficiary by an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

"(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

"(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

"(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

"(C) PERIODS NOT TAKEN INTO ACCOUNT.—

"(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

"(ii) BENEFICIARY MUST INVOLUNTARILY LOSE COVERAGE.—Clause (i) shall only apply with respect to coverage—

"(I) in the case of coverage described in clause (ii) of subparagraph (F), if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f));

"(II) in the case of coverage described in clause (i), (iii), or (iv) of subparagraph (F), if the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage; or

"(III) in the case of a beneficiary with coverage described in clause (v) of subparagraph (F), if the issuer of the policy terminates coverage under the policy.

"(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

"(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

"(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

"(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

"(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—Subject to subparagraph (G), for purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

"(i) DRUG-ONLY COVERAGE UNDER MEDICAID.—Coverage of covered outpatient drugs (as defined in section 1927) under title XIX or a waiver under 1115 that is provided to an individual who is not a dual eligible individual (as defined in section 1860D–19(a)(4)(E)).

"(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)).

"(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

"(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

"(v) PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)).

"(G) REQUIREMENT FOR CREDITABLE COVERAGE.—Coverage described in clauses (i) through (v) of subparagraph (F) shall not be considered to be creditable coverage under this part unless the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

"(H) DISCLOSURE.—

"(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (ii) (iii), (iv), or (v) of subparagraph (F) shall provide for disclosure, consistent with standards established by the Administrator, of whether the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

"(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the application of subparagraph (G) if the individual establishes that the individual was not adequately informed that the coverage the beneficiary was enrolled in did not provide the level of benefits required in order for the coverage to be considered creditable coverage under subparagraph (F).

"(2) INITIAL ELECTION PERIODS.—

"(A) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—In the case of an individual who is an eligible beneficiary as of November 1, 2005, there shall be an open enrollment period of 6 months beginning on that date under which such beneficiary may enroll under this part without the application of the late enrollment procedures established under paragraph (1)(A).

"(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who becomes an eligible beneficiary after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

"(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—

"(A) ESTABLISHMENT.—The Administrator shall establish a special open enrollment period (as described in subparagraph (B)) for an eligible beneficiary that loses creditable prescription drug coverage.

"(B) SPECIAL OPEN ENROLLMENT PERIOD.—The special open enrollment period described in this subparagraph is the 63-day period that begins on—

"(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the later of the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan or the date the beneficiary is provided with notice of such termination or reduction;

"(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the later of the date on which the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage or the date the beneficiary is provided with notice of such loss of eligibility; or

"(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the latter of the date on which the issuer of the policy terminates coverage under the policy or the date the beneficiary is provided with notice of such termination.

"(c) PERIOD OF COVERAGE.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

"(2) OPEN AND SPECIAL ENROLLMENT.—

"(A) OPEN ENROLLMENT.—An eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2006.

"(B) SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(3) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

"(3) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2006.

"(d) TERMINATION.—

"(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

"(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PART A OR B.—

"(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Administrator shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

"(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if earlier) under part B.

"(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Administrator shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a Medicare Prescription Drug plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(1)).

"ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

"SEC. 1860D–3. (a) IN GENERAL.—

"(1) PROCESS.—

"(A) ELECTION.—

"(i) IN GENERAL.—The Administrator shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization—

"(I) shall make an election to enroll in any Medicare Prescription Drug plan that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and

"(II) may make an annual election to change the election under this clause.

"(ii) CLARIFICATION REGARDING ENROLLMENT.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in any Medicare Prescription Drug plan that has been designated by the Administrator in the area. The Administrator shall establish a process for designating a plan or plans in order to carry out the preceding sentence.

"(B) REQUIREMENTS FOR PROCESS.—In establishing the process under subparagraph (A), the Administrator shall—

"(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a MedicareAdvantage plan under section 1851, including—

"(I) the establishment of special election periods under subsection (e)(4) of such section; and

"(II) the application of the guaranteed issue and renewal provisions of section 1851(g) (other than clause (i) and the second sentence of clause (ii) of paragraph (3)(C), relating to default enrollment); and

"(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

"(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT.—The process developed under paragraph (1) shall ensure that eligible beneficiaries who enroll under this part during the open enrollment period under section 1860D–2(b)(2) are permitted to elect an eligible entity prior to January 1, 2006, in order to ensure that coverage under this part is effective as of such date.

"(b) ENROLLMENT IN A MEDICAREADVANTAGE PLAN.—

"(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization shall receive access to such coverage under this part through such plan.

"(2) RULES.—Enrollment in a MedicareAdvantage plan is subject to the rules for enrollment in such plan under section 1851.

"(c) INFORMATION TO ENTITIES TO FACILITATE ENROLLMENT.—Notwithstanding any other provision of law, the Administrator may provide to each eligible entity with a contract under this part such information about eligible beneficiaries as the Administrator determines to be necessary to facilitate efficient enrollment by such beneficiaries with such entities. The Administrator may provide such information only so long as and to the extent necessary to carry out such objective.

"PROVIDING INFORMATION TO BENEFICIARIES

"SEC. 1860D–4. (a) ACTIVITIES.—

"(1) IN GENERAL.—The Administrator shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

"(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—The activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860D–3(a)(2).

"(b) REQUIREMENTS.—

"(1) IN GENERAL.—The activities described in subsection (a) shall—

"(A) be similar to the activities performed by the Administrator under section 1851(d);

"(B) be coordinated with the activities performed by—

"(i) the Administrator under such section; and

"(ii) the Secretary under section 1804; and

"(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

"(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

"(A) BENEFITS.—The benefits provided under the plan and the formularies and grievance and appeals processes under the plan.

"(B) MONTHLY BENEFICIARY OBLIGATION.—The monthly beneficiary obligation under the plan.

"(C) QUALITY AND PERFORMANCE.—The quality and performance of the eligible entity offering the plan.

"(D) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

"(E) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan (conducted pursuant to section 1860D–5(h).

"(F) ADDITIONAL INFORMATION.—Such additional information as the Administrator may prescribe.

"BENEFICIARY PROTECTIONS

"SEC. 1860D–5. (a) DISSEMINATION OF INFORMATION.—

"(1) GENERAL INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan shall disclose, in a clear, accurate, and standardized form to each enrollee at the time of enrollment, and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

"(A) Access to covered drugs, including access through pharmacy networks.

"(B) How any formulary used by the entity functions.

"(C) Copayments, coinsurance, and deductible requirements.

"(D) Grievance and appeals processes.

The information described in the preceding sentence shall also be made available on request to prospective enrollees during open enrollment periods.

"(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll in a Medicare Prescription Drug plan, the eligible entity offering such plan shall provide information similar (as determined by the Administrator) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

"(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription Drug plan shall have a mechanism for providing on a timely basis specific information to enrollees upon request, including information on the coverage of specific drugs and changes in its formulary.

"(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan must furnish to enrolled individuals in a form easily understandable to such individuals—

"(A) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

"(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to the initial coverage limit and annual out-of-pocket limit for the current year (except that such notice need not be provided more often than monthly).

"(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

"(b) ACCESS TO COVERED DRUGS.—

"(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall have in place procedures to ensure that beneficiaries are not charged more than the negotiated price of a covered drug. Such procedures shall include the issuance of a card (or other technology) that may be used by an enrolled beneficiary for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

"(2) ASSURING PHARMACY ACCESS.—

"(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established by the Administrator under section 1860D–7(g) that ensure such convenient access. Such standards shall take into account reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.

"(B) USE OF POINT-OF-SERVICE SYSTEM.—An eligible entity offering a Medicare Prescription

Drug plan shall establish an optional point-of-service method of operation under which—

"(i) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

"(ii) the plan may charge beneficiaries through adjustments in copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860D–6(c).

"(C) LEVEL PLAYING FIELD.—An eligible entity offering a Medicare Prescription Drug plan shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, and may permit a differential amount to be paid by such enrollees.

"(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity offering a Medicare Prescription Drug plan uses a formulary, the following requirements must be met:

"(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

"(i) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

"(ii) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

"(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate.

"(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

"(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered drugs (as defined by the Administrator), although not necessarily for all drugs within such categories and classes.

"(ii) REQUIREMENT.—In defining therapeutic categories and classes of covered drugs pursuant to clause (i), the Administrator shall use—

"(I) the compendia referred to section 1927(g)(1)(B)(i); and

"(II) other recognized sources of drug classifications and categorizations determined appropriate by the Administrator.

"(D) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

"(E) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries, physicians, and pharmacists.

"(F) APPEALS AND EXCEPTIONS TO APPLICATION.—The eligible entity must have, as part of the appeals process under subsection (e), a process for timely appeals for denials of coverage based on such application of the formulary.

"(c) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(1) IN GENERAL.—An eligible entity shall have in place the following with respect to covered drugs:

"(A) A cost-effective drug utilization management program, including incentives to reduce costs when appropriate.

"(B) Quality assurance measures to reduce medical errors and adverse drug interactions and to improve medication use, which—

"(i) shall include a medication therapy management program described in paragraph (2); and

"(ii) may include beneficiary education programs, counseling, medication refill reminders, and special packaging.

"(C) A program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

"(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure) or multiple prescriptions, that covered drugs under the Medicare Prescription Drug plan are appropriately used to optimize therapeutic outcomes through improved medication use and to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(B) ELEMENTS.—Such program may include—

"(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

"(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

"(iii) detection of patterns of overuse and underuse of prescription drugs.

"(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

"(D) CONSIDERATIONS IN PHARMACY FEES.—The eligible entity offering a Medicare Prescription Drug plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

"(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

"(d) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

"(1) IN GENERAL.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with Medicare Prescription Drug plans of the eligible entity under this part in accordance with section 1852(f).

"(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply to an eligible entity with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

"(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(e) APPEALS.—

"(1) IN GENERAL.—Subject to paragraph (2), the requirements of paragraphs (4) and (5) of section 1852(g) shall apply to an eligible entity with respect to drugs not included on any formulary in a manner that is similar (as determined by the Administrator) to the manner that such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

"(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered drug that is not on a formulary of the entity under the terms applicable for a formulary drug if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(f) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the Medicare Prescription Drug plan offered by the entity, the entity shall have in place procedures to—

"(1) safeguard the privacy of any individually identifiable beneficiary information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996;

"(2) maintain such records and information in a manner that is accurate and timely;

"(3) ensure timely access by such beneficiaries to such records and information; and

"(4) otherwise comply with applicable laws relating to patient privacy and confidentiality.

"(g) UNIFORM MONTHLY PLAN PREMIUM.—An eligible entity shall ensure that the monthly plan premium for a Medicare Prescription Drug plan charged under this part is the same for all eligible beneficiaries enrolled in the plan. Such requirement shall not apply to enrollees of a Medicare Prescription Drug plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement.

"(h) CONSUMER SATISFACTION SURVEYS.—An eligible entity shall conduct consumer satisfaction surveys with respect to the plan and the entity. The Administrator shall establish uniform requirements for such surveys.

"PRESCRIPTION DRUG BENEFITS

"SEC. 1860D–6. (a) REQUIREMENTS.—

"(1) IN GENERAL.—For purposes of this part and part C, the term 'qualified prescription drug coverage' means either of the following:

"(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (c)) and access to negotiated prices under subsection (e).

"(B) ACTUARIALLY EQUIVALENT PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered drugs which meets the alternative coverage requirements of subsection (d) and access to negotiated prices under subsection (e), but only if it is approved by the Administrator as provided under subsection (d).

"(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–13(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered drugs that exceeds the coverage required under paragraph (1).

"(B) REQUIREMENT.—An eligible entity may not offer a Medicare Prescription Drug plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Drug plan in the area that only provides the coverage of prescription drugs that is required under paragraph (1).

"(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan or the MedicareAdvantage plan may use a variety of cost control mechanisms, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

"(b) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

"(c) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term 'standard prescription drug coverage' means coverage of covered drugs that meets the following requirements:

"(1) DEDUCTIBLE.—

"(A) IN GENERAL.—The coverage has an annual deductible—

"(i) for 2006, that is equal to $275; or

"(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

"(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

"(3) INITIAL COVERAGE LIMIT.—

"(A) IN GENERAL.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

"(i) for 2006, that is equal to $4,500; or

"(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

"(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

"(A) IN GENERAL.—The coverage provides benefits with cost-sharing that is equal to 10 percent after the individual has incurred costs (as described in subparagraph (C)) for covered drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

"(B) ANNUAL OUT-OF-POCKET LIMIT.—

"(i) IN GENERAL.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

"(I) for 2006, is equal to $3,700; or

"(II) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

"(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(C) APPLICATION.—In applying subparagraph (A)—

"(i) incurred costs shall only include costs incurred, with respect to covered drugs, for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3) (including costs incurred for covered drugs described in section 1860D(a)(2)(C)); and

"(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860D–19 (but only with respect to the percentage of such costs that the individual is responsible for under that section), under title XIX, or under a State pharmaceutical assistance program and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement for such costs.

"(D) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the entities in which such individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may also periodically ask individuals enrolled in a plan offered by the entity whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D–2(d).

"(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered drugs in the United States for beneficiaries under this title, as determined by the Administrator for the 12-month period ending in July of the previous year.

"(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan or MedicareAdvantage plan may provide a different prescription drug benefit design from the standard prescription drug coverage described in subsection (c) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

"(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT PRESCRIPTION DRUG COVERAGE.—

"(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (f)) is at least equal to the actuarial value (as so determined) of standard prescription drug coverage.

"(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1860D–17(c) and reinsurance payments under section 1860D–20 with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (f)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (c)(3), of an amount equal to at least the product of—

"(i) such initial coverage limit minus the deductible under subsection (c)(1); and

"(ii) the percentage specified in subsection (c)(2).

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

"(2) DEDUCTIBLE AND LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES MAY NOT VARY.—The coverage may not vary the deductible under subsection (c)(1) for the year or the limitation on out-of-pocket expenditures by beneficiaries described in subsection (c)(4) for the year.

"(e) ACCESS TO NEGOTIATED PRICES.—

"(1) ACCESS.—

"(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a MedicareAdvantage organization, the entity or organization shall provide beneficiaries with access to negotiated prices used for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the deductible, any cost-sharing, or an initial coverage limit (described in subsection (c)(3)). For purposes of this part, the term 'negotiated prices' includes all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations.

"(B) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part—

"(i) the medical assistance for such a drug shall be disregarded for purposes of a rebate agreement entered into under section 1927 which would otherwise apply to the provision of medical assistance for the drug under title XIX; and

"(ii) the prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a MedicareAdvantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(2) CARDS OR OTHER TECHNOLOGY.—

"(A) IN GENERAL.—In providing the access under paragraph (1), the eligible entity or MedicareAdvantage organization shall issue a card or use other technology pursuant to section 1860D–5(b)(1).

"(B) NATIONAL STANDARDS.—

"(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the *card or other technology required under subparagraph (A). Such standards shall be compatible with parts C and D of title XI and may be based on standards developed by an appropriate standard setting organization.*

"(ii) CONSULTATION.—In developing the standards under clause (i), the Administrator shall consult with the National Council for Prescription Drug Programs and other standard-setting organizations determined appropriate by the Administrator.

"(iii) IMPLEMENTATION.—The Administrator shall implement the standards developed under clause (i) by January 1, 2008.

"(3) DISCLOSURE.—The eligible entity offering a Medicare Prescription Drug plan and the MedicareAdvantage organization offering a MedicareAdvantage plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made available to the entity or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

"(4) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D–7(f)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a MedicareAdvantage organization offering a MedicareAdvantage plan with the auditor of the Administrator's choice.

"(f) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

"(1) PROCESSES.—For purposes of this section, the Administrator shall establish processes and methods—

"(A) for determining the actuarial valuation of prescription drug coverage, including—

"(i) an actuarial valuation of standard prescription drug coverage and of the reinsurance payments under section 1860D–20;

"(ii) the use of generally accepted actuarial principles and methodologies; and

"(iii) applying the same methodology for determinations of alternative coverage under subsection (d) as is used with respect to determinations of standard prescription drug coverage under subsection (c); and

"(B) for determining annual percentage increases described in subsection (c)(5).

Such processes shall take into account any effect that providing actuarially equivalent prescription drug coverage rather than standard prescription drug coverage has on drug utilization.

"(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and MedicareAdvantage organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

"REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

"SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Drug plan shall meet the following requirements:

"(1) LICENSURE.—Subject to subsection (c), the entity is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare Prescription Drug plan.

"(2) ASSUMPTION OF FINANCIAL RISK.—

"(A) IN GENERAL.—Subject to subparagraph (B) and subsections (d)(2) and (e) of section 1860D–13, to the extent that the entity is at risk pursuant to such section 1860D–16, the entity assumes financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Drug plan and that is not covered under section 1860D–20.

"(B) REINSURANCE PERMITTED.—To the extent that the entity is at risk pursuant to section 1860D–16, the entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

"(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the case of an eligible entity that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such entity shall meet solvency standards established by the Administrator under subsection (d).

"(b) CONTRACT REQUIREMENTS.—The Administrator shall not permit an eligible beneficiary to elect a Medicare Prescription Drug plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 1860D–16 or 1860D–20, unless the Administrator has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Drug plan. Such contract shall provide that the entity agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

"(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER TO ENSURE BENEFICIARY CHOICE.—

"(1) IN GENERAL.—In the case of an eligible entity that seeks to offer a Medicare Prescription Drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) have been met.

"(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

"(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

"(4) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this subsection to Medicare Prescription Drug plans and eligible entities—

"(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

"(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (d).

"(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

"(1) ESTABLISHMENT AND PUBLICATION.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

"(2) COMPLIANCE WITH STANDARDS.—An eligible entity that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such eligible entities with respect to such solvency standards in the manner described in section 1855(c)(2).

"(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the eligible entity to meet other requirements imposed under this part for an eligible entity.

"(f) INCORPORATION OF CERTAIN MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(4), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

"(1) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

"(2) INTERMEDIATE SANCTIONS.—Section 1857(g), except that in applying such section—

"(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

"(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

"(3) PROCEDURES FOR TERMINATION.—Section 1857(h).

"(g) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Drug plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by January 1, 2005.

"(h) PERIODIC REVIEW AND REVISION OF STANDARDS.—

"(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards if the Administrator determines such revision to be appropriate.

"(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Administrator may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on an eligible entity or a Medicare Prescription Drug plan.

"(h) RELATION TO STATE LAWS.—

"(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Drug plans which are offered by eligible entities under this part—

"(A) to the extent such law or regulation is inconsistent with such standards; and

"(B) in the same manner as such laws and regulations are superseded under section 1856(b)(3).

"(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this section:

"(A) Benefit requirements, including requirements relating to cost-sharing and the structure of formularies.

"(B) Premiums.

"(C) Requirements relating to inclusion or treatment of providers.

"(D) Coverage determinations (including related appeals and grievance processes).

"(E) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare Prescription Drug plan.

"(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to—

"(A) monthly beneficiary obligations paid to the Administrator for Medicare Prescription Drug plans under this part; or

"(B) any payments made by the Administrator under this part to an eligible entity offering such a plan.

"Subpart 2—Prescription Drug Delivery System

"ESTABLISHMENT OF SERVICE AREAS

"SEC. 1860D–10. (a) ESTABLISHMENT.—

"(1) INITIAL ESTABLISHMENT.—Not later than April 15, 2005, the Administrator shall establish and publish the service areas in which Medicare Prescription Drug plans may offer benefits under this part.

"(2) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Administrator shall periodically review the service areas applicable under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

"(b) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE AREAS.—

"(1) IN GENERAL.—The Administrator shall establish the service areas under subsection (a) in a manner that—

"(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

"(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

"(2) ADDITIONAL REQUIREMENTS.—The Administrator shall establish the service areas under subsection (a) consistent with the following requirements:

"(A) There shall be at least 10 service areas.

"(B) Each service area must include at least 1 State.

"(C) The Administrator may not divide States so that portions of the State are in different service areas.

"(D) To the extent possible, the Administrator shall include multistate metropolitan statistical areas in a single service area. The Administrator may divide metropolitan statistical areas where it is necessary to establish service areas of such size and geography as to maximize the participation of Medicare Prescription Drug plans.

"(3) MAY CONFORM TO MEDICAREADVANTAGE PREFERRED PROVIDER REGIONS.—The Administrator may conform the service areas established under this section to the preferred provider regions established under section 1858(a)(3).

"PUBLICATION OF RISK ADJUSTERS

"SEC. 1860D–11. (a) PUBLICATION.—Not later than April 15 of each year (beginning in 2005), the Administrator shall publish the risk adjusters established under subsection (b) to be used in computing—

"(1) the amount of payment to Medicare Prescription Drug plans in the subsequent year under section 1860D–16(a), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage); and

"(2) the amount of payment to MedicareAdvantage plans in the subsequent year under section 1858A(c), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

"(b) ESTABLISHMENT OF RISK ADJUSTERS.—

"(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to plans referred to in subsection (a) to take into account variation in costs based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments described in paragraphs (1) and (2) of subsection (a).

"(2) CONSIDERATIONS.—In establishing the methodology under paragraph (1), the Administrator may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MedicareAdvantage organizations.

"(3) DATA COLLECTION.—In order to carry out this subsection, the Administrator shall require—

"(A) eligible entities to submit data regarding drug claims that can be linked at the beneficiary level to part A and part B data and such other information as the Administrator determines necessary; and

"(B) MedicareAdvantage organizations (except MSA plans or a private fee-for-service plan that does not provide qualified prescription drug coverage) to submit data regarding drug claims that can be linked to other data that such organizations are required to submit to the Administrator and such other information as the Administrator determines necessary.

"SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

"SEC. 1860D–12. (a) SUBMISSION.—

"(1) IN GENERAL.—Each eligible entity that intends to offer a Medicare Prescription Drug plan in an area in a year (beginning with 2006) shall submit to the Administrator, at such time in the previous year and in such manner as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b).

"(2) ANNUAL SUBMISSION.—An eligible entity shall submit the information required under paragraph (1) with respect to a Medicare Prescription Drug plan that the entity intends to offer on an annual basis.

"(b) INFORMATION DESCRIBED.—The information described in this subsection includes information on each of the following:

"(1) The benefits under the plan (as required under section 1860D–6).

"(2) The actuarial value of the qualified prescription drug coverage.

"(3) The amount of the monthly plan premium under the plan, including an actuarial certification of—

"(A) the actuarial basis for such monthly plan premium;

"(B) the portion of such monthly plan premium attributable to standard prescription drug coverage or actuarially equivalent prescription drug coverage and, if applicable, to benefits that are in addition to such coverage; and

"(C) the reduction in such monthly plan premium resulting from the payments provided under section 1860D–20.

"(4) The service area for the plan.

"(5) Whether the entity plans to use any funds in the plan stabilization reserve fund in the Prescription Drug Account that are available to the entity to stabilize or reduce the monthly plan premium submitted under paragraph (3), and if so, the amount in such reserve fund that is to be used.

"(6) Such other information as the Administrator may require to carry out this part.

"(c) OPTIONS REGARDING SERVICE AREAS.—

"(1) IN GENERAL.—The service area of a Medicare Prescription Drug plan shall be either—

"(A) the entire area of 1 of the service areas established by the Administrator under section 1860D–10; or

"(B) the entire area covered by the medicare program.

"(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as prohibiting an eligible entity from submitting separate bids in multiple service areas as long as each bid is for a single service area.

"APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

"SEC. 1860D–13. (a) APPROVAL.—

"(1) IN GENERAL.—The Administrator shall review the information filed under section 1860D–12 and shall approve or disapprove the Medicare Prescription Drug plan.

"(2) REQUIREMENTS FOR APPROVAL.—The Administrator may not approve a Medicare Prescription Drug plan unless the following requirements are met:

"(A) COMPLIANCE WITH REQUIREMENTS.—The plan and the entity offering the plan comply with the requirements under this part.

"(B) APPLICATION OF FEHBP STANDARD.—(i) The portion of the monthly plan premium submitted under section 1860D–12(b) that is attributable to standard prescription drug coverage reasonably and equitably reflects the actuarial value of the standard prescription drug coverage less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

"(ii) If the plan provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium reasonably and equitably reflects the actuarial value of the coverage provided less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

"(b) NEGOTIATION.—In exercising the authority under subsection (a), the Administrator shall have the authority to—

"(1) negotiate the terms and conditions of the proposed monthly plan premiums submitted and other terms and conditions of a proposed plan; and

"(2) disapprove, or limit enrollment in, a proposed plan based on—

"(A) the costs to beneficiaries under the plan;

"(B) the quality of the coverage and benefits under the plan;

"(C) the adequacy of the network under the plan;

"(D) the average aggregate projected cost of covered drugs under the plan relative to other Medicare Prescription Drug plans and MedicareAdvantage plans; or

"(E) other factors determined appropriate by the Administrator.

"(c) SPECIAL RULES FOR APPROVAL.—The Administrator may approve a Medicare Prescription Drug plan submitted under section 1860D–12 only if the benefits under such plan—

"(1) include the required benefits under section 1860D–6(a)(1); and

"(2) are not designed in such a manner that the Administrator finds is likely to result in favorable selection of eligible beneficiaries.

"(d) ACCESS TO COMPETITIVE COVERAGE.—

"(1) NUMBER OF CONTRACTS.—The Administrator, consistent with the requirements of this part and the goal of containing costs under this title, shall, with respect to a year, approve at least 2 contracts to offer a Medicare Prescription Drug plan in each service area (established under section 1860D–10) for the year.

"(2) AUTHORITY TO REDUCE RISK TO ENSURE ACCESS.—

"(A) IN GENERAL.—Subject to subparagraph (B), if the Administrator determines, with respect to an area, that the access required under paragraph (1) is not going to be provided in the area during the subsequent year, the Administrator shall—

"(i) adjust the percents specified in paragraphs (2) and (4) of section 1860D–16(b) in an area in a year; or

"(ii) increase the percent specified in section 1860D–20(c)(1) in an area in a year.

The administrator shall exercise the authority under the preceding sentence only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

"(B) REQUIREMENTS FOR USE OF AUTHORITY.—In exercising authority under subparagraph (A), the Administrator—

"(i) shall not provide for the full underwriting of financial risk for any eligible entity;

"(ii) shall not provide for any underwriting of financial risk for a public eligible entity with respect to the offering of a nationwide Medicare Prescription Drug plan; and

"(iii) shall seek to maximize the assumption of financial risk by eligible entities to ensure fair competition among Medicare Prescription Drug plans.

"(C) REQUIREMENT TO ACCEPT 2 FULL-RISK QUALIFIED BIDS BEFORE EXERCISING AUTHORITY.—The Administrator may not exercise the authority under subparagraph (A) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year under paragraph (1) before the application of subparagraph (A).

"(D) REPORTS.—The Administrator, in each annual report to Congress under section 1808(c)(1)(D), shall include information on the exercise of authority under subparagraph (A). The Administrator also shall include such recommendations as may be appropriate to limit the exercise of such authority.

"(e) GUARANTEED ACCESS.—

"(1) ACCESS.—In order to assure access to qualified prescription drug coverage in an area, the Administrator shall take the following steps:

"(A) DETERMINATION.—Not later than September 1 of each year (beginning in 2005) and for each area (established under section 1860D–10), the Administrator shall make a determination as to whether the access required under subsection (d)(1) is going to be provided in the area during the subsequent year. Such determination shall be made after the Administrator has exercised the authority under subsection (d)(2).

"(B) CONTRACT WITH AN ENTITY TO PROVIDE COVERAGE IN AN AREA.—Subject to paragraph (3), if the Administrator makes a determination under subparagraph (A) that the access required under subsection (d)(1) is not going to be provided in an area during the subsequent year, the Administrator shall enter into a contract with an entity to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage enrolled in a MedicareAdvantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) during the subsequent year. An entity may be awarded a contract for more than 1 of the areas for which the Administrator is required to enter into a contract under this paragraph but the Administrator may enter into only 1 such contract in each such area.

"(C) REQUIREMENT TO ACCEPT 2 REDUCED-RISK QUALIFIED BIDS BEFORE ENTERING INTO CONTRACT.—The Administrator may not enter into a contract under subparagraph (B) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year after the Administrator has exercised the authority under subsection (d)(2) in the area for the year.

"(D) ENTITY REQUIRED TO MEET BENEFICIARY PROTECTION AND OTHER REQUIREMENTS.—An entity with a contract under subparagraph (B) shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

"(E) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under subparagraph (B).

"(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

"(A) IN GENERAL.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(B), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D–17(c)) of the monthly national average premium (as computed under section 1860D–15) for the area for the year, as adjusted using the geographic adjuster under subparagraph (B).

"(B) ESTABLISHMENT OF GEOGRAPHIC ADJUSTER.—The Administrator shall establish an appropriate methodology for adjusting the monthly beneficiary obligation (as computed under subparagraph (A)) for the year in an area to take into account differences in drug prices among areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in an area and eligible beneficiaries in other areas and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Administrator had not applied such adjustment.

"(3) PAYMENTS UNDER THE CONTRACT.—

"(A) IN GENERAL.—A contract entered into under paragraph (1)(B) shall provide for—

"(i) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

"(ii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

"(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

"(i) The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and with the entity.

"(ii) The entity provides such beneficiaries with quality clinical care.

"(iii) The entity provides such beneficiaries with quality services.

"(C) ENTITY ONLY AT RISK TO THE EXTENT OF THE FEES TIED TO PERFORMANCE REQUIREMENTS.—An entity with a contract under paragraph (1)(B) shall only be at risk for the provision of benefits under the contract to the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

"(4) ELIGIBLE ENTITY THAT SUBMITTED A BID FOR THE AREA NOT ELIGIBLE TO BE AWARDED THE CONTRACT.—An eligible entity that submitted a bid to offer a Medicare Prescription Drug plan for an area for a year under section 1860D–12, including a bid submitted after the Administrator has exercised the authority under subsection (d)(2), may not be awarded a contract under paragraph (1)(B) for that area and year. The previous sentence shall apply to an entity that was awarded a contract under paragraph (1)(B) for the area in the previous year and submitted such a bid under section 1860D–12 for the year.

"(5) TERM OF CONTRACT.—A contract entered into under paragraph (1)(B) shall be for a 1-year period. Such contract may provide for renewal at the discretion of the Administrator if the Administrator is required to enter into a contract under such paragraph with respect to the area covered by such contract for the subsequent year.

"(6) ENTITY NOT PERMITTED TO MARKET OR BRAND THE CONTRACT.—An entity with a contract under paragraph (1)(B) may not engage in any marketing or branding of such contract.

"(7) RULES FOR AREAS WHERE ONLY 1 COMPETITIVELY BID PLAN WAS APPROVED.—In the case of an area where (before the application of this subsection) only 1 Medicare Prescription Drug plan was approved for a year—

"(A) the plan may (at the option of the plan) be offered in the area for the year (under rules applicable to such plans under this part and not under this subsection);

"(B) eligible beneficiaries described in paragraph (1)(B) may receive access to qualified prescription drug coverage through enrollment in the plan or with an entity with a contract under paragraph (1)(B); and

"(C) for purposes of applying section 1860D–3(a)(1)(A)(ii), such plan shall be the plan designated in the area under such section.

"(f) TWO-YEAR CONTRACTS.—Except for a contract entered into under subsection (e)(1)(B), a contract approved under this part shall be for a 2-year period.

"COMPUTATION OF MONTHLY STANDARD PRESCRIPTION DRUG COVERAGE PREMIUMS

"SEC. 1860D–14. (a) IN GENERAL.—For each year (beginning with 2006), the Administrator shall compute a monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13 and for each MedicareAdvantage plan.

"(b) REQUIREMENTS.—The monthly standard prescription drug coverage premium for a plan for a year shall be equal to—

"(1) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides standard prescription drug coverage or an actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium approved for the plan under section 1860D–13 for the year; and

"(2) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2)—

"(A) an amount that reflects only the actuarial value of the standard prescription drug coverage offered under the plan; or

"(B) if determined appropriate by the Administrator, the monthly plan premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan (or, if applicable, the MedicareAdvantage plan) that, as required under section 1860D–6(a)(2)(B) for a Medicare Prescription Drug plans and a MedicareAdvantage plan—

"(i) is offered by such entity or organization in the same area as the plan; and

"(ii) does not provide additional prescription drug coverage pursuant to such section.

"COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

"SEC. 1860D–15. (a) COMPUTATION.—

"(1) IN GENERAL.—For each year (beginning with 2006) the Administrator shall compute a monthly national average premium equal to the average of the monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan and each MedicareAdvantage plan (as computed under section 1860D–14). Such premium may be adjusted pursuant to any methodology determined under subsection (b), as determined appropriate by the Administrator.

"(2) WEIGHTED AVERAGE.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

"(b) GEOGRAPHIC ADJUSTMENT.—The Administrator shall establish an appropriate methodology for adjusting the monthly national average premium (as computed under subsection (a))

for the year in an area to take into account differences in prices for covered drugs among different areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in that area and other eligible beneficiaries and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner as to not result in a change in aggregate payments made under this part than would have been made if the Administrator had not applied such adjustment.

"(c) SPECIAL RULE FOR 2006.—For purposes of applying this section for 2006, the Administrator shall establish procedures for determining the weighted average under subsection (a)(2) for 2005.

"PAYMENTS TO ELIGIBLE ENTITIES

"SEC. 1860D–16. (a) PAYMENT OF MONTHLY PLAN PREMIUMS.—For each year (beginning with 2006), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly plan premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

"(b) PORTION OF TOTAL PAYMENTS OF MONTHLY PLAN PREMIUMS SUBJECT TO RISK.—

"(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

"(A) IN GENERAL.—For each year (beginning in 2007), the eligible entity offering a Medicare Prescription Drug plan shall notify the Administrator of the following:

"(i) TOTAL ACTUAL COSTS.—The total amount of costs that the entity incurred in providing standard prescription drug coverage (or prescription drug coverage that is actuarially equivalent pursuant to section 1860D–6(a)(1)(B)) for all enrollees under the plan in the previous year.

"(ii) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under clause (i) for the year—

"(I) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

"(II) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

"(B) CERTAIN EXPENSES NOT INCLUDED.—The amount under subparagraph (A)(i) may not include—

"(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

"(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2);

"(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20; or

"(iv) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in subparagraph (A)(i).

"(2) ADJUSTMENT OF PAYMENT.—

"(A) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN RISK CORRIDOR.—If the allowable costs (specified in paragraph (3)) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (4)(A)(i)) for the plan for the year, then no additional payments shall be made by the Administrator and no payments shall be made by (or collected from) the eligible entity offering the plan.

"(B) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

"(i) IN GENERAL.—If the allowable costs for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Administrator shall increase the total of the monthly payments made to the entity offering the plan for the year under subsection (a) by an amount equal to the sum of—

"(I) the applicable percent (as defined in subparagraph (D)) of such allowable costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(iv)); and

"(II) 90 percent of such allowable costs which are more than such second threshold upper limit of the risk corridor.

"(ii) SPECIAL TRANSITIONAL CORRIDOR FOR 2006 AND 2007.—If the Administrator determines with respect to 2006 or 2007 that at least 60 percent of Medicare Prescription Drug plans and MedicareAdvantage Plans (excluding MSA plans or private fee-for-service plans that do not provide qualified prescription drug coverage) have allowable costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year and that such plans represent at least 60 percent of eligible beneficiaries enrolled under this part, clause (i)(I) shall be applied by substituting '90 percent' for 'applicable percent'.

"(C) PLAN PAYMENT IF ALLOWABLE COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the allowable costs for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the entity offering the plan shall a make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to—

"(i) the applicable percent (as so defined) of such allowable costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(ii)); and

"(ii) 90 percent of such allowable costs which are less than such second threshold lower limit of the risk corridor.

"(D) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term 'applicable percent' means—

"(i) for 2006 and 2007, 75 percent; and

"(ii) for 2008 and subsequent years, 50 percent.

"(3) ESTABLISHMENT OF ALLOWABLE COSTS.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year.

"(4) ESTABLISHMENT OF RISK CORRIDORS.—

"(A) IN GENERAL.—For each year (beginning with 2006), the Administrator shall establish a risk corridor for each Medicare Prescription Drug plan. The risk corridor for a plan for a year shall be equal to a range as follows:

"(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

"(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

"(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (i)(II).

"(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (ii)(II).

"(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a Medicare Prescription Drug plan offered by an eligible entity in a year—

"(i) in the case of a plan offered by an eligible entity that provides standard prescription drug coverage or actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a), reduced by the percentage specified in subparagraph (D); and

"(ii) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a) that are related to standard prescription drug coverage (determined using the rules under section 1860D–14(b)), reduced by the percentage specified in subparagraph (D).

"(C) FIRST AND SECOND THRESHOLD RISK PERCENTAGE DEFINED.—

"(i) FIRST THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

"(I) for 2006 and 2007, and 2.5 percent;

"(II) for 2008 through 2011, 5 percent; and

"(III) for 2012 and subsequent years, a percentage established by the Administrator, but in no case less than 5 percent.

"(ii) SECOND THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

"(I) for 2006 and 2007, 5.0 percent;

"(II) for 2008 through 2011, 10 percent

"(III) for 2012 and subsequent years, a percentage established by the Administrator that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

"(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to paragraph (2) of section 1860D–13(d), the Administrator may reduce the applicable first or second threshold risk percentage in an area in a year in order to ensure the access to plans required under paragraph (1) of such section.

"(D) TARGET AMOUNT NOT TO INCLUDE ADMINISTRATIVE EXPENSES NEGOTIATED BETWEEN THE ADMINISTRATOR AND THE ENTITY OFFERING THE PLAN.—For each year (beginning in 2006), the Administrator and the entity offering a Medicare Prescription Drug plan shall negotiate, as part of the negotiation process described in section 1860D–13(b) during the previous year, the percentage of the payments to the entity under subsection (a) with respect to the plan that are attributable and reasonably incurred for administrative expenses for providing standard prescription drug coverage or actuarially equivalent prescription drug coverage in the year.

"(5) PLANS AT RISK FOR ENTIRE AMOUNT OF ADDITIONAL PRESCRIPTION DRUG COVERAGE.—An eligible entity that offers a Medicare Prescription Drug plan that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2) shall be at full financial risk for the provision of such additional coverage.

"(6) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

"(7) DISCLOSURE OF INFORMATION.—

"(A) IN GENERAL.—Each contract under this part shall provide that—

"(i) the entity offering a Medicare Prescription Drug plan shall provide the Administrator with such information as the Administrator determines is necessary to carry out this section; and

"(ii) the Administrator shall have the right to inspect and audit any books and records of the eligible entity that pertain to the information regarding costs provided to the Administrator under paragraph (1).

"(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

"(c) STABILIZATION RESERVE FUND.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—There is established, within the Prescription Drug Account, a stabilization reserve fund in which the Administrator shall deposit amounts on behalf of eligible entities in accordance with paragraph (2) and such amounts shall be made available by the Secretary for the use of eligible entities in contract year 2008 and subsequent contract years in accordance with paragraph (3).

"(B) REVERSION OF UNUSED AMOUNTS.—Any amount in the stabilization reserve fund established under subparagraph (A) that is not expended by an eligible entity in accordance with paragraph (3) or that was deposited for the use of an eligible entity that no longer has a contract under this part shall revert for the use of the Prescription Drug Account.

"(2) DEPOSIT OF AMOUNTS FOR 5 YEARS.—

"(A) IN GENERAL.—If the target amount for a Medicare Prescription Drug plan for 2006, 2007, 2008, 2009, or 2010 (as determined under subsection (b)(4)(B)) exceeds the applicable costs for the plan for the year by more than 3 percent, then—

"(i) the entity offering the plan shall make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to the portion of such excess that is in excess of 3 percent of the target amount; and

"(ii) the Administrator shall deposit an amount equal to the amount collected or otherwise recovered under clause (i) in the stabilization reserve fund on behalf of the eligible entity offering such plan.

"(B) APPLICABLE COSTS.—For purposes of subparagraph (A), the term 'applicable costs' means, with respect to a Medicare Prescription Drug plan and year, an amount equal the sum of—

"(i) the allowable costs for the plan and year (as determined under subsection (b)(3)(A); and

"(ii) the total amount by which monthly payments to the plan were reduced (or otherwise recovered from the plan) for the year under subsection (b)(2)(C).

"(3) USE OF RESERVE FUND TO STABILIZE OR REDUCE MONTHLY PLAN PREMIUMS.—

"(A) IN GENERAL.—For any contract year beginning after 2007, an eligible entity offering a Medicare Prescription Drug plan may use funds in the stabilization reserve fund in the Prescription Drug Account that were deposited in such fund on behalf of the entity to stabilize or reduce monthly plan premiums submitted under section 1860D–12(b)(3).

"(B) PROCEDURES.—The Administrator shall establish procedures for—

"(i) reducing monthly plan premiums submitted under section 1860D–12(b)(3) pursuant to subparagraph (A); and

"(ii) making payments from the plan stabilization reserve fund in the Prescription Drug Account to eligible entities that inform the Secretary under section 1860D–12(b)(5) of the entity's intent to use funds in such reserve fund to reduce such premiums.

"(d) PORTION OF PAYMENTS OF MONTHLY PLAN PREMIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES TIED TO PERFORMANCE REQUIREMENTS.—

"(1) IN GENERAL.—The Administrator shall establish procedures to adjust the portion of the payments made to an entity under subsection (a) that are attributable to administrative expenses (as determined pursuant to subsection (b)(4)(D)) to ensure that the entity meets the performance requirements described in clauses (ii) and (iii) of section 1860D–13(e)(4)(B).

"(2) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

"(e) PAYMENT TERMS.—

"(1) ADMINISTRATOR PAYMENTS.—Payments to an entity offering a Medicare Prescription Drug plan under this section shall be made in a manner determined by the Administrator and based upon the manner in which payments are made under section 1853(a) (relating to payments to MedicareAdvantage organizations).

"(2) PLAN PAYMENTS.—The Administrator shall establish a process for collecting (or other otherwise recovering) amounts that an entity offering a Medicare Prescription Drug plan is required to make to the Administrator under this section.

"(f) PAYMENTS TO MEDICAREADVANTAGE PLANS.—For provisions related to payments to MedicareAdvantage organizations offering MedicareAdvantage plans for qualified prescription drug coverage made available under the plan, see section 1858A(c).

"(g) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

"COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION

"SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan in a year shall be determined as follows:

"(1) MONTHLY PLAN PREMIUM EQUALS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the applicable percent (as determined in subsection (c)) of the amount of such monthly national average premium.

"(2) MONTHLY PLAN PREMIUM LESS THAN MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for the Medicare Prescription Drug plan for the year is less than the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to—

"(A) the applicable percent of the amount of such monthly national average premium; minus

"(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

"(3) MONTHLY PLAN PREMIUM EXCEEDS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the sum of—

"(A) the applicable percent of the amount of such monthly national average premium; plus

"(B) the amount by which the monthly plan premium approved by the Administrator for the plan exceeds the amount of such monthly national average premium.

"(b) BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—In the case of an eligible beneficiary that is enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), the Medicare monthly beneficiary obligation for qualified prescription drug coverage shall be determined pursuant to section 1858A(d).

"(c) APPLICABLE PERCENT.—For purposes of this section, except as provided in section 1860D–19 (relating to premium subsidies for low-income individuals), the applicable percent for any year is the percentage equal to a fraction—

"(1) the numerator of which is 30 percent; and

"(2) the denominator of which is 100 percent minus a percentage equal to—

"(A) the total reinsurance payments which the Administrator estimates will be made under section 1860D–20 to qualifying entities described in subsection (e)(3) of such section during the year; divided by

"(B) the sum of—

"(i) the amount estimated under subparagraph (A) for the year; and

"(ii) the total payments which the Administrator estimates will be made under sections 1860D–16 and 1858A(c) during the year that relate to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

"COLLECTION OF MONTHLY BENEFICIARY OBLIGATION

"SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PFEMIUM.—

"(1) IN GENERAL.—Subject to paragraph (2), the amount of the monthly beneficiary obligation (determined under section 1860D–17) applicable to an eligible beneficiary under this part (after application of any increase under section 1860D–2(b)(1)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

"(2) PROCEDURES FOR SPONSOR TO PAY OBLIGATION ON BEHALF OF RETIREE.—The Administrator shall establish procedures under which an eligible beneficiary enrolled in a Medicare Prescription Drug plan may elect to have the sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section) in which the beneficiary is enrolled pay the amount of the monthly beneficiary obligation applicable to the beneficiary under this part directly to the Administrator.

"(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

"(1) by the beginning of each year, the name, social security account number, monthly beneficiary obligation owed by each individual enrolled in a Medicare Prescription Drug plan for each month during the year, and other information determined appropriate by the Administrator; and

"(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

"(c) COLLECTION FOR BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—For provisions related to the collection of the monthly beneficiary obligation for qualified prescription drug coverage under a MedicareAdvantage plan, see section 1858A(e).

"PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

"SEC. 1860D–19. (a) AMOUNT OF SUBSIDIES.—

"(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.—In the case of a qualified medicare beneficiary (as defined in paragraph (4)(A))—

"(A) section 1860D–17 shall be applied—

"(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

"(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

"(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

"(C) section 1860D–6(c)(2) shall be applied by substituting '2.5 percent' for '50 percent' each place it appears;

"(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 5.0 percent; and

"(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

"(2) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SPECIFIED LOW INCOME MEDICARE BENEFICIARIES AND QUALIFYING INDIVIDUALS.—In the case of a specified low income medicare beneficiary (as defined in paragraph (4)(B)) or a qualifying individual (as defined in paragraph (4)(C))—

"(A) section 1860D–17 shall be applied—

"(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

"(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

"(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

"(C) section 1860D–6(c)(2) shall be applied by substituting '5.0 percent' for '50 percent' each place it appears;

"(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 10.0 percent; and

"(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

"(3) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—

"(A) IN GENERAL.—In the case of a subsidy-eligible individual (as defined in paragraph (4)(D))—

"(i) section 1860D–17 shall be applied—

"(I) in subsection (c), by substituting 'subsidy percent' for the applicable percentage that would otherwise apply under such subsection; and

"(II) in subparagraphs (A) and (B) of subsection (a)(3), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year; and

"(ii) the annual deductible applicable under section 1860D–6(c)(1)—

"(I) for 2006, shall be reduced to $50; and

"(II) for a subsequent year, shall be reduced to the amount specified under this clause for the previous year increased by the percentage specified in section 1860D–6(c)(5) for the year involved;

"(iii) section 1860D–6(c)(2) shall be applied by substituting '10.0 percent' for '50 percent' each place it appears;

"(iv) such indivjdual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 20.0 percent; and

"(v) such individual shall be responsible for the cost-sharing described in section 1860D–6(c)(4)(A).

In no case may the application of clause (i) result in a monthly beneficiary obligation that is below 0.

"(B) SUBSIDY PERCENT DEFINED.—For purposes of subparagraph (A)(i), the term 'subsidy percent' means, with respect to a State, a percent determined on a linear sliding scale ranging from—

"(i) 0 percent with respect to a subsidy-eligible individual residing in the State whose income does not exceed 135 percent of the poverty line; to

"(ii) the highest percentage that would otherwise apply under section 1860D–17 in the service area in which the subsidy-eligible individual resides, in the case of a subsidy-eligible individual residing in the State whose income equals 160 percent of the poverty line.

"(4) DEFINITIONS.—In this part:

"(A) QUALIFIED MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'qualified medicare beneficiary' means an individual who—

"(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1905(p)(1), as determined under such plan (or under a waiver of plan); and

"(iii) is not—

"(I) a specified low-income medicare beneficiary;

"(II) a qualifying individual; or

"(III) a dual eligible individual.

"(B) SPECIFIED LOW INCOME MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'specified low income medicare beneficiary' means an individual who—

"(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iii), as determined under such plan (or under a waiver of plan); and

"(iii) is not—

"(I) a qualified medicare beneficiary;

"(II) a qualifying individual; or

"(III) a dual eligible individual.

"(C) QUALIFYING INDIVIDUAL.—Subject to subparagraph (H), the term 'qualifying individual' means an individual who—

"(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX), as determined under such plan (or under a waiver of such plan); and

"(iii) is not—

"(I) a qualified medicare beneficiary;

"(II) a specified low-income medicare beneficiary; or

"(III) a dual eligible individual.

"(D) SUBSIDY-ELIGIBLE INDIVIDUAL.—Subject to subparagraph (H), the term 'subsidy-eligible individual' means an individual—

"(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

"(ii) whose income is less than 160 percent of the poverty line; and

"(iii) who is not—

"(I) a qualified medicare beneficiary;

"(II) a specified low-income medicare beneficiary;

"(III) a qualifying individual; or

"(IV) a dual eligible individual.

"(E) DUAL ELIGIBLE INDIVIDUAL.—

"(i) IN GENERAL.—The term 'dual eligible individual' means an individual who is—

"(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that is not less than the medical assistance provided to an individual described in section 1902(a)(10)(A)(i) and includes covered outpatient drugs (as such term is defined for purposes of section 1927); and

"(II) entitled to benefits under part A and enrolled under part B.

"(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

"(F) POVERTY LINE.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

"(G) ELIGIBILITY DETERMINATIONS.—Beginning on November 1, 2005, the determination of whether an individual residing in a State is an individual described in subparagraph (A), (B), (C), (D), or (E) and, for purposes of paragraph (3), the amount of an individual's income, shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

"(H) NONAPPLICATION TO DUAL ELIGIBLE INDIVIDUALS AND TERRITORIAL RESIDENTS.—In the case of an individual who is a dual eligible individual or an individual who is not a resident of the 50 States or the District of Columbia—

"(i) the subsidies provided under this section shall not apply; and

"(ii) in the case of such an individual who is not a resident of the 50 States or the District of Columbia, such individual may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with section 1935 under the State medicaid program under title XIX.

"(I) UPDATE OF ASSET OR RESOURCE TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section that are made on or after January 1, 2009, such determinations shall be made (to the extent a State, as of such date, has not already eliminated the application of an asset or resource test under section 1905(p)(1)(C)) in accordance with the following:

"(i) SELF-DECLARATION OF VALUE.—

"(I) IN GENERAL.—A State shall permit an individual applying for such subsidies to declare and certify by signature under penalty of perjury on the application form that the value of the individual's assets or resources (or the combined value of the individual's assets or resources and the assets or resources of the individual's spouse), as determined under section 1613 for purposes of the supplemental security income program, does not exceed $10,000 ($20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse).

"(II) ANNUAL ADJUSTMENT.—Beginning on January 1, 2010, and for each subsequent year, the dollar amounts specified in subclause (I) for the preceding year shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

"(ii) METHODOLOGY FLEXIBILITY.—Nothing in clause (i) shall be construed as prohibiting a State in making eligibility determinations for premium and cost-sharing subsidies under this section from using asset or resource methodologies that are less restrictive than the methodologies used under 1613 for purposes of the supplemental security income program.

"(J) DEVELOPMENT OF MODEL DECLARATION FORM.—The Secretary shall—

"(i) develop a model, simplified application form for individuals to use in making a self-declaration of assets or resources in accordance with subparagraph (I)(i); and

"(ii) provide such form to States and, for purposes of outreach under section 1144, the Commissioner of Social Security.".

"(b) RULES IN APPLYING COST-SHARING SUBSIDIES.—Nothing in this section shall be construed as preventing an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan from waiving or reducing the amount of the deductible or other cost-sharing otherwise applicable pursuant to section 1860D–6(a)(2).

"(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall establish a process whereby, in the case of an individual eligible for a cost-sharing subsidy under subsection (a) who is enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan—

"(1) the Administrator provides for a notification of the eligible entity or MedicareAdvantage organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

"(2) the entity or organization involved reduces the cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

"(3) the Administrator periodically and on a timely basis reimburses the entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

"(d) RELATION TO MEDICAID PROGRAM.—For provisions providing for eligibility determinations and additional Federal payments for expenditures related to providing prescription drug coverage for dual eligible individuals and territorial residents under the medicaid program, see section 1935.

"REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD

"SEC. 1860D–20. (a) REINSURANCE PAYMENTS.—

"(1) IN GENERAL.—Subject to section 1860D–21(b), the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

"(2) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

"(b) NOTIFICATION OF SPENDING UNDER THE PLAN FOR COSTS INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD.—

"(1) IN GENERAL.—Each qualifying entity shall notify the Administrator of the following with respect to a qualifying covered individual for a coverage year:

"(A) TOTAL ACTUAL COSTS.—The total amount (if any) of costs that the qualifying entity incurred in providing prescription drug coverage for the individual in the year after the individual had reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

"(B) AMOUNTS RESULTING IN ACTUAL COSTS.—With respect to the total amount under subparagraph (A) for the year—

"(i) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

"(ii) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

"(2) CERTAIN EXPENSES NOT INCLUDED.—The amount under paragraph (1)(A) may not include—

"(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A);

"(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2); or

"(C) discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to coverage described in paragraph (1)(A).

"(3) RESTRICTION ON USE OF INFORMATION.—The restriction specified in section 1860D–16(b)(7)(B) shall apply to information disclosed or obtained pursuant to the provisions of this section.

"(c) REINSURANCE PAYMENT AMOUNT.—

"(1) IN GENERAL.—The reinsurance payment amount under this subsection for a qualifying covered individual for a coverage year is an amount equal to 80 percent (or 65 percent with respect to a qualifying covered individual described in subsection (e)(2)(D)) of the allowable costs (as specified in paragraph (2)) incurred by the qualifying entity with respect to the individual and year.

"(2) ESTABLISHMENT OF ALLOWABLE COSTS.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year.

"(d) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

"(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

"(e) DEFINITIONS.—In this section:

"(1) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

"(2) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

"(A) is enrolled in this part and in a Medicare Prescription Drug plan;

"(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage);

"(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan; or

"(D) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified State pharmaceutical assistance program.

"(3) QUALIFYING ENTITY.—The term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

"(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

"(B) A MedicareAdvantage organization offering a MedicareAdvantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

"(C) The sponsor of a qualified retiree prescription drug plan.

"(D) A State offering a qualified State pharmaceutical assistance program.

"(4) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

"(A) IN GENERAL.—The term 'qualified retiree prescription drug plan' means employment-based retiree health coverage if, with respect to a qualifying covered individual who is covered under the plan, the following requirements are met:

"(i) ATTESTATION OF ACTUARIAL VALUE OF COVERAGE.—The sponsor of the plan shall, annually or at such other time as the Administrator may require, provide the Administrator an attestation, in accordance with the procedures established under section 1860D–6(f), that the actuarial value of prescription drug coverage under the plan is at least equal to the actuarial value of standard prescription drug coverage.

"(ii) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Administrator access to) such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this part to and by the plan.

"(B) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

"(5) QUALIFIED STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—

"(A) IN GENERAL.—The term 'qualified State pharmaceutical assistance program' means a State pharmaceutical assistance program if, with respect to a qualifying covered individual who is covered under the program, the following requirements are met:

"(i) ASSURANCE.—The State offering the program shall, annually or at such other times as the Administrator may require, provide the Administrator an attestation that, in accordance with the procedures established under section 1860D–6(f), that—

"(I) the actuarial value of prescription drug coverage under the program is at least equal to the actuarial value of standard prescription drug coverage; and

"(II) the actuarial value of subsidies to individuals provided under the program are at least equal to the actuarial value of the subsidies that would apply under section 1860D–19 if the individual was enrolled under this part rather than under the program.

"(ii) DISCLOSURE OF INFORMATION.—The State complies with the requirements described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

"(B) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—For purposes of subparagraph (A), the term 'State pharmaceutical assistance program' means a program—

"(i) that is in operation as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003;

"(ii) that is sponsored and financed by a State; and

"(iii) that provides coverage for outpatient drugs for individuals in the State who meet income- and resource-related qualifications specified under such program.

"(6) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"(f) DISTRIBUTION OF REINSURANCE PAYMENT AMOUNTS.—

"(1) IN GENERAL.—Any sponsor meeting the requirements of subsection (e)(3) with respect to a quarter in a calendar year, but which is not an employer, shall distribute the reinsurance payments received for such quarter under subsection (c) to the employers contributing to the qualified retiree prescription drug plan maintained by such sponsor during that quarter, in the manner described in paragraphs (2) and (3).

"(2) ALLOCATION.—The reinsurance payments to be distributed pursuant to paragraph (1) shall be allocated proportionally among all employers who contribute to the plan during the quarter with respect to which the payments are received. The share allocated to each employer contributing to the plan during a quarter shall be determined by multiplying the total reinsurance payments received by the sponsor for the quarter by a fraction, the numerator of which is the total contributions made by an employer for that quarter, and the denominator of which is the total contributions required to be made to the plan by all employers for that quarter. Any share allocated to an employer required to contribute for a quarter who does not make the contributions required for that quarter on or before the date due shall be retained by the sponsor for the benefit of the plan as a whole.

"(3) TIMING.—Reinsurance payments required to be distributed to employers pursuant to this subsection shall be distributed as soon as practicable after received by the sponsor, but in no event later than the end of the quarter immediately following the quarter in which such reinsurance payments are received by the sponsor.

"(4) REGULATIONS.—The Secretary shall promulgate regulations providing that any sponsor subject to the requirements of this subsection who fails to meet such requirements shall not be eligible for a payment under this section.

"DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

"SEC. 1860D–21. (a) DIRECT SUBSIDY.—

"(1) IN GENERAL.—The Administrator shall provide for the payment to a sponsor of a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) for each qualifying covered individual (described in subparagraph (C) of section 1860D–20(e)(2)) enrolled in the plan for each month for which such individual is so enrolled.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the direct subsidy percent determined for the year of the monthly national average premium for the area for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

"(B) DIRECT SUBSIDY PERCENT.—For purposes of subparagraph (A), the term 'direct subsidy percent' means the percentage equal to—

"(i) 100 percent; minus

"(ii) the applicable percent for the year (as determined under section 1860D–17(c)).

"(b) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

"(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

"DIRECT SUBSIDIES FOR QUALIFIED STATE OFFERING A STATE PHARMACEUTICAL ASSISTANCE PROGRAM FOR PROGRAM ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

"SEC. 1860D–22. (a) DIRECT SUBSIDY.—

"(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical assistance program (as defined in section 1860D–20(e)(6)) for each qualifying covered individual (described in subparagraph (D) of section 1860D–(e)(2)) enrolled in the program for each month for which such individual is so enrolled.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the amount of payment for the area and year made under section 1860D–21(a)(2).

"(b) ADDITIONAL SUBSIDY.—

"(1) IN GENERAL.—The Administrator shall provide for the payment to a State offering a qualified State pharmaceutical program (as defined in section 1860D–20(e)(6)) for each applicable low-income individual enrolled in the program for each month for which such individual is so enrolled.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be the amount the Administrator estimates would have been made to an entity or organization under section 1860D–19 with respect to the applicable low-income individual if such individual was enrolled in this part and under a Medicare Prescription Drug plan or a MedicareAdvantage plan.

"(B) MAXIMUM PAYMENTS.—In no case may the amount of the payment determined under subparagraph (A) with respect to an applicable low-income individual exceed, as estimated by the Administrator, the average amounts made in a year under section 1860D–19 on behalf of an eligible beneficiary enrolled under this part with income that is the same as the income of the applicable low-income individual.

"(3) APPLICABLE LOW-INCOME INDIVIDUAL.—For purposes of this subsection, the term 'applicable low-income individual' means an individual who is both—

"(A) a qualifying covered individual (described in subparagraph (D) of section 1860D–(e)(2)); and

"(B) a qualified medicare beneficiary, a specified low income medicare beneficiary, or a subsidy-eligible individual, as such terms are defined in section 1860D–19(a)(4).

"(c) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

"(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

"(d) CONSTRUCTION.—Nothing in this section or section 1860D–20 shall affect the provisions of section 1860D–26(b).

"Subpart 3—Miscellaneous Provisions

"PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE . TRUST FUND

"SEC. 1860D–25. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

"(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as *may be deposited in, or appropriated to, the Account as provided in this part.*

"(3) Separate from rest of trust fund.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

"(b) Payments From Account.—

"(1) In general.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

"(A) payments to eligible entities under section 1860D–16;

"(B) payments under 1860D–19 for low-income subsidy payments for cost-sharing;

"(C) reinsurance payments under section 1860D–20;

"(D) payments to sponsors of qualified retiree prescription drug plans under section 1860D–21;

"(E) payments to MedicareAdvantage organizations for the provision of qualified prescription drug coverage under section 1858A(c); and

"(F) payments with respect to administrative expenses under this part in accordance with section 201(g).

"(2) Treatment in relation to part b premium.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

"(c) Appropriations To Cover Benefits and Administrative Costs.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments and transfers made from the Account in the year.

"OTHER RELATED PROVISIONS

"Sec. 1860D–26. (a) Restriction on Enrollment in a Medicare Prescription Drug Plan Offered by a Sponsor of Employment-Based Retiree Health Coverage.—

"(1) In general.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that is a sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section), notwithstanding any other provision of this part and in accordance with regulations of the Administrator, the entity offering the plan may restrict the enrollment of eligible beneficiaries enrolled under this part to eligible beneficiaries who are enrolled in such coverage.

"(2) Limitation.—The sponsor of the employment-based retiree health coverage described in paragraph (1) may not offer enrollment in the Medicare Prescription Drug plan described in such paragraph based on the health status of eligible beneficiaries enrolled for such coverage.

"(b) Coordination With State Pharmaceutical Assistance Programs.—

"(1) In general.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), may enter into an agreement with a State pharmaceutical assistance program described in paragraph (2) to coordinate the coverage provided under the plan with the assistance provided under the State pharmaceutical assistance program.

"(2) State pharmaceutical assistance program described.—For purposes of paragraph (1), a State pharmaceutical assistance program described in this paragraph is a program that has been established pursuant to a waiver under section 1115 or otherwise.

"(c) Regulations To Carry Out This Part.—

"(1) Authority for interim final regulations.—The Secretary may promulgate initial regulations implementing this part in interim final form without prior opportunity for public comment.

"(2) Final regulations.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).".

"(d) Waiver Authority.—The Secretary shall have authority similar to the waiver authority under section 1857(i) to facilitate the offering of Medicare Prescription Drug plans by employer or other group health plans as part of employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)), including the authority to establish separate premium amounts for enrollees in a Medicare Prescription Drug plan by reason of such coverage.".

(b) Conforming Amendments to Federal Supplementary Medical Insurance Trust Fund.—Section 1841 (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking "and" before "such amounts"; and

(B) by inserting before the period the following: ", and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D–25";

(2) in subsection (g), by inserting after "by this part," the following: "the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),";

(3) in subsection (h), by inserting after "1840(d)" the following: "and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)"; and

(4) in subsection (i), by inserting after "section 1840(b)(1)" the following: ", sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),".

(c) Conforming References to Previous Part D.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(d) Submission of Legislative Proposal.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) Study.—The Administrator of the Center for Medicare Choices (as established under section 1808 of the Social Security Act, as added by section 301(a)) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) Report.—Not later than January 1, 2005, the Administrator of the Center for Medicare Choices shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.

(a) Rules Relating to Medigap Policies That Provide Prescription Drug Coverage.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(v) Rules Relating to Medigap Policies That Provide Prescription Drug Coverage.—

"(1) Prohibition on sale, issuance, and renewal of policies that provide prescription drug coverage to part d enrollees.—

"(A) In general.—Notwithstanding any other provision of law, on or after January 1, 2006, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

"(B) Penalties.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

"(2) Issuance of substitute policies if the policyholder obtains prescription drug coverage under part d.—

"(A) In general.—The issuer of a medicare supplemental policy—

"(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F' (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)), or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

"(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

"(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the open enrollment period established under section 1860D–2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

"(B) Individual described.—An individual described in this subparagraph is an individual who—

"(i) enrolls in the medicare prescription drug delivery program under part D; and

"(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' (including the benefit package classified as 'J' with a high deductible feature, as described in section 1882(p)(11)) under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

"(C) Enforcement.—The provisions of subparagraph (A) shall be enforced as though they were included in subsection (s).

"(3) Notice required to be provided to current policyholders with prescription drug coverage.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D–2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

"(A) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

"(B) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D.".

(b) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

SEC. 104. MEDICAID AND OTHER AMENDMENTS RELATED TO LOW-INCOME BENEFICIARIES.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (64);

(2) by striking the period at the end of paragraph (65) and inserting "; and"; and

(3) by inserting after paragraph (65) the following new paragraph:

"(66) provide for making eligibility determinations under section 1935(a).".

(b) NEW SECTION.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

"SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

"SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall satisfy the following:

"(1) DETERMINATION OF ELIGIBILITY FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—For purposes of section 1807A, submit to the Secretary an eligibility plan under which the State—

"(A) establishes eligibility standards consistent with the provisions of that section;

"(B) establishes procedures for providing presumptive eligibility for eligible low-income beneficiaries (as defined in section 1807A(i)(2)) under that section;

"(C) makes determinations of eligibility and income for purposes of identifying eligible low-income beneficiaries (as so defined) under that section; and

"(D) communicates to the Secretary determinations of eligibility or discontinuation of eligibility under that section for purposes of notifying prescription drug card sponsors under that section of the identity of eligible medicare low-income beneficiaries.

"(2) DETERMINATION OF ELIGIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER PART D OF TITLE XVIII FOR LOW-INCOME INDIVIDUALS.—Beginning November 1, 2005, for purposes of section 1860D–19—

"(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with such section;

"(B) establish procedures for providing presumptive eligibility for individuals eligible for subsidies under that section;

"(C) inform the Administrator of the Center for Medicare Choices of such determinations in cases in which such eligibility is established; and

"(D) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–19).

"(3) AGREEMENT TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD OFFICES.—Enter into an agreement with the Commissioner of Social Security to use all Social Security field offices located in the State as information and enrollment sites for making the eligibility determinations required under paragraphs (1) and (2).

"(4) SCREEN AND ENROLL INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—As part of making an eligibility determination required under paragraph (1) or (2), screen an individual who applies for such a determination for eligibility for medical assistance for any medicare cost-sharing described in section 1905(p)(3) and, if the individual is eligible for any such medicare cost-sharing, enroll the individual under the State plan (or under a waiver of such plan).

"(b) FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—

"(1) ENHANCED MATCH FOR ELIGIBILITY DETERMINATIONS.—Subject to paragraphs (2) and (4), with respect to calendar quarters beginning on or after January 1, 2004, the amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under section 1903(a)(7) except that, in applying such section with respect to such expenditures incurred for—

"(A) such calendar quarters occurring in fiscal year 2004 or 2005, '75 percent' shall be substituted for '50 per centum';

"(B) calendar quarters occurring in fiscal year 2006, '70 percent' shall be substituted for '50 per centum';

"(C) calendar quarters occurring in fiscal year 2007, '65 percent' shall be substituted for '50 per centum'; and

"(D) calendar quarters occurring in fiscal year 2008 or any fiscal year thereafter, '60 percent' shall be substituted for '50 per centum'.

"(2) 100 PERCENT MATCH FOR ELIGIBILITY DETERMINATIONS FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—In the case of amounts expended by a State on or after November 1, 2005, to determine whether an individual is a subsidy-eligible individual for purposes of section 1860D–19, such expenditures shall be reimbursed under section 1903(a)(7) by substituting '100 percent' for '50 per centum'.

"(3) ENHANCED MATCH FOR UPDATES OR IMPROVEMENTS TO ELIGIBILITY DETERMINATION SYSTEMS.—With respect to calendar quarters occurring in fiscal year 2004, 2005, or 2006, the Secretary, in addition to amounts otherwise paid under section 1903(a), shall pay to each State which has a plan approved under this title, for each such quarter an amount equal to 90 percent of so much of the sums expended during such quarter as are attributable to the design, development, acquisition, or installation of improved eligibility determination systems (including hardware and software for such systems) in order to carry out the requirements of subsection (a) and section 1807A(h)(1). No payment shall be made to a State under the preceding sentence unless the State's improved eligibility determination system—

"(A) satisfies such standards for improvement as the Secretary may establish; and

"(B) complies, and is compatible, with the standards established under part C of title XI and any regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

"(4) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate expenditures described in paragraph (1), (2), or (3) that may otherwise be made for similar eligibility determinations or expenditures.

"(c) FEDERAL PAYMENT OF MEDICARE PART B PREMIUM FOR STATES PROVIDING PRESCRIPTION DRUG COVERAGE FOR DUAL ELIGIBLE INDIVIDUALS.—

"(1) IN GENERAL.—Subject to paragraph (4) and notwithstanding section 1905(b), in the case of a State that provides medical assistance for covered drugs (as such term is defined in section 1860D(a)(2)) to dual eligible individuals under this title that satisfies the minimum standards described in paragraph (2), the Federal medical assistance percentage shall be 100 percent for medicare cost-sharing described in section 1905(p)(3)(A)(ii) (relating to premiums under section 1839) for individuals—

"(A) who are dual eligible individuals or qualified medicare beneficiaries; and

"(B) whose income is at least the income required for an individual to be an eligible individual under section 1611 for purposes of the supplemental security income program (as determined under section 1612), but does not exceed 100 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

"(2) MINIMUM STANDARDS DESCRIBED.—For purposes of paragraph (1), the minimum standards described in this paragraph are the following:

"(A) In providing medical assistance for dual eligible individuals for such covered drugs, the State satisfies the requirements of this title (including limitations on cost-sharing imposed under section 1916) applicable to the provision of medical assistance for prescribed drugs to dual eligible individuals.

"(B) In providing medical assistance for dual eligible individuals for such covered drugs, the State provides such individuals with beneficiary protections that the Secretary determines are equivalent to the beneficiary protections applicable under section 1860D–5 to eligible entities offering a Medicare Prescription Drug plan under part D of title XVIII.

"(C) In providing medical assistance for dual eligible individuals for such covered drugs, the State does not impose a limitation on the number of prescriptions an individual may have filled.

"(3) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State for purposes of providing medical assistance for covered drugs (as such term is defined in section 1860D(a)(2)) to dual eligible individuals that satisfies the minimum standards described in paragraph (2).

"(4) LIMITATION.—Paragraph (1) shall not apply to any State before January 1, 2006.

"(d) FEDERAL PAYMENT OF MEDICARE PART A COST-SHARING FOR CERTAIN STATES.—

"(1) IN GENERAL.—Subject to paragraph (2) and notwithstanding section 1905(b), in the case of a State that, as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, provides medical assistance for individuals described in section 1902(a)(10)(A)(ii)(X), the Federal medical assistance percentage shall be 100 percent for medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3) (relating to coinsurance and deductibles established under title XVIII) for the individuals provided medical assistance under section 1902(a)(10)(A)(ii)(X), but only—

"(A) with respect to such medicare cost-sharing that is incurred under part A of title XVIII; and

"(B) for so long as the State elects to provide medical assistance under section 1902(a)(10)(A)(ii)(X).

"(2) LIMITATION.—Paragraph (1) shall not apply to any State before January 1, 2006.

"(e) TREATMENT OF TERRITORIES.—

"(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

"(A) the previous provisions of this section shall not apply to residents of such State; and

"(B) if the State establishes a plan described in paragraph (2), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be further increased by the amount specified in paragraph (3).

"(2) PLAN.—The plan described in this paragraph is a plan that—

"(A) provides medical assistance with respect to the provision of covered drugs (as defined in section 1860D(a)(2)) to individuals described in subparagraph (A), (B), (C), or (D) of section 1860D–19(a)(3); and

"(B) ensures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

"(3) INCREASED AMOUNT.—

"(A) IN GENERAL.—The amount specified in this paragraph for a State for a fiscal year is equal to the product of—

"(i) the aggregate amount specified in subparagraph (B); and

"(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

"(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

"(i) the last 3 quarters of fiscal year 2006, is equal to $37,500,000;

"(ii) fiscal year 2007, is equal to $50,000,000; and

"(iii) any subsequent fiscal year, is equal to the aggregate amount specified in this subparagraph for the previous fiscal year increased by the annual percentage increase specified in section 1860D–6(c)(5) for the calendar year beginning in such fiscal year.

"(4) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State described in paragraph (1) for purposes of providing medical assistance described in paragraph (2)(A).

"(5) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

"(f) DEFINITIONS.—For purposes of this section, the terms 'qualified medicare beneficiary', 'subsidy-eligible individual', and 'dual eligible individual' have the meanings given such terms in subparagraphs (A), (D), and (E), respectively, of section 1860D–19(a)(4).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting "and subsections (c)(1) and (d)(1) of section 1935" after "1933(d)".

(B) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

(3) TRANSFER OF FEDERALLY ASSUMED PORTIONS OF MEDICARE COST-SHARING.—

(A) TRANSFER OF ASSUMPTION OF PART B PREMIUM FOR STATES PROVIDING PRESCRIPTION DRUG COVERAGE FOR DUAL ELIGIBLE INDIVIDUALS TO THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841(f) (42 U.S.C. 1395t(f)) is amended—

(i) by inserting "(1)" after "(f)"; and

(ii) by adding at the end the following new paragraph:

"(2) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Treasury amounts which the Secretary of Health and Human Services shall have certified are equivalent to the amounts determined under section 1935(c)(1) with respect to all States for a fiscal year.".

(B) TRANSFER OF ASSUMPTION OF PART A COST-SHARING FOR CERTAIN STATES.—Section 1817(g) (42 U.S.C. 1395i(g)) is amended—

(i) by inserting "(1)" after "(g)"; and

(ii) by adding at the end the following new paragraph:

"(2) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Treasury amounts which the Secretary of Health and Human Services shall have certified are equivalent to the amounts determined under section 1935(d)(1) with respect to certain States for a fiscal year.".

(4) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)), as amended by section 111(b), is amended—

(A) by striking "and" at the end of subclause (IV);

(B) by striking the period at the end of subclause (V) and inserting "; and"; and

(C) by adding at the end the following new subclause:

"(VI) any prices charged which are negotiated under a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a MedicareAdvantage plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3).".

(c) EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH 2008.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as follows:

"(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2008) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;".

(2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(c) (42 U.S.C. 1396u–3(c)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking "and" at the end;

(ii) in subparagraph (E)—

(I) by striking "fiscal year 2002" and inserting "each of fiscal years 2002 through 2008"; and

(II) by striking the period and inserting "; and"; and

(iii) by adding at the end the following new subparagraph:

"(F) the first quarter of fiscal year 2009, $100,000,000."; and

(B) in paragraph (2)(A), by striking "the sum of" and all that follows through "1902(a)(10)(E)(iv)(II) in the State; to" and inserting "twice the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to".

(d) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b–14) is amended—

(1) in the section heading, by inserting "AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII" after "COST-SHARING";

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting "for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies under section 1860D–19" before the semicolon; and

(ii) in subparagraph (B), by inserting ", program, and subsidies" after "medical assistance"; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting ", the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19" after "assistance"; and

(ii) in subparagraph (A), by striking "such eligibility" and inserting "eligibility for medicare cost-sharing under the medicaid program"; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting ", for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies for low-income individuals under section 1860D–19" after "1933";

(B) in paragraph (2), by inserting ", program, and subsidies" after "medical assistance"; and

(C) by adding at the end the following:

"(3) AGREEMENTS TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD OFFICES.—

"(A) IN GENERAL.—The Commissioner shall enter into an agreement with each State operating a State plan under title XIX (including under a waiver of such plan) to establish information and enrollment sites within all the Social Security field offices located in the State for purposes of—

"(i) the State determining the eligibility of individuals residing in the State for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1902(a)(10)(E) and 1933, the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19; and

"(ii) enrolling individuals who are determined eligible for such medical assistance, program, or subsidies in the State plan (or waiver), the transitional prescription drug assistance card program under section 1807A, or the appropriate category for premium and cost-sharing subsidies under section 1860D–19.

"(B) AGREEMENT TERMS.—The Secretary and the Commissioner jointly shall develop terms for the State agreements required under subparagraph (A) that shall specify the responsibilities of the State and the Commissioner in the establishment and operation of such sites.

"(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Commissioner, such sums as may be necessary to carry out this paragraph.".

(e) REPORT REGARDING VOLUNTARY ENROLLMENT OF DUAL ELIGIBLE INDIVIDUALS IN PART D.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains such recommendations for legislation as the Secretary determines are necessary in order to establish a voluntary option for dual eligible individuals (as defined in 1860D–19(a)(4)(E) of the Social Security Act (as added by section 101)) to enroll under part D of title XVIII of such Act for prescription drug coverage.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking "17" and inserting "19"; and

(B) in paragraph (2)(B), by inserting "experts in the area of pharmacology and prescription drug benefit programs," after "other health professionals,".

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C.

1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2005.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

"(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas. As part of such review, the Commission shall hold 3 field hearings in 2007.".

SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING AND DRUG UTILIZATION.

(a) STUDY.—The Secretary shall study on an ongoing basis variations in spending and drug utilization under part D of title XVIII of the Social Security Act for covered drugs to determine the impact of such variations on premiums imposed by eligible entities offering Medicare Prescription Drug plans under that part. In conducting such study, the Secretary shall examine the impact of geographic adjustments of the monthly national average premium under section 1860D–15 of such Act on—

(1) maximization of competition under part D of title XVIII of such Act; and

(2) the ability of eligible entities offering Medicare Prescription Drug plans to contain costs for covered drugs.

(b) REPORT.—Beginning with 2007, the Secretary shall submit annual reports to Congress on the study required under subsection (a).

SEC. 107. LIMITATION ON PRESCRIPTION DRUG BENEFITS OF MEMBERS OF CONGRESS.

(a) LIMITATION ON BENEFITS.—Notwithstanding any other provision of law, during calendar year 2004, the actuarial value of the prescription drug benefit of any Member of Congress enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the actuarial value of any prescription drug benefit under title XVIII of the Social Security Act passed by the 1st session of the 108th Congress and enacted in law.

(b) REGULATIONS.—The Office of Personnel Management shall promulgate regulations to carry out this section.

SEC. 108. PROTECTING SENIORS WITH CANCER.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cancer shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with cancer, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with cancer, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cancer, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

SEC. 109. PROTECTING SENIORS WITH CARDIOVASCULAR DISEASE, CANCER, OR ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cardiovascular disease, cancer, diabetes or Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income medicare beneficiary (as defined in paragraph 1860D–19(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(4)(C) of such Act) who is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 160 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

SEC. 110. REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES.

(a) REVIEW.—

(1) IN GENERAL.—The Secretary shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

(2) SPECIFIC MATTERS REVIEWED.—In conducting the review under paragraph (1), the Secretary shall—

(A) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

(B) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

(b) REPORT.—

(1) IN GENERAL.—Not later than the date that is 18 months after the date of enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a)(1), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

(2) CONTENTS.—The report submitted under paragraph (1) shall contain—

(A) a detailed description of the plans of the Secretary to implement the provisions of this Act in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

(B) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

SEC. 110A. MEDICATION THERAPY MANAGEMENT ASSESSMENT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 geographic areas, each containing not less than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(3) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the program not later than January 1, 2005, but may not implement the assessment program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as an assessment site under subsection (a)(2) may participate in the assessment program under this section if such beneficiary identifies a qualified pharmacist who agrees to furnish medication therapy management services to the eligible beneficiary under the assessment program.

(c) CONTRACTS WITH QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF QUALIFIED PHARMACISTS.—The Secretary may contract with more than 1 qualified pharmacist at each site.

(d) PAYMENT TO QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—Under an contract entered into under subsection (c), the Secretary shall pay qualified pharmacists a fee for providing medication therapy management services.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The Secretary shall, in consultation with national pharmacist and pharmacy associations, design the fee paid under paragraph (1) to test various payment methodologies applicable with respect to medication therapy management services, including a payment methodology that applies a relative value scale and fee-schedule with respect to such services that take into account the differences in—

(A) the time required to perform the different types of medication therapy management services;

(B) the level of risk associated with the use of particular outpatient prescription drugs or groups of drugs; and

(C) the health status of individuals to whom such services are provided.

(e) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the assessment program under this section.

(2) BUDGET NEUTRALITY.—In conducting the assessment program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the assessment program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the assessment program under this section.

(g) AVAILABILITY OF DATA.—During the period in which the assessment program is conducted, the Secretary annually shall make available data regarding—

(1) the geographic areas and sites designated under subsection (a)(2);

(2) the number of eligible beneficiaries participating in the program under subsection (b) and the level and types medication therapy management services used by such beneficiaries;

(3) the number of qualified pharmacists with contracts under subsection (c), the location of such pharmacists, and the number of eligible beneficiaries served by such pharmacists; and

(4) the types of payment methodologies being tested under subsection (d)(2).

(h) REPORT.—

(1) IN GENERAL.—Not later than 6 months after the completion of the assessment program under this section, the Secretary shall submit to Congress a final report summarizing the final outcome of the program and evaluating the results of the program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) ASSESSMENT OF PAYMENT METHODOLOGIES.—The final report submitted under paragraph (1) shall include an assessment of the feasibility and appropriateness of the various payment methodologies tested under subsection (d)(2).

(i) DEFINITIONS.—In this section:

(1) MEDICATION THERAPY MANAGEMENT SERVICES.—The term "medication therapy management services" means services or programs furnished by a qualified pharmacist to an eligible beneficiary, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual's understanding of the appropriate use of medications;

(C) to increase the individual's compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications; and

(E) to reduce the need for other costly medical services through better management of medication therapy.

(2) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) receiving, in accordance with State law or regulation, medication for—

(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or

(ii) such other chronic diseases as the Secretary may specify.

(3) QUALIFIED PHARMACIST.—The term "qualified pharmacist" means an individual who is a licensed pharmacist in good standing with the State Board of Pharmacy.

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

SEC. 111. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new sections:

"MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

"SEC. 1807. (a) ESTABLISHMENT.—There is established a medicare prescription drug discount card endorsement program under which the Secretary shall—

"(1) endorse prescription drug discount card programs offered by prescription drug card sponsors that meet the requirements of this section; and

"(2) make available to eligible beneficiaries information regarding such endorsed programs.

"(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

"(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish procedures—

"(i) for identifying eligible beneficiaries; and

"(ii) under which such beneficiaries may make an election to enroll in any prescription drug discount card program endorsed under this section and disenroll from such a program.

"(B) LIMITATION.—An eligible beneficiary may not be enrolled in more than 1 prescription drug discount card program at any time.

"(2) ENROLLMENT FEES.—

"(A) IN GENERAL.—A prescription drug card sponsor may charge an annual enrollment fee to each eligible beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

"(B) AMOUNT.—No enrollment fee charged under subparagraph (A) may exceed $25.

"(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is the same for all eligible medicare beneficiaries enrolled in the program.

"(D) COLLECTION.—Any enrollment fee shall be collected by the prescription drug card sponsor.

"(c) PROVIDING INFORMATION TO ELIGIBLE BENEFICIARIES.—

"(1) PROMOTION OF INFORMED CHOICE.—

"(A) BY THE SECRETARY.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs. Such dissemination shall be coordinated with the dissemination of educational information on other medicare options.

"(B) BY PRESCRIPTION DRUG CARD SPONSORS.—Each prescription drug card sponsor shall make available to each eligible beneficiary (through the Internet and otherwise) information—

"(i) that the Secretary identifies as being necessary to promote informed choice among endorsed prescription drug discount card programs by eligible beneficiaries, including information on enrollment fees, negotiated prices for prescription drugs charged to beneficiaries, and services relating to prescription drugs offered under the program;

"(ii) on how any formulary used by such sponsor functions.

"(2) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1–800–MEDICARE toll free telephone number for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established under this section and prescription drug discount card programs endorsed under such program.

"(d) BENEFICIARY PROTECTIONS.—

"(1) IN GENERAL.—Each prescription drug discount card program endorsed under this section shall meet such requirements as the Secretary identifies to protect and promote the interest of eligible beneficiaries, including requirements that—

"(A) relate to appeals by eligible beneficiaries and marketing practices; and

"(B) ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

"(2) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries. Such standards shall take into account reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.

"(3) QUALITY ASSURANCE.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall have in place adequate procedures for assuring that quality service is provided to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor.

"(4) CONFIDENTIALITY OF ENROLLEE RECORDS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(5) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under subsection (b)(2)(A).

"(6) PRICES.—

"(A) AVOIDANCE OF HIGH PRICED DRUGS.—A prescription drug card sponsor may not recommend switching an eligible beneficiary to a drug with a higher negotiated price absent a recommendation by a licensed health professional that there is a clinical indication with respect to the patient for such a switch.

"(B) PRICE STABILITY.—Negotiated prices charged for prescription drugs covered under a prescription drug discount card program endorsed under this section may not change more frequently than once every 60 days.

"(e) PRESCRIPTION DRUG BENEFITS.—

"(1) IN GENERAL.—Each prescription drug card sponsor may only provide benefits that relate to prescription drugs (as defined in subsection (i)(2)) under a prescription drug discount card program endorsed under this section.

"(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

"(A) IN GENERAL.—Subject to subparagraph (D), each prescription drug card sponsor shall provide eligible beneficiaries who enroll in a prescription drug discount card program offered by such sponsor that is endorsed under this section with access to negotiated prices used by the sponsor with respect to prescription drugs dispensed to eligible beneficiaries.

"(B) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The requirements of section 1927 relating to manufacturer best price shall not apply to the negotiated prices for prescription drugs made available under a prescription drug discount card program endorsed under this section.

"(C) GUARANTEED ACCESS TO NEGOTIATED PRICES.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures to ensure that eligible beneficiaries have access to the negotiated prices for prescription drugs provided under subparagraph (A).

"(D) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card program if the program excludes the drug under a formulary.

"(3) BENEFICIARY SERVICES.—Each prescription drug discount card program endorsed under this section shall provide pharmaceutical support services, such as education, counseling, and services to prevent adverse drug interactions.

"(4) DISCOUNT CARDS.—Each prescription drug card sponsor shall issue a card to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor that the beneficiary may use to obtain benefits under the program.

"(f) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT AND APPROVAL.—

"(1) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

"(2) APPROVAL.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to endorse the prescription drug discount card program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

"(g) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a prescription drug card sponsor offering a prescription drug discount card program uses a formulary, the following requirements must be met:

"(1) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

"(A) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

"(B) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

"(2) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

"(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

"(A) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (as defined by the Secretary), although not necessarily for all drugs within such categories and classes.

"(B) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutic categories and classes.

"(4) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

"(5) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and pharmacies.

"(h) FRAUD AND ABUSE PREVENTION.—

"(1) IN GENERAL.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

"(2) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions and may revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

"(3) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for any violation of this section. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(4) REPORTING TO SECRETARY.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall report information relating to program performance, use of prescription drugs by eligible beneficiaries enrolled in the program, financial information of the sponsor, and such other information as the Secretary may specify. The Secretary may not disclose any proprietary data reported under this paragraph.

"(5) DRUG UTILIZATION REVIEW.—The Secretary may use claims data from parts A and B for purposes of conducting a drug utilization review program.

"(i) DEFINITIONS.—In this section:

"(1) ELIGIBLE BENEFICIARY.—

"(A) IN GENERAL.—The term 'eligible beneficiary' means an individual who—

"(i) is entitled to, or enrolled for, benefits under part A and enrolled under part B; and

"(ii) is not a dual eligible individual (as defined in subparagraph (B)).

"(B) DUAL ELIGIBLE INDIVIDUAL.—

"(i) IN GENERAL.—The term 'dual eligible individual' means an individual who is—

"(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that is not less than the medical assistance provided to an individual described in section 1902(a)(10)(A)(i) and includes covered outpatient drugs (as such term is defined for purposes of section 1927); and

"(II) entitled to benefits under part A and enrolled under part B.

"(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

"(2) PRESCRIPTION DRUG.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'prescription drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

"(ii) a biological product or insulin described in subparagraph (B) or (C) of such section (including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Secretary),

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(B) EXCLUSIONS.—The term 'prescription drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E)

thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(3) NEGOTIATED PRICE.—The term 'negotiated price' includes all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations.

"(4) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' means any entity with demonstrated experience and expertise in operating a prescription drug discount card program, an insurance program that provides coverage for prescription drugs, or a similar program that the Secretary determines to be appropriate to provide eligible beneficiaries with the benefits under a prescription drug discount card program endorsed by the Secretary under this section, including—

"(A) a pharmaceutical benefit management company;

"(B) a wholesale or retail pharmacist delivery system;

"(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

"(D) any other entity; or

"(E) any combination of the entities described in subparagraphs (A) through (D).

"TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES

"SEC. 1807A. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is established a program under which the Secretary shall award contracts to prescription drug card sponsors offering a prescription drug discount card that has been endorsed by the Secretary under section 1807 under which such sponsors shall offer a prescription drug assistance card program to eligible low-income beneficiaries in accordance with the requirements of this section.

"(2) APPLICATION OF DISCOUNT CARD PROVISIONS.—Except as otherwise provided in this section, the provisions of section 1807 shall apply to the program established under this section.

"(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

"(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the enrollment procedures established under section 1807(b)(1)(A)(ii) shall apply for purposes of this section.

"(B) ENROLLMENT OF ANY ELIGIBLE LOW-INCOME BENEFICIARY.—Each prescription drug card sponsor offering a prescription drug assistance card program under this section shall permit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

"(C) SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—An eligible low-income beneficiary who enrolls in a prescription drug assistance card program offered by a prescription drug card sponsor under this section shall be simultaneously enrolled in a prescription drug discount card program offered by such sponsor.

"(2) WAIVER OF ENROLLMENT FEES.—

"(A) IN GENERAL.—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

"(B) PAYMENT BY SECRETARY.—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fee charged under section 1807(b)(2)(A) on behalf of each eligible low-income beneficiary enrolled in a prescription drug discount card program under paragraph (1)(C) offered by such sponsor.

"(c) ADDITIONAL BENEFICIARY PROTECTIONS.—

"(1) PROVIDING INFORMATION TO ELIGIBLE LOW-INCOME BENEFICIARIES.—In addition to the information provided to eligible beneficiaries under section 1807(c), the prescription drug card sponsor shall—

"(A) periodically notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the amount of coverage for prescription drugs remaining under subsection (d)(2)(A); and

"(B) notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the grievance and appeals processes under the program.

"(2) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—For purposes of determining whether convenient access has been provided under section 1807(d)(2) with respect to eligible low-income beneficiaries enrolled in a prescription drug assistance card program, the Secretary may only make a determination that such access has been provided if an appropriate arrangement is in place for eligible low-income beneficiaries who are in a long-term care facility (as defined by the Secretary) to receive prescription drug benefits under the program.

"(3) COORDINATION OF BENEFITS.—

"(A) IN GENERAL.—The Secretary shall establish procedures under which eligible low-income beneficiaries who are enrolled for coverage described in subparagraph (B) and enrolled in a prescription drug assistance card program have access to the prescription drug benefits available under such program.

"(B) COVERAGE DESCRIBED.—Coverage described in this subparagraph is as follows:

"(i) Coverage of prescription drugs under a State pharmaceutical assistance program.

"(ii) Enrollment in a Medicare+Choice plan under part C.

"(4) GRIEVANCE MECHANISM.—Each prescription drug card sponsor with a contract under this section shall provide in accordance with section 1852(f) meaningful procedures for hearing and resolving grievances between the prescription drug card sponsor (including any entity or individual through which the prescription drug card sponsor provides covered benefits) and enrollees in a prescription drug assistance card program offered by such sponsor.

"(5) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—

"(A) IN GENERAL.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply with respect to covered benefits under a prescription drug assistance card program under this section in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

"(B) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug assistance card program offered by a prescription drug card sponsor that provides for tiered pricing for drugs included within a formulary and provides lower prices for preferred drugs included within the formulary, an eligible low-income beneficiary who is enrolled in the program may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

"(C) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

"(6) APPEALS.—

"(A) IN GENERAL.—Subject to subparagraph (B), a prescription drug card sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in a similar manner (as determined by the Secretary) as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

"(B) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

"(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The prescription drug card sponsor must have, as part of the appeals process under this paragraph, a process for timely appeals for denials of coverage based on the application of the formulary.

"(d) PRESCRIPTION DRUG BENEFITS.—

"(1) IN GENERAL.—Subject to paragraph (5), all the benefits available under a prescription drug discount card program offered by a prescription drug card sponsor and endorsed under section 1807 shall be available to eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor.

"(2) ASSISTANCE FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—

"(A) $600 ANNUAL ASSISTANCE.—Subject to subparagraphs (B) and (C) and paragraph (5), each prescription drug card sponsor with a contract under this section shall provide coverage for the first $600 of expenses for prescription drugs incurred during each calendar year by an eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor.

"(B) COINSURANCE.—

"(i) IN GENERAL.—The prescription drug card sponsor shall determine an amount of coinsurance to collect from each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor for which coverage is available under subparagraph (A).

"(ii) AMOUNT.—The amount of coinsurance collected under clause (i) shall be at least 10 percent of the negotiated price of each prescription drug dispensed to an eligible low-income beneficiary.

"(iii) CONSTRUCTION.—Amounts collected under clause (i) shall not be counted against the total amount of coverage available under subparagraph (A).

"(C) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible low-income beneficiary is not enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor with a contract under this section, the amount of assistance available under subparagraph (A) shall be reduced by $50.

"(D) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—The dollar amount of coverage described in subparagraph (A) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

"(E) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Secretary may waive such requirements of this section and section 1807 as may be necessary to ensure that each eligible low-income beneficiaries has access to the assistance described in subparagraph (A).

"(3) ADDITIONAL DISCOUNTS.—A prescription drug card sponsor with a contract under this section shall provide each eligible low-income beneficiary enrolled in a prescription drug assistance program offered by the sponsor with access to negotiated prices that reflect a minimum average discount of at least 20 percent of the average wholesale price for prescription drugs covered under that program.

"(4) ASSISTANCE CARDS.—Each prescription drug card sponsor shall permit eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor to use the discount card issued under section 1807(e)(4) to obtain benefits under the program.

"(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible low-income beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug assistance card program if the program excludes the drug under a formulary and such exclusion is not successfully resolved under paragraph (4), (5), or (6) of subsection (c).

"(e) REQUIREMENTS FOR PRESCRIPTION DRUG CARD SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE CARD PROGRAMS.—

"(1) IN GENERAL.—Each prescription drug card sponsor shall—

"(A) process claims made by eligible low-income beneficiaries;

"(B) negotiate with brand name and generic prescription drug manufacturers and others for low prices on prescription drugs;

"(C) track individual beneficiary expenditures in a format and periodicity specified by the Secretary; and

"(D) perform such other functions as the Secretary may assign.

"(2) DATA EXCHANGES.—Each prescription drug card sponsor shall receive data exchanges in a format specified by the Secretary and shall maintain real-time beneficiary files.

"(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The prescription drug card sponsor offering the prescription drug assistance card program shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the eligible low-income beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest priced generic drug covered under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy or other dispenser.

"(f) SUBMISSION OF BIDS AND AWARDING OF CONTRACTS.—

"(1) SUBMISSION OF BIDS.—Each prescription drug card sponsor that seeks to offer a prescription drug assistance card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

"(2) AWARDING OF CONTRACTS.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to award a contract to the prescription drug card sponsor offering the program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

"(3) NUMBER OF CONTRACTS.—There shall be no limit on the number of prescription drug card sponsors that may be awarded contracts under paragraph (2).

"(4) CONTRACT PROVISIONS.—

"(A) DURATION.—A contract awarded under paragraph (2) shall be for the lifetime of the program under this section.

"(B) WITHDRAWAL.—A prescription drug card sponsor that desires to terminate the contract awarded under paragraph (2) may terminate such contract without penalty if such sponsor gives notice—

"(i) to the Secretary 90 days prior to the termination of such contract; and

"(ii) to each eligible low-income beneficiary that is enrolled in a prescription drug assistance card program offered by such sponsor 60 days prior to such termination.

"(C) SERVICE AREA.—The service area under the contract shall be the same as the area served by the prescription drug card sponsor under section 1807.

"(5) SIMULTANEOUS APPROVAL OF DISCOUNT CARD AND ASSISTANCE PROGRAMS.—A prescription drug card sponsor may submit an application for endorsement under section 1807 as part of the bid submitted under paragraph (1) and the Secretary may approve such application at the same time as the Secretary awards a contract under this section.

"(g) PAYMENTS TO PRESCRIPTION DRUG CARD SPONSORS.—

"(1) IN GENERAL.—The Secretary shall pay to each prescription drug card sponsor offering a prescription drug assistance card program in which an eligible low-income beneficiary is enrolled an amount equal to the amount agreed to by the Secretary and the sponsor in the contract awarded under subsection (f)(2).

"(2) PAYMENT FROM PART B TRUST FUND.—The costs of providing benefits under this section shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"(h) ELIGIBILITY DETERMINATIONS MADE BY STATES; PRESUMPTIVE ELIGIBILITY.—States shall perform the functions described in section 1935(a)(1).

"(i) APPROPRIATIONS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 such sums as may be necessary to carry out the program under this section.

"(j) DEFINITIONS.—In this section:

"(1) ELIGIBLE BENEFICIARY; NEGOTIATED PRICE; PRESCRIPTION DRUG.—The terms 'eligible beneficiary', 'negotiated price', and 'prescription drug' have the meanings given those terms in section 1807(i).

"(2) ELIGIBLE LOW-INCOME BENEFICIARY.—The term 'eligible low-income beneficiary' means an individual who—

"(A) is an eligible beneficiary (as defined in section 1807(i)); and

"(B) is described in clause (iii) or (iv) of section 1902(a)(10)(E) or in section 1905(p)(1).

"(3) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' has the meaning given that term in section 1807(i), except that such sponsor shall also be an entity that the Secretary determines is—

"(A) is appropriate to provide eligible low-income beneficiaries with the benefits under a prescription drug assistance card program under this section; and

"(B) is able to manage the monetary assistance made available under subsection (d)(2);

"(C) agrees to submit to audits by the Secretary; and

"(D) provides such other assurances as the Secretary may require.

"(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX.".

(b) EXCLUSION OF PRICES FROM DETERMINATION OF BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking "and" at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting "; and"; and

(3) by adding at the end the following new subclause:

"(V) any negotiated prices charged under the medicare prescription drug discount card endorsement program under section 1807 or under the transitional prescription drug assistance card program for eligible low-income beneficiaries under section 1807A.".

(c) EXCLUSION OF PRESCRIPTION DRUG ASSISTANCE CARD COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking "attributable to the application of section" and inserting "attributable to—

"(1) the application of section";

(2) by striking the period and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(2) the prescription drug assistance card program under section 1807A.".

(d) REGULATIONS.—

(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing sections 1807 and 1807A of the Social Security Act (as added by this section) in interim final form without prior opportunity for public comment.

(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).

(3) EXEMPTION FROM THE PAPERWORK REDUCTION ACT.—The promulgation of the regulations under this subsection and the administration the programs established by sections 1807 and 1807A of the Social Security Act (as added by this section) shall be made without regard to chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act").

(e) IMPLEMENTATION; TRANSITION.—

(1) IMPLEMENTATION.—The Secretary shall implement the amendments made by this section in a manner that discounts are available to eligible beneficiaries under section 1807 of the Social Security Act and assistance is available to eligible low-income beneficiaries under section 1807A of such Act not later than January 1, 2004.

(2) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the programs under section 1807 and 1807A of the Social Security Act. Such transition and discontinuation shall ensure that such programs continue to operate until the date on which the first enrollment period under part D ends.

Subtitle C—Standards for Electronic Prescribing

SEC. 121. STANDARDS FOR ELECTRONIC PRESCRIBING.

Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

"PART D—ELECTRONIC PRESCRIBING

"STANDARDS FOR ELECTRONIC PRESCRIBING

"SEC. 1180. (a) STANDARDS.—

"(1) DEVELOPMENT AND ADOPTION.—

"(A) IN GENERAL.—The Secretary shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as 'standards') to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information.

"(B) CONSULTATION.—In developing' and adopting the standards under subparagraph (A), the Secretary shall consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiary information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

"(2) OBJECTIVE.—Any standards developed or adopted under this part shall be consistent with the objectives of improving—

"(A) patient safety; and

"(B) the quality of care provided to patients.

"(3) REQUIREMENTS.—Any standards developed or adopted under this part shall comply with the following:

"(A) PATIENT MAY REQUEST A WRITTEN PRESCRIPTION.—The standards provide that—

"(i) a prescription shall be written and not transmitted electronically if the patient makes such a request; and

"(ii) no additional charges may be imposed on the patient for making such a request.

"(B) PATIENT-SPECIFIC MEDICATION HISTORY, ELIGIBILITY, BENEFIT, AND OTHER PRESCRIPTION INFORMATION.—

"(i) IN GENERAL.—The standards shall accommodate electronic transmittal of patient-specific medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care.

"(ii) REQUIRED INFORMATION.—The information described in clause (i) shall include the following:

"(I) Information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medication history of the patient that may be relevant to the appropriate prescription for that patient.

"(II) Cost-effective alternatives (if any) to the drug prescribed.

"(III) Information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization.

"(IV) Information on potential interactions with drugs listed on the medication history, graded by severity of the potential interaction.

"(V) Other information to improve the quality of patient care and to reduce medical errors.

"(C) UNDUE BURDEN.—The standards shall be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on the practice of medicine, pharmacy, or other health professions.

"(D) COMPATIBILITY WITH ADMINISTRATIVE SIMPLIFICATION AND PRIVACY LAWS.—The standards shall be—

"(i) consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

"(ii) compatible with the standards adopted under part C.

"(4) TRANSFER OF INFORMATION.—The Secretary shall develop and adopt standards for transferring among prescribing and insurance entities and other necessary entities appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

"(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

"(1) IN GENERAL.—The Secretary shall adopt the standards under this part by January 1, 2006.

"(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—The Secretary shall, in consultation with appropriate representatives of interested parties, review the standards developed or adopted under this part and adopt modifications to the standards (including additions to the standards), as determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

"(c) COMPLIANCE WITH STANDARDS.—

"(1) REQUIREMENT FOR ALL INDIVIDUALS AND ENTITIES THAT TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—

"(A) IN GENERAL.—Individuals or entities that transmit or receive prescriptions electronically shall comply with the standards adopted or modified under this part.

"(B) RELATION TO STATE LAWS.—The standards adopted or modified under this part shall supersede any State law or regulations pertaining to the electronic transmission of medication history, eligibility, benefit and prescription information.

"(2) TIMETABLE FOR COMPLIANCE.—

"(A) INITIAL COMPLIANCE.—

"(i) IN GENERAL.—Not later than 24 months after the date on which an initial standard is adopted under this part, each individual or entity to whom the standard applies shall comply with the standard.

"(ii) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, as defined by the Secretary for purposes of section 1175(b)(1)(B), clause (i) shall be applied by substituting '36 months' for '24 months'.

"(d) CONSULTATION WITH ATTORNEY GENERAL.—The Secretary shall consult with the Attorney General before developing, adopting, or modifying a standard under this part to ensure that the standard accommodates secure electronic transmission of prescriptions for controlled substances in a manner that minimizes the possibility of violations under the Comprehensive Drug Abuse Prevention and Control Act of 1970 and related Federal laws.

"(e) NO REQUIREMENT TO TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—Nothing in this part shall be construed to require an individual or entity to transmit or receive prescriptions electronically.

"GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION PROGRAMS

"SEC. 1180A. (a) IN GENERAL.—The Secretary is authorized to make grants to health care providers for the purpose of assisting such entities to implement electronic prescription programs that comply with the standards adopted or modified under this part.

"(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.".

Subtitle D—Other Provisions

SEC. 131. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (INCLUDING THE PRESCRIPTION DRUG ACCOUNT).—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 (including the Prescription Drug Account within such Trust Fund), in this subsection referred to as the 'Trust Funds'. Such report shall include the following information:

"(1) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds, separately stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year, for each of the following amounts:

"(A) MEDICARE BENEFITS.—The amount expended for payment of benefits covered under this title.

"(B) ADMINISTRATIVE AND OTHER EXPENSES.—The amount expended for payments not related to the benefits described in subparagraph (A).

"(2) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph.

"(3) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 50-year period beginning with the succeeding fiscal year.

"(4) RELATION TO OTHER MEASURES OF GROWTH.—A comparison of the rate of growth of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, to the rate of growth for the same period in—

"(A) the gross domestic product;

"(B) health insurance costs in the private sector;

"(C) employment-based health insurance costs in the public and private sectors; and

"(D) other areas as determined appropriate by the Board of Trustees.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction of Congress shall hold hearings on the reports submitted under section 1817(l) of the Social Security Act (as added by subsection (a)).

SEC. 132. TRUSTEES' REPORT ON MEDICARE'S UNFUNDED OBLIGATIONS.

(a) REPORT.—The report submitted under sections 1817(b)(2) and 1841(b)(2) of the Social Security Act (42 U.S.C. 1395i(b)(2) and 1395t(b)(2)) during 2004 shall include an analysis of the total amount of the unfunded obligations of the Medicare program under title XVIII of the Social Security Act.

(b) MATTERS ANALYZED.—The analysis described in subsection (A) shall compare the long-term obligations of the Medicare program to the dedicated funding sources for that program (other than general revenue transfers), including the combined obligations of the Federal Hospital Insurance Trust Fund established under section 1817 of such Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

SEC. 133. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

Subpart 3 of part D of title XVIII of the Social Security Act (as added by section 101) is amended by adding at the end the following new section:

"PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS

"SEC. 1860D–27. (a) PROHIBITION.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, an eligible entity offering a Medicare Prescription Drug plan under this part or a MedicareAdvantage organization offering a MedicareAdvantage plan under part C shall not enter into a contract with any pharmacy benefit manager (in this section referred to as a 'PBM') that is owned by a pharmaceutical manufacturing company.

"(2) PROVISION OF INFORMATION.—A PBM that manages prescription drug coverage under this part or part C shall provide the following information, on an annual basis, to the Assistant Attorney General for Antitrust of the Department of Justice and the Inspector General of the Health and Human Services Department:

"(A) The aggregate amount of any and all rebates, discounts, administrative fees, promotional allowances, and other payments received or recovered from each pharmaceutical manufacturer.

"(B) The amount of payments received or recovered from each pharmaceutical manufacturer for each of the top 50 drugs as measured by volume (as determined by the Secretary).

"(C) The percentage differential between the price the PBM pays pharmacies for a drug described in subparagraph (B) and the price the PBM charges a Medicare Prescription Drug Plan or a MedicareAdvantage organization for such drug.

"(b) FAILURE TO DISCLOSE.—

"(1) CIVIL PENALTY.—Any PBM that fails to comply with subsection (a) shall be liable for a civil penalty as determined appropriate through regulations promulgated by the Attorney General. Such penalty may be recovered in a civil action brought by the United States.

"(2) COMPLIANCE AND EQUITABLE RELIEF.—If any PBM fails to comply with subsection (a), the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General.

"(c) DISCLOSURE EXEMPTION.—Any information filed with the Assistant Attorney General under subsection (a)(2) shall be exempt from disclosure under section 552 of title 5, and no such information may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.".

SEC. 134. OFFICE OF THE MEDICARE BENEFICIARY ADVOCATE.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish within the Department of Health and Human Services, an Office of the Medicare Beneficiary Advocate (in this section referred to as the "Office").

(b) DUTIES.—The Office shall carry out the following activities:

(1) Establishing a toll-free telephone number for medicare beneficiaries to use to obtain information on the medicare program, and particularly with respect to the benefits provided under part D of title XVIII of the Social Security Act and the Medicare Prescription Drug plans and MedicareAdvantage plans offering such benefits. The Office shall ensure that the toll-free telephone number accommodates beneficiaries with disabilities and limited-English proficiency.

(2) Establishing an Internet website with easily accessible information regarding Medicare Prescription Drug plans and MedicareAdvantage plans and the benefits offered under such plans. The website shall—

(A) be updated regularly to reflect changes in services and benefits, including with respect to the plans offered in a region and the associated monthly premiums, benefits offered, formularies, and contact information for such plans, and to ensure that there are no broken links or errors;

(B) have printer-friendly, downloadable fact sheets on the medicare coverage options and benefits;

(C) be easy to navigate, with large print and easily recognizable links; and

(D) provide links to the websites of the eligible entities participating in part D of title XVIII.

(3) Providing regional publications to medicare beneficiaries that include regional contacts for information, and that inform the beneficiaries of the prescription drug benefit options under title XVIII of the Social Security Act, including with respect to—

(A) monthly premiums;

(B) formularies; and

(C) the scope of the benefits offered.

(4) Conducting outreach to medicare beneficiaries to inform the beneficiaries of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(5) Working with local benefits administrators, ombudsmen, local benefits specialists, and advocacy groups to ensure that medicare beneficiaries are aware of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(c) FUNDING.—

(1) ESTABLISHMENT.—Of the amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures, $2,000,000 may be used to establish the Office in accordance with this section.

(2) OPERATION.—With respect to each fiscal year occurring after the fiscal year in which the Office is established under this section, the Secretary may use, out of amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures for such fiscal year, such sums as may be necessary to operate the Office in that fiscal year.

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.

Section 1851 (42 U.S.C. 1395w–21) is amended to read as follows:

"ELIGIBILITY, ELECTION, AND ENROLLMENT

"SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREADVANTAGE PLANS.—

"(1) IN GENERAL.—Subject to the provisions of this section, each MedicareAdvantage eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

"(A) through—

"(i) the original Medicare fee-for-service program under parts A and B; and

"(ii) the voluntary prescription drug delivery program under part D; or

"(B) through enrollment in a MedicareAdvantage plan under this part.

"(2) TYPES OF MEDICAREADVANTAGE PLANS THAT MAY BE AVAILABLE.—A MedicareAdvantage plan may be any of the following types of plans of health insurance:

"(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans (with or without point of service options) and plans offered by provider-sponsored organizations (as defined in section 1855(d)).

"(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREADVANTAGE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a MedicareAdvantage medical savings account (MSA).

"(C) PRIVATE FEE-FOR-SERVICE PLANS.—A MedicareAdvantage private fee-for-service plan, as defined in section 1859(b)(2).

"(3) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this title, the term 'MedicareAdvantage eligible individual' means an individual who is entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

"(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice or a MedicareAdvantage plan may continue to be enrolled in that plan; and

"(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan or a MedicareAdvantage plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a 'MedicareAdvantage eligible individual' for purposes of electing to continue enrollment in another MedicareAdvantage plan.

"(b) SPECIAL RULES.—

"(1) RESIDENCE REQUIREMENT.—

"(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization only if the plan serves the geographic area in which the individual resides.

"(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1852(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost-sharing liability in obtaining such benefits.

"(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a MedicareAdvantage organization eliminates from its service area a MedicareAdvantage payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a MedicareAdvantage plan it offers so long as—

"(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

"(ii) there is no other MedicareAdvantage plan offered in the area in which the enrollee resides at the time of the organization's election.

"(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS.—

"(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

"(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

"(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in

section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

"(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

"(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

"(i) on or after January 1, 2004, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

"(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

"(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

"(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

"(c) PROCESS FOR EXERCISING CHOICE.—

"(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

"(2) COORDINATION THROUGH MEDICAREADVANTAGE ORGANIZATIONS.—

"(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization to make such election through the filing of an appropriate election form with the organization.

"(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicareAdvantage plan offered by a MedicareAdvantage organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

"(3) DEFAULT.—

"(A) INITIAL ELECTION.—

"(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

"(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a Medicare+Choice plan or another health plan (other than a MedicareAdvantage plan) offered by a MedicareAdvantage organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicareAdvantage plan offered by the organization (or, if the organization offers more than 1 such plan, such plan or plans as the Secretary identifies under such procedures).

"(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

"(i) the individual changes the election under this section; or

"(ii) the MedicareAdvantage plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

"(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

"(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

"(2) PROVISION OF NOTICE.—

"(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicareAdvantage eligible individual residing in an area the following:

"(i) GENERAL INFORMATION.—The general information described in paragraph (3).

"(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicareAdvantage plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

"(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

"(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial MedicareAdvantage enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

"(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

"(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicareAdvantage plans, the benefits under such plans, and the MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage for such plans.

"(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

"(A) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under parts A and B of the original medicare fee-for-service program, including—

"(i) covered items and services;

"(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

"(iii) any beneficiary liability for balance billing.

"(B) CATASTROPHIC COVERAGE AND COMBINED DEDUCTIBLE.—A description of the catastrophic coverage and unified deductible applicable under the plan.

"(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—The information required under section 1860D–4 with respect to coverage for prescription drugs under the plan.

"(D) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

"(E) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program (including such rights under part D) and the MedicareAdvantage program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

"(F) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

"(G) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicareAdvantage organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the MedicareAdvantage plan under this part.

"(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicareAdvantage plan for a year, shall include the following:

"(A) BENEFITS.—The benefits covered under the plan, including the following:

"(i) Covered items and services beyond those provided under the original medicare fee-for-service program option.

"(ii) Beneficiary cost-sharing for any items and services described in clause (i) and paragraph (3)(A)(i), including information on the unified deductible under section 1852(a)(1)(C).

"(iii) The maximum limitations on out-of-pocket expenses under section 1852(a)(1)(C).

"(iv) In the case of an MSA plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

"(v) In the case of a MedicareAdvantage private fee-for-service plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

"(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

"(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

"(viii) The organization's coverage of emergency and urgently needed care.

"(ix) The comparative information described in section 1860D–4(b)(2) relating to prescription drug coverage under the plan.

"(B) PREMIUMS.—

"(i) IN GENERAL.—The MedicareAdvantage monthly basic beneficiary premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, if any, for the plan or, in the case of an MSA plan, the MedicareAdvantage monthly MSA premium.

"(ii) REDUCTIONS.—The reduction in part B premiums, if any.

"(iii) NATURE OF THE PREMIUM FOR ENHANCED MEDICAL BENEFITS.—Whether the MedicareAdvantage monthly premium for enhanced benefits is optional or mandatory.

"(C) SERVICE AREA.—The service area of the plan.

"(D) QUALITY AND PERFORMANCE.—Plan quality and performance indicators for the benefits under the plan (and how such indicators compare to quality and performance indicators under the original medicare fee-for-service program under parts A and B and under the voluntary prescription drug delivery program under part D in the area involved), including—

"(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for

the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area);

"(ii) information on medicare enrollee satisfaction;

"(iii) information on health outcomes; and

"(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

"(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicareAdvantage options and the operation of this part in all areas in which MedicareAdvantage plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicareAdvantage plans.

"(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

"(7) PROVISION OF INFORMATION.—A MedicareAdvantage organization shall provide the Secretary with such information on the organization and each MedicareAdvantage plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

"(e) COVERAGE ELECTION PERIODS.—

"(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes eligible to elect to receive benefits under part B or D (whichever is later), there is 1 or more MedicareAdvantage plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a MedicareAdvantage plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

"(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), the following rules shall apply:

"(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

"(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a MedicareAdvantage eligible individual during 2006, during the first 6 months during 2006 in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

"(ii) LIMITATION OF 1 CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

"(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 3 months of 2007 and each subsequent year, or, if the individual first becomes a MedicareAdvantage eligible individual during 2007 or any subsequent year, during the first 3 months of such year in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

"(ii) LIMITATION OF 1 CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

"(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time during 2006 or any subsequent year, in the case of a MedicareAdvantage eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

"(i) to enroll in a MedicareAdvantage plan; or

"(ii) to change the MedicareAdvantage plan in which the individual is enrolled.

"(3) ANNUAL, COORDINATED ELECTION PERIOD.—

"(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

"(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2006, the month of November before such year and with respect to 2003, 2004, 2005, and 2006, the period beginning on November 15 and ending on December 31 of the year before such year.

"(C) MEDICAREADVANTAGE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 2006), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicareAdvantage eligible individuals about MedicareAdvantage plans and the election process provided under this section.

"(D) SPECIAL INFORMATION CAMPAIGN IN 2005.—During the period beginning on November 15, 2005, and ending on December 31, 2005, the Secretary shall provide for an educational and publicity campaign to inform MedicareAdvantage eligible individuals about the availability of MedicareAdvantage plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section.

"(4) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual may discontinue an election of a MedicareAdvantage plan offered by a MedicareAdvantage organization other than during an annual, coordinated election period and make a new election under this section if—

"(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

"(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

"(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

"(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

"(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

"(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

"(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective on and after January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a MedicareAdvantage plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

"(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

"(A) may elect an MSA plan only during—

"(i) an initial open enrollment period described in paragraph (1);

"(ii) an annual, coordinated election period described in paragraph (3)(B); or

"(iii) the month of November 1998;

"(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

"(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

"(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a MedicareAdvantage organization—

"(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period beginning on November 15, 2005, and ending on December 31, 2005, and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

"(B) may accept other changes to elections at such other times as the organization provides.

"(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

"(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D, except as the Secretary may provide (consistent with sections 1838 and 1860D–2)) in order to prevent retroactive coverage.

"(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

"(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

"(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

"(g) Guaranteed Issue and Renewal.—

"(1) In general.—Except as provided in this subsection, a MedicareAdvantage organization shall provide that at any time during which elections are accepted under this section with respect to a MedicareAdvantage plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

"(2) Priority.—If the Secretary determines that a MedicareAdvantage organization, in relation to a MedicareAdvantage plan it offers, has a capacity limit and the number of MedicareAdvantage eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

"(A) first to such individuals as have elected the plan at the time of the determination; and

"(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

"(3) Limitation on termination of election.—

"(A) In general.—Subject to subparagraph (B), a MedicareAdvantage organization may not for any reason terminate the election of any individual under this section for a MedicareAdvantage plan it offers.

"(B) Basis for termination of election.—A MedicareAdvantage organization may terminate an individual's election under this section with respect to a MedicareAdvantage plan it offers if—

"(i) any MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, or MedicareAdvantage monthly beneficiary premium for required or optional enhanced medical benefits required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums);

"(ii) the individual has engaged in disruptive behavior (as specified in such standards); or

"(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

"(C) Consequence of termination.—

"(i) Terminations for cause.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected to receive benefits under the original medicare fee-for-service program option.

"(ii) Termination based on plan termination or service area reduction.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicareAdvantage plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option.

"(D) Organization obligation with respect to election forms.—Pursuant to a contract under section 1857858., each MedicareAdvantage organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

"(h) Approval of Marketing Material and Application Forms.—

"(1) Submission.—No marketing material or application form may be distributed by a MedicareAdvantage organization to (or for the use of) MedicareAdvantage eligible individuals unless—

"(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review; and

"(B) the Secretary has not disapproved the distribution of such material or form.

"(2) Review.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(3) Deemed approval (1-stop shopping).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a MedicareAdvantage plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

"(4) Prohibition of certain marketing practices.—Each MedicareAdvantage organization shall conform to fair marketing standards, in relation to MedicareAdvantage plans offered under this part, included in the standards established under section 1856. Such standards—

"(A) shall not permit a MedicareAdvantage organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in section 1854(g)(1)(C)(i)); and

"(B) may include a prohibition against a MedicareAdvantage organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

"(5) Special treatment of marketing material following model marketing language.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

"(i) Effect of Election of MedicareAdvantage Plan Option.—

"(1) Payments to organizations.—Subject to sections 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a MedicareAdvantage organization under section 1853(a) with respect to an individual electing a MedicareAdvantage plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A, B, and D for items and services furnished to the individual.

"(2) Only organization entitled to payment.—Subject to sections 1853(f), 1853(h), 1853(i), 1857(f)(2), 1886(d)(11), and 1886(h)(3)(D), only the MedicareAdvantage organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.".

SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.

Section 1852 (42 U.S.C. 1395w–22) is amended to read as follows:

"BENEFITS AND BENEFICIARY PROTECTIONS

"Sec. 1852. (a) Basic Benefits.—

"(1) In general.—Except as provided in section 1859(b)(3) for MSA plans, each MedicareAdvantage plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

"(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan;

"(B) except as provided in paragraph (2)(D), qualified prescription drug coverage under part D to individuals residing in the area served by the plan;

"(C) a maximum limitation on out-of-pocket expenses and a unified deductible; and

"(D) additional benefits required under section 1854(d)(1).

"(2) Satisfaction of requirement.—

"(A) In general.—A MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

"(i) the sum of such payment amount and any cost-sharing provided for under the plan; is equal to at least

"(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

"(B) Reference to related provisions.—For provisions relating to—

"(i) limitations on balance billing against MedicareAdvantage organizations for noncontract providers, see sections 1852(k) and 1866(a)(1)(O); and

"(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(f).

"(C) Election of uniform coverage policy.—In the case of a MedicareAdvantage organization that offers a MedicareAdvantage plan in an area in which more than 1 local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to MedicareAdvantage enrollees (as identified by the Secretary) apply with respect to all MedicareAdvantage enrollees enrolled in the plan.

"(D) Special rule for private fee-for-service plans.—

"(i) In general.—A private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

"(ii) Availability of drug coverage for enrollees.—If a beneficiary enrolls in a plan making the election described in clause (i), the beneficiary may enroll for drug coverage under part D with an eligible entity under such part.

"(3) Enhanced medical benefits.—

"(A) Benefits included subject to Secretary's approval.—Each MedicareAdvantage organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), enhanced medical benefits that the Secretary may approve. The Secretary shall approve any such enhanced medical benefits unless the Secretary determines that including such enhanced medical benefits would substantially discourage enrollment by MedicareAdvantage eligible individuals with the organization.

"(B) At enrollees' option.—A MedicareAdvantage organization may not provide, under an MSA plan, enhanced medical benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

“(C) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a MedicareAdvantage private fee-for-service plan from offering enhanced medical benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

“(D) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any enhanced medical benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

“(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicareAdvantage organization may (in the case of the provision of items and services to an individual under a MedicareAdvantage plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

“(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services; or

“(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

“(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicareAdvantage organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the benchmark amount announced under section 1853(b)(1)(A) at the beginning of such period, then, unless otherwise required by law—

“(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period; and

“(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Secretary of the actuarial costs associated with the coverage determination or legislative change in benefits.

“(6) AUTHORITY TO PROHIBIT RISK SELECTION.—The Secretary shall have the authority to disapprove any MedicareAdvantage plan that the Secretary determines is designed to attract a population that is healthier than the average population residing in the service area of the plan.

“(7) UNIFIED DEDUCTIBLE DEFINED.—In this part, the term 'unified deductible' means an annual deductible amount that is applied in lieu of the inpatient hospital deductible under section 1813(b)(1) and the deductible under section 1833(b). Nothing in this part shall be construed as preventing a MedicareAdvantage organization from requiring coinsurance or a copayment for inpatient hospital services after the unified deductible is satisfied, subject to the limitation on enrollee liability under section 1854(f).

“(b) ANTIDISCRIMINATION.—

“(1) BENEFICIARIES.—

“(A) IN GENERAL.—A MedicareAdvantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

“(B) CONSTRUCTION.—Except as provided under section 1851(a)(3)(B), subparagraph (A) shall not be construed as requiring a MedicareAdvantage organization to enroll individuals who are determined to have end-stage renal disease.

“(2) PROVIDERS.—A MedicareAdvantage organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

“(c) DISCLOSURE REQUIREMENTS.—

“(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicareAdvantage organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicareAdvantage plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

“(A) SERVICE AREA.—The plan's service area.

“(B) BENEFITS.—Benefits offered under the plan, including information described section 1852(a)(1) (relating to benefits under the original medicare fee-for-service program option, the maximum limitation in out-of-pocket expenses and the unified deductible, and qualified prescription drug coverage under part D, respectively) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicareAdvantage plans.

“(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits for such option).

“(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

“(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

“(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

“(ii) the process and procedures of the plan for obtaining emergency services; and

“(iii) the locations of—

“(I) emergency departments; and

“(II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

“(F) ENHANCED MEDICAL BENEFITS.—Enhanced medical benefits available from the organization offering the plan, including—

“(i) whether the enhanced medical benefits are optional;

“(ii) the enhanced medical benefits covered; and

“(iii) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits.

“(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

“(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

“(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

“(2) DISCLOSURE UPON REQUEST.—Upon request of a MedicareAdvantage eligible individual, a MedicareAdvantage organization must provide the following information to such individual:

“(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

“(B) Information on procedures used by the organization to control utilization of services and expenditures.

“(C) Information on the number of grievances, reconsiderations, and appeals and on the disposition in the aggregate of such matters.

“(D) An overall summary description as to the method of compensation of participating physicians.

“(E) The information described in subparagraphs (A) through (C) in relation to the qualified prescription drug coverage provided by the organization.

“(d) ACCESS TO SERVICES.—

“(1) IN GENERAL.—A MedicareAdvantage organization offering a MedicareAdvantage plan may select the providers from whom the benefits under the plan are provided so long as—

“(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

“(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

“(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

“(i) the services were not emergency services (as defined in paragraph (3)), but—

“(I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

“(II) it was not reasonable given the circumstances to obtain the services through the organization;

“(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area; or

“(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

“(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

“(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

“(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicareAdvantage plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

“(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

"(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

"(i) are furnished by a provider that is qualified to furnish such services under this title; and

"(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

"(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

"(ii) serious impairment to bodily functions; or

"(iii) serious dysfunction of any bodily organ or part.

"(4) ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a MedicareAdvantage private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

"(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, B, or D for such services; or

"(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6), with a sufficient number and range of providers within such category to provide covered services under the terms of the plan,

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan.

"(e) QUALITY ASSURANCE PROGRAM.—

"(1) IN GENERAL.—Each MedicareAdvantage organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicareAdvantage plans of the organization.

"(2) ELEMENTS OF PROGRAM.—

"(A) IN GENERAL.—The quality assurance program of an organization with respect to a MedicareAdvantage plan (other than a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan) it offers shall—

"(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicareAdvantage plans and organizations;

"(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

"(iii) provide access to disease management and chronic care services;

"(iv) provide access to preventive benefits and information for enrollees on such benefits;

"(v) evaluate the continuity and coordination of care that enrollees receive;

"(vi) be evaluated on an ongoing basis as to its effectiveness;

"(vii) include measures of consumer satisfaction;

"(viii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

"(ix) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

"(x) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

"(xi) have mechanisms to detect both underutilization and overutilization of services;

"(xii) after identifying areas for improvement, establish or alter practice parameters;

"(xiii) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

"(xiv) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

"(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS, AND NONNETWORK MSA PLANS.—The quality assurance program of an organization with respect to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan it offers shall—

"(i) meet the requirements of clauses (i) through (viii) of subparagraph (A);

"(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

"(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

"(C) DEFINITION OF NONNETWORK MSA PLAN.—In this subsection, the term 'nonnetwork MSA plan' means an MSA plan offered by a MedicareAdvantage organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

"(3) EXTERNAL REVIEW.—

"(A) IN GENERAL.—Each MedicareAdvantage organization shall, for each MedicareAdvantage plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (4)(B) and (14) of section 1154(a) with respect to services furnished by MedicareAdvantage plans for which payment is made under this title. The previous sentence shall not apply to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan that does not employ utilization review.

"(B) NONDUPLICATION OF ACCREDITATION.—Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

"(C) WAIVER AUTHORITY.—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

"(4) TREATMENT OF ACCREDITATION.—

"(A) IN GENERAL.—The Secretary shall provide that a MedicareAdvantage organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

"(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

"(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

"(ii) Subsection (b) (relating to antidiscrimination).

"(iii) Subsection (d) (relating to access to services).

"(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

"(v) Subsection (i) (relating to information on advance directives).

"(vi) Subsection (j) (relating to provider participation rules).

"(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

"(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with MedicareAdvantage organizations under subsection (c)(2) of such section.

"(5) REPORT TO CONGRESS.—

"(A) IN GENERAL.—The Secretary shall submit to Congress a biennial report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

"(B) CONTENTS OF REPORT.—Each such report shall include the following:

"(i) A description of the means by which such programs focus on such racial and ethnic minorities.

"(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

"(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

"(f) GRIEVANCE MECHANISM.—Each MedicareAdvantage organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with MedicareAdvantage plans of the organization under this part.

"(g) Coverage Determinations, Reconsiderations, and Appeals.—

"(1) Determinations by organization.—

"(A) In general.—A MedicareAdvantage organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

"(B) Explanation of determination.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

"(2) Reconsiderations.—

"(A) In general.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

"(B) Physician decision on certain reconsiderations.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

"(3) Expedited determinations and reconsiderations.—

"(A) Receipt of requests.—

"(i) Enrollee requests.—An enrollee in a MedicareAdvantage plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the MedicareAdvantage organization.

"(ii) Physician requests.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

"(B) Organization procedures.—

"(i) In general.—The MedicareAdvantage organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

"(ii) Expedition required for physician requests.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

"(iii) Timely response.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

"(4) Independent review of certain coverage denials.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

"(5) Appeals.—An enrollee with a MedicareAdvantage plan of a MedicareAdvantage organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

"(h) Confidentiality and Accuracy of Enrollee Records.—Insofar as a MedicareAdvantage organization maintains medical records or other health information regarding enrollees under this part, the MedicareAdvantage organization shall establish procedures—

"(1) to safeguard the privacy of any individually identifiable enrollee information;

"(2) to maintain such records and information in a manner that is accurate and timely; and

"(3) to assure timely access of enrollees to such records and information.

"(i) Information on Advance Directives.—Each MedicareAdvantage organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

"(j) Rules Regarding Provider Participation.—

"(1) Procedures.—Insofar as a MedicareAdvantage organization offers benefits under a MedicareAdvantage plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

"(A) providing notice of the rules regarding participation;

"(B) providing written notice of participation decisions that are adverse to physicians; and

"(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

"(2) Consultation in medical policies.—A MedicareAdvantage organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

"(3) Prohibiting interference with provider advice to enrollees.—

"(A) In general.—Subject to subparagraphs (B) and (C), a MedicareAdvantage organization (in relation to an individual enrolled under a MedicareAdvantage plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

"(B) Conscience protection.—Subparagraph (A) shall not be construed as requiring a MedicareAdvantage plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicareAdvantage organization offering the plan—

"(i) objects to the provision of such service on moral or religious grounds; and

"(ii) in the manner and through the written instrumentalities such MedicareAdvantage organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

"(C) Construction.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

"(D) Health care professional defined.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicareAdvantage plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed pharmacist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

"(4) Limitations on physician incentive plans.—

"(A) In general.—No MedicareAdvantage organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

"(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

"(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

"(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group; and

"(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

"(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

"(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a MedicareAdvantage organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

"(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicareAdvantage organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicareAdvantage plan of the organization under this part by the organization's denial of medically necessary care.

"(6) SPECIAL RULES FOR MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a MedicareAdvantage organization (with respect to an individual enrolled in a MedicareAdvantage private fee-for-service plan it offers), if—

"(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

"(B) before providing such services, the provider, professional, or other entity—

"(i) has been informed of the individual's enrollment under the plan; and

"(ii) either—

"(I) has been informed of the terms and conditions of payment for such services under the plan; or

"(II) is given a reasonable opportunity to obtain information concerning such terms and conditions, in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the MedicareAdvantage organization.

"(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicareAdvantage organization described in section 1851(a)(2)(A) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicareAdvantage organization under this part) also applies with respect to an individual so enrolled.

"(2) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—

"(A) BALANCE BILLING LIMITS UNDER MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

"(i) IN GENERAL.—In the case of an individual enrolled in a MedicareAdvantage private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

"(ii) PROCEDURES TO ENFORCE LIMITS.—The MedicareAdvantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out clause (i).

"(iii) ASSURING ENFORCEMENT.—If the MedicareAdvantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

"(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provisions—

"(i) establishing a minimum payment rate in the case of noncontract providers under a MedicareAdvantage private fee-for-service plan, see section 1852(a)(2); or

"(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

"(C) INFORMATION ON BENEFICIARY LIABILITY.—

"(i) IN GENERAL.—Each MedicareAdvantage organization that offers a MedicareAdvantage private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A, B, and D, and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

"(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

"(I) notice of the fact that balance billing is permitted under such subparagraph for such services; and

"(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

"(l) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

"(1) ENSURING RETURN TO HOME SNF.—

"(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a MedicareAdvantage plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

"(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

"(ii) SNF AGREEMENT.—The facility has a contract with the MedicareAdvantage organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the MedicareAdvantage organization for the provision of such services and through which the enrollee would otherwise receive such services.

"(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

"(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the MedicareAdvantage plan.

"(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

"(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a MedicareAdvantage plan.

"(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

"(4) DEFINITIONS.—In this subsection:

"(A) HOME SKILLED NURSING FACILITY.—The term 'home skilled nursing facility' means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a MedicareAdvantage plan, any of the following skilled nursing facilities:

"(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

"(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

"(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

"(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means, with respect to an enrollee in a MedicareAdvantage plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.".

SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS.

Section 1853 (42 U.S.C. 1395w–23) is amended to read as follows:

"PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

"SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

"(1) MONTHLY PAYMENTS.—

"(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each MedicareAdvantage organization, with respect to coverage of an individual for a month under this part in a MedicareAdvantage payment area, separate monthly payments with respect to—

"(i) benefits under the original medicare fee-for-service program under parts A and B in accordance with subsection (d); and

"(ii) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicareAdvantage organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicareAdvantage plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicareAdvantage payment area (or *such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.*

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

"(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicareAdvantage organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

"(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

"(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the MedicareAdvantage organization for each individual enrolled with the organization shall equal the MedicareAdvantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

"(i) by multiplying the benchmark amount for that payment area by the ratio of—

"(I) the payment amount determined under subsection (d)(4); to

"(II) the weighted service area benchmark amount determined under subsection (d)(2); and

"(ii) using such risk adjustment factor as specified by the Secretary under subsection (b)(1)(B).

"(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

"(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of payments to plans under subsection (d)(4)(B).

"(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to MedicareAdvantage plans offered by MedicareAdvantage organizations in 2005, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

"(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

"(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicareAdvantage organizations to submit such data and other information as the Secretary deems necessary.

"(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.

"(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each MedicareAdvantage payment area for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the greater of the following amounts (adjusted as appropriate for the application of the risk adjustment methodology under paragraph (3)):

"(A) MINIMUM AMOUNT.—$^{1}/_{12}$ *of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year.*

"(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).

"(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'local fee-for-service rate' means the amount of payment for a month in a MedicareAdvantage payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive benefits under the original medicare fee-for-service program option and not enrolled in a MedicareAdvantage plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876.

"(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

"(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

"(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

"(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates are payable during the year—

"(aa) for the indirect costs of medical education under section 1886(d)(5)(B); and

"(bb) for direct graduate medical education costs under section 1886(h).

"(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

"(b) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

"(1) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

"(A) The benchmark amount for each MedicareAdvantage payment area (as calculated under subsection (a)(4)) for the year.

"(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each MedicareAdvantage payment area for the year.

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

"(A) provide for notice to MedicareAdvantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

"(B) provide such organizations with an opportunity to comment on such proposed changes.

"(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicareAdvantage organizations can compute each payment factor described in paragraph (1).

"(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

"(1) IN GENERAL.—For purposes of making payments under this part for years before 2006 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area before 2006 or a MedicareAdvantage payment area beginning with such year for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

"(A) BLENDED CAPITATION RATE.—The sum of—

"(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the MedicareAdvantage payment area, as determined under paragraph (3) for the year; and

"(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied by the budget neutrality adjustment factor determined under paragraph (5).

"(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

"(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

"(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

"(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

"(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

"(iv) For 2002 through 2013, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

"(v) For 2014 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

"(C) MINIMUM PERCENTAGE INCREASE.—

"(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

"(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

"(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

"(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

"(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting '102' for '103' in clause (v).

"(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

"(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent;

"(B) for 1999, the 'area-specific percentage' is 82 percent and the 'national percentage' is 18 percent;

"(C) for 2000, the 'area-specific percentage' is 74 percent and the 'national percentage' is 26 percent;

"(D) for 2001, the 'area-specific percentage' is 66 percent and the 'national percentage' is 34 percent;

"(E) for 2002, the 'area-specific percentage' is 58 percent and the 'national percentage' is 42 percent; and

"(F) for a year after 2002, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

"(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

"(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

"(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

"(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

"(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

"(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

"(I) 1998 is 20 percent;

"(II) 1999 is 40 percent;

"(III) 2000 is 60 percent;

"(IV) 2001 is 80 percent; and

"(V) a succeeding year is 100 percent.

"(C) PAYMENT ADJUSTMENT.—

"(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

"(I) for the indirect costs of medical education under section 1886(d)(5)(B); and

"(II) for direct graduate medical education costs under section 1886(h).

"(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

"(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

"(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

"(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year;

"(ii) the proportion of such rate for the year which is attributable to such type of services; and

"(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

"(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the 'national standardized annual Medicare+Choice capitation rate' for a year is equal to—

"(i) the sum (for all Medicare+Choice payment areas) of the product of—

"(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3); and

"(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

"(ii) the sum of the products described in clause (i)(II) for all areas for that year.

"(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

"(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

"(A) IN GENERAL.—In this part, the 'national per capita Medicare+Choice growth percentage' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

"(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

"(i) for 1998, 0.8 percentage points;

"(ii) for 1999, 0.5 percentage points;

"(iii) for 2000, 0.5 percentage points;

"(iv) for 2001, 0.5 percentage points;

"(v) for 2002, 0.3 percentage points; and

"(vi) for a year after 2002, 0 percentage points.

"(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

"(7) TRANSITION TO MEDICAREADVANTAGE COMPETITION.—

"(A) IN GENERAL.—For each year (beginning with 2006) payments to MedicareAdvantage plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

"(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2006) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1) for purposes of determining the benchmark amount under subsection (a)(4).

"(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT.—

"(1) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under section 1854(a) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part an are based on the assumptions described in section 1854(a)(2)(A)(iii).

"(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for the benefits under the original medicare fee-for-service program option for each plan equal to the weighted average of the benchmark amounts for benefits under such original medicare fee-for-service program option for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii).

"(3) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the weighted service area benchmark amount (as determined under paragraph (2)) for purposes of determining—

"(A) the payment amount under paragraph (4); and

"(B) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

"(4) DETERMINATION OF PAYMENT AMOUNT FOR ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the payment amount for MedicareAdvantage plans for the benefits under the original medicare fee-for-service program option as follows:

"(i) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount.

"(ii) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

"(B) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall adjust the amounts determined under subparagraph (A) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

"(6) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Secretary of the actuarial costs associated with the new benefits.

"(7) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—For purposes of this part, the term 'benefits under the original medicare fee-for-service program option' means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to, or enrolled for, benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.

"(e) MEDICAREADVANTAGE PAYMENT AREA DEFINED.—

"(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'MedicareAdvantage payment area' means a county, or equivalent area specified by the Secretary.

"(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicareAdvantage payment area shall be a State or such other payment area as the Secretary specifies.

"(3) GEOGRAPHIC ADJUSTMENT.—

"(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 2005) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a MedicareAdvantage payment area in the State otherwise determined under paragraph (1)—

"(i) to a single statewide MedicareAdvantage payment area;

"(ii) to the metropolitan based system described in subparagraph (C); or

"(iii) to consolidating into a single MedicareAdvantage payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

"(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for MedicareAdvantage payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicareAdvantage payment areas in the State in the absence of the adjustment under this paragraph.

"(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

"(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicareAdvantage payment area; and

"(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicareAdvantage payment area.

"(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

"(f) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

"(1) IN GENERAL.—If the amount of the MedicareAdvantage monthly MSA premium (as defined in section 1854(b)(2)(D)) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicareAdvantage MSA established (and, if applicable, designated) by the individual under paragraph (2).

"(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

"(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicareAdvantage MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986); and

"(B) if the individual has established more than 1 such MedicareAdvantage MSA, has designated 1 of such accounts as the individual's MedicareAdvantage MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

"(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicareAdvantage MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

"(g) PAYMENTS FROM TRUST FUNDS.—Except as provided in section 1858A(c) (relating to payments for qualified prescription drug coverage), the payment to a MedicareAdvantage organization under this section for individuals enrolled under this part with the organization and payments to a MedicareAdvantage MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

"(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

"(1) election under this part of a MedicareAdvantage plan offered by a MedicareAdvantage organization—

"(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicareAdvantage plan or the original medicare fee-for-service program option (as the case may be) elected before the election with such organization,

"(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge; and

"(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

"(2) termination of election with respect to a MedicareAdvantage organization under this part—

"(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge;

"(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicareAdvantage organization; and

"(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

"(i) SPECIAL RULE FOR HOSPICE CARE.—

"(1) INFORMATION.—A contract under this part shall require the MedicareAdvantage organization to inform each individual enrolled under this part with a MedicareAdvantage plan offered by the organization about the availability of hospice care if—

"(A) a hospice program participating under this title is located within the organization's service area; or

"(B) it is common practice to refer patients to hospice programs outside such service area.

"(2) PAYMENT.—If an individual who is enrolled with a MedicareAdvantage organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

"(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

"(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the MedicareAdvantage organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

"(C) the Secretary shall continue to make monthly payments to the MedicareAdvantage organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).".

SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

Section 1854 (42 U.S.C. 1395w–24) is amended to read as follows:

"SUBMISSION OF BIDS; PREMIUMS

"SEC. 1854. (a) SUBMISSION OF BIDS BY MEDICAREADVANTAGE ORGANIZATIONS.—

"(1) IN GENERAL.—Not later than the second Monday in September and except as provided in paragraph (3), each MedicareAdvantage organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each MedicareAdvantage plan that the organization intends to offer in a service area in the following year—

"(A) notice of such intent and information on the service area of the plan;

"(B) the plan type for each plan;

"(C) if the MedicareAdvantage plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

"(D) the enrollment capacity (if any) in relation to the plan and each payment area;

"(E) the expected mix, by health status, of enrolled individuals; and

"(F) such other information as the Secretary may specify.

"(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a MedicareAdvantage plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

"(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Information relating to the coverage of benefits under the original medicare fee-for-service program option as follows:

"(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under the original medicare fee-for-service program option to an individual enrolled in the plan that resides in the service area of the plan for a month.

"(ii) For the enhanced medical benefits package offered—

"(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

"(II) the portion of the actuarial value of such benefits package (if any) that will be applied toward satisfying the requirement for additional benefits under subsection (g);

"(III) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (as defined in subsection (b)(2)(C));

"(IV) a description of any cost-sharing;

"(V) a description of whether the amount of the unified deductible has been lowered or the maximum limitations on out-of-pocket expenses have been decreased (relative to the levels used in calculating the plan bid);

"(VI) such other information as the Secretary considers necessary.

"(iii) The assumptions that the MedicareAdvantage organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

"(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—The information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

"(C) DETERMINING PLAN COSTS INCLUDED IN PLAN BID.—For purposes of submitting its plan bid under subparagraph (A)(i) a Medicare- Advantage plan offered by a MedicareAdvantage organization satisfies subparagraphs (A) and (C) of section 1852(a)(1) if the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled in such plan under this part with respect to benefits under the original medicare fee-for-service program option on which that bid is based (ignoring any reduction in cost-sharing offered by such plan as enhanced medical benefits under paragraph (2)(A)(ii) or required under clause (ii) or (iii) of subsection (g)(1)(C)) equals the amount specified in subsection (f)(1)(B).

"(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted.

"(4) REVIEW.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the MedicareAdvantage organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

"(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3), or, with respect to a private fee-for-service plan (as described in section 1851(a)(2)(C)) under subparagraph (A)(i), (A)(ii)(III), or (B) of paragraph (2).

"(C) CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—Under the authority under subparagraph (A), the Secretary may disapprove the bid if the Secretary determines that the deductibles, coinsurance, or copayments applicable under the plan discourage access to covered services or are likely to result in favorable selection of MedicareAdvantage eligible individuals.

"(5) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under paragraph (1) for a MedicareAdvantage plan must reasonably and equitably reflect the cost of benefits provided under that plan.

"(b) MONTHLY PREMIUMS CHARGED.—

"(1) IN GENERAL.—

"(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization shall be equal to the sum of the following:

"(i) The MedicareAdvantage monthly basic beneficiary premium (if any).

"(ii) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (if any).

"(iii) The MedicareAdvantage monthly obligation for qualified prescription drug coverage (if any).

"(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

"(2) PREMIUM TERMINOLOGY.—For purposes of this part:

"(A) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'MedicareAdvantage monthly basic beneficiary premium' means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (d)(2) for the plan.

"(B) MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage' means, with respect to a MedicareAdvantage plan, the amount determined under section 1858A(d).

"(C) MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The term 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' means, with respect to a Medicare- Advantage plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

"(D) MEDICAREADVANTAGE MONTHLY MSA PREMIUM.—The term 'MedicareAdvantage monthly MSA premium' means, with respect to a MedicareAdvantage plan, the amount of such premium filed under subsection (a)(3) for the plan.

"(c) UNIFORM PREMIUM.—The Medicare- Advantage monthly basic beneficiary premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and the MedicareAdvantage monthly MSA premium charged under subsection (b) of a MedicareAdvantage organization under this part may not vary among individuals enrolled in the plan. Subject to the provisions of section 1858(h), such requirement shall not apply to enrollees of a MedicareAdvantage plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement.

"(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

"(1) BIDS BELOW THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the weighted service area benchmark amount exceeds the plan bid, the Secretary shall require the plan to provide additional benefits in accordance with subsection (g).

"(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be *the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be the MedicareAdvantage monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).*

“(e) Terms and Conditions of Imposing Premiums.—Each MedicareAdvantage organization shall permit the payment of any MedicareAdvantage monthly basic premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits on a monthly basis, may terminate election of individuals for a MedicareAdvantage plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in subsection (g)(1)(C)(i)).

“(f) Limitation on Enrollee Liability.—

“(1) For benefits under the original medicare fee-for-service program option.—The sum of—

“(A) the MedicareAdvantage monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (determined on the same basis as used in determining the plan's bid under paragraph (2)(C)) applicable on average to individuals enrolled under this part with a MedicareAdvantage plan described in subparagraph (A) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A); must equal

“(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive benefits under the original medicare fee-for-service program option if such individuals were not members of a MedicareAdvantage organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).

“(2) For enhanced medical benefits.—If the MedicareAdvantage organization provides to its members enrolled under this part in a MedicareAdvantage plan described in subparagraph (A) of section 1851(a)(2) with respect to enhanced medical benefits relating to benefits under the original medicare fee-for-service program option, the sum of the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year minus the actuarial value of any additional benefits pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C) that the plan specified under subsection (a)(2)(i)(II).

“(3) Determination on other basis.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the same geographic area, the State, or in the United States, eligible to enroll in the MedicareAdvantage plan involved under this part or on the basis of other appropriate data.

“(4) Special rule for private fee-for-service plans.—With respect to a MedicareAdvantage private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

“(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1852(a)(1); exceed

“(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if they were not members of a MedicareAdvantage organization for the year.

“(g) Requirement for Additional Benefits.—

“(1) Requirement.—

“(A) In general.—Each MedicareAdvantage organization (in relation to a MedicareAdvantage plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits described in subparagraph (C) as the organization may specify in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (D)).

“(B) Excess amount.—For purposes of this paragraph, the term ‘excess amount’ means, for an organization for a plan, is 100 percent of the amount (if any) by which the weighted service area benchmark amount (determined under section 1853(d)(2)) exceeds the plan bid (as adjusted under section 1853(d)(1)).

“(C) Additional benefits described.—The additional benefits described in this subparagraph are as follows:

“(i) Subject to subparagraph (F), a monthly part B premium reduction for individuals enrolled in the plan.

“(ii) Lowering the amount of the unified deductible and decreasing the maximum limitations on out-of-pocket expenses for individuals enrolled in the plan.

“(iii) A reduction in the actuarial value of plan cost-sharing for plan enrollees.

“(iv) Subject to subparagraph (E), such additional benefits as the organization may specify.

“(v) Contributing to the stabilization fund under paragraph (2).

“(vi) Any combination of the reductions and benefits described in clauses (i) through (v).

“(D) Adjusted excess amount.—For purposes of this paragraph, the term ‘adjusted excess amount’ means, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

“(E) Rule for approval of medical and prescription drug benefits.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

“(F) Premium reductions.—

“(i) In general.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a MedicareAdvantage organization may elect a reduction in its payments under section 1853(a)(1)(A)(i) with respect to a MedicareAdvantage plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

“(ii) Amount of reduction.—The amount of the reduction under clause (i) with respect to any enrollee in a MedicareAdvantage plan—

“(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

“(II) shall apply uniformly to each enrollee of the MedicareAdvantage plan to which such reduction applies.

“(G) Uniform application.—This paragraph shall be applied uniformly for all enrollees for a plan.

“(H) Construction.—Nothing in this subsection shall be construed as preventing a MedicareAdvantage organization from providing enhanced medical benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such enhanced medical benefits.

“(2) Stabilization fund.—A MedicareAdvantage organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicareAdvantage plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such Trust Funds.

“(3) Adjusted community rate.—For purposes of this subsection, subject to paragraph (4), the term ‘adjusted community rate’ for a service or services means, at the election of a MedicareAdvantage organization, either—

“(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicareAdvantage plan under this part if the rate of payment were determined under a ‘community rating system’ (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)); or

“(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicareAdvantage coverage, or MedicareAdvantage eligible individuals in the area, in the State, or in the United States, eligible to elect MedicareAdvantage coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

“(4) Determination based on insufficient data.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine the average amount of payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

“(h) Prohibition of State Imposition of Premium Taxes.—No State may impose a premium tax or similar tax with respect to payments to MedicareAdvantage organizations under section 1853.

“(i) Permitting Use of Segments of Service Areas.—The Secretary shall permit a MedicareAdvantage organization to elect to

apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of 1 or more MedicareAdvantage payment areas.".

(b) STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Secretary, in consultation with beneficiaries, consumer groups, employers, and Medicare+Choice organizations, shall conduct a study to determine the extent to which the cost-sharing structures under Medicare+Choice plans under part C of title XVIII of the Social Security Act discourage access to covered services or discriminate based on the health status of Medicare+Choice eligible individuals (as defined in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3))).

(2) REPORT.—Not later than December 31, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS.

Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

"SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

"SEC. 1858A. (a) AVAILABILITY.—

"(1) PLANS REQUIRED TO PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE TO ENROLLEES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), on and after January 1, 2006, a MedicareAdvantage organization offering a MedicareAdvantage plan (except for an MSA plan) shall make available qualified prescription drug coverage that meets the requirements for such coverage under this part and part D to each enrollee of the plan.

"(B) PRIVATE FEE-FOR-SERVICE PLANS MAY, BUT ARE NOT REQUIRED TO, PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE.—Pursuant to section 1852(a)(2)(D), a private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

"(2) REFERENCE TO PROVISION PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—For the provisions of part D, made applicable to this part pursuant to paragraph (1), that permit a plan to make available qualified prescription drug coverage that includes coverage of covered drugs that exceeds the coverage required under paragraph (1) of section 1860D–6 in an area, but only if the MedicareAdvantage organization offering the plan also offers a MedicareAdvantage plan in the area that only provides the coverage that is required under such paragraph (1), see paragraph (2) of such section.

"(3) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Pursuant to sections 1854(g)(1)(F) and 1852(a)(3)(D), a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage may not make available coverage of any prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option) to an enrollee as an additional benefit or as an enhanced medical benefit.

"(b) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a MedicareAdvantage organization under a MedicareAdvantage plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, and such other requirements under part D that the Secretary determines appropriate in the same manner as such requirements apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or the plan under this part.

"(c) PAYMENTS FOR PRESCRIPTION DRUGS.—

"(1) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—For each year (beginning with 2006), the Secretary shall pay to each MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

"(B) APPLICATION OF PART D RISK CORRIDOR, STABILIZATION RESERVE FUND, AND ADMINISTRATIVE EXPENSES PROVISIONS.—The provisions of subsections (b), (c), and (d) of section 1860D–16 shall apply to a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage and payments made to such organization under subparagraph (A) in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan and payments made to such entity under subsection (a) of section 1860D–16.

"(2) PAYMENT FROM PRESCRIPTION DRUG ACCOUNT.—Payment made to MedicareAdvantage organizations under this subsection shall be made from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

"(d) COMPUTATION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a MedicareAdvantage eligible individual receiving qualified prescription drug coverage under a MedicareAdvantage plan during a year after 2005, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage of such individual in the year shall be determined in the same manner as the monthly beneficiary obligation is determined under section 1860D–17 for eligible beneficiaries enrolled in a Medicare Prescription Drug plan, except that, for purposes of this subparagraph, any reference to the monthly plan premium approved by the Secretary under section 1860D–13 shall be treated as a reference to the monthly premium for qualified prescription drug coverage submitted by the MedicareAdvantage organization offering the plan under section 1854(a)(2)(A) and approved by the Secretary.

"(e) COLLECTION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D–18, including subsection (b) of such section, shall apply to the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage (as determined under subsection (d)) required to be paid by a MedicareAdvantage eligible individual enrolled in a MedicareAdvantage plan in the same manner as such provisions apply to the amount of the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan under part D.

"(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND REINSURANCE PAYMENTS.—For provisions—

"(1) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–19; and

"(2) providing a MedicareAdvantage organization with reinsurance payments for certain expenses incurred in providing qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–20.".

(b) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking "section 1854(f)(1)(E)" and inserting "section 1854(d)(1)(A)(i)".

SEC. 206. FACILITATING EMPLOYER PARTICIPATION.

Section 1858(h) (as added by section 211) is amended—

(1) by inserting "(including subsection (i) of such section)" after "section 1857"; and

(2) by adding at the end the following new sentence: "In applying the authority under section 1857(i) pursuant to this subsection, the Administrator may permit MedicareAdvantage plans to establish separate premium amounts for enrollees in an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B))."

SEC. 207. ADMINISTRATION BY THE CENTER FOR MEDICARE CHOICES.

On and after January 1, 2006, the MedicareAdvantage program under part C of title XVIII of the Social Security Act shall be administered by the Center for Medicare Choices established under section 1808 such title (as added by section 301), and each reference to the Secretary made in such part shall be deemed to be a reference to the Administrator of the Center for Medicare Choices.

SEC. 208. CONFORMING AMENDMENTS.

(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS.—Section 1855 (42 U.S.C. 1395w–25) is amended—

(1) in subsection (b), in the matter preceding paragraph (1), by inserting "subparagraphs (A), (B), and (D) of" before "section 1852(A)(1)"; and

(2) by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

(b) ESTABLISHMENT OF PSO STANDARDS.—Section 1856 (42 U.S.C. 1395w–26) is amended by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZATIONS.—Section 1857 (42 U.S.C. 1395w–27) is amended—

(1) in subsection (g)(1)—

(A) in subparagraph (B), by striking "amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums" and inserting "amounts of the MedicareAdvantage monthly basic premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits";

(B) in subparagraph (F), by striking "or" after the semicolon at the end;

(C) in subparagraph (G), by adding "or" after the semicolon at the end; and

(D) by inserting after subparagraph (G) the following new subparagraph:

"(H)(i) charges any individual an amount in excess of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage under section 1858A(d);

"(ii) provides coverage for prescription drugs that is not qualified prescription drug coverage;

"(iii) offers prescription drug coverage, but does not make standard prescription drug coverage available; or

"(iv) provides coverage for prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option described in section

1851(a)(1)(A)(i)) as an enhanced medical benefit under section 1852(a)(3)(D) or as an additional benefit under section 1854(g)(1)(F),''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(d) DEFINITIONS; MISCELLANEOUS PROVISIONS.—Section 1859 (42 U.S.C. 1395w–28) is amended—

(1) by striking subsection (c) and inserting the following new subsection:

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) ENHANCED MEDICAL BENEFITS.—The term 'enhanced medical benefits' is defined in section 1852(a)(3)(E).

''(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—The term 'MedicareAdvantage eligible individual' is defined in section 1851(a)(3).

''(3) MEDICAREADVANTAGE PAYMENT AREA.—The term 'MedicareAdvantage payment area' is defined in section 1853(d).

''(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The 'national per capita Medicare+Choice growth percentage' is defined in section 1853(c)(6).

''(5) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The terms 'MedicareAdvantage monthly basic beneficiary premium', 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage', and 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' are defined in section 1854(b)(2).

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' has the meaning given such term in section 1860D(9).

''(7) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' has the meaning given such term in section 1860D(10).''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(e) CONFORMING AMENDMENTS EFFECTIVE BEFORE 2006.—

(1) EXTENSION OF MSAs.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended by striking ''January 1, 2003'' and inserting ''January 1, 2004''.

(2) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2)(A), by striking ''THROUGH 2001'' and ''December 31,2004'' and inserting ''THROUGH 2005'' and ''December 31, 2005'', respectively;

(B) in the heading of paragraph (2)(B), by striking ''DURING 2005'' and inserting ''DURING 2006'';

(C) in paragraphs (2)(B)(i) and (2)(C)(i), by striking ''2005'' and inserting ''2006'' each place it appears;

(D) in paragraph (2)(D), by striking ''2004'' and inserting ''2005''; and

(E) in paragraph (4), by striking ''2005'' and inserting ''2006'' each place it appears.

(3) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

''(iv) For 2002, 2003, and 2004, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2003.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year, except that such rate shall be determined by substituting '102' for '103' in clause (v).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of enactment of this Act.

(e) OTHER CONFORMING AMENDMENTS.—

(1) CONFORMING MEDICARE CROSS-REFERENCES.—

(A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(B) Section 1840(i) (42 U.S.C. 1395s(i)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(C) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(D) Section 1876(k)(3)(A) (42 U.S.C. 1395mm(k)(3)(A)) is amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after section 1853(a).

(F) Section 1876(k)(4) (42 U.S.C. 1395mm(k)(4)(A)) is amended—

(i) in subparagraph (A), by striking ''section 1853(a)(3)(B)'' and inserting ''section 1853(a)(3)(D)''; and

(ii) in subparagraph (B), by striking ''section 1854(g)'' and inserting ''section 1854(h)''.

(G) Section 1876(k)(4)(C) (42 U.S.C. 1395mm(k)(4)(C)) in amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after ''section 1851(e)(6)''.

(H) Section 1894(d) (42 U.S.C. 1395eee(d)) is amended by adding at the end the following new paragraph:

''(3) APPLICATION OF PROVISIONS.—For purposes of paragraphs (1) and (2), the references to section 1853 and subsection (a)(2) of such section in such paragraphs shall be deemed to be references to those provisions as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003.''.

(2) CONFORMING MEDICARE TERMINOLOGY.—Title XVIII (42 U.S.C. 1395 et seq.), except for part C of such title (42 U.S.C. 1395w–21 et seq.), and title XIX (42 U.S.C. 1396 et seq.) are each amended by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

SEC. 209. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 208(d)(3) and subsection (b), the amendments made by this title shall apply with respect to plan years beginning on and after January 1, 2006.

(b) MEDICAREADVANTAGE MSA PLANS.—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if this title had not been enacted.

SEC. 210. IMPROVEMENTS IN MEDICAREADVANTAGE BENCHMARK DETERMINATIONS.

(a) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICAREADVANTAGE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(B) by adding at the end the following new subparagraph:

''(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

Subtitle B—Preferred Provider Organizations

SEC. 211. ESTABLISHMENT OF MEDICAREADVANTAGE PREFERRED PROVIDER PROGRAM OPTION.

(a) ESTABLISHMENT OF PREFERRED PROVIDER PROGRAM OPTION.—Section 1851(a)(2) is amended by adding at the end the following new subparagraph:

''(D) PREFERRED PROVIDER ORGANIZATION PLANS.—A MedicareAdvantage preferred provider organization plan under the program established under section 1858.''.

(b) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

''PREFERRED PROVIDER ORGANIZATIONS

''SEC. 1858. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Beginning on January 1, 2006, there is established a preferred provider program under which preferred provider organization plans offered by preferred provider organizations are offered to MedicareAdvantage eligible individuals in preferred provider regions.

''(2) DEFINITIONS.—

''(A) PREFERRED PROVIDER ORGANIZATION.—The term 'preferred provider organization' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to preferred provider organizations.

''(B) PREFERRED PROVIDER ORGANIZATION PLAN.—The term 'preferred provider organization plan' means a MedicareAdvantage plan that—

''(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

''(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and *"(iii) is offered by a preferred provider organization.*

"(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' means—

"(i) a region established under paragraph (3); and

"(ii) a region that consists of the entire United States.

"(3) PREFERRED PROVIDER REGIONS.—For purposes of this part the Secretary shall establish preferred provider regions as follows:

"(A) There shall be at least 10 regions.

"(B) Each region must include at least 1 State.

"(C) The Secretary may not divide States so that portions of the State are in different regions.

"(D) To the extent possible, the Secretary shall include multistate metropolitan statistical areas in a single region. The Secretary may divide metropolitan statistical areas where it is necessary to establish regions of such size and geography as to maximize the participation of preferred provider organization plans.

"(E) The Secretary may conform the preferred provider regions to the service areas established under section 1860D–10.

"(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

"(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to preferred provider organization plans offered by a preferred provider organization.

"(2) SERVICE AREA.—The service area of a preferred provider organization plan shall be a preferred provider region.

"(3) AVAILABILITY.—Each preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

"(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

"(5) ASSURING ACCESS TO SERVICES IN PREFERRED PROVIDER ORGANIZATION PLANS.—

"(A) IN GENERAL.—In addition to any other requirements under this section, in the case of a preferred provider organization plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.

"(B) DETERMINATION OF SUFFICIENT ACCESS.—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

"(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting—

"(i) the persons from whom enrollees under such plan may obtain covered benefits; or

"(ii) the categories of licensed health professionals or providers from whom enrollees under such a plan may obtain covered benefits if the covered services are provided to enrollees in a State where 25 percent or more of the population resides in health professional shortage areas designated pursuant to section 332 of the Public Health Service Act.

"(c) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS.—

"(1) PAYMENTS TO ORGANIZATIONS.—

"(A) MONTHLY PAYMENTS.—

"(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsection (e), and section 1859(e)(4), the Secretary shall make, to each preferred provider organization, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

"(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

"(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

"(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a preferred provider organization plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

"(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

"(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

"(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

"(2) ANNUAL CALCULATION OF BENCHMARK AMOUNTS FOR PREFERRED PROVIDER REGIONS.—For each year (beginning in 2006), the Secretary shall calculate a benchmark amount for each preferred provider region for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the average of each benchmark amount calculated under section 1853(a)(4) for each MedicareAdvantage payment area for the year within such region, weighted by the number of MedicareAdvantage eligible individuals residing in each such payment area for the year.

"(3) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

"(A) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

"(i) The benchmark amount for each preferred provider region (as calculated under paragraph (2)(A)) for the year.

"(ii) The factors to be used for adjusting payments described under—

"(I) the comprehensive risk adjustment methodology described in paragraph (1)(C) with respect to each preferred provider region for the year; and

"(II) the methodology used for adjustment for geographic variations within such region established under paragraph (1)(D).

"(B) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall—

"(i) provide for notice to preferred provider organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

"(ii) provide such organizations with an opportunity to comment on such proposed changes.

"(C) EXPLANATION OF ASSUMPTIONS.—In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that preferred provider organizations can compute each payment factor described in such subparagraph.

"(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

"(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

"(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The Secretary shall calculate a preferred provider regional benchmark amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

"(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

"(i) the payment amount under subparagraph (D); and

"(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

"(D) DETERMINATION OF PAYMENT AMOUNT.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a preferred provider organization for a preferred provider organization plan as follows:

"(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

"(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

"(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in paragraph (3)(A)(ii).

"(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR PREFERRED PROVIDER ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

"(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to preferred provider organizations

in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

"(5) PAYMENTS FROM TRUST FUND.—The payment to a preferred provider organization under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

"(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect preferred provider organizations.

"(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to preferred provider organizations.

"(d) SUBMISSION OF BIDS BY PPOS; PREMIUMS.—

"(1) SUBMISSION OF BIDS BY PREFERRED PROVIDER ORGANIZATIONS.—

"(A) IN GENERAL.—For the requirements on submissions by MedicareAdvantage preferred provider organization plans, see section 1854(a)(1).

"(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

"(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan must reasonably and equitably reflect the cost of benefits provided under that plan.

"(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the preferred provider organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

"(E) AUTHORITY TO LIMIT NUMBER OF PLANS IN A REGION.—If there are bids for more than 3 preferred provider organization plans in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

"(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a preferred provider organization plan offered by a preferred provider organization shall be equal to the sum of the following:

"(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

"(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

"(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

"(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

"(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a preferred provider organization to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

"(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

"(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

"(A) IN GENERAL.—For 2007 and 2008, the preferred provider organization offering a preferred provider organization plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

"(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

"(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

"(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

"(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a preferred provider organization plan may not exceed an amount determined appropriate by the Administrator.

"(2) ADJUSTMENT OF PAYMENT.—

"(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the preferred provider organization offering the plan.

"(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

"(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

"(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

"(II) 90 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

"(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

"(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

"(ii) 90 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

"(3) ESTABLISHMENT OF RISK CORRIDORS.—

"(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to a range as follows:

"(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 5 percent of such target amount.

"(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to 10 percent of such target amount.

"(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (i)(II).

"(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (ii)(II).

"(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a preferred provider organization plan offered by a preferred provider organization in a year, an amount equal to the sum of—

"(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

"(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

"(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A preferred provider organization that offers a preferred provider organization plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

"(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

"(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a preferred provider organization and a preferred provider organization plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

"(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATIONS.—A preferred provider organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a preferred provider organization plan.

"(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to preferred provider organizátions.

"(h) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—The provisions of section 1857 shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.".

(c) PREFERRED PROVIDER TERMINOLOGY DEFINED.—Section 1859(a) is amended by adding at the end the following new paragraph:

"(3) PREFERRED PROVIDER ORGANIZATION; PREFERRED PROVIDER ORGANIZATION PLAN; PREFERRED PROVIDER REGION.—The terms 'preferred

provider organization', 'preferred provider organization plan', and 'preferred provider region' have the meaning given such terms in section 1858(a)(2).".

Subtitle C—Other Managed Care Reforms

SEC. 221. EXTENSION OF REASONABLE COST CONTRACTS.

(a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended by striking "2004" and inserting "2009".

(b) APPLICATION OF CERTAIN MEDICARE+CHOICE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Prescription Drug and Medicare Improvements Act of 2003 for plan years beginning on or after January 1, 2004, shall provide that the following provisions of the Medicare+Choice program under part C (and, on and after January 1, 2006, the provisions of the MedicareAdvantage program under such part) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare+Choice organizations and Medicare+Choice plans (or, on and after January 1, 2006, MedicareAdvantage organizations and MedicareAdvantage plans, respectively) under such part:

"(A) Paragraph (1) of section 1852(e) (relating to the requirement of having an ongoing quality assurance program) and paragraph (2)(B) of such section (relating to the required elements for such a program).

"(B) Section 1852(j)(4) (relating to limitations on physician incentive plans).

"(C) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

"(D) Section 1854(g), or, on and after January 1, 2006, section 1854(h) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

"(E) Section 1856(b) (regarding compliance with the standards established by regulation pursuant to such section, including the provisions of paragraph (3) of such section relating to relation to State laws).

"(F) Section 1852(a)(3)(A) (regarding the authority of organizations to include supplemental health care benefits and, on and after January 1, 2006, enhanced medical benefits under the plan subject to the approval of the Secretary).

"(G) The provisions of part C relating to timelines for benefit filings, contract renewal, and beneficiary notification.

"(H) Section 1854(e), or, on and after January 1, 2006, section 1854(f) (relating to proposed cost-sharing under the contract being subject to review by the Secretary).".

(c) PERMITTING DEDICATED GROUP PRACTICE HEALTH MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE MEDICARE COST CONTRACT PROGRAM.—Section 1876(h)(6) of the Social Security Act (42 U.S.C. 1395mm(h)(6)), as redesignated and amended by subsections (a) and (b), is amended—

(1) in subparagraph (A), by striking "After the date of the enactment" and inserting "Except as provided in subparagraph (C), after the date of the enactment";

(2) in subparagraph (B), by striking "subparagraph (C)" and inserting "subparagraph (D)";

(3) by redesignating subparagraph (C) as subparagraph (D); and

(4) by inserting after subparagraph (B), the following new subparagraph:

"(C) Subject to paragraph (5) and subparagraph (D), the Secretary shall approve an application to enter into a reasonable cost contract under this section if—

"(i) the application is submitted to the Secretary by a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act) that, as of January 1, 2004, and except as provided in section 1301(b)(3)(B) of such Act, provides at least 85 percent of the services of a physician which are provided as basic health services through a medical group (or groups), as defined in section 1302(4) of such Act; and

"(ii) the Secretary determines that the organization meets the requirements applicable to such organizations and contracts under this section.".

SEC. 222. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w-21(a)(2)(A)) is amended by adding at the end the following new sentence: "Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.".

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w-28(b)) is amended by adding at the end the following new paragraph:

"(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

"(A) IN GENERAL.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

"(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

"(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

"(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

"(i) is institutionalized (as defined by the Secretary);

"(ii) is entitled to medical assistance under a State plan under title XIX; or

"(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.".

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w-28) is amended by adding at the end the following new subsection:

"(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2008, the plan may restrict the enrollment of individuals under the plan to individuals who are within 1 or more classes of special needs beneficiaries.".

(d) REPORT TO CONGRESS.—Not later than December 31, 2006, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 1 year after the date of enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 223. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking "part C or" and inserting "part C, with a PACE provider under section 1894 or 1934, or";

(B) by striking "(i)";

(C) by striking "and (ii)"; and

(D) by striking "members of the organization" and inserting "members of the organization or PACE program eligible individuals enrolled with the PACE provider,".

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

"(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

"(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

"(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).".

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (64), by striking "and" at the end;

(B) in paragraph (65), by striking the period at the end and inserting "; and"; and

(C) by inserting after paragraph (65) the following new paragraph:

"(66) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).".

(2) REFERENCE IN MEDICAID STATUTE.—Section 1934(b) (42 U.S.C. 1396u–4(b)) is amended by adding at the end the following new paragraphs:

"(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

"(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

"(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than the date that is 2 months after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the "Institute") shall conduct an evaluation of leading health care performance measures and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) catalogue, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance; and

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, health plans, purchasers, and consumers.

(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act, the Institute shall submit to the Secretary of Health and Human Services, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare+Choice program under part C of such title, and any other programs under such title XVIII.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for purposes of conducting the evaluation and preparing the report required by this section.

SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c–3(a)(1)) is amended by inserting ", Medicare+Choice organizations and MedicareAdvantage organizations under part C, and prescription drug card sponsors and eligible entities under part D" after "under section 1876".

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

"(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, prescription drug card sponsors and eligible entities under part D, and Medicare+Choice and MedicareAdvantage plans under part C quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

SEC. 226. EXTENSION OF DEMONSTRATION FOR ESRD MANAGED CARE.

The Secretary shall extend without interruption, through December 31, 2007, the approval of the demonstration project, Contract No. H1021, under the authority of section 2355(b)(1)(B)(iv) of the Deficit Reduction Act of 1984, as amended by section 13567 of the Omnibus Reconciliation Act of 1993. Such approval shall be subject to the terms and conditions in effect for the 2002 project year with respect to eligible participants and covered benefits. The Secretary shall set the monthly capitation rate for enrollees on the basis of the reasonable medical and direct administrative costs of providing those benefits to such participants.

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

"(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

"(1) ANNUAL DETERMINATION AND DESIGNATION.—

"(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D–11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

"(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

"(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

"(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

"(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

"(iii) Whether the Secretary expects that MedicareAdvantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

"(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

"(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

"(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

"(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

"(3) SUBMISSION OF BIDS.—

"(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

"(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a *preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).*

“(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

“(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

“(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

“(5) FUNDING LIMITATION.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period or year, as applicable, may not exceed the applicable amount (as defined in clause (ii)).

“(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term ‘applicable amount’ means—

“(I) for the period beginning on January 1, 2009, and ending on September 30, 2013, the total amount that would have been expended under this title during the period if this subsection had not been enacted plus $6,000,000,000; and

“(II) for fiscal year 2014 and any subsequent fiscal year, the total amount that would have been expended under this title during the year if this subsection had not been enacted.

“(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

“(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

“(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

“(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

“(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

“(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

“(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

“(A) a detailed description of—

“(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(iii) amounts remaining within the funding limitation specified in paragraph (5); and

“(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

“(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

“(8) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

“(A) an evaluation of—

“(i) the quality of care provided to beneficiaries enrolled in a MedicareAdvantage preferred provider plan in a highly competitive region;

“(ii) the satisfaction of beneficiaries with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

“(9) REPORT ON BUDGET NEUTRALITY FOR FISCAL YEARS AFTER 2013.—

“(A) IN GENERAL.—If the Secretary intends to designate 1 or more regions as highly competitive regions with respect to calendar 2014 or any subsequent calendar year, the Secretary shall submit a report to Congress indicating such intent no later than April 1 of the calendar year prior to the calendar year in which the applicable designation year begins.

“(B) REQUIREMENTS.—A report submitted under subparagraph (A) shall—

“(i) specify the steps (if any) that the Secretary will take pursuant to paragraph (5)(B) to ensure that the total amount expended as a result of the application of this subsection during the year will not exceed the applicable amount for the year (as defined in paragraph (5)(A)(ii)(II)); and

“(ii) contain a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that such steps will meet the requirements of paragraph (5)(A) based on an analysis using generally accepted actuarial principles and methodologies.”.

(b) CONFORMING AMENDMENT.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

“(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.”.

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) ESTABLISHMENT.—

(1) REVIEW AND REPORT ON RESULTS OF EXISTING DEMONSTRATIONS.—

(A) REVIEW.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) REPORT.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) PROJECTS.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) ENHANCED BENEFITS OR SERVICES.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care, coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) PROJECT SITES AND DURATION.—

(1) IN GENERAL.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that a region or regions are designated as such a highly competitive region.

(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) Funding.—

(1) In general.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) Limitation.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) Monitoring and reports.—

(A) Ongoing monitoring by the secretary to ensure funding limitation is not violated.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) Reports.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(C) Report on budget neutrality for fiscal years after 2013.—

(i) In general.—If the Secretary intends to continue the projects under this section for fiscal year 2014 or any subsequent fiscal year, the Secretary shall submit a report to Congress indicating such intent no later than April 1 of the year prior to the year in which the fiscal year begins.

(ii) Requirements.—A report submitted under clause (i) shall—

(I) specify the steps (if any) that the Secretary will take pursuant to paragraph (4) to ensure that the limitations described in paragraph (2)(B) will not be violated for the year; and

(II) contain a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that such steps will meet the requirements of paragraph (2) based on an analysis using generally accepted actuarial principles and methodologies.

(4) Application of limitation.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) Authority.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

Subtitle E—National Bipartisan Commission on Medicare Reform

SEC. 241. MEDICAREADVANTAGE GOAL; ESTABLISHMENT OF COMMISSION.

(a) Enrollment Goal.—It is the goal of this title that, not later than January 1, 2010, at least 15 percent of individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title should be enrolled in a MedicareAdvantage plan, as determined by the Center for Medicare Choices.

(b) Failure to Achieve Goal.—If the goal described in subsection (a) is not met by January 1, 2012, as determined by the Center for Medicare Choices, there shall be established a commission as described in section 2.

SEC. 242. NATIONAL BIPARTISAN COMMISSION ON MEDICARE REFORM.

(a) Establishment.—Upon a determination under section 241(b) that the enrollment goal has not been met, there shall be established a commission to be known as the National Bipartisan Commission on Medicare Reform (in this section referred to as the "Commission").

(b) Duties of the Commission.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under sections 1817 and 1841 of such Act (42 U.S.C. 1395i and 1395t), including—

(A) the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals; and

(B) the ability of the Federal Government to sustain the program into the future;

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals and trends in employment-related health care for retirees;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered under, and beneficiary contributions to, the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5) and (6) should be implemented;

(8) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program;

(9) make recommendations regarding a comprehensive approach to preserve the medicare program, including ways to increase the effectiveness of the MedicareAdvantage program and to increase MedicareAdvantage enrollment rates; and

(10) review and analyze such other matters as the Commission determines appropriate.

(c) Membership.—

(1) Number and appointment.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairperson of the Commission, shall be appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) Deadline for appointment.—Members of the Commission shall be appointed by not later than October 1, 2012.

(3) Terms of appointment.—The term of any member appointed under paragraph (1) shall be for the life of the Commission.

(4) Meetings.—The Commission shall meet at the call of the Chairperson or a majority of its members.

(5) Quorum.—A quorum for purposes of conducting the business of the Commission shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) Vacancies.—A vacancy in the membership of the Commission shall be filled, not later than 30 days after the Commission is given notice of the vacancy, in the same manner in which the original appointment was made. Such a vacancy shall not affect the power of the remaining members to carry out the duties of the Commission.

(7) Compensation.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) Expenses.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule under title 5, United States Code.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(1) HEARINGS AND OTHER ACTIVITIES.—The Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties under this section.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties under this section.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID.—

(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Center for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties under this section.

(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties under this section. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties under this section.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties under this section, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairperson of the Commission, the head of each such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

(f) REPORT.—Not later than April 1, 2014, the Commission shall submit to the President and Congress a report and an implementation bill that shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive the approval of at least 11 members of the Commission.

(g) TERMINATION.—The Commission shall terminate on the date that is 30 days after the date on which the report and implementation bill is submitted under subsection (f).

SEC. 243. CONGRESSIONAL CONSIDERATION OF REFORM PROPOSALS.

(a) DEFINITIONS.—In this section:

(1) IMPLEMENTATION BILL.—The term "implementation bill" means only a bill that is introduced as provided under subsection (b), and contains the proposed legislation included in the report submitted to Congress under section 242(f), without modification.

(2) CALENDAR DAY.—The term "calendar day" means a calendar day other than 1 on which either House is not in session because of an adjournment of more than 3 days to a date certain.

(b) INTRODUCTION; REFERRAL; AND REPORT OR DISCHARGE.—

(1) INTRODUCTION.—On the first calendar day on which both Houses are in session immediately following the date on which the report is submitted to Congress under section 242(f), a single implementation bill shall be introduced (by request)—

(A) in the Senate by the Majority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate; and

(B) in the House of Representatives by the Speaker of the House of Representatives, for himself and the Minority Leader of the House of Representatives, or by Members of the House of Representatives designated by the Speaker and Minority Leader of the House of Representatives.

(2) REFERRAL.—The implementation bills introduced under paragraph (1) shall be referred to any appropriate committee of jurisdiction in the Senate and any appropriate committee of jurisdiction in the House of Representatives. A committee to which an implementation bill is referred under this paragraph may report such bill to the respective House without amendment.

(3) REPORT OR DISCHARGE.—If a committee to which an implementation bill is referred has not reported such bill by the end of the 15th calendar day after the date of the introduction of such bill, such committee shall be immediately discharged from further consideration of such bill, and upon being reported or discharged from the committee, such bill shall be placed on the appropriate calendar.

(c) FLOOR CONSIDERATION.—

(1) IN GENERAL.—When the committee to which an implementation bill is referred has reported, or has been discharged under subsection (b)(3), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the implementation bill, and all points of order against the implementation bill (and against consideration of the implementation bill) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the implementation bill is agreed to, the implementation bill shall remain the unfinished business of the respective House until disposed of.

(2) AMENDMENTS.—An implementation bill may not be amended in the Senate or the House of Representatives.

(3) DEBATE.—Debate on the implementation bill, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the resolution. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the implementation bill is not in order. A motion to reconsider the vote by which the implementation bill is agreed to or disagreed to is not in order.

(4) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on an implementation bill, and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the implementation bill shall occur.

(5) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to an implementation bill shall be decided without debate.

(d) COORDINATION WITH ACTION BY OTHER HOUSE.—If, before the passage by 1 House of an implementation bill of that House, that House receives from the other House an implementation bill, then the following procedures shall apply:

(1) NONREFERRAL.—The implementation bill of the other House shall not be referred to a committee.

(2) VOTE ON BILL OF OTHER HOUSE.—With respect to an implementation bill of the House receiving the implementation bill—

(A) the procedure in that House shall be the same as if no implementation bill had been received from the other House; but

(B) the vote on final passage shall be on the implementation bill of the other House.

(e) RULES OF SENATE AND HOUSE OF REPRESENTATIVES.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementation bill described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 244. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this subtitle for each of fiscal years 2012 through 2013.

TITLE III—CENTER FOR MEDICARE CHOICES

SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 111, is amended by inserting after 1806 the following new section:

"ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES

"SEC. 1808. (a) ESTABLISHMENT.—By not later than March 1, 2004, the Secretary shall establish within the Department of Health and Human Services the Center for Medicare Choices, which shall be separate from the Centers for Medicare & Medicaid Services.

"(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

"(1) ADMINISTRATOR.—

"(A) IN GENERAL.—The Center for Medicare Choices shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall report directly to the Secretary.

"(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

"(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Choices, and shall have authority and control over all personnel and activities thereof.

"(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Center for Medicare Choices. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

"(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Center for Medicare Choices as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

"(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Center for Medicare Choices as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

"(2) DEPUTY ADMINISTRATOR.—

"(A) IN GENERAL.—There shall be a Deputy Administrator of the Center for Medicare Choices who shall be appointed by the Administrator.

"(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be the Acting Administrator of the Center for Medicare Choices during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

"(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

"(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

"(1) DUTIES.—

"(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

"(i) negotiating, entering into, and enforcing, contracts with plans for the offering of MedicareAdvantage plans under part C, including the offering of qualified prescription drug coverage under such plans; and

"(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the offering of Medicare Prescription Drug plans under part D.

"(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including duties relating to—

"(i) reasonable cost contracts with eligible organizations under section 1876(h); and

"(ii) demonstration projects carried out in part or in whole under such parts, including the demonstration project carried out through a MedicareAdvantage (formerly Medicare+Choice) project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(C) NONINTERFERENCE.—In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may not, to the extent possible, interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs

"(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

"(2) MANAGEMENT STAFF.—

"(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, such management staff as determined appropriate. Any such manager shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in the following areas:

"(i) The review, negotiation, and administration of health care contracts.

"(ii) The design of health care benefit plans.

"(iii) Actuarial sciences.

"(iv) Compliance with health plan contracts.

"(v) Consumer education and decision making.

"(B) COMPENSATION.—

"(i) IN GENERAL.—Subject to clause (ii), the Administrator shall establish the rate of pay for an individual employed under subparagraph (A).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

"(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

"(A) IN GENERAL.—The Secretary, the Administrator of the Center for Medicare Choices, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator of the Center for Medicare Choices as is appropriate to carry out the purposes of this section.

"(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator requires to carry out the duties described in paragraph (1).

"(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

"(d) OFFICE OF BENEFICIARY ASSISTANCE.—

"(1) ESTABLISHMENT.—The Secretary shall establish within the Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Center for Medicare Choices.

"(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

"(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Center for Medicare Choices, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

"(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

"(ii) Benefits, and limitations on payment under parts A, and B, including information on medicare supplemental policies under section 1882.

"(iii) Other areas determined to be appropriate by the Administrator.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, and D, and medicare supplemental policies with benefits under MedicareAdvantage plans under part C.

"(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the

MedicareAdvantage program under part C, and the voluntary prescription drug delivery program under part D.

"(3) MEDICARE OMBUDSMAN.—

"(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

"(B) DUTIES.—The Medicare Ombudsman shall—

"(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

"(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

"(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MedicareAdvantage organization, an eligible entity under part D, or the Secretary; and

"(II) assistance to such beneficiaries with any problems arising from disenrollment from a MedicareAdvantage plan under part C or a prescription drug plan under part D; and

"(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

"(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

"(i) provide information about the medicare program; and

"(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

"(e) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

"(1) ESTABLISHMENT.—There is established within the Center for Medicare Choices the Medicare Competitive Policy Advisory Board (in this section referred to as the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator with respect to the administration of parts C and D, including the review of payment policies under such parts.

"(2) REPORTS.—

"(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

"(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

"(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

"(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

"(iii) QUALITY.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

"(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

"(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

"(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

"(3) DUTY OF ADMINISTRATOR.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

"(4) MEMBERSHIP.—

"(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

"(i) Three members shall be appointed by the President.

"(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

"(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Committee on Finance of the Senate.

"(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

"(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

"(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(6) TERMS OF OFFICE.—

"(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

"(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

"(i) one shall be appointed for a term of 1 year;

"(ii) three shall be appointed for terms of 2 years; and

"(iii) three shall be appointed for terms of 3 years.

"(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

"(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

"(7) CHAIR:—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

"(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

"(9) DIRECTOR AND STAFF.—

"(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

"(B) IN GENERAL.—With the approval of the Board, the Director may appoint such additional personnel as the Director considers appropriate.

"(C) ASSISTANCE FROM THE ADMINISTRATOR.—The Administrator shall make available to the Board such information and other assistance as it may require to carry out its functions.

"(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

"(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.".

(b) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by adding at the end the following: "By not later than 1 year after the date of the enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.".

SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER AND CO-SECRETARY OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—The fifth sentence of sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking "shall serve as the Secretary" and inserting "and the Administrator of the Center for Medicare Choices shall serve as the Co-Secretaries".

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

"Administrator of the Centers for Medicare & Medicaid Services.".

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking "Administrator of the Health Care Financing Administration.".

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2004.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking "(iv) For discharges" and inserting "(iv)(I) Subject to subclause (II), for discharges"; and

(2) by adding at the end the following new subclause:

''(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) APPLICATION TO SUBSECTION (D) PUERTO RICO HOSPITALS.—Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' after the comma at the end;

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''and before October 1, 2003'' after ''October 1, 1997''; and

(ii) in the matter following clause (III), by striking the period at the end and inserting '', and''; and

(iii) by adding at the end the following new clause:

''(iii) for discharges in a fiscal year beginning on or after October 1, 2003, 50 percent of the national standardized rate (determined under paragraph (3)(D)(iii)) for hospitals located in any area.'';

(2) in subparagraph (C)—

(A) in clause (i)—

(i) by striking ''(i) The Secretary'' and inserting ''(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary; and

(ii) by adding at the end the following:

''(II) For discharges in fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in an urban area, increased by the applicable percentage increase under subsection (b)(3)(B) for fiscal year 2004.

''(III) For discharges in a fiscal year after fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (II) or this subclause for the previous fiscal year, increased by the applicable percentage increase under subsection (b)(3)(B), adjusted to reflect the most recent case mix data.'';

(B) in clause (ii), by inserting ''(or for fiscal year 2004 and thereafter, the standardized amount)'' after ''each of the average standardized amounts''; and

(C) in clause (iii)(I), by striking ''for hospitals located in an urban or rural area, respectively''.

(c) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new clause:

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

SEC. 402. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking ''WAGE LEVELS.—The Secretary'' and inserting ''WAGE LEVELS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary''; and

(2) by adding at the end the following new clause:

''(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—

''(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i).

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.''.

SEC. 403. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

''(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

''(A) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

''(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

''(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

''(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph; and

''(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

''(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term 'low-volume hospital' means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

''(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

''(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

''(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).''.

SEC. 404. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting '', and, after October 1, 2004, for any other hospital described in clause (iv),'' after ''clause (iv)(I)'' in the matter preceding subclause (I).

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xiii)'';

(ii) in subclause (III)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xii)'';

(iii) in subclause (IV)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x) or (xi)'';

(iv) in subclause (V)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xi)''; and

(v) in subclause (VI)—

(I) by inserting "and before October 1, 2004," after "April 1, 2001,"; and

(II) by inserting "or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)" after "clause (x)";

(B) in clause (viii), by striking "The formula" and inserting "For discharges occurring before October 1, 2004, the formula"; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "With respect to discharges occurring before October 1, 2004, for purposes".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2004.

SEC. 404A. MEDPAC STUDY AND REPORT REGARDING MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT PAYMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as "MedPAC") shall conduct a study to determine, with respect to additional payment amounts paid to subsection (d) hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

(1) whether such payments should be made in the same manner as payments are made with respect to graduate medical education under title XVIII and with respect to hospitals that serve a disproportionate share of low-income patients under the medicaid program; and

(2) whether to add costs attributable to uncompensated care to the formula for determining such payment amounts.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with such recommendations for legislation as MedPAC determines are appropriate.

SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

(a) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as follows:

"(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;".

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2004.

(b) ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) ELIMINATION.—

(A) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2005.

(2) TECHNICAL CORRECTION.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9).

(c) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services" and inserting "services covered under this title".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to costs incurred for services provided on or after January 1, 2005.

(d) AUTHORIZATION OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in subparagraph (C), by striking "and" after the semicolon at the end;

(B) in subparagraph (D), by adding "and" after the semicolon at the end; and

(C) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for inpatient critical access facility services furnished on or after January 1, 2005.

(e) EXCLUSION OF NEW CAHS FROM PPS HOSPITAL WAGE INDEX CALCULATION.—Section 1886(d)(3)(E)(i) (42 U.S.C. 1395ww(d)(3)(E)(i)), as amended by section 402, is amended by inserting after the first sentence the following new sentence: "In calculating the hospital wage levels under the preceding sentence applicable with respect to cost reporting periods beginning on or after January 1, 2004, the Secretary shall exclude the wage levels of any facility that became a critical access hospital prior to the cost reporting period for which such hospital wage levels are calculated.".

(f) PROVISIONS RELATED TO CERTAIN RURAL GRANTS.—

(1) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended—

(A) by redesignating paragraph (3)(F) as paragraph (5) and redesignating and indenting appropriately; and

(B) by inserting after paragraph (3) the following new paragraph:

"(4) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—

"(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible small rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

"(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

"(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

"(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.".

(2) AUTHORIZATION FOR APPROPRIATIONS.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended to read as follows:

"(j) AUTHORIZATION OF APPROPRIATIONS.—

"(1) HI TRUST FUND.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under—

"(A) subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002; and

"(B) paragraphs (1) and (2) of subsection (g), $40,000,000 in each of the fiscal years 2004 through 2008.

"(2) GENERAL REVENUES.—There are authorized to be appropriated from amounts in the Treasury not otherwise appropriated for making grants to all States under subsection (g)(4), $25,000,000 in each of the fiscal years 2004 through 2008.".

(3) REQUIREMENT THAT STATES AWARDED GRANTS CONSULT WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE SUCH GRANTS.—

(A) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i–4(g)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

"(6) REQUIRED CONSULTATION FOR STATES AWARDED GRANTS.—A State awarded a grant under paragraph (1) or (2) shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.".

(B) EFFECTIVE DATE AND APPLICATION.—The amendment made by subparagraph (A) shall take effect on the date of enactment of this Act and shall apply to grants awarded on or after such date and to grants awarded prior to such date to the extent that funds under such grants have not been obligated as of such date.

(g) EXCLUSION OF CERTAIN BEDS FROM BED COUNT AND REMOVAL OF BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

"(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 25.".

(2) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CRITICAL ACCESS HOSPITALS.—Section 1886(d)(1)(B) (42 U.S.C. 195ww(d)(1)(B)) is amended by striking "a distinct part of the hospital (as defined by the Secretary)" in the matter following cause (v) and inserting "a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations with respect to distinct part unit status, and with respect to designations, that are made on or after October 1, 2003.

SEC. 406. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other nonroutine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

"(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.".

(b) Conforming Payment Provision.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(c) Effective Date.—The amendments made by this section shall apply to hospice care provided on or after October 1, 2004.

SEC. 407. SERVICES PROVIDED TO HOSPICE PATIENTS BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS.

(a) In General.—Section 1812(d)(2)(A) (42 U.S.C. 1395d(d)(2)(A) in the matter following clause (i)(II), is amended—

(1) by inserting "or services described in section 1861(s)(2)(K)" after "except that clause (i) shall not apply to physicians' services"; and

(2) by inserting ", or by a physician assistant, nurse practitioner, or clinical nurse specialist whom is not an employee of the hospice program, and who the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care," after the "(if not an employee of the hospice program)".

(b) Permitting Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialist to Review Hospice Plans of Care.—Section 1814(a)(7)(B) is amended by inserting "(or by a physician assistant, nurse practitioner or clinical nurse specialist who is not an employee of the hospice program, and whom the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care)" after "and is periodically reviewed by the individual's attending physician".

(c) Effective Date.—The amendments made by this section shall apply to hospice care furnished on or after October 1, 2004.

SEC. 408. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS UNDER MEDICARE.

Effective for cost reporting periods beginning on or after October 1, 2004, for purposes of payments to hospitals under the medicare program under title XVIII of the Social Security Act for costs of approved educational activities (as defined in section 413.85 of title 42 of the Code of Federal Regulations), such approved educational activities shall include professional educational training programs, recognized by the Secretary, for psychologists.

SEC. 409. REVISION OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and inserting "the applicable Puerto Rico percentage (specified in subparagraph (E))"; and

(B) in clause (ii), by striking "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

(2) by adding at the end the following new subparagraph:

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before October 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

"(iii) on or after October 1, 2004, and before October 1, 2009, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent; and

"(iv) on or after October 1, 2009, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent.".

SEC. 410. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) Clarification of Congressional Intent.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

(b) Interim Final Regulatory Authority and Effective Date.—The Secretary shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.

SEC. 411. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING THE COUNTING OF RESIDENTS IN A NONPROVIDER SETTING AND A TECHNICAL AMENDMENT REGARDING THE 3-YEAR ROLLING AVERAGE AND THE IME RATIO.

(a) Clarification of Requirements for Counting Residents Training in Nonprovider Setting.—

(1) D-GME.—Section 1886(h)(4)(E) (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.".

(2) IME.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.".

(b) Limiting One-Year Lag in the Indirect Medical Education (IME) Ratio and Three-Year Rolling Average in Resident Count for IME and for Direct Graduate Medical Education (D–GME) to Medical Residency Programs.—

(1) IME ratio and IME rolling average.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by adding at the end the following new sentence: "For cost reporting periods beginning during fiscal years beginning on or after October 1, 2004, subclauses (I) and (II) shall be applied only with respect to a hospital's approved medical residency training programs in the fields of allopathic and osteopathic medicine.".

(2) D–GME rolling average.—Section 1886(h)(4)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(G)) is amended by adding at the end the following new clause:

"(iv) Application for fiscal year 2004 and subsequent years.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 2004, clauses (i) through (iii) shall be applied only with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine.".

SEC. 412. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) In General.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking "and" at the end;

(2) in subparagraph (S), by striking the period and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(T) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care—

"(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

"(ii) under a program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services).".

(b) Effective Date.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

SEC. 413. GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) Study.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(1) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(2) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(b) Report.—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

SEC. 414. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) Establishment of Rural Community Hospital (RCH) Demonstration Program.—

(1) In general.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals that furnish rural community hospital services to medicare beneficiaries.

(2) Designation of RCHs.—

(A) Application.—Each hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) Designation.—The Secretary shall designate any hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section as a rural community hospital for purposes of the demonstration program.

(C) Demonstration areas.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

(3) Duration.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) Implementation.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) Payment.—

(1) Inpatient hospital services.—The amount of payment under the demonstration program for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge; or

(B) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(2) Outpatient services.—The amount of payment under the demonstration program for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in subsection (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U) of the Social Security Act (42 U.S.C. 1395x(v)(1)(U)); or

(B) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(3) Home health services.—In determining payments under the demonstration program for home health services furnished by a qualified RCH-based home health agency (as defined in paragraph (2))—

(A) the agency may make a one-time election to waive application of the prospective payment system established under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to such services furnished by the agency; and

(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(4) Consolidated billing.—The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(5) Exemption from 30 percent reduction in reimbursement for bad debt.—In determining the reasonable costs for rural community hospitals, section 1861(v)(1)(T) of the Social Security Act (42 U.S.C. 1395x(v)(1)(T)) shall not apply.

(6) Beneficiary cost-sharing for outpatient services.—The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under the demonstration program shall be as follows:

(A) For items and services that would have been paid under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

(B) For items and services that would have been paid under section 1833(h) of such Act (42 U.S.C. 1395l(h)) if furnished by a provider or supplier, no cost-sharing shall apply.

(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.

(7) Return on equity.—

(A) In general.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(B) Services described.—The services referred to in subclause (I) are rural community hospital services.

(C) Disregard of proprietary provider status.—Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(8) Removing barriers to establishment of distinct part units by RCH facilities.—Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit rural community hospitals to establish distinct part units for purposes of applying such section.

(c) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) Budget neutrality.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) Waiver authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) Report.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) Definitions.—In this section:

(1) Rural community hospital.—

(A) In general.—The term "rural community hospital" means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to subparagraph (B), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services;

(iv) subject to subparagraph (C), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2003; and

(v) applies to the Secretary for such designation.

(B) Treatment of psychiatric and rehabilitation units.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(C) Types of hospitals that may participate.—Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

(i) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) with the same service area (as defined by the Secretary in regulations in effect on such date).

(ii) A facility obtaining a new provider number pursuant to a change of ownership.

(iii) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2003.

(D) Inclusion of CAHs.—Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)) and section 1866 of such Act (42 U.S.C. 1395cc).

(2) Qualified RCH-based home health agency defined.—The term "qualified RCH-based home health agency" is a home health agency

that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554; Appendix F, 114 Stat. 2763A–506)) of a rural community hospital that is located—

(A) in a county in which no main or branch office of another home health agency is located; or

(B) at least 35 miles from any main or branch office of another home health agency.

SEC. 415. CRITICAL ACCESS HOSPITAL IMPROVEMENT DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF CRITICAL ACCESS HOSPITAL DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test various methods to improve the critical access hospital program under section 1820 of the Social Security Act (42 U.S.C. 1395i–4).

(2) CRITICAL ACCESS HOSPITAL IMPROVEMENT.—In conducting the demonstration program under this section, the Secretary shall apply rules with respect to critical access hospitals participating in the program as follows:

(A) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subsections (c)(2)(B)(iii) and (f) of section 1820 of the Social Security Act (42 U.S.C. 1395i–4), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.

(B) EXCLUSION FROM HOME HEALTH PPS.—Notwithstanding section 1895 of the Social Security Act (42 U.S.C. 1395fff), in determining payments under the demonstration program for home health services furnished by a home health agency that is owned and operated by a critical access hospital participating in the demonstration program—

(i) the agency may make an election to waive application of the prospective payment system established under such section to such services furnished by the agency; and

(ii) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

(C) EXEMPTION OF CAH FACILITIES FROM PPS.—Notwithstanding section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), in determining payments under this part for covered skilled nursing facility services furnished by a skilled nursing facility that is a distinct part unit of a critical access hospital participating in the demonstration program or is owned and operated by a critical access hospital participating in the demonstration program—

(i) the prospective payment system established under such section shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(D) CONSOLIDATED BILLING.—The Secretary shall permit consolidated billing under section 1842(b)(6)(E) of the Social Security Act (42 U.S.C. 1395u(b)(6)(E)).

(E) EXEMPTION OF CERTAIN DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS FROM COST LIMITS.—Notwithstanding section 1886(b) of the Social Security Act (42 U.S.C. 1395ww(b)), in determining payments under the demonstration program for inpatient hospital services furnished by a distinct part psychiatric or rehabilitation unit (described in the matter following section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v))) of a critical access hospital participating in the demonstration program—

(i) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

(ii) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v) of such Act (42 U.S.C. 1395x(v)), but without regard to the amount of the customary or other charges with respect to such services.

(F) RETURN ON EQUITY.—

(i) IN GENERAL.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g)(2) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subclause (II) furnished by a critical access hospital participating in the demonstration program for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in section 1861(v)(1)(P)(i) of such Act (42 U.S.C. 1395x(v)(1)(P)(i)).

(ii) SERVICES DESCRIBED.—The services referred to in subclause (I) are inpatient critical access hospital services, outpatient critical access hospital services, extended care services, posthospital extended care services, home health services, ambulance services, and inpatient hospital services.

(iii) DISREGARD OF PROPRIETARY PROVIDER STATUS.—Payment under the demonstration program shall be made without regard to whether a provider is a proprietary provider.

(G) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CAH FACILITIES.—Notwithstanding section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit critical access hospitals participating in the demonstration program to establish distinct part units for purposes of applying such section.

(3) PARTICIPATION OF CAHS.—

(A) APPLICATION.—Each critical access hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(B) PARTICIPATION.—The Secretary shall permit any critical access hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section to participate in the demonstration program.

(C) DEMONSTRATION AREAS.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

(4) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(5) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(d) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

SEC. 416. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—The last sentence of section 1886(d)(1)(B) is amended by inserting ", and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)" before the period at the end.

(b) TREATMENT OF PROPOSED REVISION.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) EFFECTIVE DATE.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

SEC. 417. TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) BUDGET NEUTRAL WITHIN NORTH CAROLINA.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such payments that would have been made in the year if this subsection had not been enacted.

(b) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act, Iredell County, North

Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) Application and Budget Neutral Within North Carolina.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be implemented in a budget neutral manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the total amount of expenditures that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(c) Construction.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

SEC. 418. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(a) In General.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking "and" after the semicolon at the end;

(2) in subclause (VII)—

(A) by striking "on or after October 1, 2002" and inserting "during fiscal year 2003"; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subclauses:

"(VIII) during each of fiscal years 2004 and 2005, 'c' is equal to 1.36; and

"(IX) on or after October 1, 2005, 'c' is equal to 1.355.".

(b) Conforming Amendment Relating to Determination of Standardized Amount.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking "1999 or" and inserting "1999,"; and

(2) by inserting ", or the Prescription Drug and Medicare Improvement Act of 2003" after "2000".

(c) Effective Date.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 419. CALCULATION OF WAGE INDICES FOR HOSPITALS.

Notwithstanding any other provision of law, in the calculation of a wage index in a State for purposes of making payments for discharges occurring during fiscal year 2004, the Secretary may waive such other criteria for reclassification, as deemed appropriate by the Secretary.

SEC. 420. CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting "(which regulations shall exclude any cost incurred for the provision of services pursuant to a contract with an eligible entity (as defined in section 1860D(4)) operating a Medicare Prescription Drug plan or with an entity with a contract under section 1860D-13(e), for which payment is made by the entity)" after "the Secretary may prescribe in regulations".

SEC. 420A. INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.

(a) Disproportionate Share Adjustment Percentage.—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking "35 percent" and inserting "35 percent (or, for discharges occurring on or after October 1, 2003, 40 percent)".

(b) Capital Costs.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) in clause (iii), by striking "and" at the end;

(2) in clause (iv), by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new clause:

"(v) in the case of cost reporting periods beginning on or after October 1, 2003, shall provide for a disproportionate share adjustment in the same manner as section 1886(d)(5)(F)(iii).".

SEC. 420B. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) In General.—The last sentence of section 1886(d)(1)(B) is amended by inserting ", and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)" before the period at the end.

(b) Treatment of Proposed Revision.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) Effective Date.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

Subtitle B—Provisions Relating to Part B

SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking "subparagraphs (B) and (C)" and inserting "subparagraphs (B), (C), (E), and (F)"; and

(2) by adding at the end the following new subparagraphs:

"(E) Floor for Work Geographic Indices.—

"(i) In General.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

"(ii) Work Floor Index.—For purposes of clause (i), the term 'applicable floor index' means—

"(I) 0.980 with respect to services furnished during 2004; and

"(II) 1.000 for services furnished during 2005, 2006, and 2007.

"(F) Floor for Practice Expense and Malpractice Geographic Indices.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.".

SEC. 422. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) Procedures for Secretary, and Not Physicians, To Determine When Bonus Payments Under Medicare Incentive Payment Program Should Be Made.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(1) by inserting "(1)" after "(m)"; and

(2) by adding at the end the following new paragraph:

"(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).".

(b) Educational Program Regarding the Medicare Incentive Payment Program.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the medicare program on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)).

(c) Ongoing GAO Study and Annual Report on the Medicare Incentive Payment Program.—

(1) Ongoing Study.—The Comptroller General of the United States shall conduct an ongoing study on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)). Such study shall focus on whether such program increases the access of medicare beneficiaries who reside in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) as a health professional shortage area to physicians' services under the medicare program.

(2) Annual Reports.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Comptroller General considers appropriate.

SEC. 423. EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND TREATMENT OF CERTAIN SOLE COMMUNITY HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPD PPS.

(a) Small Rural Hospitals.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by inserting "and during 2006" after "2004,".

(b) Sole Community Hospitals.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by adding at the end the following:

"(iii) Temporary Treatment for Sole Community Hospitals.—In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished in 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.".

SEC. 424. INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) Increase.—

(1) In General.—In the case of an applicable covered OPD service (as defined in paragraph (2)) that is furnished by a hospital described in clause (i) or (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), as amended by section 424, on or after January 1, 2005, and before January 1, 2008, the Secretary shall increase the medicare OPD fee schedule amount (as determined under paragraph (4)(A) of such section) that is applicable for such service in that year (determined without regard to any increase under this section in a previous year) by 5 percent.

(2) Applicable Covered OPD Services Defined.—For purposes of this section, the term "applicable covered OPD service" means a covered clinic or emergency room visit that is classified within the groups of covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)))

established under paragraph (2)(B) of such section.

(b) No Effect on Copayment Amount.—The Secretary shall compute the copayment amount for applicable covered OPD services under section 1833(t)(8)(A) of the Social Security Act (42 U.S.C. 1395l(t)(8)(A)) as if this section had not been enacted.

(c) No Effect on Increase Under Hold Harmless or Outlier Provisions.—The Secretary shall apply the temporary hold harmless provision under clause (i) and (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) and the outlier provision under paragraph (5) of such section as if this section had not been enacted.

(d) Waiving Budget Neutrality and No Revision or Adjustments.—The Secretary shall not make any revision or adjustment under subparagraph (A), (B), or (C) of section 1833(t)(9) of the Social Security Act (42 U.S.C. 1395l(t)(9)) because of the application of subsection (a)(1).

(e) No Effect on Payments After Increase Period Ends.—The Secretary shall not take into account any payment increase provided under subsection (a)(1) in determining payments for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t))) under such section that are furnished after January 1, 2008.

(f) Technical Amendment.—Section 1833(t)(2)(B) (42 U.S.C. 1395l(t)(2)(B)) is amended by inserting "(and periodically revise such groups pursuant to paragraph (9)(A))" after "establish groups".

SEC. 425. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

"(10) Temporary Increase for Ground Ambulance Services.—

"(A) In General.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2005, and before January 1, 2008, for which the transportation originates in—

"(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

"(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent.

"(B) Application of Increased Payments After 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

"(11) Conversion Factor Adjustments.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.".

SEC. 426. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

(a) Coverage.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 426, is amended by adding at the end the following new paragraph:

"(11) Ensuring Appropriate Coverage of Air Ambulance Services.—

"(A) In General.—The regulations described in section 1861(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the air ambulance rate if the air ambulance service—

"(i) is medically necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

"(ii) complies with equipment and crew requirements established by the Secretary.

"(B) Medically Necessary.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if such service is requested—

"(i) by a physician or a hospital in accordance with the physician's or hospital's responsibilities under section 1867 (commonly known as the Emergency Medical Treatment and Active Labor Act);

"(ii) as a result of a protocol established by a State or regional emergency medical service (EMS) agency;

"(iii) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasbnably determines or certifies that the patient's condition is such that the time needed to transport the individual by land or the lack of an appropriate ground ambulance, significantly increases the medical risks for the individual; or

"(iv) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist attack.

"(C) Air Ambulance Services Defined.—For purposes of this paragraph, the term 'air ambulance service' means fixed wing and rotary wing air ambulance services.".

(b) Conforming Amendment.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting ", subject to section 1834(l)(11)," after "but".

(c) Effective Date.—The amendments made by this section shall apply to services furnished on or after January 1, 2005.

SEC. 427. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395l) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2005 or 2006 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) Payment Based on Reasonable Costs.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) No Beneficiary Cost-Sharing.—Notwithstanding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 428. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1833(f) (42 U.S.C. 1395l(f)) is amended—

(1) in paragraph (1), by striking ", and" at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking "in a subsequent year" and inserting "in 1989 through 2004"; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

"(3) in 2005, at $80 per visit; and

"(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.".

SEC. 429. ELIMINATION OF CONSOLIDATED BILLING FOR CERTAIN SERVICES UNDER THE MEDICARE PPS FOR SKILLED NURSING FACILITY SERVICES.

(a) Certain Rural Health Clinic and Federally Qualified Health Center Services.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (2)(A)(i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

(2) by adding at the end of paragraph (2)(A) the following new clause:

"(iv) Exclusion of Certain Rural Health Clinic and Federally Qualified Health Center Services.—Services described in this clause are—

"(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

"(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by a physician or practitioner not affiliated with a rural health clinic or a Federally qualified health center.".

(b) Certain Services Furnished by an Entity Jointly Owned by Hospitals and Critical Access Hospitals.—For purposes of applying section 411.15(p)-(3)(iii) of title 42 of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned as a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) Technical Amendments.—Sections 1842(b)(6)(E) and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E); 1395cc(a)(1)(H)(ii)) are each amended by striking "section 1888(e)(2)(A)(ii)" and inserting "clauses (ii), (iii), and (iv) of section 1888(e)(2)(A)".

(d) Effective Date.—The amendments made by this section and the provision of subsection (b) shall apply to services furnished on or after January 1, 2005.

SEC. 430. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT AND CERTAIN ORTHOTICS; ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DME PROVIDERS.

(a) Freeze for DME.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (E), by striking "and" at the end;

(2) in subparagraph (F)—

(A) by striking "a subsequent year" and inserting "2003"; and

(B) by striking "the previous year." and inserting "2002;"; and

(3) by adding at the end the following new subparagraphs:

"(G) for each of the years 2004 through 2010—

"(i) in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

"(ii) in the case of covered items not described in clause (i), 0 percentage points; and

"(H) for a subsequent year, the percentage increase described in subparagraph (B) for the year involved.".

(b) Freeze for Off-the-Shelf Orthotics.—Section 1834(h)(4)(A) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)) is amended—

(1) in clause (vii), by striking "and" at the end;

(2) in clause (viii), by striking "a subsequent year" and inserting "2003"; and

(3) by adding at the end the following new clauses:

"(ix) for each of the years 2004 through 2010—

"(I) in the case of orthotics that have not been custom-fabricated, 0 percent; and

"(II) in the case of prosthetics, prosthetic devices, and custom-fabricated orthotics, the percentage increase described in clause (viii) for the year involved; and *"(x) for 2011 and each subsequent year, the percentage increase described in clause (viii) for the year involved;".*

(c) Establishment of Quality Standards and Accreditation Requirements for Durable Medical Equipment Providers.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(1) by redesignating paragraph (17), as added by section 4551(c)(1) of the Balanced Budget Act of 1997 (111 Stat. 458), as paragraph (19); and

(2) by adding at the end the following new paragraph:

"(20) Identification of quality standards.—

"(A) In general.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for providers of durable medical equipment throughout the United States that are developed by recognized independent accreditation organizations (as designated under subparagraph (B)(i)) and with which such providers shall be required to comply in order to—

"(i) participate in the program under this title;

"(ii) furnish any item or service described in subparagraph (D) for which payment is made under this part; and

"(iii) receive or retain a provider or supplier number used to submit claims for reimbursement for any item or service described in subparagraph (D) for which payment may be made under this title.

"(B) Designation of independent accreditation organizations.—

"(i) In general.—Not later that the date that is 6 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall designate independent accreditation organizations for purposes of subparagraph (A).

"(ii) Consultation.—In determining which independent accreditation organizations to designate under clause (i), the Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, suppliers, and manufacturers to review (and advise the Secretary concerning) selection of accrediting organizations and the quality standards of such organizations.

"(C) Quality standards.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

"(D) Items and services described.—The items and services described in this subparagraph are covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection, other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

"(E) Phased-in implementation.—The application of the quality standards described in subparagraph (A) shall be phased-in over a period that does not exceed 3 years.".

SEC. 431. APPLICATION OF COINSURANCE AND DEDUCTIBLE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) Coinsurance.—

(1) In general.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (1)(D)(i), by striking "(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis)"; and

(B) in paragraph (2)(D)(i), by striking "(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866)".

(2) Conforming amendment.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A) is amended by striking "and with respect to clinical diagnostic laboratory tests for which payment is made under part B".

(b) Deductible.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(1) by striking paragraph (3); and

(2) by redesignating paragraphs (4), (5), and (6) as paragraphs (3), (4), and (5), respectively.

(c) Effective Date.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SEC. 432. BASING MEDICARE PAYMENTS FOR COVERED OUTPATIENT DRUGS ON MARKET PRICES.

(a) Medicare Market Based Payment Amount.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(1) in paragraph (1), by striking "equal to 95 percent of the average wholesale price." and inserting "equal to—

"(A) in the case of a drug or biological furnished prior to January 1, 2004, 95 percent of the average wholesale price; and

"(B) in the case of a drug or biological furnished on or after January 1, 2004, the payment amount specified in—

"(i) in the case of such a drug or biological that is first available for payment under this part on or before April 1, 2003, paragraph (4); and

"(ii) in the case of such a drug or biological that is first available for payment under this part after such date, paragraph (5)."; and

(2) by adding at the end the following new paragraphs:

"(4)(A) Subject to subparagraph (C), the payment amount specified in this paragraph for a year for a drug or biological is an amount equal to the lesser of—

"(i) the average wholesale price for the drug or biological; or

"(ii) the amount determined under subparagraph (B)

"(B)(i) Subject to clause (ii), the amount determined under this subparagraph is an amount equal to—

"(I) in the case of a drug or biological furnished in 2004, 85 percent of the average wholesale price for the drug or biological (determined as of April 1, 2003); and

"(II) in the case of a drug or biological furnished in 2005 or a subsequent year, the amount determined under this subparagraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

"(ii) In the case of a vaccine described in subparagraph (A) or (B) of section 1861(s)(10), the amount determined under this subparagraph is an amount equal to the average wholesale price for the drug or biological.

"(C)(i) The Secretary shall establish a process under which the Secretary determines, for such drugs or biologicals as the Secretary determines appropriate, whether the widely available market price to physicians or suppliers for the drug or biological furnished in a year is different from the payment amount established under subparagraph (B) for the year. Such determination shall be based on the information described in clause (ii) as the Secretary determines appropriate.

"(ii) The information described in this clause is the following information:

"(I) Any report on drug or biological market prices by the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States that is made available after December 31, 1999.

"(II) A review of drug or biological market prices by the Secretary, which may include information on such market prices from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physicians, suppliers, or any other source the Secretary determines appropriate.

"(III) Data and information submitted by the manufacturer of the drug or biological or by another entity.

"(IV) Other data and information as determined appropriate by the Secretary.

"(iii) If the Secretary makes a determination under clause (i) with respect to the widely available market price for a drug or biological for a year, the following provisions shall apply:

"(I) Subject to clause (iv), the amount determined under this subparagraph shall be substituted for the amount determined under subparagraph (B) for purposes of applying subparagraph (A)(ii)(I) for the year and all subsequent years.

"(II) The Secretary may make subsequent determinations under clause (i) with respect to the widely available market price for the drug or biological.

"(III) If the Secretary does not make a subsequent determination under clause (i) with respect to the widely available market price for the drug or biological for a year, the amount determined under this subparagraph shall be an amount equal to the amount determined under this subparagraph for the previous year increased by the percentage increase described in subparagraph (B)(i)(II) for the year involved.

"(iv) If the first determination made under clause (i) with respect to the widely available market price for a drug or biological would result in a payment amount in a year that is more than 15 percent less than the amount determined under subparagraph (B) for the drug or biological for the previous year (or, for 2004, the payment amount determined under paragraph (1)(A), determined as of April 1, 2003), the Secretary shall provide for a transition to the amount determined under clause (i) so that the payment amount is reduced in annual increments equal to 15 percent of the payment amount in such previous year until the payment amount is equal to the amount determined under clause (i), as increased each year by the percentage increase described in subparagraph (B)(i)(II) for the year. The preceding sentence shall not apply to a drug or biological where a generic version of the drug or biological first enters the market on or after January 1, 2004 (even if the generic version of the drug or biological is not marketed under the chemical name of such drug or biological).

"(5) In the case of a drug or biological that is first available for payment under this part after April 1, 2003, the following rules shall apply:

"(A) As a condition of obtaining a code to report such new drug or biological and to receive payment under this part, a manufacturer shall provide the Secretary (in a time, manner, and form approved by the Secretary) with data and information on prices at which the manufacturer estimates physicians and suppliers will be able to routinely obtain the drug or biological in the market during the first year that the drug or biological is available for payment under this part and such additional information that the manufacturer determines appropriate.

"(B) During the year that the drug or biological is first available for payment under this part, the manufacturer of the drug or biological shall provide the Secretary (in a time, manner, and form approved by the Secretary) with updated information on the actual market prices paid by such physicians or suppliers for the drug or biological in the year.

"(C) The amount specified in this paragraph for a drug or biological for the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information

provided under subparagraph (A) and other information that the Secretary determines appropriate.

"(D) The amount specified in this paragraph for a drug or biological for the year after the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (B) and other information that the Secretary determines appropriate.

"(E) The amount specified in this paragraph for a drug or biological for the year beginning after the year described in subparagraph (D) and each subsequent year is equal to the lesser of—

"(i) the average wholesale price for the drug or biological; or

"(ii) the amount determined—

"(I) by the Secretary under paragraph (4)(C)(i) with respect to the widely available market price for the drug or biological for the year, if such paragraph was applied by substituting 'the payment determined under paragraph (5)(E)(ii)(II) for the year' for 'established under subparagraph (B) for the year'; and

"(II) if no determination described in subclause (I) is made for the drug or biological for the year, under this subparagraph with respect to the drug or biological for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.".

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR ADMINISTRATION OF DRUGS AND BIOLOGICALS.—

(1) ADJUSTMENT IN PHYSICIAN PRACTICE EXPENSE RELATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking "The adjustments" and inserting "Subject to clause (iv), the adjustments"; and

(ii) by adding at the end the following new clause:

"(iv) EXEMPTION FROM BUDGET NEUTRALITY IN 2004.—Any additional expenditures under this part that are attributable to subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004."; and

(B) by adding at the end the following new subparagraph:

"(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR DRUG ADMINISTRATION SERVICES FOR 2004.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished in 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

"(i) covers practice expenses for oncology administration services; and

"(ii) meets criteria established by the Secretary for acceptance of such surveys.".

(2) PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE.—

(A) REVIEW OF POLICY.—The Secretary shall review the policy, as in effect on the date of enactment of this Act, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 anticancer chemotherapeutic agent to an individual on a single day through the push technique.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy if the Secretary determines such modification to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(3) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not disproportionately reduced relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments to such Act made by paragraph (1).

(4) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

"(6)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2004, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled 'Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost' (GAO–03–184), provide for a separate payment for the administration of such blood clotting factors in an amount that the Secretary determines to be appropriate.

"(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2004, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraphs (4) and (5) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

"(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2005 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.".

(5) INCREASE IN COMPOSITE RATE FOR END STAGE RENAL DISEASE FACILITIES.—Section 1881(b) (42 U.S.C. 1395rr(b) is amended—

(A) in paragraph (7), by adding at the end the following new sentence: "In the case of dialysis services furnished in 2004 or a subsequent year, the composite rate for such services shall be determined under paragraph (12)."; and

(B) by adding at the end the following new paragraph:

"(12)(A) In the case of dialysis services furnished during 2004, the composite rate for such services shall be the composite rate that would otherwise apply under paragraph (7) for the year increased by an amount to ensure (as estimated by the Secretary) that—

"(i) the sum of the total amount of—

"(I) the composite rate payments for such services for the year, as increased under this paragraph; and

"(II) the payments for drugs and biologicals (other than erythropoetin) furnished in connection with the furnishing of renal dialysis services and separately billed by renal dialysis facilities under paragraphs (4) and (5) of section 1842(o) for the year; is equal to

"(ii) the sum of the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in clause (i)(II) that would have been made if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

"(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased by 1.6 percent.

"(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent and further increased by 1.6 percent.

"(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 and all subsequent years, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year, increased by 0.05 percent.

"(E) If the Secretary implements a reduction in the payment amount under paragraph (4)(C) or (5) for a drug or biological described in subparagraph (A)(i)(II) for a year after 2004, the Secretary shall, as estimated by the Secretary—

"(i) increase the composite rate for dialysis services furnished in such year in the same manner that the composite rate for such services for 2004 was increased under subparagraph (A); and

"(ii) increase the percentage increase under subparagraph (C) or (D) (as applicable) for years after the year described in clause (i) to ensure that such increased percentage would result in expenditures equal to the sum of the total composite rate payments for such services for such years and the total payments for drugs and biologicals described in subparagraph (A)(i)(II) is equal to the sum of the total amount of the composite rate payments under this paragraph for such years and the payments for the drugs and biologicals described in subparagraph (A)(i)(II) that would have been made if the reduction in payment amount described in subparagraph had not been made.

"(F) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under this paragraph.".

(6) HOME INFUSION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraph (4), is amended by adding at the end the following new paragraph:

"(7)(A) Subject to subparagraph (B), in the case of infusion drugs and biologicals furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may make separate payments for furnishing such drugs and biologicals in an amount determined by the Secretary if the Secretary determines such separate payment to be appropriate.

"(B) In determining the amount of any separate payment under subparagraph (A) for a year, the Secretary shall ensure that the total amount of payments under this part for such infusion drugs and biologicals for the year and such separate payments for the year does not exceed the total amount of payments that would have been made under this part for the year for such infusion drugs and biologicals if section

433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.".

(7) INHALATION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

"(8)(A) Subject to subparagraph (B), in the case of inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may increase payments for such equipment under section 1834(a) and may make separate payments for furnishing such drugs and biologicals if the Secretary determines such increased or separate payments are necessary to appropriately furnish such equipment and drugs and biologicals to beneficiaries.

"(B) The total amount of any increased payments and separate payments under subparagraph (A) for a year may not exceed an amount equal to 10 percent of the amount (as estimated by the Secretary) by which—

"(i) the total amount of payments that would have been made for such drugs and biologicals for the year if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted; exceeds

"(ii) the total amount of payments for such drugs and biologicals under paragraphs (4) and (5).".

(8) PHARMACY DISPENSING FEE FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1842(o)(2) (42 U.S.C. 1395u(o)(2)) is amended to read as follows:

"(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary—

"(A) in the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, shall pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy; and

"(B) in the case of a drug or biological not described in subparagraph (A), may pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy.".

(9) PAYMENT FOR CHEMOTHERAPY DRUGS PURCHASED BUT NOT ADMINISTERED BY PHYSICIANS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) and (7), is amended by adding at the end the following new paragraph:

"(9)(A) Subject to subparagraph (B), the Secretary may increase (in an amount determined appropriate) the amount of payments to physicians for anticancer chemotherapeutic drugs or biologicals that would otherwise be made under this part in order to compensate such physicians for anticancer chemotherapeutic drugs or biologicals that are purchased by physicians with a reasonable intent to administer to an individual enrolled under this part but which cannot be administered to such individual despite the reasonable efforts of the physician.

"(B) The total amount of increased payments made under subparagraph (A) in a year (as estimated by the Secretary) may not exceed an amount equal to 1 percent of the total amount of payments made under paragraphs (4) and (5) for such anticancer chemotherapeutic drugs or biologicals furnished by physicians in such year (as estimated by the Secretary).".

(c) LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION.—The Secretary shall not implement the revisions in payment amounts for a category of drug or biological as a result of the amendments made by subsection (a) unless the Secretary concurrently implements the adjustments to payment amounts for administration of such category of drug or biological for which the Secretary is required to make an adjustment, as specified in the amendments made by, and provisions of, subsection (b).

(d) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—

(1) DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6), (7), and (9) of subsection (b), is amended by adding at the end the following new paragraph:

"(10) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraph (2) or paragraphs (4) through (9).".

(2) PHYSICIAN FEE SCHEDULE.—Section 1848(i)(1) (42 U.S.C. 1395w-4(i)(1)) is amended—

(A) in subparagraph (D), by striking "and" at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(F) adjustments in practice expense relative value units under subsection (c)(2)(H).".

(3) MULTIPLE CHEMOTHERAPY AGENTS AND OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(e) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON BENEFICIARY ACCESS TO DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study that examines the impact the provisions of, and the amendments made by, this section have on access by medicare beneficiaries to drugs and biologicals covered under the medicare program.

(B) REPORT.—Not later than January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under subparagraph (A) together with such recommendations as the Comptroller General determines to be appropriate.

(2) STUDY AND REPORT BY THE HHS INSPECTOR GENERAL ON MARKET PRICES OF DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct 1 or more studies that—

(i) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers; and

(ii) compare such widely available market prices to the payment amount for such drugs and biologicals under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o).

(B) REQUIREMENT.—In conducting the study under subparagraph (A), the Inspector General shall focus on those drugs and biologicals that represent the largest portions of expenditures under the medicare program for drugs and biologicals.

(C) REPORT.—The Inspector General shall prepare a report on any study conducted under subparagraph (A).

SEC. 433. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended by striking "and $100 for 1991 and subsequent years" and inserting the following: ", $100 for 1991 through 2005, $125 for 2006, and for 2007 and thereafter, the amount in effect for the previous year, increase by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar".

SEC. 434. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: "(ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if under such arrangement such entity submits the bill for such service and such arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,".

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "except to an employer or facility as described in clause (A)" and inserting "except to an employer or entity as described in subparagraph (A)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after the date of enactment of this Act.

SEC. 435. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A-551) is amended by inserting ", and for services furnished during 2005" before the period at the end.

SEC. 436. ADEQUATE REIMBURSEMENT FOR OUTPATIENT PHARMACY THERAPY UNDER THE HOSPITAL OUTPATIENT PPS.

(a) SPECIAL RULES FOR DRUGS AND BIOLOGICALS.—Section 1833(t) (42 U.S.C. 1395(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (14); and

(2) by inserting after paragraph (12) the following new paragraph:

"(13) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—

"(A) BEFORE 2007.—

"(i) IN GENERAL.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2005, and before January 1, 2007, hospitals shall be reimbursed as follows:

"(I) DRUGS AND BIOLOGICALS FURNISHED AS PART OF A CURRENT OPD SERVICE.—The amount of payment for a drug or biological described in subparagraph (D) provided as a part of a service that was a covered OPD service on May 1, 2003, shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under section 1842(o) on such date.

"(II) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price that would have been determined under section 1842(o) on May 1, 2003, if payment for such a drug or biological could have been made under this part on that date.

"(ii) UPDATE FOR 2006.—For 2006, the amounts determined under clauses (i) and (ii) shall be the amount established for 2005 increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

"(B) AFTER 2007.—

"(i) ONGOING STUDY AND REPORTS ON ADEQUATE REIMBURSEMENTS.—

"(I) STUDY.—The Secretary shall contract with an eligible organization (as defined in subclause (IV)) to conduct a study to determine the hospital acquisition, pharmacy services, and handling costs for each individual drug or biological described in subparagraph (D).

"(II) STUDY REQUIREMENTS.—The study conducted under subclause (I) shall—

"(aa) be accurate to within 3 percent of true mean hospital acquisition and handling costs for each drug and biological at the 95 percent confidence level;

"(bb) begin not later than January 1, 2005; and

"(cc) be updated annually for changes in hospital costs and the addition of newly marketed products.

"(III) REPORTS.—Not later than January 1 of each year (beginning with 2006), the Secretary shall submit to Congress a report on the study conducted under clause (i) together with recommendations for such legislative or administrative action as the Secretary determines to be appropriate.

"(IV) ELIGIBLE ORGANIZATION DEFINED.—In this clause, the term 'eligible organization' means a private, nonprofit organization within the meaning of section 501(c) of the Internal Revenue Code.

"(ii) ESTABLISHMENT OF PAYMENT METHODOLOGY.—Notwithstanding paragraph (6), the Secretary, in establishing a payment methodology on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, shall take into consideration the findings of the study conducted under clause (i)(I) in determining payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007.

"(C) APPLICABLE PERCENTAGE DEFINED.—In this paragraph, the term 'applicable percentage' means—

"(i) with respect to a biological product (approved under a biologics license application under section 351 of the Public Health Service Act), a single source drug (as defined in section 1927(k)(7)(A)(iv)), or an orphan product designated under section 526 of the Food, Drug, and Cosmetic Act to which the prospective payment system established under this subsection did not apply under the final rule for 2003 payments under such system, 94 percent;

"(ii) with respect to an innovator multiple source drug (as defined in section 1927(k)(7)(A)(ii)), 91 percent; and

"(iii) with respect to a noninnovator multiple source drug (as defined in as defined in section 1927(k)(7)(A)(iii)), 71 percent.

"(D) DRUGS AND BIOLOGICALS DESCRIBED.—A drug or biological described in this paragraph is any drug or biological—

"(i) for which the amount of payment was determined under paragraph (6) prior to January 1, 2005; and

"(ii)(I) which is assigned to a drug specific ambulatory payment classification on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003; or

"(II) that would have been reimbursed under paragraph (6) but for the application of this paragraph.".

(b) EXCEPTIONS TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: "In determining the budget neutrality adjustment required by the preceding sentence for fiscal years 2005 and 2006, the Secretary shall not take into account any expenditures that would not have been made but for the application of paragraph (13).".

SEC. 437. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

"(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

"(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

"(ii) APPLICATION.—Paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003 unless—

"(I) such application was being made to such drug or biological prior to such date of enactment; and

"(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

"(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequvalent, as determined by the Commissioner of Food and Drugs.

SEC. 438. MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.

(a) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30–1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement subsection (a)).

(c) LIMITATION OF EXPENDITURES IN YEARS PRIOR TO 2014.—

(1) IN GENERAL.—The Secretary shall ensure that the total amount of expenditures under title XVIII of the Social Security Act (including amounts expended by reason of this section) in a year prior to 2014 does not exceed the sum of—

(A) the total amount of expenditures under such title XVIII that would have made if this section had not been enacted; and

(B) the applicable amount.

(2) APPLICABLE AMOUNT.—For purposes of paragraph (1), the term "applicable amount" means—

(A) for 2005, $32,000,000;
(B) for 2006, $34,000,000;
(C) for 2007, $36,000,000;
(D) for 2008, $38,000,000;
(E) for 2009, $40,000,000;
(F) for 2010, $42,000,000;
(G) for 2011, $44,000,000;
(H) for 2012, $48,000,000; and
(I) for 2013, $50,000,000.

(3) STEPS TO ENSURE FUNDING LIMITATION NOT VIOLATED.—If the Secretary determines that the application of this section will result in the funding limitation described in paragraph (1) being violated for any year, the Secretary shall take appropriate steps to stay within such funding limitation, including through limiting the number of clinical trials deemed under subsection (a) and only covering a portion of the routine costs described in such subsection.

(d) EFFECTIVE DATE.—This section shall apply to clinical trials begun on or after January 1, 2005.

SEC. 439. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2002, 2003, 2004, or 2005 and who demonstrates to the Secretary before December 31, 2005, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2005. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2005 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin 1 year after the date of the enactment of this Act and shall end on December 31, 2005.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 440. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term "chiropractic services" has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term "demonstration project" means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is enrolled under part B of the medicare program.

(4) MEDICARE PROGRAM.—The term "medicare program" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a MedicareAdvantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 6 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

(i) 3 shall be in rural areas; and

(ii) 3 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 3 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

SEC. 441. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

"HEALTH CARE QUALITY DEMONSTRATION PROGRAM

"SEC. 1866C. (a) DEFINITIONS.—In this section:

"(1) BENEFICIARY.—The term 'beneficiary' means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the MedicareAdvantage program) under part C.

"(2) HEALTH CARE GROUP.—

"(A) IN GENERAL.—The term 'health care group' means—

"(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

"(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

"(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

"(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

"(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

"(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

"(1) the provision of incentives to improve the safety of care provided to beneficiaries;

"(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

"(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

"(4) encourage shared decision making between providers and patients;

"(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

"(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

"(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

"(c) ADMINISTRATION BY CONTRACT.—

"(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

"(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

"(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

"(B) streamline documentation and reporting requirements otherwise required under this title.

"(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the traditional fee-for-service program under parts A and B or the package of benefits available through a staff model or a dedicated group model health maintenance organization under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

"(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

"(1) be a health care group;

"(2) meet quality standards established by the Secretary, including—

"(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

"(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

"(C) encouraging patient participation in preference-based decisions;

"(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

"(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

"(3) meet such other requirements as the Secretary may establish.

"(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

"(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

"(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or

services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

"(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

"(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

"(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

"(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

"(i) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.".

SEC. 442. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section, of which at least 3 shall be in an urban area and at least 1 shall be in a rural area. One of the sites shall be located in the State of Arkansas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) PRINCIPAL CARE PHYSICIAN RESPONSIBILITIES.—The Secretary shall enter into an agreement with each principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall—

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community services organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) COMPLEX CLINICAL CARE MANAGEMENT FEE.—

(1) PAYMENT.—Under an agreement entered into under subsection (c), the Secretary shall pay to each principal care physician, on behalf of each eligible beneficiary under the care of that physician, the complex clinical care management fee developed by the Secretary under paragraph (2).

(2) DEVELOPMENT OF FEE.—The Secretary shall develop a complex care management fee under this paragraph that is paid on a monthly basis and which shall be payment in full for all the functions performed by the principal care physician under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ACTIVITY OF DAILY LIVING.—The term "activity of daily living" means eating, toiling, transferring, bathing, dressing, and continence.

(2) CHRONIC CONDITION.—The term "chronic condition" means a biological, physical, or mental condition that is likely to last a year or more, for which there is no known cure, for which there is a need for ongoing medical care, and which may affect an individual's ability to carry out activities of daily living or instrumental activities of daily living, or both.

(3) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means any individual who—

(A) is enrolled for benefits under part B of the medicare program;

(B) has at least 4 complex medical conditions (one of which may be cognitive impairment); and

(C) has—

(i) an inability to self-manage their care; or

(ii) a functional limitation defined as an impairment in 1 or more activity of daily living or instrumental activity of daily living.

(4) INSTRUMENTAL ACTIVITY OF DAILY LIVING.—The term "instrumental activity of daily living" means meal preparation, shopping, housekeeping, laundry, money management, telephone use, and transportation use.

(5) MEDICARE PROGRAM.—The term "medicare program" means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) PRINCIPAL CARE PHYSICIAN.—The term "principal care physician" means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 443. MEDICARE FEE-FOR-SERVICE CARE COORDINATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to contract with qualified care management organizations to provide health risk assessment and care management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in rural areas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a care management organization who agrees to furnish care management services to the eligible beneficiary under the demonstration program.

(c) CONTRACTS WITH CMOs.—

(1) IN GENERAL.—The Secretary shall enter into a contract with care management organizations to provide care management services to eligible beneficiaries residing in the area served by the care management organization.

(2) CANCELLATION.—The Secretary may cancel a contract entered into under paragraph (1) if the care management organization does not meet negotiated savings or quality outcomes targets for the year.

(3) NUMBER OF CMOs.—The Secretary may contract with more than 1 care management organization in a geographic area.

(d) PAYMENT TO CMOs.—

(1) PAYMENT.—Under an contract entered into under subsection (c), the Secretary shall pay care management organizations a fee for which the care management organization is partially at risk based on bids submitted by care management organizations.

(2) PORTION OF PAYMENT AT RISK.—The Secretary shall establish a benchmark for quality and cost against which the results of the care management organization are to be measured. The Secretary may not pay a care management organization the portion of the fee described in

paragraph (1) that is at risk unless the Secretary determines that the care management organization has met the agreed upon savings and outcomes targets for the year.

(e) Funding.—

(1) In general.—The Secretary shall provide for the transfer from the Federal Hospital insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) Budget neutrality.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) Waiver Authority.—

(1) In general.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(2) Waiver of medigap preemptions.—The Secretary shall waive any provision of section 1882 of the Social Security Act that would prevent an insurance carrier described in subsection (h)(3)(D) from participating in the demonstration program under this section.

(g) Report.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) Definitions.—In this section:

(1) Care management services.—The term "care management services" means services that are furnished to an eligible beneficiary (as defined in paragraph (2)) by a care management organization (as defined in paragraph (3)) in accordance with guidelines established by the Secretary that are consistent with guidelines established by the American Geriatrics Society.

(2) Eligible beneficiary.—The term "eligible beneficiary" means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) at high-risk (as defined by the Secretary, but including eligible beneficiaries with multiple sclerosis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).

(3) Care management organization.—The term "care management organization" means an organization that meets such qualifications as the Secretary may specify and includes any of the following:

(A) A physician group practice, hospital, home health agency, or hospice program.

(B) A disease management organization.

(C) A Medicare+Choice or MedicareAdvantage organization.

(D) Insurance carriers offering medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(E) Such other entity as the Secretary determines to be appropriate.

SEC. 444. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) Study.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component;

(4) an evaluation of whether there is a sound economic basis for the implementation of the adjustment under subparagraphs (E) and (F) of section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)), as added by section 421, in those areas in which the adjustment applies;

(5) an evaluation of the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(A) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(B) the mobility of physicians, including specialists, over the last decade;

(6) an evaluation of the appropriateness of extending such adjustment or making such adjustment permanent;

(7) an evaluation of the adjustment of the work geographic practice cost index required under section 1848(e)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(A)(iii)) to reflect ¼ of the area cost difference in physician work;

(8) an evaluation of the effect of the adjustment described in paragraph (7) on physician location and retention in higher than average cost-of-living areas, taking into account difference in recruitment costs and retention rates for physicians, including specialists; and

(9) an evaluation of the appropriateness of the ¼ adjustment for the work geographic practice cost index.".

(b) Report.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 445. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) Exclusion From OPD Fee Schedule.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 13951(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography".

(b) Effective Date.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2005.

SEC. 446. IMPROVEMENT OF OUTPATIENT VISION SERVICES UNDER PART B.

(a) Coverage Under Part B.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" after the semicolon at the end;

(2) in subparagraph (V)(iii), by adding "and" after the semicolon at the end; and

(3) by adding at the end the following new subparagraph:

"(W) vision rehabilitation services (as defined in subsection (ww)(1));".

(b) Services Described.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Vision Rehabilitation Services; Vision Rehabilitation Professional

"(ww)(1)(A) The term 'vision rehabilitation services' means rehabilitative services (as determined by the Secretary in regulations) furnished—

"(i) to an individual diagnosed with a vision impairment (as defined in paragraph (6));

"(ii) pursuant to a plan of care established by a qualified physician (as defined in subparagraph (C)) or by a qualified occupational therapist that is periodically reviewed by a qualified physician;

"(iii) in an appropriate setting (including the home of the individual receiving such services if specified in the plan of care); and

"(iv) by any of the following individuals:

"(I) A qualified physician.

"(II) A qualified occupational therapist.

"(III) A vision rehabilitation professional (as defined in paragraph (2)) while under the general supervision (as defined in subparagraph (D)) of a qualified physician.

"(B) In the case of vision rehabilitation services furnished by a vision rehabilitation professional, the plan of care may only be established and reviewed by a qualified physician.

"(C) The term 'qualified physician' means—

"(i) a physician (as defined in subsection (r)(1)) who is an ophthalmologist; or

"(ii) a physician (as defined in subsection (r)(4) (relating to a doctor of optometry)).

"(D) The term 'general supervision' means, with respect to a vision rehabilitation professional, overall direction and control of that professional by the qualified physician who established the plan of care for the individual, but the presence of the qualified physician is not required during the furnishing of vision rehabilitation services by that professional to the individual.

"(2) The term 'vision rehabilitation professional' means any of the following individuals:

"(A) An orientation and mobility specialist (as defined in paragraph (3)).

"(B) A rehabilitation teacher (as defined in paragraph (4)).

"(C) A low vision therapist (as defined in paragraph (5)).

"(3) The term 'orientation and mobility specialist' means an individual who—

"(A) if a State requires licensure or certification of orientation and mobility specialists, is licensed or certified by that State as an orientation and mobility specialist;

"(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in orientation and mobility; and

"(ii) has successfully completed 350 hours of clinical practicum under the supervision of an orientation and mobility specialist and has furnished not less than 9 months of supervised full-time orientation and mobility services;

"(C) has successfully completed the national examination in orientation and mobility administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

"(D) meets such other criteria as the Secretary establishes.

"(4) The term 'rehabilitation teacher' means an individual who—

''(A) if a State requires licensure or certification of rehabilitation teachers, is licensed or certified by the State as a rehabilitation teacher;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in rehabilitation teaching, or holds such a degree in a health field; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of a rehabilitation teacher and has furnished not less than 9 months of supervised full-time rehabilitation teaching services;

''(C) has successfully completed the national examination in rehabilitation teaching administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(5) The term 'low vision therapist' means an individual who—

''(A) if a State requires licensure or certification of low vision therapists, is licensed or certified by the State as a low vision therapist;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in low vision therapy, or holds such a degree in a health field; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of a physician, and has furnished not less than 9 months of supervised full-time low vision therapy services;

''(C) has successfully completed the national examination in low vision therapy administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(6) The term 'vision impairment' means vision loss that constitutes a significant limitation of visual capability resulting from disease, trauma, or a congenital or degenerative condition that cannot be corrected by conventional means, including refractive correction, medication, or surgery, and that is manifested by 1 or more of the following:

''(A) Best corrected visual acuity of less than 20/60, or significant central field defect.

''(B) Significant peripheral field defect including homonymous or heteronymous bilateral visual field defect or generalized contraction or constriction of field.

''(C) Reduced peak contrast sensitivity in conjunction with a condition described in subparagraph (A) or (B).

''(D) Such other diagnoses, indications, or other manifestations as the Secretary may determine to be appropriate.''.

(c) PAYMENT UNDER PART B.—

(1) PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(2) CARVE OUT FROM HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting ''vision rehabilitation services (as defined in section 1861(ww)(1)) or'' after ''does not include''.

(3) CLARIFICATION OF BILLING REQUIREMENTS.—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and'' before ''(G)''; and

(B) by inserting before the period the following: '', and (H) in the case of vision rehabilitation services (as defined in section 1861(ww)(1)) furnished by a vision rehabilitation professional (as defined in section 1861(ww)(2)) while under the general supervision (as defined in section 1861(ww)(1)(D)) of a qualified physician (as defined in section 1861(ww)(1)(C)), payment shall be made to (i) the qualified physician or (ii) the facility (such as a rehabilitation agency, a clinic, or other facility) through which such services are furnished under the plan of care if there is a contractual arrangement between the vision rehabilitation professional and the facility under which the facility submits the bill for such services''.

(d) PLAN OF CARE.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) in the case of vision rehabilitation services, (i) such services are or were required because the individual needed vision rehabilitation services, (ii) an individualized, written plan for furnishing such services has been established (I) by a qualified physician (as defined in section 1861(ww)(1)(C)), (II) by a qualified occupational therapist, or (III) in the case of such services furnished by a vision rehabilitation professional, by a qualified physician, (iii) the plan is periodically reviewed by the qualified physician, and (iv) such services are or were furnished while the individual is or was under the care of the qualified physician.''.

(e) RELATIONSHIP TO REHABILITATION ACT OF 1973.—The provision of vision rehabilitation services under the medicare program under title XVIII (42 U.S.C. 1395 et seq.) shall not be taken into account for any purpose under the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.).

(f) EFFECTIVE DATE.—

(1) INTERIM, FINAL REGULATIONS.—The Secretary shall publish a rule under this section in the Federal Register by not later than 180 days after the date of enactment of this Act to carry out the provisions of this section. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period for public comment of not less than 60 days.

(2) CONSULTATION.—The Secretary shall consult with the National Vision Rehabilitation Cooperative, the Association for Education and Rehabilitation of the Blind and Visually Impaired, the Academy for Certification of Vision Rehabilitation and Education Professionals, the American Academy of Ophthalmology, the American Occupational Therapy Association, the American Optometric Association, and such other qualified professional and consumer organizations as the Secretary determines appropriate in promulgating regulations to carry out this section.

SEC. 447. GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) CONCIERGE CARE.—In this section, the term ''concierge care'' means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

SEC. 448. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (V)(iii), by inserting ''and'' after the semicolon at the end; and

(C) by adding at the end the following new subparagraph:

''(W) marriage and family therapist services (as defined in subsection (ww)(1)) and mental health counselor services (as defined in subsection (ww)(3));''.

(2) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

''(ww)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

''(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(4) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree in mental health counseling or a related field;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.".

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

"(v) marriage and family therapist services and mental health counselor services;".

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and (U)" and inserting "(U)"; and

(B) by inserting before the semicolon at the end the following: ", and (V) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)".

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended in section 301(a), is amended by inserting "marriage and family therapist services (as defined in subsection (ww)(1)), mental health counselor services (as defined in section 1861(ww)(3))," after "qualified psychologist services,".

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

"(vii) A marriage and family therapist (as defined in section 1861(ww)(2)).

"(viii) A mental health counselor (as defined in section 1861(ww)(4)).".

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking "or by a clinical social worker (as defined in subsection (hh)(1))," and inserting ", by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (ww)(2)), or by a mental health counselor (as defined in subsection (ww)(4)),".

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting "or a marriage and family therapist (as defined in subsection (ww)(2))" after "social worker".

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting "marriage and family therapist (as defined in subsection (ww)(2))," after "social worker,".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2004.

SEC. 449. MEDICARE DEMONSTRATION PROJECT FOR DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the impact of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services on—

(1) costs under the medicare program under title XVIII of the Social Security Act; and

(2) the satisfaction of beneficiaries receiving such services.

(b) DEADLINE FOR ESTABLISHMENT; DURATION; SITES.—

(1) DEADLINE.—The Secretary shall establish the project not later than 1 year after the date of enactment of this Act.

(2) DURATION; SITES.—The project shall—

(A) be conducted for a period of 3 years;

(B) include sites in at least 5 States; and

(C) to the extent feasible, be conducted on a statewide basis in each State included under subparagraph (B).

(3) EARLY TERMINATION.—Notwithstanding paragraph (2)(A), the Secretary may terminate the operation of the project at a site before the end of the 3-year period specified in such paragraph if the Secretary determines, based on actual data, that the total amount expended for all services under this title for individuals at such site for a 12-month period are greater than the total amount that would have been expended for such services for such individuals for such period but for the operation of the project at such site.

(c) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program under title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary to conduct the demonstration project.

(d) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—

(A) IN GENERAL.—The Secretary shall conduct interim and final evaluations of the project.

(B) FOCUS.—The evaluations conducted under paragraph (1) shall—

(i) focus on the impact of the project on program costs under title XVIII of the Social Security Act and patient satisfaction with health care items and services for which payment is made under such title; and

(ii) include comparisons, with respect to episodes of care involving direct access to physical therapy services and episodes of care involving a physician referral for such services, of—

(I) the average number of claims paid per episode for outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services;

(II) the average number of physician office visits per episode; and

(III) the average expenditures under such title per episode.

(2) INTERIM AND FINAL REPORTS.—The Secretary shall submit to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives reports on the evaluations conducted under paragraph (1) by—

(A) in the case of the report on the interim evaluation, not later than the end of the second year the project has been in operation; and

(B) in the case of the report on the final evaluation, not later than 180 days after the closing date of the project.

(3) FUNDING FOR EVALUATION.—There are authorized to be appropriated such sums as may be necessary to provide for the evaluations and reports required by this subsection.

(e) DEFINITIONS.—In this section:

(1) COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—Subject to paragraph (2), the term "comprehensive outpatient rehabilitation services" has the meaning given to such term in section 1861(cc) of the Social Security Act (42 U.S.C. 1395x(cc)).

(2) DIRECT ACCESS.—The term "direct access" means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

(A) without regard to any requirement that—

(i) an individual be under the care of (or referred by) a physician; or

(ii) services be provided under the supervision of a physician; and

(B) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

(i) certification and recertification; and

(ii) establishment and periodic review of a plan of care.

(3) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term "fee-for-service medicare beneficiary" means an individual who—

(A) is enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.); and

(B) is not enrolled in—

(i) a Medicare+Choice plan under part C of such title (42 U.S.C. 1395w–21 et seq.);

(ii) a plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm);

(iii) a program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee); or

(iv) a social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

(4) OUTPATIENT PHYSICAL THERAPY SERVICES.—Subject to paragraph (2), the term "outpatient physical therapy services" has the meaning given to such term in section 1861(p) of the Social Security Act (42 U.S.C. 1395x(p)), except that such term shall not include the speech-language pathology services described in the fourth sentence of such section.

(5) PHYSICIAN.—The term "physician" has the meaning given to such term in section 1861(r)(1) of such Act (42 U.S.C. 1395x(r)(1)).

(6) QUALIFIED PHYSICAL THERAPIST.—The term "qualified physical therapist" has the meaning given to such term for purposes of section 1861(p) of such Act (42 U.S.C. 1395x(p)), as in effect on the date of enactment of this Act.

SEC. 450. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this

section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term "home health services" has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

SEC. 450A. DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), the amount of payment for a device of brachytherapy furnished under the demonstration project shall be equal to the hospital's charges for each device furnished, adjusted to cost.

(b) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—The Secretary shall create additional groups of covered OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.

(c) DURATION.—The Secretary shall conduct the demonstration project under this section for the 3-year period beginning on the date that is 90 days after the date of enactment of this Act.

(d) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project conducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration project under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration project under this section was not implemented.

SEC. 450B. REIMBURSEMENT FOR TOTAL BODY ORTHOTIC MANAGEMENT FOR CERTAIN NURSING HOME PATIENTS.

(a) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall issue product codes that qualified practioners and suppliers may use to receive reimbursement under section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) for qualified total body orthotic management devices used for the treatment of nonambulatory individuals with severe musculoskeletal conditions who are in the full-time care of skilled nursing facilities (as defined in section 1861(j) of such Act (42 U.S.C. 1395x(j))). In issuing such codes, the Secretary shall take all steps necessary to prevent fraud and abuse.

(b) QUALIFIED TOTAL BODY ORTHOTIC MANAGEMENT DEVICE.—For purposes of this section, the term "qualified total body orthotic management device" means a medically-prescribed device which—

(1) consists of custom-fitted individual braces with adjustable points at the hips, knee, ankle, elbow, and wrist, but only if—

(A) the individually adjustable braces are attached to a frame which is an integral component of the device and cannot function or be used apart from the frame; and

(B) the frame is designed such that it serves no purpose without the braces; and

(2) is designed to—

(A) improve function;

(B) retard progression of musculoskeletal deformity; or

(C) restrict, eliminate, or assist in the functioning of lower and upper extremities and pelvic, spinal, and cervical regions of the body affected by injury, weakness, or deformity,

of an individual for whom stabilization of affected areas of the body, or relief of pressure points, is required for medical reasons.

SEC. 450C. AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) IN GENERAL.—Section 1880(e) (42 U.S.C. 1395qq(e)) is amended—

(1) in paragraph (1)(A), by striking "for services described in paragraph (2)" and inserting "for all items and services for which payment may be made under such part";

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

SEC. 450D. COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V)(iii), by inserting "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(W) cardiovascular screening tests (as defined in subsection (ww)(1));".

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Cardiovascular Screening Tests

"(ww)(1) The term 'cardiovascular screening tests' means the following diagnostic tests for the early detection of cardiovascular disease:

"(A) Tests for the determination of cholesterol levels.

"(B) Tests for the determination of lipid levels of the blood.

"(C) Such other tests for cardiovascular disease as the Secretary may approve.

"(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

"(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 450E. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by inserting "and" at the end; and

(C) by adding at the end the following new subparagraph:

"(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

"(ii) a self-injected drug that is used to treat multiple sclerosis;".

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting ", except for any drug or biological described in subparagraph (W)," after "which".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

SEC. 450F. EXTENSION OF MEDICARE SECONDARY PAYER RULES FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.

Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting ", and before January 1, 2004" after "prior to such date)"; and

(2) by adding at the end the following new sentence: "Effective for items and services furnished on or after January 1, 2004 (with respect to periods beginning on or after June 1, 2002), clauses (i) and (ii) shall be applied by substituting '36-month' for '12-month' each place it appears in the first sentence.

SEC. 450G. REQUIRING THE INTERNAL REVENUE SERVICE TO DEPOSIT INSTALLMENT AGREEMENT AND OTHER FEES IN THE TREASURY AS MISCELLANEOUS RECEIPTS.

Notwithstanding any other provision of law, the Secretary of the Treasury is required to deposit in the Treasury as miscellaneous receipts any fee receipts, including fees from installment agreements and restructured installment agreements, collected under the authority provided by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103–329, the Treasury, Postal Service and General Government Appropriations Act, 1995. Fees collected under this section shall be available for use by the Internal Revenue Service only to the extent that such authority is provided in advance in an appropriations Act.

SEC. 450H INCREASING TYPES OF ORIGINATING TELEHEALTH SITES AND FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

"(VI) A skilled nursing facility (as defined in section 1819(a)).

"(VII) An assisted-living facility (as defined by the Secretary).

"(VIII) A board-and-care home (as defined by the Secretary).

"(IX) A county of community health clinic (as defined by the Secretary).

"(X) A community mental health center (as described in section 1861(ff)(2)(B)).

"(XI) A long-term care facility (as defined by the Secretary).

"(XII) A facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) directly, or under contract or other arrangement.".

(b) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—

(1) IN GENERAL.—For purposes of expediting the provision of telehealth services for which payment is made under the medicare program under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), across State lines, the Secretary shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of State provisions allowing for multistate practitioner licensure across State lines.

(2) DEFINITIONS.—In this subsection:

(A) TELEHEALTH SERVICE.—The term "telehealth service" has the meaning given that term in subparagraph (F)(i) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(B) PHYSICIAN, PRACTITIONER.—The terms "physician" and "practitioner" have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(C) MEDICARE PROGRAM.—The term "medicare program" means the program of health insurance administered by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 450I. DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term "surgical first assisting services" means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term "certified registered nurse first assistant" means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) PAYMENT RATES.—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) for the same services if furnished by a physician.

(d) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in 5 States selected by the Secretary.

(e) DURATION.—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the project under this section.

(2) BUDGET NEUTRALITY.—In conducting the project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the project under this section was not implemented.

(i) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 450J. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.".

SEC. 450K. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(b) (42 U.S.C. 1395w–4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "paragraph (2)" and inserting "paragraphs (2) and (4)"; and

(2) by adding at the end the following new paragraph:

"(4) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.—

"(A) IN GENERAL.—With respect to physicians' services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, the fee schedule for such services shall be determined as follows:

"(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

"(I) in the case of services furnished in calendar year 2004, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

"(II) in the case of services furnished in calendar year 2005, the amount determined under subclause (I) for 2004, increased by the annual update determined under subsection (d) for the year involved.

"(ii) In the case of a service for which there was no VA Alaska fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to the sum of—

"(I) the amount of payment for the service that would otherwise apply under this section; plus

"(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

"(B) VA Alaska fee schedule amount.—For purposes of this paragraph, the term 'VA Alaska fee schedule amount' means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians' services associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38).

"(C) Applicable percent.—For purposes of this paragraph, the term 'applicable percent' means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount for physicians' services exceeded the amount of payment for such services under this section that applied in Alaska in 2001.".

SEC. 450L. DEMONSTRATION PROJECT TO EXAMINE WHAT WEIGHT LOSS WEIGHT MANAGEMENT SERVICES CAN COST EFFECTIVELY REACH THE SAME RESULT AS THE NIH DIABETES PRIMARY PREVENTION TRIAL STUDY: A 50 PERCENT REDUCTION IN THE RISK FOR TYPE 2 DIABETES FOR INDIVIDUALS WHO HAVE IMPAIRED GLUCOSE TOLERANCE AND ARE OBESE.

(a) In General.—Inasmuch as the NIH Diabetes Primary Prevention Trial study proved that the risk of type 2 diabetes could be cut in half when the Institute of Medicine definition of successful weight loss (5 percent weight loss maintained for a year) is achieved by individuals at risk for type 2 diabetes due to obesity and impaired glucose tolerance, the Secretary shall conduct a demonstration project to examine the cost effectiveness and health benefits of providing group weight loss management services to achieve the same result for beneficiaries under the medicare program under title XVIII of the Social Security Act who are obese and have impaired glucose tolerance.

(b) Limitation.—The cost of the group weight loss management services provided under subsection (a) shall not exceed the cost per recipient per year of the medical nutritional therapy benefit currently available to medicare beneficiaries.

(c) Scope of Services.—

(1) Duration.—The project shall be conducted for a period of 2 fiscal years.

(2) Sites.—The Secretary shall designate the sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in—

(A) rural areas; or

(B) areas that have a high concentration of Native Americans with type 2 diabetes.

(3) Funding.—

(A) In general.—Subject to subparagraph (B), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(B) Limitation.—The total amount of the payments that may be made under this section shall not exceed $2,500,000 for each fiscal year in which the project is conducted under paragraph (1).

(d) Coverage as Medicare Part B Services.—

(1) In general.—Subject to the succeeding provisions of this subsection, medical nutrition therapy services furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.).

(2) Payment.—Payment for such services shall be made at a rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the fee schedule amount provided under section 1848 of the Social Security Act (42 U.S.C. 139w–4) for the same services if such services were furnished by a physician.

(3) Application of limits of billing.—The provisions of section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) shall apply to a group weight loss management professional furnishing services under the project in the same manner as they to a practitioner described in subparagraph (C) of such section furnishing services under title XVIII of such Act.

(e) Reports.—The Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project not later than the date that is 6 months after the date on which the project concludes. The final report shall include an evaluation of the impact of the use of group weight loss management services as part of medical nutrition therapy on medicare beneficiaries and on the medicare program, including any impact on reducing costs under the program and improving the health of beneficiaries.

(f) Definitions.—For purposes of this section:

(1) The term "obesity" means that an individual has a Body Mass Index (BMI) of 30 and above.

(2) Group weight loss management services.—The term "group weight loss management services" means comprehensive services furnished to individuals who have been diagnosed and referred by a physician as having impaired glucose tolerance and who are obese that consist of—

(A) assessment and treatment based on the needs of individuals as determined by a group weight loss management professional; or

(B) a specific program or method that has demonstrated its efficacy to produce and maintain weight loss through results published in peer-reviewed scientific journals using recognized research methods and statistical analysis that provides—

(i) assessment of current body weight and recording of weight status at each meeting session;

(ii) provision of a healthy eating plan;

(iii) provision of an activity plan;

(iv) provision of a behavior modification plan; and

(v) a weekly group support meeting.

(3) Group weight loss management professional.—The term "group weight loss management professional" means an individual who has completed training to provide a program or method that has completed clinical trials and has demonstrated its efficacy through publications in peer-reviewed scientific journals who—

(A)(i) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) in nutrition social work, psychology with experience in behavioral modification methods to reduce obesity; or

(ii) has completed a curriculum of training for a specific behavioral based weight management program as described in section (4)(A)(2) and recommended in the NIH Clinical Guidelines on Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, chapter 4, section H, parts 1, 2, 3, 4, and pursuant to guidelines by the Secretary; and

(B)(i) is licensed or certified as a group weight loss management professional by the State in which the services are performed; or

(ii) is certified by an organization that meets such criteria as the Secretary establishes with—

(I) national organizations representing consumers such as the American Obesity Association and the elderly; and

(II) such other organizations as the Secretary determines appropriate.

Subtitle C—Provisions Relating to Parts A and B

SEC. 451. INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) In General.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) Waiving Budget Neutrality.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) No Effect on Subsequent Periods.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 452. LIMITATION ON REDUCTION IN AREA WAGE ADJUSTMENT FACTORS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

Section 1895(b)(4)(C) (42 U.S.C. 1395fff(b)(4)(C)) is amended—

(1) by striking "Factors.—The Secretary" and inserting "Factors.—

"(i) In general.—Subject to clause (ii), the Secretary"; and

(2) by adding at the end the following new clause:

"(ii) Limitation on reduction in fiscal year 2005 and 2006.—For fiscal years 2005 and 2006, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more that 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.".

SEC. 453. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) Limits on Physician Referrals.—

(1) Ownership and investment interests in whole hospitals.—

(A) In general.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(i) by striking "and" at the end of subparagraph (A); and

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

"(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and".

(B) Definition.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

"(7) Specialty hospital.—

"(A) In general.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

"(i) patients with a cardiac condition;

"(ii) patients with an orthopedic condition;

"(iii) patients receiving a surgical procedure; or

"(iv) any other specialized category of patients or cases that the Secretary designates as

inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

"(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

"(i) determined by the Secretary—

"(I) to be in operation before June 12, 2003; or

"(II) under development as of such date;

"(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

"(iii) that meets such other requirements as the Secretary may specify.".

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

"(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

"(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

"(B) the entity is not a specialty hospital (as defined in subsection (h)(7)); and

"(C) the Secretary determines, with respect to such entity, that such services would not be available in such area but for the ownership or investment interest.".

(b) EFFECTIVE DATE.—Subject to paragraph (2), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

SEC. 454. DEMONSTRATION PROGRAM FOR SUBSTITUTE ADULT DAY SERVICES.

(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which the Secretary provides eligible medicare beneficiaries with coverage under the medicare program of substitute adult day services furnished by an adult day services facility.

(b) PAYMENT RATE FOR SUBSTITUTE ADULT DAY SERVICES.—

(1) PAYMENT RATE.—For purposes of making payments to an adult day services facility for substitute adult day services under the demonstration program, the following rules shall apply:

(A) ESTIMATION OF PAYMENT AMOUNT.—The Secretary shall estimate the amount that would otherwise be payable to a home health agency under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for all home health services described in subsection (i)(4)(B)(i) under the plan of care.

(B) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the total amount payable for substitute adult day services under the plan of care is equal to 95 percent of the amount estimated to be payable under subparagraph (A).

(2) LIMITATION ON BALANCE BILLING.—Under the demonstration program, an adult day services facility shall accept as payment in full for substitute adult day services (including those services described in clauses (ii) through (iv) of subsection (i)(4)(B)) furnished by the facility to an eligible medicare beneficiary the amount of payment provided under the demonstration program for home health services consisting of substitute adult services.

(3) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration program and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration program and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration program had not been conducted, the Secretary shall adjust the rate of payment to adult day services facilities under paragraph (1)(B) in order to eliminate such excess.

(c) DEMONSTRATION PROGRAM SITES.—The demonstration program shall be conducted in not more than 3 sites selected by the Secretary.

(d) DURATION; IMPLEMENTATION.—

(1) DURATION.—The Secretary shall conduct the demonstration program for a period of 3 years.

(2) IMPLEMENTATION.—The Secretary may not implement the demonstration program before October 1, 2004.

(e) VOLUNTARY PARTICIPATION.—Participation of eligible medicare beneficiaries in the demonstration program shall be voluntary.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration program.

(2) MAY NOT WAIVE ELIGIBILITY REQUIREMENTS FOR HOME HEALTH SERVICES.—The Secretary may not waive the beneficiary eligibility requirements for home health services under title XVIII of the Social Security Act.

(g) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration program.

(2) REPORT.—Not later than 30 months after the commencement of the demonstration program, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the eligible medicare beneficiaries participating in the demonstration program as compared to such outcomes and costs to such beneficiaries receiving only home health services under title XVIII of the Social Security Act for the same health conditions.

(B) Such recommendations regarding the extension, expansion, or termination of the program as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) ADULT DAY SERVICES FACILITY.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the term "adult day services facility" means a public agency or private organization, or a subdivision of such an agency or organization, that—

(i) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(ii) provides the items and services described in paragraph (4)(B); and

(iii) meets the requirements of paragraphs (2) through (8) of subsection (o).

(B) INCLUSION.—Notwithstanding subparagraph (A), the term "adult day services facility" shall include a home health agency in which the items and services described in clauses (ii) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) WAIVER OF SURETY BOND.—The Secretary may waive the requirement of a surety bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(2) ELIGIBLE MEDICARE BENEFICIARY.—The term "eligible medicare beneficiary" means an individual eligible for home health services under title XVIII of the Social Security Act.

(3) HOME HEALTH AGENCY.—The term "home health agency." has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) SUBSTITUTE ADULT DAY SERVICES.—

(A) IN GENERAL.—The term "substitute adult day services" means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services:

(i) Items and services described in paragraphs (1) through (7) of such section 1861(m).

(ii) Meals.

(iii) A program of supervised activities designed to promote physical and mental health and furnished to the individual by the adult day services facility in a group setting for a period of not fewer than 4 and not greater than 12 hours per day.

(iv) A medication management program (as defined in subparagraph (C)).

(C) MEDICATION MANAGEMENT PROGRAM.—For purposes of subparagraph (B)(iv), the term "medication management program" means a program of services, including medicine screening and patient and health care provider education programs, that provides services to minimize—

(i) unnecessary or inappropriate use of prescription drugs; and

(ii) adverse events due to unintended prescription drug-to-drug interactions.

SEC. 455. MEDPAC STUDY ON MEDICARE PAYMENTS AND EFFICIENCIES IN THE HEALTH CARE SYSTEM.

Not later than 18 months after the date of enactment of this Act, the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall provide Congress with recommendations to recognize and reward, within payment methodologies for physicians and hospitals established under the medicare program under title XVIII of the Social Security Act, efficiencies, and the lower utilization of services created by the practice of medicine in historically efficient and low-cost areas. Measures of efficiency recognized in accordance with the preceding sentence shall include—

(1) shorter hospital stays than the national average;

(2) fewer physician visits than the national average;

(3) fewer laboratory tests than the national average;

(4) a greater utilization of hospice services than the national average; and

(5) the efficacy of disease management and preventive health services.

SEC. 456. MEDICARE COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C.1395x) is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (U), by striking "and" at the end;

(ii) in subparagraph (V)(iii), by adding "and" at the end; and

(iii) by adding at the end the following new subparagraph:

"(W) kidney disease education services (as defined in subsection (ww));"; and

(B) by adding at the end the following new subsection:

"Kidney Disease Education Services

"(ww)(1) The term 'kidney disease education services' means educational services that are—

"(A) furnished to an individual with kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

"(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

"(C) designed—

"(i) to provide comprehensive information regarding—

"(I) the management of comorbidities;

"(II) the prevention of uremic complications; and

"(III) each option for renal replacement therapy (including peritoneal dialysis, hemodialysis (including vascular access options), and transplantation); and

"(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy.

"(2) The term 'qualified person' means—

"(A) a physician (as described in subsection (r)(1));

"(B) an individual who—

"(i) is—

"(I) a registered nurse;

"(II) a registered dietitian or nutrition professional (as defined in subsection (vv)(2));

"(III) a clinical social worker (as defined in subsection (hh)(1));

"(IV) a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)); or

"(V) a transplant coordinator; and

"(ii) meets such requirements related to experience and other qualifications that the Secretary finds necessary and appropriate for furnishing the services described in paragraph (1); or

"(C) a renal dialysis facility subject to the requirements of section 1881(b)(1) with personnel who—

"(i) provide the services described in paragraph (1); and

"(ii) meet the requirements of subparagraph (A) or (B).

"(3) The Secretary shall develop the requirements under paragraph (2)(B)(ii) after consulting with physicians, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons.

"(4) In promulgating regulations to carry out this subsection, the Secretary shall ensure that such regulations ensure that each beneficiary who is entitled to kidney disease education services under this title receives such services in a timely manner that ensures that the beneficiary receives the maximum benefit of those services.

"(5) The Secretary shall monitor the implementation of this subsection to ensure that beneficiaries who are eligible for kidney disease education services receive such services in the manner described in paragraph (4).".

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ", (2)(W)", after "(2)(S)".

(3) PAYMENT TO RENAL DIALYSIS FACILITIES.—Section 1881(b) of such Act (42 U.S.C. 1395rr(b)), as amended by section 433(b)(5), is further amended by adding at the end the following new paragraph:

"(13) For purposes of paragraph (7), the single composite weighted formulas determined under such paragraph shall not take into account the amount of payment for kidney disease education services (as defined in section 1861(ww)). Instead, payment for such services shall be made to the renal dialysis facility on an assignment-related basis under section 1848:".

(4) ANNUAL REPORT TO CONGRESS.—Not later than April 1, 2004, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the number of medicare beneficiaries who are entitled to kidney disease education services (as defined in section 1861(ww) of the Social Security Act, as added by paragraph (1)) under title XVIII of such Act and who receive such services, together with such recommendations for legislative and administrative action as the Secretary determines to be appropriate to fulfill the legislative intent that resulted in the enactment of that subsection.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 457. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SEC. 458. IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting "consistent with subsection (j)" after "the Secretary shall ensure"; and

(B) by adding at the end the following new subsection:

"(j) NATIONAL COVERAGE DETERMINATION PROCESS.—

"(1) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

"(2) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

"(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

"(B) provide a 30-day period for public comment on such draft;

"(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

"(D) include in such final decision summaries of the public comments received and responses thereto;

"(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

"(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C).

"(3) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term 'national coverage determination' has the meaning given such term in section 1869(f)(1)(B).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

SEC. 459. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

"(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

"(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

"(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).".

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following: "Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

SEC. 460. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SEC. 461. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.".

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking "such" before "paragraphs".

SEC. 462. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

SEC. 463. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

"(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

"(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

"(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).".

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S. C. 1395fff(b)(5)) is amended by adding at the end the following: "Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

SEC. 464. SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without congressional action, medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007. From 1991 through 2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities, and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts in 2004 and the following years that result from the SGR formula.

TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION OF AN INTERIM FINAL REGULATION.

(a) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) With respect to the publication of a final regulation based on the previous publication of an interim final regulation—

"(i) subject to subparagraph (B), the Secretary shall publish the final regulation within

the 12-month period that begins on the date of publication of the interim final regulation;

"(ii) if a final regulation is not published by the deadline established under this paragraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and

"(iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

"(B) If the Secretary determines before the deadline otherwise established in this paragraph that there is good cause, specified in a notice published before such deadline, for delaying the deadline otherwise applicable under this paragraph, the deadline otherwise established under this paragraph shall be extended for such period (not to exceed 12 months) as the Secretary specifies in such notice.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to interim final regulations published on or after such date.

(c) STATUS OF PENDING INTERIM FINAL REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

"(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

"(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

"(C)(i) Except as provided in clause (ii), a substantive change may not take effect before the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of enactment of this Act.

SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a)(1), is amended by adding at the end the following new subsection:

"(e)(1) Not later than 2 years after the date of enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of all communications and correspondence.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

SEC. 504. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the "Paperwork Reduction Act") to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

(d) FEASIBILITY.—If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in subsection (b)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its unfeasibility. He shall then establish a feasible reduction to be achieved by January 1, 2005.

Subtitle B—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges, including ensuring that such judges are in an office that is functionally and operationally separate from the Centers for Medicare & Medicaid Services and the Center for Medicare Choices.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff).

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as

amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO Evaluation.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress, the Commissioner of Social Security, and the Secretary a report on such evaluation.

(c) Submission of GAO Report Required Before Plan Implementation.—The Commissioner of Social Security and the Secretary may not implement the plan developed under subsection (a) before the date that is 6 months after the date the report required under subsection (b)(2) is submitted to the Commissioner and the Secretary.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) In General.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision"; and

(2) by adding at the end the following new paragraph:

"(2) Expedited access to judicial review.—

"(A) In general.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

"(B) Prompt determinations.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

"(C) Access to judicial review.—

"(i) In general.—If the appropriate review entity—

"(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);
then the appellant may bring a civil action as described in this subparagraph.

"(ii) Deadline for filing.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) Venue.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than 1 applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

"(iv) Interest on any amounts in controversy.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

(D) Review entity defined.—For purposes of this subsection, the term 'review entity' means an entity of up to 3 qualified reviewers drawn from existing appeals levels other than the redetermination level.

(b) Application to Provider Agreement Determinations.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) GAO Study and Report on Access to Judicial Review.—

(1) Study.—The Comptroller General of the United States shall conduct a study on the access of medicare beneficiaries and health care providers to judicial review of actions of the Secretary and the Department of Health and Human Services with respect to items and services under title XVIII of the Social Security Act subsequent to February 29, 2000, the date of the decision of Shalala, Secretary of Health and Human Services; et al. v. Illinois Council on Long Term Care, Inc. (529 U.S. 1 (2000)).

(2) Report.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations as the Comptroller General determines to be appropriate.

(d) Conforming Amendment.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

"(ii) Reference to expedited access to judicial review.—For the provision relating to expedited access to judicial review, see paragraph (2).".

(e) Effective Date.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) Termination and Certain Other Immediate Remedies.—

(1) In general.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) Priority for cases of termination.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) Increased Financial Support.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 514. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) Timeframes for the Completion of the Record.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

"(3) Timely completion of the record.—

"(A) Deadline.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

"(B) Extensions for good cause.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

"(C) Delay in decision deadlines until completion of record.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

"(D) Complete record described.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

"(i) written or testimonial evidence, or both, submitted by the person filing the request,

"(ii) written or oral argument, or both,

"(iii) the decision of, and the record for, the prior level of appeal, and

"(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.".

(b) Use of Patients' Medical Records.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

(c) Notice Requirements for Medicare Appeals.—

(1) Initial determinations and redeterminations.—Section 1869(a) (42 U.S.C. 1395ff(a))

is amended by adding at the end the following new paragraph:

"(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

"(A) the reasons for the determination, including, as appropriate—

"(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

"(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

"(B) the procedures for obtaining additional information concerning the determination or redetermination; and

"(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.".

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

"(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

"(i) to the extent appropriate, a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

"(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

"(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical or scientific rationale for the decision.".

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting "; NOTICE" after "SECRETARY"; and

(B) by adding at the end the following new paragraph:

"(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

"(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

"(B) the procedures for obtaining additional information concerning the decision; and

"(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.".

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking "such information as is required for an appeal" and inserting "the record for the appeal".

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting "(except in the case of a utilization and quality control peer review organization, as defined in section 1152)" after "means an entity or organization that"; and

(ii) by striking the period at the end and inserting the following: "and meets the following requirements:

"(A) GENERAL REQUIREMENTS.—

"(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

"(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

"(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

"(B) INDEPENDENCE REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

"(I) is not a related party (as defined in subsection (g)(5));

"(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

"(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional."; and

(B) in paragraph (3)(A), by striking ", and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection".

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

"(D) QUALIFICATIONS OF REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals)."; and

(B) by adding at the end the following new subsection:

"(g) QUALIFICATIONS OF REVIEWERS.—

"(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

"(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4).

"(2) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(I) a nonaffiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

"(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

"(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

"(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

"(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

"(C) The health care professional that provides the items or services involved in the case.

"(D) The institution at which the items or services (or treatment) involved in the case are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

"(F) Any other party determined under any regulations to have a substantial interest in the case involved.".

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking "12" and inserting "4".

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

"(d) EFFECTIVE DATE.—

"(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2004.

"(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) *shall apply with respect to initial determinations made on or after October 1, 2003:*

"(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

"(B) Subsection (c)(3)(C)(iii) of such section.

"(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

"(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.".

(2) CONFORMING AMENDMENTS.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 515. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

"(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

"(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

"(2) providers of services, physicians, practitioners, and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied are provided a mechanism to appeal such denial and a deadline for consideration of such appeals.".

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 502 and 503, is amended by adding at the end the following new subsection:

"(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.".

SEC. 516. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

"(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

"(5) AGGRIEVED PARTY DEFINED.—In this section, the term 'aggrieved party' means—

"(A) with respect to a national coverage determination, an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; and

"(B) with respect to a local coverage determination—

"(i) an individual who is entitled to benefits under part A, or enrolled under part B, or both, who is adversely affected by such a determination; or

"(ii) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.".

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting ", including, where appropriate, the specific requirements and clinical indications relating to the medical necessity of an item or service" before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 514(d)(2)(B), is amended by adding at the end the following new subsection:

"(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

"(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

"(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

"(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

"(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

"(B) each reversal described in subparagraph (A) involves substantially similar material facts;

"(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

"(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

"(4) APPROVAL OR REJECTION OF REQUEST.—

"(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

"(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.".

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after October 1, 2003;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of enactment of this Act.

SEC. 518. REVISIONS TO APPEALS TIMEFRAMES.

Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking "30-day period" each place it appears and inserting "60-day period";

(2) in subsection (c)(3)(C)(i), by striking "30-day period" and inserting "60-day period";

(3) in subsection (d)(1)(A), by striking "90-day period" and inserting "120-day period"; and

(4) in subsection (d)(2)(A), by striking "90-day period" and inserting "120-day period".

SEC. 519. ELIMINATION OF REQUIREMENT TO USE SOCIAL SECURITY ADMINISTRATION ADMINISTRATIVE LAW JUDGES.

The first sentence of section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking "of the Social Security Administration".

SEC. 520. ELIMINATION OF REQUIREMENT FOR DE NOVO REVIEW BY THE DEPARTMENTAL APPEALS BOARD.

Section 1869(d)(2) (42 U.S.C. 1395ff(d)(2)) is amended to read as follows:

"(2) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.".

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function;

"(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

"(C) the entity has sufficient assets to financially support the performance of such function; and

"(D) the entity meets such other requirements as the Secretary may impose.

"(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and beneficiary services functions as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

"(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 6 years.

"(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

"(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

"(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

"(3) PERFORMANCE REQUIREMENTS.—

"(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

"(B) CONSIDERATIONS.—The Secretary shall include, as 1 of the standards, provider and beneficiary satisfaction levels.

"(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

"(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

"(ii) shall be used for evaluating contractor performance under the contract; and

"(iii) shall be consistent with the written statement of work provided under the contract.

"(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative

contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(6) RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.—A contract with a medicare administrative contractor under this section to perform the function of developing local coverage determinations (as defined in section 1869(f)(2)(B)) shall provide that the contractor shall—

"(A) designate at least 1 different individual to serve as medical director for each State for which such contract performs such function;

"(B) utilize such medical director in the performance of such function; and

"(C) appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in, the development of a local coverage determination in an advisory capacity.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

"(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

"(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the "False Claims Act").

"(5) INDEMNIFICATION BY SECRETARY.—

"(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

"(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

"(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

"(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

"(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

"(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.".

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services,"; and

(II) by striking "carrier" and inserting "medicare administrative contractor";

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,";

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), by striking "carrier" and inserting "medicare administrative contractor";

(E) in paragraph (5), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier" and "carrier responses" and inserting "contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor" and "contractor responses", respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

"(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

"(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

"(2) GAO REVIEW OF METHODOLOGY.—The Comptroller General of the United States shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

"(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.".

(2) REPORT.—The Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of the Social Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)";

(B) in subparagraph (B), by striking "The amount appropriated" and inserting "Subject to subparagraph (C), the amount appropriated"; and

(C) by adding at the end the following new subparagraph:

"(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

"(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

"(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.".

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

"(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

"(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

"(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

"(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.".

(B) Effective date.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) Additional Provider Education Provisions.—

(1) In general.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

"(c) Encouragement of Participation in Education Program Activities.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

"(d) Construction.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

"(1) of the screens used for identifying claims that will be subject to medical review; or

"(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(e) Definitions.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) In General.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

"(f) Communicating With Beneficiaries and Providers.—

"(1) Communication process.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

"(2) Response to written inquiries.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

"(3) Response to toll-free lines.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) Monitoring of contractor responses.—

"(A) In general.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) Development of standards.—

"(i) In general.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) Evaluation.—In conducting evaluations of individual medicare contractors, the Secretary shall consider the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) Direct monitoring.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(5) Medicare contractor defined.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).".

(b) Effective Date.—The amendment made by subsection (a) shall take effect October 1, 2004.

(c) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).

SEC. 533. RELIANCE ON GUIDANCE.

(a) In General.—Section 1871(d), as added by section 502(a), is amended by adding at the end the following new paragraph:

"(2) If—

"(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

"(i) by the Secretary; or

"(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

"(B) the Secretary determines that—

"(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

"(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

"(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.".

(b) Effective Date.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of enactment of this Act.

SEC. 534. MEDICARE PROVIDER OMBUDSMAN.

(a) Medicare Provider Ombudsman.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; medicare provider ombudsman";

(2) by inserting "Practicing Physicians Advisory Council.—(1)" after "(a)";

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) Medicare Provider Ombudsman.—

"(1) In general.—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

"(2) Duties.—The Medicare Provider Ombudsman shall—

"(A) provide assistance, on a confidential basis, to entities and individuals providing items and services, including covered drugs under part D, under this title with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(i) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

"(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

"(3) Staff.—The Secretary shall provide the Medicare Provider Ombudsman with appropriate staff.".

(b) Funding.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account)) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (42 U.S.C. 1395ee) (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAMS.

(a) Demonstration on the Provision of Advice and Assistance to Medicare Beneficiaries at Local Offices of the Social Security Administration.—

(1) Establishment.—The Secretary shall establish a demonstration program (in this subsection referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(2) Locations.—

(A) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) DURATION.—The demonstration program shall be conducted over a 3-year period.

(4) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(b) DEMONSTRATION ON PROVIDING PRIOR DETERMINATIONS.—

(1) ESTABLISHMENT.—By not later than 1 year after the date of enactment of this Act, the Secretary shall establish a demonstration project to test the administrative feasibility of providing a process for medicare beneficiaries and entities and individuals furnishing, such beneficiaries with items and services under title XVIII of the Social Security Act program to make a request for, and receive, a determination (after an advance beneficiary notice is issued with respect to the item or service involved but before such item or service is furnished to the beneficiary) as to whether the item or service is covered under such title consistent with the applicable requirements of section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A)) (relating to medical necessity).

(2) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program conducted under paragraph (1).

(B) REPORT.—By not later than January 1, 2006, the Secretary shall submit to Congress a report on such evaluation together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

"(g) CONDUCT OF PREPAYMENT REVIEW.—

"(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

"(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

"(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

"(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

"(h) RECOVERY OF OVERPAYMENTS.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

"(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

"(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

"(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

"(ii) there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

"(2) LIMITATION ON RECOUPMENT.—

"(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

"(B) PAYMENT OF INTEREST.—

"(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

"(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

"(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

"(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

"(3) PAYMENT AUDITS.—

"(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

"(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

"(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

"(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

"(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

"(6) CONSENT SETTLEMENT REFORMS.—

"(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

"(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

"(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.".

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of overutilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.".

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services and inpatient hospital services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of enactment of this Act.

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking "hospice services" and inserting "hospice care and post-hospital extended care services"; and

(B) by inserting before the period at the end the following: "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management physician services under title XVIII of Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 554. COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395ee), as amended by section 534(a), is amended by adding at the end the following new subsection:

"(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

"(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as

defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.".

SEC. 555. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) In General.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

"(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

"(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.".

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of enactment of this Act.

TITLE VI—OTHER PROVISIONS

SEC. 601. INCREASE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEARS 2004 AND 2005.

(a) In General.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)) is amended—

(1) in the paragraph heading, by striking "FISCAL YEARS 2001 AND 2002" and inserting "CERTAIN FISCAL YEARS";

(2) in subparagraph (A)—

(A) in clause (i)—

(i) by striking "paragraph (2)" and inserting "paragraphs (2) and (3)"; and

(ii) by striking "and" at the end;

(B) in clause (ii), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

"(iii) for fiscal year 2004, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

"(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003; and

"(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2004; and

"(iv) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

"(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002, 2003, and 2001; and

"(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2005."; and

(3) in subparagraph (C)—

(A) in the subparagraph heading, by striking "AFTER FISCAL YEAR 2002" and inserting "FOR OTHER FISCAL YEARS"; and

(B) by striking "2003 or" and inserting "2003, fiscal year 2006, or".

(b) DSH Allotment for the District of Columbia.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)), as amended by paragraph (1), is amended—

(1) in subparagraph (A), by inserting "and except as provided in subparagraph (C)" after "paragraph (2)";

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following:

"(C) DSH allotment for the district of columbia.—

"(i) In general.—Notwithstanding subparagraph (A), the DSH allotment for the District of Columbia for fiscal year 2004, shall be determined by substituting "49" for "32" in the item in the table contained in paragraph (2) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such allotment, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2000, 2001, 2002, and 2003.

"(ii) No application to allotments after fiscal year 2004.—The DSH allotment for the District of Columbia for fiscal year 2003, fiscal year 2005, or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotment determined under clause (i).".

(c) Conforming Amendment.—Section 1923(f)(3) of such Act (42 U.S.C. 1396r-4(f)(3)) is amended by inserting ", paragraph (4)," after "subparagraph (B)".

(d) Urban Health Provider Adjustment.—

(1) In general.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) and subject to paragraph (3), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in paragraph (2) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r-4(f)).

(2) Hospital described.—A hospital is described in this paragraph if the hospital—

(A) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(B) is located in Marion County, Indiana.

(3) Limitation.—The payment adjustment described in paragraph (1) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r-4(g)(1)(A)).

SEC. 602. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE UNDER THE MEDICAID PROGRAM FOR FISCAL YEARS 2004 AND 2005.

(a) In General.—Section 1923(f)(5) (42 U.S.C. 1396r-4(f)(5)) is amended—

(1) by striking "In the case of" and inserting the following:

"(A) In general.—In the case of"; and

(2) by adding at the end the following:

"(B) Increase in floor for fiscal years 2004 and 2005.—

"(i) Fiscal year 2004.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year.

"(ii) Fiscal year 2005.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2001, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2004, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2004.

"(iii) No application to allotments after fiscal year 2005.—The DSH allotment for any State for fiscal year 2006 or any succeeding fiscal year shall be determined under this subsection without regard to the DSH allotments determined under this subparagraph.".

(b) Allotment Adjustment.—

(1) In general.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following:

"(6) Allotment adjustment.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 that was implemented on January 1, 1994, is revoked or terminated before the end of either such fiscal year, the Secretary shall—

"(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

"(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that provides for the maximum amount (permitted consistent with paragraph (3)(B)(ii)) that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.".

(2) Treatment of institutions for mental diseases.—Section 1923(h)(1) of the Social Security Act (42 U.S.C. 1396r-4(h)(1)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting "(subject to paragraph (3))" after "the lesser of the following"; and

(B) by adding at the end the following new paragraph:

"(3) Special rule.—The limitation of paragraph (1) shall not apply in the case of a State to which subsection (f)(6) applies.".

(3) Application to Hawaii.—Section 1923(f) (42 U.S.C. 1396r-4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) Treatment of Hawaii as a low-DSH state.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).".

SEC. 603. INCREASED REPORTING REQUIREMENTS TO ENSURE THE APPROPRIATENESS OF PAYMENT ADJUSTMENTS TO DISPROPORTIONATE SHARE HOSPITALS UNDER THE MEDICAID PROGRAM.

Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

"(j) ANNUAL REPORTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to submit an annual report that—

"(1) identifies each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year; and

"(2) includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.".

SEC. 604. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: "(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)".

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

"(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking "paragraph (2)" and inserting "paragraphs (2) and (4)"; and

(2) by adding at the end the following new paragraph:

"(4)(A) With respect to any or all of fiscal years 2005 through 2007, a State may elect (in a plan amendment under this title) to provide medical assistance under this title (including under a waiver authorized by the Secretary) for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

"(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

"(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

"(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

"(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).".

(b) SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) Section 1903(v)(4) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX and only with respect to any or all of fiscal years 2005 through 2007.".

SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(i) CONSUMER OMBUDSMAN ACCOUNT.—

"(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Consumer Ombudsman Account' (in this subsection referred to as the 'Account').

"(2) APPROPRIATED AMOUNTS TO ACCOUNT FOR HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.—

"(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year beginning with fiscal year 2005, the amount described in subparagraph (B) for such fiscal year for the purpose of making grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

"(B) AMOUNT DESCRIBED.—For purposes of subparagraph (A), the amount described in this subparagraph for a fiscal year is the amount equal to the product of—

"(i) $1; and

"(ii) the total number of individuals receiving benefits under this title for the calendar year ending on December 31 of the preceding fiscal year.".

(b) CONFORMING AMENDMENT.—Section 4360(g) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–4(g)) is amended to read as follows:

"(g) FUNDING.—The Secretary shall use amounts appropriated to the Consumer Ombudsman Account in accordance with section 1817(i) of the Social Security Act for a fiscal year for making grants under this section for that fiscal year.".

SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR LOW-INCOME BENEFICIARIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered drugs for an individual described in subsection (b) differs from the drug utilization and access to covered drugs of an individual who qualifies for the transitional assistance prescription drug card program under section 1807A of the Social Security Act (as added by section 111) or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act (as added by section 101).

(b) INDIVIDUAL DESCRIBED.—An individual is described in this subsection if the individual does not qualify for the transitional assistance prescription drug card program under section 1807A of the Social Security Act or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act solely as a result of the application of an assets test to the individual.

(c) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(d) DEFINITIONS.—In this section:

(1) COVERED DRUGS.—The term "covered drugs" has the meaning given that term in section 1860D(a)(D) of the Social Security Act.

(2) QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARY; QUALIFYING INDIVIDUAL.—The terms "qualified medicare beneficiary", "specified low-income medicare beneficiary" and "qualifying individual" have the meaning given those terms under section 1860D–19 of the Social Security Act.

SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.

At the end of the Social Security Act, add the following new title:

"TITLE XXII—HEALTH CARE INFRASTRUCTURE IMPROVEMENT

"SEC. 2201. DEFINITIONS.

"In this title, the following definitions apply:

"(1) ELIGIBLE PROJECT COSTS.—The term 'eligible project costs' means amounts substantially all of which are paid by, or for the account of, an obligor in connection with a project, including the cost of—

"(A) development phase activities, including planning, feasibility analysis, revenue forecasting, environmental study and review, permitting, architectural engineering and design work, and other preconstruction activities;

"(B) construction, reconstruction, rehabilitation, replacement, and acquisition of facilities and real property (including land related to the project and improvements to land), environmental mitigation, construction contingencies, and acquisition of equipment;

"(C) capitalized interest necessary to meet market requirements, reasonably required reserve funds, capital issuance expenses, and other carrying costs during construction;

"(D) major medical equipment determined to be appropriate by the Secretary; and

"(E) refinancing projects or activities that are otherwise eligible for financial assistance under subparagraphs (A) through (D).

"(2) FEDERAL CREDIT INSTRUMENT.—The term 'Federal credit instrument' means a secured loan, loan guarantee, or line of credit authorized to be made available under this title with respect to a project.

"(3) INVESTMENT-GRADE RATING.—The term 'investment-grade rating' means a rating category of BBB minus, Baa3, or higher assigned by a rating agency to project obligations offered into the capital markets.

"(4) LENDER.—The term 'lender' means any non-Federal qualified institutional buyer (as defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known as Rule 144A(a) of the Securities and Exchange Commission and issued under the Securities Act of 1933 (15 U.S.C. 77a et seq.)), including—

"(A) a qualified retirement plan (as defined in section 4974(c) of the Internal Revenue Code of 1986) that is a qualified institutional buyer; and

"(B) a governmental plan (as defined in section 414(d) of the Internal Revenue Code of 1986) that is a qualified institutional buyer.

‘‘(5) LINE OF CREDIT.—The term ‘line of credit’ means an agreement entered into by the Secretary with an obligor under section 2204 to provide a direct loan at a future date upon the occurrence of certain events.

‘‘(6) LOAN GUARANTEE.—The term ‘loan guarantee’ means any guarantee or other pledge by the Secretary to pay all or part of the principal of and interest on a loan or other debt obligation issued by an obligor and funded by a lender.

‘‘(7) LOCAL SERVICER.—The term ‘local servicer’ means a State or local government or any agency of a State or local government that is responsible for servicing a Federal credit instrument on behalf of the Secretary.

‘‘(8) OBLIGOR.—The term ‘obligor’ means a party primarily liable for payment of the principal of or interest on a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

‘‘(9) PROJECT.—The term ‘project’ means any project that is designed to improve the health care infrastructure, including the construction, renovation, or other capital improvement of any hospital, medical research facility, or other medical facility or the purchase of any equipment to be used in a hospital, research facility, or other medical research facility.

‘‘(10) PROJECT OBLIGATION.—The term ‘project obligation’ means any note, bond, debenture, lease, installment sale agreement, or other debt obligation issued or entered into by an obligor in connection with the financing of a project, other than a Federal credit instrument.

‘‘(11) RATING AGENCY.—The term ‘rating agency’ means a bond rating agency identified by the Securities and Exchange Commission as a Nationally Recognized Statistical Rating Organization.

‘‘(12) SECURED LOAN.—The term ‘secured loan’ means a direct loan or other debt obligation issued by an obligor and funded by the Secretary in connection with the financing of a project under section 2203.

‘‘(13) STATE.—The term ‘State’ has the meaning given the term in section 101 of title 23, United States Code.

‘‘(14) SUBSIDY AMOUNT.—The term ‘subsidy amount’ means the amount of budget authority sufficient to cover the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a net present value basis, excluding administrative costs and any incidental effects on governmental receipts or outlays in accordance with the provisions of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.).

‘‘(15) SUBSTANTIAL COMPLETION.—The term ‘substantial completion’ means the opening of a project to patients or for research purposes.

“SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT SELECTION.

‘‘(a) ELIGIBILITY.—To be eligible to receive financial assistance under this title, a project shall meet the following criteria:

‘‘(1) APPLICATION.—A State, a local servicer identified under section 2205(a), or the entity undertaking a project shall submit a project application to the Secretary.

‘‘(2) ELIGIBLE PROJECT COSTS.—To be eligible for assistance under this title, a project shall have total eligible project costs that are reasonably anticipated to equal or exceed $40,000,000.

‘‘(3) SOURCES OF REPAYMENTS.—Project financing shall be repayable, in whole or in part, from reliable revenue sources as described in the application submitted under paragraph (1).

‘‘(4) PUBLIC SPONSORSHIP OF PRIVATE ENTITIES.—In the case of a project that is undertaken by an entity that is not a State or local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be publicly sponsored or sponsored by an entity that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code.

‘‘(b) SELECTION AMONG ELIGIBLE PROJECTS.—

‘‘(1) ESTABLISHMENT.—The Secretary shall establish criteria for selecting among projects that meet the eligibility criteria specified in subsection (a).

‘‘(2) SELECTION CRITERIA.—

‘‘(A) IN GENERAL.—The selection criteria shall include the following:

‘‘(i) The extent to which the project is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

‘‘(ii) The creditworthiness of the project, including a determination by the Secretary that any financing for the project has appropriate security features, such as a rate covenant, credit enhancement requirements, or debt services coverages, to ensure repayment.

‘‘(iii) The extent to which assistance under this title would foster innovative public-private partnerships and attract private debt or equity investment.

‘‘(iv) The likelihood that assistance under this title would enable the project to proceed at an earlier date than the project would otherwise be able to proceed.

‘‘(v) The extent to which the project uses or results in new technologies.

‘‘(vi) The amount of budget authority required to fund the Federal credit instrument made available under this title.

‘‘(vii) The extent to which the project helps maintain or protect the environment.

‘‘(B) SPECIFIC REQUIREMENTS.—The selection criteria shall require that a project applicant—

‘‘(i) be engaged in research in the causes, prevention, and treatment of cancer;

‘‘(ii) be designated as a cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State; and

‘‘(iii) be located in a State that, on the date of enactment of this title, has a population of less than 3,000,000 individuals.

‘‘(C) RATING LETTER.—For purposes of subparagraph (A)(ii), the Secretary shall require each project applicant to provide a rating letter from at least 1 rating agency indicating that the project's senior obligations have the potential to achieve an investment-grade rating with or without credit enhancement.

“SEC. 2203. SECURED LOANS.

‘‘(a) IN GENERAL.—

‘‘(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements with 1 or more obligors to make secured loans, the proceeds of which shall be used—

‘‘(A) to finance eligible project costs;

‘‘(B) to refinance interim construction financing of eligible project costs; or

‘‘(C) to refinance existing debt or prior project obligations;

of any project selected under section 2202.

‘‘(2) LIMITATION ON REFINANCING OF INTERIM CONSTRUCTION FINANCING.—A loan under paragraph (1) shall not refinance interim construction financing under paragraph (1)(B) later than 1 year after the date of substantial completion of the project.

‘‘(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

‘‘(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a secured loan under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

‘‘(A) the Secretary may fund an amount of the secured loan not to exceed the capital reserve subsidy amount determined under paragraph (3) prior to the obligations receiving an investment-grade rating; and

‘‘(B) the Secretary may fund the remaining portion of the secured loan only after the obligations have received an investment-grade rating by at least 1 rating agency.

‘‘(b) TERMS AND LIMITATIONS.—

‘‘(1) IN GENERAL.—A secured loan under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

‘‘(2) MAXIMUM AMOUNT.—The amount of the secured loan shall not exceed 100 percent of the reasonably anticipated eligible project costs.

‘‘(3) PAYMENT.—The secured loan—

‘‘(A) shall—

‘‘(i) be payable, in whole or in part, from reliable revenue sources; and

‘‘(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

‘‘(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

‘‘(4) INTEREST RATE.—The interest rate on the secured loan shall be not less than the yield on marketable United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

‘‘(5) MATURITY DATE.—The final maturity date of the secured loan shall be not later than 30 years after the date of substantial completion of the project.

‘‘(6) NONSUBORDINATION.—The secured loan shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

‘‘(7) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

‘‘(c) REPAYMENT.—

‘‘(1) SCHEDULE.—The Secretary shall establish a repayment schedule for each secured loan under this section based on the projected cash flow from project revenues and other repayment sources.

‘‘(2) COMMENCEMENT.—Scheduled loan repayments of principal or interest on a secured loan under this section shall commence not later than 5 years after the date of substantial completion of the project.

‘‘(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include any revenue generated by the project.

‘‘(4) DEFERRED PAYMENTS.—

‘‘(A) AUTHORIZATION.—If, at any time during the 10 years after the date of substantial completion of the project, the project is unable to generate sufficient revenues to pay the scheduled loan repayments of principal and interest on the secured loan, the Secretary may, subject to subparagraph (C), allow the obligor to add unpaid principal and interest to the outstanding balance of the secured loan.

‘‘(B) INTEREST.—Any payment deferred under subparagraph (A) shall—

‘‘(i) continue to accrue interest in accordance with subsection (b)(4) until fully repaid; and

‘‘(ii) be scheduled to be amortized over the remaining term of the loan beginning not later than 10 years after the date of substantial completion of the project in accordance with paragraph (1).

"(C) Criteria.—

"(i) In general.—Any payment deferral under subparagraph (A) shall be contingent on the project meeting criteria established by the Secretary.

"(ii) Repayment standards.—The criteria established under clause (i) shall include standards for reasonable assurance of repayment.

"(5) Prepayment.—

"(A) Use of excess revenues.—Any excess revenues that remain after satisfying scheduled debt service requirements on the project obligations and secured loan and all deposit requirements under the terms of any trust agreement, bond resolution, reimbursement agreement, credit agreement, loan agreement, or similar agreement securing project obligations may be applied annually to prepay the secured loan without penalty.

"(B) Use of proceeds of refinancing.—The secured loan may be prepaid at any time without penalty, regardless of whether such repayment is from the proceeds of refinancing from non-Federal funding sources.

"(6) Forgiveness of indebtedness.—The Secretary may forgive a loan secured under this title under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the project of—

"(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

"(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

"(C)(i) unique research resources (such as population databases); or

"(ii) an affiliation with an entity that has unique research resources.

"(d) Sale of Secured Loans.—

"(1) In general.—Subject to paragraph (2), as soon as practicable after substantial completion of a project and after notifying the obligor, the Secretary may sell to another entity or reoffer into the capital markets a secured loan for the project if the Secretary determines that the sale or reoffering can be made on favorable terms.

"(2) Consent of obligor.—In making a sale or reoffering under paragraph (1), the Secretary may not change the original terms and conditions of the secured loan without the written consent of the obligor.

"(e) Loan Guarantees.—

"(1) In general.—The Secretary may provide a loan guarantee to a lender in lieu of making a secured loan if the Secretary determines that the budgetary cost of the loan guarantee is substantially the same as that of a secured loan.

"(2) Terms.—The terms of a guaranteed loan shall be consistent with the terms set forth in this section for a secured loan, except that the rate on the guaranteed loan and any prepayment features shall be negotiated between the obligor and the lender, with the consent of the Secretary.

"SEC. 2204. LINES OF CREDIT.

"(a) In General.—

"(1) Agreements.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements to make available lines of credit to 1 or more obligors in the form of direct loans to be made by the Secretary at future dates on the occurrence of certain events for any project selected under section 2202.

"(2) Use of proceeds.—The proceeds of a line of credit made available under this section shall be available to pay debt service on project obligations issued to finance eligible project costs, extraordinary repair and replacement costs, operation and maintenance expenses, and costs associated with unexpected Federal or State environmental restrictions.

"(3) Risk assessment.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate subsidy amount for each secured loan, taking into account such letter.

"(4) Investment-grade rating requirement.—The funding of a line of credit under this section shall be contingent on the project's senior obligations receiving an investment-grade rating from at least 1 rating agency.

"(b) Terms and Limitations.—

"(1) In general.—A line of credit under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

"(2) Maximum amounts.—

"(A) Total amount.—The total amount of the line of credit shall not exceed 33 percent of the reasonably anticipated eligible project costs.

"(B) 1-year draws.—The amount drawn in any 1 year shall not exceed 20 percent of the total amount of the line of credit.

"(3) Draws.—Any draw on the line of credit shall represent a direct loan and shall be made only if net revenues from the project (including capitalized interest, any debt service reserve fund, and any other available reserve) are insufficient to pay the costs specified in subsection (a)(2).

"(4) Interest rate.—The interest rate on a direct loan resulting from a draw on the line of credit shall be not less than the yield on 30-year marketable United States Treasury securities as of the date on which the line of credit is obligated.

"(5) Security.—The line of credit—

"(A) shall—

"(i) be payable, in whole or in part, from reliable revenue sources; and

"(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

"(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

"(6) Period of availability.—The line of credit shall be available during the period beginning on the date of substantial completion of the project and ending not later than 10 years after that date.

"(7) Rights of third-party creditors.—

"(A) Against federal government.—A third-party creditor of the obligor shall not have any right against the Federal Government with respect to any draw on the line of credit.

"(B) Assignment.—An obligor may assign the line of credit to 1 or more lenders or to a trustee on the lenders' behalf.

"(8) Nonsubordination.—A direct loan under this section shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

"(9) Fees.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of providing a line of credit under this section.

"(10) Relationship to other credit instruments.—A project that receives a line of credit under this section also shall not receive a secured loan or loan guarantee under section 2203 of an amount that, combined with the amount of the line of credit, exceeds 100 percent of eligible project costs.

"(c) Repayment.—

"(1) Terms and conditions.—The Secretary shall establish repayment terms and conditions for each direct loan under this section based on the projected cash flow from project revenues and other repayment sources.

"(2) Timing.—All scheduled repayments of principal or interest on a direct loan under this section shall commence not later than 5 years after the end of the period of availability specified in subsection (b)(6) and be fully repaid, with interest, by the date that is 25 years after the end of the period of availability specified in subsection (b)(6).

"(3) Sources of repayment funds.—The sources of funds for scheduled loan repayments under this section shall include reliable revenue sources.

"SEC. 2205. PROJECT SERVICING.

"(a) Requirement.—The State in which a project that receives financial assistance under this title is located may identify a local servicer to assist the Secretary in servicing the Federal credit instrument made available under this title.

"(b) Agency; Fees.—If a State identifies a local servicer under subsection (a), the local servicer—

"(1) shall act as the agent for the Secretary; and

"(2) may receive a servicing fee, subject to approval by the Secretary.

"(c) Liability.—A local servicer identified under subsection (a) shall not be liable for the obligations of the obligor to the Secretary or any lender.

"(d) Assistance From Expert Firms.—The Secretary may retain the services of expert firms in the field of project finance to assist in the underwriting and servicing of Federal credit instruments.

"SEC. 2206. STATE AND LOCAL PERMITS.

"The provision of financial assistance under this title with respect to a project shall not—

"(1) relieve any recipient of the assistance of any obligation to obtain any required State or local permit or approval with respect to the project;

"(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

"(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

"SEC. 2207. REGULATIONS.

"The Secretary may issue such regulations as the Secretary determines appropriate to carry out this title.

"SEC. 2208. FUNDING.

"(a) Funding.—

"(1) In general.—There are authorized to be appropriated to carry out this title, $49,000,000 to remain available during the period beginning on July 1, 2004 and ending on September 30, 2008.

"(2) Administrative costs.—From funds made available under paragraph (1), the Secretary may use, for the administration of this title, not more than $2,000,000 for each of fiscal years 2004 through 2008.

"(b) Contract Authority.—Notwithstanding any other provision of law, approval by the Secretary of a Federal credit instrument that uses funds made available under this title shall be deemed to be acceptance by the United States of a contractual obligation to fund the Federal credit instrument.

"(c) Availability.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

"SEC. 2209. REPORT TO CONGRESS.

"Not later than 4 years after the date of enactment of this title, the Secretary shall submit to Congress a report summarizing the financial performance of the projects that are receiving,

or have received, assistance under this title, including a recommendation as to whether the objectives of this title are best served—

"(1) by continuing the program under the authority of the Secretary;

"(2) by establishing a Government corporation or Government-sponsored enterprise to administer the program; or

"(3) by phasing out the program and relying on the capital markets to fund the types of infrastructure investments assisted by this title without Federal participation.".

SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) In General.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

"CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

"Sec. 1603. (a) Authority To Make and Guarantee Loans.—

"(1) Authority to make loans.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

"(A) the acquisition of land necessary for the capital improvements;

"(B) the renovation or modernization of any building;

"(C) the acquisition or repair of fixed or major movable equipment; and

"(D) such other project expenses as the Secretary determines appropriate.

"(2) Authority to guarantee loans.—

"(A) In general.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

"(B) Interest subsidies.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

"(b) Amount of Loan.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

"(c) Funding Limitations.—

"(1) Government credit subsidy exposure.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

"(2) Total amounts.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

"(d) Capital Assessment and Planning Grants.—

"(1) Nonrepayable grants.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

"(2) Limitation.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

"(e) Termination of Authority.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2008.".

(b) Rural Entity Defined.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s-3) is amended by adding at the end the following new paragraph:

"(14)(A) The term 'rural entity' includes—

"(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

"(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

"(I) a county that is not part of a metropolitan statistical area; or

"(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

"(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

"(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

"(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).".

(c) Conforming Amendments.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q-2) is amended—

(1) in subsection (b)(2)(D), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)"; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking "section 1601(a)(2)(B)" and inserting "sections 1601(a)(2)(B) and 1603(a)(2)(B)"; and

(B) in paragraph (2)(A), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)".

SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) Total Amount Available for Allotment.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $250,000,000 for each of fiscal years 2005 through 2008, for the purpose of making allotments under this section to States described in paragraph (1) or (2) of subsection (b). Funds appropriated under the preceding sentence shall remain available until expended.

(b) State Allotments.—

(1) Based on percentage of undocumented aliens.—

(A) In general.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) Formula.—The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State with respect to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) Based on number of undocumented alien apprehension states.—

(A) In general.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) Determination of allotments.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall bear the same ratio to the total amount available for allotments under this paragraph for the fiscal year as the ratio of the number of undocumented alien apprehensions in the State in that fiscal year bears to the total of such numbers for all such States for such fiscal year.

(C) Data.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the 4 most recent quarterly apprehension rates for undocumented aliens in such States, as reported by the Immigration and Naturalization Service.

(3) Rule of construction.—Nothing in this section shall be construed as prohibiting a State that is described in both of paragraphs (1) and (2) from receiving an allotment under both paragraphs for a fiscal year.

(c) Use of Funds.—

(1) Authority to make payments.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay directly to local governments, hospitals, or other providers located in the State (including providers of services received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization) that provide uncompensated emergency health services furnished to undocumented aliens during that fiscal year, and to the State, such amounts (subject to the total amount available from such allotments) as the local governments, hospitals, providers, or State demonstrate were incurred for the provision of such services during that fiscal year.

(2) Limitation on state use of funds.—Funds paid to a State from allotments made under subsection (b) for a fiscal year may only be used for making payments to local governments, hospitals, or other providers for costs incurred in providing emergency health services to undocumented aliens or for State costs incurred with respect to the provision of emergency health services to such aliens.

(3) Inclusion of costs incurred with respect to certain aliens.—Uncompensated emergency health services furnished to aliens who have been allowed to enter the United States for the sole purpose of receiving emergency health services may be included in the determination of costs incurred by a State, local government, hospital, or other provider with respect to the provision of such services.

(d) Applications; Advance Payments.—

(1) Deadline for establishment of application process.—24 (A) In general.—Not later than September 1, 2004, the Secretary shall establish a process under which States, local governments, hospitals, or other providers located in the State may apply for payments from allotments made under subsection (b) for a fiscal year for uncompensated emergency health services furnished to undocumented aliens during that fiscal year.

(B) Inclusion of measures to combat fraud.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that fraudulent payments are not made from the allotments determined under subsection (b).

(2) Advance payment; retrospective adjustment.—The process established under paragraph (1) shall allow for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) Definitions.—In this section:

(1) Hospital.—The term "hospital" has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

(2) Indian tribe; tribal organization.—The terms "Indian tribe" and "tribal organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(3) Provider.—The term "provider" includes a physician, any other health care professional licensed under State law, and any other entity that furnishes emergency health services, including ambulance services.

(4) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

(5) State.—The term "State" means the 50 States and the District of Columbia.

SEC. 611. INCREASE IN APPROPRIATION TO THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by striking "and" at the end; and

(B) by striking subclause (III), and inserting the following new subclauses:

"(III) for fiscal year 2004, the limit for fiscal year 2003 increased by $10,000,000;

"(IV) for fiscal year 2005, the limit for fiscal year 2003 increased by $15,000,000;

"(V) for fiscal year 2006, the limit for fiscal year 2003 increased by $25,000,000; and

"(VI) for each fiscal year after fiscal year 2006, the limit for fiscal year 2003."; and

(2) in clause (ii)—

(A) in subclause (VI), by striking "and" at the end;

(B) in subclause (VII)—

(i) by striking "each fiscal year after fiscal year 2002" and inserting "fiscal year 2003"; and

(ii) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

"(VIII) for fiscal year 2004, $170,000,000;

"(IX) for fiscal year 2005, $175,000,000;

"(X) for fiscal year 2006, $185,000,000; and

"(XI) for each fiscal year after fiscal year 2006, not less than $150,000,000 and not more than $160,000,000.".

SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE CLAIMS ACT.

(a) In General.—Section 3729(a) of title 31, United States Code, is amended—

(1) by striking "$5,000" and inserting "$7,500"; and

(2) by striking "$10,000" and inserting "$15,000".

(b) Effective Date.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

SEC. 613. INCREASE IN CIVIL MONETARY PENALTIES UNDER THE SOCIAL SECURITY ACT.

(a) In General.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), in the matter following paragraph (7), is amended—

(1) by striking "$10,000" each place it appears and inserting "$12,500";

(2) by striking "$15,000" and inserting "$18,750"; and

(3) striking "$50,000" and inserting "$62,500".

(b) Effective Date.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

SEC. 614. EXTENSION OF CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking "September 30, 2003" and inserting "September 30, 2013".

SEC. 615. REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) Reimbursement.—

(1) In general.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended to read as follows:

"(3) in the case of services described in section 1832(a)(2)(D)—

"(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

"(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

"(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

"(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);".

(b) Continuation of MedicareAdvantage Monthly Payments.—

(1) In general.—Section 1853 (42 U.S.C. 1395w–23), as amended by this Act, is amended by adding at the end the following new subsection:

"(j) Payment Rule for Federally Qualified Health Center Services.—If an individual who is enrolled with a MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

"(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

"(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).".

(2) Conforming amendments.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w–21(i)(1)), as amended by this Act, are each amended by inserting "1853(j)," after "1853(i),".

(B) Section 1853(c)(5) is amended by striking "subsections (a)(3)(C)(iii) and (i)" and inserting "subsections (a)(3)(C)(iii), (i), and (j)(1)".

(c) Additional MedicareAdvantage Contract Requirements.—Section 1857(e) (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

"(3) Agreements with Federally Qualified Health Centers.—

"(A) Payment levels and amounts.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

"(B) Cost-sharing.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).".

(d) Safe Harbor From Antikickback Prohibition.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in subparagraph (E), by striking "and" after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).".

(e) Effective Date.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

SEC. 616. PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b-2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking "The notice" and inserting "(1) The notice"; and

(3) by adding at the end the following:

"(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

"(B) In this section:

"(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

"(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.".

SEC. 617. SENSE OF THE SENATE REGARDING IMPLEMENTATION OF THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003.

(a) In General.—It is the sense of the Senate that the Committee on Finance of the Senate should hold not less than 4 hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003 (hereinafter in this section referred to as the "Act") during which the Secretary or his designee should testify before the Committee.

(b) Initial Hearing.—It is the sense of the Senate that the first hearing described in subsection (a) should be held not later than 60 days after the date of the enactment the Act. At the hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) The progress toward implementation of the prescription drug discount card under section 111 of the Act.

(2) Development of the blueprint that will direct the implementation of the provisions of the Act, including the implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(3) Any problems that will impede the timely implementation of the Act.

(4) The overall progress toward implementation of the Act.

(c) SUBSEQUENT HEARINGS.—It is the sense of the Senate that the additional hearings described in subsection (a) should be held in each of May 2004, October 2004, and May 2005. At each hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) Progress on implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(2) Any problems that will impede timely implementation of the Act.

SEC. 618. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking "December 31, 2004", and inserting "December 31, 2006".

SEC. 619. STUDY ON MAKING PRESCRIPTION PHARMACEUTICAL INFORMATION ACCESSIBLE FOR BLIND AND VISUALLY-IMPAIRED INDIVIDUALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall undertake a study of how to make prescription pharmaceutical information, including drug labels and usage instructions, accessible to blind and visually-impaired individuals.

(2) STUDY TO INCLUDE EXISTING AND EMERGING TECHNOLOGIES.—The study under paragraph (1) shall include a review of existing and emerging technologies, including assistive technology, that makes essential information on the content and prescribed use of pharmaceutical medicines available in a usable format for blind and visually-impaired individuals.

(b) REPORT.—

(1) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study required under subsection (a).

(2) CONTENTS OF REPORT.—The report required under subsection (a) shall include recommendations for the implementation of usable formats for making prescription pharmaceutical information available to blind and visually-impaired individuals and an estimate of the costs associated with the implementation of each format.

SEC. 620. HEALTH CARE THAT WORKS FOR ALL AMERICANS-CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this Act are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens' Health Care Working Group (referred to in this Act as the "Working Group").

(d) APPOINTMENT.—Not later than 45 days after the date of enactment of this Act, the Speaker and Minority Leader of the House of Representatives and the Majority Leader and Minority Leader of the Senate (in this section referred to as the "leadership") shall each appoint individuals to serve as members of the Working Group in accordance with subsections (e), (f), and (g).

(e) MEMBERSHIP CRITERIA.—

(1) APPOINTED MEMBERS.—

(A) SEPARATE APPOINTMENTS.—The Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate, shall each appoint 1 member of the Working Group described in subparagraphs (A), (G), (J), (K), and (M) of paragraph (2).

(B) JOINT APPOINTMENTS.—Members of the Working Group described in subparagraphs (B), (C), (D), (E), (F), (I), and (N) of paragraph (2) shall be appointed jointly by the leadership.

(C) COMBINED APPOINTMENTS.—Members of the Working Group described in subparagraphs (H) and (L) shall be appointed in the following manner:

(i) One member of the Working Group in each of such subparagraphs shall be appointed jointly by the leadership.

(ii) The remaining appointments of the members in each of such subparagraphs shall be divided equally such that the Speaker of the House of Representatives jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate each appoint an equal number of members.

(2) CATEGORIES OF APPOINTED MEMBERS.—Members of the Working Group shall be appointed as follows:

(A) 2 members shall be patients or family members of patients who, at least 1 year prior to the date of enactment of this Act, have had no health insurance.

(B) 1 member shall be a representative of children.

(C) 1 member shall be a representative of the mentally ill.

(D) 1 member shall be a representative of the disabled.

(E) 1 member shall be over the age of 65 and a beneficiary under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(F) 1 member shall be a recipient of benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(G) 2 members shall be State health officials.

(H) 3 members shall be employers, including—

(i) 1 large employer (an employer who employed 50 or more employees on business days during the preceding calendar year and who employed at least 50 employees on the first of the year);

(ii) 1 small employer (an employer who employed an average of at least 2 employees but less than 50 employees on business days in the preceding calendar year and who employs at least 2 employees on the first of the year); and

(iii) 1 multi-state employer.

(I) 1 member shall be a representative of labor.

(J) 2 members shall be health insurance issuers.

(K) 2 members shall be health care providers.

(L) 5 members shall be appointed as follows:

(i) 1 economist.

(ii) 1 academician.

(iii) 1 health policy researcher.

(iv) 1 individual with expertise in pharmacoeconomics.

(v) 1 health technology expert.

(M) 2 members shall be representatives of community leaders who have developed State or local community solutions to the problems addressed by the Working Group.

(N) 1 member shall be a representative of a medical school.

(3) SECRETARY.—The Secretary, or the designee of the Secretary, shall be a member of the Working Group.

(f) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include members of Congress or other elected government officials (Federal, State, or local) other than those individuals specified in subsection (e). To the extent possible, individuals appointed to the Working Group shall have used the health care system within the previous 2 years and shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(g) APPOINTMENT CRITERIA.—

(1) HOUSE OF REPRESENTATIVES.—The Speaker and Minority Leader of the House of Representatives shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the House of Representatives:

(A) The Committee on Ways and Means.

(B) The Committee on Energy and Commerce.

(C) The Committee on Education and the Workforce.

(2) SENATE.—The Majority Leader and Minority Leader of the Senate shall make the appointments described in subsection (d) in consultation with the chairperson and ranking member of the following committees of the Senate:

(A) The Committee on Finance.

(B) The Committee on Health, Education, Labor, and Pensions.

(h) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a term of 2 years. Such term is renewable and any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(i) APPOINTMENT OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d), the leadership shall make a joint designation of the chairperson of the Working Group. If the leadership fails to make such designation within such time period, the Working Group Members shall, not later than 10 days after the end of such time period, designate a chairperson by majority vote.

(j) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(k) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of appointment of the chairperson under subsection (i), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this Act. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, "The Health Report to the American People". Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Working Group shall initiate health care community meetings throughout the United States (in this section referred to as "community meetings"). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) MEETING REQUIREMENTS.—

(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) TOPICS.—The community meetings shall, at a minimum, address the following issues:

(I) The optimum way to balance costs and benefits so that affordable health coverage is available to as many people as possible.

(II) The identification of services that provide cost-effective, essential health care services to maintain and improve health and which should be included in health care coverage.

(III) The cost of providing increased benefits.

(IV) The mechanisms to finance health care coverage, including defining the appropriate financial role for individuals, businesses, and government.

(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(l) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (k)(4)(D), the Working Group shall submit to Congress and the President a final set of recommendations.

(m) ADMINISTRATION.—

(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this Act. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) POSTAL SERVICES.—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(n) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(o) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(p) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(q) SUNSET OF WORKING GROUP.—The Working Group shall terminate when the report described in subsection (l) is submitted to Congress.

(r) ADMINISTRATION REVIEW AND COMMENTS.—Not later than 45 days after receiving the final recommendations of the Working Group under subsection (l), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for such legislation and administrative actions as the President considers appropriate.

(s) REQUIRED CONGRESSIONAL ACTION.—Not later than 45 days after receiving the report submitted by the President under subsection (r), each committee of jurisdiction of Congress shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (l).

(t) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this Act, other than subsection (k)(3), $3,000,000 for each of fiscal years 2004, 2005, and 2006.

(2) HEALTH REPORT TO THE AMERICAN PEOPLE.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (k)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SEC. 621. GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G–7 COUNTRIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) the pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance;

(2) the proportion of the cost for innovation borne by American consumers, compared with consumers in the other six countries;

(3) a review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production ("Ramsey prices");

(4) a review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the

absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health;

(5) the impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States;

(6) the existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied;

(7) in parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant; and

(8) how much cost is imposed on the owner of a property right from counterfeiting and from international violation of intellectual property rights for prescription medicines.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).

SEC. 622. SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without congressional action, medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991–2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the Government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

SEC. 623. RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DEFINITIONS.—In this section:

(1) CLERICAL ERROR.—The term "clerical error" means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) TRUST FUND.—The term "Trust Fund" means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) CORRECTION OF TRUST FUND HOLDINGS.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) APPROPRIATION.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

SEC. 624. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

"PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

"(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

"(1) REVIEW.—The Commission shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

"(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

"(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

"(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

"(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

"(E) supporting the development of new data systems where existing data are insufficient or inadequate;

"(F) developing criteria and indicators of impending core health care safety net failure;

"(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

"(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate of the projected consequences of such failures and the impact of such a failure on the community;

"(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

"(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

"(ii) the degree to which these plans may be overburdened by adverse selection; and

"(iii) the degree to which emergency departments are used by enrollees of these plans; and

"(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

"(2) REPORTS.—

"(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

"(i) the health care needs of the uninsured; and

"(ii) the financial and infrastructure stability of the Nation's core health care safety net.

"(B) AGENDA AND ADDITIONAL REVIEWS.—

"(i) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

"(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

"(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

"(II) If the Commission deems such additional reviews and reports appropriate.

"(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(3) DEFINITIONS.—In this section:

"(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term 'appropriate committees of Congress' means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

"(B) CORE HEALTH CARE SAFETY NET.—The term 'core health care safety net' means any health care provider that—

"(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

"(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any

other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

"(C) HEALTH CARE SAFETY NET PROGRAMS.—The term 'health care safety net programs' includes the following:

"(i) MEDICAID.—The medicaid program under title XIX.

"(ii) SCHIP.—The State children's health insurance program under title XXI.

"(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

"(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(l)(2)(B)) receives funds.

"(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(l)(1)) receives funds.

"(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

"(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

"(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

"(D) VULNERABLE POPULATIONS.—The term 'vulnerable populations' includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

"(c) MEMBERSHIP.—

"(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the 'Comptroller General'), in consultation with the appropriate committees of Congress.

"(2) QUALIFICATIONS.—

"(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

"(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

"(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

"(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

"(3) TERMS.—

"(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

"(i) four to serve a term of 1 year;

"(ii) four to serve a term of 2 years; and

"(iii) five to serve a term of 3 years.

"(B) VACANCIES.—

"(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

"(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

"(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

"(4) COMPENSATION.—

"(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

"(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

"(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

"(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

"(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

"(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

"(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

"(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(4) make advance, progress, and other payments which relate to the work of the Commission;

"(5) provide transportation and subsistence for persons serving without compensation; and

"(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(e) POWERS.—

"(1) OBTAINING OFFICIAL DATA.—

"(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

"(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

"(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

"(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

"(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

"(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

"(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

"(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

"(g) AUTHORIZATION OF APPROPRIATIONS.—

"(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

"(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.".

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SEC. 625. URBAN HEALTH PROVIDER ADJUSTMENT.

(a) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in subsection (b) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

(b) HOSPITAL DESCRIBED.—A hospital is described in this subsection if the hospital—

(1) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(2) is located in Marion County, Indiana.

(c) LIMITATION.—The payment adjustment described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(1)(A)).

SEC. 626. COMMITTEE ON DRUG COMPOUNDING.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an Committee on Drug Compounding (referred to in this section as the "Committee") within the Food and Drug Administration on drug compounding to ensure that patients are receiving necessary, safe and accurate dosages of compounded drugs.

(b) MEMBERSHIP.—The membership of the Advisory Committee shall be appointed by the Secretary of Health and Human Services and shall include representatives of—

(1) the National Association of Boards of Pharmacy;

(2) pharmacy groups;

(3) physician groups;

(4) consumer and patient advocate groups;

(5) the United States Pharmacopoeia; and

(6) other individuals determined appropriate by the Secretary.

(c) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Committee shall submit to the Secretary a report concerning the recommendations of the Committee to improve and protect patient safety.

(d) TERMINATION.—The Committee shall terminate on the date that is 1 year after the date of enactment of this Act.

SEC. 627. SENSE OF THE SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) FINDINGS.—The Senate makes the following findings:

(1) America's seniors deserve a fiscally-strong medicare system that fulfills its promise to them and future retirees.

(2) The impending retirement of the "baby boom" generation will dramatically increase the costs of providing medicare benefits. Medicare costs will double relative to the size of the economy from 2 percent of GDP today to 4 percent in 2025 and double again to 8 percent of GDP in 2075. This growth will accelerate substantially when Congress adds a necessary prescription drug benefit.

(3) Medicare's current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease management programs, and host of other advances. Reforming medicare to create a more self-adjusting, innovative structure is essential to improve medicare's efficiency and the quality of the medical care it provides.

(4) Private-sector choice for medicare beneficiaries would provide two key benefits: It would be tailored to the needs of America's seniors, not the Government, and would create a powerful incentive for private-sector medicare plans to provide the best quality health care to seniors at the most affordable price.

(5) The method by which the national preferred provider organizations in the Federal Employees Health Benefits Program have been reimbursed has proven to be a reliable and successful mechanism for providing Members of Congress and Federal employees with excellent health care choices.

(6) Unlike the medicare payment system, which has had to be changed by Congress every few years, the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most.

(2) Provide that Government contributions used to support MedicareAdvantage plans are based on market principles beginning in 2006 to ensure the long- and short-term viability of such options for America's seniors.

(3) Develop a payment system for the MedicareAdvantage preferred provider organizations similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program.

(4) Limit the addition of new unfunded obligations in the medicare program so that the long-term solvency of this important program is not further jeopardized.

(5) Incorporate private sector, market-based elements, that do not rely on the inefficient medicare price control structure.

(6) Keep the cost of structural changes and new benefits within the $400,000,000,000 provided for under the current Congressional Budget Resolution for implementing medicare reform and providing a prescription drug benefit.

(7) Preserve the current employer-sponsored retiree health plans and not design a benefit which has the unintended cohsequences of supplanting private coverage.

(8) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(9) Restore the right of medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the Government contribution.

SEC. 628. SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

SEC. 629. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of medicare patients;

(9) between 1996 and 2002, annual medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and

should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating "tolerance" corridors for variations around the update target trend.

SEC. 630. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection. In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SEC. 631. EMPLOYER FLEXIBILITY.

(a) MEDICARE.—Nothing in part D of title XVIII of the Social Security Act, as added by section 101, shall be construed as—

(1) preventing employment-based retiree health coverage (as defined in section 1860D–20(e)(4)(B) of such Act, as so added) from providing coverage that is supplemental to the benefits provided under a Medicare Prescription Drug plan under such part or a MedicareAdvantage plan under part C of such title, as amended by this Act; or

(2) requiring employment-based retiree health coverage (as so defined) that provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act or under a plan maintained by a State or an agency thereof to provide medical benefits, or the same medical benefits, to retired participants who are so eligible.

(b) ADEA.—

(1) IN GENERAL.—Section 4(l) of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 623(l)) is amended by adding at the end the following:

"(4) An employee benefit plan (as defined in section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3))) shall not be treated as violating subsection (a), (b), (c), or (e) solely because the plan provides medical benefits to retired participants who are not eligible for medical benefits under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a plan maintained by a State or an agency thereof, but does not provide medical benefits, or the same medical benefits, to retired participants who are so eligible."

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply as of the date of the enactment of this Act.

SEC. 632. ONE HUNDRED PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ", and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a federally-qualified health center or a Native Hawaiian health care system and another health care provider" before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SEC. 633. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking "until December 31, 2002", and

(2) by striking "Kent Community Hospital Complex in Michigan or."

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SEC. 634. GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G–7 COUNTRIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. The study shall include the following:

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance.

(2) The proportion of the cost for innovation borne by American consumers, compared with consumers in the other 6 countries.

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production ("Ramsey prices").

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health.

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States.

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied.

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant.

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violations of intellectual property rights for prescription medicines.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).

SEC. 635. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

"PART D—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION

"SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission (in this section referred to as the 'Commission').

"(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS AND REPORTING REQUIREMENTS.—

"(1) REVIEW.—The Commission shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

"(A) monitoring each health care safety net program to document and analyze the effects of changes in these programs on the core health care safety net;

"(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, medicaid beneficiaries, and other vulnerable populations;

"(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

"(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

"(E) supporting the development of new data systems where existing data are insufficient or inadequate;

"(F) developing criteria and indicators of impending core health care safety net failure;

"(G) establishing an early-warning system to identify impending failures of core health care safety net systems and providers;

"(H) providing accurate and timely information to Federal, State, and local policymakers on the indicators that may lead to the failure of the core health care safety net and an estimate *of the projected consequences of such failures and the impact of such a failure on the community;*

“(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1932(a)(1)(B)), including the review of—

“(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to provide quality managed care services to such an individual;

“(ii) the degree to which these plans may be overburdened by adverse selection; and

“(iii) the degree to which emergency departments are used by enrollees of these plans; and

“(J) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

“(2) REPORTS.—

“(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

“(i) the health care needs of the uninsured; and

“(ii) the financial and infrastructure stability of the Nation's core health care safety net.

“(B) AGENDA AND ADDITIONAL REVIEWS.—

“(i) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda.

“(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

“(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

“(II) If the Commission deems such additional reviews and reports appropriate.

“(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

“(3) DEFINITIONS.—In this section:

“(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term ‘appropriate committees of Congress’ means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

“(B) CORE HEALTH CARE SAFETY NET.—The term ‘core health care safety net’ means any health care provider that—

“(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services; and

“(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

“(C) HEALTH CARE SAFETY NET PROGRAMS.—The term ‘health care safety net programs’ includes the following:

“(i) MEDICAID.—The medicaid program under title XIX.

“(ii) SCHIP.—The State children's health insurance program under title XXI.

“(iii) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.—The maternal and child health services block grant program under title V.

“(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(l)(2)(B)) receives funds.

“(v) RHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(l)(1)) receives funds.

“(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a disproportionate share hospital receives funds.

“(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

“(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—Such term also includes any other health care program that the Commission determines to be appropriate.

“(D) VULNERABLE POPULATIONS.—The term ‘vulnerable populations’ includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

“(c) MEMBERSHIP.—

“(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the ‘Comptroller General’), in consultation with the appropriate committees of Congress.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

“(B) INCLUSION.—The membership of the Commission shall include health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net.

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

“(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

“(3) TERMS.—

“(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

“(i) four to serve a term of 1 year;

“(ii) four to serve a term of 2 years; and

“(iii) five to serve a term of 3 years.

“(B) VACANCIES.—

“(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

“(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

“(iii) TERMS.—A member may serve after the expiration of that member's term until a successor has taken office.

“(4) COMPENSATION.—

“(A) MEMBERS.—While serving on the business of the Commission (including travel time), a member of the Commission—

“(i) shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and

“(ii) while so serving away from home and the member's regular place of business, may be allowed travel expenses, as authorized by the Commission.

“(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

“(5) CHAIR; VICE CHAIR.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member's term.

“(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

“(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

“(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

“(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

“(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

“(4) make advance, progress, and other payments which relate to the work of the Commission;

“(5) provide transportation and subsistence for persons serving without compensation; and

“(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

“(e) POWERS.—

“(1) OBTAINING OFFICIAL DATA.—

“(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

“(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

"(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

"(A) use existing information, both published and unpublished, where possible, collected and assessed either by the staff of the Commission or under other arrangements made in accordance with this section;

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

"(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

"(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The expense of providing such information shall be borne by the General Accounting Office.

"(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

"(f) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

"(g) AUTHORIZATION OF APPROPRIATIONS.—

"(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

"(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.".

(b) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SEC. 636. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—

(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i-3(b)) is amended by adding at the end the following:

"(8) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

"(A) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

"(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

"(ii) require, as a condition of employment, that such worker—

"(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

"(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

"(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

"(IV) provide any other identification information the Secretary may specify in regulation;

"(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

"(iv) if that system does not contain any such disqualifying information—

"(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(6); and

"(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

"(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

"(i) IN GENERAL.—A skilled nursing facility may not knowingly employ any skilled nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

"(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a skilled nursing facility may provide for a provisional period of employment for a skilled nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the covered individual during the worker's provisional period of employment.

"(iii) EXCEPTION FOR SMALL RURAL SKILLED NURSING FACILITIES.—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of skilled nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

"(C) REPORTING REQUIREMENTS.—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

"(D) USE OF INFORMATION.—

"(i) IN GENERAL.—A skilled nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

"(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility that, in denying employment for an individual selected for hiring as a skilled nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

"(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

"(E) CIVIL PENALTY.—

"(i) IN GENERAL.—A skilled nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

"(I) for the first such violation, $2,000; and

"(II) for the second and each subsequent violation within any 5-year period, $5,000.

"(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a skilled nursing facility that—

"(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

"(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

"(F) DEFINITIONS.—In this paragraph:

"(i) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

"(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

"(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

"(ii) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

"(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

"(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

"(II) such other types of acts as the Secretary may specify in regulations.

"(iv) SKILLED NURSING FACILITY WORKER.—The term 'skilled nursing facility worker' means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.".

(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396r(b)) is amended by adding at the end the following new paragraph:

"(8) SCREENING OF NURSING FACILITY WORKERS.—

"(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a nursing facility selects an individual for a position as a nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

"(i) give the worker written notice that the facility is required to perform background checks with respect to provisional employees;

"(ii) require, as a condition of employment, that such worker—

"(I) provide a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse;

"(II) provide a statement signed by the worker authorizing the facility to request the search and exchange of criminal records;

"(III) provide in person to the facility a copy of the worker's fingerprints or thumb print, depending upon available technology; and

“(IV) provide any other identification information the Secretary may specify in regulation;

“(iii) initiate a check of the data collection system established under section 1128E in accordance with regulations promulgated by the Secretary to determine whether such system contains any disqualifying information with respect to such worker; and

“(iv) if that system does not contain any such disqualifying information—

“(I) request through the appropriate State agency that the State initiate a State and national criminal background check on such worker in accordance with the provisions of subsection (e)(8); and

“(II) submit to such State agency the information described in subclauses (II) through (IV) of clause (ii) not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after completion of the check against the system initiated under clause (iii).

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(i) IN GENERAL.—A nursing facility may not knowingly employ any nursing facility worker who has any conviction for a relevant crime or with respect to whom a finding of patient or resident abuse has been made.

“(ii) PROVISIONAL EMPLOYMENT.—After complying with the requirements of clauses (i), (ii), and (iii) of subparagraph (A), a nursing facility may provide for a provisional period of employment for a nursing facility worker pending completion of the check against the data collection system described under subparagraph (A)(iii) and the background check described under subparagraph (A)(iv). Subject to clause (iii), such facility shall maintain direct supervision of the worker during the worker's provisional period of employment.

“(iii) EXCEPTION FOR SMALL RURAL NURSING FACILITIES.—

“(I) IN GENERAL.—In the case of a small rural nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing beneficiaries of such services, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with clause (ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

“(C) REPORTING REQUIREMENTS.—A nursing facility shall report to the State any instance in which the facility determines that a nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

“(D) USE OF INFORMATION.—

“(i) IN GENERAL.—A nursing facility that obtains information about a nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

“(ii) IMMUNITY FROM LIABILITY.—A nursing facility that, in denying employment for an individual selected for hiring as a nursing facility worker (including during the period described in subparagraph (B)(ii)), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall not be liable in any action brought by such individual based on the employment determination resulting from the information.

“(iii) CRIMINAL PENALTY.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

“(E) CIVIL PENALTY.—

“(i) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed—

“(I) for the first such violation, $2,000; and

“(II) for the second and each subsequent violation within any 5-year period, $5,000.

“(ii) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that—

“(I) knowingly continues to employ a nursing facility worker in violation of subparagraph (A) or (B); or

“(II) knowingly fails to report a nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

“(F) DEFINITIONS.—In this paragraph:

“(i) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

“(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

“(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

“(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information about a conviction for a relevant crime or a finding of patient or resident abuse.

“(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under subsection (g)(1)(C) or a Federal agency that a nursing facility worker has committed—

“(I) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

“(II) such other types of acts as the Secretary may specify in regulations.

“(iv) NURSING FACILITY WORKER.—The term ‘nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing such services, as defined by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and attendants.”.

(2) FEDERAL RESPONSIBILITIES.—

(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisional employee at a nursing facility may complete and Federal and State agencies may use to conduct the criminal background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b), 1396r(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate response to long-term care providers using the system.

(3) NO PREEMPTION OF STRICTER STATE LAWS.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8), 1396r(b)(8)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1128E(g)(6) of the Social Security Act (as added by subsection (e)) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as so defined) to conduct a background check prior to employing an individual in an employment position that is not included in the positions for which a background check is required under such sections.

(4) TECHNICAL AMENDMENTS.—Effective as if included in the enactment of section 941 of BIPA (114 Stat. 2763A–585), sections 1819(b) and 1919(b) (42 U.S.C. 1395i–3(b), 1396r(b)), as amended by such section 941 are each amended by redesignating the paragraph (8) added by such section as paragraph (9).

(b) FEDERAL AND STATE REQUIREMENTS CONCERNING BACKGROUND CHECKS.—

(1) MEDICARE.—Section 1819(e) (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following:

“(6) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—

“(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

“(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

“(C) STATE REPORTING OF INFORMATION TO SKILLED NURSING FACILITY.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

“(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

“(ii) immediately report to the skilled nursing facility in writing the results of such review; and

“(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

“(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

“(i) AUTHORITY TO CHARGE FEES.—

“(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting *the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation until expended.*

"(II) State.—A State may charge a skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

"(ii) Prohibition on charging.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

"(E) Regulations.—

"(i) In general.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(9), including regulations regarding the security confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

"(ii) Appeal procedures.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

"(F) Report.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

"(i) the number of requests for searches and exchanges of records made under this section;

"(ii) the disposition of such requests; and

"(iii) the cost of responding to such requests.".

(2) Medicaid.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

"(8) Federal and State requirements concerning criminal background checks on nursing facility employees.—

"(A) In general.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information (as defined in subsection (b)(8)(F)(ii)), shall immediately submit such request and information to the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to the individual as described in subparagraph (B).

"(B) Search and exchange of records by Attorney General.—Upon receipt of a submission pursuant to subparagraph (A), the Attorney General shall direct a search of the records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the State.

"(C) State reporting of information to nursing facility.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

"(i) review the information to determine whether the individual has any conviction for a relevant crime (as defined in subsection (b)(8)(F)(i));

"(ii) immediately report to the nursing facility in writing the results of such review; and

"(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E.

"(D) Fees for performance of criminal background checks.—

"(i) Authority to charge fees.—

"(I) Attorney General.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to this paragraph and subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation, until expended.

"(II) State.—A State may charge a nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

"(ii) Prohibition on charging.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

"(E) Regulations.—

"(i) In general.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

"(ii) Appeal procedures.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has not been updated to reflect changes in the provisional employee's or employee's criminal record.

"(F) Report.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

"(i) the number of requests for searches and exchanges of records made under this section;

"(ii) the disposition of such requests; and

"(iii) the cost of responding to such requests.".

(c) Application to Other Entities Providing Home Health or Long-Term Care Services.—

(1) Medicare.—Part D of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following:

"APPLICATION OF SKILLED NURSING FACILITY PREVENTIVE ABUSE PROVISIONS TO ANY PROVIDER OF SERVICES OR OTHER ENTITY PROVIDING HOME HEALTH OR LONG-TERM CARE SERVICES

"Sec. 1897. (a) In General.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a 'medicare beneficiary').

"(b) Supervision of Provisional Employees.—

"(1) In general.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1819(b)(8)(B)(ii) or 1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

"(2) Requirements.—The regulations required under paragraph (1) shall provide the following:

"(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a medicare beneficiary.

"(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

"(i) Follow-up telephone calls to the medicare beneficiary.

"(ii) Unannounced visits to the medicare beneficiary's home while the provisional employee is serving the medicare beneficiary.

"(iii) To the extent practicable, limiting the provisional employee's duties to serving only those medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the medicare beneficiary is present.

"(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such regulations should encourage the provision of monitoring and oversight activities whenever practicable with respect to such an entity, and if such activities would not impose an unreasonable cost or other burden on the entity.".

(2) Medicaid.—Section 1902(a) (42 U.S.C. 1396a), as amended by section 104(a), is amended—

(A) in paragraph (65), by striking "and" at the end;

(B) in paragraph (66), by striking the period and inserting "; and"; and

(C) by inserting after paragraph (66) the following:

"(67) provide that any entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services for which medical assistance is available under the State plan to individuals requiring long-term care complies with the requirements of subsections (b)(8) and (e)(8) of section 1919 and section 1897(b) (in the same manner as such section applies to a medicare beneficiary).".

(3) Expansion of State Nurse Aide Registry.—

(A) Medicare.—Section 1819 (42 U.S.C. 1395i–3) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking "NURSE AIDE REGISTRY" and inserting "EMPLOYEE REGISTRY";

(II) in subparagraph (A)—

(aa) by striking "By not later than January 1, 1989, the" and inserting "The";

(bb) by striking "a registry of all individuals" and inserting "a registry of (i) all individuals"; and

(cc) by inserting before the period the following: ", (ii) all other skilled nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property"; and

(III) in subparagraph (C), by striking "a nurse aide" and inserting "an individual"; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: "The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a skilled nursing facility employee of a resident in a skilled nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii)."; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "NURSE AIDE"; and

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (i)(I), by striking "nurse aide" and inserting "individual".

(B) Medicaid.—Section 1919 (42 U.S.C. 1396r) is amended—

(i) in subsection (e)(2)—

(I) in the paragraph heading, by striking "NURSE AIDE REGISTRY" and inserting "EMPLOYEE REGISTRY";

(II) in subparagraph (A)—

(aa) by striking "By not later than January 1, 1989, the" and inserting "The";

(bb) by striking "a registry of all individuals" and inserting "a registry of (i) all individuals"; and

(cc) by inserting before the period the following: ", (ii) all other nursing facility employees with respect to whom the State has made a finding described in subparagraph (B), and (iii) any employee of an entity that is eligible to be paid under the State plan for providing home health services, hospice care (including routine home care and other services included in hospice care under title XVIII), or long-term care services and with respect to whom the entity has reported to the State a finding of patient neglect or abuse or a misappropriation of patient property"; and

(III) in subparagraph (C), by striking "a nurse aide" and inserting "an individual"; and

(ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following: "The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility employee of a resident in a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iii)."; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "NURSE AIDE"; and

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (i)(I), by striking "nurse aide" and inserting "individual".

(d) Reimbursement of Costs for Background Checks.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1819(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1395i–3(b)(8), 1396r(b)(8)), as added by this section.

(e) Inclusion of Abusive Acts Within a Long-Term Care Facility or Provider in the National Health Care Fraud and Abuse Data Collection Program.—

(1) In general.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a–7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

"(v) A finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient's or resident's property.".

(2) Coverage of long-term care facility or provider employees.—Section 1128E(g)(2) (42 U.S.C. 1320a–7e(g)(2)) is amended by inserting ", and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, providing services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)" before the period.

(3) Reporting by long-term care facilities or providers.—

(A) In general.—Section 1128E(b)(1) (42 U.S.C. 1320a–7e(b)(1)) is amended by striking "and health plan" and inserting ", health plan, and long-term care facility or provider".

(B) Correction of information.—Section 1128E(c)(2) (42 U.S.C. 1320a–7e(c)(2)) is amended by striking "and health plan" and inserting ", health plan, and long-term care facility or provider".

(4) Access to reported information.—Section 1128E(d)(1) (42 U.S.C. 1320a–7e(d)(1)) is amended by striking "and health plans" and inserting ", health plans, and long-term care facilities or providers".

(5) Mandatory check of database by long-term care facilities or providers.—Section 1128E(d) (42 U.S.C. 1320a–7e(d)) is amended by adding at the end the following:

"(3) Mandatory check of database by long-term care facilities or providers.—A long-term care facility or provider shall check the database maintained under this section prior to hiring under an employment or other contract, or both, (other than in a provisional status) any individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, and nonlicensed individuals, as defined by the Secretary, that will provide services at the facility or through the provider, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants).".

(6) Definition of long-term care facility or provider.—Section 1128E(g) (42 U.S.C. 1320a–7e(g)) is amended by adding at the end the following:

"(6) Long-term care facility or provider.—The term 'long-term care facility or provider' means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(dd)(1)), a long-term care hospital (as described in section 1886(d)(1)(B)(iv)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, home health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program under title XVIII or the medicaid program under title XIX.".

(7) Authorization of appropriations.—There is authorized to be appropriated to carry out the amendments made by this subsection, $10,200,000 for fiscal year 2004.

(f) Prevention and Training Demonstration Project.—

(1) Establishment.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) Eligibility.—To be eligible to receive a grant under paragraph (1), an entity shall be a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) Use of funds.—Amounts received under a grant under this subsection shall be used to—

(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsman programs, the long-term care industry, and local community members;

(B) examine patient care issues relating to regulatory oversight, community involvement, and facility staffing and management with a focus on staff training, staff stress management, and staff supervision;

(C) examine the use of patient abuse prevention training programs by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used; and

(D) identify and disseminate best practices for preventing and reducing patient abuse.

(4) Authorization of appropriations.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

(g) Effective Date.—

(1) In general.—With respect to a skilled nursing facility (as defined in section 1819(a) of

the Social Security Act (42 U.S.C. 1395i–3(a)) or a nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 6 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2006.

(2) LONG-TERM CARE FACILITIES AND PROVIDERS.—With respect to a long-term care facility or provider (as defined in section 1128E(g)(6) of the Social Security Act (42 U.S.C. 1320a–7e(g)(6)) (as added by subsection (e)), this section and the amendments made by this section shall take effect on the date that is the earlier of—

(A) 18 months after the effective date of final regulations promulgated to carry out this section and such amendments; or

(B) January 1, 2007.

SEC. 637. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking "and" after the comma at the end;

(2) in paragraph (4), by inserting "and" after the comma at the end; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.".

TITLE VII—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 701. SHORT TITLE.

This title may be cited as the "Greater Access to Affordable Pharmaceuticals Act".

SEC. 702. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

"(B) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

"(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

"(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

"(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

"(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(II) the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking "under the following" and inserting "by applying the following to each certification made under paragraph (2)(A)(vii)"; and

(ii) in clause (iii)—

(I) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted."; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

"(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(aa) the date on which the court enters judgment reflecting the decision; or

"(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(bb) by striking subclause (II) and inserting the following:

"(II) if before the expiration of such period the district court decides that the patent has been infringed—

"(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

"(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(cc) in subclause (III), by striking "on the date of such court decision." and inserting "as provided in subclause (I); or"; and

(dd) by inserting after subclause (III) the following:

"(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II).";

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

"(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

"(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under paragraph (2)(B) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

"(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

"(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).".

(b) APPLICATIONS GENERALLY.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b), by striking paragraph (3) and inserting the following:

"(3) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

"(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

"(B) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

"(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

"(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

"(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking "under the following" and inserting "by applying the following to each certification made under subsection (b)(2)(A)(iv)";

(B) in subparagraph (C)—

(i) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.";

(ii) in the second sentence—

(I) by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(II) by striking clause (i) and inserting the following:

"(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(I) the date on which the court enters judgment reflecting the decision; or

"(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(III) by striking clause (ii) and inserting the following:

"(ii) if before the expiration of such period the district court decides that the patent has been infringed—

"(I) if the judgment of the district court is appealed, the approval shall be made effective on—

"(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(II) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(IV) in clause (iii), by striking "on the date of such court decision." and inserting "as provided in clause (i); or"; and

(V) by inserting after clause (iii), the following:

"(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii)."; and

(iii) in the third sentence, by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

"(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

"(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

"(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

"(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).".

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

"(5) The filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought by the applicant under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.".

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 703. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 702) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

"(iv) 180-DAY EXCLUSIVITY PERIOD.—

"(I) DEFINITIONS.—In this paragraph:

"(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

"(bb) FIRST APPLICANT.—The term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

"(cc) SUBSTANTIALLY COMPLETE APPLICATION.—As used in this subsection, the term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

"(dd) TENTATIVE APPROVAL.—

"(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

"(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

"(II) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant."; and

(2) by inserting after subparagraph (C) the following:

"(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

"(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

"(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

"(aa) the earlier of the date that is—

"(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

"(BB) 30 months after the date of submission of the application of the first applicant; or

"(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

"(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

"(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

"(CC) The patent expires.

"(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

"(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

"(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

"(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

"(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

"(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

"(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

"(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

"(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

"(II) no applicant shall be eligible for a 180-day exclusivity period.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term "decision of a court" as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 704. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

"(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

"(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action."; and

(2) by adding at the end the following:

"(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.".

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 705. REMEDIES FOR INFRINGEMENT.

Section 287 of title 35, United States Code, is amended by adding at the end the following:

"(d) CONSIDERATION.—In making a determination with respect to remedy brought for infringement of a patent that claims a drug or a method or using a drug, the court shall consider whether information on the patent was filed as required under 21 U.S.C. 355 (b) or (c), and, if such information was required to be filed but was not, the court may refuse to award treble damages under section 284.".

SEC. 706. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking "(j)(5)(D)(ii)" each place it appears and inserting "(j)(5)(F)(ii)";

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking "(j)(5)(D)" each place it appears and inserting "(j)(5)(F)"; and

(3) in subsections (e) and (l), by striking "505(j)(5)(D)" each place it appears and inserting "505(j)(5)(F)".

TITLE VIII—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 801. IMPORTATION OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

"SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

"(a) DEFINITIONS.—In this section:

"(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

"(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

"(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

"(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

"(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

"(C) an infused drug (including a peritoneal dialysis solution);

"(D) an intravenously injected drug; or

"(E) a drug that is inhaled during surgery.

"(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

"(5) WHOLESALER.—

"(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

"(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

"(b) REGULATIONS.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

"(c) LIMITATION.—The regulations under subsection (b) shall—

"(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

"(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

"(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a

means to facilitate the importation of prescription drugs.

"(d) INFORMATION AND RECORDS.—

"(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

"(A) The name and quantity of the active ingredient of the prescription drug.

"(B) A description of the dosage form of the prescription drug.

"(C) The date on which the prescription drug is shipped.

"(D) The quantity of the prescription drug that is shipped.

"(E) The point of origin and destination of the prescription drug.

"(F) The price paid by the importer for the prescription drug.

"(G) Documentation from the foreign seller specifying—

"(i) the original source of the prescription drug; and

"(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

"(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

"(I) The name, address, telephone number, and professional license number (if any) of the importer.

"(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

"(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

"(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

"(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

"(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

"(i) is approved for marketing in the United States; and

"(ii) meets all labeling requirements under this Act.

"(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

"(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

"(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

"(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

"(e) TESTING.—The regulations under subsection (b) shall require—

"(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

"(2) if the tests are conducted by the importer—

"(A) that information needed to—

"(i) authenticate the prescription drug being tested; and

"(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

"(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

"(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

"(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

"(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

"(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

"(i) PROHIBITION OF DISCRIMINATION.—

"(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

"(2) DISCRIMINATION.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

"(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

"(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

"(j) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

"(k) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—

"(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

"(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

"(B) exercise discretion to permit individuals to make such importations in circumstances in which—

"(i) the importation is clearly for personal use; and

"(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

"(2) WAIVER AUTHORITY.—

"(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

"(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

"(3) DRUGS IMPORTED FROM CANADA.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

"(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

"(B) is accompanied by a copy of a valid prescription;

"(C) is imported from Canada, from a seller registered with the Secretary;

"(D) is a prescription drug approved by the Secretary under chapter V;

"(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

"(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

"(l) STUDIES; REPORTS.—

"(1) BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES.—

"(A) STUDY.—

"(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

"(I) importations of prescription drugs made under the regulations under subsection (b); and

"(II) information and documentation submitted under subsection (d).

"(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—

"(I) evaluate the compliance of importers with the regulations under subsection (b);

"(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

"(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

"(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(2) BY THE COMPTROLLER GENERAL.—

"(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

"(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

"(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

"(n) EFFECTIVENESS OF SECTION.—

"(1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

"(2) PROCEDURE.—The Secretary shall not submit a certification under paragraph (1) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

"(A)(i) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

"(ii) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

"(iii) identifies specifically the causes of the increased risk; and

"(iv)(I) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

"(II) if the Secretary determines that any measures described in subclause (I) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

"(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

"(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

"(ii) determines that the benefits do not outweigh the detriment.

"(o) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.".

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking "covered product in violation of section 804" and inserting "prescription drug in violation of section 804"; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(a)" and inserting "prescription drug under section 804(b)".

(c) CONDITIONS.—This section shall become effective only if the Secretary of Health and Human Services certifies to the Congress that the implementation of this section will—

(1) pose no additional risk to the public's health and safety; and

(2) result in a significant reduction in the cost of covered products to the American consumer.

TITLE IX—DRUG COMPETITION ACT OF 2003

SEC. 901. SHORT TITLE.

This title may be cited as the "Drug Competition Act of 2003".

SEC. 902. FINDINGS.

Congress finds that—

(1) prescription drug prices are increasing at an alarming rate and are a major worry of many senior citizens and American families;

(2) there is a potential for companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs to enter into financial deals that could tend to restrain trade and greatly reduce competition and increase prescription drug expenditures for American citizens; and

(3) enhancing competition among these companies can significantly reduce prescription drug expenditures for Americans.

SEC. 903. PURPOSES.

The purposes of this title are—

(1) to provide timely notice to the Department of Justice and the Federal Trade Commission regarding agreements between companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs; and

(2) by providing timely notice, to enhance the effectiveness and efficiency of the enforcement of the antitrust and competition laws of the United States.

SEC. 904. DEFINITIONS.

In this title:

(1) ANDA.—The term "ANDA" means an Abbreviated New Drug Application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(aa)).

(2) ASSISTANT ATTORNEY GENERAL.—The term "Assistant Attorney General" means the Assistant Attorney General in charge of the Antitrust Division of the Department of Justice.

(3) BRAND NAME DRUG.—The term "brand name drug" means a drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)).

(4) BRAND NAME DRUG COMPANY.—The term "brand name drug company" means the party that received Food and Drug Administration approval to market a brand name drug pursuant to an NDA, where that drug is the subject of an ANDA, or a party owning or controlling enforcement of any patent listed in the Approved Drug Products With Therapeutic Equivalence Evaluations of the Food and Drug Administration for that drug, under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)).

(5) COMMISSION.—The term "Commission" means the Federal Trade Commission.

(6) GENERIC DRUG.—The term "generic drug" means a product that the Food and Drug Administration has approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(7) GENERIC DRUG APPLICANT.—The term "generic drug applicant" means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(8) NDA.—The term "NDA" means a New Drug Application, as defined under section 505(b) et seq. of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b) et seq.)

SEC. 905. NOTIFICATION OF AGREEMENTS.

(a) IN GENERAL.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(2)(vii)(IV)) and a brand name drug company that enter into an agreement described in paragraph (2), prior to the generic drug that is the subject of the application entering the market, shall each file the agreement as required by subsection (b).

(2) DEFINITION.—An agreement described in this paragraph is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the subject of the generic drug applicant's ANDA;

(B) the manufacture, marketing or sale of the generic drug that is the subject of the generic drug applicant's ANDA; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(B)(iv)) as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) FILING.—

(1) AGREEMENT.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any such agreement, except that the generic drug applicant and the brand-name drug company shall not be required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

(2) OTHER AGREEMENTS.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any other agreements not described in subsection (a)(2) between the generic drug applicant and the brand name drug company which are contingent upon, provide a contingent condition for, or are otherwise related to an agreement which must be filed under this title.

(3) DESCRIPTION.—In the event that any agreement required to be filed by paragraph (1) or (2) has not been reduced to text, both the generic drug applicant and the brand name drug company shall file written descriptions of the non-textual agreement or agreements that must be filed sufficient to reveal all of the terms of the agreement or agreements.

SEC. 906. FILING DEADLINES.

Any filing required under section 5 shall be filed with the Assistant Attorney General and the Commission not later than 10 business days after the date the agreements are executed.

SEC. 907. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Assistant Attorney General or the Commission pursuant to this title shall be exempt from disclosure under section 552 of title 5, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. 908. ENFORCEMENT.

(a) CIVIL PENALTY.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this title shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this title. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section

16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) COMPLIANCE AND EQUITABLE RELIEF.—If any brand name drug company or generic drug applicant fails to comply with any provision of this title, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Commission.

SEC. 909. RULEMAKING.

The Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5 United States Code, consistent with the purposes of this title—

(1) may define the terms used in this title;

(2) may exempt classes of persons or agreements from the requirements of this title; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this title.

SEC. 910. SAVINGS CLAUSE.

Any action taken by the Assistant Attorney General or the Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this title shall not bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant at any time under any other provision of law, nor shall any filing under this title constitute or create a presumption of any violation of any antitrust or competition laws.

SEC. 911. EFFECTIVE DATE.

This title shall—

(1) take effect 30 days after the date of enactment of this title; and

(2) shall apply to agreements described in section 905 that are entered into 30 days after the date of enactment of this title.

Amend the title so as to read: "An Act to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes.".

The PRESIDING OFFICER. The passage of S. 1 is vitiated and the bill is placed back on the calendar.

ORDERS FOR TUESDAY, JULY 8, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:30 a.m., Tuesday, July 8. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then begin a period of morning business until 11:30 a.m., with the time equally divided between the two leaders or their designees; provided that at 11:30 a.m., the Senate proceed to executive session to consider Executive Calendar No. 227, the nomination of David Campbell to be a U.S. District Judge for the District of Arizona, and that the time until 11:45 a.m. be equally divided between the chairman and ranking member of the Judiciary Committee or their designees.

I further ask unanimous consent that the Senate recess from 12:30 p.m. to 2:15 p.m. for the weekly party lunches.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Mr. President, for the information of all Senators, tomorrow the Senate will be in a period of morning business until 11:30 a.m. Following morning business, the Senate will begin up to 15 minutes of debate on the nomination of David Campbell to be a U.S. District Judge for the District of Arizona. At 11:45 a.m., the Senate will vote on the Campbell nomination. Immediately following that vote, the Senate will proceed to a vote on the motion to invoke cloture on the nomination of Victor Wolski to be a judge of the U.S. Court of Federal Claims. Therefore, the first vote in tomorrow's session will occur at 11:45 a.m. That vote will be the first of two back-to-back votes.

For the remainder of the day, the Senate will resume debate on the motion to proceed to S. 11, the Patients First Act. A short while ago, I filed a cloture motion on the motion to proceed to the bill and that cloture vote will occur on Wednesday.

In addition to debating the motion to proceed tomorrow, the Senate may proceed to any Executive Calendar item that can be cleared for action. Therefore, Senators should anticipate additional votes during tomorrow's session.

I thank the distinguished majority whip for his leadership on managing the attempt to proceed to the underlying bill today. The debate, I thought, was superb. I outlined a number of the issues that we should aggressively be addressing on the floor of the Senate for the benefit of the American people.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. FRIST. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 7:16 p.m., adjourned until Tuesday, July 8, 2003, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate July 7, 2003:

DEPARTMENT OF DEFENSE

JAMES G. ROCHE, OF MARYLAND, TO BE SECRETARY OF THE ARMY, VICE THOMAS E. WHITE, RESIGNED.

DEPARTMENT OF STATE

JEANE J. KIRKPATRICK, OF MARYLAND, FOR THE RANK OF AMBASSADOR DURING HER TENURE OF SERVICE AS REPRESENTATIVE OF THE UNITED STATES OF AMERICA ON THE HUMAN RIGHTS COMMISSION OF THE ECONOMIC AND SOCIAL COUNCIL OF THE UNITED NATIONS.

DONALD K. STEINBERG, OF CALIFORNIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE FEDERAL REPUBLIC OF NIGERIA.

DEPARTMENT OF JUSTICE

FEDERICO LAWRENCE ROCHA, OF CALIFORNIA, TO BE UNITED STATES MARSHAL FOR THE NORTHERN DISTRICT OF CALIFORNIA FOR THE TERM OF FOUR YEARS, VICE JAMES J. MOLINARI, RESIGNED.

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES MARINE CORPS TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. ROBERT M. SHEA, 3652

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

REAR ADM. GARY ROUGHEAD, 6126

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

VICE ADM. JAMES C. DAWSON JR., 7743

IN THE ARMY

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

DAVID A. ARCHER, 3554
JAMES B. BAXTER, 1354
MICHAEL D. BISH, 5004
EDWARD S. CLARK, 9369
LYNN D. FISHER, 0901
FERGAL I. FOLEY, 4415
DEBRA A. SPEAR, 0096

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY DENTAL CORPS, UNDER TITLE 10, U.S.C., SECTIONS 624 AND 3064:

To be major

NATHAN E BAKER, 4151
BRIAN D BARNHART, 3155
MATTHEW K BRUNER, 7929
STEPHANIE CALHOUNJAMISON, 1216
JERRY M CARBONE, 2893
MYUNGSOOK CHO, 9063
SO B CHOI, 9397
STEPHEN E CLARY, 0400
SCOTT P DAY, 8253
EDWARD L DONALDSON, 4149
RUSSELL S EDDY, 8365
KENNETH J ERLEY, 5102
WILLIE R FAISON, 6451
ROBERT N GALBREATH, 9057
CRAIG M GAYTON, 9915
MICHAEL J GLIDDON, 4626
MARRERO J GONZALEZ, 2212
BRETT H HENSON, 1771
TYLER J INGERSOLL, 8677
FAISON T JONES, 9458
MICHAEL R KERTES, 9833
NEIL E MOREY, 1623
SANDRA N MUOGHALU, 8789
TODD E PIENKOS, 4792
RODNEY R RICHARDS, 8127
DAVID C SCHAEFER, 6911
YILDIZTERESA SILTA, 2401
YUN U SONG, 3011
JASON C STRANGE, 9227
MICHAEL S TROUT, 7642
RYAN J WANG, 6498
FREDERICK V WRIGHT, 0686

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY AND FOR REGULAR APPOINTMENT IN THE DENTAL CORPS (IDENTIFIED BY AN ASTERISK(*)) UNDER TITLE 10, U.S.C., SECTIONS 624, 531, AND 3064:

To be lieutenant colonel

LISA M *ANDERSON, 2388
CHRISTOPHER L *ARNHEITER, 6537
SHAN K *BAGBY, 4504
DAVID R *BEANLAND, 4593
HOWELL I *BEARD, 7954
JEFFREY G *CHAFFIN, 7914
PETER H *GUEVARA, 8522
ROBERT W *HEROLD, 9111
JAMES M *HOWELL III, 6617
SHAUN L *KANION, 8076
COLLINS T *LYONS, 6189
DAVID V *MALAVE, 5649
KATHLEEN *MCNALLY, 0271
RAMON E *MELENDEZ, 5891
GRANT K *NAKASHIMA, 0222
GEN B *PAEK, 0394
DIANNE D *PANNES, 8640
CHRISTOPHER D *PERRIN, 2976
MICHAEL L *ROBERTS, 7753
ALFRED J *TERP, 5395

ANTHONY S *THOMAS, 6945
JAMES W *TURONIS, 5568

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL CORPS AND FOR REGULAR APPOINTMENT (IDENTIFIED BY AN ASTERISK(*)) UNDER TITLE 10, U.S.C., SECTIONS 624, 531, AND 3064:

To be lieutenant colonel

BRETT T *ACKERMANN, 1069
ALEXANDER D *ALLAIRE, 8437
ANTHONY W *ALLEN, 7636
PEDRO *ARCHEVALD, 7010
KRISTEN C BARNER, 7154
ROSS BARNER, 5681
PATRICK J BENNETT, 2146
MARY J BORSES, 7126
FRED H *BRENNAN JR., 6333
CHRISTOPHER M *BRIAN, 9565
NORI Y BUISING, 7981
CHRISTOPHER P *CANNON, 0023
RICHARD L *CATALAN, 6700
TIMOTHY T *CHANG, 2907
MICHAEL K *CHINN, 5840
FRANCIS M *CHIRICOSTA, 9659
FRANK L *CHRISTOPHER, 4556
MATHEW H *CHUNG, 9097
CYNTHIA L CLAGETT, 8811
DAVID B CLINE, 3240
TERESA A *COLEMAN, 3379
JAN M COMBS, 8770
WILLIAM C CONNER, 0450
PATRICK J CONTINO, 7356
MARICELA *CONTRERAS, 1083
JOHN W *COURSEY, 8300
JOHN J *CRAWFORD, 9345
MARK H CROLEY, 1629
TELITA CROSLAND, 5864
MARTIN P *CURRY, 5966
LEONARD E *DEAL, 3203
JOSE C *DEHOYOS, 1023
DIANE *DEVITA, 2725
KEVIN D DEWEBER, 3586
PHILIP A *DINAUER, 4321
DARREL W *DODSON, 7898
MARIE A DOMINGUEZ, 5386
MICHAEL E DOYLE, 3203
ETHAN E EMMONS, 1698
JOHN J *FAILLACE, 6987
CYDNEY L *FENTON, 6946
GINAMARIE *FOGLIA, 2561
DIMITRY A FOMIN, 2676
JOHN T FRIEDLAND 5830
MICHAEL S FRIEDMAN, 8830
MARK M *FUKUDA, 8936
MATTHEW D *GILMAN, 1329
JOHN E *GLORIOSO JR., 2159
ALFRED C *GORMAN, 9820
BLAKE D GRAHAM, 6249
JOHNNIE A *HAM, 1354
MICHAEL T *HANDRIGAN, 6828
BRIAN K *HARRIS, 7040
WILLIAM B *HENGHOLD II, 2871
ANTHONY D *HIRTZ, 8180
JOHN D *HORWHAT, 6250
JAMES W *HOWARD, 7947
JOHN P *HUSAK, 2419
SUSAN N *ISHIKAWA, 0180
LUKE S *JANOWIAK, 9334
NIEL A JOHNSON, 0364
SCOTT J JOHNSON, 1075
SCOTT M *KAMBISS, 9869
BETTY S *KIM, 1040
ROSALYNN K *KIM, 7302
MICHAEL E *KIRK, 1699
JORGE O *KLAJNBART, 1748
BRIAN N KRAVITZ, 5437
MICHELLE B KRAVITZ, 8266
MICHAEL D *KWAN, 6918
ROBERT K LATHER, 0810
GREGORY Y LEE, 8740
SUNMEE *LEE, 2667
JONATHAN G *LEONG, 7159
JOHN A *LINFOOT JR., 4142
FORREST *LITTLEBIRD JR., 0053
ROBERT H LUTZ, 8196
ARTHUR G *LYONS, 2673
KENDELL L *MANN, 9106
BARRY D *MARTIN, 8173
MATTHEW M *MCCAMBRIDGE, 8539
ROBERT T MCCLELLAND, 7147
DAVID E *MCCUNE, 9267
MARK A MCGRAIL, 9199
TIMOTHY P *MCHENRY, 6912
JOHN G *MCMANUS JR., 2368
JOHN S *MILIZIANO, 6335
MICHAEL A MILLER, 7394
MICHAEL C *MOORE, 2577
GEORGINA L *MURRAY, 2976
ANNE L NACLERIO, 4473
MARK L NELSON, 9069
JOEL B *NILSSON, 2261
SUSAN *NOE, 7420
KEVIN C *OCONNOR, 2660
ERIC J *ORMSETH, 6008
KEVIN J *OSHEA, 6836
NICOLE M OWENS, 1023
JOHN M PALMER, 0617
ROSANGELA *PARSONS, 3387
JOHN F *PAYNE, 9532
ANDRE M *PENNARDT, 5486
MARK E *POLHEMUS, 8376
JOHN R *PRAHINSKI, 0858
BRET K *PURCELL, 4825
DANA K RENTA, 5316
MATTHEW S RETTKE, 0567
MARYJO K ROHRER, 6362
DANIEL S ROY, 1894
ROBERT S *RUDOLPHI, 2431
JEFFREY S *SAENGER, 3509
STEVEN D *SIDES, 2346
DAVID A SIEGEL, 3557
DANIEL E *SIMPSON, 9443
JOHN A SMYRSKI III, 1965
DOUGLAS M SORENSEN, 7610
H *SPRING, JR 3150
BENJAMIN W *STARNES, 4734
JEREMIAH *STUBBS, 9938
RICHARD D *STUTZMAN, 9447
GREGORY P *THIBAULT, 1946
JENNIFER C *THOMPSON, 5707
NATHAN *TILLOTSON, 3937
JEANNE K TOFFERI, 2687
JAMES S *WADDING, 1050
HARLAN M *WALKER II, 3313
JAMIE K WASELENKO, 7929
GREGORY P *WELCH, 2285
ALLEN C *WHITFORD JR., 7113
DONNA C *WHITNEY, 7977
DAVID J WILKIE, 6903
CHRISTOPHER J *WILSON, 2231
FRANKLIN H WOOD, 6664
JOSEPH C *WOOD, 0303
MICHAEL J *ZAPOR, 1962

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL CORPS UNDER TITLE 10, U.S.C., SECTIONS 624 AND 3064:

To be major

ADIO ABDU, 6153
FRANCISCO J ALBERT, 3826
GREGORY D ALES, 3277
NOEL C ALES, 7241
JAMES A ALFORD, 8845
COLEMAN E ALTMAN, 7412
MADHUMITA ANANTHAKRISHNAN, 2585
DAVID E ANDRUS, 3464
JAYSON D AYDELOTTE, 0344
FIONA O AZUBUIKE, 8335
DOUGLAS A BADZIK, 7621
REGINALD L BAKER, 1459
LESLEE I BALL, 8666
KEVIN P BANKS, 6521
DARRELL J BARANKO, 7962
STEVEN J BAUER, 2528
THERESA A BENCHOFF, 7303
ADAM J BENSON, 6757
MARY T BERNARD, 9608
REONO BERTAGNOLLI, 2111
GLENN T BESSINGER, 4953
DANIEL P BIGLEY, 7023
DANIELLE N BIRD, 9730
JASON R BOOLE, 8131
CHRISTOPHER G BOQUIST, 7226
CHRISTOPHER C BRAGA, 6152
PREETINDER BRAR, 7018
ROGER D BROCKBANK, 0421
ADAM G BUCHANAN, 6031
CHARLES P BUCK, 9529
DAVID W BUNDY, 8229
JEANETTE R BURGESS, 5857
RICARDO M BURGOS, 4675
ROBERT E BURNETTE JR., 6393
MARK G CARMICHAEL, 0123
AUTUMN H CAYCEDO, 0090
MARIO CAYCEDO, 0663
JAMES H CHANG, 9933
RODNEY C CHARLES, 6714
MATTHEW A CODY, 3357
MARC A COOPER, 9132
JOHN D CRAMER, 3186
JAMES V CRAWFORD, 0262
SANTO J CRESPO, 0112
PETER J CUENCA, 4415
STEVEN J CURRIER, 3959
BRIAN B CUSHING, 9255
SCOTT R DALTON, 0186
CHRISTINE M DALY, 2209
JASON L DAVIS, 0708
KEPLER A DAVIS, 2552
MICHAEL DAVIS, 6302
MICHAEL D DAVIS, 1040
ROBERT W DAVIS, 0150
TIMOTHY C DAWSON, 8772
HERBERT A DAY, 6868
ALAN J DEANGELO, 9400
MATTHEW J DEETER, 5873
GERALD T DELK, 1761
MARIA DICARLANTONIO, 7960
TIMOTHY J DICKASON, 7214
JAMES A DICKERSON II, 5080
MINHLUAN N DOAN, 5666
KRISTIN J DOBAY, 8226
MARTIN DOPERAK, 4433
MARTEN B DUNCAN, 6791
ROBERT E ECKART, 5870
MARY E EDGECOMB, 1606
JESS D EDISON, 8025
HERBERT C EIDT, 6680
ANTHONY R ELIAS, 8383
ALICIA A ELMORE, 2424
LAURENCE D FINE, 6833
LISA M FOGLIA, 3000
JANIS L FOLLWELL, 6105
NEOMIE H FRIEDMAN, 4777
ERIC R FRIZZELL, 1479
CHERYL FULTON, 0130
DAVID Y GAITONDE, 4747
CARLOS A GARCIA, 0547
VINAYA A GARDE, 5087
ROBERT P GARNETT JR., 6411
BABETTE GLISTERCARLSON JR., 8652
JOHN GODINO JR., 2892
EDUARDO R GODOY, 6585
RODNEY S GONZALEZ, 4501
JENNIFER L GOTKIN, 8618
SCOTT R GRIFFITH, 7614
ROBERT J GUSTAFSON, 7034
DAVID D HAIGHT, 1350
CHARLES G HAISLIP, 1501
CHAD A HALEY, 6771
CHRISTOPHER S HALL, 9002
KATRINA D HALL, 3181
MARK A HALL, 4605
MARC R HAPPE, 4073
MOHAMAD I HAQUE, 0134
CLAYTON HARGIS, 7431
SCOTTE R HARTRONFT, 1289
DUANE R HENNION, 7554
JENNIFER B HENSING, 7108
ANNA D HOHLER, 1809
MICHAEL S HOOKER, 0782
AARON Z HOOVER, 0173
LANCE R HOOVER, 4056
MITCHELL F HOWO, 1045
CHRISTOPHER W HUMPHREYS, 3793
JON R JACOBSON, 0183
CLAIRE S JENKINS, 5327
ANTHONY E JOHNSON, 8117
CHRISTINE L JOHNSON, 0079
CHRISTOPHER M JOHNSON, 1612
JEREMIAH J JOHNSON, 0062
DANIEL T JOHNSTON, 4193
CHERYL H JORDAN, 4888
ALINA A JOYCE, 5775
DANIEL B JUDD, 2688
JEFFREY A KAHL, 1681
ANDREW C KIM, 9010
ANN KIM, 3036
SAM Y KIM, 3911
CHRISTOPHER J KOCHAN, 7015
CATHERINE L KODAMA, 4268
FAITH L KOSCHMANN, 1662
PAUL W KRANTZ, 6562
MICHAEL V KRASNOKUTSKY, 0300
GENE L KRISHINGNER, 6911
ADAM J LABORE, 5730
CRAIG S LABUDA, 9687
MICHAEL T LAKE, 9781
STEVEN J LALLISS, 6443
JENNIFER M LANE, 0175
CHRISTINE E LANG, 8932
JANET C LARSON, 2435
PENNY L LARSON, 0621
CHARLOTTE M LEE, 4829
EVAN H LEE, 3801
JAMES R LEE, 9009
CHRISTINE N LEGLER, 3473
PETROS G LEINONEN, 2800
CHRISTINE F LETTIERI, 9036
CHRISTOPHER J LETTIERI, 9223
JEFFREY A LEVY, 3816
ROBERT D LEWIS, 8746
PETER A LINDENBERG, 2073
COLIN A LINEHAN, 0905
RAULIE H LO, 5361
YINCE LOH, 1413
GRANT C LYNDE, 9907
JOSEPH C MACDONALD, 2554
CHRISTINA B MAIER, 2638
CHETAN P MAINGI, 1969
MARSHALL J MALINOWSKI, 6270
JAMES D MANCUSO, 4492
BRYANT G MARCHANT, 7393
JONATHAN E MARTIN, 3136
NICHOLAS A MARTYAK, 2144
MATTHEW L MASTERSON, 6079
LAWRENCE N MASULLO, 9336
CHRISTOPHER J MATHEWS, 1603
KATHERINE A MATHEWS, 8087
DOUGLAS MAURER, 7573
JAMES R MAXWELL JR., 7230
DEAN L MAYNARD, 6980
RICHARD V MAZZAFERRO, 8667
STEWART C MCCARVER, 3242
GAYLE P MCDERMOTT, 0983
CRAIG C MCFARLAND, 9657
CRAIG H MCHOOD, 2116
BRIAN T MCKINLEY, 1536
JOEL W MCMASTERS, 5704
COLIN A MEGHOO, 5491
WILLIAM A MERCANTI JR., 6078
CECILIA P MIKITA, 1245
MARIA C MOJICAOROURKE, 3102
MEREDITH L MONA, 0549
SCOTT C MORAN, 0508
TOMMY J MORGAN, 7017
PABLO M MOUJAN, 1497
MONICA D MURDOCHCUENCA, 7785
JEFFREY B MUSSER, 4188
OTHA MYLES, 4450
HONGHUNG D NGUYEN, 0451
MARK W NOLLER, 0133

MEGAN M OBRIEN, 8450
SETH D OBRIEN, 7591
MARK S OCHOA, 6116
JOHN S OH, 8441
ROBERT C OH, 3627
LISA J OLSEN, 7767
LYLE J ONSTAD, 4916
ERIK OSBORN, 5454
CLIFTON S OTTO, 2560
LAURA A PACHA, 4172
ELLEN L PARTRICH, 9816
MAUREEN M PETERSEN, 9990
SCOTT M PETERSEN, 6464
MICHAEL PIESMAN, 4257
JEFFREY D PINCO, 2066
MARK D PORTER, 9796
MARTIN T PREEN, 9996
ROBERT C PRICE, 9552
CHRISTOPHER M PRIOR, 5589
SHELLEY A QUARLESS, 6120
ELDEN RAND, 2545
JOSEPH W REARDON, 3239
RUTH A REARDON, 9611
KYLE N REMICK, 2151
THOMAS B REPINE, 9619
III G RESTA, 1819
JOEL C REYNOLDS, 6533
ANTHONY K RICE, 1616
TRAVIS B RICHARDSON, 8012
KYLE W RICKNER, 2881
GADDIEL D RIOS, 6181
WAYNE L ROSEN, 0968
JASON E ROTH, 0036
ERIK J RUPARD, 5205
HAYRI E SANGIRAY, 0350
GEORGE T SAWABINI, 9812
JOHN D SCHABER, 6401
GREGORY A SCHERLE, 9696
CARRIE L SCHMITT, 9871
ERIK P SCHOBITZ, 1640
BETH A SCHULZBUTULIS, 9182
RAFAEL A SCHULZE, 4253
JENIFER L SCHWARZ, 0255
ROBERT SETLIK, 3257
JAMES F SIMON, 4475
ERIC B SMITH, 8509
REGINALD M SMITH, 6976
SIDNEY B SMITH, 6113
RODNEY J SPARKS, 8531
JONATHAN R STABILE, 7759
MICHAEL G STANLEY, 0091
CRAIG G STARK, 3745
MICHAEL J STARKEY, 2029
SCOTT R STEELE, 8139
BENJAMIN J STEVENS, 8145
DARRELL T STOCK, 4101
ANN M STRAIGHT, 8342
TIMOTHY M STRAIGHT, 1971
WILLIAM J STRIMEL, 1990
ANTHONY SULLIVAN, 5956
MARY P SULLIVAN, 9453
MOLLY A SZERLIP, 6601
TING J TAI, 8289
SHAWN F TAYLOR, 0705
CHRISTOPHER E TEBROCK, 2943
MELISSA J TEBROCK, 1912
SIMON H TELIAN, 8297
RENEE Q THAI, 4398
DANA L THOMAS, 4482
FRED N THOMAS III, 0117
JON C THOMPSON, 8611
WILLIAM L THOMPSON, 3832
JOSHUA A TOBIN, 7723
JOMARI S TORRES, 2683
ALEXANDER G TRUESDELL, 6715
VU TRUONG, 5588
CREIGHTON C TUBB, 4220
DANIEL L TURNER, 5847
TIMOTHY M UENG, 3540
FRANK E VALENTIN, 9310
MICHAEL K VAUGHAN, 8463
TRICIAMAY C VILLANUEVA, 4870
FELIPE D VILLENA, 1058
RODNEY C WADLEY, 1702
WENDI M WAITS, 2894
MATTHEW C WAKEFIELD, 8970
PAUL J WALTING, 9047
RICHARD D WARREN, 9156
ERIN L WASHBURN, 0135
MICHAEL B WATTO, 7656
BRENDAN M WEISS, 7623
JANINE G WEST, 1725
DEREK C WHITAKER, 5244
ANNETTE S WILLIAMS, 3840
JOHN K WILSON, 0421
JENNIFER S WINK, 9193
ROBERT N WOODMORRIS, 5375
AMY L YOUNG, 1646
RICARDO M YOUNG, 9035

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

DAVID A BARR, 4442
FRANK E BROWN, 5239
CRAIG A CANDELORE, 3375
CHRISTIAN C CHATFIELD, 1342
WAYNE A CHRISTIAN II, 8450
ROBERT J DANNEMILLER, 9833
CHARLES P DONAGHEY, 3083
FREDERICK R FOWLER, 8332
WALTER H FREDERICK III, 2639
JOHN FRIEDLANDER, 0555
RICHARD R GAARD, 3294
BRIAN J GEORGE, 1612
DAVID K GILBERT, 5113
JON H GOLD, 2709
PETER A GOLDMAN, 5224
HARRIS B I HOLTMAN, 1165
JAMES T HORNSTEIN, 1288
ROY H HOULTON JR., 5328
DANA B HOWARTH, 2024
JOHN P KACSAN JR., 2526
JEFFREY R KEANE, 5277
ROBERT B KELSO, 6053
ARTHUR L KITT, 4737
ROBERT G KOVAL, 1525
RANDALL E MATHEWS, 1865
CHERYL K MOORE, 1780
LAURENCE C NELSON, 8064
JOHN NYE, 3223
MARTIN J OCHSNER, 6642
JOSEPH E PAQUIN, 8720
JAMES P PIERSON, 3993
PETER M PIETROWSKI, 5295
EVIN D PLANTO, 0426
JOHN R RAGLAND, 1326
MITCHELL C SARTAIN, 1380
ROBIN S SPOFFORD, 9548
JAMES A WIEGEL, 0681
ANTHONY L YELDELL, 9176
SAMUEL R YOUNG, 3299

EXTENSIONS OF REMARKS

HONORING FUTURE "FROST" DAVIS

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, July 7, 2003

Mr. RADANOVICH. Mr. Speaker, I rise today to recognize Mr. Future "Frost" Davis. Mr. Davis is going to celebrate his 100th birthday on July 17, 2003.

Future "Frost" Davis was born on July 17, 1903, in Lubbock, Texas, to Mattie Ella Townsend and Charles Lee Davis. Mr. Davis attended California Christian College, now Chapman College, and graduated in 1931 with a degree in Interior Design. While in college, he was the president of the Art Club, Student Body Treasurer, member of the Chi Phi Omega fraternity and the art editor of the yearbook.

On June 23, 1933, Mr. Davis married Marjorie Wirt Jones. He then married Wilda Marie Collins in 1962. They moved to Oakhurst in 1970 and have lived there ever since. He has two children and two grandchildren. Most of Mr. Davis' life has been spent being an interior designer. His hobbies include dancing, woodworking and since his retirement he has become an accomplished watercolor painter. Mr. Davis' life has been filled with accomplishment and enjoyment. His motto is "Life is good if you don't weaken."

Mr. Speaker, I urge my colleagues to join me in wishing all the best to Mr. Future "Frost" Davis on the occasion of his 100th birthday.

IN MEMORY OF RICHARD "DICK" MORGAN, RETIRED EXECUTIVE DIRECTOR OF FHWA

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Monday, July 7, 2003

Mr. WOLF. Mr. Speaker, I want to share with our colleagues the recent passing of Richard D. "Dick" Morgan, who retired in 1989 as executive director of the Federal Highway Administration (FHWA), the highest civil service post in the FHWA. He died on June 18 at a hospital in Easton, MD, following a year long battle with leukemia. He was 69.

Many of our colleagues who have been here for a while will remember Dick Morgan as the highway expert who helped steer the reauthorization of the federal highway program in 1982, which included a motor fuel tax increase, the first in more than two decades, to fund repairs for what was described then as the nation's crumbling highways and bridges.

Mr. Morgan received a B.S. degree in civil engineering, graduating with honors from Michigan State University in 1956. The following year he began his federal career as a highway engineer trainee with the Bureau of Public Roads, the FHWA's predecessor agency. Except for a stint in the U.S. Army from 1957–58, he stayed with the agency until he retired.

Over the years, Dick Morgan, a registered professional engineer, held a variety of positions at FHWA. After serving in the Arkansas, Ohio, and Texas divisions, he joined the Washington headquarters staff in 1972 as chief of Special Procedures Branch in the Federal-Aid Division. He became chief of that division and later was name director of the Office of Highway Planning before being appointed associate administrator for engineering and operations in 1979. In that slot, he helped develop a program that saved $225 million in bridge construction costs and shepherded a national traffic signal timing demonstration program, which has been credited with saving millions of gallons of fuel.

After assuming the executive director position in 1982, Dick Morgan is widely credited with helping to move the FHWA from an era of highway expansion to an era of highway preservation. He was one of the originators and strongest supporters of the Strategic Highway Research Program developed to identify pavement design and maintenance techniques that work—and those that don't work. That program has evolved over the years to help highway agencies across the nation provide smoother, longer lasting roads.

Mr. Morgan also was a strong backer of innovative techniques for increasing highway capacity, such as "smart" highways, surveillance systems, and computer applications which today are working to reduce traffic congestion in the nation's urban areas.

Having played a major role in the construction of the National System of Interstate and Defense Highways, Dick Morgan was deeply involved in the FHWA's efforts to plan for the post-Interstate era. With the Interstate program coming to an end in the 1990's, he formed a "Futures Task Force" to identify and study alternatives for the Department of Transportation's legislative initiatives and also worked with organizations such as the American Association of State Highway and Transportation Officials to develop post-Interstate proposals.

Dick Morgan received many honors during his career. His first recognition was a cash award in 1959. Over the years, he received the Secretary's Award for Superior Achievement (1974), the Senior Executive Service Performance Award on several occasions, and the Federal Highway Administrator's Award for Superior Achievement (1983). In 1982, he received the Presidential Rank Award of Meritorious Executive and in 1987 he was given the President Rank Award of Distinguished Executive. The American Public Works Association recognized Mr. Morgan as one of the Top Ten Public Works Leaders of the Year in 1988.

When he retired from the FHWA in 1989, he became vice president of the National Asphalt Pavement Association in Washington, where he remained until 1998.

Mr. Morgan was born in Cleveland and raised in Royal Oak, MI. In addition to his degree from Michigan State, he received a J.D. degree from the Capital School of Law in Columbus, Ohio.

After living in Anne Arundel County, MD, he moved in the late 1990s to Maryland's Eastern Shore community of Easton Club. He remained active in the community, volunteering with Habitat for Humanity in Talbot County and the Chesapeake Bay Maritime Museum in St. Michaels, MD, where he was a docent.

He was a member of St. Peter and Paul Catholic Church in Easton, where his funeral service was held on June 25. We express our sympathies to his wife of 45 years, Anna Louise Morgan of Easton, and their three children, Thomas Richard Morgan of Oakland, CA, Karen Ann Yocum of Churchton, MD, and Anthony Patrick Morgan of Liberty, SC, his three brothers, a sister, and three grandchildren.

Mr. Speaker, we remember Dick Morgan as the ultimate professional whose public service career left a legacy of unparalleled achievement, providing the example for those at the Federal Highway Administration today to follow.

IN RECOGNITION OF BROWN COUNTY GENERAL HOSPITAL BEING NAMED ONE OF THE NATION'S TOP 100 HOSPITALS

HON. ROB PORTMAN

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Monday, July 7, 2003

Mr. PORTMAN. Mr. Speaker, I rise today to pay tribute to all of the employees, physicians, and volunteers of the Brown County General Hospital, which was recently recognized as one of the nation's top 100 hospitals according to a study conducted by a leading health care information organization.

The study, 100 Top Hospitals: National Benchmarks for Success, utilized objective and quantitative data collected from over 5,600 hospitals nationwide in its analysis. Hospitals were evaluated in groups based on hospital size and teaching status. Brown County General Hospital, a medium sized hospital, has earned this designation because of its commitment to quality service and continual improvement.

When the hospital was founded in 1952 it was a 50-bed facility providing emergency and maternity care. Since then, the hospital has expanded a great deal, providing the community with the most advanced medical technologies and one of the first home care units

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

in Ohio. Today, the hospital is a 115-bed facility with two regional healthcare centers that offer a wide variety of services to Brown County and the surrounding area. After 50 years of operation, the hospital continues to be a community-owned not-for-profit facility. It is Brown County's largest employer with over 300 employees that are known for their high level of patient care, having been named one of the nation's top patient satisfaction providers.

Mr. Speaker, I hope my colleagues will join me in recognizing Brown County General Hospital for being named one of the nation's top 100 hospitals. All of us in southern Ohio are thankful for the outstanding service and dedication of its employees, volunteers, and community members.

EXPRESSING SUPPORT FOR FREEDOM IN HONG KONG

SPEECH OF

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. HASTINGS of Florida. Mr. Speaker, I rise today to voice my support for H. Res. 277: Expressing Support for Freedom in Hong Kong. This former British colony has been known to many in recent years as one of the world's freest economies due to its low taxes, free trade, and strong rule of law. Mr. Speaker, Hong Kong has recently undergone a number of political changes, which are in opposition to long-held agreements and understandings, which it maintained with its western trading partners.

The government in Beijing is promoting changes in the internal security laws of Hong Kong that will change the basic freedoms in that territory. These laws will restrict distribution of publications and an appointee of the Chinese government, not an elected official, could waive basic fundamental rights of the people.

The Chinese agreed in 1984 through the Sino-British Joint Declaration to explicitly guarantee that all of Hong Kong's freedom, including press freedom, religious freedom and freedom of association will continue for at least 50 years. The Chinese government also has pledged to respect Hong Kong Basic Law of 1990, which explicitly protects freedom of speech, press, publication, association, assembly, procession, demonstration, conscience and religion.

Since July of 1977, Mr. Speaker, the Chinese authorities have gradually chipped away at the freedoms it promised to keep for 50 years. For example, the system of electing representatives to the Legislative Council is less democratic. Appointed members have been added to district councils, and the central government has reversed Hong Kong courts, and declined to admit entry of numerous American visitors and other foreign nationals.

The proposed Article 23 laws that deal with sedition, treason, and subversion against the Chinese Communist Party threaten the rights of the people of Hong Kong. We know China's record in the application of the law to its citizens. This record is one that brings grave concern that China will not administer the laws in Hong Kong in a fair, equitable, and honorable manner.

Mr. Speaker, for all the above reasons, among others, I condemn any restrictions of freedom of thought, freedom of expression, or association in Hong Kong. Furthermore, I strongly urge the People's Republic of China to withdraw the proposed implementation of Article 23 as it affects negatively the freedoms of the people of Hong Kong. I call on President Bush and his Administration, to express to the People's Republic of China the concerns as outlined in H. Res. 277.

TRIBUTE TO BILL BARRETT

HON. LYNN C. WOOLSEY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, July 7, 2003

Ms. WOOLSEY. Mr. Speaker, Mr. THOMPSON of California and I rise today, to recognize Bill Barrett who is retiring this month after twenty-six and a half years with the United States Postal Service.

Mr. Barrett began his career as a letter carrier in Milpitas, California in 1976. In 1978 he worked briefly in his hometown of Yakima, Washington before returning to Milpitas, where he worked until 1985. He spent the last eighteen years of his career in Santa Rosa, California.

During this time Mr. Barrett also served his co-workers as a Trustee of the National Association of Letter Carriers Branch 183 from 1987 to 2002, and as Legislative Liaison from 1994 to 1998. He has also been a District Officer with the California State Association of Letter Carriers from 1998 to the present.

Prior to his career with the USPS, Mr. Barrett was a Staff Sergeant in the United States Air Force and served a tour of duty in Vietnam from 1968 to 1970. He is also active with his military service group, Blind Bat.

Mr. Barrett and his wife, Fran, are very proud of their two daughters, Amy, 26 and Missy, 22.

In his retirement, Mr. Barrett plans to continue his work with persons with special needs and to travel on his new motorcycle, with its special license plate that reads: XMAILMN.

His other hobbies are reading and researching genealogy on his computer.

Mr. Speaker, Bill Barrett has been a dedicated public servant all of his adult life, both in service to his country in the U.S. military and as an employee with the United States Postal Service. It is appropriate that we honor him today for his many contributions.

INTERNET SAFETY

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, July 7, 2003

Mr. CUNNINGHAM. Mr. Speaker, I rise today to recognize I-Safe and the Home Depot for announcing June 2003 as National Internet Safety Month. I-Safe and the Home Depot have teamed up to combat victimization of America's youth on the internet. They have chosen the month of June because it marks the beginning of summer when children spend the most time without supervision and the most time online. I know that we are all aware of the dangers the internet potentially holds, not only to us, but to our families and children as well. This is why I support educating America's citizens about the internet. Each month, forty-eight million children in the United States go online to chat with their friends, play, and/or do research. These children spend a combined five billion hours online each year and the numbers continue to increase. With children spending more time online, predators are presented with more opportunity. One in five children who use chat rooms has received an unwanted solicitation online and this is unacceptable.

We must teach our kids about the serious threats they can face on-line. Recent studies have shown that forty percent of students do not understand the danger of exchanging pictures with strangers they have met on the internet and sixty percent do not understand the danger of meeting a stranger they have met online in person. Often times, parents do not know their children are meeting strangers on-line and this contributes to the problem. Seventy-five percent of parents say they know when their children spend time online, but the majority of teenagers log on right after school, before their parents arrive home. Also, most children who are harassed online do not usually reveal the harassment to their parents because they are afraid their parents may ban computer usage.

Many tend to think that harm on the internet extends only to children, however this is a false assumption. Most adults do not realize their identity can also be easily stolen on the internet. According to the FBI, identity theft has become the fastest growing financial crime in America, simply because a person can be identified based on three things: their date of birth, gender, and zip code. Most importantly, during this turbulent time in our nation's history, education is key to protecting not only personal security, but also national security. Our critical e-infrastructure must be protected from hacking, net vandalism, and virus proliferation.

Thank you for the opportunity to discuss internet safety. I urge other Members to become involved on this issue. The internet has vastly improved our lives and opened the door to a world of opportunity, but with these technological advances comes a great deal of responsibility. Unfortunately, there are people out there who seek to exploit this new medium in communication. I applaud I-Safe's effort to educate children and adults on the internet and will continue to work with this organization to promote internet safety. Thank you.

PERSONAL EXPLANATION

HON. TODD TIAHRT

OF KANSAS

IN THE HOUSE OF REPRESENTATIVES

Monday, July 7, 2003

Mr. TIAHRT. Mr. Speaker, on June 19, I was unavoidably detained and missed rollcall vote No. 296. Rollcall vote No. 296 was on passage of H.R. 660, the Small Business Health Fairness Act of 2003. Had I been present, I would have voted "yea" on H.R. 660.

Also, Mr. Speaker, on June 23, I was unavoidably detained and missed rollcall vote No. 300. Rollcall vote number 300 was on passage of H.R. 2465, the Family Farmer Bankruptcy Relief Act of 2003. Had I been present, I would have voted "yea" on H.R. 2465.

TRIBUTE TO WILLIAM MENNA AS HE CELEBRATES HIS 80TH BIRTHDAY

HON. ROSA L. DeLAURO

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Monday, July 7, 2003

Ms. DELAURO. Mr. Speaker, it is with great pleasure that I rise today to join the many family, friends, and well-wishers who have gathered to extend my sincere congratulations to William Menna—known to friends as "Wild Bill"—as he celebrates his eightieth birthday. This is an important milestone for one of the most well-known and respected of our community leaders.

For "Wild Bill," public service has not been just a job, but a way of life. Born and raised in Derby—Connecticut's smallest city—Bill joined the United States Navy upon graduating. Serving for four years during the World War II, he did tours in both the European and Pacific Theaters. After leaving the service, Bill returned to Connecticut and made a home with his wife, Mary, in Ansonia where they lived happily for almost fifty years before her passing.

For as long as Valley residents can remember, Bill has been involved in both local and state politics. A State Representative, Mayor, and vocal community advocate—Bill's commitment and dedication to his community is unquestioned. He has long been known as one to fight for and give voice to those most in need. In addition to his political life, Bill has also volunteered countless hours to a variety of local service organizations. Currently he serves as a Board member for the Birmingham Group, United Way, Boy Scouts of America, and UNICO. He is a past president of the Rotary Club and has long been a volunteer for the St. Michael's Carnival, St. Mary's Food Festival and Holy Rosary's Food Fiesta. Bill's generosity is seemingly unending and the communities of Derby and Ansonia have truly been blessed to be the beneficiaries of his time, energy, and compassion.

When we speak of the ideal public servant, of what it means to give back to your community, we talk of those who willingly devote their energies to enrich the lives of others. Bill Menna—with his enduring dedication and many years of unparalleled service—is a reflection of the very spirit of public service. His hard work has made a real difference and for that we owe him a debt of gratitude.

Bill has left an indelible mark on this community—he is a true living treasure. I am proud to join all of those gathered today to extend my heart-felt congratulations to William Menna on this his 80th birthday. Happy Birthday! My very best wishes for many more years of health and happiness.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Tuesday, July 8, 2003 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

JULY 9

9:30 a.m.

Armed Services

To hold hearings to examine lessons learned during Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom, and to receive testimony on ongoing operations in the United States Central Command region; followed by a closed session in SH–219.

SH–216

Judiciary

To hold hearings to examine the nominations of James O. Browning, to be United States District Judge for the District of New Mexico, Kathleen Cardone, to be United States District Judge for the Western District of Texas, James I. Cohn, to be United States District Judge for the Southern District of Florida, Frank Montalvo, to be United States District Judge for the Western District of Texas, Xavier Rodriguez, to be United States District Judge for the Western District of Texas, and Rene Acosta, of Virginia, to be an Assistant Attorney General, Department of Justice.

SD–226

Rules and Administration

To hold hearings to examine S. Res. 173, to amend Rule XVI of the Standing Rules of the Senate with respect to new or general legislation and unauthorized appropriations in general appropriations bills and amendments thereto, and new or general legislation, unauthorized appropriations, new matter, or nongermane matter in conference reports on appropriations Acts, and unauthorized appropriations in amendments between the Houses relating to such Acts.

SR–301

Joint Economic Committee

To hold hearings to examine technology and innovation in relation to health care costs.

SD–628

10 a.m.

Indian Affairs

To hold oversight hearings to examine the Indian Gaming Regulatory Act.

SD–106

10:30 a.m.

Appropriations

Homeland Security Subcommittee

Business meeting to markup proposed legislation making appropriations for the Deparment of Homeland Security for the fiscal year ending September 30, 2004.

SD–124

11 a.m.

Appropriations

Interior Subcommittee

Business meeting to markup proposed legislation making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2004.

SD–138

JULY 10

9:30 a.m.

Armed Services

To hold hearings to examine the nominations of Paul Morgan Longsworth, of Virginia, to be Deputy Administrator for Defense Nuclear Nonproliferation, National Nuclear Security Administration, and Thomas W. O'Connell, of Virginia, to be an Assistant Secretary of Defense.

SR–222

Judiciary

Business meeting to consider pending calendar business.

SD–G50

Small Business and Entrepreneurship

Business meeting to markup proposed legislation authorizing appropriations for fiscal year 2004 for Small Business Administration programs.

SR–428A

10 a.m.

Banking, Housing, and Urban Affairs

To hold hearings to examine "The Accuracy of Credit Report Information and the Fair Credit Reporting Act".

SD–538

Energy and Natural Resources

To hold hearings to examine the high price of natural gas, its effect on the economy and to consider potential solutions.

SH–216

2:30 p.m.

Veterans' Affairs

To hold hearings to consider proposed legislation regarding VA-provided benefits programs, including the following: S. 257, S. 517, S. 1131, S. 1133, S. 1188, S. 1213, S. 1239, S. 1281, S. 249, S. 938, S. 1132, S. 792, S. 806, S. 1136, S. 978, S. 1124, S. 1199, S. 1282.

SR–418

Intelligence

To hold closed hearings to examine certain intelligence matters.

SH–219

3:30 p.m.

Health, Education, Labor, and Pensions

Children and Families Subcommittee

To hold hearings to examine proposed legislation authorizing funds for Community Services Block grant programs.

SD–430

JULY 15

9:30 a.m.
Governmental Affairs
To hold hearings to examine castaway children, focusing on whether parents must relinquish custody in order to secure mental health services for their children.
SD–342

10 a.m.
Judiciary
To hold hearings to examine bankruptcy and competition issues in relation to the WorldCom Case.
SD–226

2:30 p.m.
Veterans' Affairs
To hold hearings to receive a report by the National Commander of The American Legion, Ronald F. Conley, of his tenure.
SR–418

JULY 16

10 a.m.
Indian Affairs
To hold hearings to examine S. 556, to amend the Indian Health Care Improvement Act to revise and extend that Act.
SR–485

Governmental Affairs
Oversight of Government Management, the Federal Workforce, and the District of Columbia Subcommittee
To hold hearings to examine the recent General Accounting Office report entitled: "An Overall Strategy and Indicators for Measuring Progress Are Needed to Better Achieve Restoration Goals", focusing on the ramifications of an uncoordinated Great Lakes restoration strategy, current management of various environmental programs, and possible next steps to improve the management of Great Lakes programs.
SD–342

2:30 p.m.
Energy and Natural Resources
To hold hearings to examine the nomination of Suedeen G. Kelly, of New Mexico, to be a Member of Federal Energy Regulatory Commission for the remainder of the term expiring June 30, 2004.
SD–366

JULY 17

9:30 a.m.
Commerce, Science, and Transportation
Business meeting to consider pending calendar business.
SR–253

Governmental Affairs
To resume hearings to examine castaway children, focusing on whether parents must relinquish custody in order to secure mental health services for their children.
SD–342

JULY 22

10 a.m.
Energy and Natural Resources
To hold hearings to examine S. 1314, to expedite procedures for hazardous fuels reduction activities on National Forest System lands established from the public domain and other public lands administered by the Bureau of Land Management, to improve the health of National Forest System lands established from the public domain and other public lands administered by the Bureau of Land Management, and H.R. 1904, to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape; to examine the impacts of insects, disease, weather-related damage, and fires on public and private forest lands. Processes for inplementing forest health and hazardous fuels reduction projects on public and private lands, and processes for implementing forest health and hazardous fuels reduction projects will also be discussed.
Room to be announced

JULY 23

10 a.m.
Indian Affairs
To hold hearings to examine S. 556, to amend the Indian Health Care Improvement Act to revise and extend that Act.
SR–485

Judiciary
To hold oversight hearings to examine certain pending matters.
SD–226

JULY 30

10 a.m.
Indian Affairs
To hold hearings to examine S. 578, to amend the Homeland Security Act of 2002 to include Indian tribes among the entities consulted with respect to activities carried out by the Secretary of Homeland Security.
SR–485

SEPTEMBER 16

10 a.m.
Veterans' Affairs
To hold joint hearings with the House Committee on Veterans' Affairs to receive the legislative presentation of The American Legion.
SH–216

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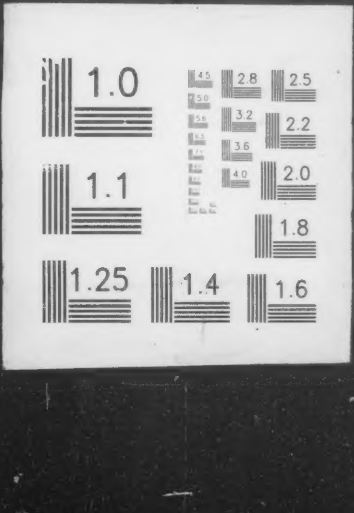
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